Reporting of Community Benefits Programs by Hospitals and Health Plans in Connecticut Calendar Years 2001 & 2004

Report to the General Assembly, State of Connecticut

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Connecticut Department of Public Health
J. Robert Galvin, MD, MPH, Commissioner

Planning Branch, State Health Planning Section
410 Capitol Avenue, MS#13PWD
Hartford, CT 06134-0308
Telephone: 860 509-8070
Fax: 860 509-7160
E-Mail: webmaster.dph@po.state.ct.us

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INTRODUCTION

This report is produced pursuant to Section 19a-127k, of the Connecticut General Statutes, as amended (see Appendix A). The statute requires each hospital and managed care organization (MCO) operating in Connecticut to report to the Department of Public Health (DPH) biennially whether or not they have a Community Benefits Program. Legislation defines a "Community Benefits Program" as any voluntary program to promote preventive care and to improve the health status for working families and populations at risk in the service areas of the MCO or hospital.

REPORTING HISTORY

The first Community Benefits Reporting survey was developed and administered by the School of Medicine, Department of Epidemiology and Public Health at Yale University. Slightly more than half of the eligible hospitals completed surveys on their community benefit activities in calendar year 2000. None of the 36 eligible MCOs reported that they had a community benefits program in 2000.

DPH developed and administered the calendar year 2001 Community Benefits Reporting program. Twenty-six out of 42 hospitals completed the survey. Eight hospitals had a Community Benefits Program and were required to submit a survey, while 18 hospitals voluntarily completed a survey. One out of the 34 MCOs reported it had a Community Benefits Program and submitted a survey.

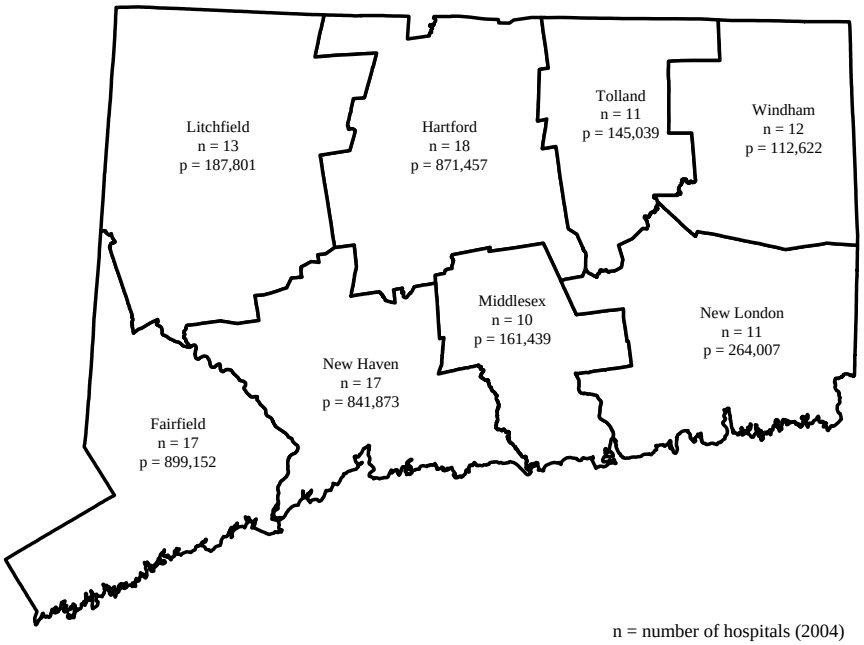
C.G.S. 19a-127k was amended in 2003, changing the reporting requirements from annual to biennial reporting. It also put in place an option for DPH to impose civil penalties of up to $50.00 per day, after the opportunity for a hearing, for failure to report to DPH whether or not an organization has a Community Benefits Program.

2004 SURVEY

As in previous years, information on community benefit programs was solicited through a mail survey. For the 2003/2004 biennium reporting, DPH planning staff pared down the survey from the original 149 questions to 49. Similar to previous years, a list of organizations required to report their community benefit activities was developed from information provided by the DPH Regulatory Services Branch and the Connecticut Department of Insurance (see Appendix B). Community benefit surveys were sent to 43 acute care inpatient and specialty hospitals and 31 MCOs in November 2004. All hospitals and MCOs responded (see Appendix C).

Figure 1 presents the service areas of the hospitals participating in the 2004 survey. Thirty-two out of forty-three hospitals completed the 2004 Community Benefits Survey. Nine hospitals reported they had a Community Benefits Program as defined by state statute and were required to complete the survey. An additional 23 hospitals indicated they had programs, but they did not meet the definitions of the statute. These 23 hospitals voluntarily completed and submitted a survey, the results of which are included in this report.

Figure 1: Counties Served by Hospitals Participating in the 2004 Community Benefit Survey



Saint Vincent's Health Services submitted a single survey for Saint Vincent's Medical Center and Hall Brooke Behavioral Health, representing two of the nine hospitals that reported having a Community Benefits Program. A single survey was also submitted for Rockville Hospital and Manchester Memorial Hospital as part of the Eastern Connecticut Health Network; Saint Francis Hospital and Medical Center submitted a joint survey for Saint Francis Hospital and the Rehabilitation Hospital of Connecticut, Inc.; and Masonic Healthcare Center submitted a survey on behalf of its chronic care and psychiatric components. These latter organizations are part of the 23 hospitals that reported not having a Community Benefits Program, but completed a survey voluntarily.

Although it does not have a Community Benefits Program as defined in statute, Aetna Life Insurance Company and Aetna U.S. Healthcare, Inc. submitted a survey on behalf of the Aetna Foundation. ConnectiCare Inc. and ConnectiCare Insurance Company, Inc. have a community benefits program and also submitted a survey for the 2003/2004 biennium.

COMMUNITY BENEFIT ACTIVITIES

In 2004, 12 hospitals reported a median budget of $1,523,885 for their Community Benefits Program and a median of 19 full-time equivalents (FTEs) involved in such activities. The scope of community benefit activities varies widely, ranging from subsidies to cover the cost of health care services for special needs populations to health education and prevention programs for the community at large. The 2003 and 2004 information submitted by hospitals shows little variation between years. For this reason, the report presents hospital data for 2004 only. However, for comparative purposes, results from the 2001 report are included. (Please refer to the aggregation of hospital survey data for 2001 and 2004 in Appendix D.) A strict comparison of information has not been undertaken between years due to differences in the number of facilities reporting.

However, the information may be viewed as a general indication of community benefit activity across the state.

The reader is reminded that all data are self-reported without independent verification or audit. In addition, the data presented in the Table and Figures are not necessarily comparable because information was submitted by differing numbers of facilities between 2001 and 2004, and under different reporting consequences. For this reason, survey results from 2004 are emphasized in this report.

1. Targeting of Community Benefit Activities to Special Population Groups

Table 1 below presents the number and proportion of hospitals that have an activity focused on a special population either *often* or *always*. Responses of *never*, *rarely*, *sometimes*, or *unable to determine* are interpreted as not a focus of the hospital and are not displayed in the table.

The proportion of hospitals targeting special need populations was similar for both 2001 and 2004 in three of the seven categories*: Low-Income Neighborhoods*, *Medically Underserved Areas*, and *Inner Cities*. The proportion of hospitals targeting *Rural Areas* decreased between 2001 and 2004. The proportion of hospitals targeting special needs that increased between 2001 and 2004 were: *Neighborhoods with High Immigrant Populations*, *Areas with Concentrated Racial Minorities*, and populations *At Risk of Particular Illness.*

Table1: Hospital Community Benefits Programs Targeted Often or Always to Special Needs Populations in Calendar Years 2001 and 2004.

Target Areas	2001		2004	
	Number of Responding Hospitals	Percentage	Number of Responding Hospitals	Percentage
Low-Income Neighborhoods	25	68.0%	30	70.0%
At Risk of Particular Illness	25	60.0%	30	63.3%
Racial Minorities	24	58.3%	30	63.3%
Medically Underserved Areas	24	62.5%	31	61.3%
Immigrant Populations	25	48.0%	30	56.7%
Inner Cities	24	54.2%	30	53.3%
Rural Areas	25	24.0%	31	19.4%

The following data are organized according to three categories of community benefit activities: 1) most prevalent, 2) moderately supported, and 3) minimally supported. The most prevalent community benefit activities were found among 70% to 100% of responding hospitals. Moderately supported activities were found in 30% to70% of responding hospitals, while minimally supported activities were rarely found among Connecticut hospitals (0% to 30%).

Between 2001 and 2004, "Support for Safety-Net Agencies" changed from the *moderately supported* category to the *most prevalent* category. "Distributing Reports Documenting Community Benefit Activities" changed from the *moderately supported* category to the *minimally supported* category between 2001 and 2004. All other activities fall within the same ranges between 2001 and 2004.

2. Most Prevalent Community Benefit Activities

In 2004, Connecticut hospitals were actively involved in the following community benefit activities: a) free or subsidized health services; b) educational programs for the general public; c) training sites for health care professionals; and d) support for safety net agencies.

Free or Subsidized Health Treatment Services: Thirty out of 32 hospitals reported providing free or subsidized health services. The frequency of hospitals providing free or subsidized health services varied by areas. *Inpatient services* and *clinical preventive services* were most frequently provided either free or subsidized, while *dental services, adult physicals,* and *pharmaceuticals* were least frequently provided (Figure 2). According to survey results, free and subsidized services were provided to at least 177,892 residents in Connecticut.

Health Education in the Community: Twenty-seven of 32 hospitals reported providing some type of health education and screening in the community. Education in the areas of *exercise*, *nutrition,* and *weight control* were most frequently offered, while education for *safer sexual behavior* was offered least often (Figure 3).

Provide a Training Site for Health Care Professionals: All of the responding hospitals provided a training site for *nursing training* and *other health professional training*. Thirty of the hospitals provided *public health training*. *Graduate medical education* and *medical training* was provided at 26 and 22 of the hospitals responding, respectively (Figure 4).

Support for Safety-Net Agencies: Twenty-eight out of 32 hospitals provided support for *school clinics*. Approximately two-thirds of the reporting hospitals supported *health departments*, *community mental health centers* or *community health centers* (Figure 5).

3. Moderately Supported Community Benefit Activities

In 2004, six categories of community benefit activities were reported as moderately supported by hospitals. They include: a) support for social service agencies in the community; b) support for family caregivers of patients; c) working with public safety agencies; d) initiatives to address health hazards in the home; e) reducing the transmission of infectious diseases, and f) setting community benefit program policy.

Support for Social Service Agencies: Twenty-four out of 32 hospitals reported supporting *homeless or victims assistance shelters*. Twenty-three and eighteen hospitals respectively reported supporting *social service agencies* and *elderly housing projects* (Figure 6).

Support for Family Caregivers: Twenty-seven out of the 32 reporting hospitals have *established support groups for patient families*. Approximately 60% of the hospitals have *created policies for referring caregivers to support groups*, *provided caregivers with in-kind/financial support*, or *provided respite care* (Figure 7).

Collaboration with Local Public Safety Agencies: Two out of three reporting hospitals promoted *helmet use for bicyclists and motorcycle riders*, and *worked to reduce traffic-related injuries*. Eighteen hospitals worked with police or neighborhood groups to reduce crime. Slightly more than half of the hospitals *worked to address indoor air quality problems* (Figure 8).

Programs to Reduce Health Hazards in Homes: Seventeen out of 31 responding hospitals participated in or supported programs to reduce *second-hand tobacco exposure* or enhance *poison control* efforts. Fifteen hospitals had programs addressing *fire safety* and twelve had programs addressing *lead paint* hazards in the home (Figure 9).

Programs to Reduce Transmission of Infectious Diseases: *Immunization programs* to the general public were the most frequently offered programs in this category, with 21 of the hospitals addressing this need. Approximately 45% of the hospitals had programs that addressed *sexually transmitted diseases*, *tuberculosis identification* or *animal vectored diseases*. Only 3 of the 31 hospitals reported having *clean needle or bleach programs* for substance abusers (Figure 10).

Community Participation in Policy Development for Community Benefit Activities: Twenty-four out of 32 responding hospitals used *community advisory boards* to develop community benefit policies. Approximately one-third of hospitals reported involvement of *town meetings*, sending *reports to city/town selectmen*, or *public dissemination of community benefit reports* in policy development. Only three of the hospitals reported involvement at *open board meetings* as a means of policy development (Figure 11).

4. Minimally Supported Community Benefit Activities

Community benefit activities found least often among Connecticut hospitals include: a) distributing reports documenting community benefit activities; and b) direct grants from the hospital to various community-based groups.

Distributing Reports Documenting Community Benefit Activities: Survey results indicate eight hospitals distributed reports to 5 of the 7 categories of recipients. Nine hospitals provided reports to local health departments and 10 reported to community groups (Figure 12).

Direct Grants to Community Agencies: Very few of the reporting hospitals made grants to community agencies. *Social service* agencies received grant support from 12 hospitals followed by the *United Way,* which received grants from 9 hospitals. *Community health centers* received grants from 7 hospitals (Figure 13).

Summary of the Managed Care Organization Surveys

As described above, Aetna Health, Inc. and Aetna Life Insurance Company do not have a formal community benefit program as defined by statute. However the Aetna Foundation, described as the independent and charitable arm of Aetna, is reported to provide activities similar to some of those listed in the survey utilized by DPH. The community benefit activities described in their survey are those of the Aetna Foundation.

In 2001, ConnectiCare was the first MCO to submit a community benefit survey in Connecticut. ConnectiCare again reported having a community benefit program in place for 2004 and submitted a survey on behalf of ConnectiCare, Inc. and ConnectiCare Insurance Company, Inc.

ConnectiCare's community benefit policy is "to participate in the betterment of the communities in which the company conducts business and provides service to its members." The Aetna Foundation collaborates with the non-profit sector and Aetna employees volunteer to decrease disparities among all Americans. Both organizations report the entire state as served by their community benefit activities. ConnectiCare and the Foundation target their community benefit activities to special population groups either sometimes or often. *Neighborhoods with limited incomes* and *populations living in inner cities* are targeted often by both organizations.

ConnectiCare has programs that allow Connecticut residents to receive free or subsidized care. Both organizations provide support to social service agencies and homeless shelters or victim assistance programs. Neither organization had specific community health education programs in areas such as domestic violence, substance abuse, or identifying depression. ConnectiCare does have education programs in areas such as reducing smoking, encouraging weight control, nutrition, and prenatal care. The Foundation does operate programs in health literacy, health education for immigrants and eligibility for social welfare. Both organizations operated or subsidized health fairs. Both organizations made grants available to organizations such as community health centers, hospitals, and long term care organizations, etc. Lastly, the Foundation sends its community benefits report to organizations upon request. ConnectiCare sends its report to state regulatory agencies and management at the regional and national level.

SUMMARY AND RECOMMENDATIONS FOR THE COMMUNITY BENEFIT REPORTING PROGRAM

This is the third report summarizing the community benefit activity in the state based upon data submitted by 32 hospitals, one MCO and the charitable foundation of another MCO. The data demonstrate the wide scope and variety of community health benefit activities currently provided to local communities. This variety is based many times on the mission of the organization.

Full report participation was achieved by both hospitals and MCOs in this, the first biennial survey. This may be because the community benefits statute now includes an enforcement component for failure to report. The reader is reminded that the basic requirement is for designated organizations to report whether or not they have a community benefits program, as defined in statute. An organization reporting that it does not have a program "as defined" meets the statutory requirements.

Generally speaking, community benefit activities in the state appear to be increasing. However, this may be due to the reporting enforcement component. It is conceivable that the decrease in the survey size has increased the ease of reporting compliance. It also appears there are not significant changes in the information reported from year to year. Continued reporting on a biennial basis with the enforcement component may allow for increased comparison of information between reporting periods in the future.

Lastly, the information submitted is self reported with no validation or audit component. However, contact with the reporting organizations has revealed intent to provide accurate and complete information to DPH.

Figure 2: Community Benefit Activity -
Free or Subsidized Health Services

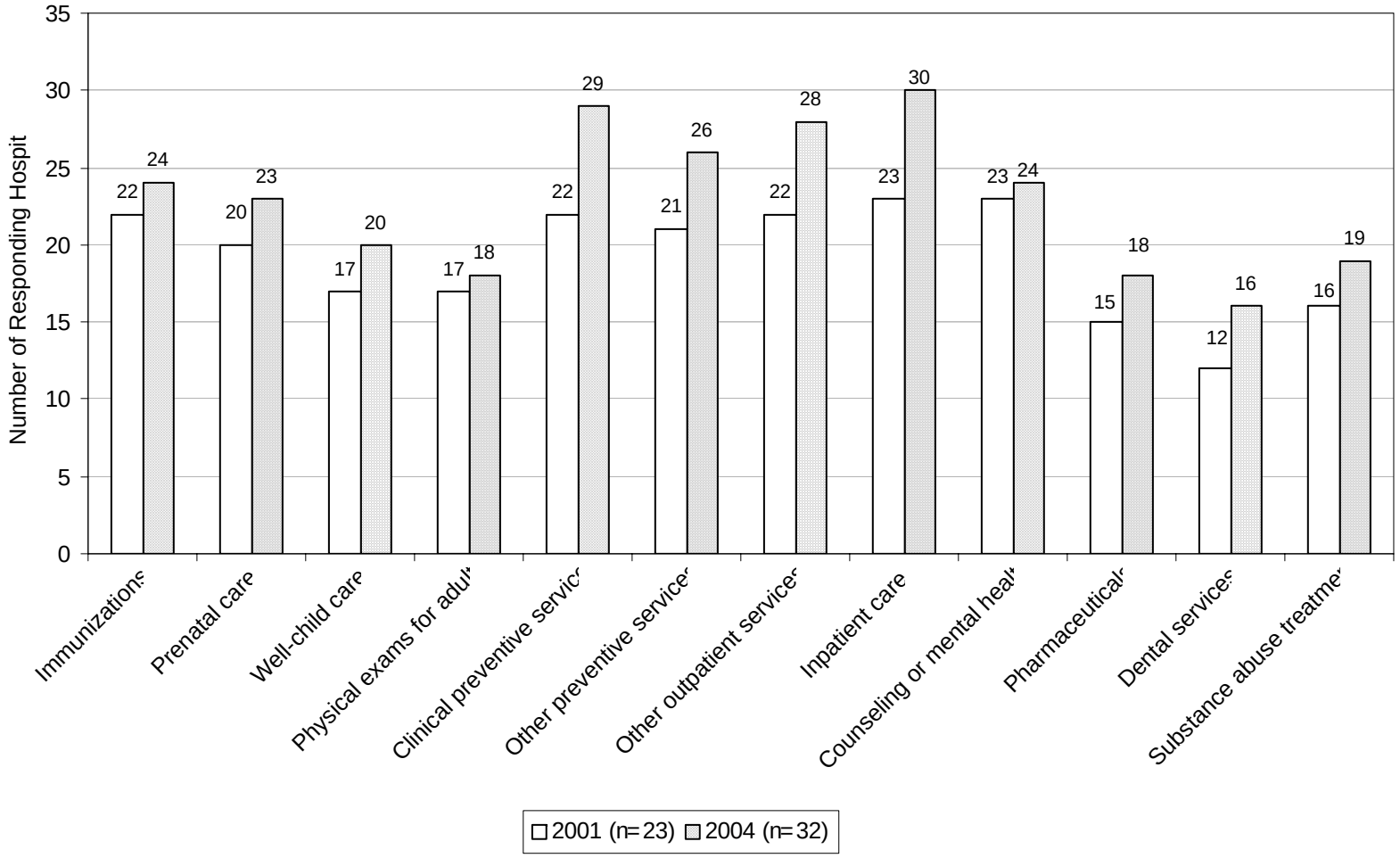


Figure 3: Community Benefit Activity - Health Education in the Community

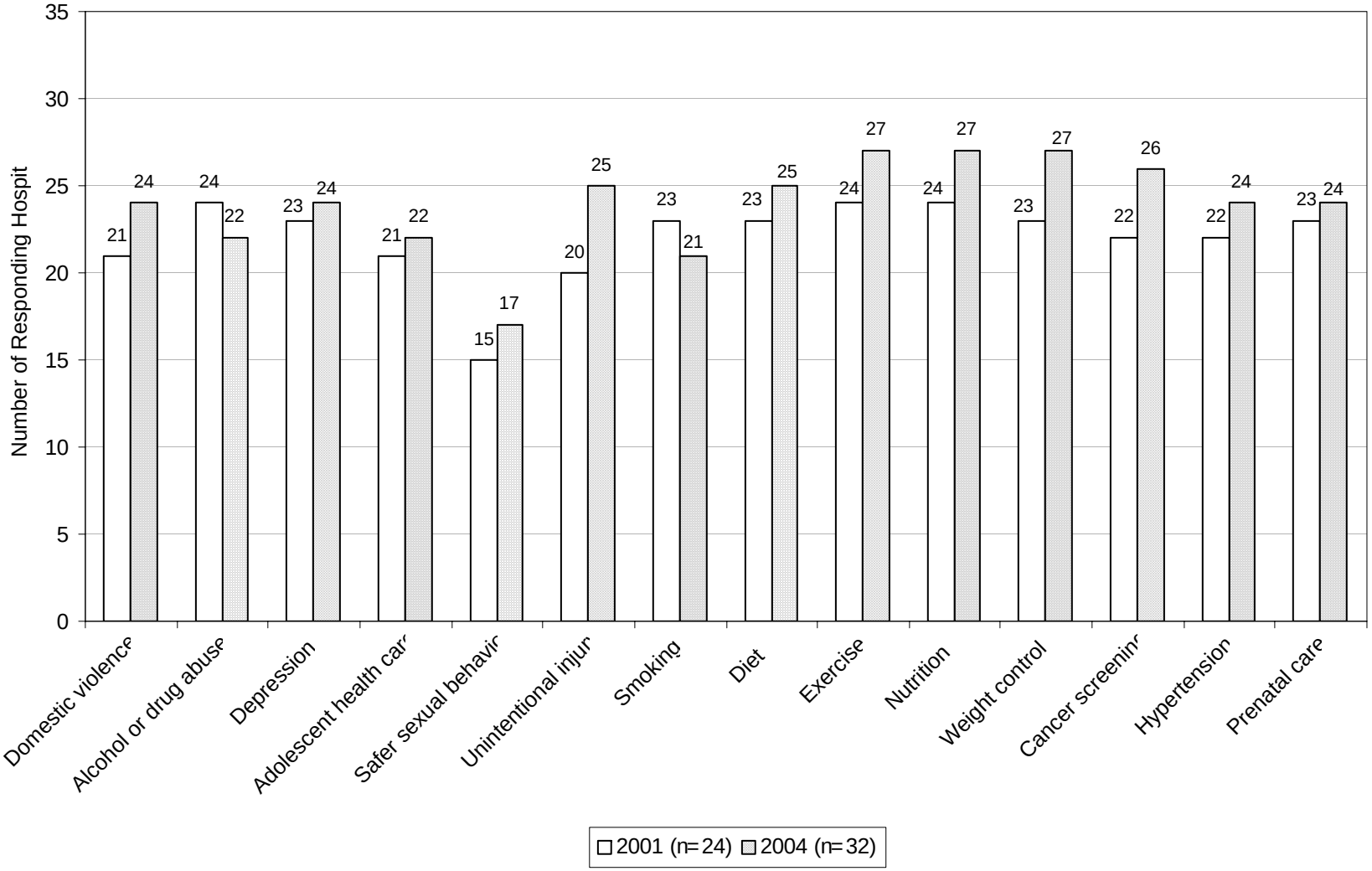


Figure 4: Community Benefit Activity -
Providing a Training Site for Health Professionals

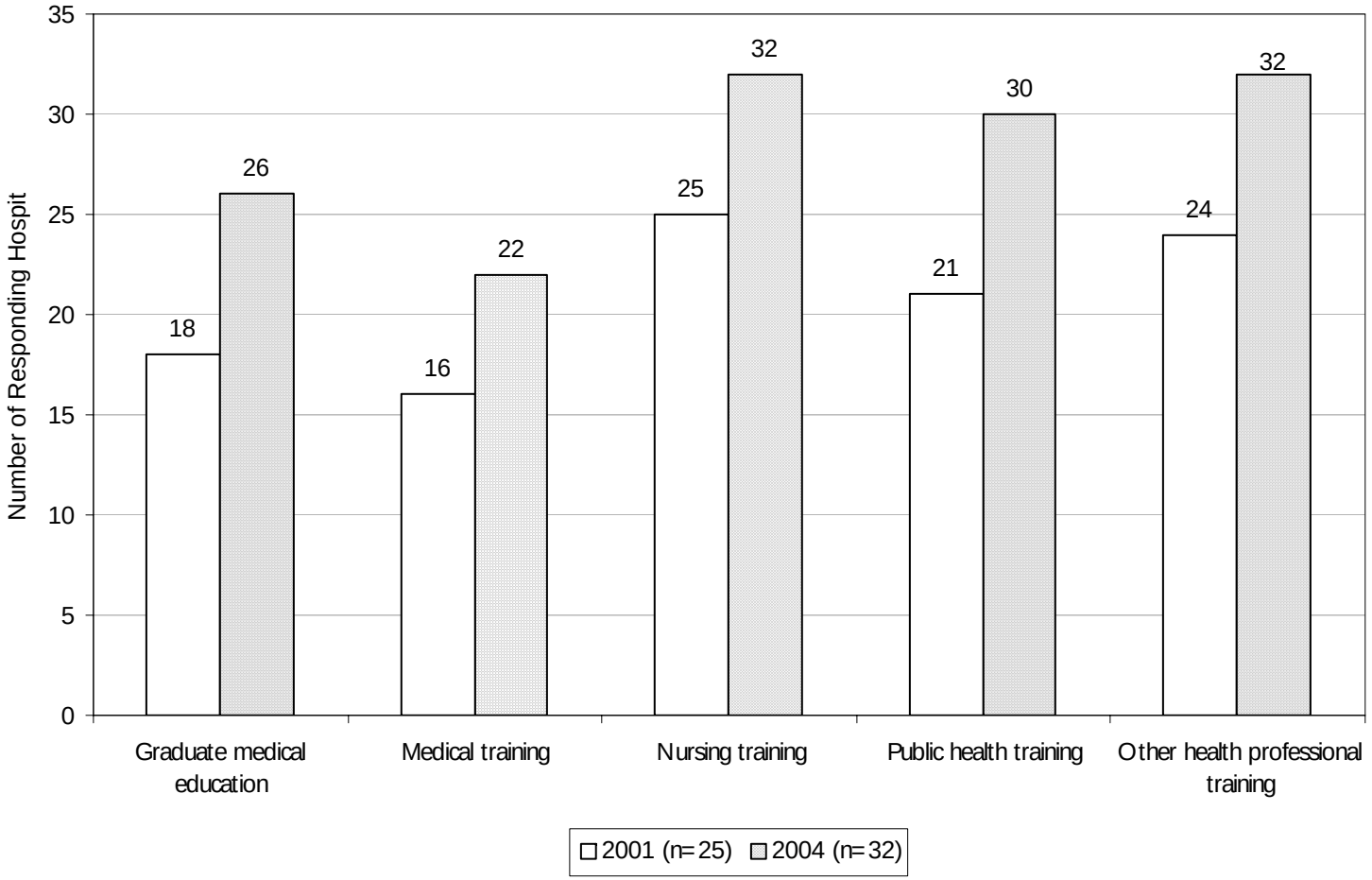


Figure 5: Community Benefit Activity -
Frequency of Support for Safety Net Agencies

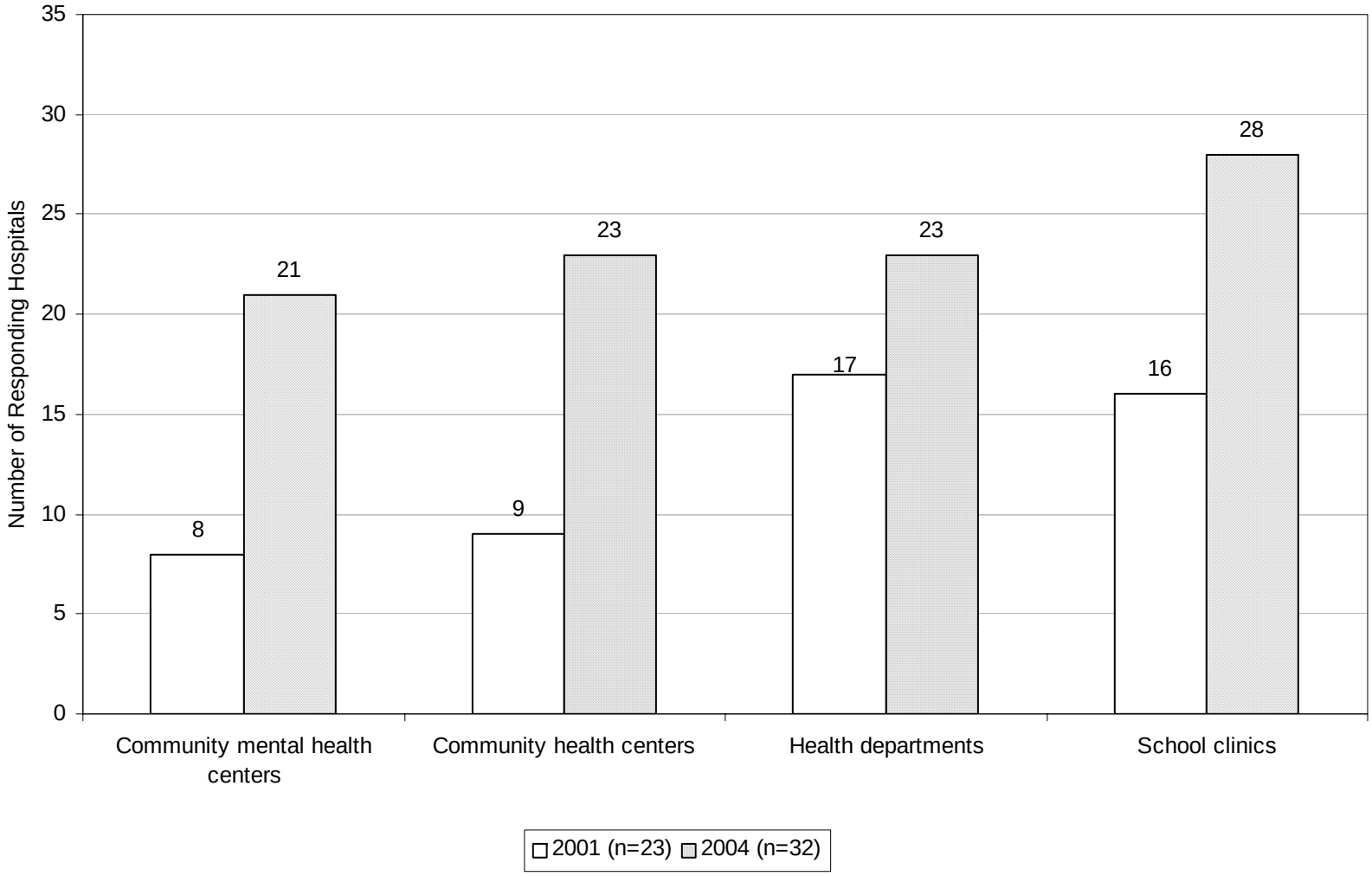


Figure 6: Community Benefit Activity -
Support for Social Service Agencies

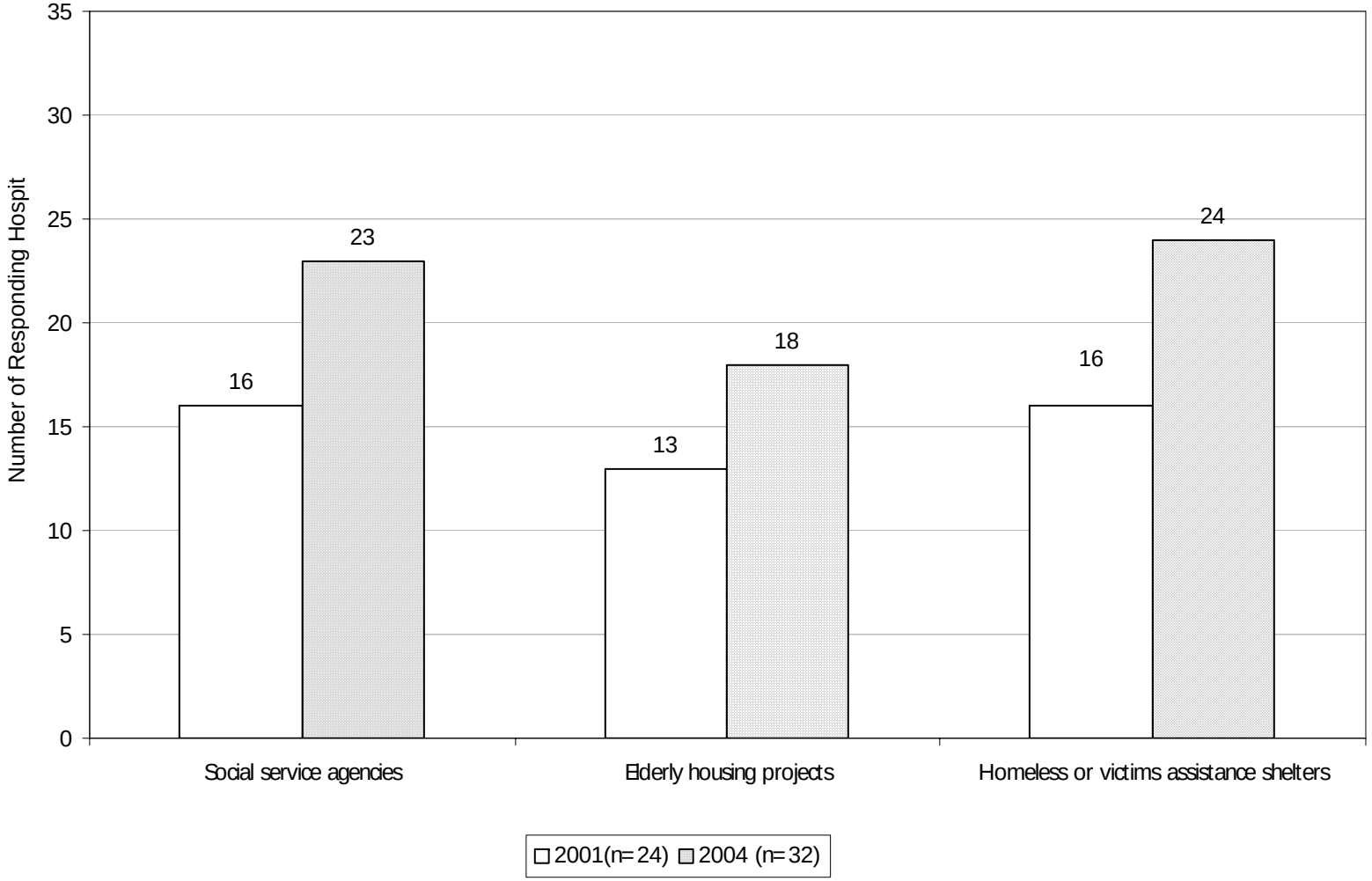


Figure 7: Community Benefit Activity - Support for Family Caregivers

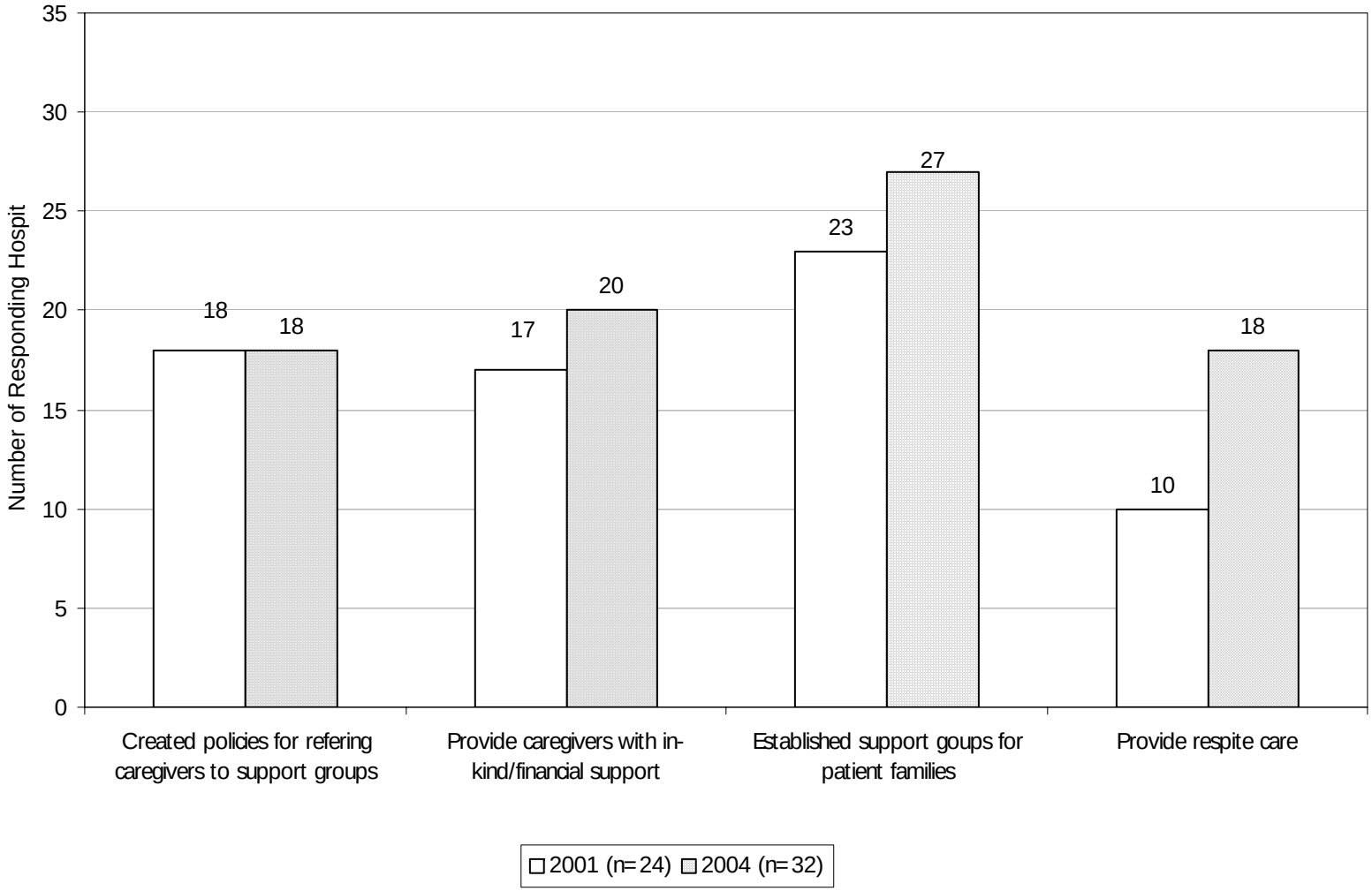


Figure 8: Community Benefit Activity -
Collaboration with Local Public Safety Agencies

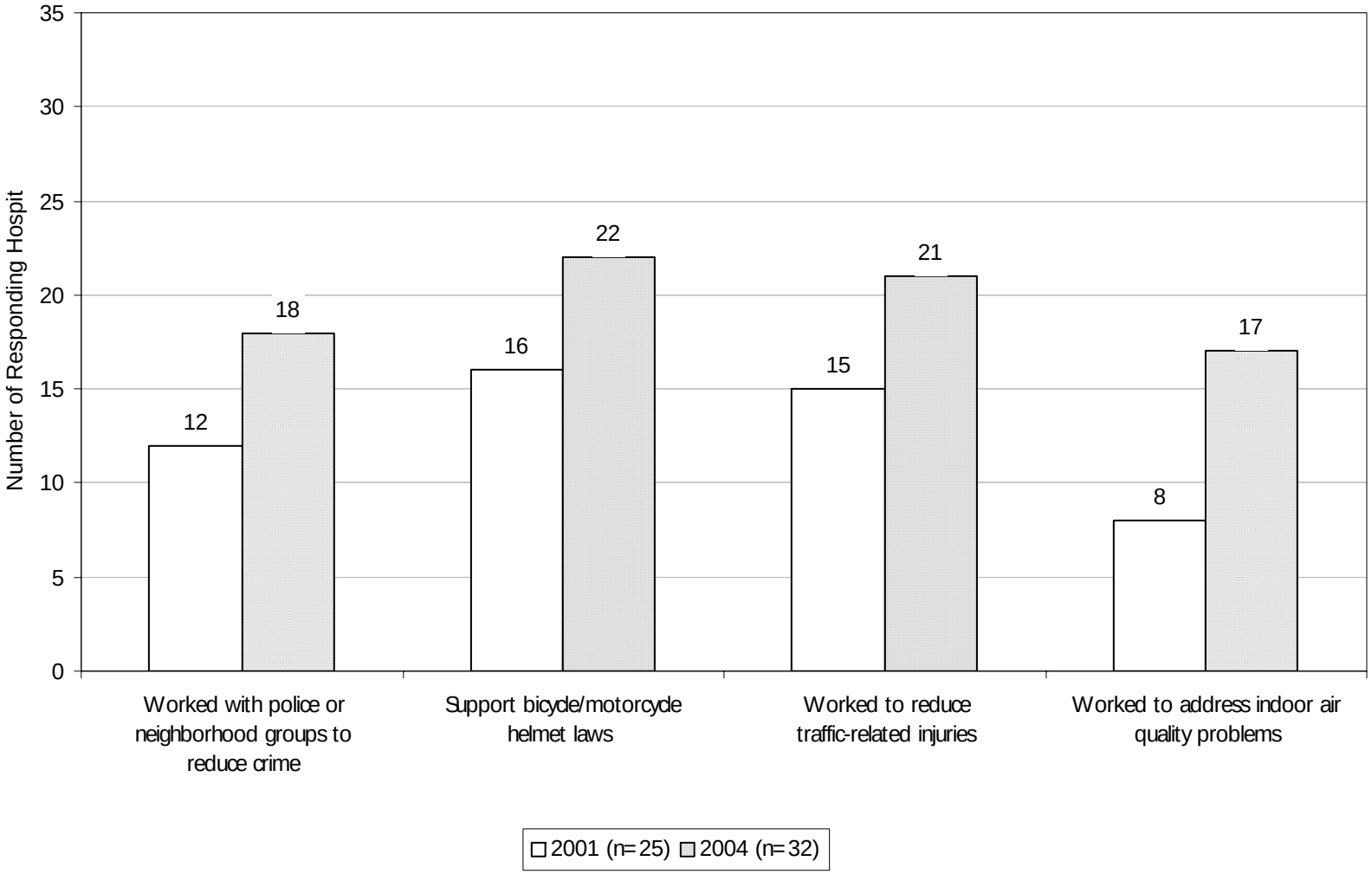


Figure 9: Community Benefit Activity -
Programs to Reduce Health Hazards in the Home

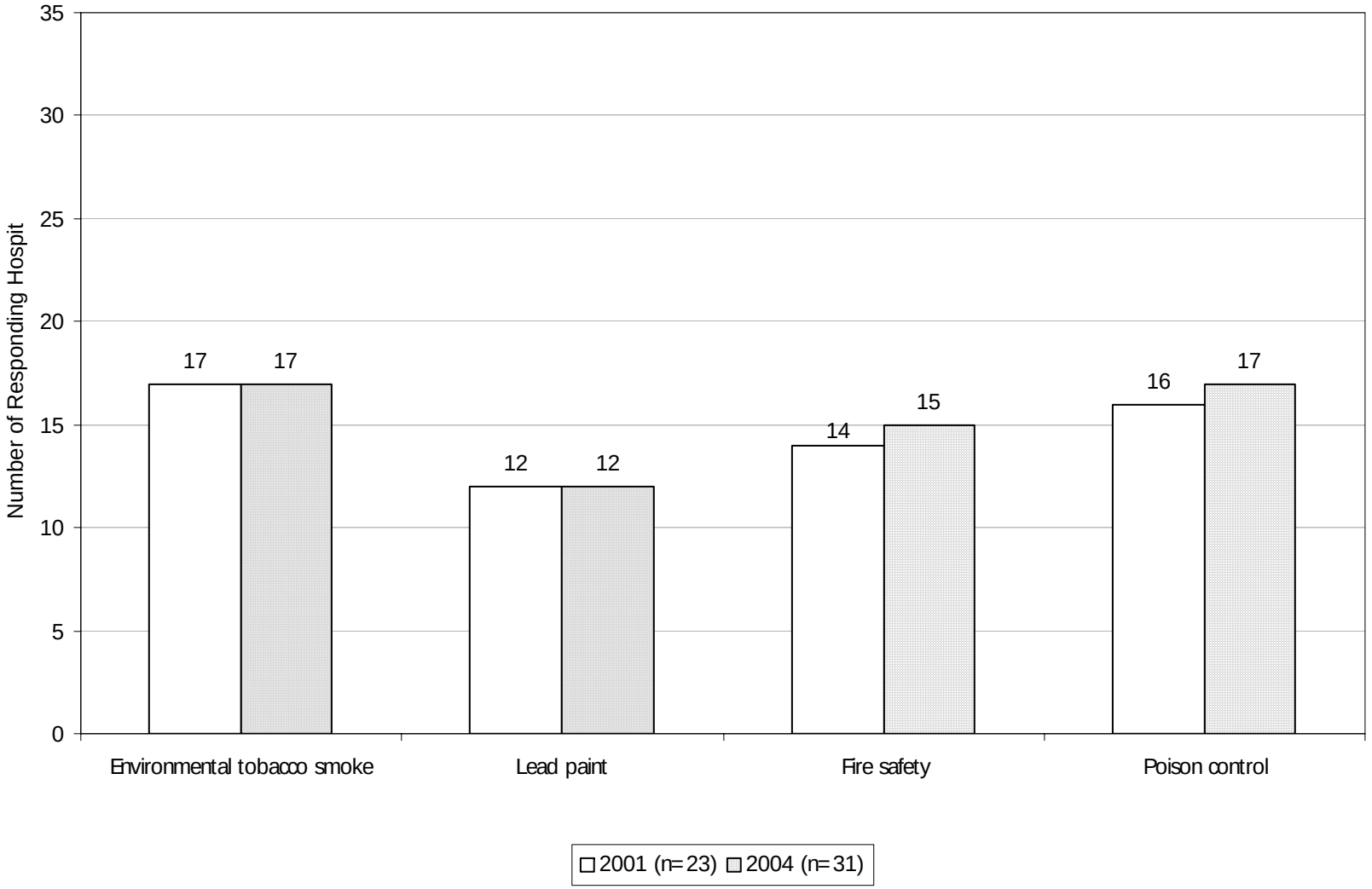


Figure 10: Community Benefit Activity -
Programs to Reduce Transmission of Infectious Diseases

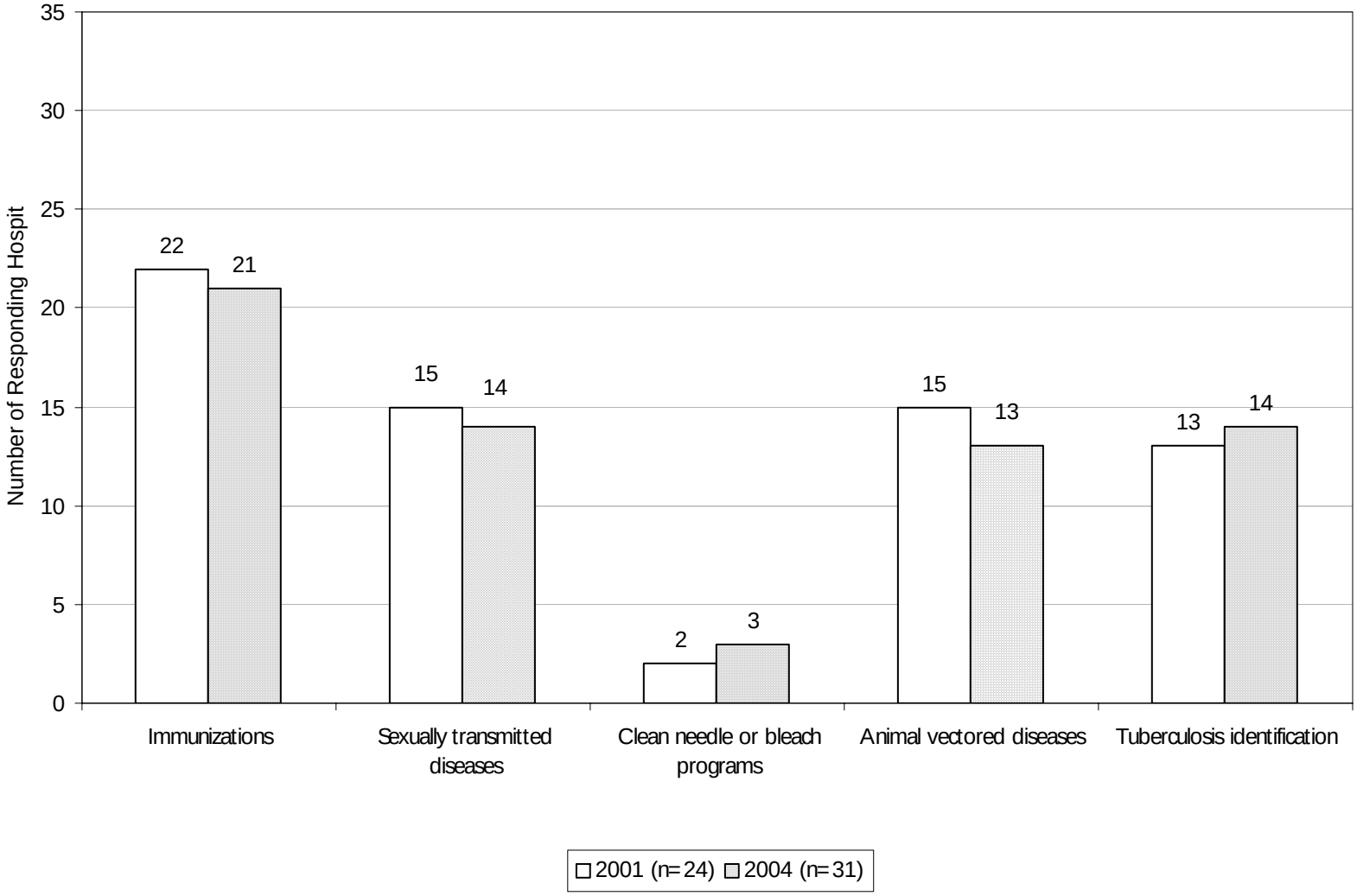


Figure 11: Community Participation in Policy Development for Community Benefit Activities

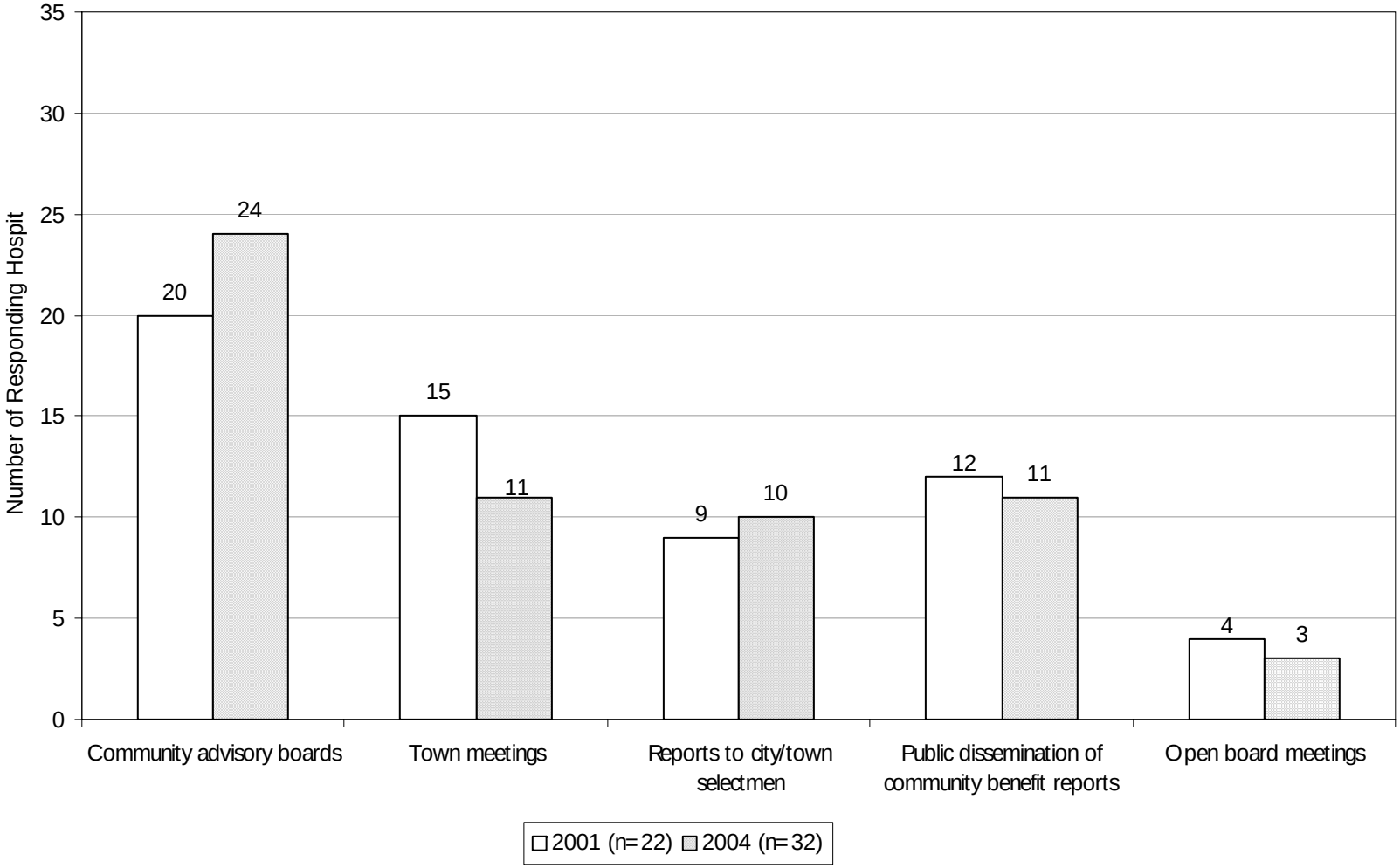


Figure 12: Community Benefit Activity -
Distributing Reports Documenting Community Benefit Activities

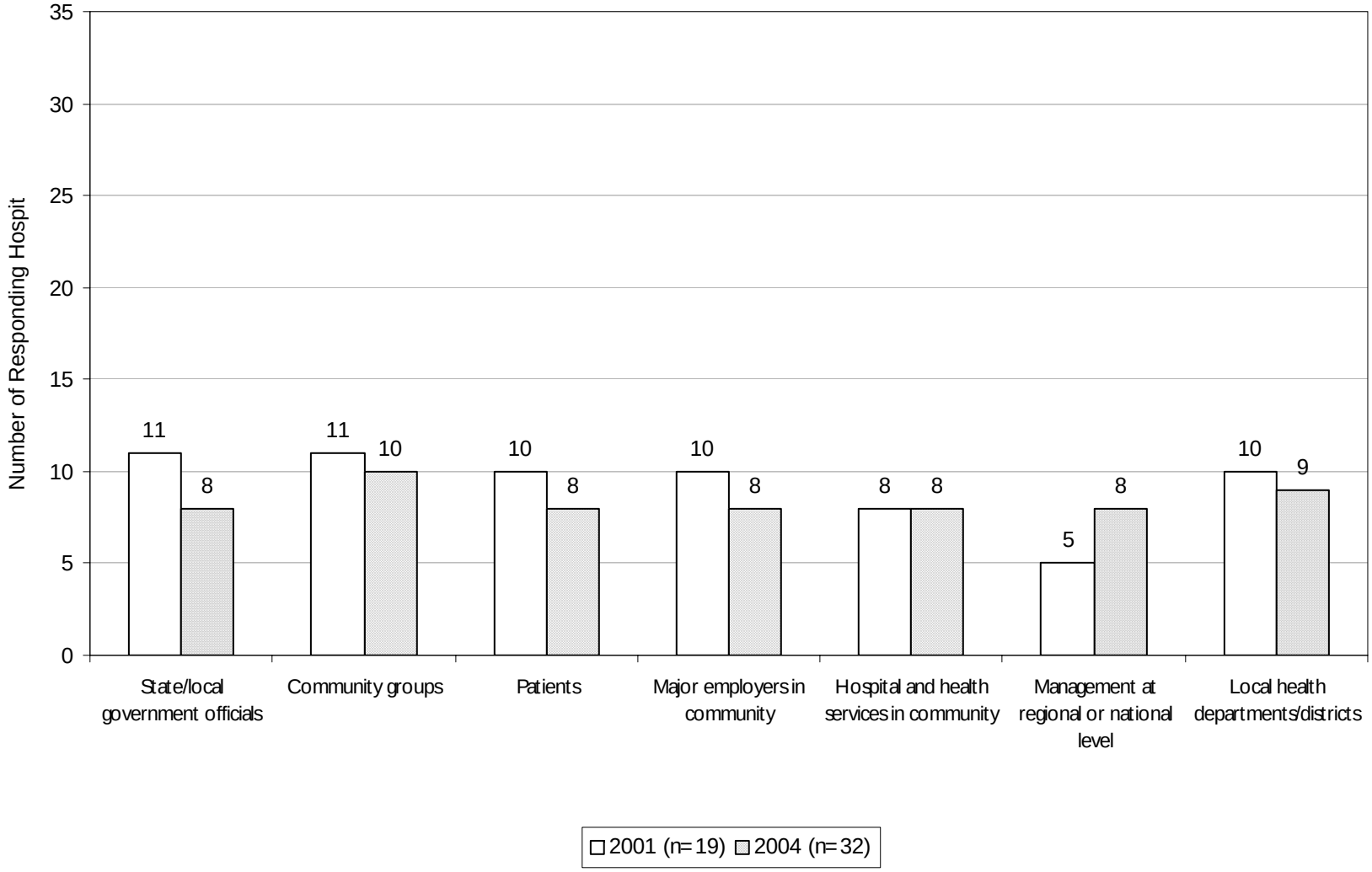
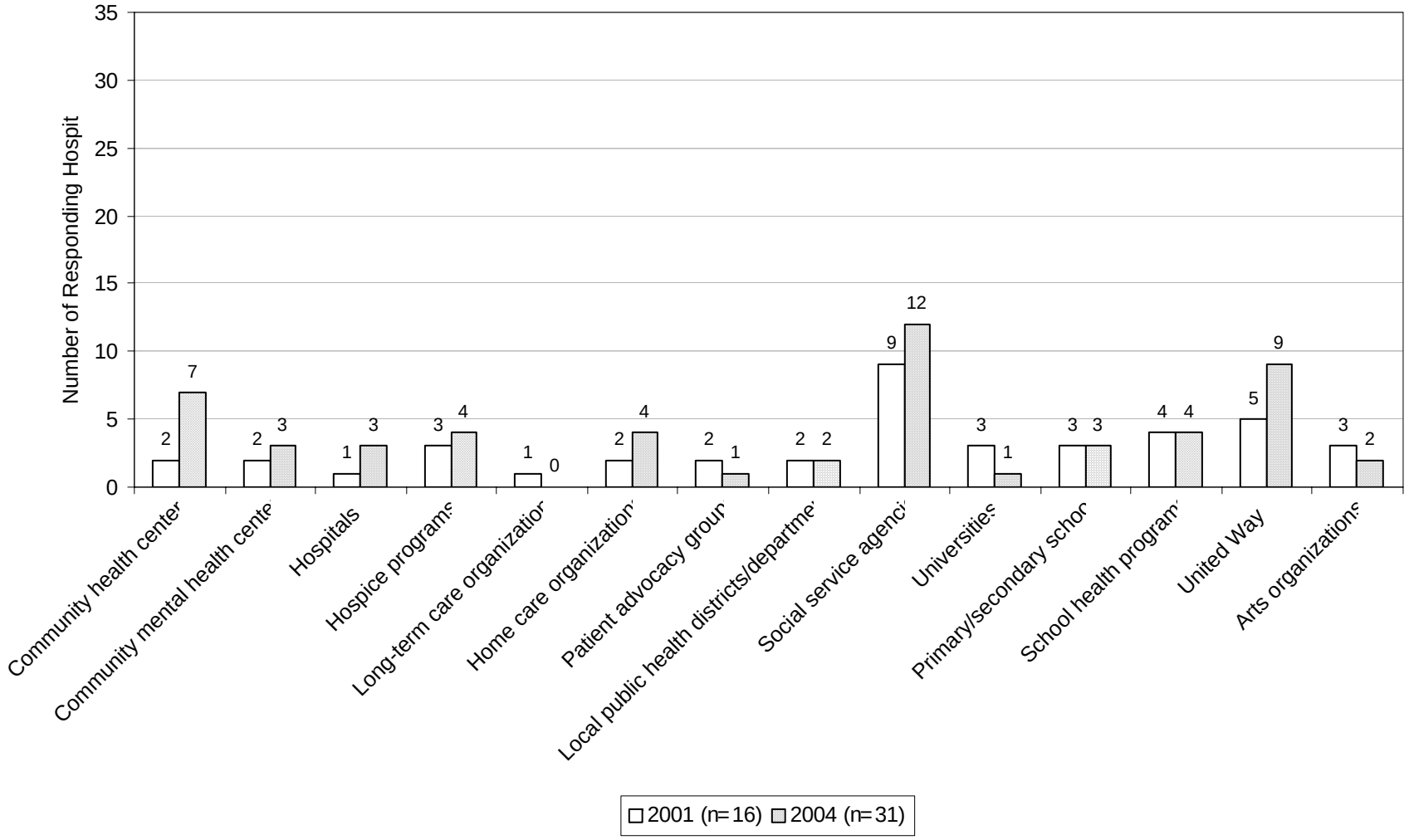


Figure 13: Community Benefit Activity -
Direct Grants to Community Agencies



APPENDICES

Appendix A Connecticut General Statutes, Section 19a-127k

Appendix B Hospitals and Managed Care Organizations Subject to Community Benefits Reporting

Appendix C Year 2004 Community Benefit Survey Respondents

Appendix D Year 2001 and 2004 Community Benefit Hospital Survey Responses

APPENDIX A

CONNECTICUT GENERAL STATUTE

SECTION 19A-127K, COMMUNITY BENEFITS PROGRAMS

(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;

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

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

(b) On or before January 1, 2005, and biennially 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; 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 biennial 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, 2005, and biennially thereafter, the commissioner, or the commissioner's designee, shall make such summary and analysis available to the public upon request.

(f) The commissioner may, after notice and opportunity for a hearing, in accordance with Chapter 54, impose a civil penalty on any managed care organization or hospital that fails to submit the report required pursuant to this section by the date specified in subsection (b) of this section. Such penalty shall be not more than fifty dollars a day for each day after the required submittal date that such report is not submitted.

APPENDIX B

CONNECTICUT HOSPITALS SUBJECT TO SECTION 19A-127K, C.G.S.

Bradley Memorial Hospital and Health Center
Bridgeport Hospital
Bristol Hospital, Inc.
Charlotte Hungerford Hospital
Connecticut Childbirth & Women's Center
Connecticut Children's Medical Center
Connecticut Hospice
Danbury Hospital
Day Kimball 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 of the UCONN H.C.
Johnson Memorial Hospital
Lawrence & Memorial Hospital
Manchester Memorial Hospital
Masonic Healthcare Center (chronic)
Masonic Healthcare Center (psychiatric)
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 Hospital and Medical Center
Saint Mary's Hospital
Saint Vincent's Medical Center
Sharon Hospital
Silver Hill Hospital
Stamford Hospital
Veterans' Home and 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 Section 19a-127k, C.G.S. 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 SECTION 19A-127K, C. G.S.

Aetna Life Insurance Co.
Aetna U.S. Healthcare, Inc.
Alta Health & Life Insurance Company
American Republic Insurance Co.
Anthem Blue Cross & Blue Shield
Celtic Insurance Company
CIGNA HealthCare of Connecticut, Inc.
ConnectiCare, Inc.
ConnectiCare Insurance Company, Inc.
Connecticut General Life Insurance Co.
Conseco Medical Insurance Company
First Allmerica Financial Life Ins. Co.
Fortis Benefits Insurance Company
Fortis Insurance Company
GE Group Life Assurance Company
Golden Rule Insurance Company
Guardian Life Insurance Company
Health Net Insurance of Connecticut, Inc.
Health Net of Connecticut, Inc.
John Alden Life Insurance Company
Mutual of Omaha Insurance Company
National Health Insurance Company
New England Life Insurance Company
Nippon Life Insurance Co. of America
Oxford Health Insurance, Inc.
Oxford Health Plans (CT), Inc.
Phoenix Home Life Mutual Insurance Co.
Trustmark Insurance Company
UniCare Life & Health Insurance Company
United HealthCare Insurance Company
United States Life Insurance Co., City of New York

The above entities meet the definition of a "managed care organization" as provided in Section 19a-127k, C.G.S. and Section 38a-478 of the Connecticut General Statutes. ***Source****: Connecticut Department of Insurance*

APPENDIX C

YEAR 2004 COMMUNITY BENEFIT SURVEY RESPONDENTS

	Have CB Program	Submitted CB Survey
Hospitals		
Bridgeport Hospital	X	X
Connecticut Children's Medical Center	X	X
Danbury Hospital	X	X
Greenwich Hospital Association	X	X
Hall-Brooke Hospital*	X	X
Hartford Hospital	X	X
Midstate Medical Center	X	X
Saint Vincent's Medical Center*	X	X
Yale New Haven Hospital	X	X
Bristol Hospital, Inc.		X
Charlotte Hungerford Hospital		X
Gaylord Hospital		X
Griffin Hospital		X
Hospital for Special Care		X
Johnson Memorial Hospital		X
Manchester Memorial Hospital**		X
Masonic Healthcare Center***		X
Masonic Healthcare Center****		X
Hospital of Saint Raphael		X
Middlesex Hospital		X
Milford Hospital		X
Natchaug		X
Norwalk Hospital		X
Rehabilitation Hospital Of Connecticut, Inc.*****		X
Rockville General Hospital**		X
Saint Francis Hospital*****		X
Saint Mary's Hospital		X
Sharon Hospital		X
Stamford Hospital		X
Waterbury Hospital		X
William W. Backus Hospital		X
Windham Community Memorial Hospital		X
Managed Care Organizations		
ConnectiCare, Inc.******	X	X
Aetna Foundation, Inc.*******		X
Total	**10**	**34**

* Saint Vincent's Health Services
** Eastern Connecticut Health Network Insurance Company, Inc.
*** Chronic component
**** Psychiatric component
***** Saint Francis Hospital & Medical Center
****** ConnectiCare, Inc./ConnectiCare
*******Aetna Life Insurance Company & Aetna U.S. Healthcare, Inc.

APPENDIX D

YEAR 2001 & 2004 HOSPITAL COMMUNITY BENEFIT SURVEY RESPONSES

The Community Benefit survey questions and aggregate responses for 2001 & 2004 are listed below. The "n" for each question represents the number of hospitals responding.

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.

1. Does your organization have a distinct program for its community benefit activities in Connecticut, as defined by Section 19a-127k, C.G.S.?

		2001		2004
(n=24)	Yes	7	(n=32)	9
	No	17		23

2. 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?

		2001		2004
(n=24)	Yes	18	(n=26)	25
	No	6		0
	NA	-		1

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

		2001		2004
(n=25)	Yes	4	(n=32)	5
	No	21		27

4. If your organization does have a formal community benefits policy statement, please include it as Attachment A. (n=4)

5. 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?

		2001		2004
(n=22)	Yes	20	(n=30)	28
	No	2		2

6. If your organization's approach to community service is addressed in your mission statement, please include it as Attachment B. (n=22)

7. Provide an identification of the community health needs that were considered in developing and implementing the organization's community benefits program. Include in your responses a prioritized list of the needs identified and a description of the criteria utilized for the prioritization. Please attach your response as Attachment C. (n=11)

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

		2001		2004
(n=25)	Yes	5	(n=31)	6
	No	20		25

9. Does your community benefits program have a formal budget?

		2001		2004
(n=23)	Yes	9	(n=30)	7
	No	14		22
	NA	-		1

10. What was the budget for the community benefits program for calendar 2003 and estimated for calendar 2004? (The range and median are listed)

	2001		2004
(n=12)	-	(n=12)	$0 to $22,047,661
median	$750,000		$1,523,885

11. How much staff time (# of FTE's) is involved in the community benefits program and its activities?

	2001		2004
(n=13)	4.5 median	(n=13)	19 median

12. Operational Community. Please identify the geographic area encompassing the communities that you serve, i.e. your service area.

		2001		2004
The entire state of Connecticut	(n=25)	2	(n=32)	7
Fairfield County		7		10
Hartford County		6		12
Litchfield County		4		6
Middlesex County		3		3
New Haven County		9		10
New London County		2		4
Tolland County		1		4
Windham County		3		5

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

		2001		2004
(n=25)	Never	1	(n=30)	2
	Rarely	0		2
	Sometimes	5		4
	Often	13		17
	Always	4		4
	Unable to determine	2		1

14. Within your service area, how frequently do you target your community benefit activities to neighborhoods with high immigrant populations?

		2001		2004
(n=25)	Never	0	(n=30)	2
	Rarely	1		3
	Sometimes	7		5
	Often	10		15
	Always	2		2
	Unable to determine	5		3

15. Within your service area, how frequently do you target your community benefit activities to neighborhoods with populations at risk of particular illness?

		2001		2004
(n=25)	Never	0	(n=30)	3
	Rarely	1		0
	Sometimes	6		6
	Often	12		17
	Always	3		2
	Unable to determine	3		2

16. Within your service area, how frequently do you target your community benefit activities to populations living in inner cities?

		2001		2004
(n=24)	Never	4	(n=30)	5
	Rarely	2		5
	Sometimes	3		1
	Often	9		12
	Always	4		4
	Unable to determine	2		3

17. Within your service area, how frequently do you target your community benefit activities to populations who live in rural areas?

		2001		2004
(n=25)	Never	9	(n=31)	8
	Rarely	5		10
	Sometimes	3		6
	Often	3		5
	Always	3		1
	Unable to determine	2		1

18. Within your service area, how frequently do you target your community benefit activities to those who live in federally-designated medically underserved communities?

		2001		2004
(n=24)	Never	0	(n=31)	5
	Rarely	2		2
	Sometimes	5		2
	Often	11		15
	Always	4		4
	Unable to determine	2		3

19. Within your service area, how frequently do you target your community benefit activities to neighborhoods with concentrated racial minorities?

		2001		2004
(n=24)	Never	1	(n=30)	3
	Rarely	0		1
	Sometimes	6		4
	Often	12		15
	Always	2		4
	Unable to determine	3		3

20. Does your organization have programs or policies that allow residents in Connecticut to receive free or subsidized health services under some circumstances?

		2001		2004
(n=24)	Yes	23	(n=32)	30
	No	1		2

21. Approximately how many residents received free or subsidized services under the auspices of your program? (Your best estimate is fine.)

		2001		2004
(n=20)	median	4,900	(n=26)	median 4,137
	total	-		Total 177,892

22. Which of the following clinical services are provided on a free or subsidized basis? (2001, n=23; 2004, n=32)

	2001	2004
Immunizations	22	24
Prenatal or peri-natal care	20	23
Physical exams for adults	17	18
Counseling or mental health	23	24
Substance abuse treatment	16	19
Clinical preventive services (e.g. hypertension screening)	22	29
Other preventive services (breast, colorectal cancer)	21	26
Other outpatient medical or surgical services	22	28
Other clinical services we have not mentioned?	18	22
Wellchild care	17	20
Dental services	12	16
Pharmaceuticals	15	18
Inpatient care	23	30

23. 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?

		2001		2004
(n=24)	Yes	22	(n=32)	26
	No	2		5
	NA	-		1

24. Which of the following prevention activities has your organization made available to the general public? (2001, n=24; 2004, n=31)

	2001	2004
immunization programs?	22	21
sexually transmitted disease prevention programs?	15	14
clean needle or bleach programs for IV drug users?	2	3
animal vectored diseases (rabies, Lyme disease)?	15	13
tuberculosis identification programs?	13	14

25. Has your organization provided financial, technical, or other support for any community mental health centers in Connecticut?

		2001		2004
(n=22)	Yes	8	(n=32)	21
	No	14		11

26. Has your organization provided any financial, technical, or other support for any community health centers in Connecticut?

		2001		2004
(n=23)	Yes	9	(n=32)	23
	No	14		9

27. Has your organization provided any financial, technical, or other support for any local health departments or regional health districts in Connecticut?

		2001		2004
(n=23)	Yes	17	(n=32)	23
	No	6		9

28. Has your organization provided financial, technical, or other support for social service agencies in Connecticut?

		2001		2004
(n=24)	Yes	16	(n=32)	23
	No	8		9

29. Was your organization involved with either homeless shelters or victim assistance programs in Connecticut? Note: Involvement may include serving on the board.

		2001		2004
(n=24)	Yes	16	(n=32)	24
	No	8		8

30. Did your organization operate any healthcare programs in elderly housing projects in Connecticut?

		2001		2004
(n=24)	Yes	13	(n=32)	18
	No	11		14

31. Did your organization provide 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.

		2001		2004
(n=23)	Yes	16	(n=32)	28
	No	7		4

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

		2001		2004
(n=25)	Yes	24	(n=32)	32
	No	1		0

33. Which of the following issues were addressed over the past year in your community-based health education programs in the state? (2001, n=24; 2004, n=32)

	2001	2004
Addressing domestic violence and other abuse?	21	24
Abuse of alcohol or other illicit drugs?	24	22
Identifying depression?	23	24
Health promotion for adolescents?	21	22
Encouraging safer sexual behavior?	15	17
Reducing unintentional injury?	20	25
Reducing smoking and other tobacco use?	23	21
Addressing diet and other forms of cholesterol control?	23	25
Encouraging exercise?	24	27
Encouraging better nutrition?	24	27
Encouraging weight control?	23	27
Cancer screening?	22	26
Hypertension detection and control?	22	24
Need for prenatal care?	23	24

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

		2001		2004
(n=25)	Yes	18	(n=32)	26
	No	7		6

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

		2001		2004
(n=25)	Yes	16	(n=32)	22
	No	9		10

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

		2001		2004
(n=25)	Yes	25	(n=32)	32
	No	0		0

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

		2001		2004
(n=25)	Yes	21	(n=32)	30
	No	4		2

38. 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)?

		2001		2004
(n=25)	Yes	24	(n=32)	32
	No	1		0

39. Has your organization operated or subsidized any of the following programs in the past year in this state? (2001, n=25; 2004, n=32)

	2001	2004
Health literacy programs?	15	18
Health education programs for immigrants?	8	13
Information programs about eligibility for social welfare	18	18
Health fairs?	24	28

40. What are your organization's practices regarding informal caregivers--that is, friends and family members who provide care to patients. (2001, n=24; 2004, n=32)

	2001	2004
created policies for referring caregivers to support groups?	18	18
provided financial or in-kind support to such groups?	17	20
established support groups for patients' families?	23	27
provided respite care?	10	18

41. Has your organization carried out the following types of activities in Connecticut? Indicate . . (2001, n=25; 2004, n=32)

2001	Not at all	Sometimes	A great deal
worked with police or neighbor hood groups to reduce crime?	12	9	3
publicly supported bicycle or motorcycle helmet laws?	7	9	7
worked to reduce traffic-related injuries?	10	9	6
worked to address indoor air quality problems?	17	7	1

2004	Not at all	Sometimes	A great deal
worked with police or neighbor hood groups to reduce crime?	14	10	8
publicly supported bicycle or motorcycle helmet laws?	10	10	12
worked to reduce traffic-related injuries?	11	7	14
worked to address indoor air quality problems?	15	13	4

42. Does the Community Benefit program have a component that addressed reducing any of the following home-based environmental health hazards? (2001, n=23; 2004, n=31)

	2001	2004
Environmental tobacco smoke	17	17
Lead paint	12	12
Fire safety	14	15
Poison control	16	17

43. Were grants made available to any of the following types of organizations? (2001, n=16; 2004, n=31)

	2001	2004
Community health centers	2	7
Community mental health centers	2	3
Hospitals	1	3
Hospice programs	3	4
Long term care organizations	1	0
Home care organizations	2	4
Patient advocacy groups	2	1
Local public health districts or departments	2	2
Social service agencies	9	12
Universities	3	1
Primary/secondary schools	3	3
School health programs	4	4
United Way or other federated giving programs	5	9
Arts organizations (visual or performing)	3	2

44. Does your organization evaluate the success of its community benefits activities?

		2001		2004
(n=24)	Yes	20	(n=32)	20
	No	4		10
	NA	-		2

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

		2001		2004
(n=24)	Yes	9	(n=32)	10
	No	15		20
	NA	-		2

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

		2001		2004
(n=24)	Yes	18	(n=32)	23
	No	6		8
	NA	-		1

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

		2001		2004
(n=24)	Yes	12	(n=32)	13
	No	12		18
	NA	-		1

48. Which of the following mechanisms are used by your organization to allow for community involvement? (2001, n=22; 2004, n=32)

	2001	2004
Advisory boards drawn from the local community	20	24
Town meetings with the public	15	11
Reports to city or town boards of selectmen	9	10
Public dissemination of community benefit reports	12	11
Open board meetings	4	3

49. Is your community benefit report regularly sent to any of the following groups or organizations? (2001, n=19; 2004, n=32)

	2001	2004
State regulatory agencies?	4	7
State or local government officials?	11	8
Community groups?	11	10
Patients	10	8
Major employers in the community?	10	8
Hospital and health services in the community?	8	8
Management at the regional or national level?	5	8
Local health departments or districts?	10	9