OFFICE OF HEALTH CARE ACCESS

CRISTINE A. VOGEL, COMMISSIONER

June 2006

Studying Health Care Utilization in Connecticut

Report to the Governor and General Assembly

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Studying Health Care Utilization in Connecticut: A Report to the Governor and the Legislature

Section 19a-634 of the Connecticut General Statutes (CGS) requires the Office of Health Care Access (OHCA) to "carry out a continuing state-wide health care facility utilization study of existing health care delivery systems; recommend improvements in health care procedures to the health care facilities and institutions; recommend legislation in the area of health care programs; and report annually to the Governor and General Assembly its findings, recommendations and proposals for improving efficiency, lowering health care costs, coordinating use of facilities and services and expanding the availability of health care throughout the state."

The mandate requires that OHCA establish and maintain a state-wide health care facilities plan, with an ongoing evaluation of the utilization study to determine the availability of acute care, long-term care and home-health care services in private and public institutional and community-based facilities, determine the scope of such services and anticipate future needs for such facilities and services.

Introduction

Connecticut's health care is delivered within many different settings – hospitals, outpatient surgical centers, home care agencies, community health centers, private physician offices and more. The Office of Health Care Access oversees a portion of this delivery system, mainly the hospitals and surgical centers. One of OHCA's responsibilities is to examine capacity and utilization of health care services. Basically, capacity is a measurement of the maximum volume of services that can be provided (e.g., number of MRI scans, number of staffed beds in a hospital unit) in a specific region; and utilization is the measurement of actual volume or procedures that have been provided to patients. Utilization studies are used in planning efforts to accommodate future growth or shifting of patient needs and demographics.

This utilization report serves as a foundation for discussing the development of a realistic and feasible approach to identifying what data are currently available to OHCA and where gaps exist in data collection to accurately report the state's health care utilization.

Purpose of Utilization Studies

The reasons people use Connecticut's health care delivery system are numerous. Connecticut citizens access health care services in the delivery system to cure illness, to prevent future health care problems, to monitor ongoing conditions, to improve quality of life and to obtain information about their health status and prognosis.

Health care utilization rates serve as indicators of what types of care specific populations use, and demonstrate how services may be shifting from one site to another. Health care utilization data are used by policymakers, planners, researchers and others in the health care community for a multitude of purposes, such as identifying shifts in the use of health care resources and services, monitoring specific diseases and examining the impact of new medical technologies or procedures. Examining health care utilization provides important information regarding the appropriateness, quality or cost of care, and may indicate areas that warrant further study. Utilization studies may also serve as a foundation for projecting

Table 1: Health Care Utilization Forces	
Factors that may increase health service utilization	Factors that may decrease health service utilization
▪ Increased supply (e.g., imaging centers, assisted living residences)	▪ Decreased supply (e.g., hospital/facility/program closures, number of physicians retiring)
▪ Growing population, growing elderly population	▪ Public health advances/better understanding of risk factors of diseases and prevention methods
▪ New procedures and technologies	▪ Discovery/implementation of treatments that cure/eliminate diseases
▪ Guidelines that recommend increased utilization	▪ Guidelines that recommend decreased utilization
▪ New disease entities (e.g., HIV/AIDS)	▪ Shift to other sites of care (e.g., ambulatory surgery for procedures previously requiring overnight hospital stays)
▪ New drugs/expanded use of existing drugs	▪ Payer pressures to reduce costs
▪ Changes in federal government insurance payment policies (e.g., SCHIP)	▪ Changes in federal government insurance payment policies
▪ Increased health insurance coverage	▪ Changes in practice patterns (e.g., reduced length of stay)
▪ Changes in practice patterns (e.g., more aggressive treatment)	▪ Changes in consumer preferences (e.g., home birthing, alternative medicine)
▪ Changes in consumer demand/preference (e.g., cosmetic surgery, direct marketing of drugs)	▪ Preventative care/lifestyle

future health care needs, to forecast future health care expenditures or as the basis for determining resource needs (e.g., personnel, training or facilities planning).[1]

Major Forces Affecting Health Care Utilization

Many factors influence how much health care people use, what types of health care are utilized, and the timing of that care. Our health care delivery system continues to evolve as new and emerging technologies, drugs, devices, procedures, tests and provider practice patterns influence how and where care is provided. For example, the continuing development of antibiotics and ongoing public health initiatives have reduced the need for people to require facility-based health care for many infectious diseases, thus decreasing utilization. However, consumer demand, new procedures and technologies and the rise in the prevalence of chronic diseases, such as asthma, have increased utilization.

Additionally, advances in relatively new therapeutic technologies, such as corrective eye surgeries, may increase demand.

Socio-demographic population shifts and changes in the prevalence and incidence of certain diseases are other factors that influence the need for care. In addition, the cost of health care to the patient, provider and payer also influences the utilization of health care services, and need to be considered as attempts are made to control the rate of health care spending.

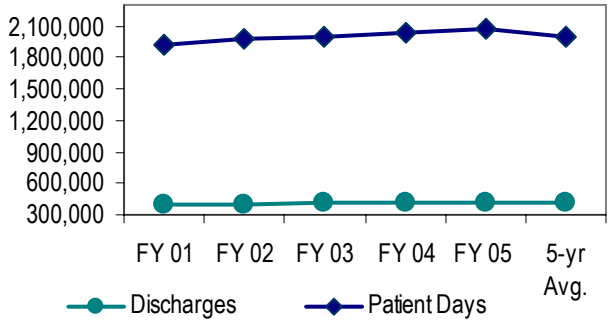
Table 1 lists some factors that affect trends in overall health care utilization over time. Some forces encourage more utilization while others deter use. Moreover, a combination of increasing or decreasing factors may exert pressure on the health care system at once.[2]

Acute Care Hospital Utilization Trends in Connecticut: Fiscal Years 2001 to 2005

Connecticut has 31 acute care hospitals, 9,241 licensed beds, with 7,182 staffed to serve its 3.5 million residents (See Appendix I for a breakdown of hospitals and beds). For this report, actual utilization data for hospital inpatient services were analyzed, since hospitalization represents a considerable portion of the market and OHCA receives comprehensive data from hospitals.

Inpatient discharge data contained in this report are through fiscal year (FY) 2005. Data from OHCA's Hospital Budget System are through FY 2004.[3] Unless specifically noted, this report uses five-year averages to minimize random annual changes in data, thus providing a more meaningful pattern of utilization.

Figure 1: Acute Care Discharges and Patient Days, FYs 2001-2005



Source: CT Office of Health Care Access Acute Care Hospital Discharge Database

Inpatient utilization

The state saw declining inpatient utilization in the late 1990s, with discharges, patient days and average length of stay reaching lows of 369,470, 1,791,769 and 4.8, respectively. The average length of stay in Connecticut was almost equivalent to the national average of 4.9 days.[4] Over the last five years, hospitals averaged 408,700 inpatient discharges per year (see Appendix II for hospital details). Total patient stays averaged approximately 2,000,000 days per year (see Appendix III for hospital details). From FY 2001 to FY 2005, discharges and patient days grew steadily by about 2% annually, as shown in **Figure 1**. Since discharges and patient days were increasing at the same pace, average length of stay remained at 4.9 days per discharge.

Table 2: Acute Care Inpatient Utilization Rate, FYs 2001-2005

	Discharges	Patient Days	Connecticut Population[1]	Utilization per 1,000 Population
FY 01	393,202	1,923,200	3,317,131	119
FY 02	402,279	1,973,425	3,350,345	120
FY 03	408,775	1,986,474	3,371,241	121
FY 04	416,300	2,037,488	3,389,483	123
FY 05	423,179	2,077,620	3,510,297	121
5-yr Avg.	408,747	1,999,641	3,387,699	121

Source: CT Office of Health Care Access Acute Care Hospital Discharge Database

[1]US. Census Bureau American Community Survey (ACS) estimates are of the household population and excludes population living in institutions, college dormitories and other group quarters. FY 05 estimate is from the US Census Bureau Population Estimates Program.

By analyzing the number of discharges per 1,000 population, it can be determined if more patients are using hospital inpatient services from year to year. Bed availability and access to services plays a significant role in the hospitalization rate. **Table 2** shows that the overall inpatient utilization rate per 1,000 population rose from 119 in FY 2001 to 121 in FY 2005. Although this does not indicate a large shift in utilization, it does warrant a more detailed analysis to identify specific services, particular populations or regions within the state that may be contributing to the higher rate.

Inpatient readmissions

Readmissions to the same hospital contributed to the growth in discharges over the five-year period. The share of first time patients dropped from 57% in FY 2001 to 49% in FY 2005.[5] Conversely, readmissions increased from 43% to 51% of all discharges. Readmissions within 30 days of a prior hospitalization remained at one in ten of all discharges but accounted for significant portions of increases in total discharges between FY 2001 and FY 2005. Approximately 50% of patients readmitted to the same hospital were over age 65 while 44% were between the ages of 18 and 64.

Outpatient utilization

Technological advances have increased the number and type of procedures that can be performed in an outpatient setting. There has been a significant shift of health care services from hospitals to such facilities in Connecticut and nationwide, as reimbursement for these services becomes more available. Only hospital-owned facilities report data to OHCA, whereas many outpatient facilities are joint partnerships with or solely owned by physician groups or are owned by hospital affiliates. Data from those facilities are not included in this report.

In contrast to inpatient discharges, Connecticut hospitals experienced a net decrease of 6% in all hospital-based outpatient visits between 2001 and 2004 (see Appendix IV for a distribution of emergency department (ED) and outpatient visits by hospital).[6] Some of this decrease may be associated with the ownership structure of many outpatient facilities.

Despite the net decline in volume, Connecticut residents used hospital-based outpatient care, on average, about twice a year, as illustrated in **Table 3**. Nearly one-half of these visits originated from private referrals (46%), over one fifth from emergency departments (22%), 17% from other clinics, 6% from psychiatric clinics and 5% from home care. This decline in volume is likely due to the impact of competing facilities newly introduced into the market and a trend of hospitals reorganizing the corporate structure of their outpatient services as noted above to improve reimbursement rates.

Table 3: Hospital-Based Outpatient Utilization, FYs 2001-2004

	Total Outpatient Visits[1]	Connecticut Population[2]	Outpatient Utilization
FY 01	6,444,923	3,317,131	1.9
FY 02	6,749,711	3,350,345	2.0
FY 03	5,933,030	3,371,241	1.8
FY 04	6,090,185	3,389,483	1.8
4-yr Avg.	6,304,462	3,357,050	1.9

[1]CT Office of Health Care Access Hospital Budget System Schedule 500.
[2]US. Census Bureau American Community Survey (ACS) estimates are of the household population and excludes population living in institutions, college dormitories and other group quarters.

Emergency Department utilization

Emergency department care is a critical component of Connecticut's health care system and serves as the safety net for many who may not have access to other available resources. All 31 acute care hospitals provide their communities with emergency care 24 hours a day.

Emergency department (ED) visits include patients "treated and discharged" and those "treated and admitted" for inpatient care in an acute care hospital or transferred to other types of institutions.[7] On average, about 15% of ED patients were admitted to Connecticut hospitals for inpatient care. Inpatient admissions through the ED increased from 44% in FY 2001 to 50% in FY 2005.

As shown in **Table 4**, the ED utilization rate per 1,000 population has increased by about 7% since FY 2001.

Table 4: Emergency Department Utilization Rate, FYs 2001-2004

	ED Visits	Annual % Change in ED Visits	Connecticut Population[1]	Annual % Change in Population	Utilization per 1,000 of Population	Annual % Change in Utilization
FY 01	1,350,053	-	3,317,131	-	407	-
FY 02	1,407,465	4%	3,350,345	1%	420	3%
FY 03	1,414,507	1%	3,371,241	1%	420	0%
FY 04	1,446,736	2%	3,389,483	1%	427	2%
4-yr Avg.	1,404,690	N/A	3,357,050	N/A	418	N/A

Source: CT Office of Health Care Access Acute Care Hospital Budget System Schedule 500

[1]US. Census Bureau American Community Survey (ACS) estimates are of the household population and excludes population living in institutions, college dormitories and other group quarters.

Connecticut's ED utilization is higher than the national rate. In 2003, the national ED utilization rate was just under 400 visits per 1,000 population, as compared to 420 per 1,000 in Connecticut.[8, 9]

How many beds are available for services?

Hospitals are licensed for a specific number of beds but may operate or "staff" fewer beds. As shown in **Table 5**, Connecticut's 31 acute care hospitals had 9,241 licensed beds with approximately 7,182 (78%) staffed for patient use in 2004. Hospital beds can be used as a measure of the size or capacity of the inpatient hospital system. The occupancy rate is a critical measurement that determines if there is available capacity within the system. In FY 2004, the statewide staffed beds occupancy rate, which indicates the percentage of staffed beds that are in use on any given day, was 78%.[10]

Table 5: Acute Care Beds Occupancy Rates,[1] FYs 2001-2004

	Patient days	Licensed beds	Staffed beds	Occupancy Rate of Staffed Beds	% of Licensed Beds Staffed
FY 01	1,923,200	9,178	6,994	75%	76%
FY 02	1,973,425	9,137	7,151	76%	78%
FY 03	1,986,474	9,140	7,152	76%	78%
FY 04	2,037,488	9,241	7,182	78%	78%
4-yr Avg.	1,980,147	9,174	7,120	76%	78%

Source: CT Office of Health Care Access Acute Care Hospital Discharge Database & Hospital Budget System Schedule 500

[1]The rate is average number of beds in use on a given day and is derived by the formula: total patient days/(staffed beds*365)

Table 6: Average Number of Beds Staffed for Inpatient Acute Care Services, FY 2000-2004

						Change between FY 01 & FY 04	
Service	FY 01	FY 02	FY 03	FY 04	4-yr Avg.	Beds	%
Medical/Surgical[1]	4,649	4,789	4,788	4,816	4,761	167	4%
Behavioral Health[2]	700	694	698	706	700	6	1%
Maternity	533	562	558	553	552	20	4%
Newborn[3]	694	699	706	707	702	13	2%
Rehabilitation	115	135	131	133	129	18	16%
Pediatric	303	272	271	267	278	-36	-12%
Total	6,994	7,151	7,152	7,182	7,120	188	3%

Source: OHCA Hospital Budget System Schedule 500

[1]87% adult medical/surgical, 13% ICC/CCU and 0.2% other beds.

[2]98% psychiatric and 2% drug and alcohol treatment beds.

[3]70% bassinets and 30% neonatal ICU beds.

The vast majority of staffed beds were for medical/surgical patients. **Table 6** shows that, on average, staffed beds available for inpatient acute care grew by 3% (188 beds) from FY 2001 to FY 2004 (see Appendix V for a distribution of staffed beds by hospital). With the exception of pediatric beds, down approximately 12%, hospitals increased staffed beds for all service categories over the four year period.

In terms of utilization by service, **Table 7** illustrates that Connecticut's acute care behavioral health beds had the highest average occupancy rate, on average, from 2001 to 2004. There were 21 beds for every 100,000 of the state's population. On any given day, approximately 140 behavioral health beds were available. Medical/surgical and rehabilitation beds had the second and third highest average occupancy rates, at 79% and 78%, respectively. Beds for all other services had occupancy rates below the state average.

Table 7: Inpatient Acute Care Services Staffed Beds Utilization and Availability, FY 2001-2004

Service	4-yr Avg Staffed Beds	4-yr Avg Discharges	4-yr Avg Patient Days	Staffed Beds Occupancy Rate[1]	Connecticut Population	Bed Availability per 100,000 Population
Medical/Surgical[2]	4,761	269,927	1,376,793	79%	2,563,877	186
Behavioral Health[3]	700	22,678	203,436	80%	3,405,565	21
Maternity[4]	552	47,366	136,364	68%	686,010	80
Newborn[5]	702	44,370	162,900	64%	42,719	1,642
Rehabilitation[6]	129	3,010	36,374	78%	2,563,877	5
Pediatric[7]	278	17,788	64,281	63%	841,688	33
Total	7,120	405,139	1,980,147	76%	3,405,565	209

Sources: Office of Health Care Access Hospital Budget System Schedule 500 and Acute Care Hospital Discharge Database and US Census Bureau Census 2000

[1]The rate is average number of beds in use on a given day and is derived by the formula: total patient days/(staffed beds*365)

[2]Adults over 17 years old, although 0.3% (or 975) of discharges who accessed the service were between 13 and 17 years old.

[3]All ages and discharges include psychiatric and substance abuse patients.

[4]The Centers for Disease Control and Prevention (CDC) assumes the female childbearing age is between 18 and 45 years, however about 2.6% (or 1,219) of discharges were outside the age range and 96% of those were between 11 and 17 years old, with the remaining 4% between 46 and 56 years old.

[5]Under age one population and newborns and neonates under age one born with significant problems.

[6]Adults over 17 years old, however 0.4% (or 14) of discharges were under 18 years old.

[7]Between one and 17 years old.

Who is admitted to Connecticut hospitals?

Rates of hospitalization in Connecticut vary considerably by age group, as illustrated in **Table 8**. The elderly (65+) accounted for a disproportionate share of inpatient discharges. That is, while individuals age 65 and older comprised about 14% of the state's population, they accounted for approximately 36% of all hospital stays. Consequently, the inpatient utilization rate among seniors was about 2.6 times that of the statewide utilization rate (317 versus 120 per 1,000 of the respective populations).

Table 8: Acute Care Discharges Age Distribution and Utilization Per 1,000 Population, FYs 2000-2005

	Discharges		Census 2000		Utilization per 1,000 Population
Age Cohort[1]	5-yr Avg.	% Distribution	Connecticut Population	% Distribution	
Children	66,373	16%	841,688	25%	79
Adults	193,211	47%	2,093,694	61%	92
Seniors	149,163	36%	470,183	14%	317
Total	408,747	100%	3,405,565	100%	120

Source: CT Office of Health Care Access Acute Care Hospital Discharge Database and US Census 2000.

[1]Children are under 18 years old, adults are between 18 and 64 years old and seniors are 65 years old and over.

Table 9: Acute Care Discharges Gender Distribution and Utilization Rates, FYs 2001-2005

	Discharges		Census 2000		Utilization per 1,000 Population
	5-yr Avg.	% Distribution	Connecticut Population	% Distribution	
Female	237,932	58%	1,756,246	52%	135
0 - 17	32,108	8%	410,599	12%	78
18 - 44	78,391	19%	658,189	19%	119
45 - 64	43,089	11%	407,277	12%	106
65+	84,344	21%	280,181	8%	301
Male	170,814	42%	1,649,319	48%	104
0 - 17	34,265	8%	431,089	13%	79
18 - 44	28,857	7%	646,085	19%	45
45 - 64	42,873	10%	382,143	11%	112
65+	64,819	16%	190,002	6%	341
Total	408,747	100%	3,405,565	100%	120

Source: CT Office of Health Care Access Acute Care Hospital Discharge Database and US Census 2000.

As shown in **Table 9**, women in Connecticut were hospitalized more frequently than men, as approximately 58% of the discharges over the past five years have been female. Women in the 18 to 44 age group were more than 2.5 times as likely as their male counterparts to be hospitalized. The primary reasons for the high rate of utilization by women in this age group are related to pregnancy and childbirth. While younger women were hospitalized at higher rates than men, older women were hospitalized at lower rates than their male peers, especially in the 65+ age group.

Table 10 shows that overall, inpatient utilization rates were comparatively higher for minorities than for whites (128 versus 118 per 1,000 of the respective populations). Blacks used inpatient care at a higher rate than all other race/ethnicity categories (136 per 1,000 of the population).

Table 10: Acute Care Discharges Race and Ethnicity Distributions and Utilization Per 1,000 of Population: FYs 2001 - 2005

	Discharges		Census 2000		Utilization Rate per 1,000 Population
Race	5-yr Avg.	% Distribution	Connecticut Population[1]	% Distribution	
White	310,901	76%	2,638,845	77%	118
Minorities	97,848	24%	766,720	23%	128
Black	42,057	10%	309,843	9%	136
American Indian/Eskimo/Aleut	465	0%	9,639	0%	48
Hawaiian/Pacific Islander	84	0%	1,366	0%	62
Asian	3,709	1%	82,313	2%	45
Other[2]	15,915	4%	222,049	7%	72
Hispanics[3]	35,617	9%	320,323	9%	111
Total	408,749	100%	3,405,565	100%	120

Source: CT Office of Health Care Access Acute Care Hospital Discharge Database and US Census 2000.

[1]Census race categories are one race only.

[2]Discharges other category comprise other non-white race; Census categories are some other race or two or more races.

[3]Hispanics or Latinos of any race.

As illustrated in **Table 11**, three-quarters of discharges were from the state's three largest counties: Fairfield, Hartford and New Haven. New Haven County had the third largest population but the highest inpatient care utilization rate (128 per 1,000 of the population). In contrast, Tolland County had the second lowest population and the lowest utilization rate (94 per 1,000 of the population). In the last five years, New Haven and Windham counties showed the largest growth in residents using inpatient hospital care, growing by 12% and 11%, respectively. Although out-of-state patients accounted for, on average, only 3% of discharges, they showed the most growth, 15%, over the five year period. The majority of those patients were from New York (64%), Massachusetts (9%) and Rhode Island (4%).

Table 11: Acute Care Hospital Patient County Discharge Distribution and Utilization Per 1,000 Population, FY 2001-2005

	Discharges			Census 2000		
Patient County	5-yr-Avg	5-yr % Change	Ave Share of Total	Connecticut Population	Share of Population	Utilization per 1,000
Fairfield	96,221	5%	24%	882,567	26%	109
Hartford	102,016	7%	25%	857,183	25%	119
New Haven	105,459	12%	26%	824,008	24%	128
New London	29,727	4%	7%	259,088	8%	115
Litchfield	19,644	8%	5%	182,193	5%	108
Middlesex	16,354	6%	4%	155,071	5%	105
Tolland	12,856	4%	3%	136,364	4%	94
Windham	12,487	11%	3%	109,091	3%	114
Other *	13,981	15%	3%	N/A	N/A	N/A
Statewide	408,747	8%	100	3,405,565	100%	120

Source: CT Office of Health Care Access Acute Care Hospital Discharge Database

* Includes NY, MA, RI , other states and US Territories and other countries.

Why are patients admitted to Connecticut hospitals?

Routine admissions and admissions through the ED

Table 12 shows that, in FY 2005, admissions through the ED were frequently more serious than routine admissions. While routine admissions were frequently birth-related, ED admissions were more likely to involve respiratory or coronary diagnoses.

Table 12: Top Ten Primary Reasons for ED or Routine Admissions: FY 2005

ED Admissions			Routine Admissions		
ICD-9 Diagnosis Description	Diagnosis Code	FY 2005	ICD-9 Diagnosis Description	Diagnosis Code	FY 2005
1. Pneumonia, organism unspecified	486	10,747	1. Single liveborn (born in hospital)	V30.00	27,746
2. Heart failure	428	8,151	2. Single liveborn (in-hospital cesarean delivery)	V30.01	12,344
3. Chest pain, unspecified	786.59	5,922	3. Coronary atherosclerosis of native coronary artery	414.01	6,133
4. Volume depletion	276.5	3,653	4. Previous cesarean delivery	654.21	4,448
5. Syncope & collapse	780.2	3,541	5. Second-degree perineal laceration	664.11	4,297
6. Acute renal failure, unspecified	584.9	3,446	6. First-degree perineal laceration	664.01	3,899
7. Obstructive chronic bronchitis	491.21	3,257	7. Lower leg osteoarthrosis, localizes not specified whether primary or secondary	715.36	3,339
8. Atrial fibrillation & flutter	427.31	3,236	8. Displacement of thoracic or lumbar intervertebral disc without myelopathy	722.1	2,648
9. Subendocardial infarction	410.71	3,182	9. Abnormality in fetal heart rate rhythm	659.71	2,463
10. Other disorders of urethra & urinary tract	599.0	3,178	10. Other specified rehabilitation procedure	V57.89	2,306
Top Ten Total		48,313	Top Ten Total		69,623
Total ED		212,856	Total Routine		210,323
Top 10 % of Total ED		23%	Top 10 % of Total Routine		33%

Source: CT Office of Health Care Access Acute Care Hospital Discharge Database

By Principal Diagnosis

To understand why patients are admitted to Connecticut's acute care hospitals, the primary diagnosis at discharge was examined.[11] Overall, the top ten principal diagnoses accounted for almost one-quarter of all discharges.

As shown in **Table 13**, the primary reason for hospitalization was infant birth. In 2005, as in prior years, single live births accounted for two-fifths (42%) of the top ten reasons for inpatient hospitalizations. Cesarean deliveries grew by 34% from FY 2001 to FY 2005, increasing from approximately 10% of all principal diagnoses in FY 2001 to 13% in FY 2005.

Cardiovascular disease continued to be a common reason for inpatient hospitalization, and constituted over one-third of the top ten principal diagnoses in FY 2005. Five of the top ten conditions for hospitalization were related to cardiovascular conditions.

Table 13: Top Ten Primary Reasons for Hospitalizations, FY 2005

ICD-9 Diagnosis Description	ICD-9 Diagnosis Code	FY05
Single liveborn (born in hospital)	V30.00	27,746
Pneumonia, organism unspecified	486	12,648
Single liveborn (in hospital cesarean delivery)	V30.01	12,344
Heart failure	428	9,876
Coronary atherosclerosis of native coronary artery	414.01	8,936
Chest pain, unspecified	786.59	6,531
Volume depletion	276.5	4,792
Subendocardial infarction	410.71	4,656
Previous cesarean delivery	654.21	4,455
Atrial fibrillation & flutter	427.31	4,375
Total		96,359
Total Discharges		423,179
Top 10 as % of Total		23%

Source: *CT Office of Health Care Access Acute Care Hospital Discharge Database*

By Principal Procedure

Childbirth- and newborn-related procedures such as circumcisions and cesarean-sections were the most frequently performed. As cardiovascular diseases are the most common reason for acute care inpatient hospitalizations, procedures related to these conditions also accounted for a significant portion of the most common primary procedures performed, as shown in **Table 14**.[12]

Table 14: Top Ten Primary Procedures Performed, FY 2005

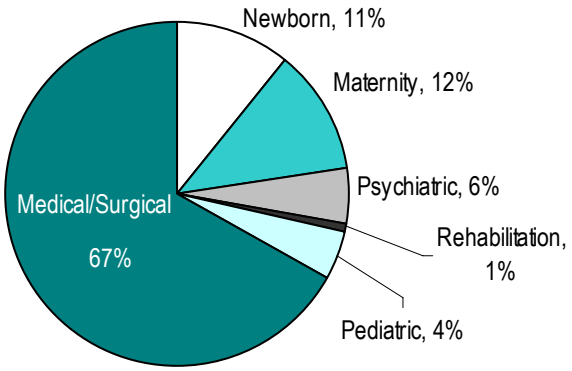
ICD-9 Procedure Description	ICD-9 Procedure Code	FY05
Circumcision	64.0	15,572
Low cervical cesarean section	74.1	12,999
Manually assisted delivery	73.59	10,070
Repair of other current obstetric laceration	75.69	8,754
Single vessel percutaneous transluminal coronary angioplasty (PTCA) or coronary atherectomy w/o mention of thrombolytic agent	36.01	5,702
Venous catheterization , not else where classified	38.93	5,206
Total knee replacement	81.54	5,110
Diagnostic procedures on heart and pericardium	37.22	4,989
Other vaccinations & inoculations	99.55	4,856
Esophagogastroduodenoscopy (EGD) with closed biopsy	45.16	3,990
Total of Top 10		77,248
Total Discharges		423,179
Top 10 as % of Total		18%

Source: *CT Office of Health Care Access Acute Care Hospital Discharge Database*

What services are patients receiving in CT hospitals?

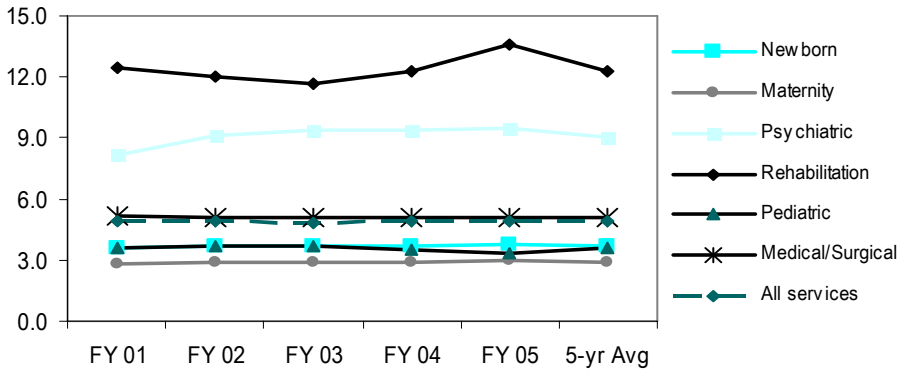
The clinical services patients received at Connecticut hospitals are grouped into six service categories by OHCA. As shown in **Figure 2**, approximately two-thirds of discharges were hospitalized for medical or surgical care. The remaining one-third were for maternity (12%), newborn (11%), psychiatric (6%), pediatric (4%) and rehabilitation (1%) services.

Figure 2: Service Discharge Distribution: FYs 2000-2005 (annual average)



Source: CT Office of Health Care Access Acute Care Hospital Discharge Database

Figure 3: Average Length of Stay in Acute Care by Service, FYs 2001 - 2005



Source: CT Office of Health Care Access Acute Care Hospital Discharge Database

Patients' length of stay for medical/surgical discharges were, on average, slightly higher than the statewide average for all services combined. **Figure 3** shows that, while comparatively fewer, rehabilitation and psychiatric discharges tended to have the longest average length of stay (12.3 and 9.1 days, respectively).

How much do Connecticut hospitals charge?

The rates that hospitals charge for their services are not regulated by the state but rather are business decisions made by each individual hospital. Conditions with the highest average charges tended to be uncommon and, represented far less than 1% of all discharges. In FY 2005, the top ten highest average charges involved conditions originating in the perinatal period, congenital anomalies, serious spinal and abdominal injuries and burns and generally had longer stays. As shown by the highlighted rows in **Table 15**, three of the top ten conditions with highest average charges also were among those conditions with the longest average length of stay.

Table 15: Top Ten Average Charges & Average Length of Stay by Primary Diagnosis: FY 2005

ICD-9 Diagnosis Description	Primary Diagnosis	Average Charge	ICD-9 Diagnosis Description	Primary Diagnosis	Average Length of Stay (days)
1. Unspecified fetal growth retardation, 500-749g	764.92	$1,070,187	1. Unspecified fetal growth retardation, 500-749g	764.92	243
2. Injury to inferior vena cava, other	902.19	$845,229	2. Sudden infant death syndrome	798.0	152
3. Sudden infant death syndrome	798.0	$705,087	3. Close skull vault fracture-coma NOS	800.16	143
4. Motor neuron disease NEC	335.29	$681,971	4. Colon injury multiple site-open	863.56	117
5. Deep 3rd degree burn head-multiple sites	941.49	$539,349	5. Childhood disintegrative psychosis-active	299.10	111
6. Deep 3rd degree burn abdominal wall	942.43	$493,205	6. Motor neuron disease NEC	335.29	92
7. Double outlet right ventricle	745.11	$401,676	7. Extreme immaturity, 500-749g	765.02	89
8. Colon injury multiple site-open	863.56	$378,845	8. Chronic membranous glomerulonephritis	582.1	87
9. C_5-C_7 level W unspecified spinal cord injury	806.05	$364,347	9. T_7-T_{12} level with other specified spinal chord injury	806.39	82
10. Necrotizing enterocolitis in fetus or newborn	777.5	$363,487	10. Unspecified fetal growth retardation, 1250-1499g	764.95	78
STATEWIDE		$19,141	STATEWIDE		4.9

Source: CT Office of Health Care Access Acute Care Hospital Discharge Database

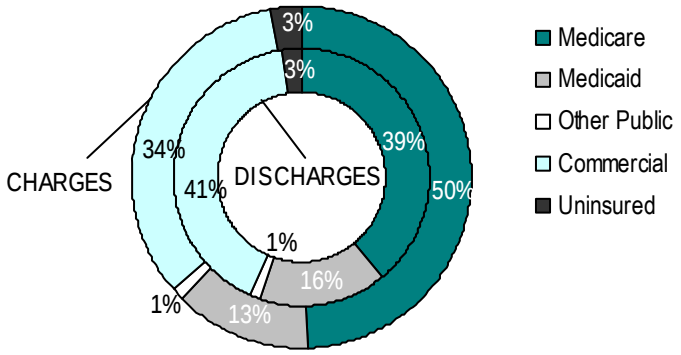
Who is billed for Connecticut hospital care?

Charges are the amount the hospital bills for an inpatient hospital stay. While OHCA collects data on billed charges, it is important to note that charges do not reflect actual costs or payments.

For this report, the payers billed are grouped into five major categories: Medicare, Medicaid, Other Public (e.g., Worker's Compensation, other federal programs, TriCare/CHAMPUS, the US government health program for the uniformed services and Title V, the Maternal and Child Health Block Grant Program), Commercial (private insurance such as Blue Cross, commercial carriers, and private HMOs and PPOs) and Uninsured (payer status of self pay, no charge or other).[13]

Figure 4 illustrates that, statewide, public payers (Medicare, Medicaid and "other public") accounted for 56% of total discharges and almost two-thirds of the $6.6 billion total hospital charges. Commercial payers accounted for, on average, 41% of all discharges and just over one-third of total charges. The uninsured made up 3% of discharges and accounted for 2% of total charges.

Figure 4: Primary Payer Mix by Discharges & Charges: FYs 2001- 2005



Source: *CT Office of Health Care Access Acute Care Hospital Discharge Database*

In FY 2005, the most frequent reason for hospitalization for Medicare beneficiaries was pneumonia, followed by heart failure and coronary atherosclerosis. Six of the top ten most frequent reasons for hospitalization billed to Medicaid in FY 2005 were related to childbirth, translating to almost one in four Medicaid hospitalizations. Similarly, five of the top ten most frequent reasons for hospitalization billed to private insurers in FY 2005 were related to childbirth, translating to almost one in five of every private payer discharges. Acute appendicitis and pneumonia ranked among the top 10 hospitalizations attributed to the uninsured.

How much is paid for Connecticut hospital care?

Hospitals enter into discount agreements with different payers that affect actual payment. Therefore, a hospital may charge the same amount for a service to all patients, but what a hospital actually receives in payment for that care may vary markedly among payers. The federal government sets hospital payment rates for Medicare patients, state governments set payment rates for Medicaid patients, and private insurance companies, whose payment rates vary widely, negotiate payment rates with hospitals. Because nearly all of a hospital's payments are set by either government or through negotiations with private insurance companies, the vast majority of patients do not pay full charges.[14]

Information on actual payments made on behalf of individual patients is not available in OHCA's discharge database. But a commonly-used measure of actual hospital costs to the charges billed is the ratio of cost-to-charges. The lower the cost to charge ratio, the greater the difference between the cost of providing the care and the charges billed by the hospital. The ratio of cost to charges has declined each of the last four fiscal years.

Payment to cost ratios measure the amount above or below costs that hospitals are reimbursed by a payer as compared to their average costs. The greater the ratio, the more gain. Hospitals have negotiated favorable discount agreements with commercial payers. In FY 2001 the statewide ratio of payment to cost with commercial payers was 1.11; by FY 2004 it had increased to 1.18. Government payment ratios are less favorable; for example, the Medicaid payment to cost ratio has dropped from 0.77 in FY 2001 to 0.73 in FY 2004.

Summary and Recommendations

Comprehensive system data are essential for planning and research efforts and to properly report on access to and utilization of the health care system. OHCA has a solid understanding of inpatient acute care hospital activity because it has collected inpatient administrative and financial data from hospitals for over a decade. The agency uses these data for various research projects, CON evaluations, and joint planning efforts with other health care agencies, as well as regularly analyzing and publishing trend information pertaining to specific inpatient service utilization. While the currently collected data enables the agency to successfully evaluate specific requests for changes within hospitals, it is difficult to comprehensively plan system-wide improvements without additional data from the myriad facilities that operate outside inpatient acute care.

In attempting to address Sec. 19a-634 CGS, OHCA encountered numerous challenges in its efforts to obtain data necessary for a comprehensive utilization study. The agency has statutory authority to collect outpatient data from health care facilities and institutions, and it plans to develop regulations, as outpatient care represents a significant portion of overall health care utilization. Outpatient regulations will allow OHCA to provide a more comprehensive analysis of health care utilization.

Data collection efforts are resource intensive and desire for data must be balanced within the confines of available dollars and the capacity of health care providers to supply and transmit necessary data. At this time, OHCA is recommending an incremental approach to addressing the mandate with both short- and long- term actions.

Recommendation 1

Improve data collection by re-evaluating information currently collected and identifying ways to improve data so that they are more meaningful and relevant. Existing data that can be easily collected with minimal expense as well as data that may not be as readily available and/or more expensive to collect and store will be identified.

Recommendation 2

Establish and convene an advisory group to assist OHCA in setting standards to measure and understand existing capacity and utilization of health care resources.

Recommendation 3

Begin discussions with other state agencies and organizations on obtaining health care data relevant to OHCA's mandated study of the availability of acute care, long-term care and home-health care services in private and public institutional and community-based facilities.

Endnotes

[1]Bernstein AB, Hing E, Moss AJ, Allen KF, Siller AB, Tiggle, RB. Health care in America: Trends in utilization. Hyattsville, Maryland. National Center for Health Statistics. 2003.

[2]Ibid.

[3]Fiscal Year is from October 1st through September 30th of the following year. Hospital Budget System Schedule 500 data are "as filed" by the hospitals and are not audited by OHCA, with the exception of FY 2004 licensed beds, which were cross-checked with Department of Public Health licensure data.

[4]1999 National Hospital Discharge Survey. Advance Data No. 319. 18 pp. (PHS) 2001-1250.

[5]OHCA collects data on readmissions *to the same hospital within a fiscal year* for the following time periods: <31 days, >30 days but <61, >61 days but <91, >90 days but <181 days and >180 days. Readmissions may be for either the same or a different principal diagnosis than the initial admission.

[6]The decrease was mostly due to changes in accounting practices of one hospital implemented in FY 2003.

[7]OHCA collects aggregate information on patients treated in and released from emergency departments, as well as hospital home care, psychiatric and other clinics, and private referred visits. The agency currently collects detailed demographic, diagnostic and procedure detail information on patients treated in the state's emergency departments and then admitted as inpatients, but this information is only 4% of all outpatient encounters. Hospitals provide information on patients treated and released from the state's EDs aggregated at hospital level within the Hospital Budget System. (See Appendix IV for hospital details).

[8]2003 is the most recent year of national data available.

[9]McCaig, LF, Burt CW. National Hospital Ambulatory Medical Care Survey: 2003 Emergency Department Summary. Advance data from vital and health statistics; no 358. Hyattsville, Maryland: National Center for Health Statistics, 2005.

[10]Occupancy rates may fluctuate seasonally, with higher occupancy during flu season, for example.

[11]A patient may have more than one diagnosis. OHCA collects information on up to 10 diagnoses.

[12]Not all hospitalizations have associated procedures.

[13]Self pay may pertain to the uninsured or could also pertain to paying for elective procedures not covered.

[14]www.caringforcommunities.org/caringforcommunities/ content/031209_hosp_charges_explained.pdf

Appendix I: Connecticut Acute Care Hospitals

Hospital Name	Corporate Parent/Affiliation		County	Teaching	FY 2004 Licensed Beds*	FY 2004 Staffed Beds*
Bradley Memorial Hospital	Central Connecticut Health Alliance	Southington	Hartford		84	46
Bridgeport Hospital	Yale-New Haven Health Services Corporation	Bridgeport	Fairfield	√	425	334
Bristol Hospital	Bristol Hospital & Health Care Group	Bristol	Hartford		154	154
Charlotte Hungerford Hospital	Charlotte Hungerford Hospital	Torrington	Litchfield		122	114
Connecticut Children's Medical Center	CCMC Corporation, Inc.	Hartford	Hartford	√	123	114
Danbury Hospital	Danbury Health Systems, Inc.	Danbury	Fairfield	√	371	237
Day Kimball Hospital	Day Kimball Healthcare Inc.	Putnam	Windham		122	72
Greenwich Hospital	Yale-New Haven Health Services Corporation	Greenwich	Fairfield	√	206	194
Griffin Hospital	Griffin Health Services Corporation	Derby	New Haven	√	180	91
Hartford Hospital	Hartford Health Care Corporation	Hartford	Hartford	√	867	767
Hospital of St. Raphael	Saint Raphael Healthcare System, Inc.	New Haven	New Haven	√	533	474
John Dempsey Hospital	University of Connecticut Health Center	Farmington	Hartford	√	224	224
Johnson Memorial Hospital	Johnson Memorial Corporation	Stafford	Tolland		98	75
Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	New London	New London	√	308	249
Manchester Memorial Hospital	Eastern Connecticut Health Network, Inc.	Manchester	Hartford		283	140
Middlesex Hospital	Middlesex Health System, Inc.	Middletown	Middlesex	√	297	159
MidState Medical Center	Hartford Health Care Corporation	Meriden	New Haven		142	136
Milford Hospital	Milford Health and Medical Incorporated	Milford	New Haven		118	66
New Britain General Hospital	Central Connecticut Health Alliance	New Britain	Hartford	√	362	272
New Milford Hospital	New Milford Hospital Holding Corporation	New Milford	Litchfield		95	72
Norwalk Hospital	Norwalk Health Services Corporation	Norwalk	Fairfield	√	366	229
Rockville General Hospital	Eastern Connecticut Health Network, Inc.	Vernon	Tolland		118	66
St. Francis Hospital and Medical Center	Saint Francis Care, Inc.	Hartford	Hartford	√	682	576
St. Mary's Hospital	Slocum Corporation	Waterbury	New Haven	√	379	168
Saint Vincent's Medical Center	Ascension Health/St. Vincent's Health Services Corporation	Bridgeport	Fairfield	√	444	337
Sharon Hospital	Essent Healthcare Inc.	Sharon	Litchfield		94	47
Stamford Hospital	Stamford Health System	Stamford	Fairfield	√	330	321
Waterbury Hospital	Greater Waterbury Health Network	Waterbury	New Haven	√	393	300
William W. Backus Hospital	Backus Corporation	Norwich	New London		233	197
Windham Community Memorial Hospital	Windham Community Memorial Hospital	Willimantic	Windham		144	92
Yale-New Haven Hospital	Yale-New Haven Health Services Corporation	New Haven	New Haven	√	944	859
					9,241	7,182

Source: CT Office of Health Care Access Hospital Budget System Schedule 500

*Includes newborn bassinets

Appendix II

Connecticut Acute Care Discharges: FYs 2001-2005

	Discharges					Annual Change (%)				
Hospitals	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	01/02	02/03	03/04	04/05	01/05
Bradley Memorial Hospital and Health Center	2,601	2,533	2,513	2,319	2,326	-3	-1	-8	0	-11
Bridgeport Hospital	20,292	19,461	20,012	20,091	20,113	-4	3	0	0	-1
Bristol Hospital	7,887	8,292	8,171	8,357	8,082	5	-1	2	-3	2
Charlotte Hungerford Hospital	6,179	6,156	6,424	6,304	6,201	0	4	-2	-2	0
Connecticut Children's Medical Center	4,875	4,870	5,202	5,498	5,520	0	7	6	0	13
Danbury Hospital	17,701	18,614	18,976	19,522	19,871	5	2	3	2	12
Day Kimball Hospital	5,984	5,934	6,429	6,475	6,471	-1	8	1	0	8
Greenwich Hospital	10,349	10,929	11,093	11,391	11,920	6	2	3	5	15
Griffin Hospital	6,989	7,469	7,214	7,341	7,148	7	-3	2	-3	2
Hartford Hospital	36,465	37,985	37,113	37,734	39,312	4	-2	2	4	8
Hospital of St. Raphael	23,424	24,307	24,823	25,378	25,100	4	2	2	-1	7
John Dempsey Hospital	7,731	8,708	8,945	9,556	9,789	13	3	7	2	27
Johnson Memorial Hospital	3,644	3,639	3,707	3,624	3,844	0	2	-2	6	5
Lawrence and Memorial Hospital	14,748	15,106	15,372	14,869	15,213	2	2	-3	2	3
Manchester Memorial Hospital	8,091	8,258	7,907	8,668	8,953	2	-4	10	3	11
Middlesex Hospital	11,249	11,900	12,599	12,089	12,354	6	6	-4	2	10
MidState Medical Center	8,380	8,607	8,758	9,038	9,864	3	2	3	9	18
Milford Hospital	4,602	4,866	4,726	5,058	5,123	6	-3	7	1	11
New Britain General Hospital	16,039	16,104	16,177	16,663	17,578	0	0	3	5	10
New Milford Hospital	3,240	3,267	3,182	3,316	3,377	1	-3	4	2	4
Norwalk Hospital	14,639	14,716	15,578	15,945	15,721	1	6	2	-1	7
Rockville General Hospital	4,709	4,756	4,630	4,017	3,935	1	-3	-13	-2	-16
Saint Francis Hospital and Medical Center	31,334	31,134	31,559	32,527	32,184	-1	1	3	-1	3
Saint Mary's Hospital	11,779	11,502	12,064	12,069	12,241	-2	5	0	1	4
Saint Vincent's Medical Center	18,020	18,275	18,345	19,182	19,365	1	0	5	1	7
Sharon Hospital	3,167	2,937	2,787	3,040	2,966	-7	-5	9	-2	-6
Stamford Hospital	17,434	17,630	17,763	17,231	17,407	1	1	-3	1	0
Waterbury Hospital	13,412	14,391	14,633	15,027	15,486	7	2	3	3	15
William W. Backus Hospital	11,671	11,299	11,542	11,923	11,900	-3	2	3	0	2
Windham Community Memorial Hospital	5,059	5,110	5,160	5,091	5,205	1	1	-1	2	3
Yale-New Haven Hospital	41,508	43,524	45,371	46,957	48,610	5	4	3	4	17
Statewide	393,202	402,279	408,775	416,300	423,179	2	2	2	2	8

Source: CT Office of Health Care Access Acute Care Hospitals Discharge Database

Appendix III

Connecticut Acute Care Patient Days: FYs 2001-2005

Hospitals	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	01/02	02/03	03/04	04/05	01/05
Bradley Memorial Hospital and Health Center	11,678	11,737	11,812	10,694	10,157	1	1	-9	-5	-13
Bridgeport Hospital	103,196	100,625	104,534	107,654	108,044	-2	4	3	0	5
Bristol Hospital	34,948	35,542	35,026	36,976	36,941	2	-1	6	0	6
Charlotte Hungerford Hospital	28,726	28,914	29,289	28,353	27,163	1	1	-3	-4	-5
Connecticut Children's Medical Center	28,731	31,568	32,156	31,414	30,095	10	2	-2	-4	5
Danbury Hospital	73,688	76,008	78,191	78,914	84,433	3	3	1	7	15
Day Kimball Hospital	23,001	22,234	23,033	22,873	22,075	-3	4	-1	-3	-4
Greenwich Hospital	43,774	45,546	45,057	48,725	45,475	4	-1	8	-7	4
Griffin Hospital	28,972	30,770	28,684	32,272	31,335	6	-7	13	-3	8
Hartford Hospital	204,533	212,742	214,015	217,755	228,487	4	1	2	5	12
Hospital of St. Raphael	122,497	131,890	130,624	142,168	136,821	8	-1	9	-4	12
John Dempsey Hospital	52,374	54,693	55,634	58,558	60,329	4	2	5	3	15
Johnson Memorial Hospital	16,903	16,194	17,496	19,030	21,584	-4	8	9	13	28
Lawrence and Memorial Hospital	68,695	71,709	72,658	69,150	71,361	4	1	-5	3	4
Manchester Memorial Hospital	37,030	39,962	37,947	39,506	42,997	8	-5	4	9	16
Middlesex Hospital	43,926	49,004	49,751	50,113	52,012	12	2	1	4	18
MidState Medical Center	35,594	36,212	36,948	41,085	43,115	2	2	11	5	21
Milford Hospital	20,637	22,464	21,884	22,732	23,083	9	-3	4	2	12
New Britain General Hospital	67,444	67,937	68,123	68,061	75,381	1	0	0	11	12
New Milford Hospital	14,393	14,723	13,970	14,405	14,682	2	-5	3	2	2
Norwalk Hospital	77,252	79,013	82,365	83,694	82,671	2	4	2	-1	7
Rockville General Hospital	17,084	18,530	17,483	15,475	15,464	8	-6	-11	0	-9
St. Francis Hospital and Medical Center	152,756	156,716	158,091	163,437	162,454	3	1	3	-1	6
St. Mary's Hospital	52,475	52,887	53,282	54,181	55,038	1	1	2	2	5
St. Vincent's Medical Center	96,937	96,965	94,545	99,364	102,144	0	-2	5	3	5
Sharon Hospital	13,351	12,411	12,031	12,741	12,778	-7	-3	6	0	-4
Stamford Hospital	83,511	82,542	83,027	78,876	79,271	-1	1	-5	1	-5
Waterbury Hospital	60,921	68,042	69,132	69,130	70,824	12	2	0	2	16
William W. Backus Hospital	50,438	47,487	49,819	52,370	52,716	-6	5	5	1	5
Windham Community Memorial Hospital	19,558	20,861	19,934	20,934	20,261	7	-4	5	-3	4
Yale-New Haven Hospital	238,177	237,497	239,933	246,848	258,429	0	1	3	5	9
Statewide	1,923,200	1,973,425	1,986,474	2,037,488	2,077,620	3	1	3	2	8

Source: CT Office of Health Care Access Acute Care Hospitals Discharge Database

Appendix IV

Connecticut Emergency Department and Other Outpatient Visits: FYs 2001-2004

	FY 2004		FY 2003		FY 2002[1]		FY 2001	
Hospital	ED Visits	Other OP visits	ED Visits	Other OP visits	ED Visits	Other OP visits	ED Visits	Other OP visits
Bradley Memorial Hospital and Health Center	14,446	37,655	14,156	35,981	14,429	31,880	14,132	23,204
Bridgeport Hospital	61,086	88,590	59,864	90,156	62,279	90,023	61,648	77,331
Bristol Hospital	36,657	157,472	36,640	163,457	37,605	180,784	36,549	168,159
Charlotte Hungerford Hospital	41,546	145,315	37,512	223,271	40,197	221,348	30,539	201,647
CT Children's Medical Center	37,951	0	37,640	0	33,263	0	31,302	0
Danbury Hospital	65,907	146,150	63,628	146,440	64,198	151,204	60,420	170,172
Day Kimball Hospital	25,850	364,696	24,792	356,579	26,592	363,892	25,085	351,082
Greenwich Hospital	31,506	336,953	29,910	323,333	28,709	321,904	26,130	301,139
Griffin Hospital	35,833	13,601	36,024	13,335	36,740	16,676	35,883	14,532
Hartford Hospital	79,544	126,258	76,858	130,202	73,047	123,263	71,482	120,269
Hospital of St. Raphael	50,263	212,013	46,271	203,408	48,144	199,864	49,080	189,257
John Dempsey Hospital	27,925	86,788	26,299	82,893	25,810	73,497	23,407	65,689
Johnson Memorial Hospital	18,770	84,881	18,147	77,096	17,781	71,229	16,099	55,640
Lawrence & Memorial Hospital	83,905	31,524	84,835	32,419	85,039	33,186	81,536	31,325
Manchester Memorial Hospital	55,126	226,866	48,315	190,465	47,291	198,810	47,263	167,950
Middlesex Hospital	83,231	452,013	79,933	578,345	81,039	609,567	78,091	580,628
MidState Medical Center	63,505	4,589	64,850	8,283	67,566	11,166	62,892	13,315
Milford Hospital	31,548	46,078	32,455	43,763	32,644	50,345	30,000	42,455
New Britain General Hospital	58,083	121,724	56,133	102,563	55,601	84,918	52,498	83,280
New Milford Hospital	19,049	76,223	19,155	70,864	19,286	70,585	17,708	66,659
Norwalk Hospital	44,097	67,536	44,904	68,225	42,550	65,303	40,830	24,135
Rockville General Hospital	25,884	81,384	26,034	80,526	23,200	91,885	23,446	90,844
Sharon Hospital[1]	16,812	66,386	17,086	0	8,908	0	17,172	0
St. Francis Hospital and Medical Center	60,309	596,152	64,350	538,544	67,609	513,248	63,573	524,078
St. Mary's Hospital	59,625	142,859	59,125	149,498	57,087	168,995	57,791	157,098
St. Vincent's Hospital	55,718	133,534	52,452	129,450	50,814	132,784	48,715	141,359
Stamford Hospital	41,977	130,755	40,070	138,911	45,789	140,372	44,927	127,486
William W. Backus Hospital	47,992	326,358	47,764	307,369	46,324	222,837	42,936	211,407
Waterbury Hospital	55,689	179,572	55,861	185,289	55,072	943,983	50,881	940,580
Windham Hospital	20,345	11,715	21,563	14,894	21,593	17,726	21,397	16,616
Yale-New Haven Hospital	96,557	147,809	91,881	141,795	91,259	140,972	86,641	137,534
Total	1,446,736	4,643,449	1,414,507	4,627,354	1,407,465	5,342,246	1,350,053	5,094,870

Source: CT Office of Health Care Access Hospital Budget System Schedule 500

[1]Sharon Hospital was sold to Essent-Sharon Hospital on April 12, 2002.

Appendix V

Connecticut Acute Care Hospital Staffed Beds by Service: FY 2001

	FY 2001											
	Adult Medical or Surgical	ICU/CCU	Exempt Psychiatric	Maternity	Newborn	Neonatal ICU	Exempt Rehabilitation	Pediatric	Long Term Care Alcohol & Drug Treatment		Other	Total
Bradley Memorial Hospital	68	6	0	0	0	0	0	0	0	0	0	74
Bridgeport Hospital	163	22	34	25	16	16	14	9	0	0	0	299
Bristol Hospital	86	14	16	15	20	0	0	3	0	0	0	154
Charlotte Hungerford Hospital	61	10	15	5	13	0	0	5	0	0	0	109
CT Children's Medical Center	0	16	0	0	0	26	0	64	0	0	0	106
Danbury Hospital	113	13	18	19	15	8	14	18	0	0	0	218
Day Kimball Hospital	42	6	15	5	4	0	0	0	0	0	0	72
Greenwich Hospital	114	10	0	24	18	0	0	6	0	6	0	178
Griffin Hospital	118	14	16	12	15	0	0	0	0	0	0	175
Hartford Hospital	460	62	139	43	48	0	10	0	0	0	0	762
Hospital of St. Raphael	271	78	25	22	24	8	16	16	0	0	0	460
John Dempsey Hospital	96	15	35	18	10	40	0	0	0	0	10	224
Johnson Memorial Hospital	33	4	12	4	4	0	0	2	0	0	0	59
Lawrence & Memorial Hospital	145	20	18	22	14	14	16	6	0	0	0	255
Manchester Memorial Hospital	76	8	30	10	10	0	0	6	0	0	0	140
Middlesex Hospital	93	10	16	10	8	0	0	0	0	0	0	137
MidState Medical Center	75	7	6	12	12	0	0	0	0	0	0	112
Milford Hospital	44	7	0	4	4	0	0	1	0	0	0	60
New Britain General Hospital	172	23	0	27	24	8	0	23	0	9	0	286
New Milford Hospital	40	8	0	8	10	0	0	6	0	0	0	72
Norwalk Hospital	107	32	20	15	12	7	23	5	0	0	0	221
Rockville General Hospital	40	6	0	6	4	0	0	12	0	0	0	68
Sharon Hospital	32	11	12	8	16	0	0	6	0	0	0	85
St. Francis Hospital and Medical Center	325	42	61	46	27	28	0	13	0	0	0	542
St. Mary's Hospital	120	14	8	16	10	0	0	0	0	0	0	168
St. Vincent's Hospital	208	18	16	19	32	0	10	4	0	0	0	307
Stamford Hospital	180	18	25	31	25	0	0	13	0	0	0	292
Waterbury Hospital	158	20	30	22	22	0	0	8	0	0	0	260
William W. Backus Hospital	117	12	18	15	18	0	0	0	0	0	0	180
Windham Hospital	54	12	0	14	12	0	0	0	0	0	0	92
Yale-New Haven Hospital	410	80	100	56	46	46	12	77	0	0	0	827
Total	4,021	618	685	533	493	201	115	303	0	15	10	6,994

Source: CT Office of Health Care Access Hospital Budget System Schedule 500

Appendix V (continued)

Connecticut Acute Care Hospital Staffed Beds by Service: FY 2004

	FY 2004											
	Adult Medical or Surgical	ICU/CCU	Exempt Psychiatric	Maternity	Newborn	Neonatal ICU	Exempt Rehabilitation	Pediatric	Long Term Care	Alcohol & Drug Treatment	Other	Total
Bradley Memorial Hospital	42	4	0	0	0	0	0	0	0	0	0	46
Bridgeport Hospital	188	23	36	28	18	16	15	10	0	0	0	334
Bristol Hospital	86	14	16	15	20	0	0	3	0	0	0	154
Charlotte Hungerford Hospital	72	10	17	5	5	0	0	5	0	0	0	114
CT Children's Medical Center	0	16	0	0	0	26	0	72	0	0	0	114
Danbury Hospital	136	10	19	20	15	13	14	10	0	0	0	237
Day Kimball Hospital	44	6	14	4	4	0	0	0	0	0	0	72
Greenwich Hospital	116	10	0	24	32	0	0	6	0	6	0	194
Griffin Hospital	59	8	12	6	6	0	0	0	0	0	0	91
Hartford Hospital	461	66	139	43	48	0	10	0	0	0	0	767
Hospital of St. Raphael	286	75	25	19	22	8	16	23	0	0	0	474
John Dempsey Hospital	91	15	34	20	20	30	0	0	0	0	14	224
Johnson Memorial Hospital	47	6	14	2	4	0	0	2	0	0	0	75
Lawrence & Memorial Hospital	143	20	18	22	14	10	16	6	0	0	0	249
Manchester Memorial Hospital	82	8	30	10	10	0	0	0	0	0	0	140
Middlesex Hospital	108	11	16	13	11	0	0	0	0	0	0	159
MidState Medical Center	95	7	10	12	12	0	0	0	0	0	0	136
Milford Hospital	47	8	0	5	5	0	0	1	0	0	0	66
New Britain General Hospital	175	24	0	27	24	8	0	8	0	6	0	272
New Milford Hospital	40	8	0	8	10	0	0	6	0	0	0	72
Norwalk Hospital	115	36	18	14	12	5	24	5	0	0	0	229
Rockville General Hospital	40	6	0	6	8	0	0	6	0	0	0	66
Sharon Hospital	22	5	12	4	4	0	0	0	0	0	0	47
St. Francis Hospital and Medical Center	326	42	85	56	27	28	0	12	0	0	0	576
St. Mary's Hospital	112	20	10	16	10	0	0	0	0	0	0	168
St. Vincent's Hospital	241	18	16	25	23	0	10	4	0	0	0	337
Stamford Hospital	185	14	20	32	25	16	16	13	0	0	0	321
Waterbury Hospital	167	20	30	32	36	0	0	15	0	0	0	300
William W. Backus Hospital	134	12	18	15	18	0	0	0	0	0	0	197
Windham Hospital	54	12	0	14	12	0	0	0	0	0	0	92
Yale-New Haven Hospital	462	92	85	56	46	46	12	60	0	0	0	859
Total	4,176	626	694	553	501	206	133	267	0	12	14	7,182

Source: CT Office of Health Care Access Hospital Budget System Schedule 500

OFFICE OF HEALTH CARE ACCESS

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