CHAPTER 5 CONCLUSIONS AND NEXT STEPS

This 2016 Supplemental Plan focuses on the health and healthcare outcomes of vulnerable populations. It also describes initiatives in Connecticut that are identifying and addressing gaps in services and unmet need. This Supplement also examines statewide changes in health status and care delivery over a period in which there have been considerable systems-level changes in healthcare access and quality. As in prior Plans, this Supplement continues to assess availability of appropriate, timely access to services.

Based on US Census data, overall, Connecticut residents' perception of their health status appears to be improving.[i] The proportion of the total population self-reporting poor health status has declined. The PPACA's individual mandate reduced Connecticut's uninsured rate to 8.7% in 2015, lower than the rate for the US overall (10.8%).[ii] This decline was notable among many vulnerable populations in the state, particularly young adults, Hispanics or Latinas/os, those with incomes less than $35,000 and those with a high school education or less.

Demographically, compared to the nation overall, with the exception of the elderly, Connecticut has relatively lower proportions of vulnerable populations. While all vulnerable populations have been growing since 2010, racial/ethnic minorities and those living below the federal poverty level have increased at a faster rate in Connecticut than observed nationally. These demographic shifts within Connecticut suggest vulnerable populations may be increasing as a proportion of the total population and thus healthcare access and health equity will continue to be an important focus.

CURRENT HEALTHCARE ENVIRONMENT

Connecticut residents are served in various settings and by numerous types of healthcare providers. Among its diverse resources available for treating healthcare needs, Connecticut has 28 acute care hospitals with 8,644 licensed beds for inpatient care. There is also an ED at each acute care hospital and five hospital-owned freestanding satellites to treat patients 24/7. Additionally, there are over 100 outpatient surgical departments/facilities providing ambulatory surgical care.

There are many initiatives at the Connecticut DPH, in collaboration with hospitals, local leadership, and other sectors, which aim to reduce health inequities, improve access to preventive care, and strengthen the coordination of healthcare. Moreover, as part of its mandate, OHCA considers implications of CON applications on vulnerable populations' access to healthcare services.

The healthcare landscape continues to change as the focus of care shifts toward prevention and early intervention. Hospital acquisitions, mergers, and the consolidation of services within and between delivery systems are common as the landscape evolves and operational and economic challenges arise. Hospitals are shifting delivery models in favor of outpatient settings to remain competitive. Mirroring national trends, they are regionalizing or specializing in core services in response to declining revenues, operational challenges, and new reimbursement models under the PPACA. It is important to note that the long-term consequences of potential changes in healthcare at both the federal and state level may be profound, but are still uncertain.

Utilization and Trends

Increases in acute care discharges covered by Medicaid and other public coverage reflect the effect of the PPACA coverage expansion in Connecticut. White non-Hispanics, women, adults 50 years of age and older and those with Medicaid coverage continue to be higher users of emergency services than other groups.

With respect to ED visits, one in ten are behavioral-health related and most likely to be made by vulnerable populations. The majority of opioid overdose/dependence related ED visits were made by White non-Hispanic males with Medicaid coverage and residing in an urban core or periphery town.

Some towns are not included in a Connecticut hospital's primary service area, but residents may still receive services from a Connecticut hospital. All Connecticut towns though are covered by a CHNA. Mental health and substance abuse care continue to be the leading healthcare needs of most Connecticut communities, according to most recent CHNAs. Although Connecticut has a statewide surplus of inpatient beds, some hospitals may have to increase the number of beds staffed for certain services to meet the healthcare demands.

GAPS AND UNMET NEED

While aggregate data suggest that for the total population, Connecticut residents have experienced improvements in chronic conditions since publication of the 2014 Supplement, health outcomes, CHNAs, and unmet healthcare need indices indicate that certain health conditions and outcomes remain disproportionately concentrated among at-risk and vulnerable populations. Health disparity and barriers to opportunities to live a healthy life remain critical areas of focus for certain populations in Connecticut. As healthcare systems changes continue to unfold, it is important to remain attentive to health and healthcare patterns over time for vulnerable populations.

Access to Care and Availability of Services

Healthcare costs and availability of services remain barriers to care for certain populations, particularly lower income and rural populations in Connecticut. Access to care was identified as a priority need in nearly half of all CHNAs. Counties that are home to Connecticut's largest towns are characterized by having the greatest number of medically underserved areas or health professional shortages. Additionally, there are 21 towns that have an unmet need composite index higher than the state index.

Chronic Disease

Vulnerable populations are disproportionately burdened by certain chronic health conditions including high blood pressure, diabetes, and asthma. Chronic disease was identified as a priority need in most CHNAs. Despite the expansion of healthcare insurance coverage, access to care continues to be a challenge for some Connecticut residents, with 11% of adults reporting postponing or not receiving needed medical care because of cost.

Behavioral Health

Behavioral health issues are a growing concern for Connecticut residents and the leading cause of hospitalizations for residents between 5 and 44 years of age. Mirroring a national trend, there has been an increase in deaths due to opioid overdoses in Connecticut. Most CHNAs identified substance abuse and mental health as priority needs. In 2016, there were 30 designations of mental health HPSAs in Connecticut.

LIMITATIONS

As with all assessments, there are limitations and this Supplement should be considered in the same context. Lack of comprehensive data limits OHCA's ability to fully assess population needs. The utilization and outcomes data currently available is insufficient. Therefore evaluations of availability of and access to healthcare services are limited.

NEXT STEPS

- Continue to analyze outpatient surgical data for planning purposes as healthcare resources continue to shift from inpatient to outpatient care;

- Delve further into ED use to identify the factors such as specific day of use and type, severity and number of co-morbidities, that drive utilization and readmissions to help determine the appropriate interventions;
- Analyze data from the All Payers Claims Database to identify any disparities in healthcare availability and delivery;
- Further study the 21 towns that have been identified as exceeding the state unmet need composite index; and
- Monitor current initiatives in the state that seek to improve care coordination and delivery, and link healthcare to community assistance, such as the Person-Centered Medical Homes-Plus (PCMH+) Initiative. Explore opportunities to scale up and spread success.

In future planning efforts, OHCA will continue its examination of available data to determine how best to address the unmet needs of residents and to assist providers in their transformations to meet those needs.

References

[i] US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2013 and 2015. https://www.census.gov/cps/data/cpstablecreator.html
[ii] US Behavioral Risk Factor Surveillance System. Accessed March 9, 2017. https://www.cdc.gov/brfss/data_tools.htm.