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Report to the Department of Public Health. State of Connecticut

Reporting of Community Benefits by Hospitals and Health Plans in Connecticut For the Calendar Year 2000

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Executive Summary

Pursuant to Public Act 00-57, hospitals and managed care organizations operating in the state of Connecticut are required to report to the state whether or not they have a community benefit program. Those that have such programs are required to report on the details of their community benefit activities. Under contract to the state, we (a) developed a new protocol for identifying the full range of activities and programs that might benefit the health of communities, (b) designed a survey to collect information on these activities, (c) met with representatives from the state hospital and managed care associations to inform them about the protocols, (d) distributed to all potentially eligible organizations a form for reporting whether they operated a community benefit program, (e) for those that did, provided technical assistance in completing the reporting form, (f) compiled the information collected from responding organizations into an EXCEL database, and (g) developed a report summarizing the findings from the community benefit reports, describing the process through which they were collected, and making recommendations about the future of the community benefit reporting system in the state. A draft of this final report was reviewed by the Department of Public Health and modified to reflect their concerns.

The protocol developed for this report is the most comprehensive instrument currently available for measuring the community involvement of hospitals and health plans. It incorporates 21 distinct dimensions of community benefit activity, drawn from four different paradigms for the appropriate connections between health care organizations and the localities in which they are sited. The importance of this broader definition of community benefit is made evident by the extensive community involvements of responding organizations that would have been overlooked by narrower conventional definitions of community benefits. Indeed, a number of responding organizations expressed concern that even this framework was too narrow and might overlook some of the ways in which they were potentially benefiting their communities.

Implementing the data gathering system involved a number of operational challenges. First, managed care organizations viewed the entire concept of community benefit with considerable skepticism. For some insurers, this reflected their modest involvement in the state – they had no real community presence, though some Connecticut residents were enrolled in their health plans. For other insurers, there was a pronounced suspicion of the legislative motives behind the enactment of the community benefit reporting law, combined with a concern that they might be held accountable for activities that were beyond what they considered to be the appropriate purview of a managed care plan. There is reason to believe that the health plans in the state decided as a group to effectively boycott the community benefit reporting system.

A second challenge was related to the fears of hospitals that any reporting system for community benefits would be the first step in the creation of minimum standards of community benefit activity. (This is a concern that has emerged in virtually all states with community benefit reporting laws.) Indeed, one rationale for a broadly defined notion of community benefits involves the need to capture those activities that are potentially important for a

healthy community, but which may be difficult to quantify. The importance of these dimensions of organizational involvement argues against any simple quantifiable standard of performance.

A third challenge involved logistical details. At the request of the Department of Public Health, we designed a fully electronic reporting system, with information entered over the Internet by responding organizations. This proved to be a problematic strategic decision. The software that is available for Internet based surveys is inadequate for the complex data gathering associated with the community benefit protocol. After evidence of repeated breakdowns in the program, we abandoned the Internet-based reporting system and replaced it with one based on a written survey, with data directly entered into a standard spreadsheet program. Because the time involved in data entry proved modest, we believe that this approach represents the most cost effective and reliable format for data collection, at least until better survey software comes on the market.

The results from the survey reveal a broad range of community involvements, as well as some persisting gaps in the ways in which hospitals address the broader health needs of populations in their service areas. The aspects of community benefit in which Connecticut hospitals are most extensively involved (more than 75% of responding facilities) include: (a) the provision of free or subsidized health services, (b) educational programs for the general public or affiliated health care professionals, (c) sharing clinical data with researchers, (d) programs designed to reduce the transmission of infectious diseases, and (e) initiatives intended to stimulate philanthropy or volunteering among employees. A second set of community involvements were moderately available, found at 30-70 percent of responding institutions. These included: (a) support for safety-net providers, (b) support for social service agencies in the community, (c) needs assessments for local communities, (d) support for family caregivers of patients, (e) initiatives to address health hazards in the home, (f) collaborations with local protective service agencies (police and fire departments) to address health-related problems in the community, and (g) mentoring or training programs to encourage people from disadvantaged groups to become hospital employees.

A third set of community benefit activities were rarely found among Connecticut hospitals and represent potentially important unmet aspects of population health. These include: (a) subsidizing premiums to make health insurance more affordable to local residents, (b) using hospital data bases to help identify emerging diseases, (c) involvements in collaborative initiatives to address local environmental concerns, (d) direct grants from the hospital to various community-based groups, and (e) effective engagement of local groups in establishing priorities for the community benefit activities at the hospital.

The report concludes with a set of recommendations for future implementation of Public Act 00-57. In our assessment, there are four important challenges facing the community benefit reporting program. First, it is essential to ensure the involvement of all health care institutions with substantial presence in the state. A small number of hospitals claimed to have no community benefit program and thus to be exempt from the law, though it seems likely

that they were engaged in activities that did affect their local community. To ensure their future participation, the definition of a community benefit program under the law will need to be clarified.

Clearly a bigger issue involved the lack of participation by the managed care plans. Although some have no more than a nominal presence in Connecticut, a number have a substantial number of enrollees residing in the state (this is probably about half of the plans with operating licenses). Apart from suspicion within the industry, there is no strong rationale for plans not participating. Although health plans are less likely than hospitals to think in terms of community benefits, there is considerable evidence that virtually every plan engages in numerous policies and practices that have implications for the health of local communities. Health plans in Massachusetts and Minnesota have had no great difficulty complying with community benefit reporting requirements in those states. Our experience with a national survey of comparable scope to the reporting protocol used in Connecticut suggests that plans can assemble the necessary information with little more than 5-6 person-hours of labor. We believe that it will likely prove necessary to mandate involvement through amended legislation.

Second, it is important to increase the reliability and validity of the information reported on the protocol. The current protocol relies on entirely on self-reported data. Given the obvious incentives for respondents to hedge toward a more positive image in their community involvements, it makes sense to design site visit audits to ensure that data is being reported accurately. Because this will increase the burdens for both hospitals and the Department of Public Health, we believe that (a) additional resources should be allocated to the Department for program administration, and (b) data should be collected every two years, rather than annually.

Third, there are a variety of challenges related to the content of community benefit activities in the state and the ways in which they are reported. Some organizational practices – e.g., efforts to identify problematic practitioners in the community – proved too controversial to incorporate into the first version of the reporting protocols. Information on the geographic coverage for each type of community benefit activity would prove complicated to collect, but is important for identifying gaps in the distribution of these benefits among particular neighborhoods. Finally, there is a need to more accurately assess the extent of community participation in the setting of community benefit reporting. This may require collecting information from community-based informants, an additional methodological challenge.

The fourth challenge for the future is related to effective dissemination the information collected through the community benefit reporting system and foster appropriate community participation in the process of setting priorities for community benefits at hospitals and health plans. Reports that vanish into the file drawers of state bureaucrats provide hospitals and health plans little incentive to carefully document their activities, particularly when the current law contains no particularly effective enforcement mechanisms. As revealed in the first-year reports from Connecticut's hospitals, there is much being accomplished by these organizations that has important potential benefits for the localities in which they operate. We expect that a comparable record will emerge for

managed care plans. It is in the interests of both hospitals and health plans to have these activities recognized by community residents and leaders. It is equally important that those in each community learn what it is that hospitals and health plans are purportedly doing for their benefit. Only if they are aware of these activities can they effectively influence the priorities that are set and ensure that the most important health needs are given prominence. Whether and how this participation should be mandated by law remains an open question.

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Introduction

Pursuant to Public Act 00-57, hospitals and managed care organizations in Connecticut are required to report to the state whether or not they have a community benefit program. Those that have such programs are required to report on the details of their community benefit activities. Under contract to the state, we (a) developed a new protocol for identifying the full range of activities and programs that might benefit the health of communities, (b) designed a survey to collect information on these activities, (c) met with representatives from the state hospital and managed care associations to inform them about the protocols, (d) distributed to all potentially eligible organizations a form for reporting whether they operated a community benefit program, (e) for those that did, provided technical assistance in completing the reporting form, (f) compiled the information collected from responding organizations

into an EXCEL database, and (g) developed a report summarizing the findings from the community benefit reports, describing the process through which they were collected, and making recommendations about the future of the community benefit reporting system in the state of Connecticut.

This report summarizes these activities and the lessons learned over the first year of program implementation. We will discuss these matters in six sections: A) developing a new framework for assessing community benefits; (B) designing a new protocol for collecting data on community benefits; (c) engaging representatives from state hospital and managed care associations; (d) the checkered logistics of data collection; (e) principal findings about the community benefits activities at Connecticut hospitals; (f) recommendations for the future of the community benefit reporting program

A. Developing a New Framework for Assessing Community Benefits,

The "community benefit" standard for judging the performance of health care organizations emerged from the dominant historical role of nonprofit enterprise in American medicine. The role of nonprofit hospitals had long been justified by their provision of charity care.[1] As government assumed greater responsibility for financing health care for formerly indigent patients during the 1960s, some alternative justification was seen by policymakers as increasingly important. In 1969, the Internal Revenue Service promulgated a new "community benefit" standard for federal tax exemption, deeming hospitals as "charitable" if they operated an emergency room, had a "board of directors drawn from the general community", avoided blanket policies denying service to indigent patients, and did not discriminate against patients covered by public programs.

The appropriate scope of the "community benefit" criteria, their application to health care organizations other than hospitals, and their importance compared to the provision of charity care, all remained controversial issues among policymakers for the subsequent three decades.[2] Through a series of court cases and legislative

[1] See Daniel Fox and Daniel Schaffer, "Tax Administration as Health Policy: Hospitals, the Internal Revenue Service and the Courts" Journal of Health Politics, Policy and Law 1991; 16(2): 251-280 and John Simon, "The Tax Treatment of Nonprofit Organizations: A Review of Federal and State Policies" in The Nonprofit Sector: A Research Handbook Ed. Walter Powell (New Haven, Yale University Press. 1987): 67-99.. The charity care rationale for nonprofit ownership was often conflated with a somewhat different justification – that the services provided by the nonprofit health care sector relieved government of the burden of activities that it would otherwise need to finance through tax revenues (Thomas K. Hyatt and Bruce R. Hopkins, The Law of Tax-Exempt Healthcare Organizations (New York, John Wiley and Sons, 2001). It was certainly true that many nonprofit hospitals in the nineteenth century received funds from local governments to help finance treatment of indigent patients. But during the twentieth century, local, state and federal governments assumed responsibility for health care and health-related programs that were not limited to the poor. Medicare, for example, embodies a national commitment to ensure access to health care for all of America's elders. Consequently, the activities of nonprofit health care providers might reduce government burdens in a variety of ways that do not involve charity care.

[2] Kevin Barnett, The Future of Community Benefit Programming (Berkeley CA: The Public Health Institute, 1997); Fox and Schaffer, "Tax Administration as Health Policy"

initiatives, the boundaries of community benefit have been expanded beyond their 1969 definition. Nonetheless, the prevailing emphasis in these past initiatives has been on a limited number of activities thought to affect the health of local populations, including health promotion and public health education initiatives, needs assessments, and various forms of subsidized medical services or insurance premiums.[3]

We will refer to this perspective derived from tax policy as the "legal-historical" paradigm for community benefits. Although clearly broader than the "relief of poverty" standard that it replaced in 1969, "community benefit" has been defined in an episodic, haphazard, and somewhat inconsistent fashion. It is, moreover, far from comprehensive in identifying ways in which health plans could affect the health of communities. One can find in the academic literature several additional paradigms for understanding the linkages between the activities of health care organizations and the health of the local community.

Three distinctive perspectives have been identified, each derived from a different academic field or fields. The first perspective, derived from economic theory, will be labeled here the "market failures" paradigm.[4] It highlights those circumstances under which the costs and benefits that face either health plans or individual consumers differ from the impact that their decisions have on society as a whole. Managed care plans might act to compensate for the biases that would otherwise be produced in the nature or distribution of health-related interventions.

More specifically, this perspective suggests that nonprofits might address four types of market failures. First, plans might provide higher quality services than can be supported in the market because consumers or collective purchasers (e.g. employers) are too ill-informed to select the plans that perform well in these aspects of medical care. Second, plans might forego shifting costs that could be displaced ("externalized") to other parts of the health care system, either by transferring high-cost enrollees or limiting access to medical services, so that the burden of caregiving is shifted to other parties. Third, plans may provide services even when they cannot fully appropriate the economic return, as with various public goods such as medical research. Finally, plans may act in ways that enhance the overall performance of the managed care industry or local health care system (e.g., by encouraging the adoption of collaborative practices or performance standards), even if this reduces the plan's own competitive advantage.

A second alternative paradigm, which we term the "community health" orientation, is drawn more from the

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[3] Mark Schlesinger, Bradford H. Gray and Elizabeth Bradley, "Charity and Community: the Role of Nonprofit Ownership in a Managed Health Care System". Journal of Health Politics Policy and Law 1996; 21(4): 697-752.

[4] Mark Pauly, "Health Systems Ownership: Can Regulation Preserve Community Benefits" Frontiers of Health Services Management 1996; 12(3): 3-34; Schlesinger et al., "Charity and Community" ; Carolyn Madden, and Aaron Katz, 'Community Benefits and Not-for-Profit Health Care: Policy Issues and Perspectives Report prepared for the Catholic Health Association (Seattle, WA: University of Washington School of Public Health and Community Medicine, 1995)

health services literature. It focuses on the organization's contributions to maintaining a robust health care system – that is, one that can serve the full range of health needs in the local community and that has the capacity to respond to changing needs or changing circumstances (new technologies, new regulations, new ways of paying for medical care) in a timely fashion.[5] It also emphasizes the need for health care providers to be accountable to the community by providing regular reports on their activities.

To make this sort of contribution to the local service system, a health care organization might inform the community about its practices and performance (so that residents can use their services appropriately), to share its resources and expertise to address local needs, as well as to treat a "fair share" of unprofitable patients. The epitome of this approach involves collaborations among health care agencies, particularly in support of safety net providers – community health centers, community mental health centers, academic medical centers – that focus on the needs of the most disadvantaged. It also would count as a community benefit any training of local health care professionals, to ensure their availability to community residents and increase their awareness of local health needs.

The third perspective, which we refer to as the "healthy community" paradigm, combines some elements from communitarian policy proposals with some observations from social epidemiology. In the communitarian tradition, health plans are argued to have the capacity –given their broad oversight over a range of health services -- to foster more effective local decisionmaking about how health resources ought to be allocated.[6] Under this perspective managed care plans are seen as a partial remedy for "government failure," analogous to the emphasis on market failures in the first of the alternative paradigms.

The healthy community perspective joins this participatory orientation with the findings of social epidemiologists, who have identified the various social and environmental factors that affect population health.[7] Applying their insights might entail shifting resources from medical care to other health-related services, to parts of the local non-medical infrastructure with important health consequences (e.g., traffic safety, fire prevention, crime reduction), or even to programs of income assistance. In contrast to the community health perspective, which emphasizes a strong and influential role for health care professionals in the local community, the healthy community

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5 David. Kindig, Purchasing Population Health: Paying for Results (Ann Arbor: University of Michigan Press, 1997); Jonathan Showstack, Nicole Lurie, Sheila Leatherman, Elliot Fisher and Thomas Inui, "Health of the Public: The Private-Sector Challenge" Journal of the American Medical Association 1996; 276(13): 1071-4; Helen H Schauffler and Tracey Rodriguez,"Exercising Purchasing Power for Preventive Care" Health Affairs 1996; 15(1): 73-85

6 David G Whiteis,"Unhealthy Cities: Corporate Medicine, Community Economic Underdevelopment, and Public Health" International Journal of Health Services 1997; 27(2): 227-42; John McKnight, The Careless Society: Community and Its Counterfeits (New York: Basic Books, 1995)

7 Michael Marmot and Richard G Wilkinson, Social Determinants of Health (New York: Oxford University Press, 1999).

perspective argues for subordinating professional prerogatives to the preferences of community residents.[8]

The healthy community approach also places greater emphasis on the need to redistribute resources and give political voice to disenfranchised portions of the community. In this role, health care organizations might act as catalysts (advocates) enhancing the capacity of community groups and agencies to determine for themselves the appropriate priorities for collective spending and policies related to health. Although this third paradigm has had very limited application to legal or legislative understandings of community benefit in health care,[9] it has been powerfully embodied in other arenas of health policy, most notably the WHO's Healthy Cities program.[10]

We have identified these four paradigms (the legal-historical perspective and the three alternative approaches) because each identifies a distinctive set of causal pathways through which a health care organization could affect the well-being of its community. There is certainly some overlap among the four perspectives -- activities like community needs assessments or health promotion initiatives targeted to the entire community could be justified from all for perspectives. But each reflects a distinctive understanding of the appropriate links between health care providers and their communities.

Public Act 00-57 incorporates aspects from several of these perspectives. Following the legal-historical perspective, it emphasizes "preventive care" though allows for a broader range of activities that "improve the health status for working families and populations at risk". It draws on some aspects of the community health perspective by calling for accountability in the form of "adoption and publication of a community benefits policy statement." It reflects the values of the community health perspective in its requirements that hospitals and managed care plans seek "assistance and meaningful participation from the communities within the organization's or hospital's geographic service areas".

By carefully developing each of these four perspectives, we can ensure that a community benefit reporting protocol is both comprehensive in its purview and balanced in terms of the different understandings of community benefit that it captures. Because different audiences may value each of the four perspectives to differing extents, we believe that it is important to present profile for all four perspectives. We provide a template for this presentation later in this report.

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8 Jonathan Lomas, "Reluctant Rationers: Public Input to Health Care Priorities" Journal of Health Services Research and Policy 1997; 2(2): 103-111.

9 Barnett, The Future of Community Benefit Programming

10 Donald Patrick and Thomas Wickizer,"Community and Health" in Society and Health Eds. Benjamin Amick, Sol Levine, Alvin Tarlov and Diana Chapman Walsh, (New York: Oxford University Press, 1995): 46-92

B. Designing a New Protocol for Collecting Data on Community Benefits

As a first step in operationalizing the community benefit reporting protocol, we translated the four-paradigm conceptual framework into a set of concrete questions about organizational practices and policies. We designed to protocols for managed care organizations and hospitals to be as consistent as possible, although there are some practices were unique to each type of organization. (No managed care plans, for example, operated trauma centers. No hospitals offered their own insurance arrangements, making it irrelevant to ask them about pricing or underwriting practices that might make insurance more affordable to households with modest incomes or members who had chronic medical conditions.) All told, there was about an 85 percent overlap in the questions on the two protocols.

More specifically, we identified 21 distinct dimensions of community benefit activity, derived from the four paradigms. These were:

From the Legal-Historical Perspective

- providing free or subsidized health services
- funding programs for subsidized premiums for health insurance
- health education targeted at the general public
- needs assessment identifying unmet health problems in local communities
- programs to prevent the spread of infectious diseases

From the Market Failures Perspective

- reporting geographic clusters of diseases or medical conditions
- improving the training or practices of affiliated medical professionals
- supporting medical research
- supporting family caregivers for patients

From the Community Health Perspective

- serving as a site for the training of new health care professionals
- supporting the local health care safety-net agencies
- sharing of clinical data with researchers or community-based agencies
- disseminating information on community benefit activities to residents or local agencies

From the Healthy Community Perspective

- collaborations with local protective service agencies (e.g. police, fire departments)
- addressing health burdens on local social service or educational programs
- addressing health-related threats in the homes of community residents

- addressing environmental problems in local communities
- grants to other community-based agencies
- mentoring/training programs to employ residents from disadvantaged backgrounds
- community participation in the setting of community benefit priorities
- encouraging philanthropy among current employees

Issues in the Development of the Reporting Protocols: Following the development of preliminary protocols, the draft documents were reviewed by representatives of the Department of Public Health, the Connecticut Hospital Association and the state association of managed care plans. This feedback proved helpful in refining a number of aspects of the protocol, including the addition of various information required by Public Act 00-57 (e.g., whether the reporting organization had a formal community benefit policy statement; what approaches were used for evaluating their community benefit activities) as well as some substantive issues that had been left out of the preliminary protocols (e.g., the extent of collaboration with local departments of public health).

One issue arose, however, that was less constructive. (We identify it here as a concern, then discuss possible solutions in the later section of the report that focuses on recommendations.) As part of the sequence of questions addressing the ongoing training of affiliated medical providers, we had originally included a series of questions on the practices used by hospitals and managed care plans to identify health care professionals who were practicing sub-standard medicine. Given the substantial evidence that exists on the frequency of consistent medical errors among some practitioners,[11] we believe that this form of quality assurance is an essential aspect of practices for improving the health and welfare of local communities. The inclusion of these questions, however, raised concerns on the part of both the Department of Public Health and the hospital association, related to the possible conflicts between the Department's role in enforcing laws on health safety and its mission to collect information on community benefits. Hospitals were concerned that certain responses to the questions on this topic could be misinterpreted as indicating they were in violation of state or federal law.

While we believe that these concerns have some validity, in our assessment the community benefit protocol can be designed in a manner that minimizes these conflicts. To avoid conflict in the initial stages of community benefit reporting and increase hospital participation, however, we followed the strategy that had been negotiated between the Department and the Association to not include these questions in this version of the protocol.

C. Engaging Representatives from State Hospital and Managed Care Associations

Whenever a new set of regulations are implemented, it is natural that they will be viewed by the affected parties with some suspicion. This was certainly true of the community benefit reporting requirements. Representatives from

[11] L Kohn, J Corrigan et al., To Err is Human: Building a Safer Health System (Washington DC: National Academy Press, 1999).

both hospitals and managed care associations were initially skeptical about the merits of this initiative, albeit for quite different reasons.

Those from the managed care association found the concept of community benefits foreign to their understanding of the standard operating practices of managed care plans. This attitude was reinforced by the largely for-profit ownership for most managed care organizations in Connecticut. It is true that until recently health plans have been judged entirely in terms of the care they provide for their enrollees, not populations in their local communities. Nonetheless, the concept of a more population-based mission for managed care has begun to emerge in the latter half of the 1990s.[12] There is evidence that many managed care plans are engaged in substantial initiatives that generate community benefits.[13]

Despite our efforts to convince representatives from the managed care industry that a systematic assessment of their community involvements would actually have a salutary effect on the public image of the insurance industry in the state, it was clear that their initial suspicions were never entirely assuaged. Indeed, the entire community benefit initiative was viewed in part as another in a series of government actions to "punish" health plans. We believe that this assessment led to a collective decision by plans affiliated with the association to report that they did not have any community benefit activities, and thus to avoid reporting on the content of these activities.

The concerns of the state's hospitals were somewhat different. Because of their nonprofit ownership, hospital administrators were familiar with the history of the community benefit concept. A number of hospital associations and private foundations have, since the early 1990s, worked to make the measurement of community benefits an intrinsic part of the agenda for hospital administrators.[14] In this case, however, the suspicion came from the notion that the community benefit reports might be used as a report card for judging the performance of hospitals, or might be used to pursue a narrow definition of community benefit focusing on the provision of uncompensated care. These concerns are not unique to Connecticut. They have been expressed by hospitals in all of the dozen states that currently require community benefit reporting. And a handful of states (Texas, Utah and Pennsylvania) have in fact established minimum performance criteria for uncompensated care as a prerequisite for tax exemption.

For reasons that we develop further in a later section of this report, we believe that the focus on a narrow set of quantifiable indicators of community benefit would be a serious mistake. Having convinced the hospitals that the

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[12] M Schlesinger and B.Gray "A Broadened Vision for Managed Care, Part 1: Community Benefits as a Measure of Plan Performance" Health Affairs 1998; 17(3): 152-68' Kindig, Purchasing Population Health

[13] M. Schlesinger, Gray B, Carrino G, Duncan M, Gusmano M, Antonelli V and Stuber J, "A Broadened Vision for Managed Care, Part 2: Toward a Typology of Community Benefits Provided by HMOs" Health Affairs 1998; 17(5): 26-49

[14] Anthony Kovner and Paul Harris, "Benefiting Communities" Health Care Management Quarterly 1990; 12(4): 6-10

reporting protocol was designed to justify a broad conception of community benefit, we were able to secure participation from most facilities. Nonetheless, a half dozen hospitals refused to participate, claiming that they had no community benefit program as defined under the law. (These were Bradley, Danbury, New Britain, New Milford and Windham Community hospitals, as well as the Veterans Hospital at Rocky Hill.) Two other hospitals (Rockville and Manchester) reported jointly as the Eastern Connecticut Health Network. Most of the chronic care and rehabilitation facilities that the Department of Public Health had initially believed to be covered by the provisions of the law disagreed with that interpretation.

D. The Checkered Logistics of Data Collection

Actually collecting the data raised a number of logistical challenges. At the request of the Department of Public Health, we designed a fully electronic reporting system, with information entered over the Internet by responding organizations. This proved to be a problematic strategic decision, given the current state of development for software for web-based surveys.

After reviewing the published literature and information available over the Internet, we identified the software system as being the most sophisticated and flexible for designing a web-based survey instrument. This software was developed and marketed by Creative Research Systems of Pentaluma, California. Unfortunately, their marketing proved to be more creative than their product design. Problems were immediately apparent for a data collection protocol as complex as the one needed to accurately assess community benefits. Although the program documentation had promised the ability to incorporate skip patterns into the survey, doing so made it impossible for respondents entering data over the web to return to earlier sections of their survey and change previous entries. A second concern involved the difficulty of establishing the software on the state's computer system in a timely fashion. This led us to create the prototype web-survey for the reporting protocol on a computer system at Yale.

Despite some of these initial logistical challenges, the program was made operational as of January 15, 2001. The system was tested by entering data through the Yale system and appeared to record this information accurately. Once the system was operational, each of hospitals that had indicated that it engaged in community benefit activities was provided with a password for entering the system. All were apparently successful in sending their data through the Internet. The final hospital to complete its data entry had done so by June 15, 2001.

As the result of other time commitments, we did not begin to examine this data until July 1, 2001. It was only at this point that we discovered that the survey system had a number of catastrophic problems. These resulted in the data being partially garbled for a number of the reporting hospitals. Consultation with the survey designers revealed that the system had a number of shortcomings that had not been identified in the documentation for the software. In eight cases – for reasons that we have yet to be able to identify – the entire entry for a hospital was lost by the program.

Once these problems were identified, we solicited from all responding hospitals hard copies of the data that they had previously submitted electronically. Although this imposed some additional time burdens on the hospitals, virtually all of the respondents were quite helpful in dealing with this data snafu. Nonetheless, collecting this data imposed some additional delays in data analysis and the preparation of this report.

Data from these hard copies was entered by hand into an EXCEL database developed by Ms. Mattocks. Because the time involved in data entry proved modest, we believe that this approach represents the most cost effective and reliable format for data collection, at least until better survey software comes on the market.

E. The Scope of Community Benefits Activities at Connecticut Hospitals

The responses of the hospitals to the first year of the community benefit reporting protocol reveal the tremendous breadth of activities through which these institutions can potentially affect the health and well-being of the communities in which they are located. Because the protocol collected extensive data (almost 350 variables for each responding hospital) we provide here only a broad overview of the findings.

One initial finding is important for setting the stage, since it touches on the scope of legal purview of Public Act 00-57. The law requires that only those hospitals or managed care organizations with a "community benefits program" are required to report on their activities. This initially created some confusion about which organizations were in fact expected to report under the law. Fewer than a quarter of the hospitals in the state reported that they had "a distinct program for ...community benefit activities." Under a narrow interpretation of the law as currently worded, three-quarters of the hospitals could have been considered exempt, although almost every hospital (94%) responded affirmatively when asked whether if their hospitals "approach to community service" was an explicit part of the mission statement for their organization and ever hospital engaged in multiple activities that affected the health and welfare of their local communities.

We suspect that the same situation would apply to health plans. In our nationally representative survey of HMOs, we found that just over half had a formal community benefits program, although every one of the responding plans engaged in a variety of activities that generated community benefits. Consequently, it may be necessary to change the wording of the law to cover all organizations whose practices can substantively affect the health of the localities in which they are situated.

Construction of Community: An important aspect in the operationalization of community benefits involves the ways in which hospitals are defining the communities whose needs they are attempting to address. This operational definition has two aspects. First, what is the geographic area that is the focus of the hospital's initiatives? Second, to what extent does the hospital focus on particular types of neighborhoods within these geographic areas?

Hospitals were asked to indicate the counties which they served. The results are presented in Figure 1. There are obviously significant differences in the number of hospitals that treat particular counties as their effective communities, with the smaller counties gaining the attention of a smaller number of hospitals, as well as the hospitals with more limited resources..

The second key aspect in the definition of community involves the neighborhoods within each geographic area that are the focus of the hospitals community benefit activities. Respondents were asked about targeting to (a) neighborhoods with limited income (i.e., greater than 20% of the population living in poverty), (b) neighborhoods with a concentration of immigrants (i.e., greater than 20 percent of the residents being immigrants), (c) neighborhoods at risk of particular illnesses, (d) neighborhoods in the inner cities, or (e) rural areas, or (f) neighborhoods with high concentrations (greater than 20% of the residents) of racial minorities. As indicated in Figure 2, each of these forms of program targeting are quite common. Although rural areas are least often targeted, when hospitals do so they appear to make a more consistent commitment to addressing those areas in particular. (Note that five hospitals indicate that they <u>always</u> target their community benefit activities to rural settings. Of the six forms of targeting, this was the only one to evoke that level of commitment.)

<u>The Four Paradigms for Community Benefit:</u> Earlier in this report we identified the four paradigms of community benefit. In Figure 3, we report the frequency with which particular forms of community benefit are identified among hospitals in Connecticut. Because each of the twenty-one categories actually subsume a variety of specific activities, the number reported in this Figure is the <u>average</u> among these more specific measures. As such, it will understate the provision of certain form of community benefits, while overstating others. For our current purposes, however, averages provide a reasonable sense of the frequency with which we observe these various activities. (The specific questions used to construct these groupings are presented in Appendix A)

Perhaps the most striking finding to emerge from this figure is the frequency with which one observes forms of community benefit that go beyond the conventional legal-historical definition. It is certainly true that a number of the activities covered by the more conventional definitions are among the most common found in the state's hospitals. (The reported frequency of needs assessments captured only those studies done in the past year. These might have been more common if a longer time frame had been used.) On the other hand, each of the other three paradigms captures some aspects of community benefit that are found in many Connecticut hospitals. This includes programs of continuing education for affiliated physicians, serving as a site for the training of new health care professionals, supporting medical research or assisting family care-givers.

Many other forms of community benefit, though not quite as common as those identified above, are found among a substantial number of hospitals. (The intensity of these involvements is discussed below.) In other words,

to provide a reasonably comprehensive portrayal of the ways in which Connecticut hospitals are affecting the health of their communities, one needs to incorporate all four paradigms on community benefit. Nonetheless, we can see that there are some systematic differences in the frequency of particular forms of community benefit activities.

Most Prevalent Forms of Community Benefit: The aspects of community benefit in which Connecticut hospitals are most extensively involved (found among more than 75% of responding facilities) include: (a) the provision of free or subsidized health services, (b) educational programs for the general public, (c) additional training for affiliated health care professionals, (d) sharing clinical data with researchers, (e) programs designed to reduce the transmission of infectious diseases, (f) engaging in medical research, (g) providing a site for the training of new health professionals and (h) initiatives fostering philanthropy or volunteering among employees.

- Subsidized Treatment: Depending on the specific activity, these range from those reported by all hospitals (inpatient care, disease screening programs) to those that are reported by about half of the responding facilities (prescription drugs, dental care) (See Figure 4). This category of activities involved by far the largest commitment of resources of the 21 dimensions of community involvement. In aggregate,[15] hospitals reported spending slightly more than $200 million dollars in this category, ranging from $250,000 to $58 million.

- Health Education for the Community: Although all hospitals reporting having programs of this sort, there was again considerable variation in their content. The most frequently observed forms of health education conveyed information about mental illness, cancer identification, and nutritional issues. Less common topics (still found in between one-half and two-thirds of all hospitals) including health problems of adolescents and concerns about reducing the risks of sexual behavior (Figure 5). Aggregate spending in this category is also substantial, representing a total of roughly $17 million.[16] Some hospitals, however, indicated that they had spent no money in community health education.

- Continuing Medical Education for Affiliated Physicians: These programs were found at roughly three-quarters of all hospitals. Again, the least common content involved health issues related to adolescents, including safer sexual practices (Figure 6)

- Sharing Clinical Data With Researchers: About three-quarters of the responding hospitals indicated that they had such data sharing agreements with academic researchers or government agencies. By way of contrast, only a third reported sharing data with private corporations (Figure 7).

- Programs to Reduce Transmission of Infectious Diseases: Although 79 percent of the hospitals indicated that they supported such programs, these findings are a bit deceptive. Apart from immunization programs, no more than half the hospitals engaged in programs targeted to specific health problems – the most frequent being programs to limit the spread of sexually transmitted or animal-vectored diseases. The least common of these programs involved needle exchanges – found at only 12 percent of the hospitals (Figure 8).Annual expenditures for the reporting hospitals came to $2.3 million.

- Medical Research: Eighty-eight percent of the hospitals reported that they were engaged in some research in the past year, although only 13 percent had formalized these activities in a separate research department

[15] Missing information was imputed for two hospitals in constructing this assessment of aggregate spending.

[16] Missing information was imputed for four hospitals in constructing this assessment of aggregate spending

or director of research

- Training New Health Care Professionals: The training of health care professionals is found at virtually every hospital in the state, with the most common forms of training programs involving nurses or para-professionals (Figure 9). There is, however, considerable variation in the intensity of these programs. The primary focus was on the training of nurses, with substantial commitments to educating doctors and other health professionals.

- Stimulating Philanthropy Among Employees: There is considerable variation in the frequency of these activities. Although 75-80 percent of the responding hospitals indicated that they had encouraged philanthropy by recognizing their most beneficent workers, not a single hospital indicated that it had a program for matching employees charitable contributions. (Figure 10).

Forms of Community Benefit with Moderate or Mixed Support: A second set of community involvements were moderately available, found at 30-70 percent of responding institutions. These included: (a) support for safety-net providers, (b) support for social service agencies in the community, (c) needs assessments for local communities, (d) support for family caregivers of patients, (e) disseminating reports about community benefit activities, (f) initiatives to address health hazards in the home, (g) mentoring or training programs to encourage people from disadvantaged groups to become hospital employees, and (h) working with public safety agencies.

- Support for the Local Safety-Net: Hospitals' involvement here is mixed, varying in two dimensions. The first involves differences in support across different types of safety net providers. School-based health clinics get the most frequent assistance, community mental health centers the least frequent (Figure 11). There is also variation in the types of assistance provided by hospitals. Various forms of technical assistance and in-kind support are the most frequent forms of assistance provided to community mental health agencies or local public health agencies. For community mental health centers, by contrast, the most common form of support involve endorsement to help obtain financing from government sources. Financial support is rare – offered by only 15-20 percent of the state's hospitals.

- Support for Social Service Agencies: There is even greater variation in support for these agencies (Figure 12). 71 percent of all hospitals reporting assisting homeless or victims assistance shelters, 60 percent social service agencies and 55 percent elderly housing programs. Here again, technical assistance was the most common form of support, financial assistance the least common.

- Needs Assessments: Given the high priority that needs assessments have been accorded in past community benefit initiatives developed by hospital associations,[17] it is perhaps surprising that less than half of the state's hospitals reported having conducted a needs assessment in the past year. Almost certainly some hospitals had done so in previous years – 60 percent indicate that they had distributed a needs assessment report to government officials or community groups.

- Support for Family Care-givers: Although virtually every hospital indicates that it has encouraged support groups for family care-givers, programs to provide care-givers with supportive services are less common (Figure 13). Roughly tree-quarters of the hospitals indicate that they routinely provided counseling programs, one third respite services.

- Distributing Reports Documenting Community Benefit Activities: Only about half the hospitals in the state have reports that summarize their community benefit activities. These are most frequently distributed to government officials (Figure 14).

[17] Daniel Longo, "The Measurement of Community Benefit: Issues, Options and Questions for Further Research" Journal of Health Administration Education 1994; 12(3): 291-318.

- Programs to Reduce Health Hazards in Homes: Two-thirds of the hospitals operate or support programs of this type. Their efforts are most frequently directed at either poison control or second-hand tobacco exposure (Figure 15). Programs to address heat or cold exposure in the home are least common, supported by roughly 20 percent of the responding hospitals.

- Mentoring Programs for Potential Employees: Although not typically considered for their health benefits, programs that increase the employment opportunities in disadvantaged communities can clearly have important indirect health outcomes.[18] Half of Connecticut hospitals have such programs. They are most frequently directed at residents of low-income communities or potential employees with health disabilities (Figure 16). Programs of this sort are least often targeted to immigrant groups or older workers.

- Collaborations with Local Public Safety Agencies: These involvements are moderately common. The most frequent involves the promotion of helmet use for bicyclists and motorcycle riders, found in fifty-five percent of all hospitals (Figure 17). (By contrast, almost two-thirds of all hospitals work with employers in work-site health promotion initiatives.)

Least Common Forms of Community Benefit: A third set of community benefit activities were rarely found among Connecticut hospitals and represent potentially important unmet aspects of population health. These include: (a) subsidizing premiums to make health insurance more affordable to local residents, (b) using hospital data bases to help identify disease clusters, (c) involvements in collaborative initiatives to address local environmental concerns, (d) direct grants from the hospital to various community-based groups, and (e) effective engagement of local groups in establishing priorities for the community benefit activities at the hospital.

- Subsidized Premiums for Health Insurance: Twenty percent of the hospitals report supporting programs to subsidize health insurance. But their investment appears to be quite limited – in aggregate, the subsidies cover only 46 people in the entire state.

- Reporting Disease Clusters: Ten percent of the responding hospitals indicated that they had reported a disease cluster in the past year. Of the remainder, 30% said that they had not identified clusters; the reasons for a lack of reporting among the remaining hospitals is unclear.

- Addressing Local Environmental Issues: Problems of the community's environment were addressed less frequently than substantively similar problems within homes. The initiatives that most frequently engaged hospitals involved air pollution and food safety (reported by 15-20 percent of all respondents) (Figure 18). Issues of toxic waste and noise pollution evoking the least involvement (5 percent of the responding hospitals).

- Direct Grants to Community Agencies: These were also quite scarce. The type of agency most frequently receiving grant support from hospitals were community mental health centers, though even for these agencies support was rare (Figure 19). No other type of community agency received support from more than 10 percent of the responding hospitals. Collectively, the hospitals reported that they spent $2.6 million on grants to community agencies in the past year.

- Community Participation in Setting Priorities for Community Benefit Activities: This is perhaps the most difficult of the 21 dimensions of performance to effectively measure. It is difficult to distinguish involvement that actually provides real authority for the community from practices that create the facade of participation.[19] Community advisory boards are common (75 percent of responding hospitals) and many

[18] James Auerbach and Barbara Krimgold (Eds.), Income, Socioeconomic Status and Health: Exploring the Relationships (Washington DC: National Policy Association, 2001)

[19] James Morone, The Democratic Wish: Popular Participation and the Limits of American Government (New

hospitals report that local residents are quite influential in setting community benefit policies (Figure 20). But meetings in which the key decisions are made (those of the hospitals governing board) are rarely open to the public. And the influence of organized community interests – local nonprofit organizations or safety net providers is rarely reported to be influential (in stark contrast to the influence of local physicians or health professionals who are affiliated with the hospital). Indeed, it was not common for these organized interests to even get a copy of a report on the community benefit activities of their local hospital.

F. Recommendations for the Future of the Community Benefit Reporting Program

The community benefit reporting program provides the first comprehensive portrait of the ways in which Connecticut hospitals are engaging their local communities. It reveals the richness and breadth of these community connections. But this account also demonstrates that there are aspects of community health that are receiving less attention than others. Whether these differences accurately reflect the relative importance of different community needs remains an open and important question.

There are a number of challenges to the effective future implementation of Public Act 00-57. We summarize these under four broad headings: (1) achieving full participation from hospitals and managed care plans in the state, (2) assuring the validity and reliability of the reported data, (3) logistical issues about program implementation, and (4) dissemination of the information, to promote more complete participation in the setting of priorities for community benefit activities.

Achieving Full Participation Among Hospitals and Health Plans: Hospitals reported few difficulties completing the community benefit reporting protocol. Assuming that the Department of Public Health can (a) ensure that reporting burden does not increase in the future and (b) can disseminate the information it collects in a manner that gives adequate credit for existing activities, we anticipate that participation by the state's hospitals is reasonably certain in the future. Nonetheless, it may be helpful to address the issue identified above about the scope of the law's requirements. The language of the act should be amended to make it clear that it applies to all health care organizations whose practices have a significant impact on the health of their local communities, not simply those that have a formal community benefit program. Indeed, the reporting mandate could be extended beyond hospitals and health plans to other nonprofit health agencies, as has been done in New Hampshire.

The managed care industry represents a more difficult challenge. Although managed care is growing rapidly in scope and influence over the health care system, many plans within the industry remain beset by financial pressures and operational challenges. Given the rapid spread of state regulations applied to managed care,[20] it is easy to understand that administrators and representatives of the industry feel beleaguered, and view additional state

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York: Basic Books, 1990).

[20] Alice Noble and Troyen Brennan, "The Stages of Managed Care Regulation: Developing Better Rules" Journal of Health Politics, Policy and Law 1999; 24(6): 1275-1935

reporting requirements as something to be avoided if at all possible. The motives of state agencies and legislatures often are viewed with considerable suspicion.

This said, the decision of managed care plans in the state to circumvent the reporting requirements is problematic in several senses. Our own research has documented the many ways in which managed care organizations affect the health and health care of local communities, both intentionally and as a side-effect of practices intended for other purposes.[21] The positive aspects of these community benefit activities are often unrecognized, certainly by local residents and often by plan administrators. We anticipate that effective documentation of these practices would significantly enhance the public image of managed care plans operating in the state.

But the very fact that managed care practices are not recognized as effecting community health and health care means that decisions about these practices are made with little community input. And there are other managed care practices which may have negative consequences for community health, with these undesirable outcomes not even recognized by the plans in question. Effectively documenting the role of managed care vis-a-vis Connecticut's communities would provide an important first step in establishing greater connectedness between these communities and plan administrators. Certainly this has been the experience in Massachusetts and Minnesota, the states in which community benefit reporting requirements have been applied to health plans.

Nor would participation impose undue burdens on the plans. Our experience with a national survey of comparable scope to the reporting protocol used in Connecticut suggests that plans can assemble the necessary information with about 5 to 6 person-hours of labor. Nonetheless, it is unclear whether voluntary participation could be achieved through future consultation with the administrators and representatives of managed care organizations in the state. Suspicions run deep and there are few venues for negotiation. It is therefore our recommendation that participation of the plans be made mandatory under an amended law, again with the modification that the act applies to all organizations, whether or not they have a formal community benefit program.

Assuring the Reliability and Validity of Reported Information: We have no reason to believe that the information reported by hospitals on the protocol was not accurate. Nonetheless, the more extensively the results of the community benefit report are disseminated in the future (more on this below), the higher the stakes for each responding organization to do well in as many dimensions as possible. This creates considerable incentive to report even those activities that are marginal, in terms of their scope or resource commitment.

In this initial year, measures of expenditures were incorporated into the protocol for as many forms of

[21] Schlesinger et al, "A Broader Vision for Managed Care, Part 2"

community benefit activity as seemed feasible, given a modest time burdens that we wanted to place on respondents. (Expenditure data was collected on 7 of the 21 dimensions, with additional quantifiable measures used for several other dimensions.) We believe that in the future these efforts at quantification should be extended to every one of the 21 dimensions in the protocol. These new questions would supplement, not replace, questions in the current protocol (thereby allowing for a consistent set of questions that can be compared over time).

For example, the current protocol contains questions on the nature of interactions with local or regional health departments (Questions 69-72) but does not assess the resources devoted to these arrangements. Some of these contacts might be easiest to measure in terms of expenditure data -- such as the value of direct grants or contracts. In other cases, the interactions will be more readily measured in terms FTE commitments of personnel, as in the case of technical assistance arrangements. In still other cases, the readiest measure will be the number of community residents who participated (e.g., received particular types of services), such as when the hospital/health plan has a collaborative service program operated in conjunction with the department of public health.

A second type of information is needed to have a more complete picture of the geographic distribution of community benefits. Although the current protocol asked in general about the types of neighborhoods to which community benefit activities are targeted, it is likely that this focus varies among the 21 dimension measured in the protocol. And even if a hospital or managed care plan reports that it targets programs to, say, low-income neighborhoods, this does not mean that those initiatives are equally available to <u>every</u> low-income neighborhood in the entire service area. This is not meant as a criticism – there's no reason to inherently prefer an approach that spreads benefits thinly across a large number of neighborhoods to one that targets a few neighborhoods for more intensive interventions. But it is important to identify those neighborhoods that are benefiting the most, while also documenting those that may be receiving little attention from any hospital or health plan.

Increasing the use of both quantifiable measures and information about neighborhoods targeting will impose additional demands on responding organizations. We believe that the reliability of the information used for reporting on the protocol could be better assessed if the Department of Public Health had staff who could site visit the reporting organizations and work with staff at the hospitals or health plans as they completed the reporting form. Indeed, we think it essential that there be designated staff within the Department focused on the community benefit program (discussed further under logistical issues). The impact of hospitals and health plans on the community is a vital aspect of their performance. But to develop the public awareness of its importance and to strengthen the ties that hospitals and health plans have with their communities, the state needs to nurture this perspective. It cannot simply be mandated by laws but must be developed through relationships. That requires an active role for the state, as embodied in the commitment of dedicated staff. To make this feasible, the Department must be allocated the additional resources required in order to hire appropriately trained personnel.

The site visits that we have proposed here would also increase the time demands on the reporting organizations. In order to avoid undue burden, we would suggest that the current law be amended to require that community benefit reports be filed biennially. We will offer further justification for this change in the section discussing the logistics of community benefit reporting.

Logistical Issues Related to Community Benefit Reporting: The approach that was requested by the Department of Public Health in their initial RFP was intended to minimize staff time required for the administration of this program. To this end, the program was intended to have an electronic reporting format, with information that could then be converted into a set of reports for easy dissemination.

As reported above, our experience with the design and implementation of a web-based survey has not been an entirely positive one. Quite the contrary, the requirements for information gathering of the complexity required for this protocol exceeds the capacity of existing software to effectively compile the responses. Although we are certain that suitable web-based software could be designed and implemented by suitably sophisticated software engineers, the price of this would far exceed the resources that are currently allocated for program implementation.

In light of this experience, we favor an alternative model of program administration, albeit one that requires a more substantial commitment of staff within the Department of Public Health. Our ongoing evaluation of a half dozen community benefit reporting programs from around the country suggests that only one state has implemented their program in a manner that provides any reliability in terms of the information being collected. This positive example is found in Massachusetts, where the community benefit reporting system is housed in the Office of the Attorney General. That office has between two and three FTEs dedicated the program. We believe that a somewhat smaller commitment of resources would be adequate in Connecticut.

More specifically, we envision one staff member being responsible for the program. (Masters level training in public health or health administration would be suitable for this position.) During the data collection phase of the program, the staff person would site visit each reporting organization and work with staff at that organization in completing the reporting protocol. We believe that approximately two organizations could be completed each week, allowing the entire data collection process to be completed for the hospital industry in roughly a 4 month period. Assuming that data collection among managed care plans was limited to those organizations with a substantial presence in the state, data collection would be completed over a significantly shorter period of time for these respondents. Once this data was collected, we estimate that it could be entered by the staff member into the EXCEL database that we have designed in no more than 5 days.

During the remaining part of the year, the staff person responsible for the program would be charged with disseminating reports on community benefits to interested parties, working with community groups in each service area to ensure that they could effectively participate in setting priorities related to community benefits, and working with the hospital and managed care associations to ensure their continued involvement in and support for the program. In other words, this reformulated program would allow the Department of Public Health to have an active role in the ongoing process of defining community benefit priorities and activities, rather than have it simply be a passive collector of information related to these activities. By so doing, we believe that the Department could enhance its working relationships with both hospitals and managed care plans.

Because the additional data requirements identified above would add to the respondent burden, we further propose that hospitals and managed care organizations be required to report on their community benefit activities every other year. The two could alternative, with hospitals reporting in even years, managed care plans in odd years. The staff member overseeing the program would thus focus on each industry in alternating years. Although most other states with community benefit reporting programs require annual reports (New York requires an update every three years), there is not much evidence that community benefit activities or community health needs change with this frequency. In our assessment, the time that would otherwise have been used to complete an annual report could be better utilized in establishing stronger linkages to community-based groups in the hospital or managed care plan's service area.

Although we would endorse this alternative approach to program administration, we recognize that budgetary constraints at the state level may make it infeasible to allocate additional resources to the Department of Public Health. If these fiscal constraints persist, there will clearly be a need to continue to pursue and refine an approach that relies on more automated forms of data reporting. To this end, we plan to work with the Department over the next several months to explore several alternative forms of computerized surveys, which could be disseminated by mail or e-mail, completed by the hospitals and health plans, and then merged into a single data file once returned to the state.

Dissemination and Participation in Community Benefit Priority Setting: The final challenge relates to the broader goals for the reporting of community benefit activities. Although it is useful for the Department of Public Health or state legislators to have a broad picture of the ways in which hospitals and health plans are relating to their communities, ultimately the greatest value of this program is likely to come from its potential to empower community groups to have a larger role in setting priorities for community benefit programs. That certainly has been the experience that has emerged from other states that have older community benefit reporting laws.

The question then becomes one of how best to ensure this participation. Most past community benefit

initiatives, whether fostered by hospital associations or state laws, emphasize participation and priority setting at the local level. The notion is that health needs and community preferences differ from one locale to the next, so that these decisions are best decentralized to the maximum extent possible. To pursue this strategy, the Department of Public Health should focus on distributing information collected through the community benefit reporting process to key community groups and activists, particularly in those neighborhoods that appear to be least served by the current community benefit programs. If the program is reconfigured in the manner suggested above, the staff person dedicated to the program could serve as a liaison for community groups, helping them to connect with the appropriate administrators within hospitals or managed care plans.

Although there is considerable appeal to this decentralized approach, we believe that there is also a role for the Department of Public Health to play in coordinating community benefit activities throughout the state. Without this guidance, it is likely that the positive outcomes from community benefit activities will be scattered in a patchwork fashion through the state. This sort of haphazard evolution may leave some communities without benefits and without effective mechanisms for influencing the practices of hospitals or managed care plans. Equally important, the Department could and should play a role disseminating information about the most innovative community-oriented initiatives. In our experience, many hospitals and health plans haven't engaged local public safety agencies, or worked with groups advocating for the environment, simply because they haven't been confronted by obvious opportunities and haven't considered how these linkages might be formed. This could be remedied through the creation of one-page "program briefs" which describe the innovative programs and are shared with health care providers and community groups throughout the state. By collecting more detailed information about the hospitals and health plans that have already formed these connections, the Department can stimulate the diffusion of creative ideas throughout the state.

Figure 2: Prevalence of Community Benefit Activities in Connecticut Hospitals During 2000, Four Alternative Paradigms

Legal-Historical	%	Market Failure	%	Community Health	%	Healthy Community	%
Free/Subsidized Services	100	Support CME to Address Social Problems	96	Hospital is Site for Education of Health Professionals	100	Addressing Health Related Threats in the Homes of Community Residents	68
Health Education for General Public	100	Supporting Medical Research	90	Sharing of Clinical Data	81		
				with Researchers or		Stimulating Philanthropy Among Employees	65
		Supporting Family Caregivers for Patients	81	Community-Based Agencies			
Programs to Limit Spread of Infectious Diseases	80					Support for Social Service Agencies	64
		Reporting Geographic Clusters of Diseases or Medical	14	Disseminating Information on Community Benefit	55		
Community Needs Assessments	48						
		Conditions		Activities to Residents or Local Agencies		Grant to Other Community-Based Agencies	52
Subsidized Premiums for Health Insurance	14						
						Collaborations with Local Protective Service Agencies (e.g. Police, Fire Depts)	47
				Supporting the Local Health Care Safety Net Agencies	51		
						Community Participation in Setting of Community Benefit Priorities	44
						Mentorship or Training Programs to Support Employment of Residents from Disadvantaged Backgrounds	38
						Addressing Environmental Problems in Local Communities	23

ATTACHMENT A: Public Act No. 00-57

PUBLIC ACT NO. 00-57

An Act Establishing the Reporting of Community Benefit Programs by Managed Care Organizations and Hospitals.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

(NEW) (a) As used in this section:

(1) "Community benefits program" means any voluntary program to promote preventive care and to improve the health status for working families and populations at risk in the communities within the geographic service areas of a managed care organization or a hospital in accordance with guidelines established pursuant to subsection (c) of this section;

(2) "Managed care organization" has the same meaning as provided in section 38a-478 of the general statutes;

(3) "Hospital" has the same meaning as provided in section 19a-490 of the general statutes; and

(4) "Commissioner" means the Commissioner of Public Health.

(b) On or before January 1, 2001, and annually thereafter, each managed care organization and each hospital shall submit to the commissioner, or the commissioner's designee, a report on whether the managed care organization or hospital has in place a community benefits program. If a managed care organization or hospital elects to develop a community benefits program, the report required by this subsection shall comply with the reporting requirements of subsection (d) of this section.

(c) A managed care organization or hospital may develop community benefit guidelines intended to promote preventive care and to improve the health status for working families and populations at risk, whether or not those individuals are enrollees of the managed care plan or patients of the hospital. The guidelines shall focus on the following principles:

(1) Adoption and publication of a community benefits policy statement setting forth the organization's or hospital's commitment to a formal community benefits program;

(2) The responsibility for overseeing the development and implementation of the community benefits program, the resources to be allocated and the administrative mechanisms for the regular evaluation of the program;

(3) Seeking assistance and meaningful participation from the communities within the organization's or hospital's geographic service areas in developing and implementing the program and in defining the targeted populations and the specific health care needs it should address. In doing so, the governing body or management of the organization or hospital shall give priority to the public health needs outlined in the most recent version of the state health plan prepared by the Department of Public Health pursuant to section 19a-7 of the general statutes; and

(4) Developing its program based upon an assessment of the health care needs and resources of the targeted populations, particularly low and middle-income, medically underserved populations and barriers to accessing health care, including, but not limited to, cultural, linguistic and physical barriers to accessible health care, lack of information on available sources of health care coverage and services, and the benefits of preventive health care. The program shall consider the health care needs of a broad spectrum of age groups and health conditions.

(d) Each managed care organization and each hospital that chooses to participate in developing a community benefits program shall include in the annual report required by subsection (b) of this section the status of the program, if any, that the organization or hospital established. If the managed care organization or hospital has chosen to participate in a community benefits program, the report shall include the following components: (1) The community benefits policy statement of the managed care organization or hospital; (2) the mechanism by which community participation is solicited and incorporated in the community benefits program; (3) identification of community health needs that were considered in developing and implementing the community benefits program; (4) a narrative description of the community benefits, community services, and preventive health education provided or proposed, which may include measurements related to the number of people served and health status outcomes; (5) measures taken to evaluate the results of the community benefits program and proposed revisions to the program; (6) to the extent feasible, a community benefits budget and a good faith effort to measure expenditures and administrative costs associated with the community benefits program, including both cash and in-kind commitments; and (7) a summary of the extent to which the managed care organization or hospital has developed and met the guidelines listed in subsection (c) of this section. Each managed care organization and each hospital shall make a copy of the report available, upon request, to any member of the public.

(e) The commissioner, or the commissioner's designee, shall develop a summary and analysis of the community benefits program reports submitted by managed care organizations and hospitals under this section and shall review such reports for adherence to the guidelines set forth in subsection (c) of this section. Not later than October 1, 2001, and annually thereafter, the commissioner, or the commissioner's designee, shall make such summary and analysis available to the public upon request.

Approved May 16, 2000

ATTACHMENT B: Connecticut Hospitals and Managed Care Organizations Subject to Public Act 00-57

Connecticut Hospitals Subject to Public Act 00-57

Bradley Memorial Hospital and Health Center
Bridgeport Hospital
Bristol Hospital, Inc.
Charlotte Hungerford Hospital
Connecticut Children's Medical Center
Connecticut Hospice
Danbury Hospital
Day Kimball Hospital
Dept. of Veterans' Affairs/Veterans' Home and Hospital
Gaylord Hospital
Greenwich Hospital Association
Griffin Hospital
Hall-Brooke Hospital
Hartford Hospital
Hebrew Home and Hospital, Inc.
Hospital for Special Care
Hospital of Saint Raphael
John Dempsey Hospital
Johnson Memorial Hospital
Lawrence & Memorial Hospital
Manchester Memorial Hospital
Masonic Geriatric Healthcare Center
Middlesex Hospital
Midstate Medical Center
Milford Hospital
Natchaug Hospital, Inc.
New Britain General Hospital
New Milford Hospital
Norwalk Hospital
Rehabilitation Hospital of Connecticut, Inc.
Rockville General Hospital
Saint Francis Care Behavioral Health
Saint Francis Hospital and Medical Center
Saint Mary's Hospital
Saint Vincent's Medical Center
Sharon Hospital
Silver Hill Hospital
Stamford Hospital
Stamford Rehabilitation Hospital
Waterbury Hospital
William W. Backus Hospital
Windham Community Memorial Hospital
Yale New Haven Hospital

*****The facilities above meet the definition of a "hospital" as defined in Public Act 00-57 and Section 19a-490 of the Connecticut General Statutes. **Source**: Connecticut Department of Public Health, Bureau of Regulatory Services

Connecticut Managed Care Organizations Subject to Public Act 00-57

Aetna Life Insurance Co.
Aetna U.S. Healthcare, Inc.
American Republic Insurance Co.
Anthem Blue Cross & Blue Shield
CIGNA HealthCare of Connecticut, Inc.
ConnectiCare, Inc.
Connecticut General Life Insurance Co.
Conseco Medical Insurance Company
First Allmerica Financial Life Ins. Co.
FirstChoice HealthPlan of CT, Inc.
Fortis Benefits Insurance Company
Fortis Insurance Company
Golden Rule Insurance Company
Guardian Life Insurance Company
John Alden Life Insurance Company
MedSpan Health Options, Inc.
MEGA Life & Health Insurance Company
Mid-West National Life Ins. Co. of Tennessee
National Health Insurance Company
New England Life Insurance Company
Nippon Life Insurance Co. of America
Oxford Health Plans, Inc.
PFL Life Insurance Company
Phoenix American Life Insurance Co.
Phoenix Home Life Mutual Insurance Co.
Physicians Health Services of CT, Inc.
Principal Mutual Life Insurance Company
Protective Life Insurance Company
Prudential Health Care Plan of CT, Inc.
Prudential Insurance Co. of America
Sentry Life Insurance Company
Sentry Select Insurance Company
Trustmark Insurance Company
UniCare Life & Health Insurance Company
United HealthCare Insurance Company
United States Life Insurance Company

*The above entities meet the definition of a "managed care organization" as provided in Public Act 00-57 and Section 38a-478 of the Connecticut General Statutes. **Source**: Connecticut Department of Insurance

Dimension	Topic	Question Number
Legal-Historical Perspective		
	Providing free or subsidized health services	22-27
	Funding programs for subsidized premiums for health insurance	28-33
	Health education targeted at the general public	37-44
	Needs assessment identifying unmet health problems in the community	85-90
	Programs to prevent the spread of infectious diseases	79-84
Market Failures Perspective		
	Reporting geographic clusters of diseases or medical conditions	34-36
	Improving the training or practices of affiliated medical professionals	46-48
	Supporting medical research	73-76
	Supporting family caregivers for patients	119-120
Community Health Perspective		
	Serving as a site training of new health care professionals	49-60
	Supporting local health care safety net agencies	61-72
	Sharing of clinical data with researchers or community based agencies	77-78
	Disseminating information on community benefit activities to local residents	146-147
Healthy Communities Perspective		
	Collaborations with local protective service agencies (e.g., police, fire departments)	45
	Addressing health burdens on local social service or educational programs	91-93, 109-118
	Addressing health-related threats in the homes of community residents	94-99
	Addressing environmental problems in local communities	100-102
	Grants to other community-based agencies	121-125
	Mentorship or training programs for those from disadvantaged backgrounds	131-132
	Community participation in the setting of community benefit priorities	148-149
	Stimulating philanthropy among employees	126-130

Figure 1: Geographic Areas Served by Hospitals Participating in the Community Benefit Survey

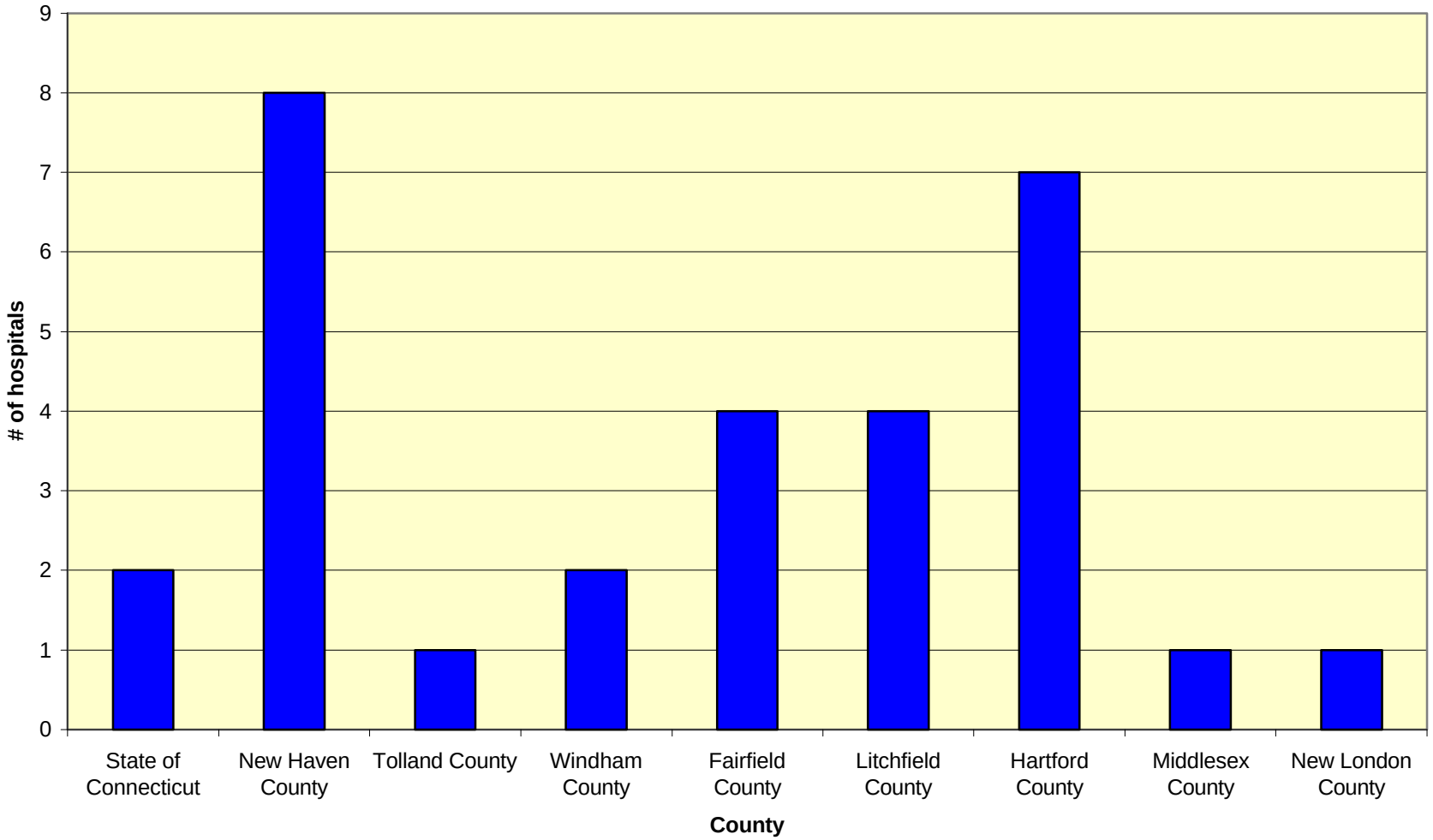


Figure 2A: Targeting to medically underserved areas

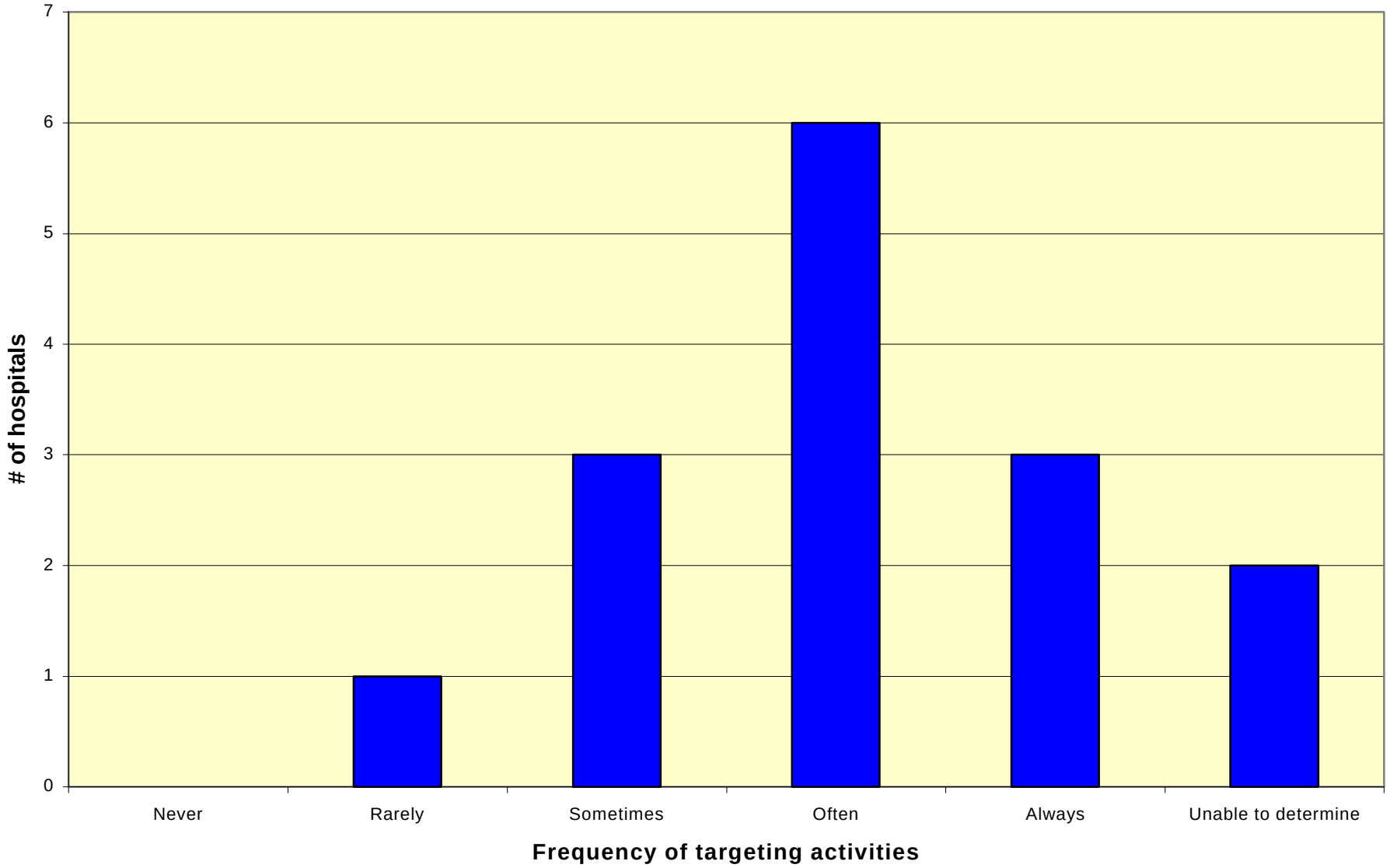


Figure 2B: Targeting to Rural Areas

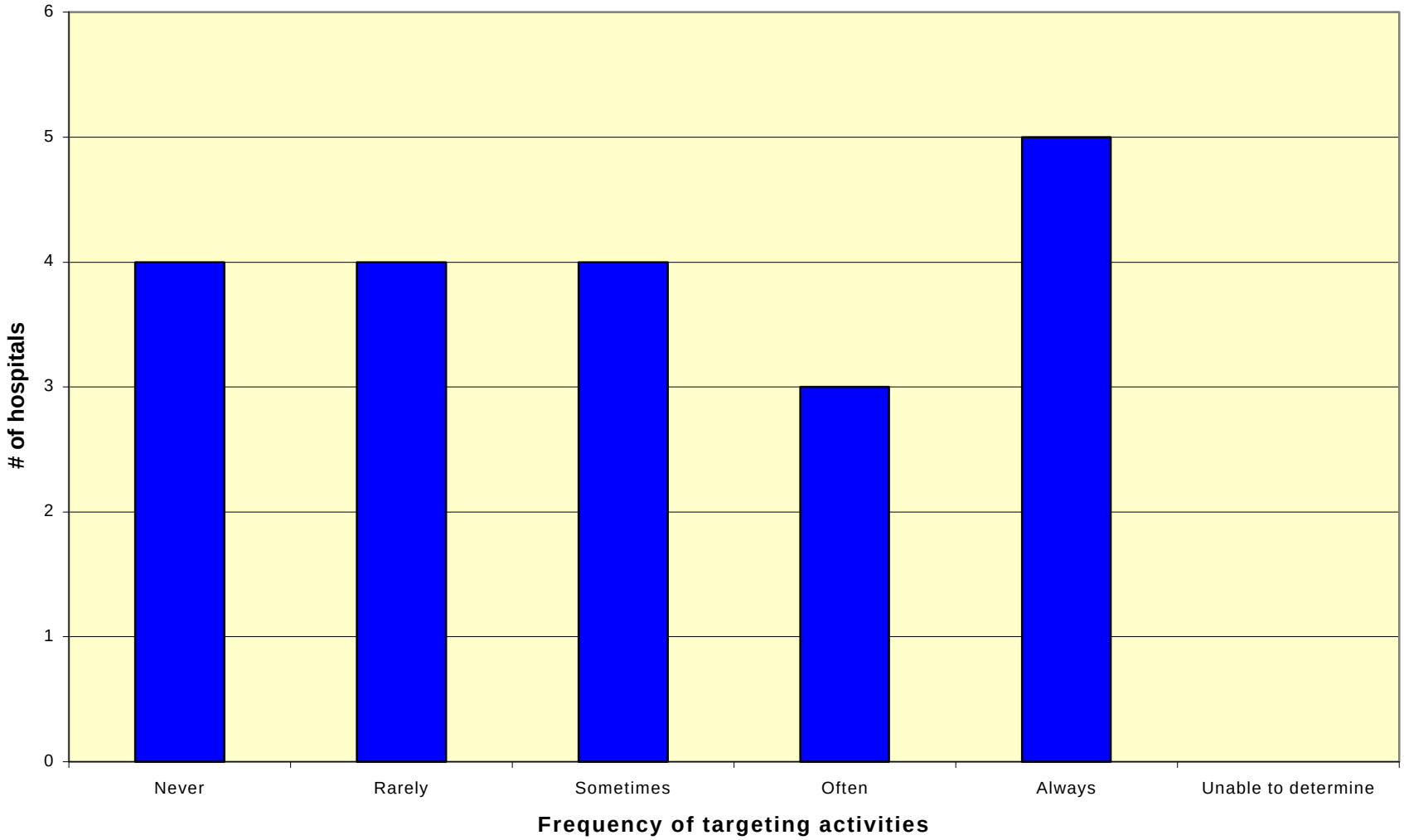


Figure 2C: Targeting to Inner Cities

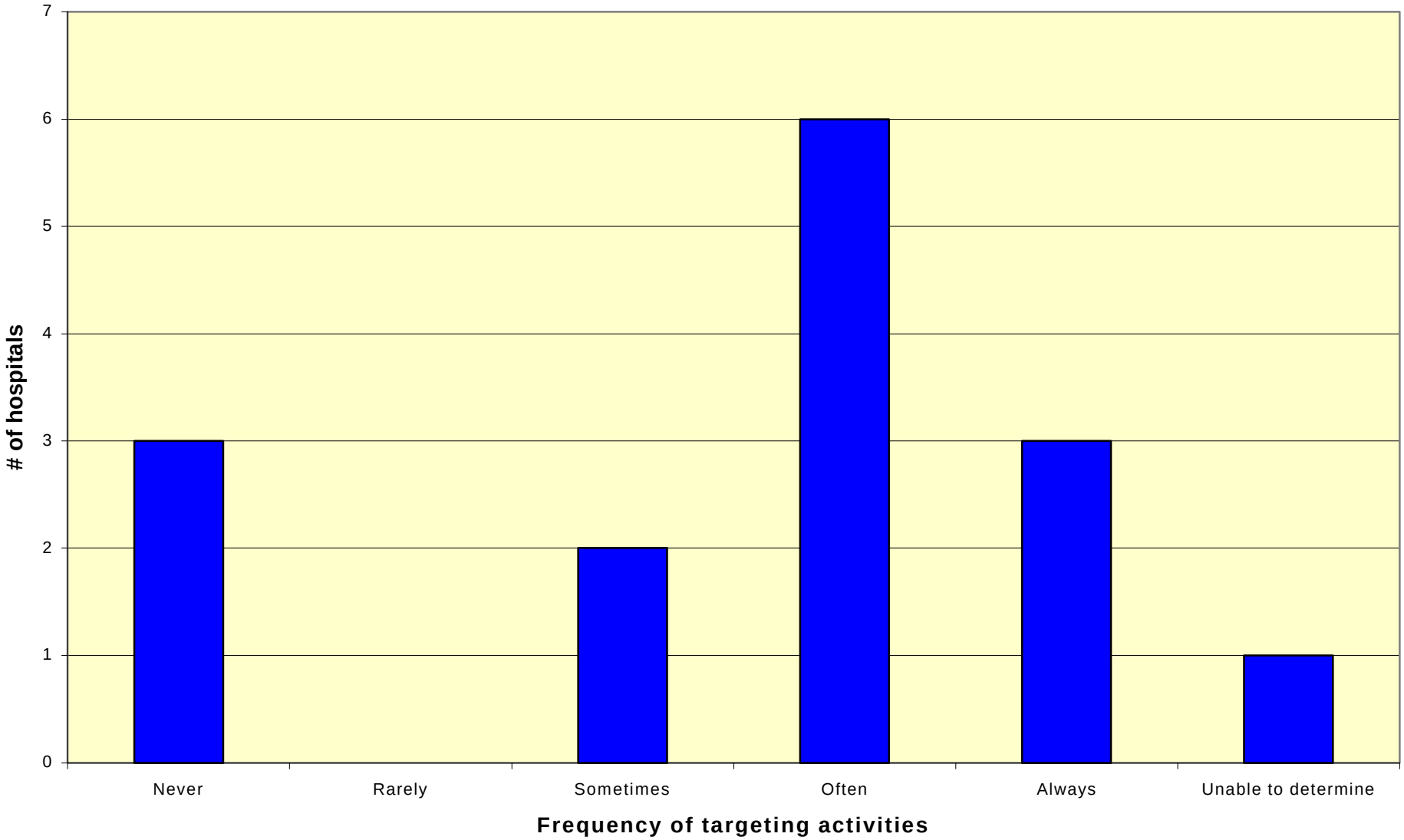


Figure 2D: Targeting to Neighborhood with Risk of a Particular Illness

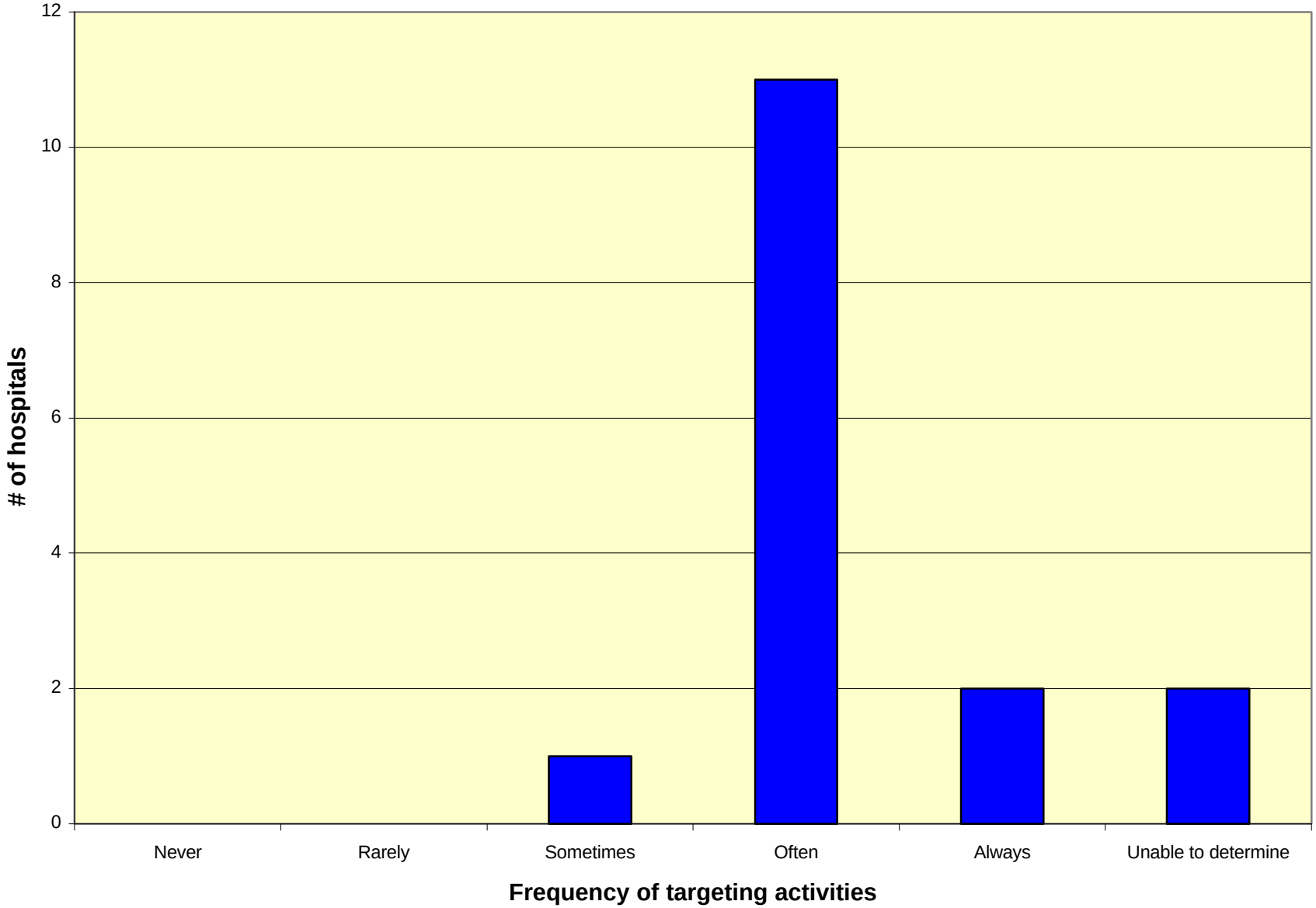


Figure 2E: Community Benefit Activities Targeted to Low Income Neighborhoods

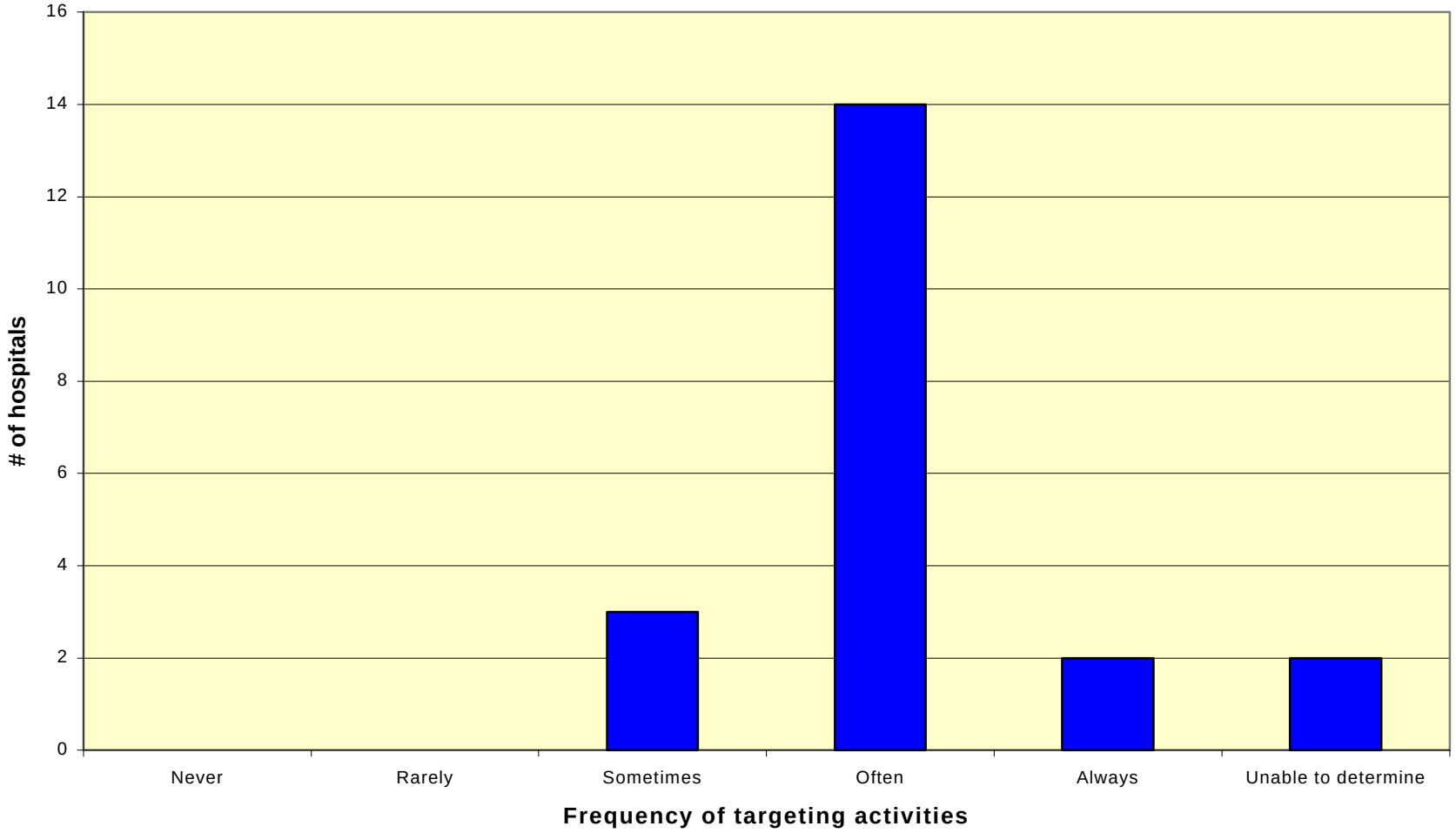


Figure 2F: Targeted CB Activities to Neighborhoods with High Immigrant Populations

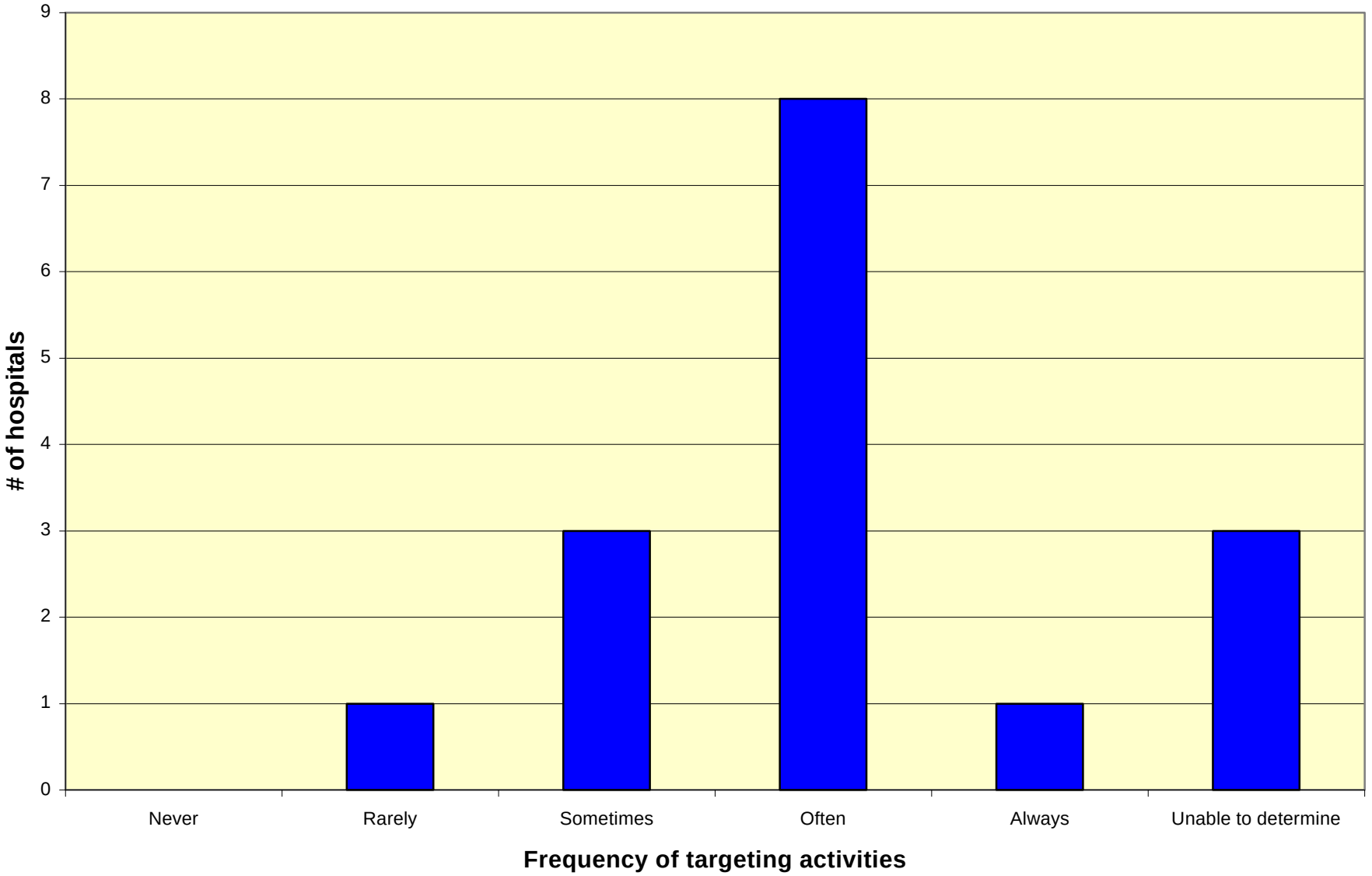


Figure 2G: Targeting to areas with concentrated racial minorities

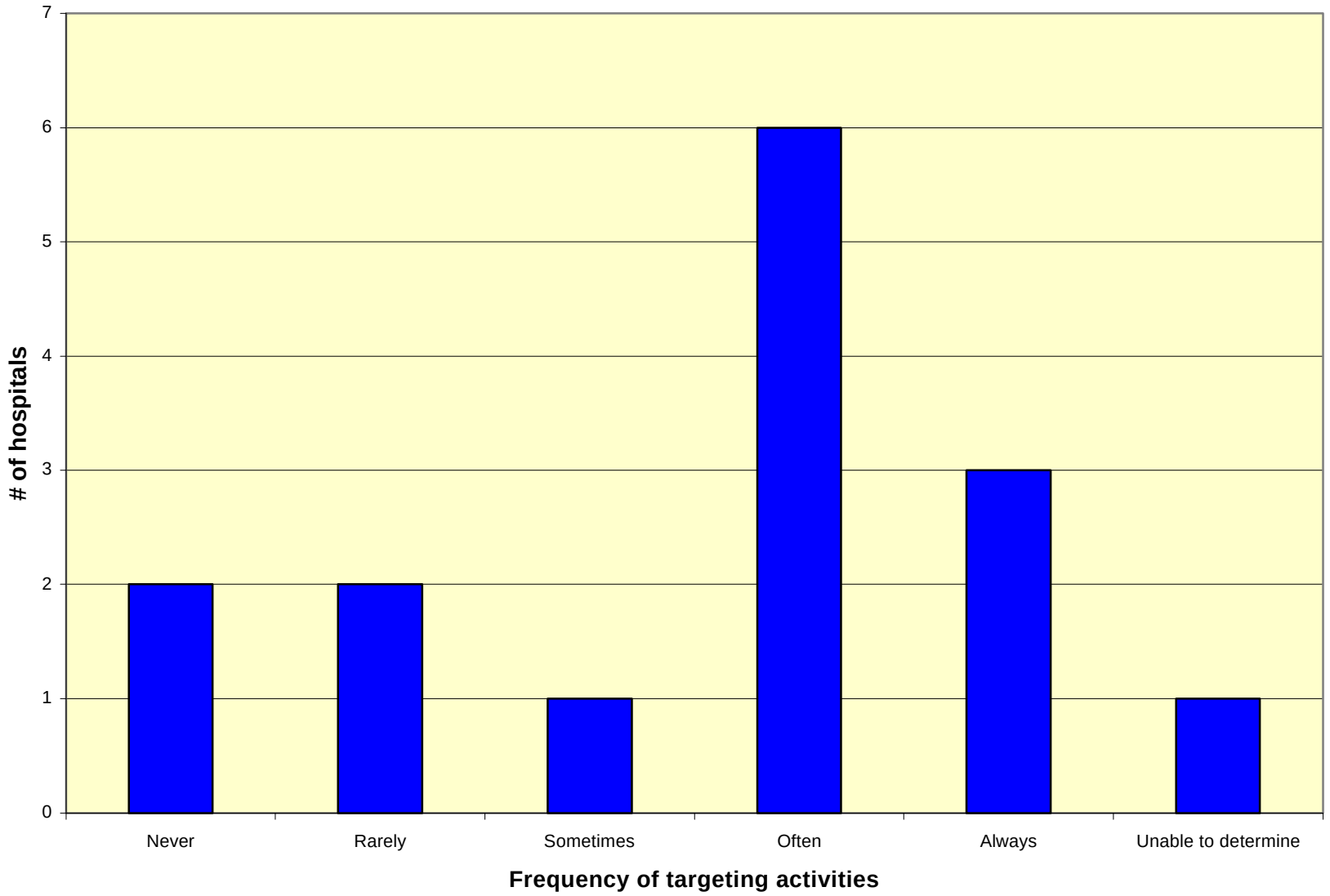


Figure 4: Frequency of Providing Free or Subsidized Health Services

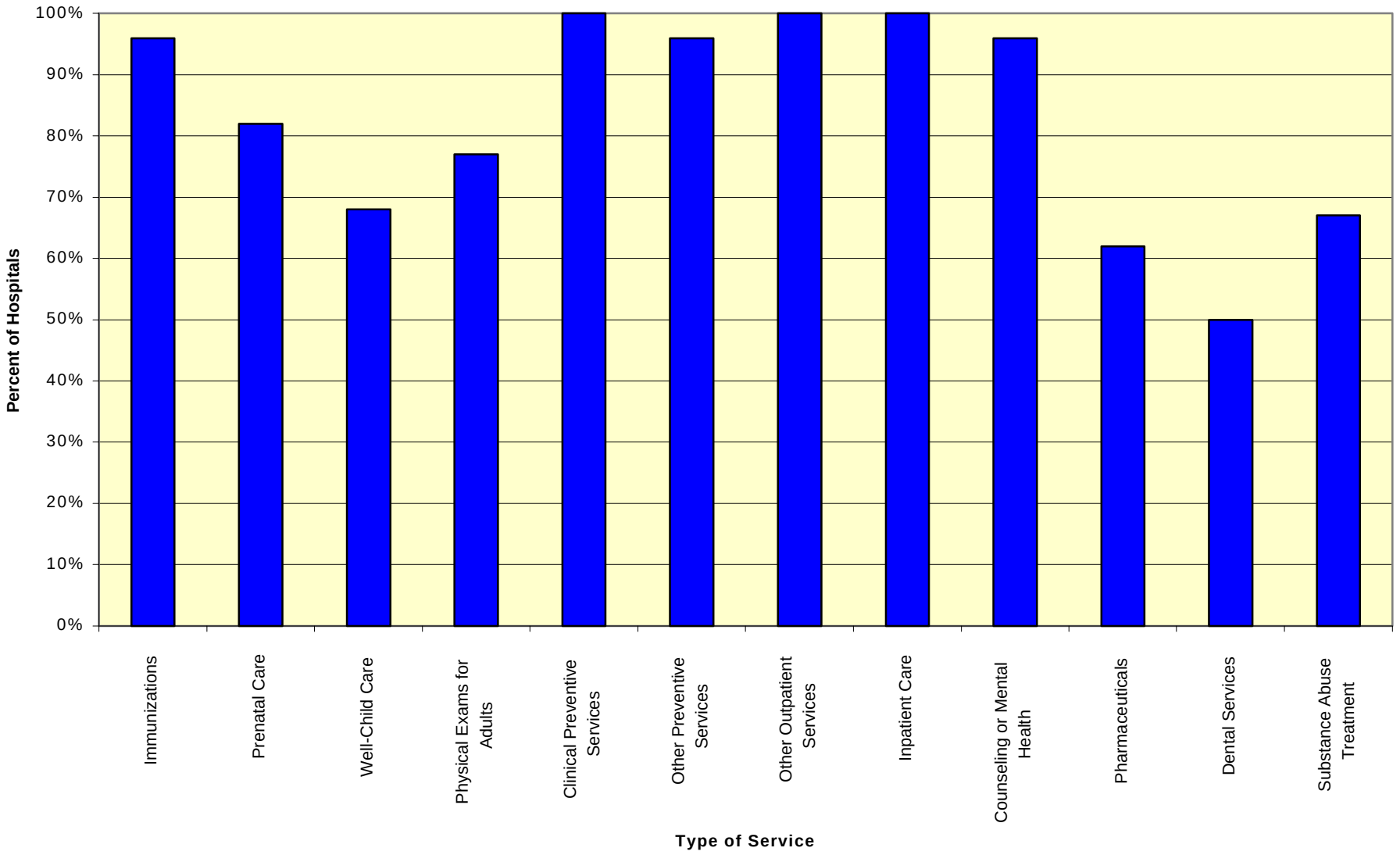


Figure 5: Health Education in the Community

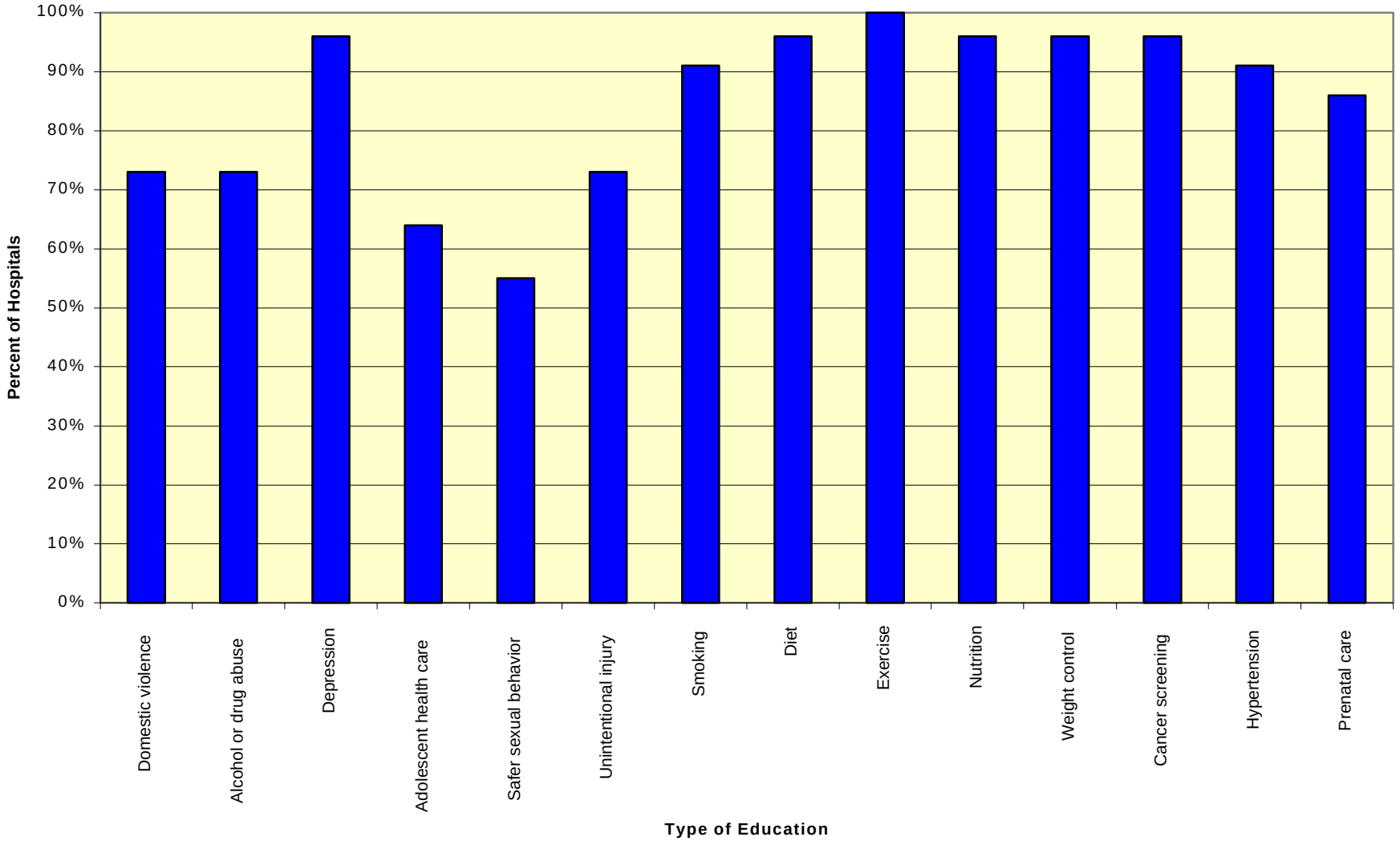


Figure 6: Continuing Medical Education for Affiliated Health Professionals

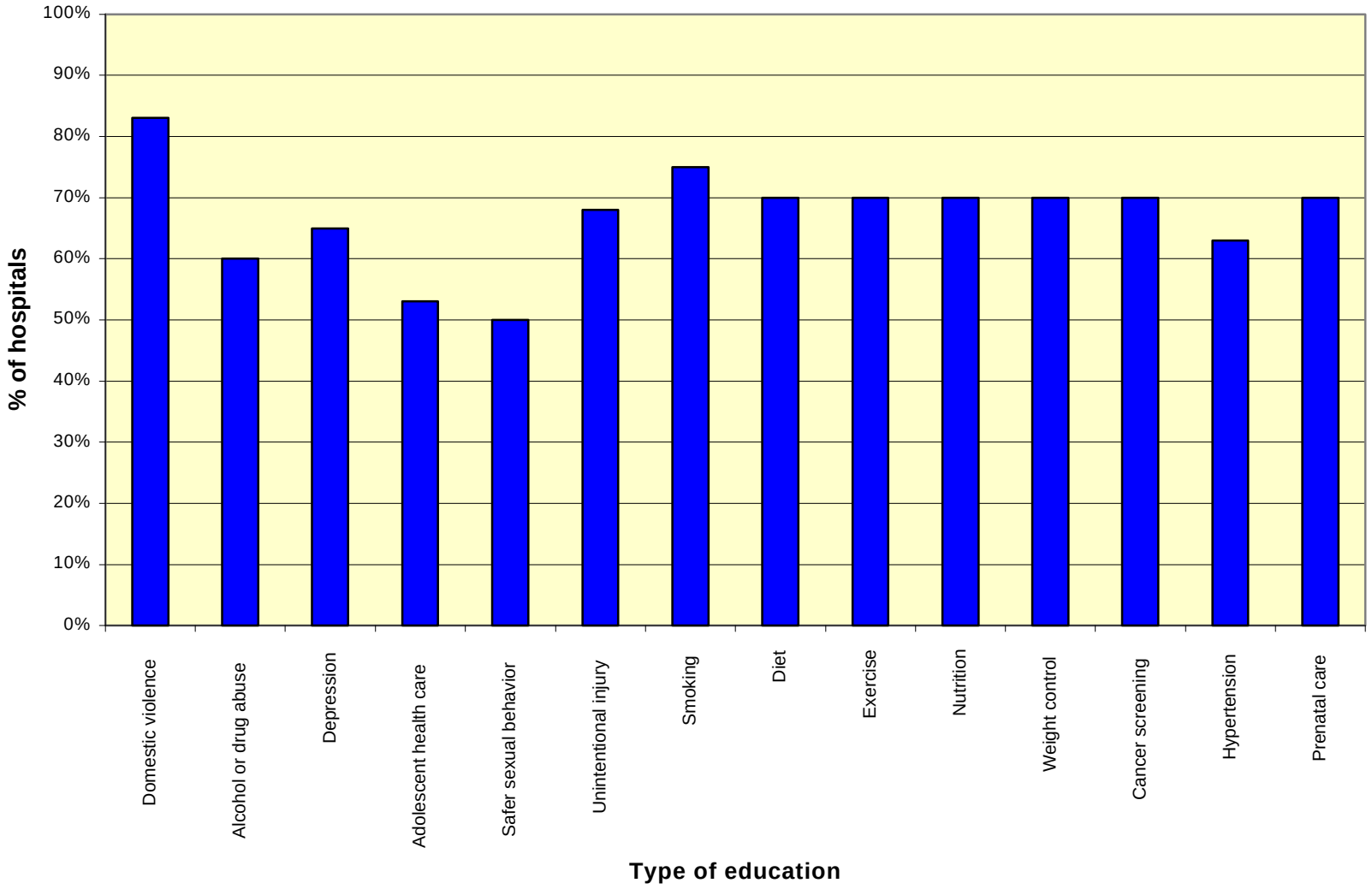


Figure 7: Sharing Clinical Data with Researchers

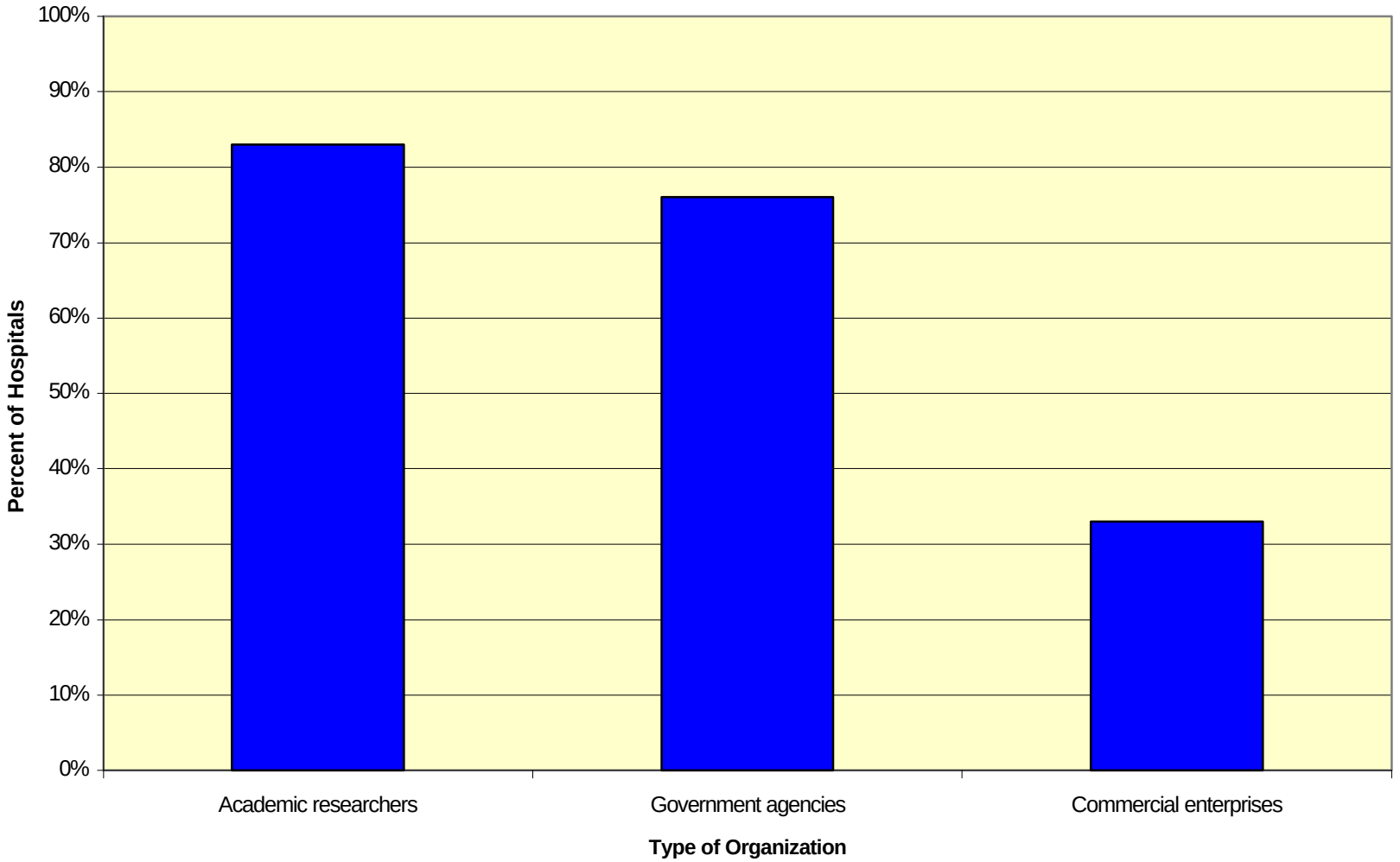


Figure 8: Programs to Reduce Transmission of Infectious Diseases

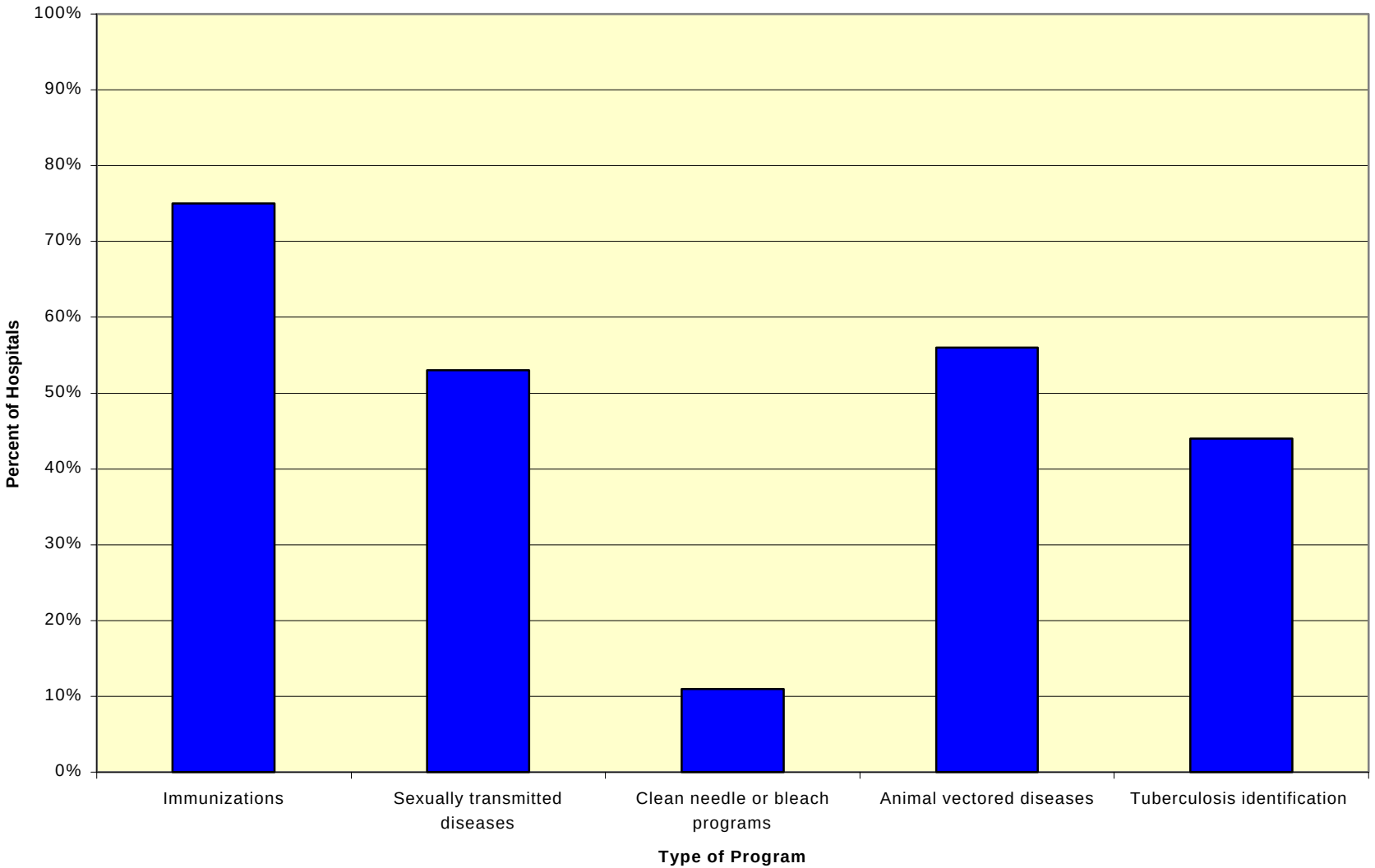


Figure 9: Training New Health Professionals

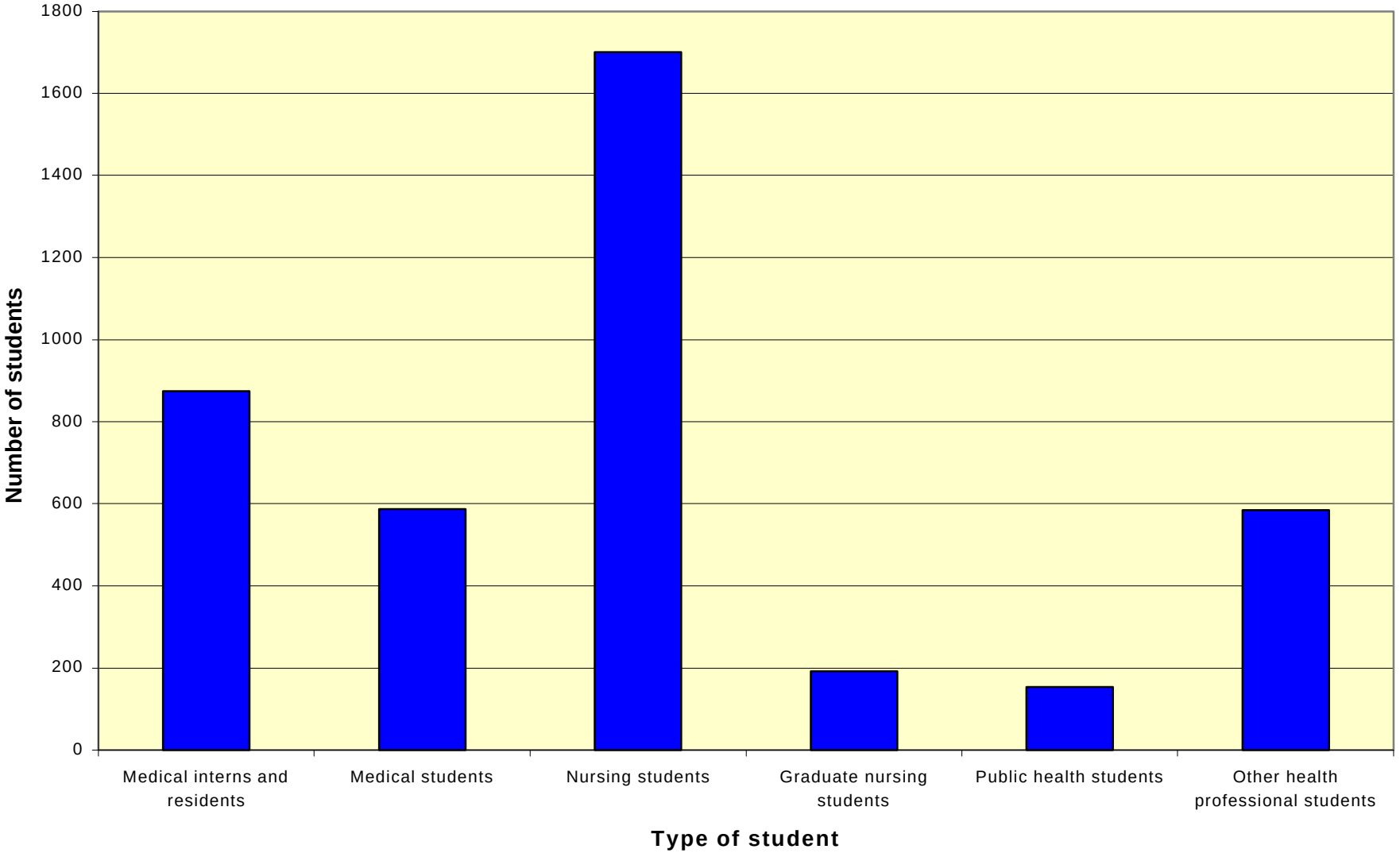


Figure 10: Stimulating Philanthropy Among Employees

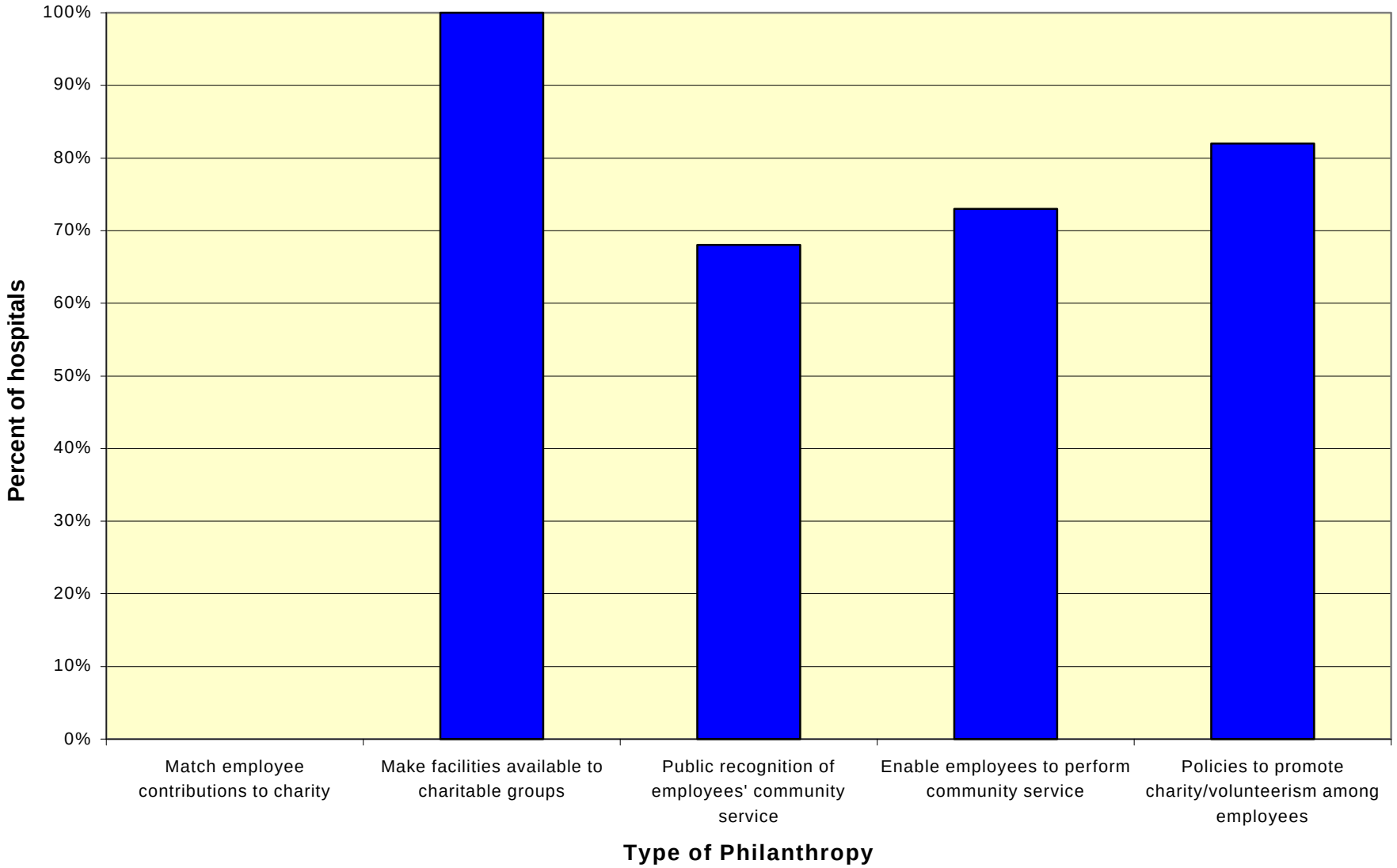


Figure 11: Frequency of Support for Safety Net Agencies

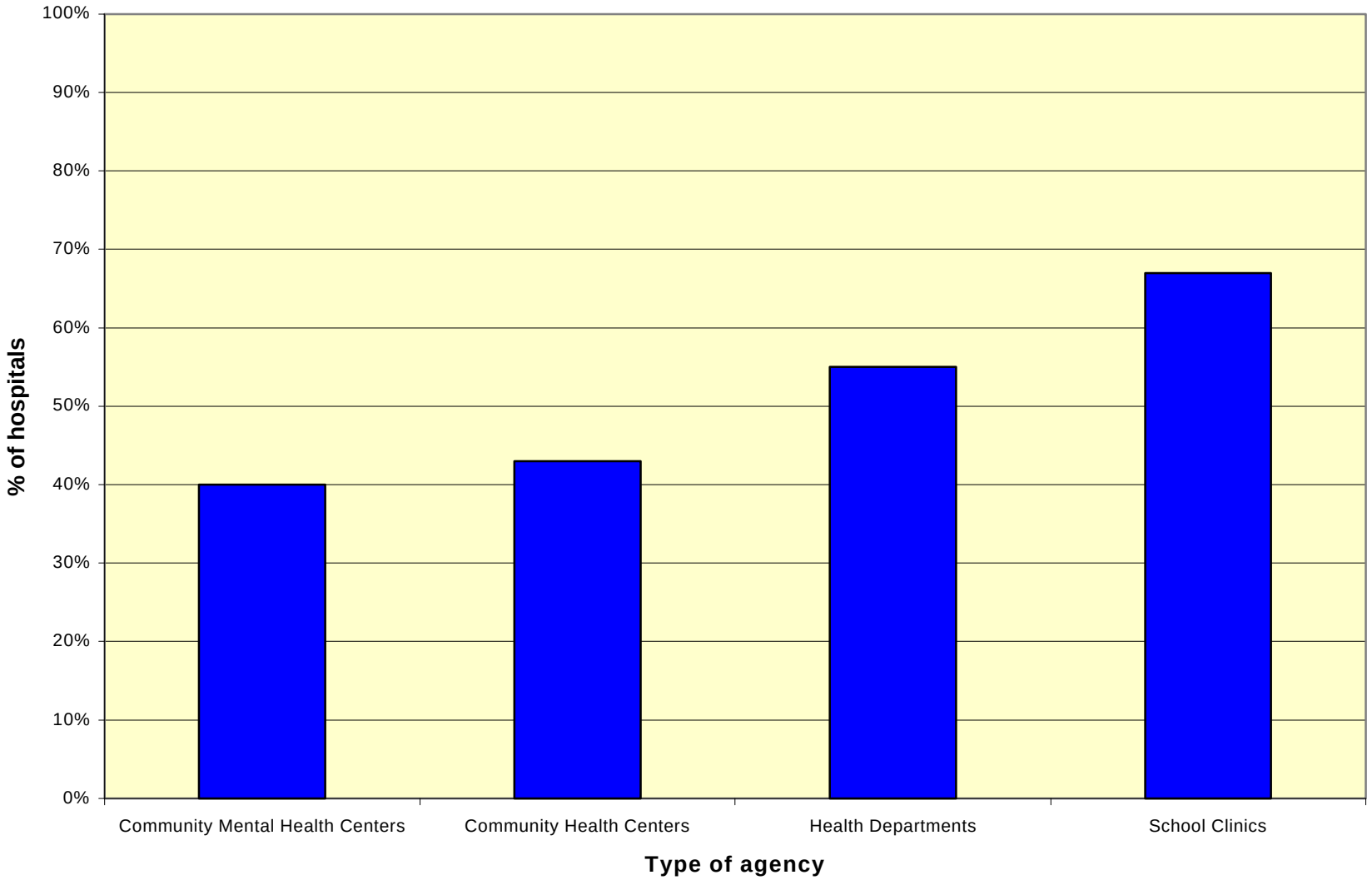


Figure 12: Support for Social Service Agencies

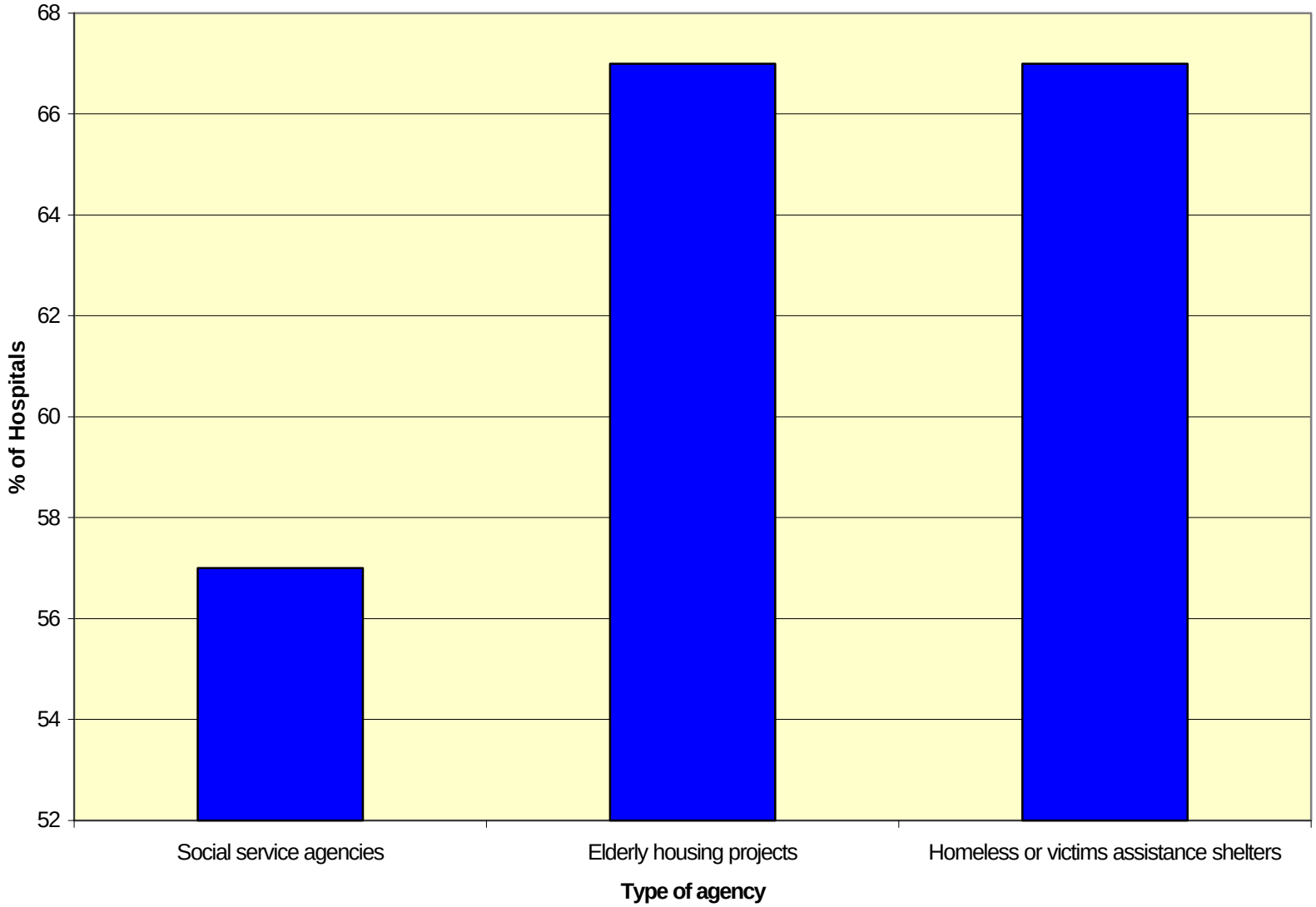


Figure 13: Support for Family Caregivers

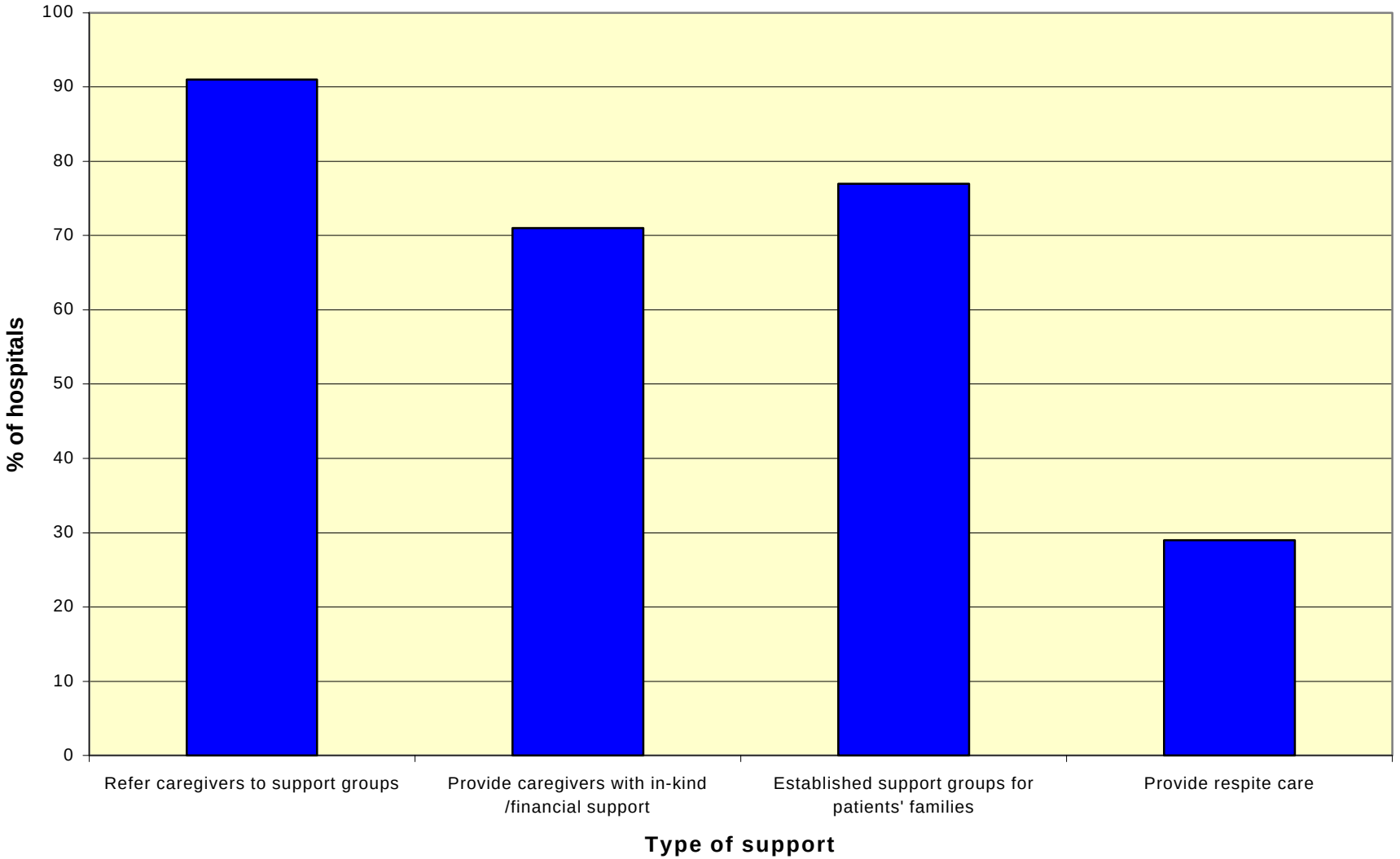


Figure 14: Distributing Reports Documenting Community Benefit Activities

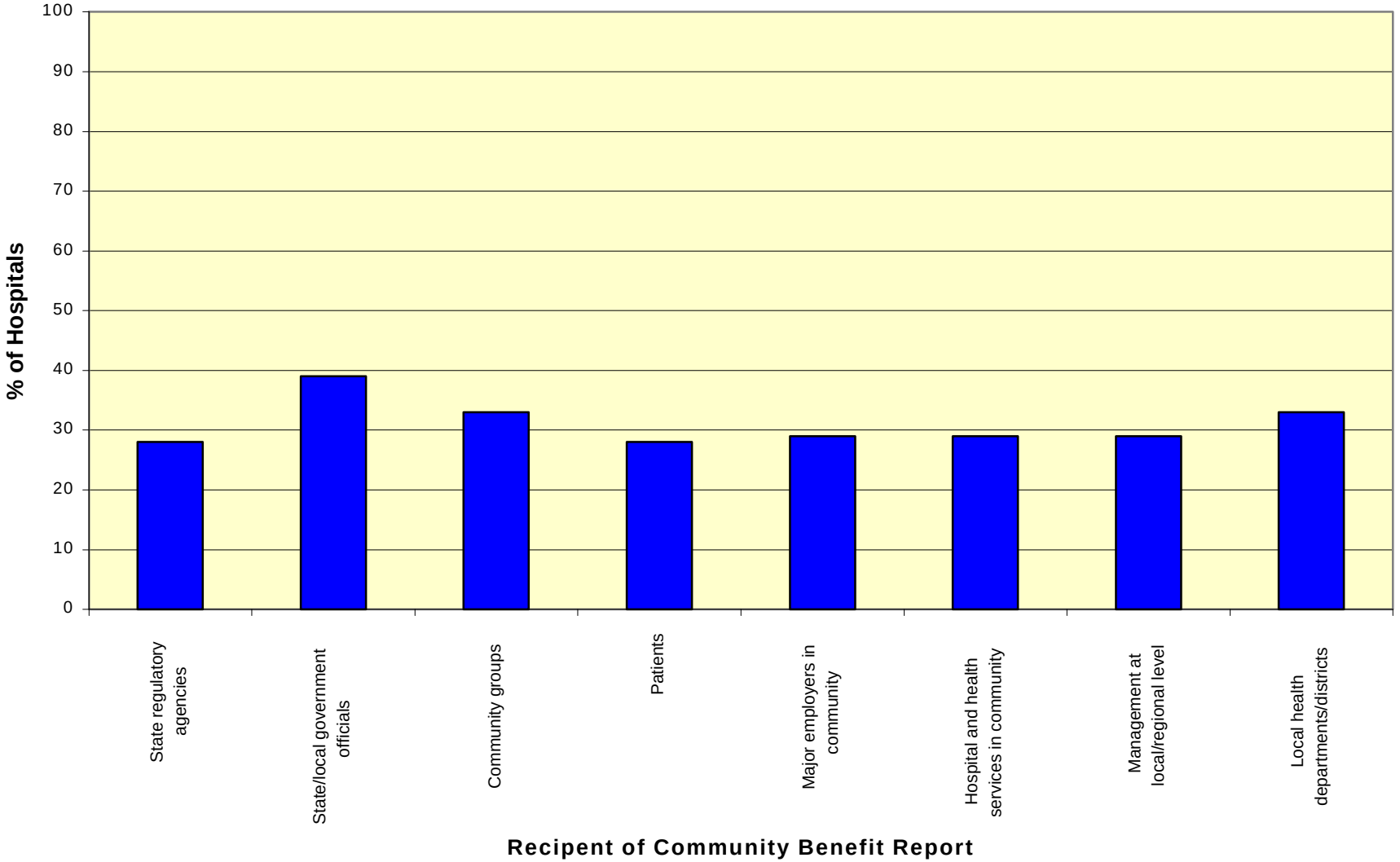


Figure 15: Programs to Reduce Health Hazards in the Home

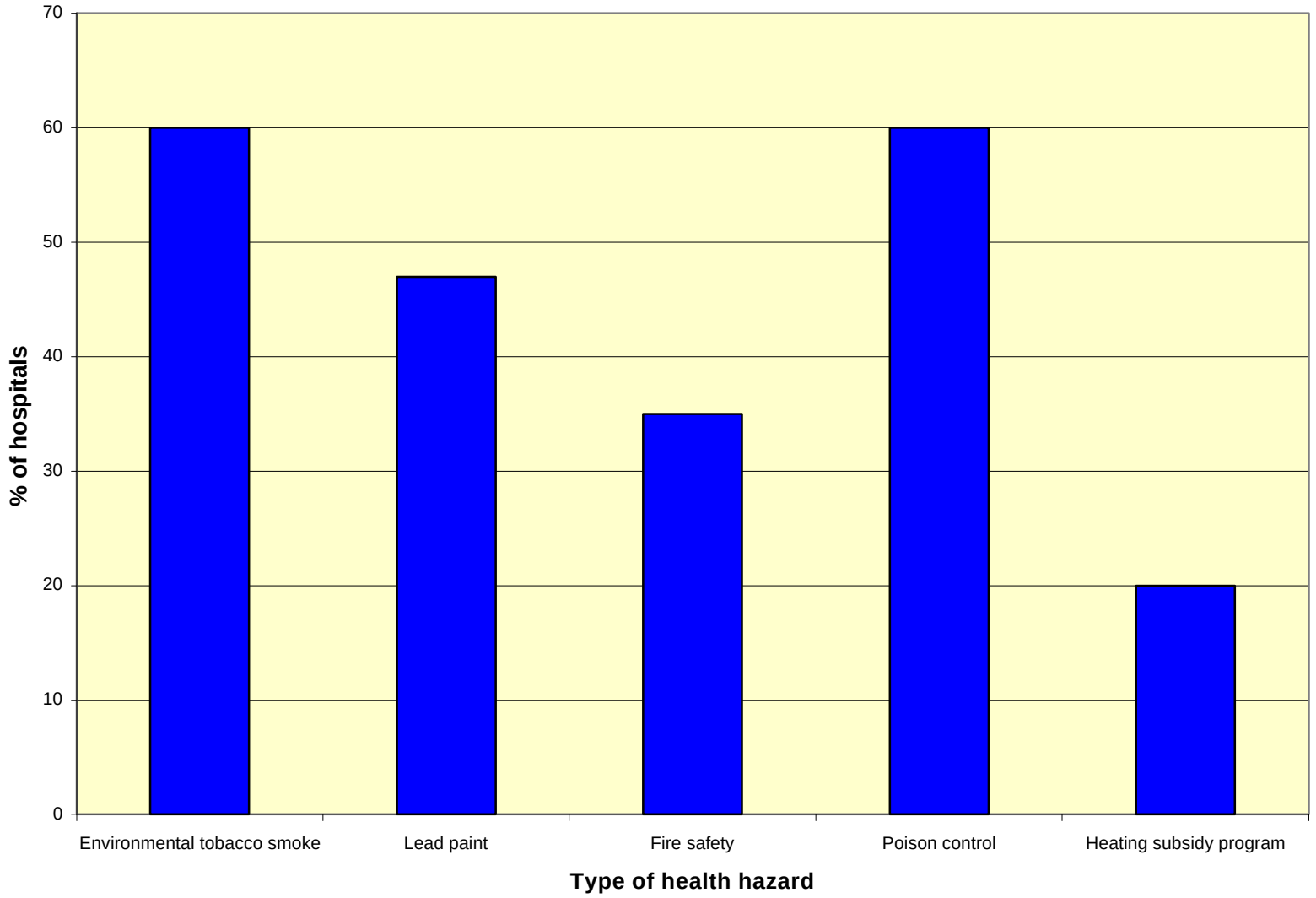


Figure 16: Mentoring Programs for Potential Employees

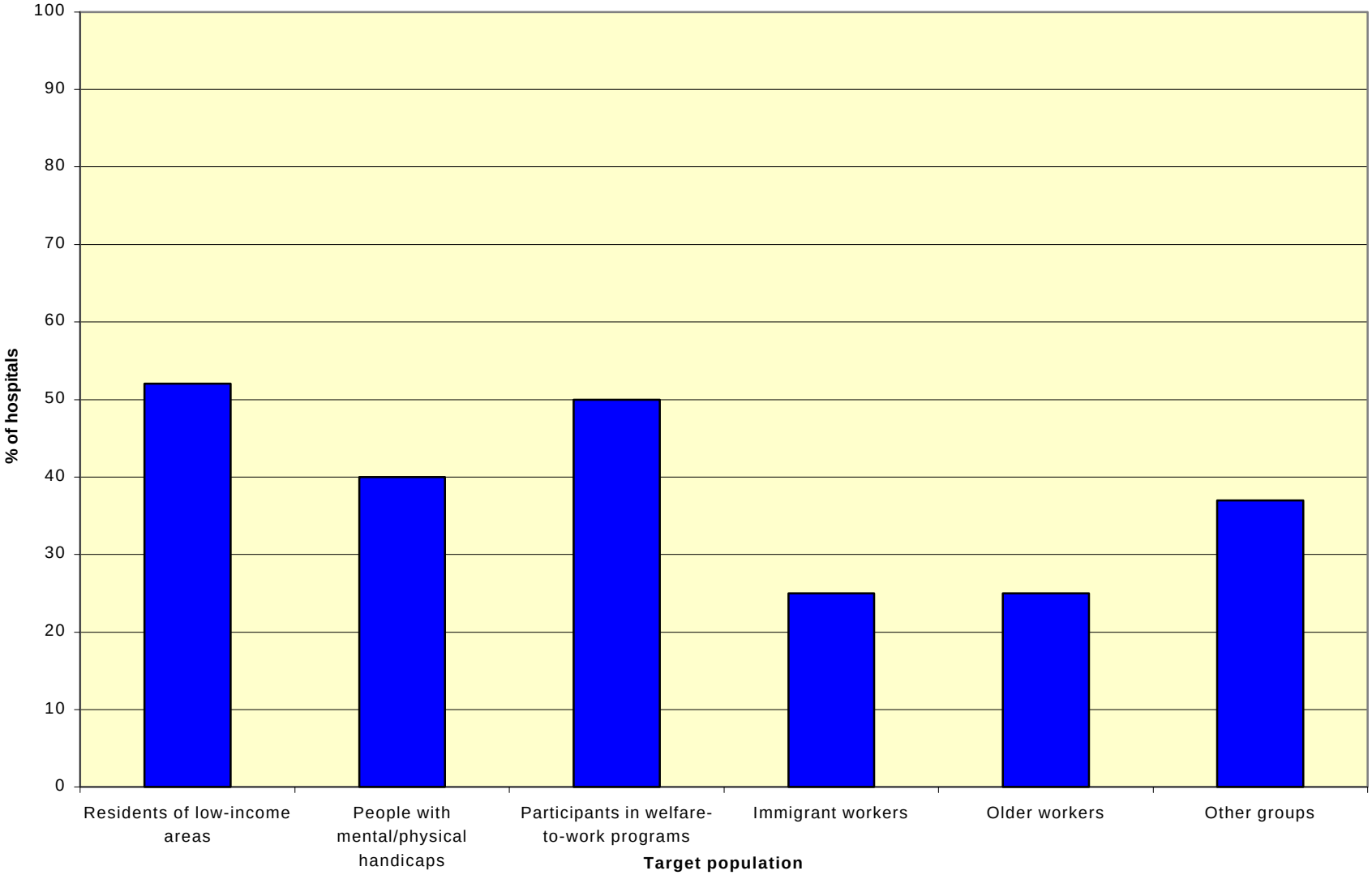


Figure 17: Collaboration with local public safety agencies

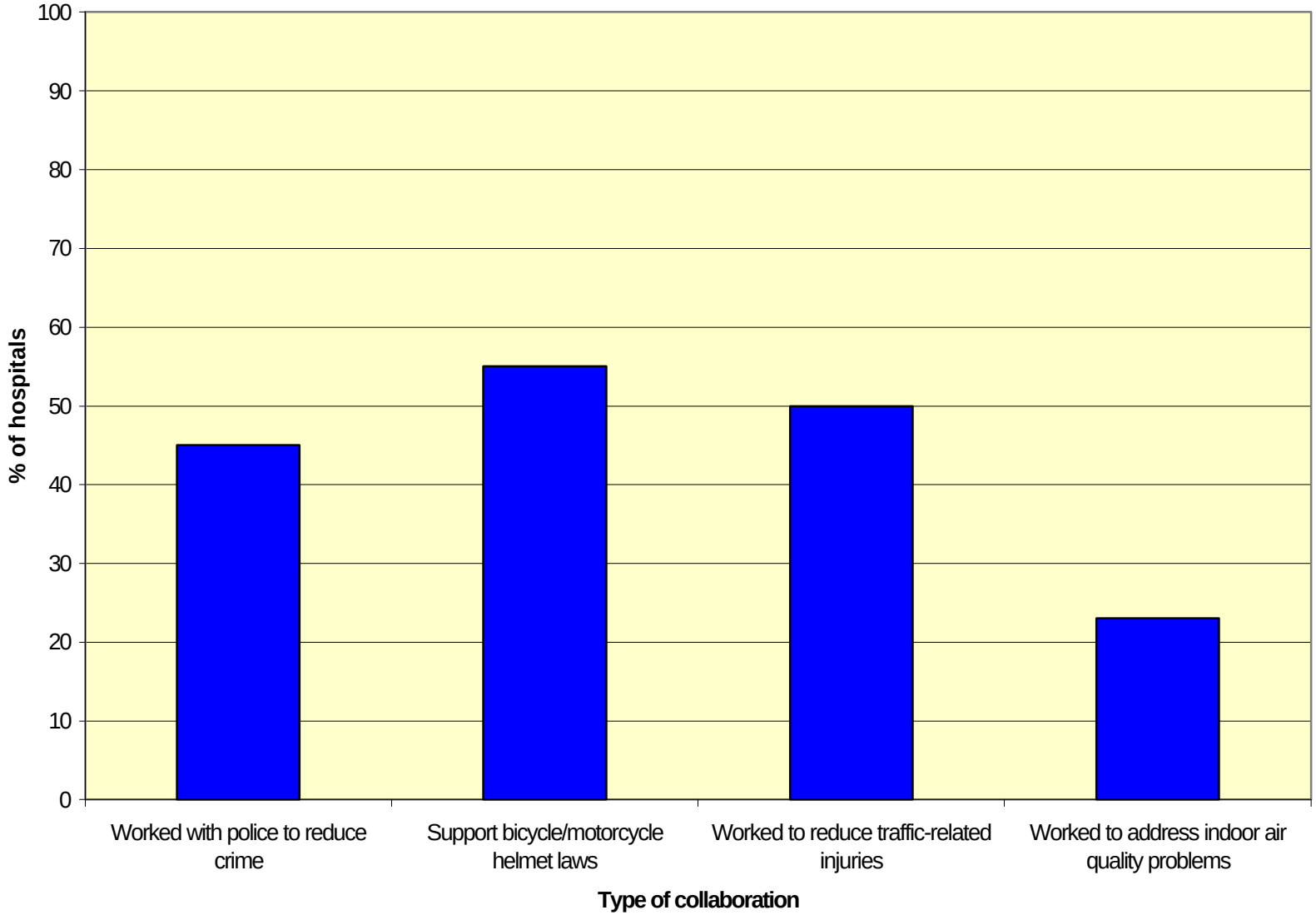


Figure 18: Addressing Local Environmental Issues

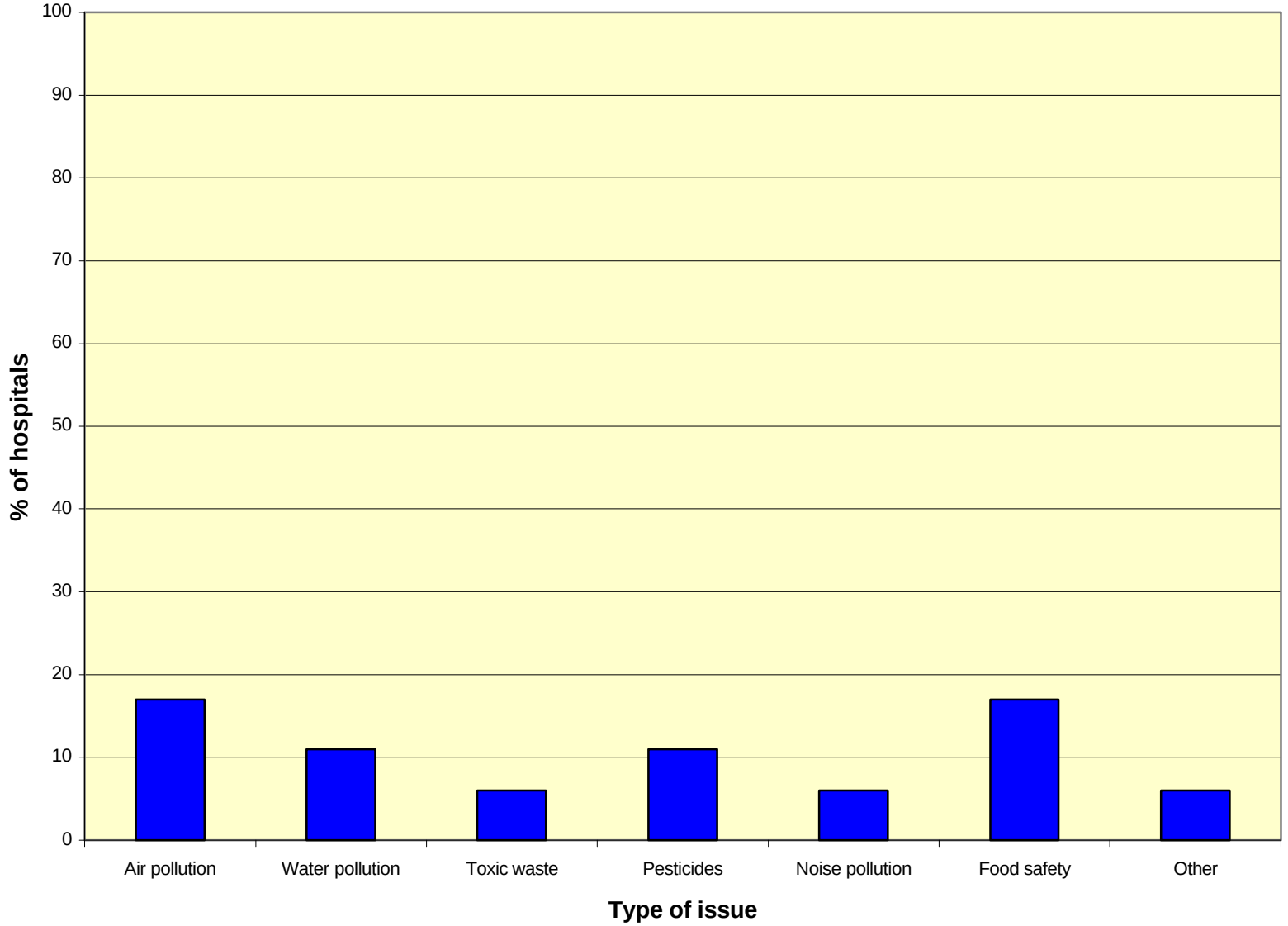


Figure 19: Direct grants to community agencies

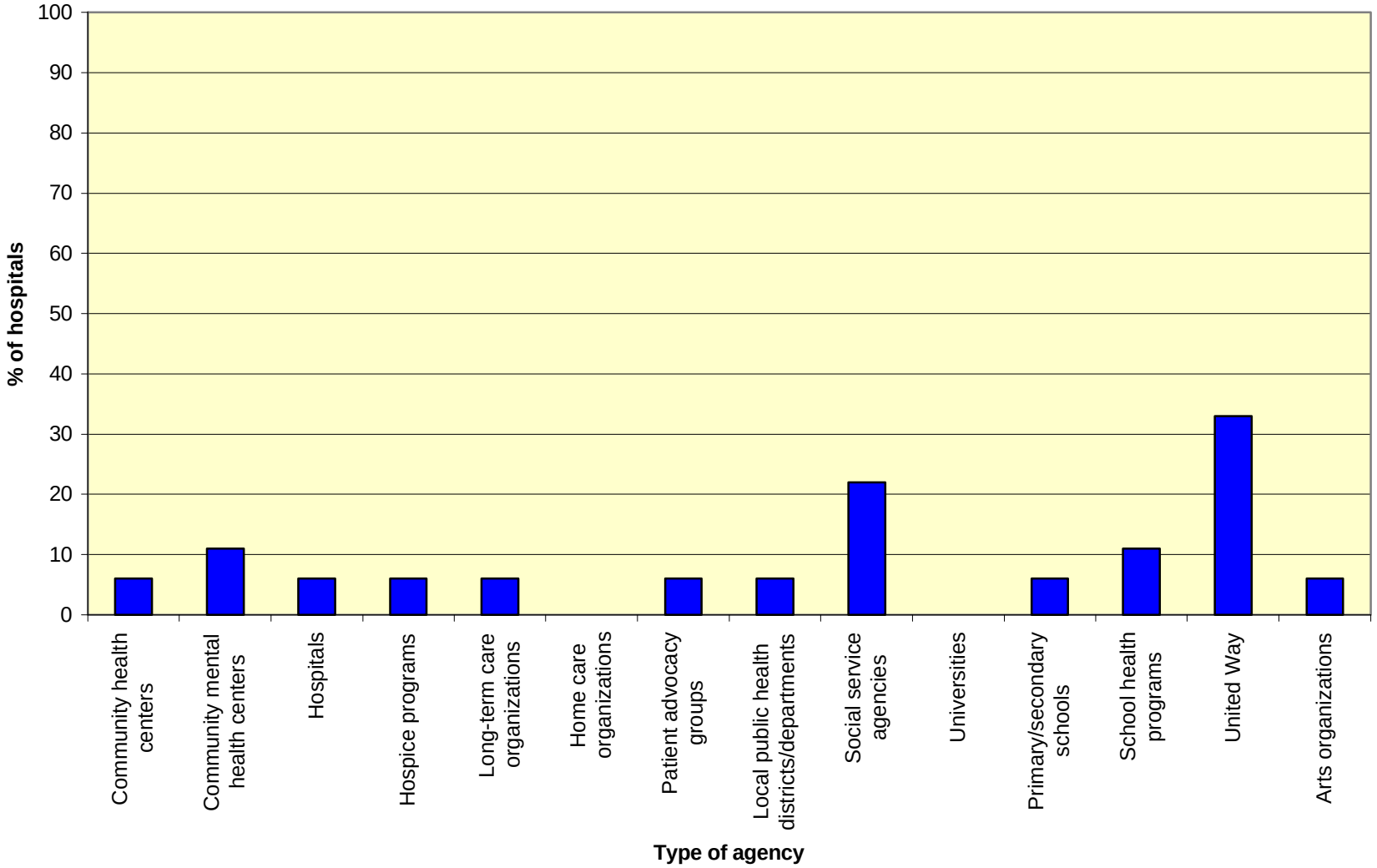
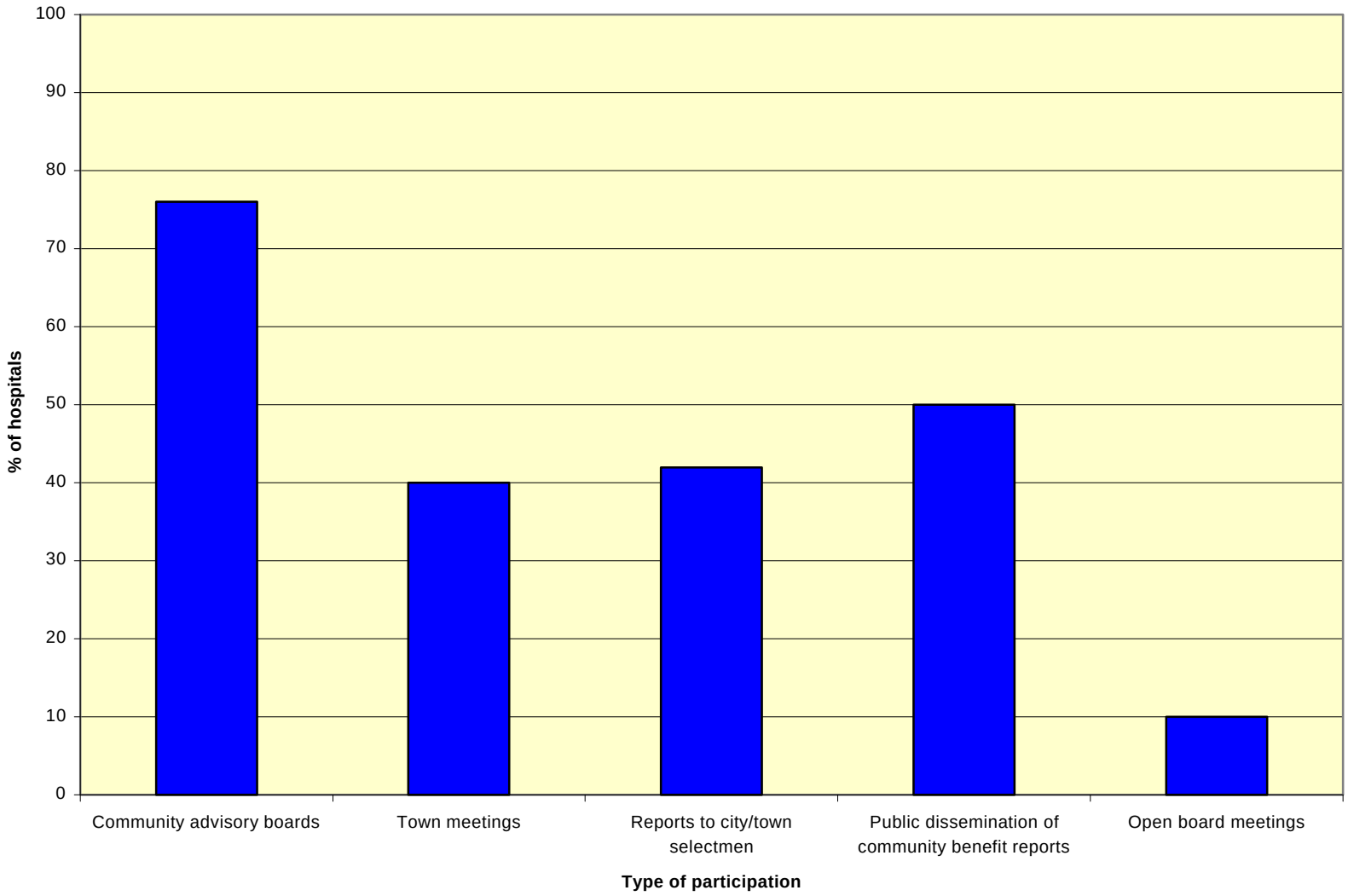


Figure 20: Community Participation in Setting Priorities for Community Benefit Activities



Hospital Name: _____

1. ## Definitions of terms used in this survey:

   Neighborhoods with limited incomes: Greater than 20% of population living in poverty.

   Neighborhoods with high immigrant populations: Greater than 20% of residents are recent immigrants.

   Rural areas: Areas outside of metropolitan statistical areas.

   Neighborhoods with high concentrations of racial minorities: Greater than 20% of population is composed of people of color.

   Social services: Services such as family counseling, case management, and information about program benefits.

2. Does your organization have a distinct program for its community benefit activities in Connecticut, as defined by Public Act No. 00-57?

   q Yes
   q No

3. If your organization does not have a distinct program for community benefits, has your organization provided services, programs, or other interventions designed to improve the health or health care for the residents of the state?

   q Yes
   q No

4. Does your organization have a formal community benefits policy statement?

   q Yes
   q No

5. If your organization does have a formal community benefits policy statement, please include it in the space provided below.

   _____

6. If your organization does not have a formal community benefits policy statement, is your organization's approach to community service addressed in your mission statement?

   q Yes
   q No

7. If your organization's approach to community service is addressed in your mission statement, please include the mission statement in the space provided below.

   _____

8. In what year did your organization's community benefit program begin?

   Year .. __

9. Does this community benefit program have a formal budget?

q Yes
q No

10. What was the budget for community benefits for the past fiscal year?

$ .. __

11. In terms of full-time equivalents, how much staff time is involved in the community benefits program and its activities?

FTEs .. __

12. In the next few years, do your expect your organization's community benefit activities will...

Increase substantially .. __
Increase slightly ..... __
Remain the same ..... __
Decrease slightly ..... __
Decrease substantially __
Unable to determine ... __

13. **Operational Community**
We are interested in understanding the geographic areas that you consider the communities that you serve. For simplicity, we will ask in terms of counties--if you are serving <u>any</u> communities in these counties, you should indicate that you are serving that county.

q The entire state of Connecticut
q New Haven County
q Tolland County
q Windham County
q Fairfield County
q Litchfield County
q Hartford County
q Middlesex County
q New London County

14. Within this service area, how frequently do you target your community benefit activities to neighborhoods with limited incomes?

q Never
q Rarely
q Sometimes
q Often
q Always
q Unable to determine

15. How frequently do you target your community benefit activities to neighborhoods with high immigrant populations?

q Never
q Rarely
q Sometimes
q Often
q Always
q Unable to determine

16. How frequently do you target your community benefit activities to neighborhoods with populations at risk of particular illness?

- q Never
- q Rarely
- q Sometimes
- q Often
- q Always
- q Unable to determine

17. How frequently do you target your community benefit activities to populations living in inner cities?

- q Never
- q Rarely
- q Sometimes
- q Often
- q Always
- q Unable to determine

18. How frequently do you target your community benefit activities to populations who live in rural areas?

- q Never
- q Rarely
- q Sometimes
- q Often
- q Always
- q Unable to determine

19. How frequently do you target your community benefit activities to those who live in federally-designated medically underserved communities?

- q Never
- q Rarely
- q Sometimes
- q Often
- q Always
- q Unable to determine

20. How often do you target your community benefit activities to neighborhoods with concentrated racial minorities?

- q Never
- q Rarely
- q Sometimes
- q Often
- q Always
- q Unable to determine

21. Does your organization's governing board have a committee with formal responsibilities for overseeing community benefit activities in Connecticut?

- q Yes
- q No

22. Does your organization have programs or policies that allow residents in Connecticut to receive free or subsidized

health services under some circumstances?

q Yes
q No

23. Over the past year, approximately how many residents received free or subsidized services in Connecticut under the auspices of your program?
(Your best estimate is fine.)

Residents .. _____

24. Does your organization have an explicit budget for this purpose?

q Yes
q No

25. Over the past year, what were your organization's approximate expenditures for free or subsidized services? (Your best estimate is fine).

Annual expenditures .. _____

26. Which of the following clinical services are provided on a free or subsidized basis?

	YES	NO
Immunizations	q	q
Prenatal or peri-natal care	q	q
Well-child care	q	q
Physical exams for adults	q	q
Clinical preventive services (e.g. hypertension screening)	q	q
Other preventive services (breast, colorectal cancer)	q	q
Other outpatient medical or surgical services	q	q
Inpatient care	q	q
Counseling or mental health	q	q
Pharmaceuticals	q	q
Other clinical services we haven't mentioned?	q	q
Dental services?	q	q
Substance abuse treatment?	q	q

27. Over the past year, what percentage of your organization's costs were attributed to uncompensated care? (Your best estimate is fine).

Percent .. _____

28. Other than practices mandated by law, does your organization have a program to subsidize health insurance premiums for people who cannot afford to pay regular rates?

q Yes
q No

29. Over the past year, how many patients served by this institution have had their premiums subsidized under this program? (Your best estimate is fine).

Number of patients .. _____

30. What was the cost of this premium subsidy over the last year? (Your best estimate is fine).

Premium Subsidy .. _____

31. Over the past year, how much money did your organization spend on uncompensated care in Connecticut? (Your best estimate is fine).

Annual Expenditures .. _____

32. Does your facility operate as a trauma center?

q Yes
q No

33. Approximately how many of your patients in Connecticut are enrolled in...

Medicare? .. _____
Medicaid? .. _____
HUSKY? .... _____

34. Other than diseases that providers are legally required to report, over the past year has your organization shared information with public health agencies about geographic clusters or unusual patterns of medical conditions?

q Yes
q No
q No unusual patterns detected

35. Over the past year, how many times has your organization reported case clusters of outbreaks of diseases in the state to state or local public health agencies?

Number of times .. __

36. Has your organization operated or subsidized any of the following programs in the past year in this state?

	YES	NO
Health literacy programs?	q	q
Health education programs for immigrants?	q	q

Information programs about eligibility for social welfare	q	q
Health fairs?	q	q

37. Over the past year, has your organization engaged in health educational efforts aimed at the public, either independently or in collaboration with other organizations in Connecticut?

q Yes
q No

38. Do your organization's health education activities in Connecticut have a separate budget? Note: Please include all health education activities, not just activities aimed at the public.

q Yes
q No

39. Over the past year, how much did your organization spend for health education (including both for your patients and the general public)? Your best estimate is fine.

$ .. _____

40. Approximately what percent of that expenditure was for health education activities that were available to the general public in the state beyond your patient population?

Percent .. _____

41. Does your organization's health education efforts have their own staff?

q Yes
q No

42. Over the past year, approximately how many full-time equivalent staff were involved in health education (both for patients and the general public)?

FTE Staff .. _____

43. Approximately what percentage of the staff's time was devoted to general health education that was available to the general public beyond your patient population?

Percent .. _____

44. Which of the following issues were addressed over the past year in your community-based health education programs in the state?

	YES	NO
Addressing domestic violence and other abuse?	q	q
Abuse of alcohol or other illicit drugs?	q	q

Identifying depression?	q	q
Health promotion for adolescents?	q	q
Encouraging safer sexual behavior?	q	q
Reducing unintentional injury?	q	q
Reducing smoking and other tobacco use?	q	q
Addressing diet and other forms of cholesterol control?	q	q
Encouraging exercise?	q	q
Encouraging better nutrition?	q	q
Encouraging weight control?	q	q
Cancer screening?	q	q
Hypertension detection and control?	q	q
Need for prenatal care?	q	q

45. Over the past year, to what extent has your organization carried out the following types of activities in Connecticut? Have you...

	Not at all	Sometimes	A great deal
worked with police or neighbor hood groups to reduce crime?	q	q	q
encouraged employers to provide	q	q	q
publicly supported bicycle or motorcycle helmet laws?	q	q	q
worked to reduce traffic-related	q	q	q
worked to address indoor air quality problems?	q	q	q

46. Does your organization require or strongly encourage its affiliated health care providers to receive training in the following areas?

	YES	NO
domestic violence and other abuse?	q	q
abuse of alcohol or illicit drugs?	q	q
diagnosing depression?	q	q

health promotion for adolescents?	q	q
encouraging safer sexual behavior?	q	q
prevention of unintentional injury?	q	q
reducing smoking and other tobacco use?	q	q
diet and other forms of cholesterol control?	q	q
encouraging exercise?	q	q
encouraging better nutrition?	q	q
encouraging weight control?	q	q
cancer screening?	q	q
hypertension detection and control?	q	q
prenatal care?	q	q

47. Does your organization sponsor any continuing education programs for health care providers?

q Yes
q No

48. In the past year, has your organization sponsored continuing education programs or distributed educational materials to health care professionals on any of the following topics...

	YES	NO
domestic violence and other abuse?	q	q
abuse of alcohol or illicit drugs?	q	q
diagnosing depression?	q	q
health promotion for adolescents?	q	q
encouraging safer sexual behavior?	q	q
reducing unintentional injury?	q	q
reducing smoking or other tobacco use?	q	q
addressing diet and other forms of cholesterol control?	q	q
encouraging exercise?	q	q
encouraging better nutrition?	q	q

encouraging weight control?	q	q
cancer screening?	q	q
hypertension detection and control?	q	q
prenatal care?	q	q

49. The next questions are about health professional education. In the past year, has your organization provided teaching sites or training experiences in Connecticut for students in any of the health professions?

q Yes
q No

50. Did your organization provide a site or rotation for graduate medical education?

q Yes
q No

51. How many positions did you have?

Number of positions .. _____

52. Did your organization provide a clerkship rotation or site for medical students?

q Yes
q No

53. Over the past year, how many medical students participated?

Number of medical students .. _____

54. Did your organization participate in or provide a training site for nursing students or graduate nurses in advanced practice nursing or other programs?

q Yes
q No

55. Over the past year, how many student nurses participated?

Number of student nurses .. _____

56. Over the past year, how many graduate nurses participated?

Number of graduate nurses .. _____

57. Did your organization provide internship or educational opportunities for students in public health, health administration or health services research programs?

q Yes

q No

58. Over the past year, how many students participated?

Number of students .. _____

59. Did your organization provide training sites for students in other clinical health professions besides nursing and medicine (e.g. physical or occupational therapy, nutrition, or social work)?

q Yes
q No

60. Over the past year, how many students participated?

Number of students .. _____

61. In the past year, did your organization have a contract that supported any community mental health centers in Connecticut for the provision of mental health services?

q Yes
q No

62. With how many community mental health centers in the state did you have such contracts to provide mental health services? Please give us the total number of community mental health centers, not including satellites.

# of community mental health centers .. _____

63. Apart from these contracts, over the past year, has your organization provided financial, technical, or other support for any community mental health centers in Connecticut?

q Yes
q No

64. Which of the following forms of support did you provide to community mental health centers in the state?

	YES	NO
Technical assistance	q	q
Other forms of in-kind support (personnel, space, supplies)	q	q
Endorsements in seeking government support	q	q
Grants or direct financial support	q	q
Participation on boards of directors at CMHCs	q	q
Encouraging employees to contribute time to these centers	q	q
Other support we haven't mentioned	q	q

65. In the past year, did your organization have a contract that supported any community health centers in Connecticut for the provision of services?

q Yes
q No

66. With how many community health centers in the state did your organization have such contracts to provide primary care? Please give us the total number of health centers, not including satellites.

# of community health centers .. _____

67. Other than through these contracts, over the past year has your organization provided any financial, technical, or other support for any community health centers in Connecticut?

q Yes
q No

68. Which of the following forms of support did you provide to community health centers in the state?

	YES	NO
Technical assistance	q	q
In-kind support such as personnel, space, or supplies	q	q
Endorsements in seeking government support	q	q
Financial support that doesn't involve contracts for services	q	q
Participation on boards of directors	q	q
Encouraging employees to contribute their time	q	q
Any other kind of support?	q	q

69. In the past year, did your organization have a contract that supported any local health departments or regional health districts in the state?

q Yes
q No

70. With how many departments or regional health districts did your organization have such contracts?

Number of health departments or districts .. _____

71. Other than through these contacts, over the past year has your organization provided any financial, technical, or other support for any local health departments or regional health districts in Connecticut?

q Yes
q No

72. Which of the following forms of support did you provide to local health departments or regional health districts in the state

	YES	NO
Technical assistance	q	q
In-kind support such as space, personnel, or equipment	q	q
Endorsements in seeking government support	q	q
Financial support that doesn't involve contracts for services	q	q
Participation on boards of directors	q	q
Encouraging employees to contribute their time	q	q
Any other support provided?	q	q

73. Does your organization have a research department or research director? Note: This may include an affiliated research organization or foundation.

q Yes
q No

74. In the past year, has your organization been engaged in research in this state, either independently or in collaboration with other organizations?

q Yes
q No

75. In the most recent year, what was the total amount spent on research in this institution, including money from both internal and external sources? Note: Your best estimate is fine.

$ ..... _____
Don't Know .. _____
$0000 ..... _____

76. Approximately what percentage of this funding came from each of the following sources? Note: Your best estimate is fine.

government grants/contracts? _____%
foundations/nonprofit philanthropy _____%
commercial companies? _____%
internal funds/general revenue _____%

77. Changing topics, in the past year, has your organization made clinical data available to outside researchers or agencies, other than as required by law or contractual commitments?

q Yes
q No

78. Over the past year, which of the following groups have been granted access to your organization's data for research purposes?

	YES	NO
Academic researchers	q	q
Government agencies	q	q
Commercial enterprises	q	q

79. In the past year in Connecticut, has your organization, either independently or in collaboration with others, such as local health departments, conducted programs aimed at reducing transmission of infectious diseases in the community and the population at large--not just among members?

q Yes
q No

80. Which of the following prevention activities has your organization made available to the general public...

	YES	NO
immunization programs?	q	q
sexually transmitted disease prevention programs?	q	q
clean needle or bleach programs for IV drug users?	q	q
animal vectored diseases (rabies, Lyme disease)?	q	q
tuberculosis identification programs?	q	q

81. Do you directly employ staff in these programs to reduce infectious diseases?

q Yes
q No

82. In terms of full-time equivalents, how much staff time is dedicated to the reduction of infectious disease in the community?

Number of FTEs .. _____

83. Does the program have a formal budget?

q Yes
q No

84. What was the budget for the past fiscal year?

$ .. _____

85. In the past year, did your organization conduct or support any systematic health needs assessments of residents of Connecticut? These could be general studies, studies of particular neighborhoods, or studies of particular conditions.

q Yes
q No

86. Have these reports been distributed outside the organization, such as to government agencies or community groups?

q Yes
q No

87. Roughly how many copies of these reports were distributed?

q 1-9
q 10-49
q 50-99
q 100-499
q 500+

88. In terms of annual full-time equivalents, approximately how much staff time or consultant time did your plan devote to the conduct and distribution of needs assessments in the state over the past year?

Number of FTEs .. __

89. Do these needs assessment efforts have their own budget?

q Yes
q No

90. Over the past year, how much did your organization spend on needs assessments in Connecticut? Note: Your best estimate is fine.

Annual Expenditures .. _____

91. In the past year did your organization have a contract that supported any public agencies or community organizations for the provision of social services?

q Yes
q No

92. Over the past year, has your organization provided financial, technical, or other support for social service agencies in Connecticut?

q Yes
q No

93. Which of the following forms of support did you provide to social service agencies in the state?

	YES	NO
Technical assistance	q	q
In-kind support such as space, personnel, or equipment	q	q
Endorsements in seeking government support	q	q
Financial support that doesn't involve contracts for services	q	q
Participation on boards of directors	q	q
Encouraging employees to contribute their time	q	q
Any other kind of support?	q	q

94. During the last year, has your organization participated in or supported activities in Connecticut to address environmental health hazards **in the home**, such as second-hand smoke, lead paint, or home accidents?

q Yes
q No

95. Which of the following home-based environmental health hazards were addressed by these initiatives?

	YES	NO
Environmental tobacco smoke	q	q
Lead paint	q	q
Fire safety	q	q
Poison control	q	q
Heating subsidy programs	q	q

96. In terms of full-time equivalents, how much staff time or consultant time did your organization devote to addressing home-based health hazards in Connecticut over the past year?

Number of FTEs .. _____

97. Do these home-based environmental health improvement efforts have their own budget?

q Yes
q No

98. Over the past year, how much money did your organization spend on home-based environmental health hazards in Connecticut? Note: Your best estimate is fine.

Annual expenditures .. _____

99. Over the past year, has your organization provided any of the following kinds of support in Connecticut for organizations or agencies that address environmental health hazards in the home?

	YES	NO
Technical assistance	q	q
In-kind support such as space, personnel, or equipment	q	q
Endorsements in seeking government support	q	q
Financial support that doesn't involve contracts for services	q	q
Participation on boards of directors	q	q
Encouraging employees to contribute their time	q	q
Any other kind of support?	q	q

100. Over the past year, has your organization been involved in any activities that address environmental health threats such as air pollution, water pollution, or toxic waste sites?

q Yes
q No

101. Which of the following environmental threats were addressed through these initiatives?

	YES	NO
Air pollution	q	q
Water pollution	q	q
Toxic waste	q	q
Pesticides	q	q
Noise pollution	q	q
Food safety (or foodborne illnesses)	q	q
Other? Specify_____	q	q

102. Over the past year, has your organization provided any of the following kinds of support for organizations that address environmental health issues in Connecticut?

	YES	NO
Technical assistance	q	q
In-kind support such as space, personnel, or	q	q

equipment		
Endorsements in seeking government support	q	q
Financial support that doesn't involve contracts for services	q	q
Participation on boards of directors	q	q
Encouraging employees to contribute their time	q	q
Any other kind of support?	q	q

103. In the past year, has your organization worked with any schools in Connecticut to address or to prevent health problems among children?

q Yes
q No

104. Does your organization contract with any school-based health clinics?

q Yes
q No

105. Did your organization operate or staff a school-based health center or clinic?

q Yes
q No

106. Was your organization paid to operate these centers or clinics?

q Yes
q In some cases
q No

107. Did this payment cover your full costs for these services?

q Yes
q In some cases
q No

108. Did your organization provide other support or technical assistance to school-based health centers or clinics or health education programs in the schools? Note: Technical assistance may include supplies, how-to-manuals, etc., but does not include the provision of funds.

q Yes
q No

109. Does your organization contract with any organizations providing social services to non-enrollees in elderly housing projects?

q Yes
q No

110. In the past year, did your organization operate any healthcare programs in elderly housing projects in Connecticut?

- q Yes
- q No

111. Was your organization paid to operate these services?

- q Yes
- q In some cases
- q No

112. Did this payment cover the full costs for these services?

- q Yes
- q No

113. In the past year, was your organization involved with either homeless shelters or victim assistance programs in Connecticut? Note: Involvement may include serving on a board.

- q Yes
- q No

114. In the past year, did your organization operate any healthcare programs in any homeless shelters or victim assistance programs in Connecticut?

- q Yes
- q No

115. Was your organization paid to operate these services?

- q Yes
- q In some cases
- q No

116. Did this payment cover your full costs for these services?

- q Yes
- q In some cases
- q No

117. Does your organization contract with any programs providing health care to non-enrollees based in homeless shelters or victim assistance programs?

- q Yes
- q No

118. Over the past year did your organization staff or provide in-kind support or technical assistance to homeless shelters or victim assistance programs in Connecticut?

	YES	NO
Technical assistance	q	q
In-kind support such as space, personnel, or equipment	q	q

Endorsements in seeking government support	q	q
Participation on boards of directors	q	q
Encouraging employees to contribute their time	q	q
Any other kind of support?	q	q

119. Now, we have some questions about your organization's practices regarding informal caregivers--that is, friends and family members who provide care to patients. Over the past year has your organization done any of the following in Connecticut. Has your organization...

	YES	NO
created policies for referring caregivers to support groups?	q	q
provided financial or in-kind support to such groups?	q	q
established support groups for patients' families?	q	q
provided respite care?	q	q

120. Now we would like to ask about particular examples of policies or practices that may affect family care givers for patients with serious illness. How frequently does your organization:

	Never	Rarely	Sometimes	Often	Always
offer counseling to family care givers?	q	q	q	q	q
provide or pay for respite home care for caregivers?	q	q	q	q	q

121. Over the past year, has your organization made any grants or contributions to public agencies or private not-for-profit organizations in Connecticut to enable them to carry out their work? Note: If your organization has a separately incorporated foundation, please include its activities in your response.

q Yes
q No

122. What was the total amount of these grants and contributions over the past year? Your best estimate is fine.

Annual expenditures .. _____

123. We are going to shift now and ask about the types of organizations to which you made grants in the most recent grant-making year. Were grants made available to any of the following types of organizations:

	YES	NO
Community health centers	q	q
Community mental health centers	q	q

Hospitals	q	q
Hospice programs	q	q
Long term care organizations	q	q
Home care organizations	q	q
Patient advocacy groups	q	q
Local public health districts or departments	q	q
Social service agencies	q	q
Universities	q	q
Primary/secondary schools	q	q
School health programs	q	q
United Way or other federated giving programs	q	q
Arts organizations (visual or performing)	q	q

124. In the past year, has your organization conducted employee fund drives for the United Way or other charities in Connecticut?

q Yes
q No

125. In the past year, has your organization participated in other fund-raising activities for charitable organizations in Connecticut?

q Yes
q No

126. In the past year, has your organization matched employee contributions to charity?

q Yes
q No

127. In the past year, has your organization made facilities available to charitable groups in Connecticut for free or at reduced charges?

q Yes
q No

128. During the past year, has your organization given public recognition of employees' community service activities?

q Yes
q No

129. In the past year, has your organization enabled employees to perform community service on company time?

q Yes
q No

130. In the past year, has your organization had other policies or practices that promote charity or volunteering among employees?

q Yes
q No

131. Does your organization have a policy or program to give special attention to the employment, training, or mentoring of disadvantaged groups in Connecticut?

q Yes
q No

132. Does this policy or program cover...

	YES	NO
residents of low-income areas?	q	q
people with mental/physical handicaps?	q	q
participants in welfare-to-work training programs?	q	q
immigrant groups?	q	q
older workers?	q	q
some other group?	q	q

133. Does your organization evaluate the success of its community benefit activities?

q Yes
q No

134. Does your organization conduct surveys of health care providers to evaluate the success of its community benefit activities?

q Yes
q No

135. Does your organization conduct surveys of those using community benefit services to evaluate the success of its community benefit activities?

q Yes
q No

136. Does your organization conduct surveys of the general public in the communities you serve to evaluate the success of its community benefit activities?

- q Yes
- q No

137. Does your organization conduct focus groups with members of the public to evaluate the success of your community benefits activities?

- q Yes
- q No

138. Does your organization conduct interviews with local public offices to evaluate the success of your community benefit activities?

- q Yes
- q No

139. Does your organization conduct interviews with leaders of health care organizations in the communities you serve to evaluate the success of your community benefit activities?

- q Yes
- q No

140. Does your organization measure community-based health outcomes in order to evaluate the success of your community benefit activities?

- q Yes
- q No

141. Does your organization conduct case-control trials of community-based interventions in order to evaluate the success of your community benefit activities?

- q Yes
- q No

142. Does your organization conduct randomized trials of community-based interventions as a means to evaluate the success of your community benefit activities?

- q Yes
- q No

143. As a result of your evaluative efforts, are you planning over the next year to change the neighborhoods to which you target your community benefits? Will you target neighborhoods...

	YES	NO
With limited incomes?	q	q
With high immigrant population	q	q
In inner cities?	q	q

In rural areas?	q	q
Medically underserved areas?	q	q
With concentrated racial minorities?	q	q

144. As a result of your evaluative efforts, what changes are you likely to make in the focus of your community benefit activities? Do you expect to increase or decrease any of the following involvements over the next year?

	Increase focus	Keep the same	Decrease focus
Unprofitable services	q	q	q
Health education programs	q	q	q
Health promotion activities, other than education programs	q	q	q
Health professional education	q	q	q
Health-related research	q	q	q
Programs to limit communicable diseases	q	q	q
Support for local health infrastructure	q	q	q
Collaboration with local public health agencies	q	q	q
Charitable contributions/ volunteer programs	q	q	q
Home-based health initiatives	q	q	q
Environmental health initiatives	q	q	q
Caregiver support programs	q	q	q
Support for schools or social service agencies	q	q	q
Community health needs assessments	q	q	q

145. Are there any other features of your community benefit activities that you expect to change over the next year, based on what you have learned through your evaluations?

146. Is an annual report prepared describing your organization's community benefit activities? Note: This report may be a part of your organization's regular annual report.

q Yes
q No

147. Is your community benefit report regularly sent to any of the following groups or organizations?

	YES	NO

State regulatory agencies?	q	q
State or local government officials?	q	q
Community groups?	q	q
Patients?	q	q
Major employers in the community?	q	q
Hospital and health services in the community?	q	q
Management at the regional or national level?	q	q
Local health departments or districts?	q	q

148. We would like to conclude by asking about community participation in the development of policies related to community benefit activities. Which of the following mechanisms are used by your organization to allow for community involvement:

	YES	NO
Advisory boards drawn from the local community	q	q
Town meetings with the public	q	q
Reports to city or town boards of selectmen	q	q
Public dissemination of community benefit reports	q	q
Open board meetings	q	q

149. How much influence do each of the following groups have over the nature of your organization's community benefit activities?

	No Influence	Limited Influence	Some Influence	Considerable Influence
Local residents	q	q	q	q
City councils or town board of selectmen	q	q	q	q
Local nonprofit organizations	q	q	q	q
Community health centers	q	q	q	q
Community mental health centers	q	q	q	q
Local physicians	q	q	q	q
Local business groups	q	q	q	q

State agencies	q	q	q	q
Local health departments or districts	q	q	q	q
Patients at your hospital	q	q	q	q
Health care providers at your hospital	q	q	q	q