Facilities & Services Plan

2020 Supplement

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ACKNOWLEDGEMENTS

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The Office of Health Strategy would like to extend a special thank you to all members of the Statewide Health Care Facilities and Services Plan Advisory Body, which continues to provide valuable insight regarding the evolving healthcare system, operations of healthcare facilities and providers, delivery of services, and access to care in the state. The participants reviewed this Supplement and supplied additional material or provided suggestions on areas to include or clarify to aid better understanding of the delivery of and access to care environment.

In addition to the Plan's Advisory Body and Subcommittee participants, the following OHS staff contributed to the development of this Plan or provided input, feedback or information used in the Plan's development: Olga Armah, Brian Carney, Ron Ciesones, Laurence Grotheer, Brent Miller, Hanna Nagy, Gloria Sancho and Alla Veyberman.

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Note:
In this document Fiscal Year (FY) refers to Federal Fiscal Year (FFY), which runs from October 1 - September 30 each year.

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Table of Contents

Letter From the Executive Director 04

Executive Summary 05

Certificate of Need 11

Hospital Locations in Connecticut 13

Inpatient Utilization 15

Opioid Related Inpatient Utilization 21

Emergency Department Utilization 22

Opioid Related Emergency Department Utilization 27

Emergency Department Utilization by Super Utilizers 29

Behavioral Health Emergency Department Utilization 31

Insurance Coverage Demographics 32

Preventable Hospitalizations 33

Outpatient Surgery 36

Acronyms / Abbreviations 39

Letter from the Executive Director

Dear Friends of the Office of Health Strategy,

I am pleased to present the *Statewide Healthcare Facilities and Services Plan 2020 Supplement*, to provide for you a more complete overview of Connecticut's current healthcare landscape. This report strives to address constantly evolving healthcare by promoting a long-term vision for the future of healthcare, focused on more equitable health outcomes, lower costs, and a more efficient healthcare system.

The 2020 Supplemental plan builds upon the original 2012 plan and the 2014, 2016 and 2018 Supplements with updated information to demonstrate continuous change in the state's health care landscape, provide information on Connecticut's health care quality, and emphasize the increasing costs associated with providing those services.

In 2012, the first Statewide Healthcare Facilities and Services Plan was published with Certificate of Need (CON)-related standards, guidelines, and methodologies for inpatient bed need, cardiac services, outpatient surgical facilities, imaging equipment and new technology. The 2014 Supplement highlighted the unmet healthcare needs of Connecticut's vulnerable and at-risk populations and recommended the alignment of public health and healthcare initiatives to address those needs. In 2016, the Supplement integrated the results of multiple standards for assessing unmet healthcare needs and included indices developed based on social determinants of health status and outcomes. The 2018 Supplement described recent CON activity, provided utilization data related to inpatient, emergency department, and outpatient surgical facility care, and offered a vision for the future of healthcare in Connecticut.

I would also share with you my gratitude for the efforts of all the individuals and organizations that participated in the planning and producing this report. OHS plans to use the information in this report with other data it collects to inform ongoing activities and policy actions. I encourage others to also utilize the information contained in this document as a resource for ongoing planning activities as you and your organization/community work toward a healthier population.

Sincerely,

Victoria Veltri, JD, LLM
Executive Director

Executive Summary

OVERVIEW

Formally established in 2018, the Office of Health Strategy (OHS) was created in 2017 through a bipartisan effort of the Connecticut General Assembly to promote high-quality, affordable, and accessible healthcare for all residents. Connecticut re-organized existing state resources into one-entity, uniting health policymaking and advancing healthcare reform initiatives that will drive down healthcare costs; close deeply entrenched racial, economic, and gender health disparities; and undertake technology-driven modernization efforts throughout the system.

OHS' mission is to implement comprehensive, data driven strategies that promote equal access to high-quality healthcare, control costs, and ensure better health for residents.

Section 19a-634 of the Connecticut General Statutes (Conn. Gen. Stat.) charges the Health Systems Planning Unit (HSP)[1] with the responsibility of developing and maintaining a Statewide Health Care Facilities and Services Plan (the Plan) along with establishing and maintaining an inventory of all Connecticut health care facilities and services and conducting a biennial utilization study. The Plan is an advisory document intended to be a blueprint for health care delivery in Connecticut, a resource for policymakers and those involved in the Certificate of Need (CON) process and a planning tool to identify unmet needs and gaps in service. It is also one of twelve enumerated guidelines contained in Conn. Gen. Stat. Section 19a-639 that HSP must take into consideration when analyzing CON applications.

The CON program is intended to guide the establishment of healthcare facilities and services which best serve public needs, ensure that high quality health services are provided, prevent unnecessary duplication of health care facilities and services and promote cost containment. However, the CON statutes do not include a definition of "clear public need." Accordingly, the Health Systems Planning Unit has utilized professional societies and organizations[2] held to be the experts to establish standards, guidelines and need methodologies to facilitate the review and analysis of Certificate of Need applications. In reviewing CON applications, HSP first applies the guidelines and principles in Conn. Gen. Stat. 19a-639, and then considers any additional standards, guidelines and need methodologies provided in the Plan.

HSP is currently in the process of convening advisory committees and workgroups to assist in reviewing and updating the standards, guidelines and need methodologies in prior iterations of the Plan. In the fall of 2019, HSP convened an imaging workgroup to evaluate whether the standards and guidelines for the acquisition of imaging equipment required revision (see report). In the fall of 2020, HSP plans to convene a cardiac workgroup to examine the most recent national guidelines promulgated by the American College of Cardiology Foundation/American Health Association/Society for Cardiovascular Angiography and Interventions and the Advisory Council for Cardiothoracic Surgery to update the standards and guidelines for percutaneous coronary intervention (PCI) and cardiac surgical programs.

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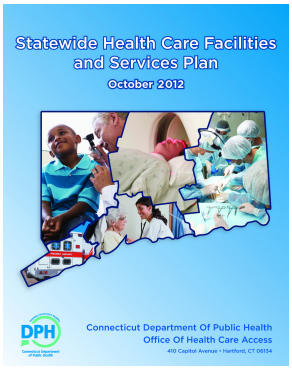
1 P.A. 17-2 established the Office of Health Strategy, effective January 1, 2018. Effective May 14, 2018, the Office of Health Care Access was renamed the "Health Systems Planning Unit" of the Office of Health Strategy pursuant to P.A. 18-91.

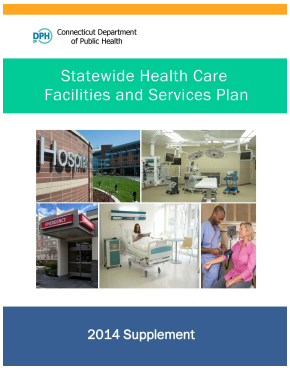
2 Societies and organizations that HSP has utilized to establish standards, guidelines and need methodologies include the American College of Cardiology, the American Heart Association, the Advisory Council for Cardiothoracic Surgery, the Radiological Society of Connecticut, the Connecticut Hospital Association and the Connecticut State Medical Society.

Executive Summary

PREVIOUS PUBLICATIONS OF THE FACILITIES AND SERVICES PLAN

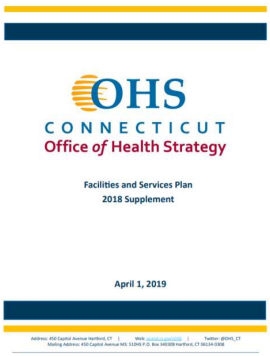


2012



2014

2016



2018

CURRENT INITIATIVES

The Office of Health Strategy coordinates a broad cross-section of stakeholders in a collaborative process, creating opportunities to understand what works in healthcare and what needs attention. OHS is committed to enhancing tools to gather, analyze and share clinical data, which will advance quality health and policymaking. OHS has remained responsive to the ever-evolving healthcare landscape and is working hard to address many of the concerns regarding healthcare in our state. Below is an overview of several of the larger initiatives that OHS has recently been engaged in:

- OHS, under Governor Lamont's Executive Order #5, is directed to develop annual health care cost growth benchmarks for 2021 through 2025, establish quality benchmarks, convene advisory boards for the benchmarks, set primary care spending targets, and monitor and report on healthcare spending growth. OHS has begun convening necessary advisory boards and is working to report back to the legislature on the cost growth benchmarks.

- OHS launched HealthscoreCT, a consumer-facing website established pursuant to Conn. Gen. Stat. § 19a-755 that uses claims data in the state's APCD to provide consumers with important information about the quality of certain health providers in the state and the median cost of certain health services. This site better enables consumers to make informed decisions about the cost and quality of their treatment and start conversations with their providers and health insurers about cost and quality.

- OHS provides ongoing support for the Community Health Worker Advisory Body, established pursuant to Conn. Gen. Stat. § 20-195ttt(b), housed within OHS to: (1) advise OHS and DPH on matters relating to the educational and certification requirements for training programs for CHW's, including the minimum number of hours and internship requirements for certification of CHW's, (2) conduct a continuous review of such educational and certification programs, and (3) provide DPH with a list of approved educational and certification programs for CHWs.

Executive Summary

- The Health Information Exchange was incorporated as the Health Information Alliance, Inc. (HIA), and convened its Board of Directors in October 2019 to continue OHS' ongoing efforts to support the rollout of the first statewide Health Information Exchange, pursuant to Conn. Gen. Stat. § 17b-59d. The HIA is designed to: (1) allow real-time, secure access to patient health information and complete medical records across all healthcare provider settings; (2) provide patients with secure electronic access to their health information; (3) allow voluntary participation by patients to access their health information at no cost; (4) support care coordination through real-time alerts and timely access to clinical information; (5) reduce costs associated with preventable readmissions, duplicative testing and medical errors; (6) promote the highest level of interoperability; (7) meet all state and federal privacy and security requirements; (8) support public health reporting, quality improvement, academic research and health care delivery and payment reform through data aggregation and analytics; (9) support population health analytics; (10) be standards-based; and (11) provide for broad local governance that (A) includes stakeholders, including, but not limited to, representatives of the Department of Social Services, hospitals, physicians, behavioral health care providers, long-term care providers, health insurers, employers, patients and academic or medical research institutions, and (B) is committed to the successful development and implementation of the State-wide Health Information Exchange.

- OHS continues to implement Public Act 18-41, which requires drug manufacturers to provide information about certain drugs that may have an impact on the cost of care in Connecticut. In early 2020 OHS launched a Prescription Drug Reporting portal to collect required submissions from pharmaceutical manufacturers, and continues to work closely with the Comptroller and the Insurance Department on other aspects of Public Act 18-41 to contain prescription drug costs by mandating that drug companies justify price increases. OHS has reported on some of the most highly utilized and highest cost prescription drugs in Connecticut across payers.

- OHS and the Comptroller launched a joint project to create a Healthcare Affordability Index. During this fiscal year, OHS and OSC updated the Self-Sufficiency Standard, a calculation that identifies what income is required for families in Connecticut to afford their basic needs, such as housing, childcare, food, transportation, and healthcare without any financial assistance from any sources. Building on that formula, OHS and the Comptroller will launch a Health Care Affordability Index to better understand the specific costs of healthcare for different households in Connecticut and evaluate the implication of policy change on healthcare costs on a variety of family types.

- OHS is continuing to support the development of sustainable Health Enhancement Communities, which are geographic areas that target interventions, help prevent costly health conditions, and improve social determinants of health like housing, education, and jobs.

Executive Summary

- OHS continues to administer the Certificate of Need (CON) program, a regulatory and planning tool designed to improve access to high-quality health services, minimize unnecessary duplication of services, facilitate healthcare market stability and help contain the cost of healthcare. Members of the public have the ability to keep abreast of changes to healthcare services in their communities and to voice their opinions about those changes at CON administrative hearings. Each CON application is carefully analyzed, and the corresponding decision narrowly tailored to ensure that CON applications meet the requisite criteria set forth in Conn. Gen. Stat. § 19a-639 prior to CON approval.

- The Health Systems Planning Unit continued its oversight of hospitals and healthcare providers' utilization and finances, reporting to policymakers on healthcare trends in the state, including: the FY18 Financial Status of Connecticut's Short Term Hospitals, the 2015-2018 Facility Fee Filing Trend report, and the establishment of a Data Compendium that provides comprehensive information on OHS' databases, why each data set is collected and how the public can access the data.

KEY FINDINGS

The Supplement identifies key findings surrounding the delivery of health care in Connecticut:

- Technology surrounding healthcare is constantly evolving. The technology may increase costs to Connecticut's healthcare system but not necessarily provide better outcomes. In addition, research utilizing new technology may be incomplete.

- Connecticut's healthcare landscape has evolved through the acquisition and consolidation of several hospitals in the state: Sharon, Norwalk and Danbury (Western CT Health Network/Nuvance); Bridgeport (Yale New Haven Health Services Corporation) and Milford Health and Medical, Inc.; St. Vincent's Medical Center and Hartford HealthCare Corporation/St. Vincent's Medical Center Holdings, Inc.

- Government payers (e.g. Medicare and Medicaid) accounted for approximately two-thirds of all inpatient discharges in FY 2019.

- The number of hospital patient days, for inpatient utilization, have increased over the past year with approximately 37,600 more patient days in FY 2019 than FY 2018.

- Emergency Department visits have been declining since FY 2016.

- The total charges for CT residents have increased every year since FY 2014.

- Non-Hispanic White individuals were most likely to have health insurance (96.6%) followed by Non-Hispanic Other (91.8%), Non-Hispanic Black (88.5 %) and Hispanic (75.8%), respectively.

Executive Summary

Community Benefits

Community benefit may be defined as "programs or activities that provide treatment and/or promote health and healing as a response to identified community needs...and meet at least one of the following criteria: 1) improve access to health care services, 2) enhance health of the community, 3) advance medical or health knowledge, 4) relieve or reduce the burden of government or other community efforts.[3]" Nonprofit hospitals as recognized by the Internal Revenue Service (IRS), demonstrate community benefit in exchange for not paying local, state, or federal taxes.

In addition to these requirements, the Patient Protection and Affordable Care Act (ACA) requires nonprofit hospitals to conduct community health needs assessments (CHNA) every three years, and to adopt a community health improvement plan (CHIP) to address those needs.[4] The CHNA and CHIP process in Connecticut is especially important as the state ranked 41st in disparities in health status in 2019 (where the higher the ranking the larger the disparities). [5]

CHNAs are a sound source of identification of the health needs and disparities that are present in the many unique communities stretching across Connecticut. CHNAs include community and public health stakeholder input, as well as an analysis of the community health needs and assets. Given the health disparities gap in Connecticut, CHNAs and their corresponding CHIPs provide a lens into the individual health needs of communities, and describe what hospitals are doing to address these needs.

The Connecticut Office of Health Strategy and nonprofit hospitals have an opportunity before them to redress the inequities and disparities that have been laid bare by the COVID-19 pandemic. By listening to communities, prioritizing needs, and applying interventions at root causes, we can work with communities and hospitals and other partners to provide a tailored approach to improve the health of the people of Connecticut.

3 https://www.chausa.org/communitybenefit/resources/defining-community-benefit

4 https://www.federalregister.gov/documents/2014/12/31/2014-30525/additional-requirements-for-charitable-hospitals-community-health-needs-assessments-for-charitable

5 https://www.americashealthrankings.org/explore/annual/measure/healthstatus_disparity/state/CT

Executive Summary

LIMITATIONS

As with all assessments, there are limitations and this Supplement should be considered in the same context. Lack of comprehensive data limits OHS' ability to fully assess population needs. Therefore, evaluations of access to healthcare services are limited. It should be noted that part of OHS's mission is working to address and mitigate these information gaps.

A NOTE REGARDING COVID-19

Over the past few months, the coronavirus has impacted almost every aspect of day-to-day life. Connecticut, as part of one of the epicenters of the virus, had to quickly react and adjust the way healthcare was delivered in order to meet the immediate needs of its residents.

Hospitals had to adapt, making changes to the Connecticut healthcare landscape such as the need for hospitals to restructure themselves to temporarily increase licensed bed capacity. Under Governor Lamont's Executive Order 7B, OHS published guidance regarding the Certificate of Need Process and the State's Response to COVID-19, which allowed hospitals to temporarily increase their licensed bed capacity and/or acquire additional equipment as necessary to assist during the public health emergency without applying for a CON. Instead providers were required to submit a COVID-19 Waiver or Notification Form and receive an approval or denial on an expedited basis.

Due to the coronavirus reaching Connecticut in early 2020, future iterations of this document, particularly surrounding comparable data, may differ due to the anomaly that is the pandemic.

RECOMMENDATIONS AND NEXT STEPS

The recommendations and next steps are intended to build upon discussions that occurred since the publication of the 2018 Supplement and to reflect the needs of Connecticut's healthcare landscape.

- The healthcare landscape continues to change as the focus of care shifts toward prevention and early intervention. OHS is working to establish a Cost Growth Benchmark, primary care spending targets and quality benchmarks for providers and payers as a part of the framework ensure better quality care and advance primary care.

- Collect granular race, ethnicity and other demographic data and analyze healthcare data.

- Further analyze ED use to identify factors regarding utilization and readmission rates and determine appropriate interventions.

Certificate of Need

The current healthcare environment is partially shaped through the Certificate of Need program which improves access to high-quality health services, minimizes unnecessary duplication of services, facilitates healthcare market stability, and helps contain the cost of healthcare.

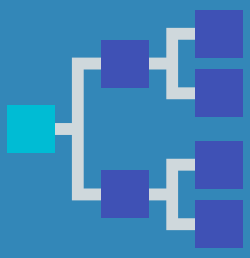
The Certificate of Need program benefits Connecticut residents and improves healthcare by:

Promoting health equity and helping eliminate healthcare disparities

Ensuring access to high-quality healthcare services for vulnerable populations

Improving population health by addressing social determinants

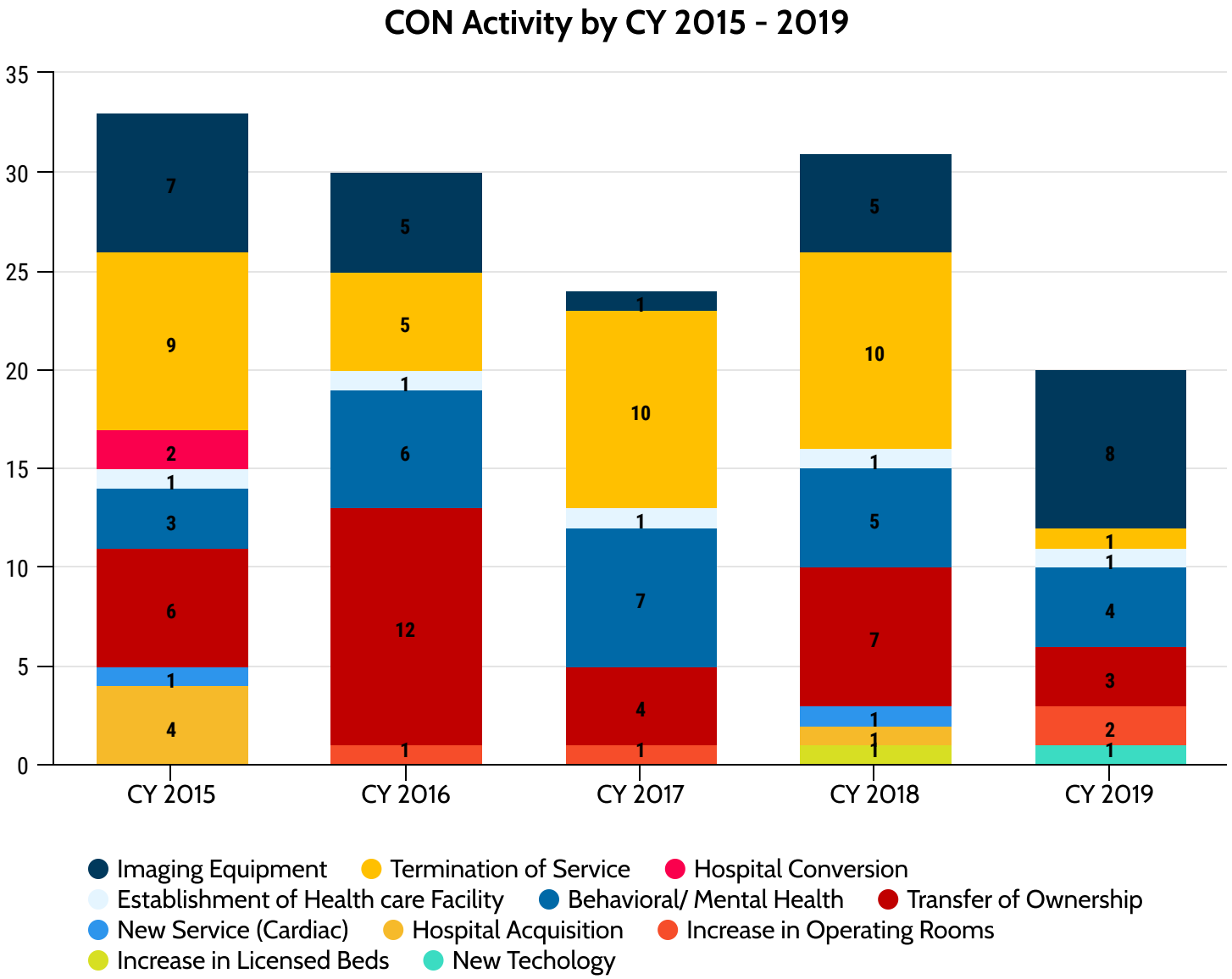
Holding public hearings to ensure residents are heard and facilitating engagement through the public comment process



Aligning community health priorities and hospital community benefit allocations

Monitoring impact of hospital acquisitions and consolidations on quality, access and cost to consumers

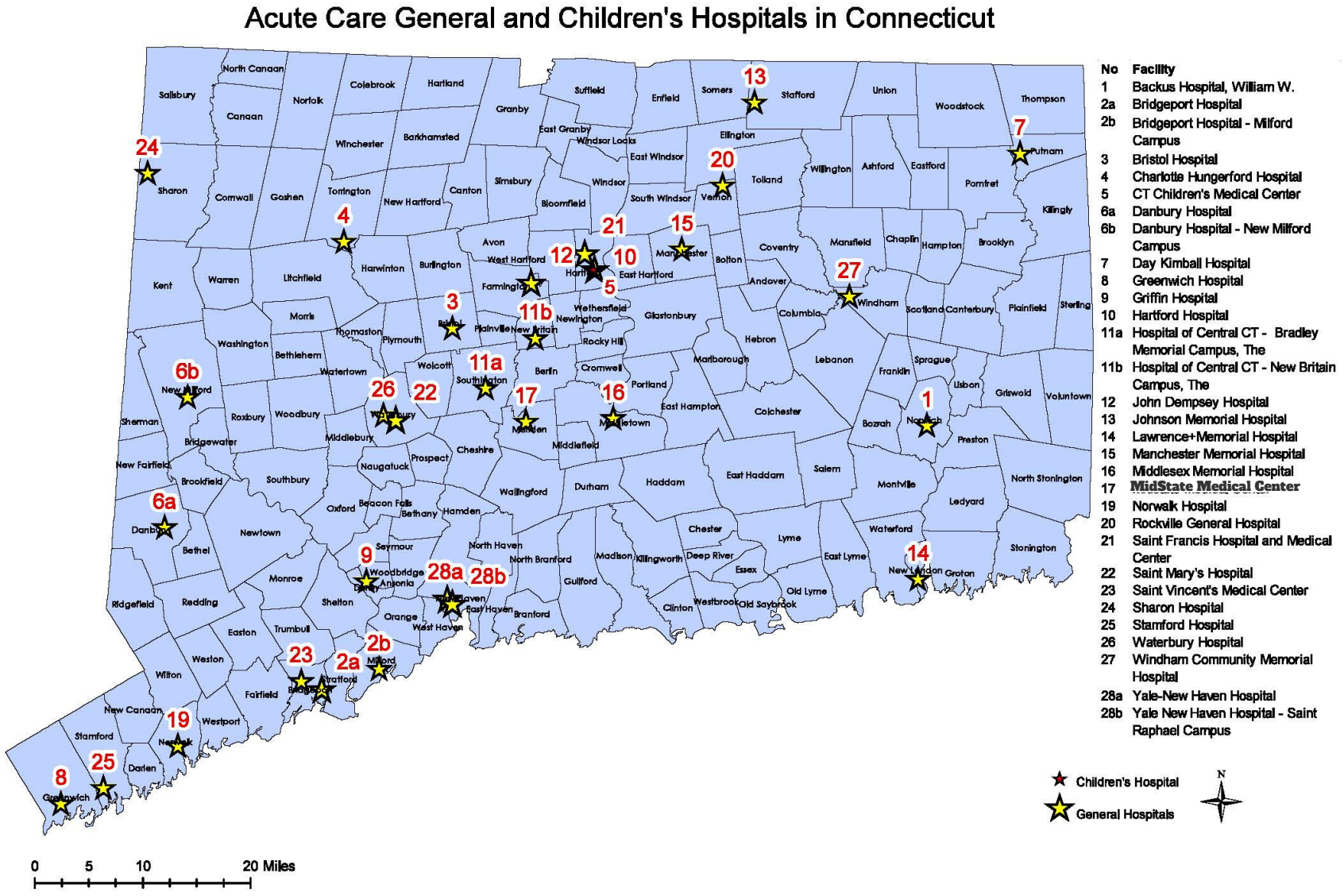
Certificate of Need (CON) Activity



Source: OHS CON Summary Data

The chart above notes the type and number of Certificate of Need applications from the past five calendar years. From CY 2018 to CY 2019, the CON program experienced an increase in applications for imaging equipment, and increases in operating rooms, as well as received an application for new technology to be used in the state. There was a decrease in the amount of termination of service applications and transfers of ownership during the same time period.

Hospital Locations in Connecticut



Recently, Connecticut's hospitals have been evolving and restructuring—since our last supplement, in 2018, we have had several hospital acquisitions, mergers and affiliations:

- Sharon, Norwalk and Danbury (Western CT Health Network/Nuvance)
- Bridgeport (Yale New Haven Health Services Corporation) and Milford Health and Medical, Inc.
- St. Vincent's Medical Center and Hartford HealthCare Corporation/St. Vincent's Medical Center Holdings, Inc.

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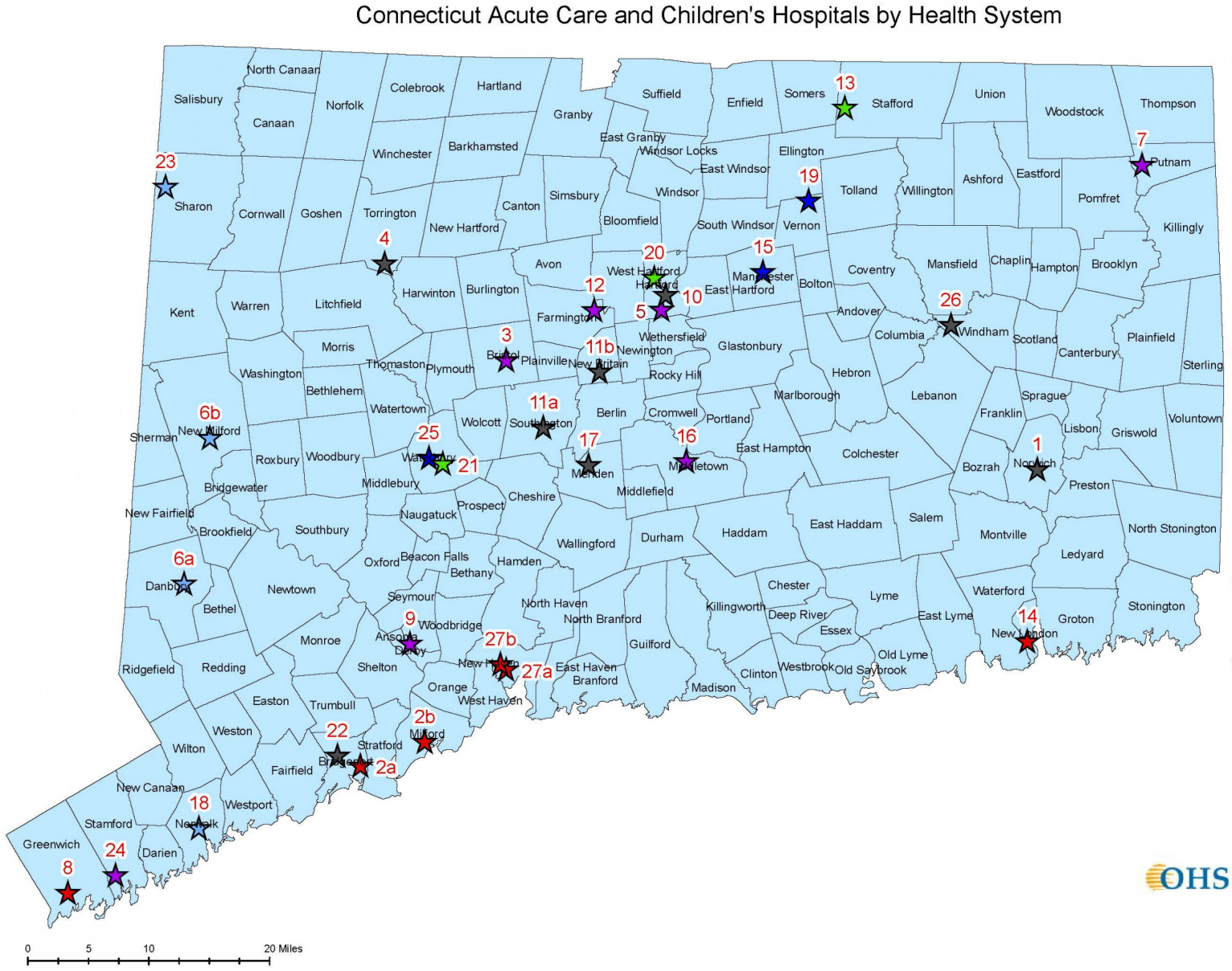
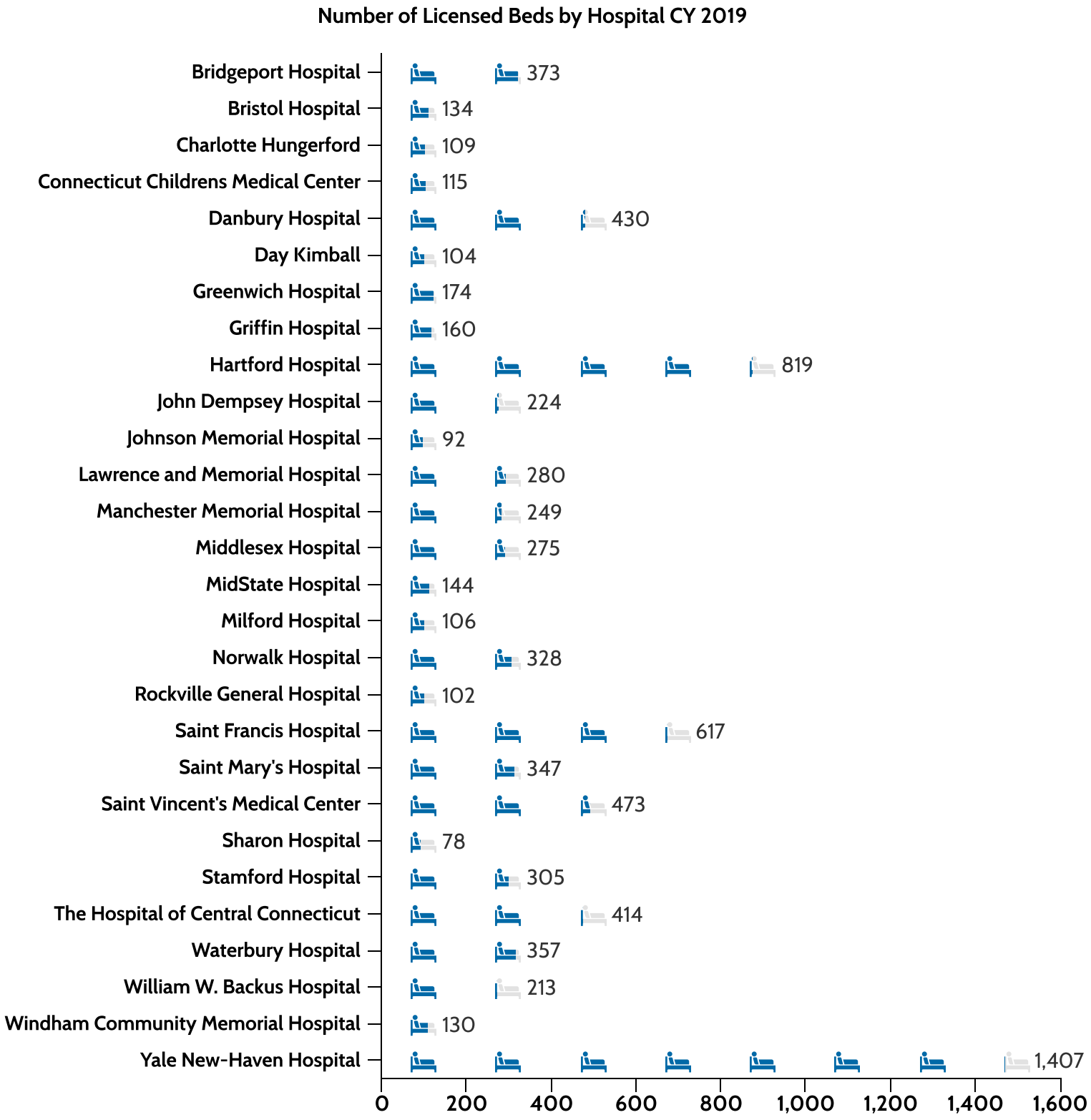
Hospital Locations in Connecticut



Inpatient Utilization



*Licensed Beds Excluding Bassinets Source: OHS Hospital System Report 400

The Hospitals with the largest inpatient bed capacity are Yale New-Haven Hospital, Hartford Hospital and Saint Francis Hospital.

Note: This chart includes only officially licensed bed--it does not include the temporary bed increases associated with COVID-19.

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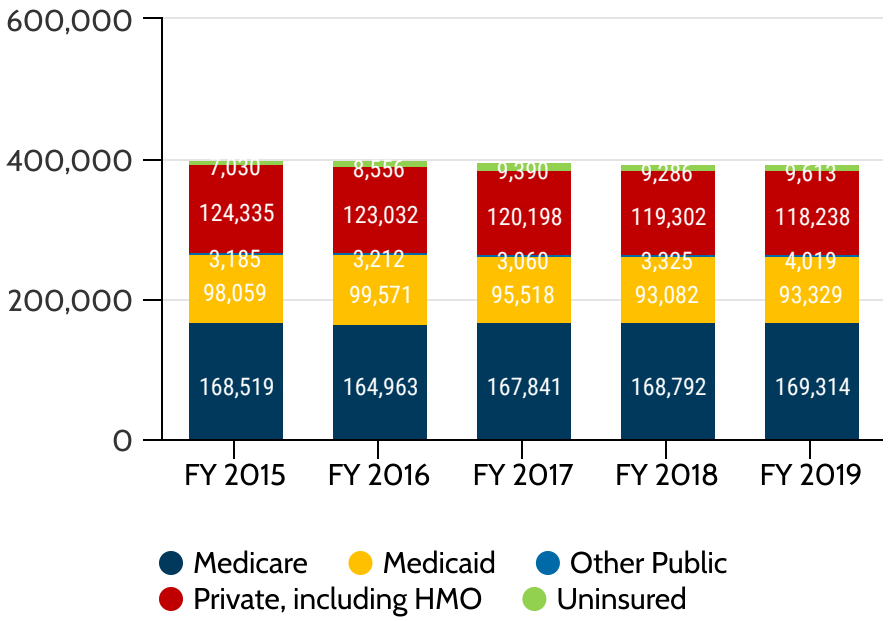
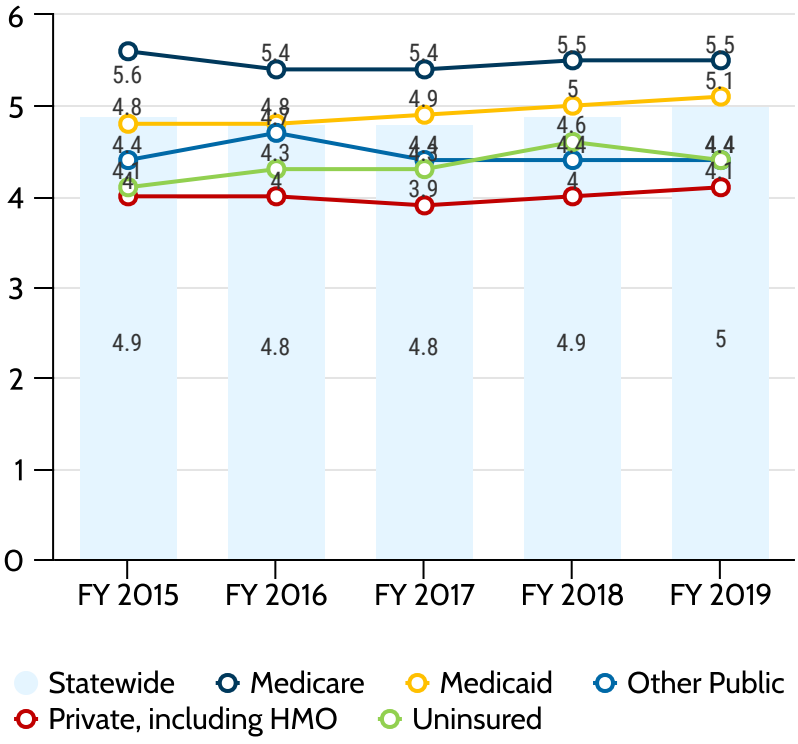
Inpatient Utilization

Continuing the recent trends, government payers accounted for approximately two-thirds of all inpatient discharges in FY 2019.

Payer Mix for Inpatient Discharges FY 2015 - 2019

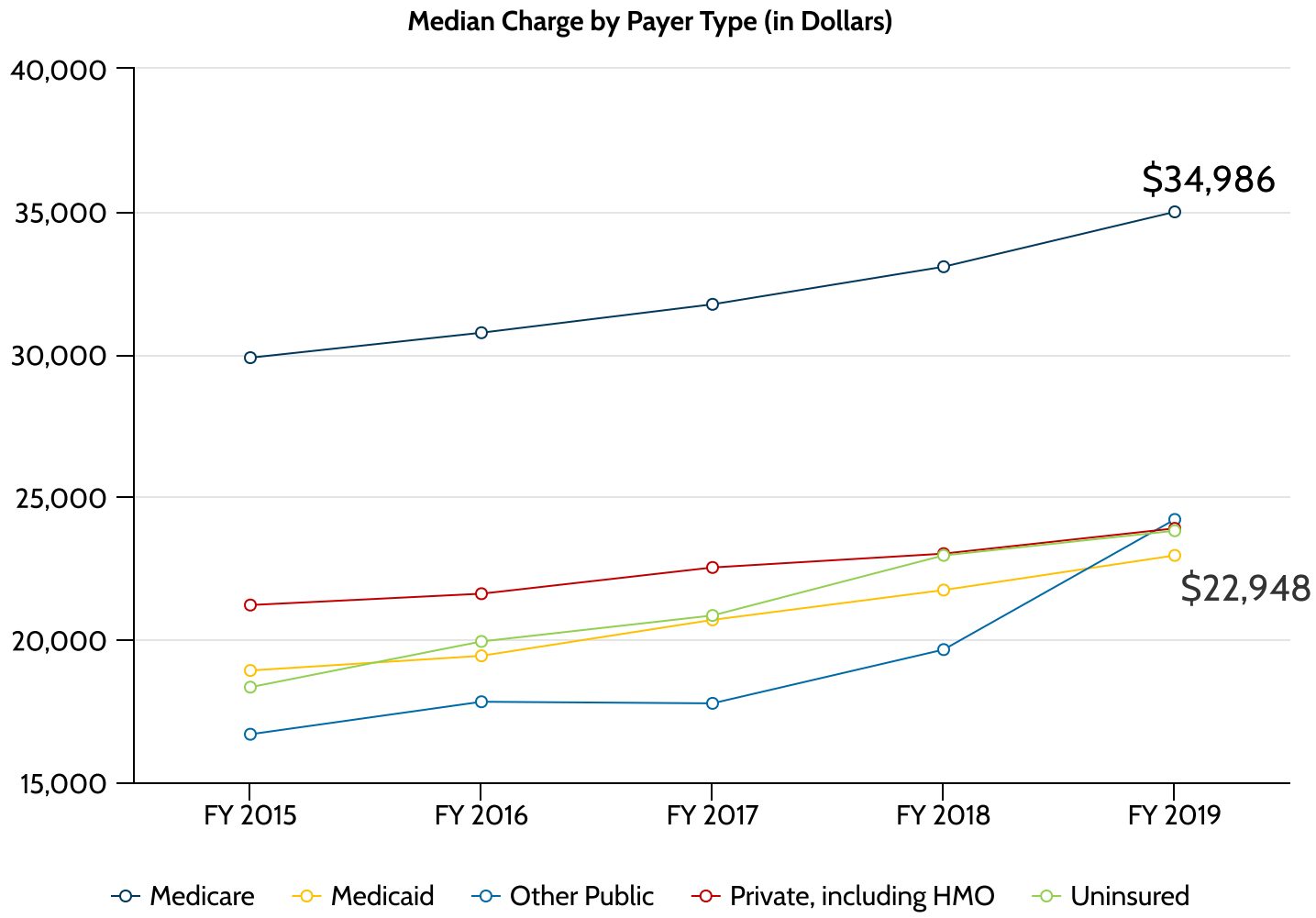


Average Length of Stay by Payer Type



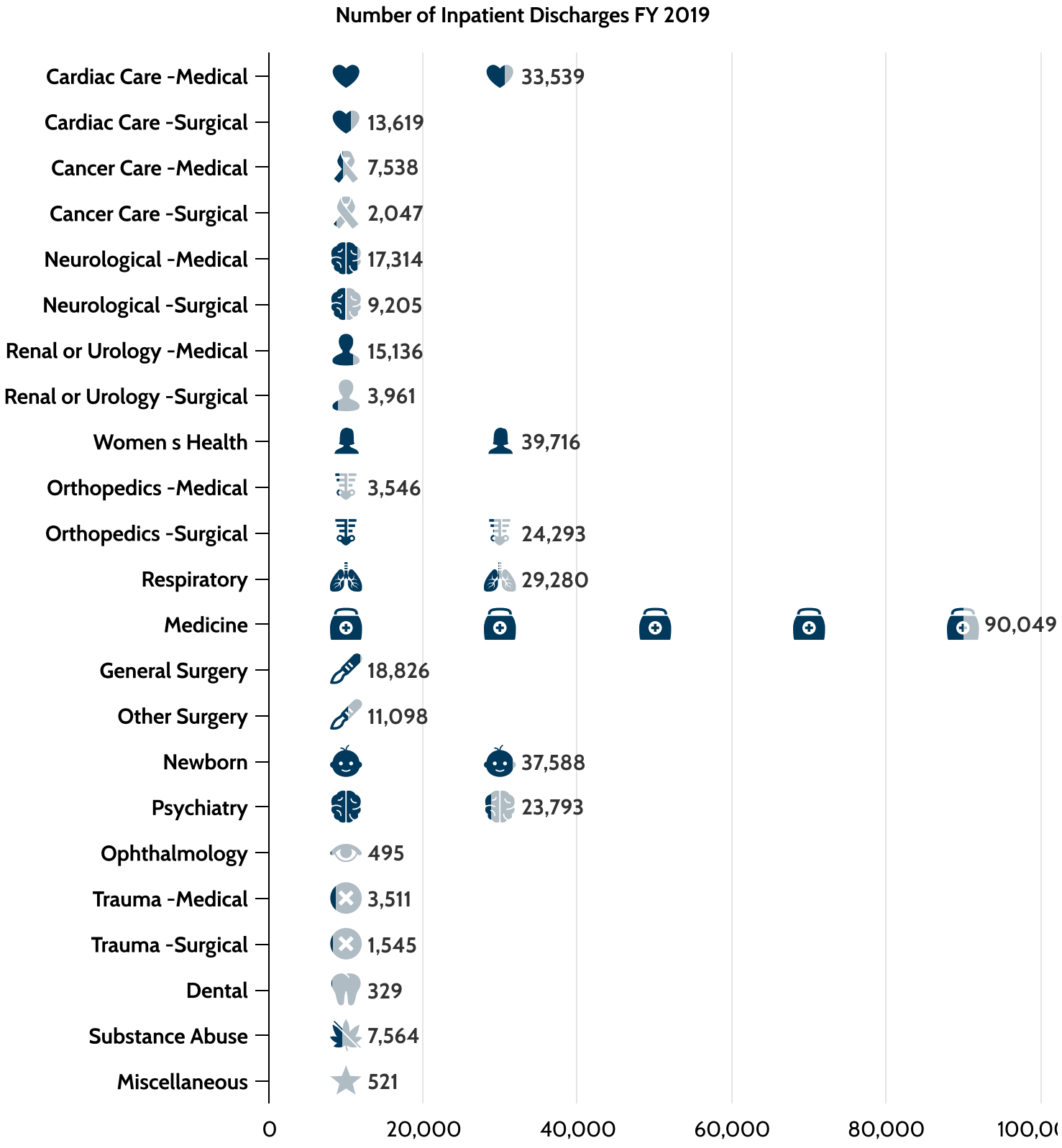
In FY 2019, Medicare patients had the longest average length of stay and private (commercial) payers had the shortest.

Inpatient Utilization



Median charges by payer type have remained relatively consistent in recent years. In FY 2019 there was an increase in all payer types, with the median charges between Medicaid, other public, private (commercial) and uninsured approaching a similar amount. Medicare patients tend to be older and/or have complex disabilities and require longer stays than the average population leading to higher charges overall.

Inpatient Utilization



Medicine (non-surgical care) accounted for the majority of patient discharges at Connecticut hospitals in FY 2019.

Data Source: OHS Acute Care Hospital Discharge Database

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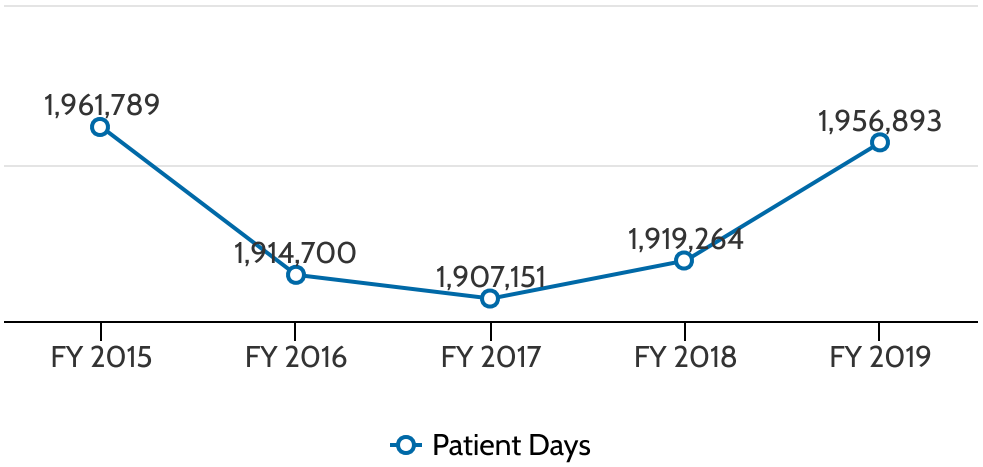
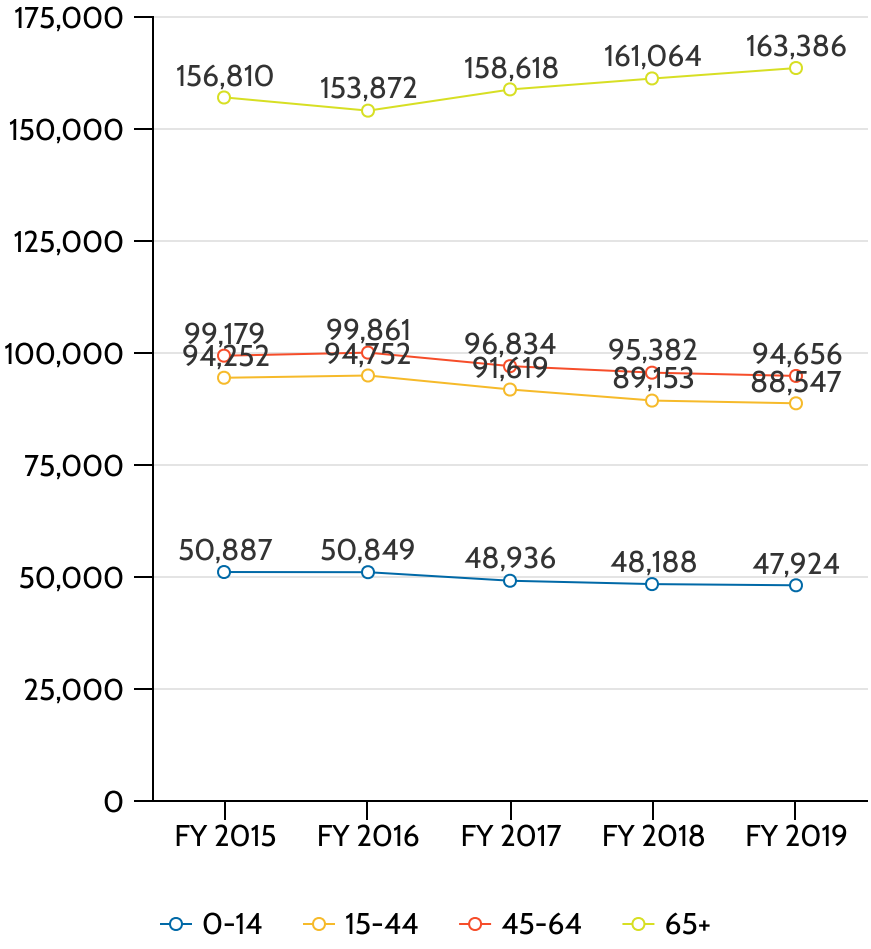
Inpatient Utilization

Patient days have risen slightly over the past fiscal year. In FY 2019, there were 1,956,893 patient days, approximately 37,600 more patient days than FY 2018.

Number of Hospital Patient Days



Inpatient Discharges by Age Group



There were 394,513 inpatient discharges in FY 2019, up slightly from 393,787 in FY 2018.

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Data Source: OHS Acute Care Hospital Discharge Database

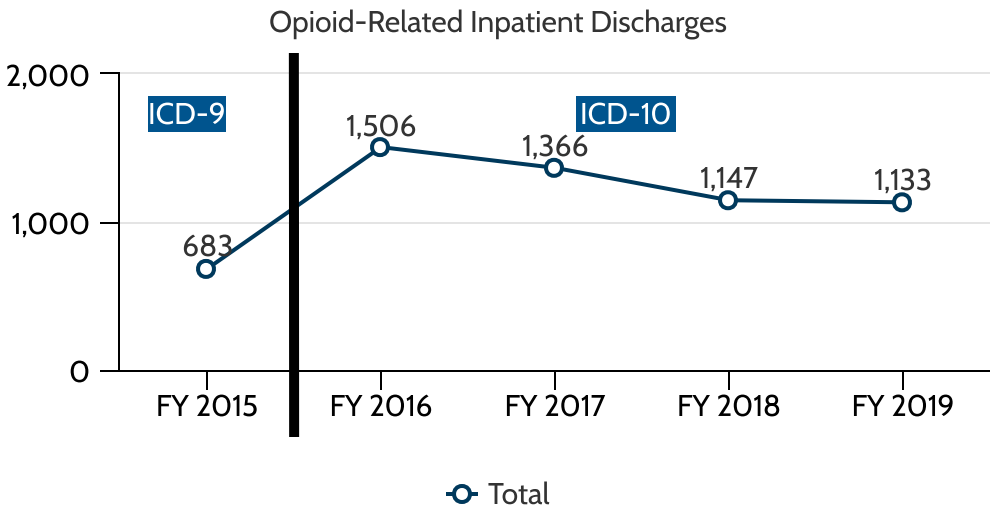
Inpatient Utilization By Department

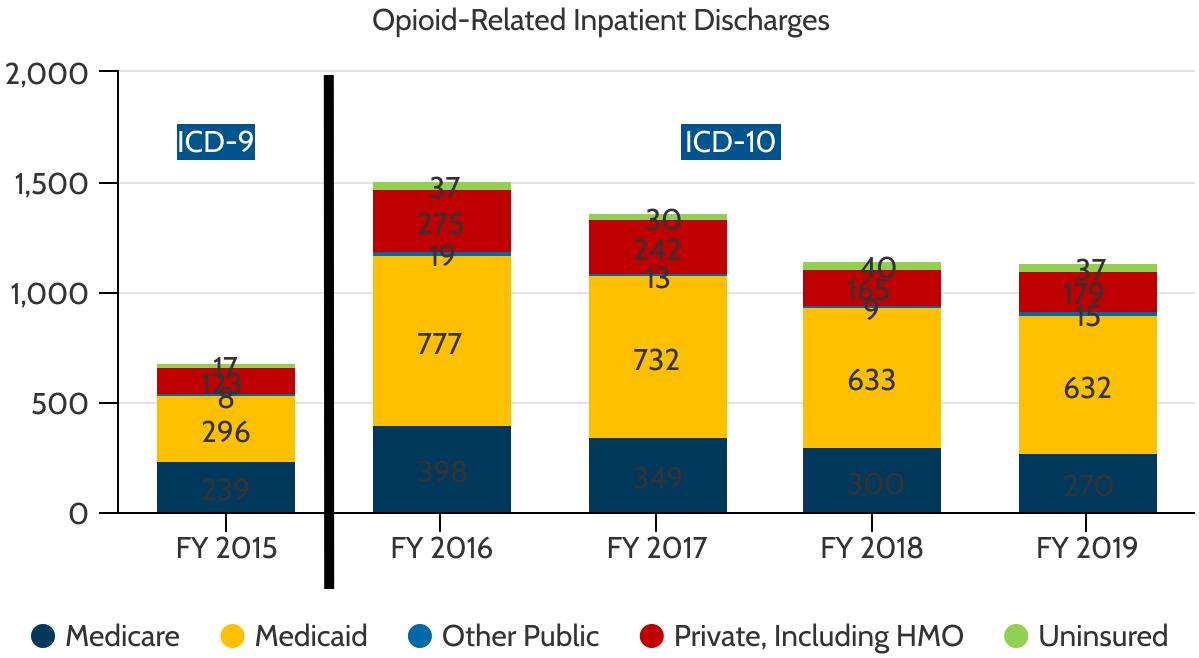
Description	Number of Available Beds in FY 2019	Number of Staffed Beds in FY 2019	Occupancy of Available Beds in FY 2019	Occupancy of Staffed Beds in FY 2019
Adult Medical/Surgical	5,091	4,011	66.57%	84.50%
ICU/CCU (Excludes Neonatal ICU)	733	595	59.65%	73.48%
Total Psychiatric	858	778	75.77%	83.57%
Rehabilitation	107	99	76.40%	82.57%
Maternity	605	419	49.19%	71.02%
Newborn	540	332	38.83%	63.16%
Neonatal ICU	309	263	53.77%	63.17%
Pediatric	234	203	51.17%	58.98%
Total Inpatient Bed Utilization	8,477	6,700	63.13%	79.87%

Source: CT Office of Health Strategy Acute Care Hospitals Reporting System (HRS) Report 400

The overall Connecticut Hospital Inpatient Bed ***occupancy rate for staffed beds*** is approximately 80%, which is a widely-accepted industry target. However, the ***occupancy rate for available beds*** is lower, suggesting that there are more hospitals beds available than necessary.

Opioid-Related Inpatient Utilization



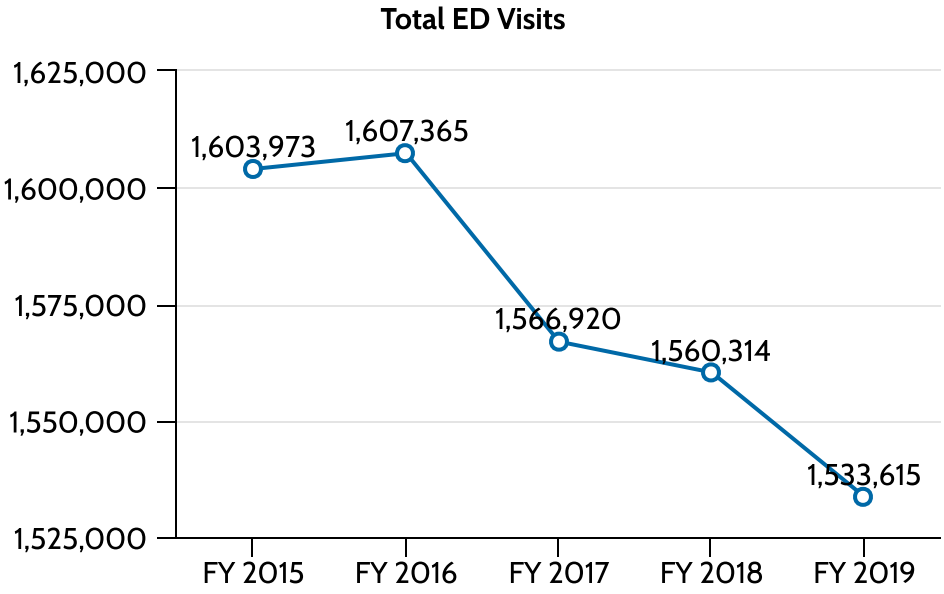


Source: International Classification of Diseases, ninth and tenth revision (ICD9-9 and ICD-10) codes: 304.00-304.03, 304.70-304.73, 305.50-305.53,965.00, E850.2, E935.2, F11.10-F11.99, T40.0X1A-T40.695D

Data Source: OHS Acute Care Hospital Discharge Database

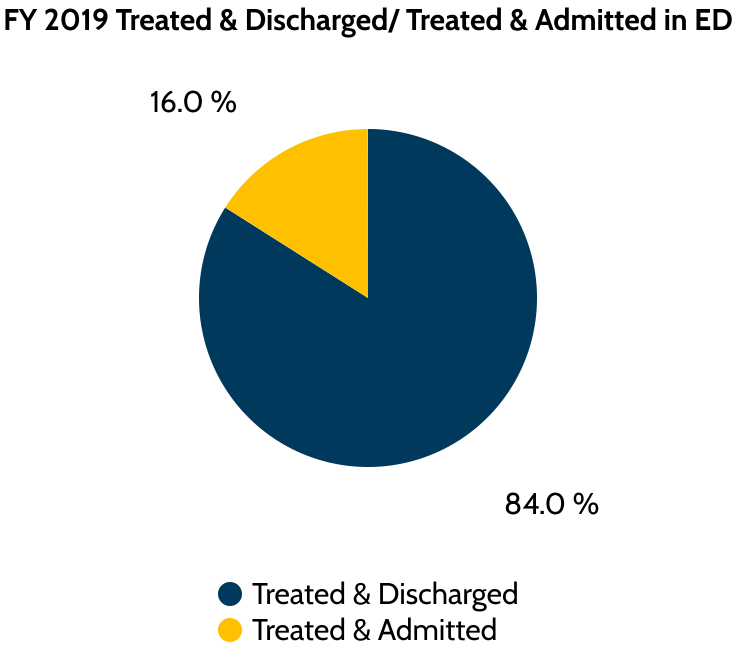
Opioid-related inpatient discharges decreased slightly from FY 2018 to FY 2019, demonstrating a downward trend. The large increase between FY 2015 and FY 2016 is due to the change from ICD-9 to ICD-10 codes for diagnosis.

Emergency Department Utilization



The total amount of emergency department visits has continued to decline each year since FY 2016.

In FY 2019, 16% of patients were treated in the emergency department and were then admitted to the hospital.



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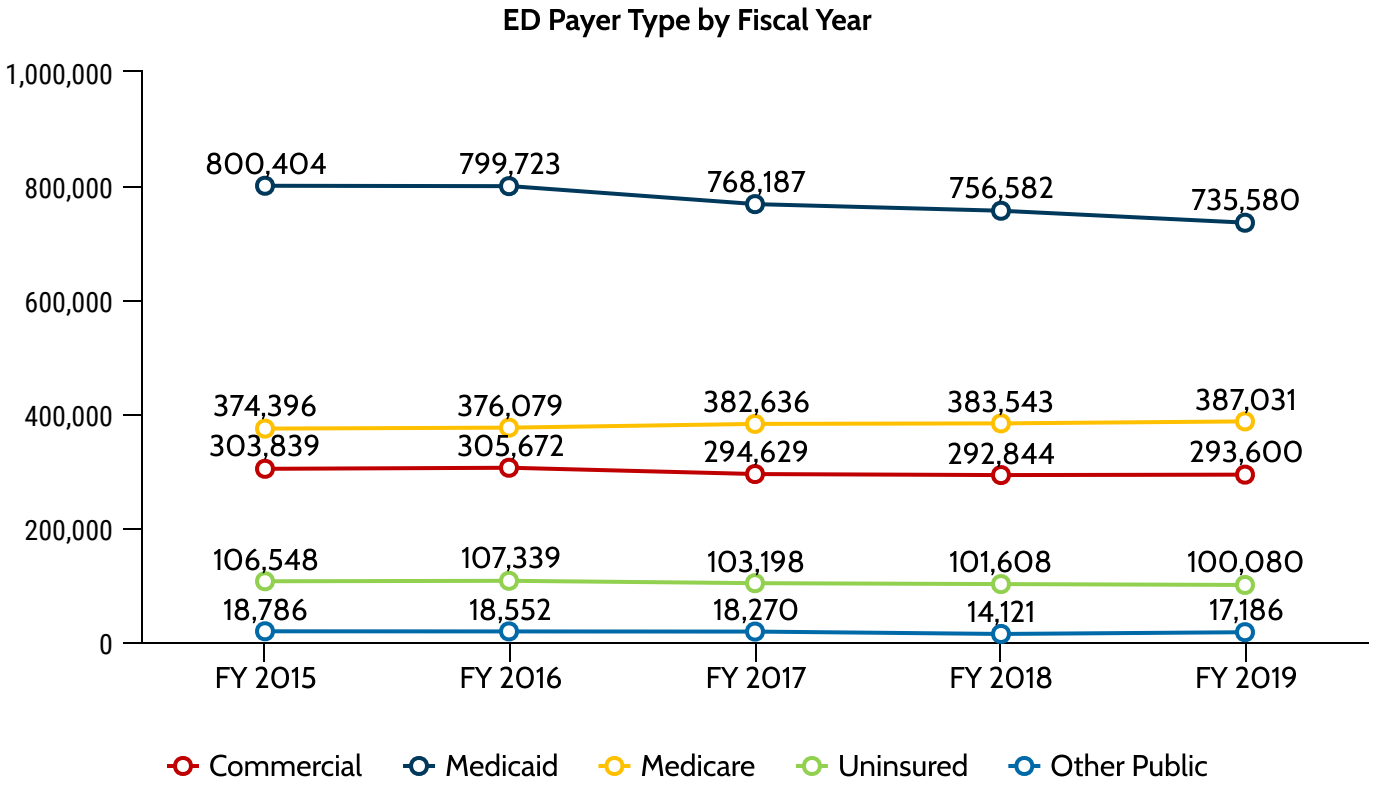
Data Source: OHS Inpatient Discharge Database System (HIDDS), Sharon Hospital Emergency Department Database and Connecticut Hospital Association (CHA)/CHIME Emergency Department Database System

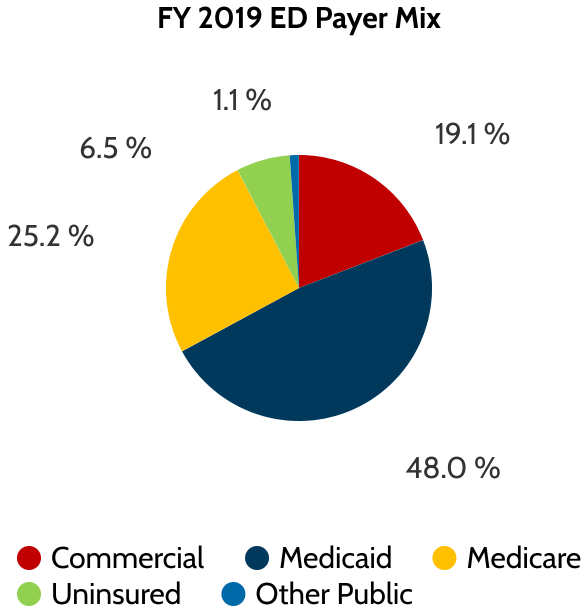
Note: For technical reasons, OHS included a three year average variable (2016,2017 and 2018) as a stand in for the 2019 data for Sharon Hospital

Emergency Department Utilization



The Emergency Department payer mix has remained relatively constant over the past five fiscal years. There was a slight decrease in the number of visits by Medicaid and the uninsured to the emergency department during the current fiscal year. Whereas, there was an increase in Medicare, Commercial, and Other Public over the same period.

The majority of ED visits during FY 2019 were conducted by Medicaid patients.



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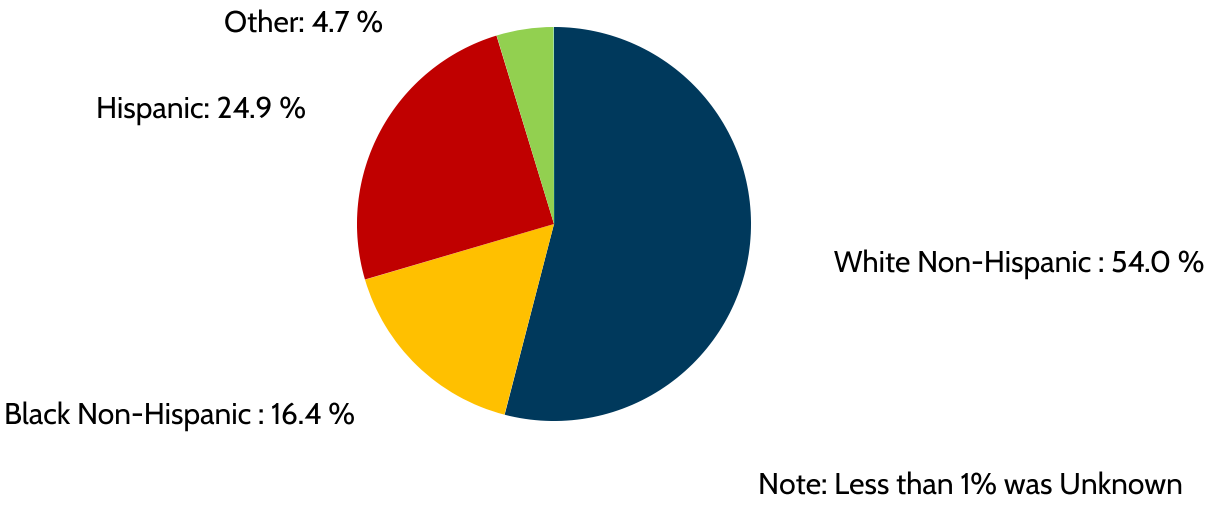
Data Source: OHS Inpatient Discharge Database System (HIDDS), Sharon Hospital Emergency Department Database and Connecticut Hospital Association (CHA)/CHIME Emergency Department Database System

Note: For technical reasons, OHS included a three year average variable (2016,2017 and 2018) as a stand in for the 2019 data for Sharon Hospital

Emergency Department Utilization

FY 2019 Emergency Department Visits by Race



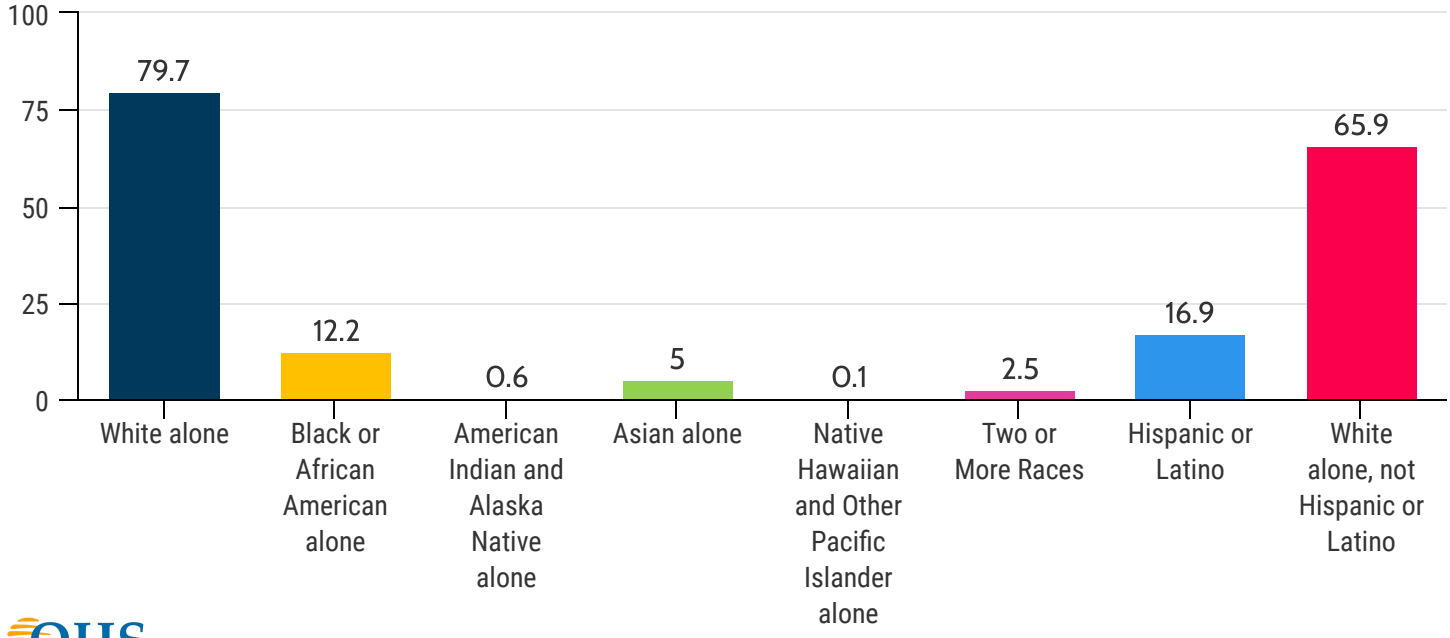
Note: Less than 1% was Unknown

The majority of emergency department visits in FY 2019 were by White Non-Hispanic individuals.

Data Source: OHS Inpatient Discharge Database System (HIDDS), Sharon Hospital Emergency Department Database and Connecticut Hospital Association (CHA)/CHIME Emergency Department Database System

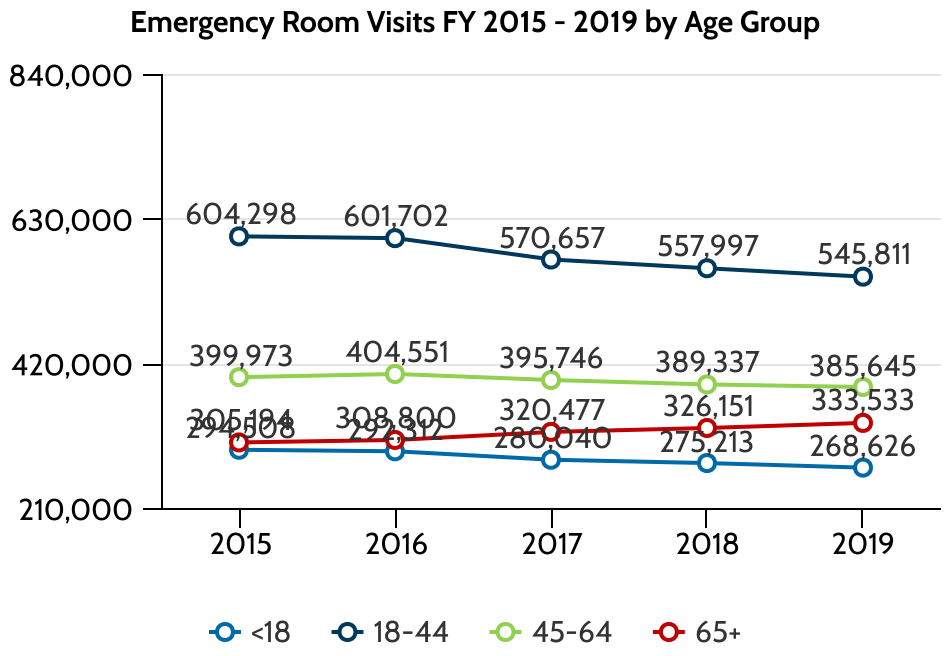
Note: For technical reasons, OHS included a three year average variable (2016,2017 and 2018) as a stand in for the 2019 data for Sharon Hospital

2019 Connecticut Demographics by Race (Percent of Population)



Source: The American Community Survey at census.gov/quickfacts/fact/table/CT/RHI125219

Emergency Department Utilization



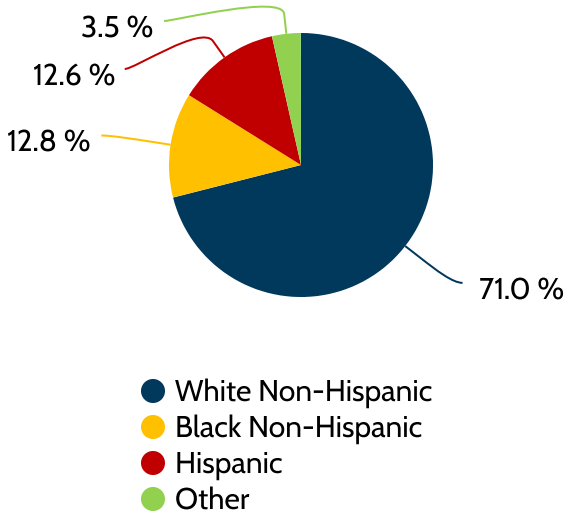
Over 545,000 emergency room visits were by patients ages 18-44.

Data Source: OHS Inpatient Discharge Database System (HIDDS), Sharon Hospital Emergency Department Database and Connecticut Hospital Association (CHA)/CHIME Emergency Department Database System

Note: For technical reasons, OHS included a three year average variable (2016,2017 and 2018) as a stand in for the 2019 data for Sharon Hospital

Emergency Department Utilization

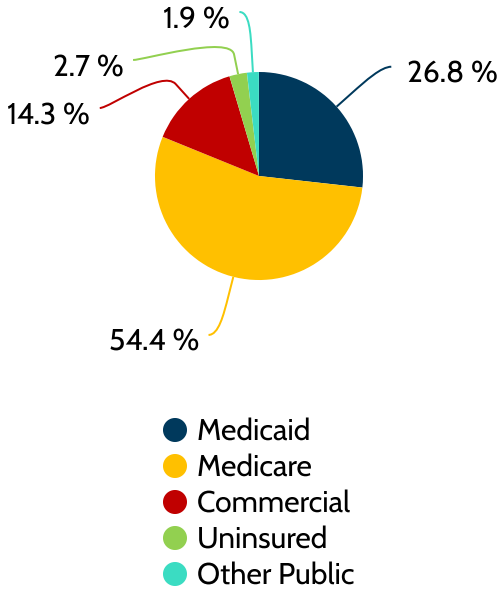
FY 2019 Treated and Admitted Emergency Department Visits by Race



Note: Less than 1% was Unknown

In FY 2019, 71% of patients who were treated in the emergency department and then admitted to the hospital identified as White Non-Hispanic. Black Non-Hispanic, Hispanic, and Other made up 12.8%, 12.6% and 3.5% respectively.

FY 2019 Treated and Admitted Emergency Department Visits by Payer



In FY 2019, over half of the patients who were treated in the emergency department and then admitted to the hospital were on Medicare.

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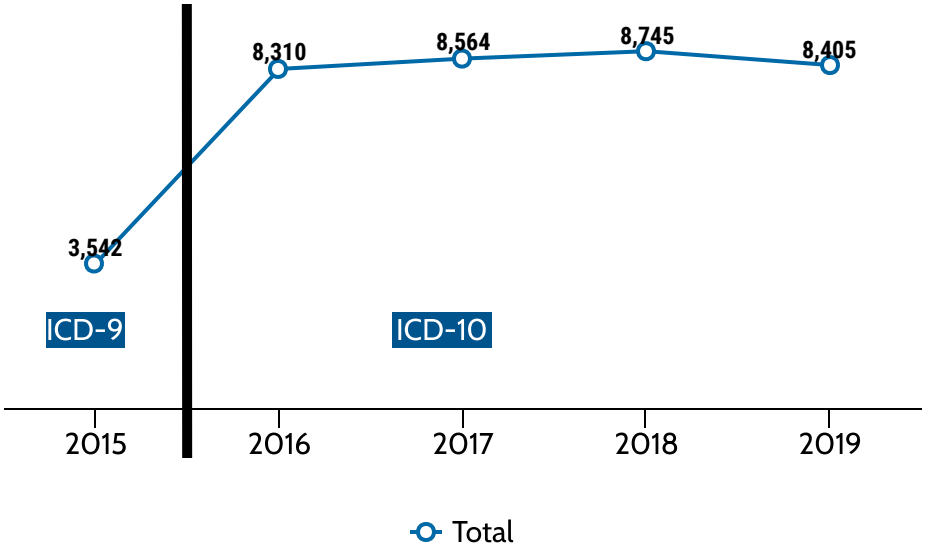
Data Source: OHS Inpatient Discharge Database System (HIDDS), Sharon Hospital Emergency Department Database and Connecticut Hospital Association (CHA)/CHIME Emergency Department Database System

Note: For technical reasons, OHS included a three year average variable (2016,2017 and 2018) as a stand in for the 2019 data for Sharon Hospital

Opioid- Related ED Utilization

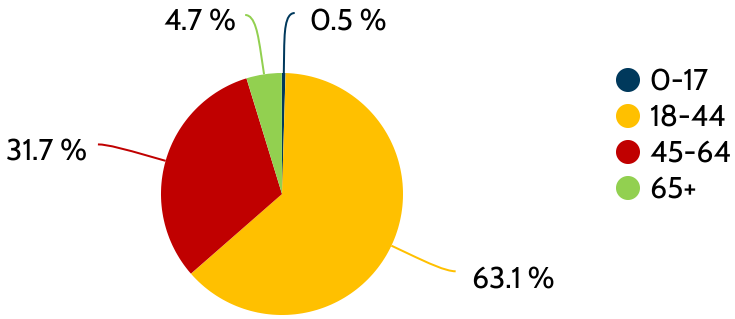
Opioid- Related Emergency Department Visits



Opioid-related emergency department visits remained relatively consistent over the past four fiscal years. The large increase from FY 2015 to FY 2016 is likely due to the change from ICD-9 to ICD-10 coding.

Approximately 63% of opioid-related emergency department visits were patients ages 18-44 years old.

Total Opioid-Related Emergency Department Visits FY 2019 by Age



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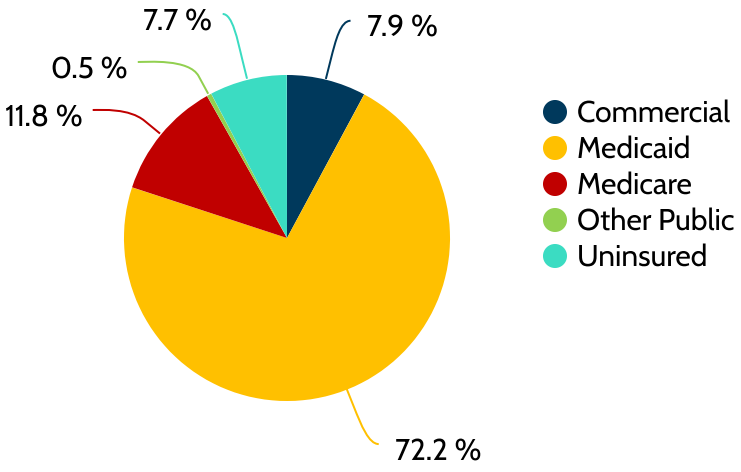
Data Source: OHS Inpatient Discharge Database System (HIDDS), Sharon Hospital Emergency Department Database and Connecticut Hospital Association (CHA)/CHIME Emergency Department Database System

Note: For technical reasons, OHS included a three year average variable (2016,2017 and 2018) as a stand in for the 2019 data for Sharon Hospital

Opioid- Related ED Utilization

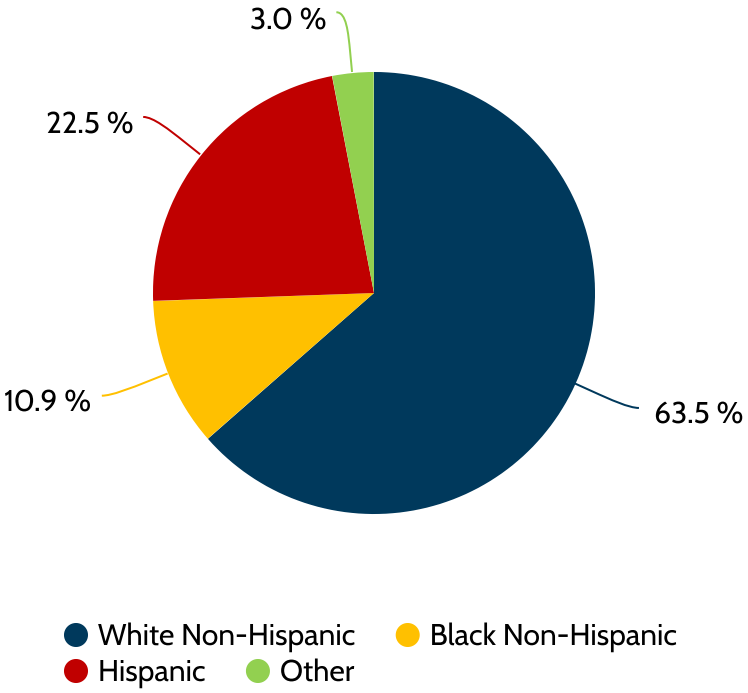
Total Opioid-Related Emergency Department Visits FY 2019 by Payer



Medicaid patients made up the majority of opioid-related emergency department visits in FY 2019.

FY 2019 Opioid-Related Emergency Department Visits by Race

In FY 2019, about 63% of opioid-related emergency department visits were by individuals who identified as White-Non Hispanic followed by 22.5% Hispanic, 10.9% Black Non-Hispanic and 3% Other.



Note: Less than 1% was Unknown

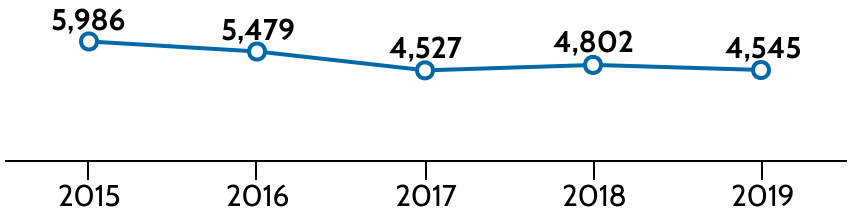
OHS CONNECTICUT Office of Health Strategy

Data Source: OHS Inpatient Discharge Database System (HIDDS), Sharon Hospital Emergency Department Database and Connecticut Hospital Association (CHA)/CHIME Emergency Department Database System

Note: For technical reasons, OHS included a three year average variable (2016,2017 and 2018) as a stand in for the 2019 data for Sharon Hospital

ED Utilization by Super Utilizers

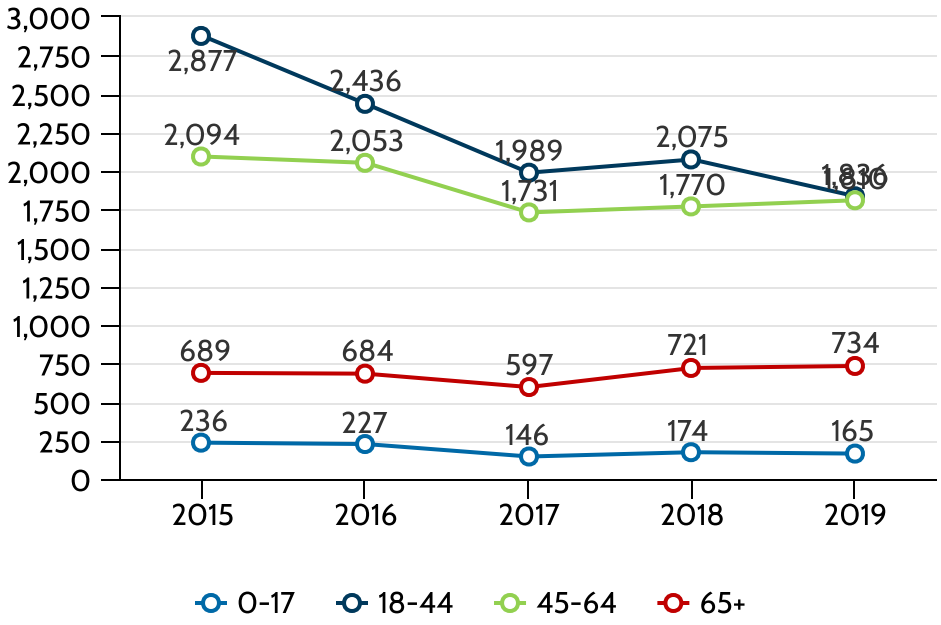
Emergency Department Visits by Super Utilizers



The number of emergency department visits by super utilizers (a person who has 10 or more visits to the ED within a year) decreased by approximately 250 visits between FY 2018 and FY 2019.

In FY 2019 the number of visits by ED super utilizers ages 18-44 decreased by over 200.

Emergency Department Super Utilizers by Age Group

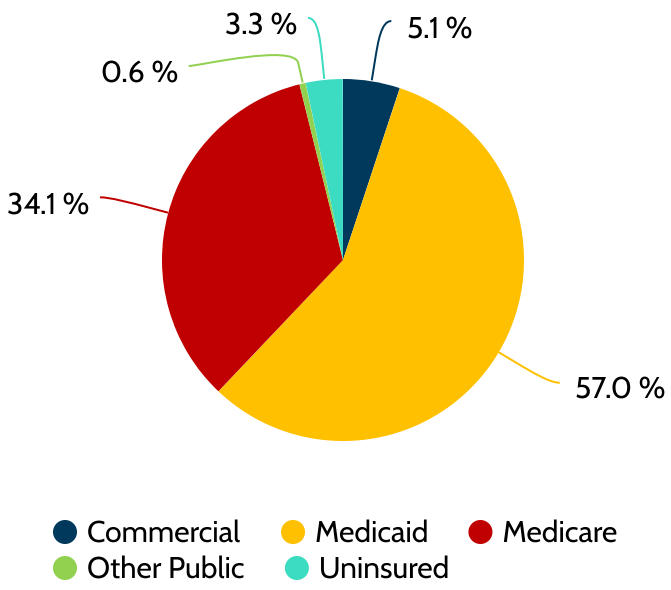


Data Source: OHS Inpatient Discharge Database System (HIDDS), Sharon Hospital Emergency Department Database and Connecticut Hospital Association (CHA)/CHIME Emergency Department Database System

Note: For technical reasons, OHS included a three year average variable (2016,2017 and 2018) as a stand in for the 2019 data for Sharon Hospital

ED Utilization by Super Utilizers

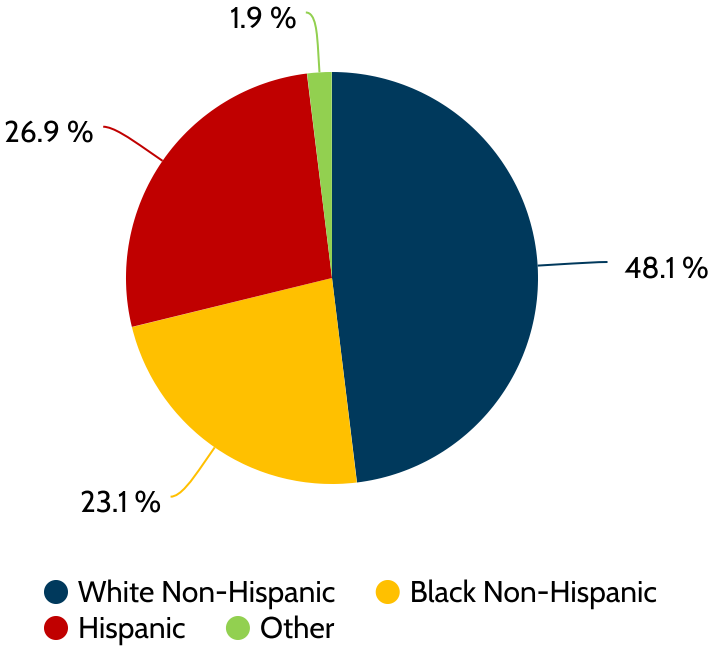
FY 2019 Super Utilizers by Payer



Medicaid and Medicare patients made up approximately 91% of emergency department super utilizers in FY 2019.

In FY 2019, almost half of super utilizers identified as White-Non Hispanic.

FY 2019 Super Utilizers by Race



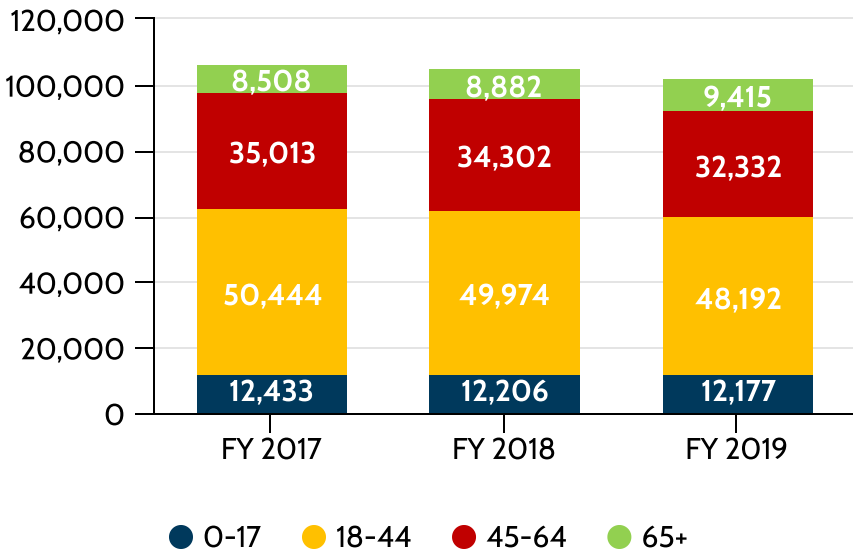
OHS CONNECTICUT Office of Health Strategy

Data Source: OHS Inpatient Discharge Database System (HIDDS), Sharon Hospital Emergency Department Database and Connecticut Hospital Association (CHA)/CHIME Emergency Department Database System

Note: For technical reasons, OHS included a three year average variable (2016,2017 and 2018) as a stand in for the 2019 data for Sharon Hospital

Behavioral Health ED Utilization

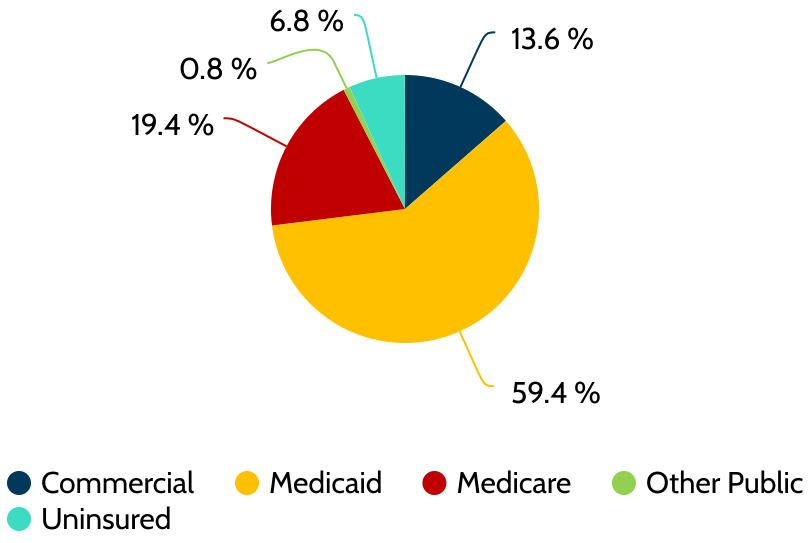
CT Residents: Behavioral Health (Mental Disease & Disorders, Alcohol/Drug Use/Induced Organic Mental Disorders) FY 2017 -FY 2019



The number of emergency room visits by CT residents for behavioral health (mental disease & disorders, alcohol/drug use/induced organic mental disorders) has remained relatively constant over the past three fiscal years.

In FY 2019 the majority of emergency department visits by CT Residents for behavioral health (mental disease & disorders, alcohol/drug use induced organic mental disorders) were by individuals on Medicaid.

CT Residents: Behavioral Health (Mental Disease & Disorders, Alcohol/Drug Use/Induced Organic Mental Disorders) for FY 2019 by Payer



Data Source: OHS Inpatient Discharge Database System (HIDDS), Sharon Hospital Emergency Department Database and Connecticut Hospital Association (CHA)/CHIME Emergency Department Database System

Note: For technical reasons, OHS included a three year average variable (2016,2017 and 2018) as a stand in for the 2019 data for Sharon Hospital

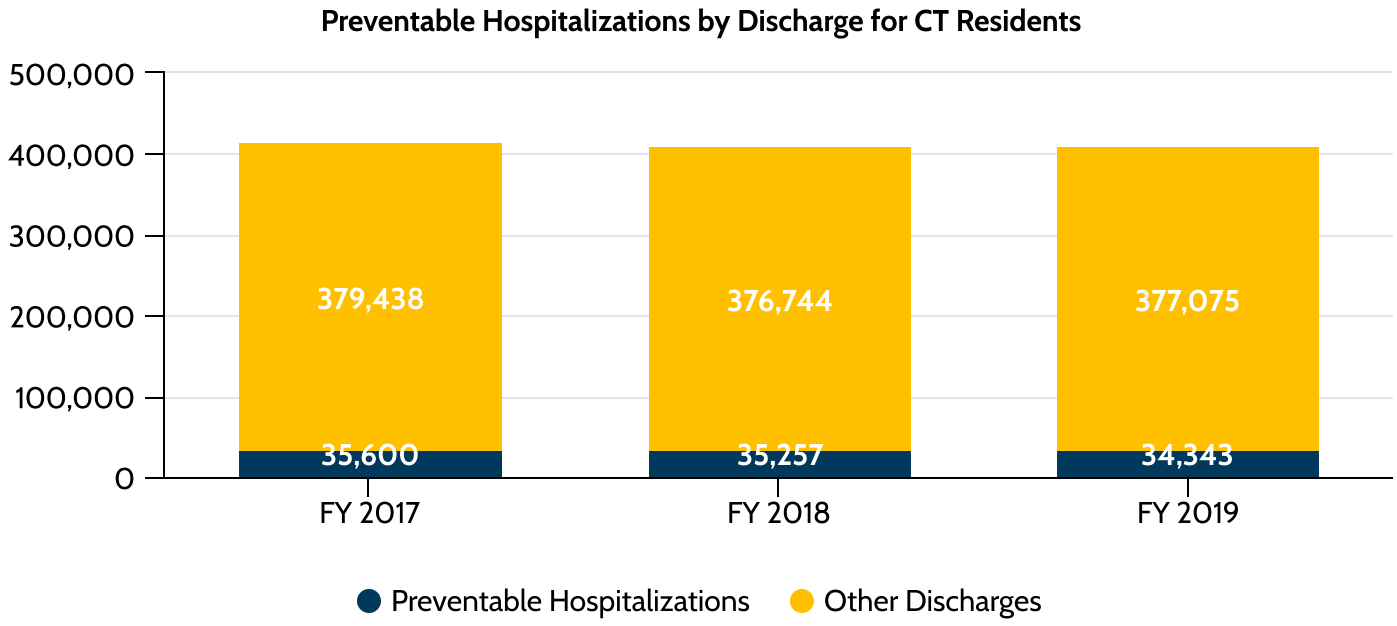
Insurance Coverage Demographics

Demographics		%	95% CI	
	Total	92.5	91.7	93.3
Age	18-34 years old	87.1	84.9	89.4
	35-54 years old	92.0	90.6	93.4
	55 and over	96.6	95.9	97.1
Sex	Male	91.2	89.9	92.5
	Female	93.7	92.7	94.7
Race/Ethnicity	Non-Hispanic White	96.6	96.0	97.3
	Non-Hispanic Black	88.5	85.4	91.5
	Hispanic	75.8	72.2	79.4
	Non-Hispanic Other	91.8	88.3	95.4
Income	Less than $35,000	84.6	82.3	86.9
	$35,000-$74,999	92.1	90.2	93.9
	$75,000 and more	97.8	97.0	98.5
Disability	Disabled	91.0	89.2	92.9
	Non-Disabled	93.2	92.3	94.1
Education	High School Graduate or Less	86.8	85.0	88.5
	More than High School	96.1	95.4	96.8

Source: DPH BFRSS Data courtesy of Xi Zheng and her team

Approximately 93% of Connecticut residents have some type of health insurance. though there is some variation when race/ethnicity is considered. Non-Hispanic White individuals were most likely to have health insurance (96.6%) followed by Non-Hispanic Other (91.8%), Non-Hispanic Black (88.5 %) and Hispanic (75.8%), respectively.

Preventable Hospitalizations

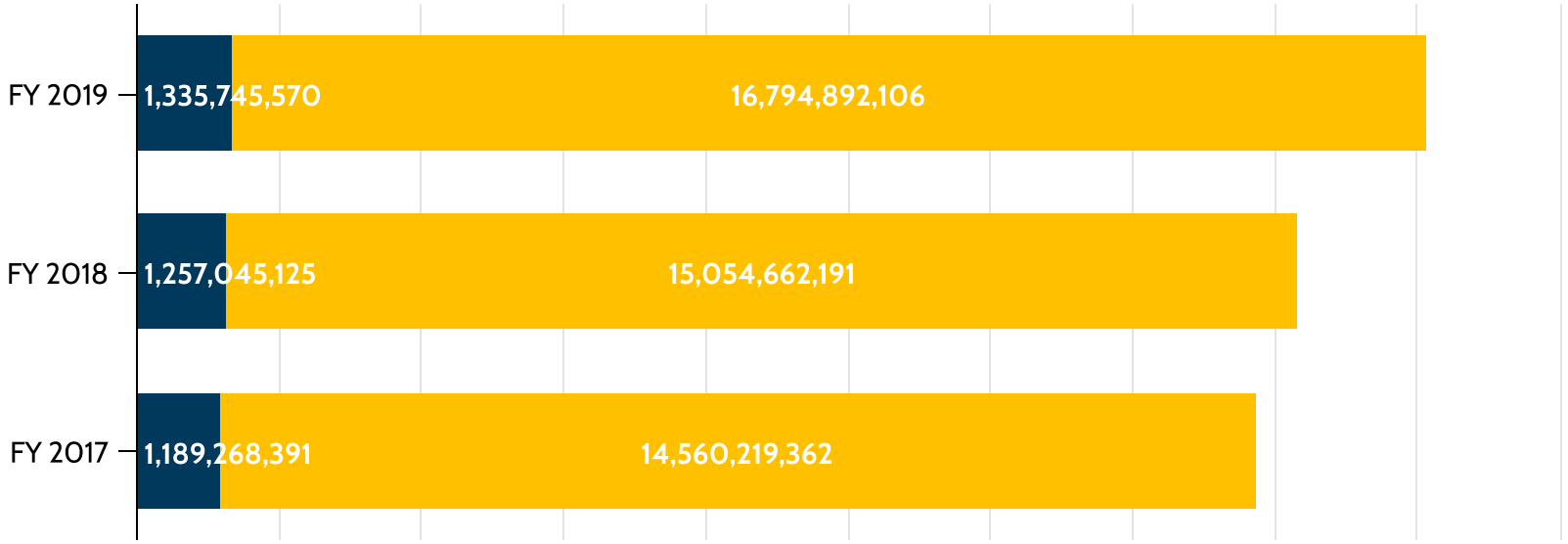


Data Source:CT OHS Acute Care Hospital Inpatient Discharge Database and Agency for Healthcare Research and Quality WinQI v2019

The number of preventable hospitalizations (hospitalizations that may have been avoided if conditions or illnesses were successfully managed in other healthcare settings, has decreased by over 900 from FY 2018 to FY 2019.

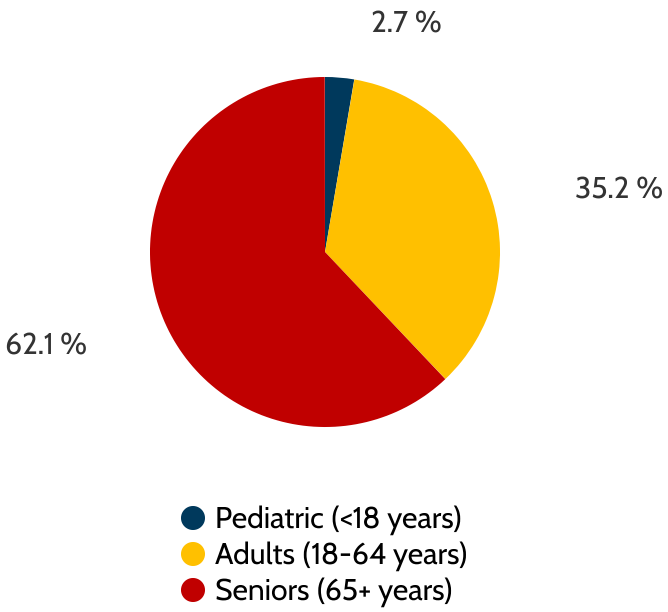
Preventable Hospitalizations

Total Charges by Fiscal Year for CT Residents



Total charges for both preventable hospitalization and other discharges increased from FY 2018 to FY 2019 for Connecticut residents.

FY 2019 Preventable Hospitalization Discharges by Age Group



The majority of preventable hospitalizations were by seniors (ages 65+) at approximately 62% in FY 2019.

Data Source:CT OHS Acute Care Hospital Inpatient Discharge Database and Agency for Healthcare Research and Quality Winnow2019

Preventable Hospitalizations

Adult Preventable Hospitalizations Rates - Top 5 Conditions, Connecticut, FY 2019	Rate Per 100,000
Community-Acquired Pneumonia Admission Rate	441.0
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults	196.0
Urinary Tract Infection Admission Rate	136.5
Uncontrolled Diabetes Admission Rate	120.1
Diabetes Long-term Complications Admission Rate	104.5

Connecticut's top preventable health condition in adults is community-acquired pneumonia, with 441 people per 100,000 being admitted to the hospital.

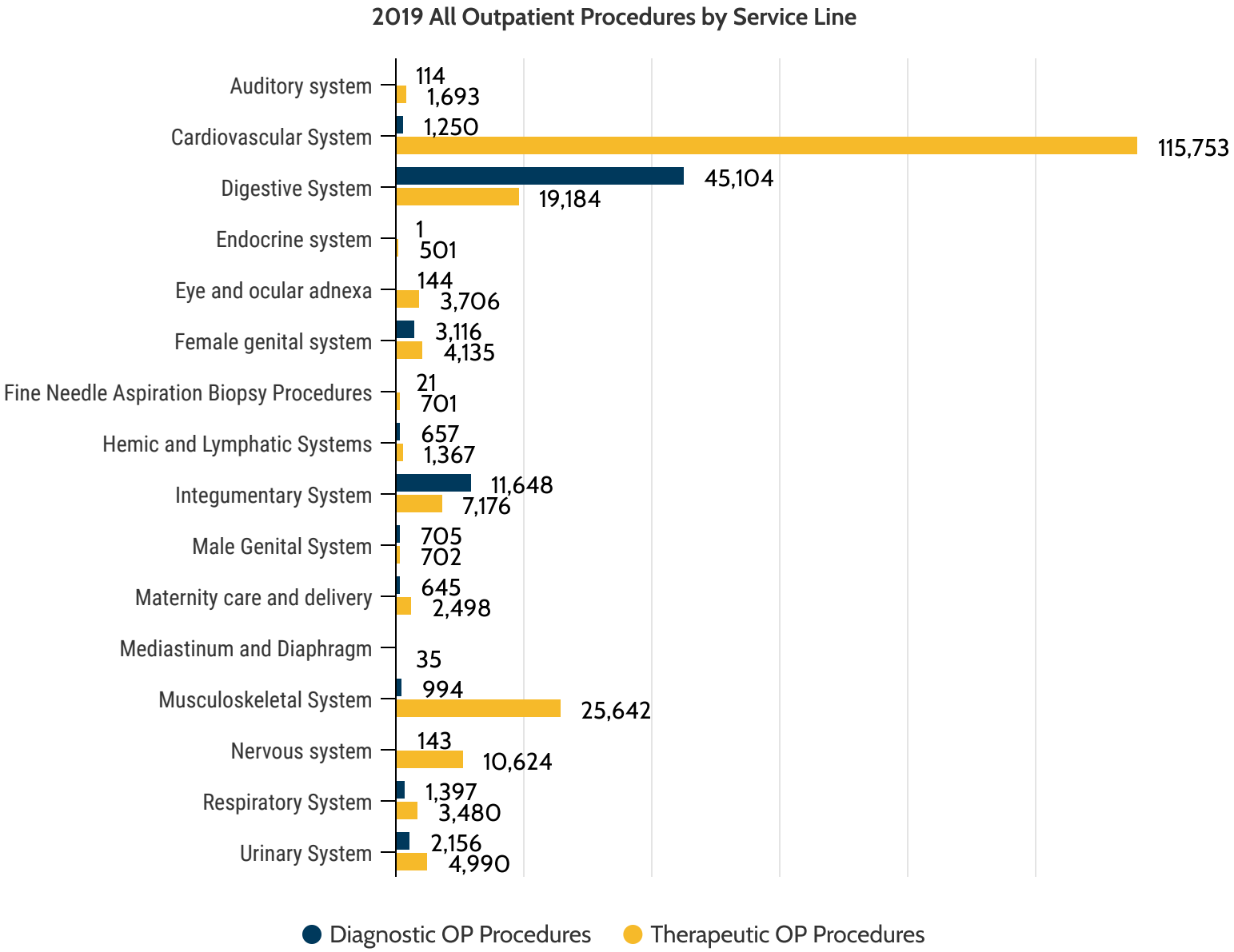
Pediatric Preventable Hospitalization Rates--Top 5 Conditions, Connecticut FY 2019	Rate Per 100,000
Asthma Admission Rate	77.7
Gastroenteritis Admission Rate	31.9
Urinary Tract Infection Admission Rate	12.6
Diabetes Short-term Complications Admission Rate	11.1
Postoperative Sepsis Rate	2.1
Central Venous Catheter-Related Blood Stream Infection Rate	2.1

Connecticut's top pediatric preventable health condition is asthma, with 77.7 children per 100,000 being admitted to the hospital.

Data Source:CT OHS Acute Care Hospital Inpatient Discharge Database and Agency for Healthcare Research and Quality WinQI v2019

Outpatient Surgery

Outpatient or ambulatory surgery is a planned operation for which the patient is not expected to be admitted to a hospital for an overnight stay. In Connecticut, outpatient surgeries are provided at an acute care hospital's main campus outpatient department or a satellite location or at a licensed freestanding outpatient surgical facility. In 2019, there were 28 hospital outpatient surgical departments, 15 hospital satellites and 60 licensed outpatient surgical facilities in the state.



In FY 2019 the majority of outpatient procedures were for problems with the cardiovascular system.

Data Source: CT Office of Health Strategy All Payer Claims Database (APCD), includes fully insured and State Employee/Retiree and Medicare Plans

Top 25 Most Commonly Performed Outpatient Procedures for Commercially Insured

Top 25 Most Commonly Performed Outpatient Procedures for the Commercially Insured*, 2019

CPT Description	CPT Codes	No. Procedures in Performed Hospital Outpatient Surgery Departments (HOSD)	No. Procedures Performed in Ambulatory Surgery Centers (ASC)	Total Procedures	Average Allowed Amount (HOSD)[1]	Average Patient Out of Pocket Share (HOSD)[2]	Average Allowed Amout (ASC)[1]	Average Patient Out of Pocket Share (ASC)[2]
Routine venipuncture	36415	110,644	9	110,653	$ 41.56	25%	$ 21.43	32%
Colonoscopy and biopsy	45380	6,459	9,258	15,717	$ 2,036.13	6%	$ 828.19	10%
Egd biopsy single/multiple	43239	5,597	8,151	13,748	$ 1,944.61	17%	$ 830.19	27%
Diagnostic colonoscopy	45378	4,375	6,585	10,960	$ 2,313.97	3%	$ 844.71	6%
Colonoscopy with lesion removal	45385	3,849	6,808	10,657	$ 1,993.48	4%	$ 774.45	7%
Fetal non-stress test	59025	2,306	-	2,306	$ 1,306.51	13%		
Cataract surgery with insertion of intraocular lens prosthesis	66984	865	1,191	2,056	$ 5,273.58	16%	$ 2,713.42	22%
Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet	12001	1,910	9	1,919	$ 398.53	37%	$ 233.67	31%
Capillary blood draw	36416	1,707	-	1,707	$ 41.84	25%	-	-
Knee arthroscopy/surgery	29881	376	1,133	1,509	$ 4,968.16	13%	$ 3,255.64	18%
Hysteroscopy biopsy	58558	1,366	130	1,496	$ 3,759.93	18%	$ 1,457.06	25%
Us urine capacity measure	51798	1,493	-	1,493	$ 198.66	31%	-	-
N block inj brachial plexus	64415	148	1,025	1,173	$ 1,636.38	7%	$ 535.77	6%
Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes	12011	1,103		1,103	$ 422.42	42%	-	-
Breast biopsy 1st lesion ultasound imaging	19083	1,093	-	1,093	$ 3,656.97	24%	-	-
Create eardrum opening	69436	576	465	1,041	$ 1,766.49	18%	$ 2,317.26	23%
Shoulder arthroscopy/surgery	29826	312	715	1,027	$ 2,508.50	8%	$ 2,179.95	5%
Egd diagnostic brush wash	43235	622	356	978	$ 1,986.14	15%	$ 590.83	29%
Laparoscopic cholecystectomy	47562	951	9	960	$ 6,332.53	11%	$ 3,596.11	22%
Njx interlaminar lmbr/sac	62323	557	384	941	$ 3,496.97	13%	$ 1,338.40	24%
Arthroscop rotator cuff repr	29827	292	600	892	$ 3,534.76	8%	$ 4,229.54	12%
Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet)	12002	890	-	890	$ 405.61	39%	-	-
Breast biospy with placement of localization device	19081	801	-	801	$ 3,778.83	24%	-	-
Injection foramen epidural in lumbar/sacral area	64483	379	419	798	$ 2,232.17	19%	$ 1,227.88	24%
Apply forearm splint	29125	724	-	724	$ 287.53	30%		

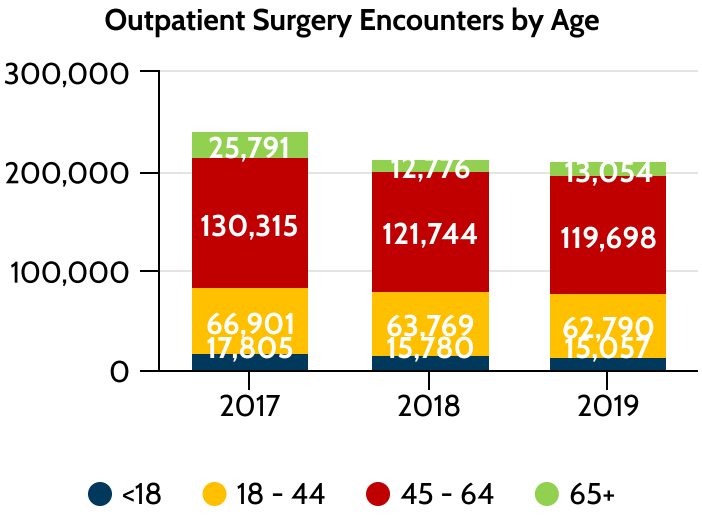
Source: CT Office of Health Strategy All Payer Claims Database (APCD), includes fully insured and State Employee/Retiree and Medicare Plans*

[1] Includes amount paid by plan and subscriber out of pocket cost (i.e. deductible, coinsurance, co-pay)

[2] Includes plan subscriber out of pocket cost (i.e. deductible, coinsurance, co-pay)

OHS CONNECTICUT Office of Health Strategy

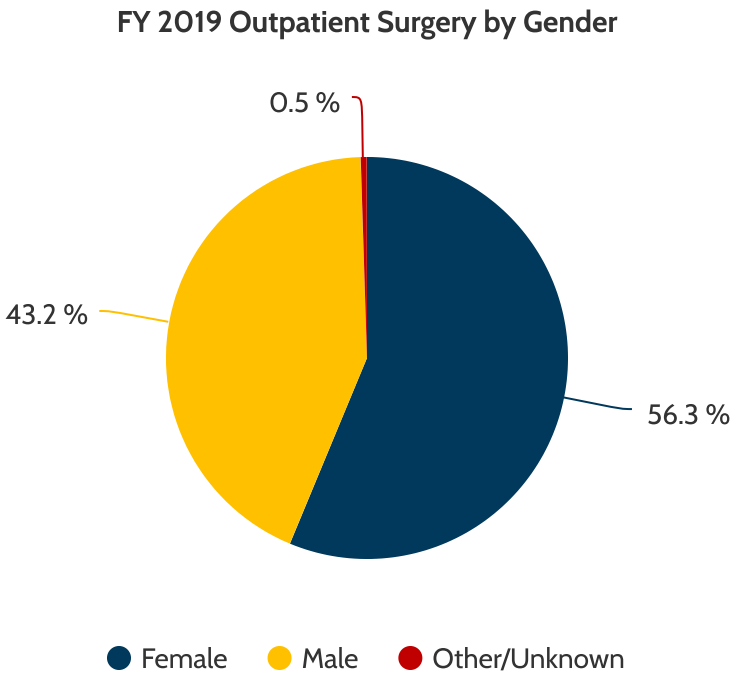
Outpatient Surgery



There has been a slight decrease in the number of outpatient surgery visits over the past three years.

Source: CT Office of Health Strategy All Payer Claims Database (APCD), includes fully insured and State Employee/Retiree Plans only

There were 118,501 females, 91,036 males and 1062 other/unknown patients which received outpatient surgical care in FY 2019.



Source: CT Office of Health Strategy All Payer Claims Database (APCD), includes fully insured and State Employee/Retiree and Medicare Plans

Appendix-Acronyms/Abbreviations

AAMR	Age-Adjusted Mortality Rate
ACO	Accountable Care Organizations
AHA	American Hospital Association
AN	Advanced Networks
APCD	Connecticut All Payers Claims Database
BRFSS	Behavioral Risk Factor Surveillance Survey
CBO	Community Based Organizations
CDC	Centers for Disease Control and Prevention
CGS	Connecticut General Statutes
CHIP	Community Health Improvement Plans
CHNA	Community Health Needs Assessment
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid
CON	Certificate of Need
DCF	Connecticut Department of Children and Families
DPH	Department of Public Health
DSS	Department of Social Services
ED	Emergency Department
FQHC	Federally Qualified Health Centers
Access Health CT	Connecticut Health Insurance Exchange
HIE	Health Information Exchange
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HITO	Health Information Technology Officer
HPSA	Health Professional Shortage Area

Appendix-Acronyms/Abbreviations

HRSA	Health Resources and Services Administration
HSS	Department of Health and Human Services
LHD	Local Health Departments/Districts
MUA/P	Medically Underserved Areas and Populations
OHS	Office of Health Strategy
PA	Public Act
PCMH+	Patient-Centered Medical Homes
PCO	Primary Care Office
PHP	Population Health Plan
PPACA	Patient Protection and Affordable Care Act
PSA	Primary Service Area
SAMHSA	Substance Abuse and Mental Health Services Administration
SES	Socioeconomic Status
SHA	Healthy Connecticut 2020 State Health Assessment Plan
SHIP	Healthy Connecticut 2020 State Health Improvement Plan
SIM	Connecticut State Innovation Model
The Plan	Statewide Healthcare Facilities and Services Plan
US	United States
VCA	Value Care Alliance

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