

REPORT OF THE CONNECTICUT HOSPITAL ASSOCIATION

Pursuant to Section 19a-490ii of the Connecticut General Statutes on Emergency Department

Boarding

March 2026

REPORT OF THE CONNECTICUT HOSPITAL ASSOCIATION SUBMITTED TO THE PUBLIC HEALTH COMMITTEE March 1, 2026

Pursuant to Section 19a-490ii of the Connecticut General Statutes, the Connecticut Hospital Association (CHA) appreciates the opportunity to submit this report on behalf of its member hospitals. The appendices to this report contain each individual hospital's data, which tracks the categories set forth in 19a-490ii.

This is the second annual report being filed by CHA pursuant to 19a-490ii.

Connecticut hospitals make our state stronger by delivering nationally recognized, world-class care, supporting jobs and economic growth, and serving communities across Connecticut. Every day, hospitals improve access, affordability, and health equity — providing care to all patients regardless of ability to pay. At the same time, hospitals invest in their workforce and local communities, even as they navigate significant financial and federal challenges.

INTRODUCTION AND EXECUTIVE SUMMARY

Public Act 24-4, An Act Concerning Emergency Department Crowding (now codified at Section 19a-490ii), requires each hospital with an emergency department (ED), beginning January 1, 2025, and ending January 1, 2029, to analyze certain emergency department data from the previous calendar year with the goals of reducing wait times, informing methods to improve admission efficiencies, and examining root causes for delays in admission times. This combined report fulfills the 2026 obligation of each hospital to submit its second report by March 1, 2026, and annually thereafter until March 1, 2029, to the Public Health Committee on the findings of the analysis and recommendations on the above goals. The first report was filed on [February 28, 2025](#).

The ED continues to be the front door of the hospital system and is subject to unique challenges, such as the simultaneous treatment of low-acuity and high-acuity patients, balancing both medical and behavioral health needs, and providing a compassionate response to patient and caregiver emotional needs at a time of significant stress. Given recent federal changes to healthcare coverage (expiration of Affordable Care Act (ACA) enhanced premium tax credits and stricter Medicaid eligibility requirements), there are additional concerns regarding the future health of patients who may experience coverage loss and the increased reliance on EDs for care.

These concerns further the level of urgency to address pressures faced by EDs across the state, which include, but are not limited to:

- Medicaid Underfunding and Long-Term Care Application Processing
- Housing Instability, Homelessness, and Financial Risk
- Lack of Appropriate Behavioral Health Services and Need To Enhance Overall Healthcare Delivery System Capacity
- Patients With Complex Discharge Needs
- Prior Authorization
- Conservatorship and Streamlining Proxy Decision-Making

DATA ANALYSIS BY PATIENT TYPE

Statewide results for analyzed 2025 data are presented below; individual hospital-level details are available in the appendices to this report.

In 2025, Connecticut saw nearly 1.7 million visits (1,668,963) to hospitals' EDs, with 14.1% of those patients needing inpatient-level care (236,123).

Hospitals are constantly reviewing procedures and guidelines aimed at improving throughput within and beyond the ED. There are policies and procedures to reduce wait times and methods to improve admission efficiencies, such as establishing triage in the waiting area or establishing temporary observation units. Having clinicians meet patients in designated areas for assessment is critical, particularly when the ED becomes overwhelmed with patients who need a higher level of care than what is referred to as Treat & Release (T&R), which involves a medical evaluation and treatment of lower-acuity conditions, followed by a release without further, more intensive hospital-based care. Additionally, many EDs across the state have implemented a version of a "fast track" protocol, which is a separate workflow for low-acuity patients that treats them in a separate environment from the main ED and improves throughput for the majority of patients.

For the minority of patients who are admitted to the hospital (14.1%), they may be subject to additional wait times in the ED while a bed is made available on an inpatient floor. The delays for these beds are multifaceted and can be the result of internal factors such as cleaning time, clinical factors such as a patient not being a match for a certain room (e.g., mixed sex roommate, communicable disease, or specialized bed need such as behavioral health or inpatient rehabilitation), or external placement factors resulting in discharge delays (e.g., post-acute bed availability at either a skilled nursing facility (SNF) or long-term acute care hospital (LTACH)). These delays, if lengthy, lead to boarding. When the most direct line of care is unavailable, ED teams must create complex care plans utilizing complementary services, which requires additional time and resources. For the purpose of this report, boarding is defined as a patient who is held in the ED for four hours or longer after their admission decision has been made, awaiting the availability of an appropriate inpatient bed.

For patients admitted to the hospital after presenting to the emergency department, the average length of time from the patient's first presentation to the emergency department until an order was placed for the patient's admission to the hospital was 6.0 hours (with a median of 4.4 hours).

The percentage of patients who were admitted after presenting to the ED and were transferred to an available bed located in a physical location other than the ED more than four hours after an admitting order for the patient was completed was 37.9%.

Overall, the boarding rate decreased slightly, even though the rate of people being admitted to the hospital through the ED increased. It should be noted that the odds of any given patient boarding within the ED is only 8.8%.

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|-------------------------|------------|
| Statewide | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 1,668,963 | 236,123 | 357.93 | 37.9% |

It is important to understand the difference between crowding and boarding. Crowding refers to the demand placed on the ED for patients continuing to need care within the walls of the ED and by ED providers. Boarding refers to those patients who should no longer be in an ED setting and should be receiving care on an inpatient floor, but, due to various delays in throughput, are still receiving their care within the ED. The focus of these reports has been on boarding and boarding rates, but it is critical, particularly in the context of the title of the legislation, to understand crowding as well.

In addition to inpatient, meaning patients who have been admitted to the hospital, there is another patient class known as “observation.” These are patients who need more care or need to be observed for changes in condition, more so than a typical T&R patient. Despite these patients not being truly “admitted,” they do require resources and space either in an ED (ED observation) or on an inpatient floor (hospital observation). For those observation patients who move to an inpatient floor, they will directly contribute to boarding, as they are taking a bed or space that could have been dedicated to another patient requiring an inpatient bed. In the case of ED observation, these patients are not expected or intended to leave the ED and will contribute to crowding and the patient load for the ED staff. Observation patients, regardless of their ED observation or hospital observation designation, spend considerably more time within an ED setting. In 2025, observation patients spent 36% more time in the ED than their inpatient counterparts.

As a subset of both inpatient and observation patient types, the behavioral health population has its own set of unique challenges inside and outside of the ED. The improving, but still limited, outpatient resources continue to contribute to ED demand, including repeat visits and readmissions. The discharge process for behavioral health patients, regardless of whether they are discharged from the ED or from an inpatient unit, is more complex than for non-behavioral health patients, requiring significantly more resources and coordination. As a result of this resource demand, and the need, in many cases, for placement in another site of care (e.g., a specialized inpatient facility or a longer-term recovery facility), the time these patients wait within a hospital is significantly longer than their non-behavioral health counterparts. These challenges are illustrated in the difference in ED timepoints/lengths of stay, detailed below, and can be exacerbated for special populations (e.g., children). In 2025, behavioral health patients spent approximately 30 hours in the ED (131% longer than inpatient counterparts), with pediatric behavioral health patients spending another 30% longer, an approximate total of 38 hours in the ED. Pediatric behavioral health patients face their own set of unique challenges and spend more

time in EDs than adult behavioral health patients, as not all hospitals have the appropriate beds to be able to admit these pediatric patients, and there is an overall shortage in placement options (in addition to increased coordination burden between schools, families, and other entities (e.g., DCF)).

Hospitals continue to refine the processes they can directly control, such as room cleaning and turnaround times. They have far less control over the clinical characteristics of patients seeking care, including whether patients can be treated safely in the same room. While hospitals can attempt to move patients to optimize space, this approach often negatively affects the patient experience. Hospitals do not have control or influence over the external factors that are some of the major contributors to discharge delays. These factors, which are described in greater detail in the root causes section of this report, are the challenges that hospitals need support from the Connecticut General Assembly to address.

ROOT CAUSES

| | |
|---|---|
| Medicaid Underfunding and Long-Term Care Application Processing | Housing Instability, Homelessness, and Financial Risk |
| Lack of Appropriate Behavioral Health Services and Need To Enhance Overall Healthcare Delivery System Capacity | Patients With Complex Discharge Needs |
| Prior Authorization | Conservatorship and Streamlining Proxy Decision-Making |

Medicaid Underfunding and Long-Term Care Application Process

Medicaid underpayment has long been a significant issue in Connecticut, and it remains unaddressed. This ongoing financial shortfall has serious implications for the healthcare delivery system and the communities hospitals serve. In fiscal year (FY) 2024, Connecticut hospitals incurred \$1.46 billion in losses from Medicaid underpayment.

Emergency departments are often on the frontline of experiencing the impacts of inadequate Medicaid reimbursement and its effect on access to care. Connecticut’s chronic underinvestment in Medicaid significantly affects multiple components of care delivery, including workforce retention, facility operations, and patient access. Underpayment hampers hospitals’ ability to attract and retain physician specialists, which is essential for comprehensive patient care. It also restricts investments in technology and data analytics. Moreover, underpayment limits hospitals’ capacity to invest in community programs and initiatives that address upstream health determinants, further compounding ED usage. Hospitals’ ability to address behavioral health needs and streamline care coordination practices is also stifled, ultimately affecting patient outcomes and perpetuating barriers to discharge.

Outside of hospital settings, Medicaid underpayment influences the number of available post-acute beds (e.g., skilled nursing facility) for patients. Some post-acute locations limit the number of Medicaid patients they take at any given time to balance financial pressures, creating a backlog of Medicaid

patients awaiting placement within hospitals. These patients may wait in the hospital for days or weeks before proper placement, occupying a bed that could be available to patients boarding in the ED. Mandating that post-acute locations accept more Medicaid patients is unlikely to solve the issue and could exacerbate capacity challenges; locations that struggle to meet financial obligations may be forced to close their doors. Having fewer beds available is a suboptimal outcome.

In addition to the limited number of post-acute beds available, the process for patients to apply for Title 19 Long-Term Medicaid is incredibly lengthy and demanding. The time from initial application to the first request for information is two weeks, and by the time all the information has been collected through family members or conservators, more than a month may pass. During this time, a patient, who is no longer in need of high-acuity care, is occupying a bed within a hospital while additional patients needing that level of care await placement. There is a need to modernize the application system, reduce timelines, or create a temporary payment method for post-acute care while applications are processing to prevent these bottlenecks in hospital systems and encourage patient throughput.

Housing Instability, Homelessness, and Financial Risk

Housing instability and homelessness present significant barriers to timely discharge and contribute directly to prolonged ED and inpatient stays. Connecticut's annual point-in-time count found that 3,735 individuals were experiencing homelessness in 2025, a more than 9% increase from the prior year, with unsheltered homelessness jumping by roughly 45% in a single year, highlighting rising housing insecurity despite statewide efforts to expand shelter capacity.

Economic pressures at the community level further compound these challenges. According to the 2025 *DataHaven Community Wellbeing Survey*, 11% of adults statewide reported running out of money for housing in the past year, roughly double the rate from a decade ago. At the same time, recent analyses of federal policy changes indicate that low-income families and individuals in the bottom 25% of the income distribution in Connecticut could lose an average of \$417 per year due to H.R.1, including due to SNAP and Medicaid cuts. These shifts, along with broader cost-of-living pressures, place additional strain on households' ability to maintain stable housing and access community support services.

Patients who struggle financially and teeter on the edge of housing insecurity, while facing higher out-of-pocket health insurance costs or the loss of coverage entirely, may be forced to choose between rent and their health. Patients experiencing homelessness or housing instability often cannot be safely discharged to lower-acuity settings, including home care, rehabilitation, or other post-acute services, due to the absence of stable housing or financial environment necessary to support/afford recovery and follow-up care. This challenge is compounded by the limited availability of medical respite beds, supportive housing options, and community-based services capable of addressing both medical and behavioral health needs. As a result, patients who no longer require acute hospital care may remain hospitalized solely because appropriate discharge options are unavailable, occupying inpatient beds and contributing to ED boarding and crowding. Addressing these challenges will require coordinated, cross-agency strategies that strengthen community capacity and align healthcare, housing, and social service resources to support safe and timely transitions of care.

We urge the creation and expansion of supportive housing programs, crisis respite, and intensive community care management that offer hand-in-hand mental health and substance use clinical services with practical, safe housing respite. Programs like rapid rehousing and substance use recovery housing treat basic needs like housing as an integral part of recovery and provide the resources for hospitals to create safe discharge plans, knowing the system safety net will facilitate treatment continuity.

Lack of Appropriate Behavioral Health Services and Need To Enhance Overall Healthcare Delivery System Capacity

Connecticut patients of all ages deserve timely access to the behavioral health services they need in the most appropriate setting. Hospitals are doing their part to support the system of care, but the growing demand for mental health and substance use services, coupled with a severe behavioral health workforce shortage, has resulted in an ongoing crisis in timely access to care for patients of all ages.

Each day, hospitals are working to find available inpatient psychiatric, residential psychiatric, group home, foster, respite, detox, and intensive in-home care for behavioral health patients stuck in an ED. These placement delays deny patients the best care in the most appropriate setting and expend hospital staff and resources that would be better used to care for patients who meet criteria for hospital-based behavioral health services.

We urge the state to make additional investments in the system of care to meet current needs and achieve system improvements to meet future demand, as outlined below.

First, we urge the state to leverage the impact of existing investments in the behavioral health system and enact additional measures to improve access to care. Hospitals support the establishment of sustainable Medicaid rate structures for new initiatives, such as children's behavioral health urgent crisis centers (UCC), statewide emergency mobile psychiatric services, mobile crisis care for adults, and other community-based and school-based services.

Second, we strongly encourage the state to implement Medicaid reimbursement for collaborative care model (CoCM) services, as authorized by Section 17b-307a, originally enacted as Section 59 of **Public Act 22-47 (HB 5001), An Act Concerning Children's Mental Health**. No action has been taken to date to implement this requirement. Coordinated and collaborative care supports the patient as they move through the continuum of care and navigate the often disjointed behavioral health system to ensure that hospital EDs are being used for acute care assessments and treatment rather than as stopgaps for medication management, family discord, detoxification, and adverse experiences brought on by complex social drivers of health.

Finally, we ask the state to direct additional financial resources to support the timely and safe discharge of patients with sufficient home-based, community-based, and hospital-based outpatient services. For hospitals, increasing Medicaid rates for partial hospitalization programs (PHP), intensive outpatient programs (IOP), and in-home psychiatric care programs will enhance timely and safe discharge from hospitals, reduce waiting lists, and improve timely access to behavioral health services.

These suggestions align with other committee recommendations toward an integrated approach to mental health. The need for additional funding to support the behavioral health system is clear, and we believe that these increases and extensions should be provided now, aligned with the Connecticut Department of Social Services' (DSS) comprehensive study of Medicaid rates.

Patients With Complex Discharge Needs

Connecticut hospitals face persistent and mounting challenges in securing appropriate post-acute care placements for patients with complex medical and social needs. There is a significant shortage of in-state post-acute options for patients requiring ventilator support, including those who also need dialysis. Patients with behavioral health conditions who require post-acute care but do not meet admission criteria for skilled nursing facilities (SNF) or residential care homes similarly experience prolonged hospital stays due to limited placement options.

Additional populations face growing barriers to appropriate placement. Individuals eligible for services through the Connecticut Department of Developmental Services (DDS) face an expanding need for specialized post-acute care settings, while available placements remain scarce. Hospitals also struggle to identify appropriate post-acute options for undocumented, international, and homeless patients, often resulting in extended inpatient stays. One additional patient population that faces significant placement barriers is those who need SNF placements and are also on opioid use disorder treatment plans. There are very few SNF locations that have volunteered to be trained in co-managing medical and substance use treatment. We encourage efforts to incentivize SNF participation and education to improve regional options for patients with these comorbid conditions.

For pediatric patients with complex behavioral or medical presentations, foster and kinship placements can be challenging, particularly when sudden or unplanned removals occur. The Connecticut Department of Children and Families (DCF) often seeks medical clearance from EDs for children following a removal or complex allegation of abuse or neglect, and then it is determined there are no discharge placements available. These children, who require safe and thoughtful discharge plans, become social admissions to hospitals when no alternative placements can be secured. These stays are considered medically unnecessary and, therefore, are often unreimbursable. Children in these situations require an abundance of inpatient services to ensure their emotional and support needs are met, along with hours of complex care coordination with DCF and community support services.

As a result of a complex and often disjointed system of acute and post-acute care, some patients remain hospitalized for weeks, months, or even years, not due to medical necessity, but because no appropriate post-acute care setting is available. No patient expects to live in a hospital, and these medically unnecessary extended stays are detrimental to patient well-being while exacerbating ED crowding and limiting access to inpatient beds for others. These challenges have been raised with the state, and hospitals look forward to continued collaboration to address this issue. Hospitals remain committed to helping patients transition to the least restrictive and most appropriate post-acute care setting and welcome legislative attention to this pressing problem.

Prior Authorization

Prior authorization requirements imposed by health plans have a direct and negative impact on hospital throughput and patient discharge timelines. Health plans frequently employ inconsistent administrative protocols, varying timelines, and complex documentation requirements for authorization requests, reviews, approvals, and communication. These inefficient and often manual processes result in delays, denials, and, in some cases, lost reimbursement.

Hospitals routinely dedicate multiple full-time staff solely to managing prior authorization requests. These burdensome administrative demands worsen workforce shortages and contribute to physician and staff burnout at a time when hospitals face unprecedented challenges in recruiting and retaining essential healthcare workers.

Beyond the impact on providers, prior authorization delays directly affect patients by postponing discharges to appropriate post-acute settings, even when a patient is returning to their pre-admission environment, including their home with supportive services. These delays unduly prolong hospital stays, place additional strain on patients and caregivers, and tie up inpatient beds that are critically needed elsewhere in the healthcare delivery system.

Conservatorship and Streamlining Proxy Decision-Making

Hospitals and EDs frequently care for patients who lack the capacity to make healthcare decisions and do not have an appointed healthcare representative or an available family member to serve in that role. When no advance arrangements exist, a conservator must be appointed through the Connecticut Probate Court system, creating significant barriers to timely medical decision-making.

Hospitals report ongoing difficulties in both identifying whether a patient is conserved and securing conservators for newly admitted patients. Even when a willing conservator has been identified, the appointment process can take weeks or months, as there is no expedited pathway to address urgent medical decision-making needs. These challenges are exacerbated by a statewide shortage of qualified conservators. Increasing compensation for conservators, as recommended by a recently released report from the Conservator Working Group, may also assist with recruitment.

Once appointed, conservators may be difficult to reach outside of standard business hours and often require probate court approval before consenting to necessary treatments. Obtaining court hearings can take weeks or months, further delaying care. Conservators also frequently request that hospitals delay discharges to allow additional time to arrange post-acute services, resulting in extended hospital stays that are not medically necessary.

When hospitals seek guidance or relief from probate courts, judges often err on the side of keeping patients hospitalized rather than ordering discharge, even when a less restrictive setting would be more appropriate. These prolonged, non-medical hospitalizations are harmful to patients, strain hospital staff and resources, and reduce access to care for others.

These situations are becoming increasingly frequent across Connecticut hospitals, leading to excessively long inpatient stays and unacceptable delays in delivering timely, appropriate care in the most suitable setting. Hospitals encourage the General Assembly to adopt improvements that may better address hospitals' unique experiences, including dedicated conservators to work specifically with hospitals.

CONCLUSION

While ED crowding is not a new issue, too few state resources have been devoted to helping resolve the root causes. To date, much of the legislative and state emphasis has been on data collection for a known problem with known root causes. Consistent with hospitals' 2025 ED Boarding and Crowding Report submitted to the Public Health Committee, we continue to encourage the Connecticut General Assembly to invest state resources into solutions that address these identified issues:

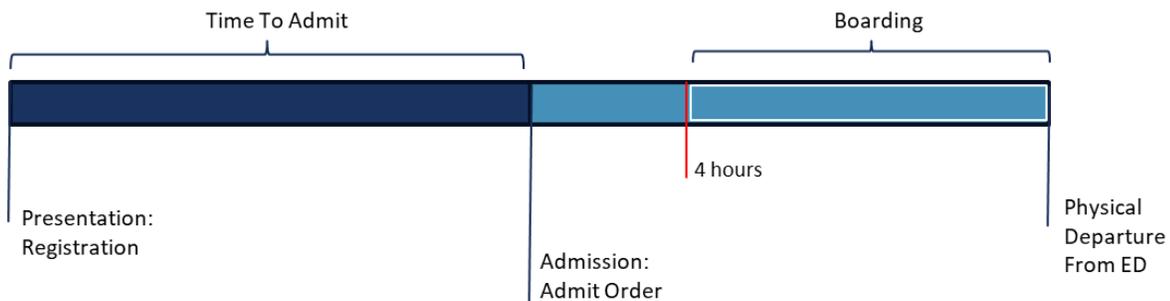
- Medicaid Underfunding and Long-Term Care Application Process
- Housing Instability, Homelessness, and Financial Risk
- Lack of Appropriate Behavioral Health Services and Need To Enhance Overall Healthcare Delivery System Capacity
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- Prior Authorization
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These factors directly contribute to prolonged ED boarding by delaying discharge or preventing timely admission to appropriate care settings. As always, we stand ready to partner with the state on legislative changes that will achieve meaningful improvements.

Appendix 1: Data Definitions

[CHA] shall analyze the following data from the previous calendar year concerning its emergency department: (1) The number of patients who received treatment in the emergency department; (2) the number of emergency department patients who were admitted to the hospital; (3) for patients admitted to the hospital after presenting to the emergency department, the average length of time from the patient's first presentation to the emergency department until the patient's admission to the hospital; and (4) the percentage of patients who were admitted to the hospital after presenting to the emergency department but were transferred to an available bed located in a physical location other than the emergency department more than four hours after an admitting order for the patient was completed.

Data Definitions:



For these analyses, volumes from calendar year 2025 were collected, and patients were included based on their arrival at the hospital (registration or admission date), as opposed to their discharge date. For all timepoints, encounter counts were used, as opposed to unique patients. The distinction is that a single patient may have multiple encounters. No patient type (e.g., medical, surgical, behavioral health, etc.) was excluded from any analyses. Pre-admitted or direct-admit patients are not included. “First presentation” is defined as the point at which a patient is registered into the electronic health record (e.g., Epic, Cerner, etc.).

The number of patients who received treatment in the emergency department (ED) is inclusive of all treatment categories, regardless of whether they were released the same day, admitted, or held for observation. Observation patients have not historically been included; as a result, these numbers may not match other data sources.

Patients who are admitted to the hospital are those individuals who were intended for admission into the inpatient space. The volumes and timeframes represented are reflective of the intention of the admitting provider and not reflective of the final determination for patient class. In other words, if a patient was initially admitted, but then converted/billed/discharged as observation, for the purposes of this report, they are considered inpatient.

A patient’s “admission” is defined as the point at which an admission or placement determination was entered, whether this be through an admission order, placement order, or a bed request (utilizing the timepoint that occurs first).

All inpatients were included in the boarding count, regardless of whether their entire stay resided in the ED. For the purposes of the boarding percentages reported here, observation patients were not included. Observation patients are a significant portion of the long length-of-stay ED population requiring substantial resources; however, observation designations are complex and assigned for a variety of reasons. Over the next several years, efforts will be made to improve understanding and be able to parse the various components of observation stays to more accurately report on these patients.

Appendix 2: Individual Hospital Data Reports

The William W. Backus Hospital
Bridgeport Hospital
Bristol Health
The Hospital of Central Connecticut
Connecticut Children's
Danbury Hospital
Day Kimball Health
Greenwich Hospital
Griffin Health
Hartford Hospital
Charlotte Hungerford Hospital
Johnson Memorial Hospital
Lawrence + Memorial Hospital
Manchester Memorial Hospital/Rockville General Hospital
Middlesex Health
MidState Medical Center
Norwalk Hospital
Saint Francis Hospital
Saint Mary's Hospital
St. Vincent's Medical Center
Sharon Hospital
Stamford Health
UConn John Dempsey Hospital
Waterbury HEALTH
Windham Hospital
Yale New Haven Hospital

Calendar Year 2025 ED Throughput

The William W. Backus Hospital

| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
|-------------------------|--------------------------|------------------------------------|-------------------|
| 79,768 | 6,636 | 502.84 | 36.7% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Bridgeport Hospital | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 116,754 | 17,763 | 284.45 | 39.2% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Bristol Health | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 30,686 | 3,756 | 352.60 | 24.8% |

| Calendar Year 2025 ED Throughput | | | |
|-------------------------------------|-------------------|----------------------------|------------|
| The Hospital of Central Connecticut | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 87,141 | 9,007 | 395.03 | 22.4% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Connecticut Children's | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 58,081 | 4,098 | 294.10 | 4.6% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Danbury Hospital | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 86,269 | 14,112 | 312.17 | 33.2% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Day Kimball Health | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 19,526 | 3,076 | 338.87 | 40.1% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Greenwich Hospital | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 41,761 | 5,906 | 197.65 | 10.8% |

Calendar Year 2025 ED Throughput

Griffin Health

| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
|-------------------------|--------------------------|------------------------------------|-------------------|
| 34,392 | 4,588 | 349.08 | 36.6% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Hartford Hospital | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 109,166 | 28,322 | 533.46 | 62.0% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Charlotte Hungerford Hospital | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 45,279 | 4,241 | 502.07 | 37.3% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Johnson Memorial Hospital | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 18,570 | 1,799 | 324.61 | 23.9% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Lawrence + Memorial Hospital | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 87,573 | 8,391 | 230.91 | 33.9% |

| Calendar Year 2025 ED Throughput | | | |
|--|-------------------|----------------------------|------------|
| Manchester Hospital/Rockville General Hospital | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 50,929 | 7,583 | 345.72 | 32.2% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Middlesex Health | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 84,057 | 6,738 | 224.39 | 28.0% |

Calendar Year 2025 ED Throughput

MidState Medical Center

| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
|-------------------------|--------------------------|------------------------------------|-------------------|
| 53,935 | 7,215 | 464.68 | 52.8% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Norwalk Hospital | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 45,806 | 8,250 | 254.25 | 27.5% |

Calendar Year 2025 ED Throughput

Saint Francis Hospital

| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
|-------------------------|--------------------------|------------------------------------|-------------------|
| 64,598 | 14,444 | 339.88 | 58.4% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Saint Mary's Hospital | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 54,159 | 5,298 | 425.71 | 52.3% |

Calendar Year 2025 ED Throughput

St. Vincent's Medical Center

| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
|-------------------------|--------------------------|------------------------------------|-------------------|
| 64,968 | 8,172 | 432.62 | 16.5% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Sharon Hospital | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 13,276 | 1,752 | 240.16 | 8.2% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Stamford Health | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 65,112 | 8,534 | 257.48 | 10.6% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| UConn John Dempsey Hospital | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 60,377 | 7,158 | 334.78 | 6.8% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Waterbury HEALTH | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 35,081 | 6,947 | 403.60 | 31.2% |

Calendar Year 2025 ED Throughput

Windham Hospital

| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
|------------------|-------------------|----------------------------|------------|
| 33,334 | 1,319 | 393.37 | 30.7% |

| Calendar Year 2025 ED Throughput | | | |
|----------------------------------|-------------------|----------------------------|------------|
| Yale New Haven Hospital | | | |
| Patients Treated | Patients Admitted | Avg Time to Admit (min) | % Boarding |
| 228,586 | 41,980 | 325.27 | 47.9% |