REPORT OF THE CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE PUBLIC HEALTH COMMITTEE
February 28, 2025

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit the report specified in PA 24-4 **(SB 181), An Act Concerning Emergency Department Crowding** on behalf of its member hospitals.

After consulting with the Committee on the requirement of PA 24-4, CHA is submitting this report on behalf of all hospitals subject to PA 24-4. The appendices to this report contain each individual hospital's data, which tracks the categories set forth in PA 24-4.

Introduction and Executive Summary

PA 24-4, An Act Concerning Emergency Department Crowding 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 2025 obligation of each hospital to submit a report, by March 1, 2025 and annually thereafter until March 1, 2029, to the Public Health Committee on the findings of the analysis and recommendations on the above goals.

On a daily basis, hospitals are working to continually improve the efficient management of the ED to improve patient experience and increase hospital throughput. Hospitals will continue to innovate, learn, and adjust their practices over the 5-year timeline of the legislation.

The ED is largely the front door to the hospital system, screening and handling all levels and types of patients. Most efforts focused on improving patient flow have been approached systemically; for example, the implementation of a bed management department with staff solely dedicated to anticipating patient movements, or procedures to achieve benchmarks relating to discharge times (e.g., 11am discharge or 3pm discharge). Additional efforts to improve throughput include more efficient workflows and patient processing through radiology, transport, and custodial departments.

Because the length of stay for patients is increasing, whether due to rising acuity, greater frequency in difficult to place patients, increasing insurance burden, or continuing closures of post-acute locations (e.g., skilled nursing facilities), hospitals continue to be challenged to balance the influx of new patients with the continuing care and management of those already there.

Root causes for delays in admission times for patients who present to the ED for treatment are multifactorial. We encourage the Connecticut General Assembly to take action to remedy the following identified issues:

- Medicaid Underfunding
- Delayed Implementation of Mobile Integrated Health
- Lack of Appropriate Behavioral Health Services and Need to Enhance Overall System Capacity
- Difficult to Place Patients
- Prior Authorization
- Conservatorship and Streamlining Proxy Decision-Making

Summary Data Analysis: Calendar Year 2024

Statewide results for 2024 data are presented below; individual hospital-level details are available in the appendices to this report.

Connecticut hospitals saw over 1.6 million ED patients (1,663,899) in 2024. Of those patients, 13.7% (228,180) were admitted as inpatients to the hospital.

Statewide ED Metrics			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
1,663,899	228,180	328.19	38.7%

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 328 minutes (5.5 hours), with a median of 4.2 hours.

The percentage of patients boarding, defined in the legislation as patients who were admitted after presenting to the ED but 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 38.7%.

An analysis of ED throughput would not be complete without understanding how observation patients (i.e., patients receiving outpatient hospital care while their medical condition is being evaluated to determine if they require an inpatient admission or can be discharged) contribute to ED crowding. Observation patient volume accounts for 9% of ED volume, and has increased by more than 30% since 2021. Most hospitals do not have dedicated treatment spaces for observation patients and instead manage them within the ED; the average length of stay for an observation patient is 15.6 hours, during which observation patients are occupying an ED bed and consuming already limited and stretched ED resources.

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 better understand and parse the various components of observation stays to more accurately report on these patients.

Findings

Policies and Procedures to Reduce Wait Times and Methods to Improve Admission Efficiencies
The ED is largely the front door to the hospital system, screening and handling all levels and types of patients. Most efforts focused on improving patient flow have been approached systemically, a few examples include the implementation of a bed management department with individuals solely dedicated to anticipating patient movements, implementing incentives to achieve benchmarks relating to discharge times (e.g., 11am discharge or 3pm discharge), or color indicators for medical readiness for discharge that can help providers understand which patients to prioritize for discharge.

Hospitals are constantly reviewing procedures and guidelines aimed at improving throughput within the ED. For example, many EDs across the state have implemented a version of a "fast track" which is a separate workflow for low acuity patients, keeping them away from the main ED and improving throughput.

Additional efforts that could improve throughput include more efficient workflows and patient processing through radiology, transport, and custodial departments. One method mentioned in The Connecticut Emergency Department Boarding and Crowding Working Group's report is the use of "discharge lounges" to reduce stays. Unfortunately, that approach is not likely to improve (reduce) length of stay dramatically, only incrementally. Moreover, because the length of stay for patients is increasing, whether due to rising acuity, greater frequency of difficult to place patients, a result of increasing insurance burden, or continuing closures of post-acute locations (e.g., skilled nursing facilities), hospitals will continue to be challenged to balance the influx of new patients with the continuing care and management of those already there.

It is evident that patient experience would benefit from reducing ED crowding. Lesser-known impacts of ED crowding include staff burn-out, the inability to retain talent (i.e., turnover), and substantial financial implications of unreimbursed care. It is in everyone's interest to improve the situation.

EDs are the face of a larger throughput challenge across the continuum of care, which primarily occurs at discharge. The ability to discharge a patient safely, and to the appropriate site-of-care is absolutely essential to success for both the patient and the provider. Failure to do so will often result in a patient readmission, which is not in the best interest of the patient and has significant financial ramifications for the hospital. Most individuals are discharged to home without additional care, or in the care of a loved one. A smaller proportion of patients are discharged to another care facility or are in need of special services to complete their course of care. This small proportion of patients account for the vast majority of long lengths of stay and medically unnecessary hospital days. Patients continue to be in the hospital setting awaiting discharge for numerous reasons: insurance denials, prior authorization red tape, conservatorships and identifying proxy decisionmakers, or lack of access to appropriate sites of care because of too few beds being available (e.g., skilled nursing facilities, long-term care facilities, rehabilitation, behavioral health, etc.). For example, between 1995-2021 more than 7,250 nursing home beds closed in the State. This trend has not slowed; since 2021, 15 skilled nursing facilities have closed.

Over the past 5 years the number of patient days has increased (6.4%) while the number of discharges has decreased (2.9%), which suggests that patients are staying in the hospital longer. Over the same time period, the case-mix index (CMI) of the patient population has increased by 7.5%. CMI is a measure of resource utilization and is a proxy for severity of illness. In simple terms, patients are sicker and more complex, requiring more resources and time to treat them.

Note that severity of illness is not the only reason why a patient may stay longer. As mentioned above, there are situational reasons (preauthorization, access to next setting of care, etc.) that can also influence length of stay. Patients spending increased time in a hospital slows bed turnover. **The impact of this is that the inpatient space within hospitals remains full for longer periods of time, preventing new patients from being able to receive an inpatient bed, resulting in backlogs in the ED and eventually ED crowding.**

Increased patient demand through the increasing volume of patients traversing the ED, high acuity and corresponding admission rates, and reduction in throughput (longer length of stay, more complex patients), results in hospital beds being in high demand, a surge in capacity followed by a domino effect that backs up in the ED.

ED crowding is also financially detrimental to hospitals. ED staff turnover, the use of expensive contract labor, and subsequent longer lengths of stay for patients that boarded in the ED are all consequences of ED crowding that weaken the financial health of hospitals.

Root Causes for Delays in Admission Times
Taken together, ED crowding, boarding, and delays in admission times for patients who present to the ED for treatment are symptoms of broader, multifactorial issues. They include those itemized below and we encourage the Connecticut General Assembly to take action to remedy the issues identified.

Medicaid Underfunding
Medicaid underpayment has long been a significant issue in Connecticut, and it remains unaddressed. This ongoing financial shortfall has serious implications for our healthcare system and the communities we serve. In 2023, Medicaid underpayments to hospitals in Connecticut reached $1.43 billion. The DSS Phase 1 report, completed in February 2024, reviewed Connecticut Medicaid fee-for-service rates for behavioral health services (BHS), dental services, physicians, and other professional services providers finding that reimbursement for these providers feel below benchmarks, and in many cases, well below. The consequence of this physician underfunding is more limited access to healthcare services for Medicaid beneficiaries.

Emergency departments often serve as the frontline in experiencing the impacts of inadequate Medicaid reimbursement and its effect on access to care. Connecticut's chronic underinvestment in Medicaid significantly affects multiple sectors, including workforce retention, facility operations, and patient access. Underpayment hampers our 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 impacts our capacity to invest in community programs that address upstream health determinants, further compounding ED usage. Our ability to address behavioral health needs and streamline care coordination practices is also stifled, ultimately affecting patient outcomes and perpetuating barriers to discharge.

Our emergency departments are frequently the last resort, and in many cases the only available option, for community members seeking care, often to address chronic medical conditions that should be managed in a community setting. Despite the ongoing challenges of rising labor costs and drug prices, inflation, and prior authorization barriers, hospitals and ED providers remain dedicated to patient care. However, without proper recognition and resolution of these financial challenges, patients face delays, reduced access to timely care and poorer outcomes. It is essential that we advocate for fair

reimbursement rates to ensure our healthcare system can continue to provide the safe, high-quality care that our communities deserve.

Delayed Implementation of Mobile Integrated Health
Mobile Integrated Healthcare (MIH) is a patient-centered approach to the provision of 24-hour/7 day needs-based care provided in an at-home or mobile setting. MIH integrates the scope of practice of licensed paramedics with the services of existing healthcare stakeholders in the provision of acute care, chronic care, and preventive care. MIH leverages the availability of, and accessibility to, existing healthcare resources (paramedics) functioning within the Emergency Medical Services (EMS) system, who are either licensed or certified by the State of Connecticut Department of Public Health (DPH) and performing responsibilities within an approved scope of practice under the medical direction of a sponsor hospital.

Development of collaborative MIH programs is intended to help break down silos in healthcare delivery models by coordinating communication pathways and care plans among a variety of community healthcare providers and agencies to deliver a broad spectrum of patient-centered preventive, primary, specialty, and rehabilitative care outside of medical facilities. MIH programs also leverage technology to triage and connect non-urgent 9-1-1 callers with relevant caregivers and assistance instead of dispatching an ambulance crew.

Recently, after a lengthy delay, the Connecticut Department of Public Health published policies and procedures to permit the start of the implementation of Mobile Integrated Health Care Programs (MIH) in the state.

Lack of Appropriate Behavioral Health Services and Need to Enhance Overall System Capacity
Connecticut residents 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.

- During 2024, the average daily number of patients in emergency departments (EDs) seeking treatment for behavioral health disorders was 186 patients
- During that same year, the average daily number of evaluated adult behavioral health patients awaiting an inpatient bed was 43 patients and the average daily number of evaluated child/adolescent behavioral health patients awaiting an inpatient bed was 23 patients
- One hospital reported that the average wait time for a behavioral health bed was between 28-33 hours for adult and adolescent patients.

These numbers provide some insight into the breadth and scope of this crisis. Each day, hospitals are working to find available inpatient psychiatric, residential psychiatric, intermediate care, group home, foster, and home care beds for behavioral health patients stuck in an emergency department. These placement delays deny these patients the best care in the most appropriate setting, and occupy staff and resources in hospitals 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 suggest the state 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 the children's behavioral health urgent crisis centers, statewide emergency mobile psychiatric services, mobile crisis care for adults, and other community-based and school-based services.

Second, we urge 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). No action has been taken to date to implement this requirement.

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 enable timely and safe discharge from hospitals, reduce waiting lists, and improve timely access to behavioral health services.

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, even as DSS completes its comprehensive study of Medicaid rates.

Difficult to Place Patients
Connecticut hospitals face the daily challenge of finding appropriate post-acute care placements for patients with complex medical needs. For example, there is a lack of available post-acute placements within Connecticut to meet the existing needs of patients on ventilators, or those on ventilators who need dialysis treatment. Similarly, patients with behavioral health issues who need post-acute care but do not meet the typical criteria for existing placements within skilled nursing facilities or residential care homes, often remain stuck in the hospital.

Additionally, Department of Developmental Services eligible clients have become a population with ever increasing post-acute care setting needs, coupled with a shortage of available placements for these patients. Hospitals also struggle to find post-acute care placement for undocumented individuals, with a likely outcome of those patients remaining stuck in the hospital

For some patients, time in the hospital is measured in weeks, months, or even years, as no appropriate post-acute care is available. These issues have been raised with the state and we look forward to our continued work together in this area of focus. We remain committed to assisting patients to find the least restrictive post-acute care placement. No patient expects to live in the hospital, and we must work together to address this issue for the betterment of the individual patient as well as the goal of reducing ED crowding which relies on the availability of hospital inpatient beds. We welcome a legislative focus on addressing this pressing issue.

Prior Authorization
The impacts of prior authorization delays and processes have a direct, negative impact on the throughput of patients within, and discharges, from hospitals. Health plans commonly use inconsistent administrative protocols and a dizzying array of timelines and requirements for prior authorization requests, reviews, approvals, and communication. In addition, prior authorization processes are woefully inefficient. The burdensome processes, complex requirements, and manual processing inevitably result in delay, as well as some denials, or a loss of reimbursement.

Hospitals often have multiple full-time employees whose sole role is to manage health plan prior authorization requests. Prior authorization processes exacerbate workforce challenges and contribute to physician and other staff burnout. Expending staff resources to respond to health plan administrative requirements is unreasonable at any time, and far worse as we confront unprecedented and likely enduring challenges recruiting and retaining essential healthcare workers.

In addition to the negative impact on providers, prior authorization is known to delay the discharge of patients to appropriate post-acute care settings, even when the patient is only returning to their pre-admission setting (including to home). This process unnecessarily impacts the patient and their caregivers and ties up hospital inpatient beds. The outcome is that patients remain in the hospital longer than necessary when a more appropriate placement or setting is elsewhere.

Conservatorship and Streamlining Proxy Decision-Making
Emergency departments often treat patients who are no longer capable of caring for themselves and do not have a designated healthcare representative or family member able to take on this role. In some cases, the patient may not have made any arrangements for the appointment of a healthcare representative or conservator in advance of the onset of an incapacitating condition or event, so a conservator must be appointed for them through a probate court process. These situations present an array of challenges to hospitals and other healthcare providers, in terms of making timely decisions regarding a patient's medical care, resulting in longer hospital stays for these patients, and reducing access to hospital resources and services for other patients.

Hospitals are reporting challenges in securing conservators for newly-admitted patients. It may take weeks or even months to get a conservator appointed by a probate court, even in cases where a willing conservator has been identified. There is no expedited process to appoint a conservator to make timely medical decisions for a patient. There is also a shortage of qualified conservators available.

In addition, court-appointed conservators are often difficult to contact off business hours or on weekends, since they are often attorneys in private practice. Moreover, conservators often refuse to make a treatment decision for a patient, and will request a hearing with the probate judge in order to obtain a court order to allow for various healthcare services to be administered. It may take weeks or even months to get a hearing.

In addition, conservators will often ask a hospital to delay the patient's discharge from the hospital in order to afford the conservator more time to arrange for post-acute treatment. In these cases, hospitals are forced to extend a patient's hospital stay, not for sound treatment-related reasons, but for want of a safe discharge option. When hospitals seek relief from the probate court, judges will typically opt to keep the patient in the hospital rather than order their discharge. These extended non-medical hospital stays are detrimental to the patient's health and well-being and place undue burdens on hospital staff and resources.

These situations are occurring on a more frequent basis in hospitals around the state, resulting in inordinately long hospital stays and untenable delays in obtaining timely and necessary healthcare in the most appropriate setting.

<u>Conclusion</u>

Hospitals have developed a variety of approaches to improve patient flow, including the implementation of bed management systems, procedures to achieve benchmarks relating to discharge times, and more efficient workflows and patient processing through radiology, transport, and custodial departments.

However, additional state resources are required to address the root causes of ED crowding. To date, much of the legislative and state emphasis has been on data collection for a known problem with known root causes. We encourage the Connecticut General Assembly to take action to focus state resources to address these identified root cause issues:

- Medicaid Underfunding
- Delayed Implementation of Mobile Integrated Health
- Lack of Appropriate Behavioral Health Services and Need to Enhance Overall System Capacity
- Difficult to Place Patients
- Prior Authorization
- Conservatorship and Streamlining Proxy Decision-Making

As always, we stand ready to partner with the state on legislative changes that will bring about meaningful change.

Appendix 1: Data Definitions

Legislative Language: Not later than January 1, 2025, and annually thereafter until January 1, 2029, each hospital in the state with an emergency department shall, and each hospital operated exclusively by the state may, directly or in consultation with a hospital association in the state, 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 Used in This Report:
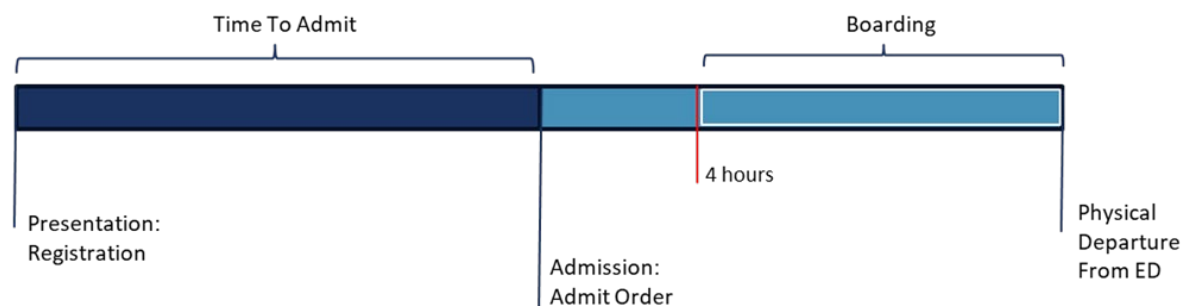
Patient volumes are from calendar year 2024, and patients were included based on their arrival date at the hospital (registration or admission date) as opposed to their discharge date. For all timepoints, encounter counts were used as opposed to unique patients. All patient types (e.g., medical, surgical, behavioral health) were included in the analysis. Pre-admitted or direct-admit patients are not included.

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, and as a result these data may not match other data sources.

"First presentation" is defined as the point in which a patient is registered into the electronic health record (e.g., Epic, Cerner, etc.).

A patient's "admission" (the "admit order") is defined as the point at which an admission order or placement determination is entered into the electronic health record, whether through an admission order, placement order, or a bed request (utilizing the timepoint that occurs first).

"Boarding" is defined as patients waiting more than 4 hours to physically leave the ED after the admit order was entered.

The number admitted, average time to admission, and the boarding percentages are for ED-admit/inpatient only and do not include observation 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 Healthcare
Greenwich Hospital
Griffin Health
Hartford Hospital
Charlotte Hungerford Hospital
Johnson Memorial Hospital
Lawrence + Memorial Hospital
Manchester Memorial Hospital
Middlesex Health
MidState Medical Center
Norwalk Hospital
Rockville General 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 2024 ED Throughput			
The William W. Backus Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
80,235	8,016	303.44	54.5%

Calendar Year 2024 ED Throughput			
Bridgeport Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
118,491	17,130	298.84	32.6%

Calendar Year 2024 ED Throughput			
Bristol Health			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
30,849	3,753	368.59	30.0%

Calendar Year 2024 ED Throughput			
The Hospital of Central Connecticut			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
85,546	10,075	346.94	29.2%

Calendar Year 2024 ED Throughput			
Connecticut Children's			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
59,704	5,635	271.66	10.5%

Calendar Year 2024 ED Throughput			
Danbury Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
65,036	10,960	310.04	22.4%

Calendar Year 2024 ED Throughput			
Day Kimball Healthcare			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
19,340	2,766	370.74	40.6%

Calendar Year 2024 ED Throughput			
Greenwich Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
42,417	5,378	188.61	13.6%

Calendar Year 2024 ED Throughput			
Griffin Health			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
34,234	4,579	372.40	33.9%

Calendar Year 2024 ED Throughput			
Hartford Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
108,280	28,193	387.65	63.1%

Calendar Year 2024 ED Throughput			
Charlotte Hungerford Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
44,235	4,963	330.91	53.3%

Calendar Year 2024 ED Throughput			
Johnson Memorial Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
18,513	1,244	413.75	20.0%

Calendar Year 2024 ED Throughput			
Lawrence + Memorial Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
88,076	7,878	213.55	26.0%

Calendar Year 2024 ED Throughput			
Manchester Memorial Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
36,522	6,359	363.13	26.9%

Calendar Year 2024 ED Throughput			
Middlesex Health			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
82,676	6,455	224.12	33.9%

Calendar Year 2024 ED Throughput			
MidState Medical Center			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
52,898	7,131	303.94	52.7%

Calendar Year 2024 ED Throughput			
Norwalk Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
45,756	6,243	249.26	21.9%

Calendar Year 2024 ED Throughput			
Rockville General Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
23,334	1,304	446.15	38.1%

Calendar Year 2024 ED Throughput			
Saint Francis Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
67,264	11,499	339.92	62.2%

Calendar Year 2024 ED Throughput			
Saint Mary's Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
56,602	5,485	366.30	55.3%

Calendar Year 2024 ED Throughput			
St. Vincent's Medical Center			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
64,771	8,185	307.91	21.5%

Calendar Year 2024 ED Throughput			
Sharon Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
13,097	938	232.29	8.8%

Calendar Year 2024 ED Throughput			
Stamford Health			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
63,356	7,090	259.60	24.6%

Calendar Year 2024 ED Throughput			
UConn John Dempsey Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
58,376	7,787	351.55	8.7%

Calendar Year 2024 ED Throughput			
Waterbury HEALTH			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
37,145	7,340	575.66	25.6%

Calendar Year 2024 ED Throughput			
Windham Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
33,434	1,927	281.68	31.8%

Calendar Year 2024 ED Throughput			
Yale New Haven Hospital			
Patients Treated	Patients Admitted	Avg Time to Admit (min)	% Boarding
233,597	38,057	345.39	46.7%