Reporting of Community Benefits by Hospitals and Health Plans in Connecticut for Calendar Year 2001

Second Annual Report to the General Assembly, State of Connecticut

October 1, 2002

Connecticut Department of Public Health
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INTRODUCTION

Pursuant to Section 19a-127k of the Connecticut General Statutes (Appendix A), each hospital and managed care organization (MCO) in Connecticut is required to annually report to the Department of Public Health (DPH) whether or not they have a community benefit program (Appendix B). Hospitals or organizations that have community benefit programs are required to report the details of their program activities each year. Beginning in 2001, DPH is responsible for analyzing and preparing a summary of the community benefit reports and making the report available to the public.

YEAR 2000 SURVEY AND REPORT

In 2000, the DPH contracted with the Yale University, School of Medicine, Department of Epidemiology and Public Health, to develop the first community benefit survey and report. Two slightly different surveys were designed to reflect the differences in organizational focus between hospitals and MCOs. The survey addressed 21 different aspects of community benefit activity originating from four models of beneficial relationships between health care organizations and the communities they serve (Appendix C).

Twenty-three out of 43 eligible hospitals completed surveys on their community benefit activities in calendar year 2000, and the state's first community benefit activities report was issued on September 12, 2001.[1] None of the 36 eligible MCOs reported community benefit programs in 2000 (Appendix D).

The most common activities reported by responding hospitals in 2000 were free or subsidized health services, and education programs for allied health care professionals or the general public. A moderate degree of community benefit activity supported safety net providers, social service agencies, and family caregivers, and minimal community benefit activity supported improving the affordability of health care insurance through subsidized premiums.

The Year 2000 report recommended modifications to the community benefit program legislation to achieve greater participation from the hospitals and MCOs and to assure the reliability and validity of the reported data (Appendix E).

YEAR 2001 SURVEY AND REPORT

DPH's Office of Health Care Quality and Best Practices assumed responsibility for the community benefit program in 2001. The Year 2001 report presents: 1) the 2001 survey; 2) a description of the community benefit activities reported by the hospitals and one MCO for 2001; and 3) recommendations for the continued implementation of the community benefit program.

By statute, Connecticut hospitals and MCOs are required to report annually whether or not they have a community benefit program. If one of these organizations has a community benefit program, it must complete a survey. An organization may also voluntarily complete a survey even if it does not have a community benefit program.

The Year 2000 hospital and MCO survey forms were used again in the Year 2001 report. The original format and organization of the Year 2000 report were repeated in this report to maintain continuity for the reader.

A list of organizations required to report their activities to the DPH was developed from information

[1] Schlesinger, M., K. Mattocks. *Reporting of Community Benefits by Hospitals and Health Plans in Connecticut for the Calendar Year 2000.* Department of Epidemiology and Public Health, Yale University, School of Medicine. September 12, 2001.

provided by the DPH Bureau of Regulatory Services and the Connecticut Department of Insurance (Appendix B). Community benefit surveys were sent to 42 acute care inpatient and specialty hospitals and 34 MCOs at the end of July, 2002.

Twenty-six out of 42 hospitals completed the 2001 Community Benefits Survey. Eight hospitals had a community benefit program and were required to submit a survey, while 18 hospitals voluntarily completed a survey. One out of 34 MCOs reported it had a community benefit program and submitted a survey (Appendix F). A single survey was submitted for Rockville General and Manchester Memorial Hospitals as the Eastern Connecticut Health Network, and Saint Francis Hospital and Medical Center submitted a joint survey for St. Francis Hospital, the Rehabilitation Hospital of Connecticut, Inc., and Saint Francis Care Behavioral Health. Appendix G includes the hospital survey questions and aggregate hospital responses. The reader is reminded that all data are self-reported without independent verification or audit.

COMMUNITY BENEFIT ACTIVITIES

In general, the "community benefit" concept, as applied to hospitals and MCOs, refers to the efforts made by these organizations to improve and maintain the health of the people living in their communities. This may include developing strategies, policies, and guidelines to promote preventive care and improving the health status of their communities, especially for at-risk populations.

The scope of community benefit activities varies widely, ranging from subsidized health services to encouraging employee philanthropy. The community benefit activities described by survey respondents are summarized below and by Figures 1-19. The hospital responses across years were not compared, because the number of respondents differed between years and between questions. The information should be taken as a general indication of community benefit activity.

The median year for the beginning of the community benefit programs among the responding hospitals was 1985. Fifteen hospitals reported a median budget of $750,000 for community benefit and a median of 4.5 full-time equivalents (FTEs) involved in such activities. Fourteen hospitals expect to increase their community benefit activities, 7 will remain the same, and 1 expects to decrease activities in the future.

This report groups the data results under three category headings: 1) Most Prevalent Community Benefit Activities, 2) Moderately Supported Community Benefit Activities, and 3) Minimally Supported Community Benefit Activities. 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%).

MOST PREVALENT COMMUNITY BENEFIT ACTIVITIES

In 2001, the responding Connecticut hospitals were actively involved in the following community benefit activities; a) provision of free or subsidized health services; b) educational programs for the general public; c) required training for affiliated health care providers; d) training sites for health care professionals; and e) initiatives fostering philanthropy or volunteering among employees.

Free or Subsidized Health Treatment Services: The frequency of hospitals providing free or subsidized health services varied by specific area during 2001. All of the responding hospitals reported they provided free or subsidized service in the areas of inpatient care and counseling or mental health. Only half provided free or subsidized dental services (Figure 4). In aggregate, the reporting hospitals spent slightly more than $219 million in this category, ranging from $143,750 to $64 million. The median expenditure amount was $2,925,000, providing subsidized services for a median of 4,900 residents.

Health Education in the Community: With the exception of one facility, all responding hospitals provided health education programs. All responding hospitals offered education in 3 areas: alcohol or drug

abuse, exercise, and nutrition (Figure 5). Less than two-thirds of responding hospitals offered education for safe sex. A median of $400,000 was spent on education programs with 50% available for the general public. Aggregate hospital spending for community health education was an estimated $15.2 million. Some hospitals indicated that no money was spent on community health education.

Required Training for Affiliated Health Care Providers: Eight out of 10 hospitals required their affiliated health care providers to be trained in the following community programs: domestic violence, smoking cessation, exercise, nutrition, and weight-control (Figure 6).

Provide a Training Site for Health Care Professionals: All of the responding hospitals provided a training site for nursing training (Figure 7). Four out of 5 hospitals offered a site for public health students and 2 out of 3 hospitals provided a site for graduate and undergraduate medical training.

Stimulating Philanthropy Among Employees: Nearly all of the responding hospitals indicated that they had made facilities available to charitable groups, recognized employees' community service, and promoted volunteerism among employees. In contrast, only two hospitals indicated that they had programs for matching employees' charitable contributions (Figure 8).

MODERATELY SUPPORTED COMMUNITY BENEFIT ACTIVITIES

Nine categories of community benefit activities were reported as moderately supported by hospitals. They include; a) reducing the transmission of infectious diseases, b) support for safety-net providers; c) support for social service agencies in the community; d) needs assessments, e) support for family caregivers of patients; f) disseminating reports about community benefit activities; g) initiatives to address health hazards in the home; h) working with public safety agencies; and i) setting community benefit program policy.

Programs to Reduce Transmission of Infectious Diseases: While 22 out of 24 responding hospitals provide immunization programs to the general public, approximately two-thirds engaged in programs targeted to specific health problems – the most frequent being programs to limit the spread of sexually transmitted and animal-vectored diseases. The least common of these programs involved needle exchange programs, found at only 2 of the hospitals (Figure 9).

Support for the Safety-Net Agencies: In 2001, hospital support for safety-net providers was varied. Two-thirds of the reporting hospitals supported health departments and school clinics. Only 1 in 3 hospitals supported community mental health or community health centers (Figure 10). The most common form of support for all safety-net providers involved technical assistance.

Support for Social Service Agencies: Two out of 3 responding hospitals assisted social service agencies, while one out of 2 hospitals operated health care projects in elderly housing projects (Figure 11). Only 1 in 3 hospitals operated healthcare programs in homeless shelters or victim assistance programs in Connecticut.

Needs Assessments: Nearly 2 out of 3 responding hospitals conducted a systematic health needs assessment in the past year. The assessments could focus on a particular neighborhood, a particular condition, or be a general study. The facilities were not required to identify the type of assessment. A median of 5 FTEs was devoted to conducting the assessments.

Support for Family Caregivers: Nearly all of the reporting hospitals established support groups for patient families, while 4 in 10 offered respite services. Three out of 4 reporting hospitals created policies for referring family caregivers to support groups or provided caregivers with in-kind or financial support (Figure 12).

Distributing Reports Documenting Community Benefit Activities: Over half of the responding hospitals in the state have reports that summarize their community benefit activities. These are most frequently

distributed to community groups and local government officials (Figure 13).

Programs to Reduce Health Hazards in Homes: Three out of 4 responding hospitals participated in or supported programs to reduce home health hazards. Their efforts were most frequently directed at either second-hand tobacco exposure or poison control (Figure 14). Heating subsidy programs were only provided by 2 responding hospitals.

Collaboration with Local Public Safety Agencies: Three out of 5 reporting hospitals promoted helmet use for bicyclists and motorcycle riders, and worked to reduce traffic-related injuries. Half of the hospitals worked with police or neighborhood groups to reduce crime. Only 1 in 3 hospitals worked to address air quality problems (Figure 15).

Community Participation in Policy Development for Community Benefit Activities: Twenty out of 22 responding hospitals used community advisory boards to develop community benefit policies. Fifteen hospitals used town meetings with the public (Figure 16). Hospital patients and providers, local residents and physicians were reported to have considerable influence in setting community benefit activities.

MINIMALLY SUPPORTED COMMUNITY BENEFIT ACTIVITIES

A third set of community benefit activities that are important unmet aspects of population health were rarely found among Connecticut hospitals. These include: a) mentoring programs for potential employees, b) subsidizing premiums health insurance, c) addressing local environmental issues, and d) direct grants from the hospital to various community-based groups.

Mentoring Programs for Potential Employees: Three out of 5 responding hospitals have programs designed to give special attention to the employment, training, or mentoring of disadvantaged groups in Connecticut. They were most frequently directed at residents of low-income communities or people with physical handicaps (Figure 17). Only 3 hospitals give attention to training immigrant groups.

Subsidized Premiums for Health Insurance: Fewer than 1 in 6 reporting hospitals support programs to subsidize health insurance. The subsidies covered the insurance costs of only 40 Connecticut residents in 2001.

Addressing Local Environmental Issues: Only 5 out of 15 responding hospitals addressed water pollution issues as a community benefit activity (Figure 18). The environmental threats of pesticides, noise pollution, and food safety evoked the least hospital involvement.

Direct Grants to Community Agencies: Less than half of the reporting hospitals (9 out of 16) provided grants to community agencies. Social service agencies received grant support from all 9 hospitals followed by the United Way who received grants from 5 hospitals (Figure 19). Thirteen hospitals reported that they spent a median of $23,530 on grants to community agencies in the past year.

SUMMARY OF THE MANAGED CARE ORGANIZATION SURVEY

ConnectiCare is the first MCO to submit a community benefit survey in Connecticut. Its stated policy is: "to participate in the betterment of the communities in which the company conducts business and provides service to its members." The community benefit program at ConnectiCare began in 1985, and last year $30,000 and one-half of a full-time equivalent was allocated to its activities. The company reports that its service area encompasses the entire state and that its community benefit activities often target special populations living in inner cities.

ConnectiCare estimated that $1 million was spent on making health education resources available to members and the general public in 2001. Prenatal care was addressed through community-based health education programs in the state. The company encourages its health care providers to receive training in

many areas, including exercise, nutrition, and cancer screening, and it provided educational or internship opportunities for a few students during 2001. The company also reports that academic researchers, government agencies, and commercial enterprises have been granted access to its data for research purposes.

Grants are provided to some organizations, such as hospice programs, United Way, and social service agencies, but not to hospitals, long term care organizations, or universities. ConnectiCare matches its employee charity contributions.

ConnectiCare is planning to continue to target its community benefit program to special populations and is likely to increase its focus on community benefit activities in the areas of health professional education, health-related research, and collaboration with local public health agencies. Local residents, local physicians, and local business groups were noted as having limited or some influence over the nature of the company's community activities. The MCO allows for community participation in advisory boards to develop policies related to community benefit activities.

SUMMARY AND RECOMMENDATIONS FOR THE COMMUNITY BENEFIT REPORTING PROGRAM

This second annual report summarizes the community benefit activity data submitted to the DPH by 26 of Connecticut's hospitals and 1 MCO for 2001. As in the initial survey, the data demonstrate the wide scope and variety of community health benefit activities currently provided to local communities.

Participation in the second annual survey increased by 3 hospitals and one managed care organization, however, full participation in the community benefit survey remains an important challenge for the DPH Community Benefit Reporting Program.

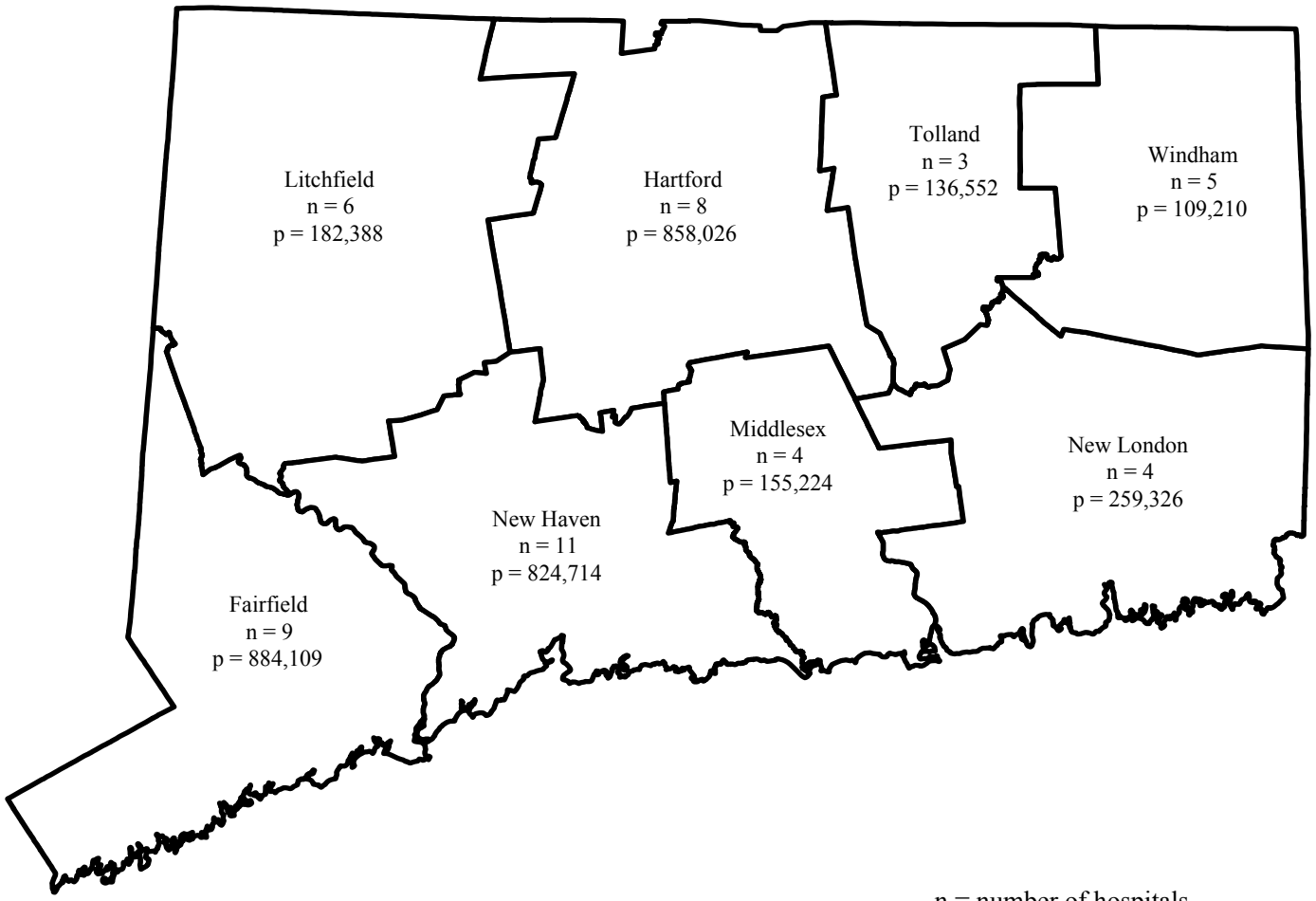
Survey completion did not appear as a major obstacle this year, as only a few organizations commented that the amount of information needed to complete the survey was "extensive." Assuring the validity and reliability of reported data remains a problem, as there are no staffing resources allocated to validate the data or perform site audits.

Logistically, there were considerable problems with the 2000 electronic survey reporting process, that were subsequently addressed by eliminating "on-line" surveys. In 2001, the process was simplified by allowing the submission of paper or electronic surveys.

Because three-quarters of the responding hospitals expect to maintain their community benefit activities over the next year, it is recommended that the community benefit program legislation be modified to require survey completion once every two years. This modification will benefit the hospitals and MCOs by reducing their reporting burden and encourage greater reporting participation in the program.

FIGURES

Figure 1: Geographic Areas Served by Hospitals Participating in the 2001 Community Benefit Survey (by county)



n = number of hospitals
p = DPH 7-1-2000 population estimate

Figure 2A: Community Benefit Activities Targeted to Medically Underserved Areas

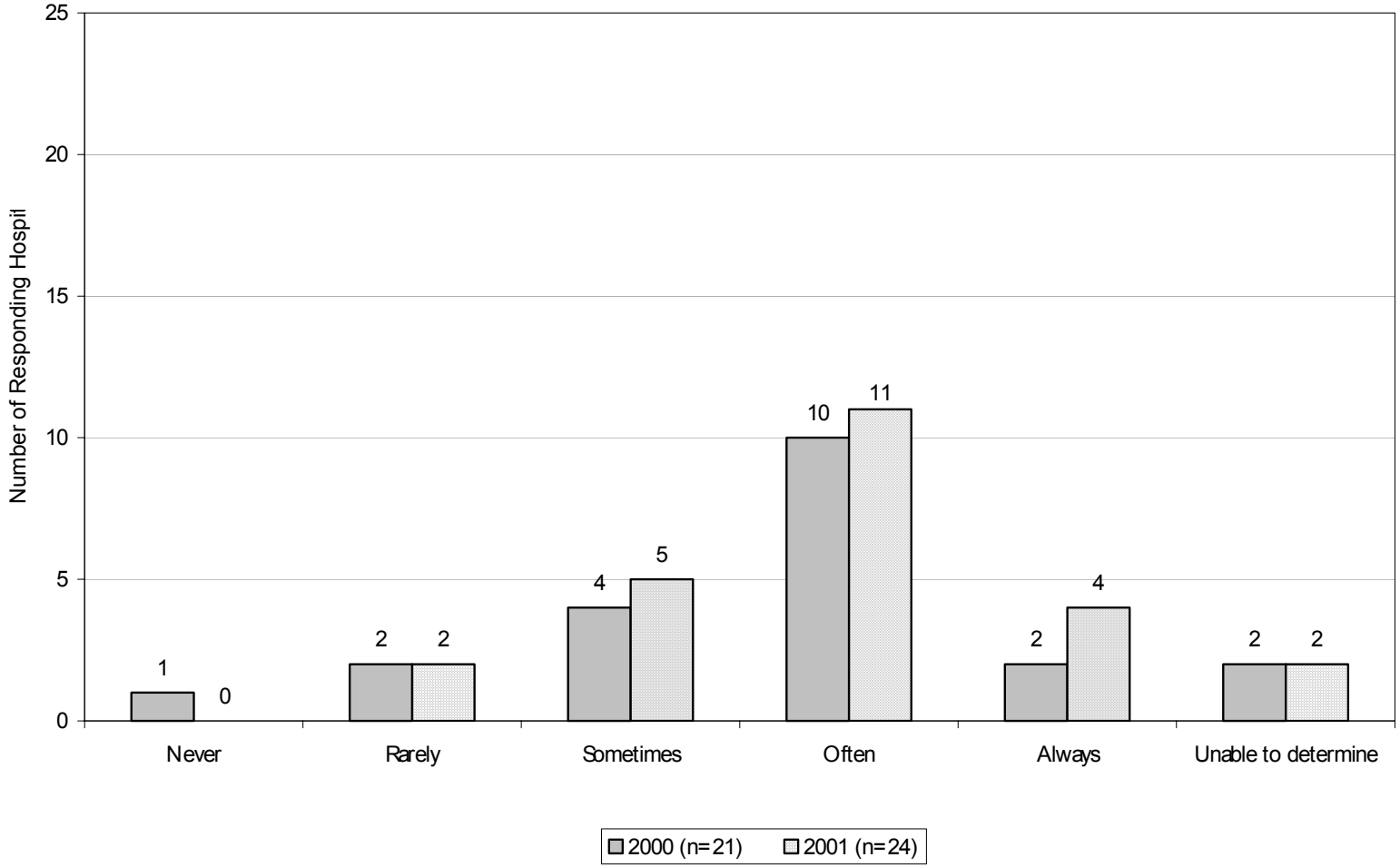


Figure 2B: Community Benefit Activities Targeted to Rural Areas

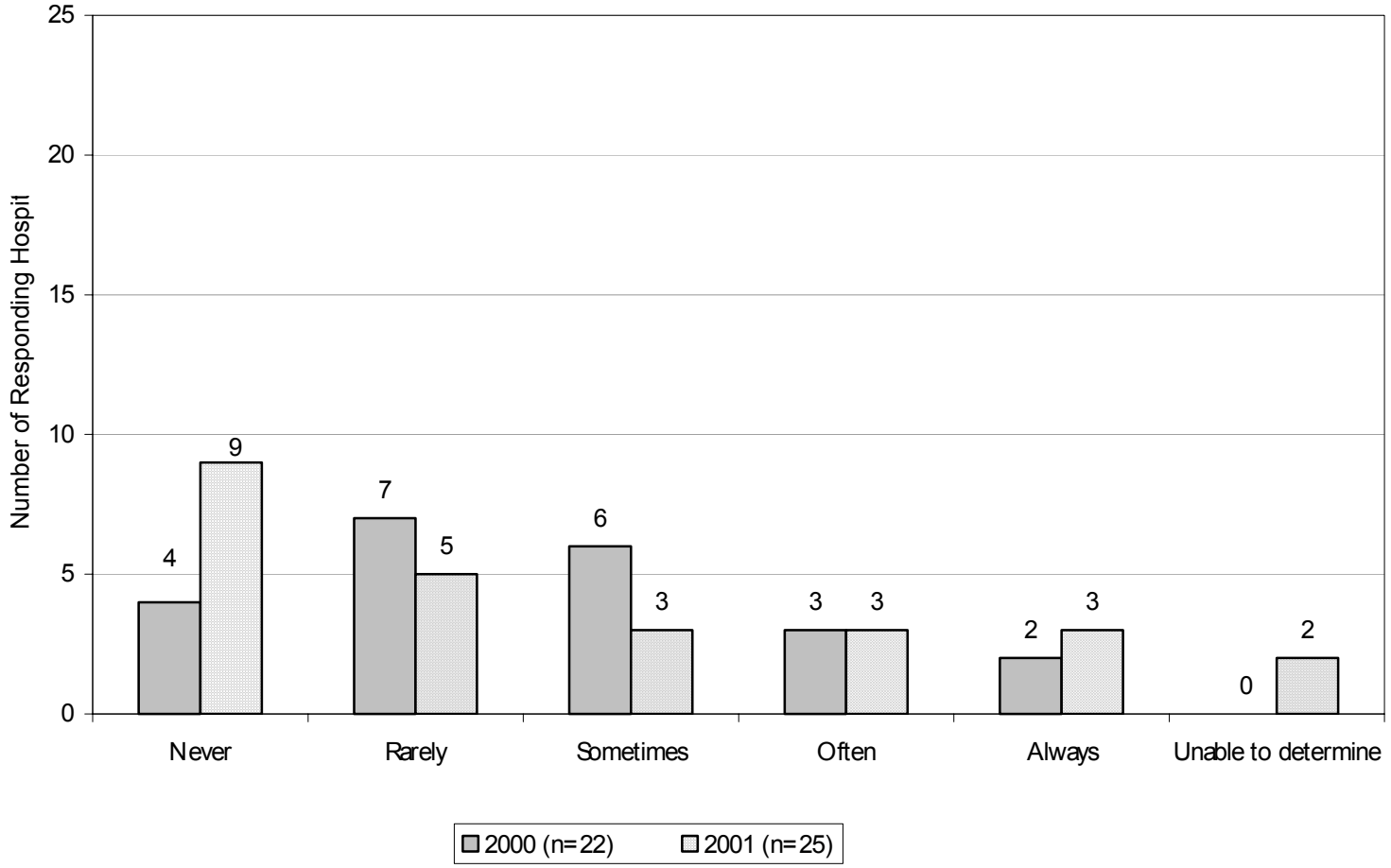


Figure 2C: Community Benefit Activities Targeted to Inner Cities

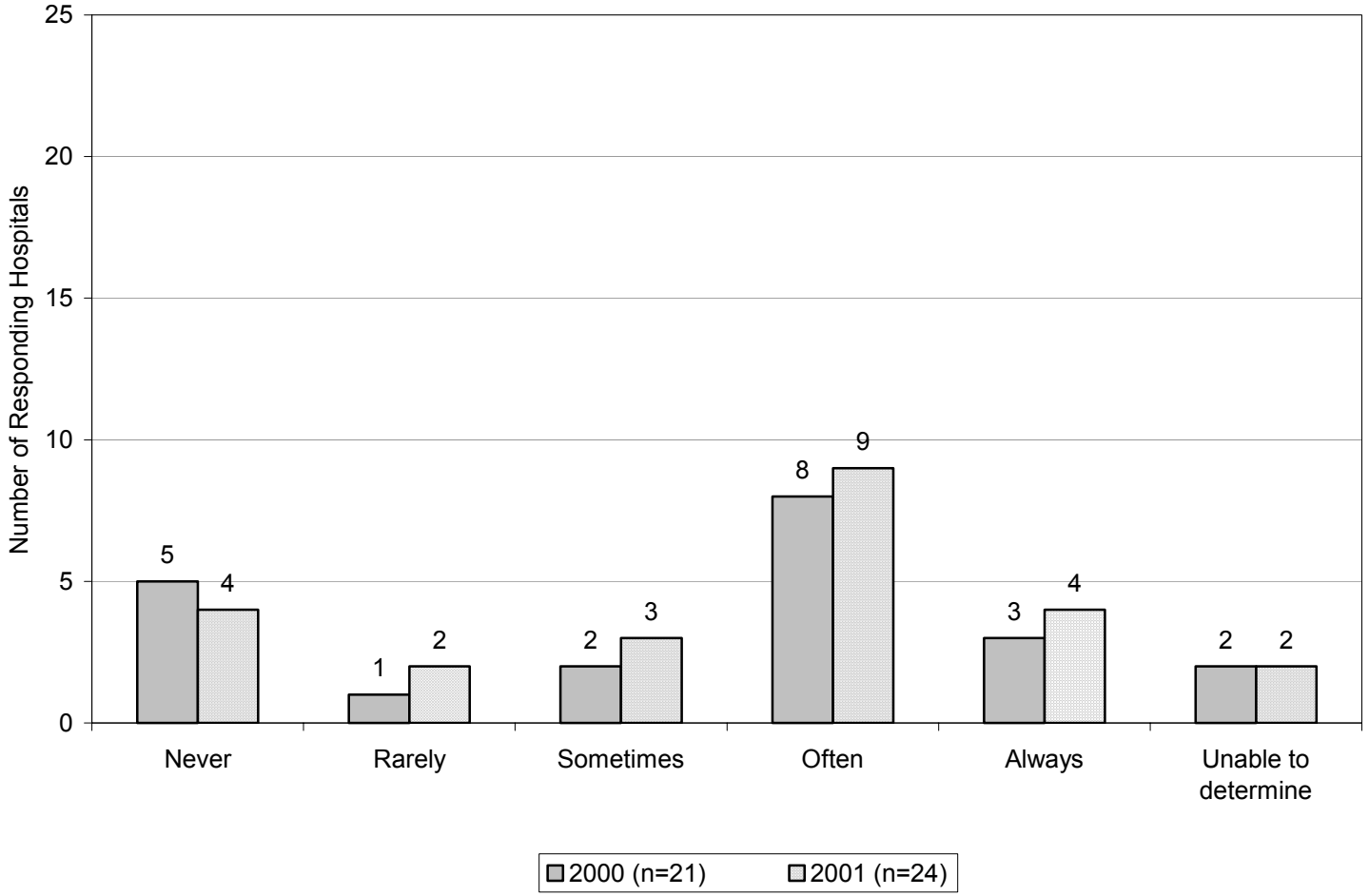


Figure 2D: Community Benefit Activities Targeted to Neighborhoods with Risk of a Particular Illness

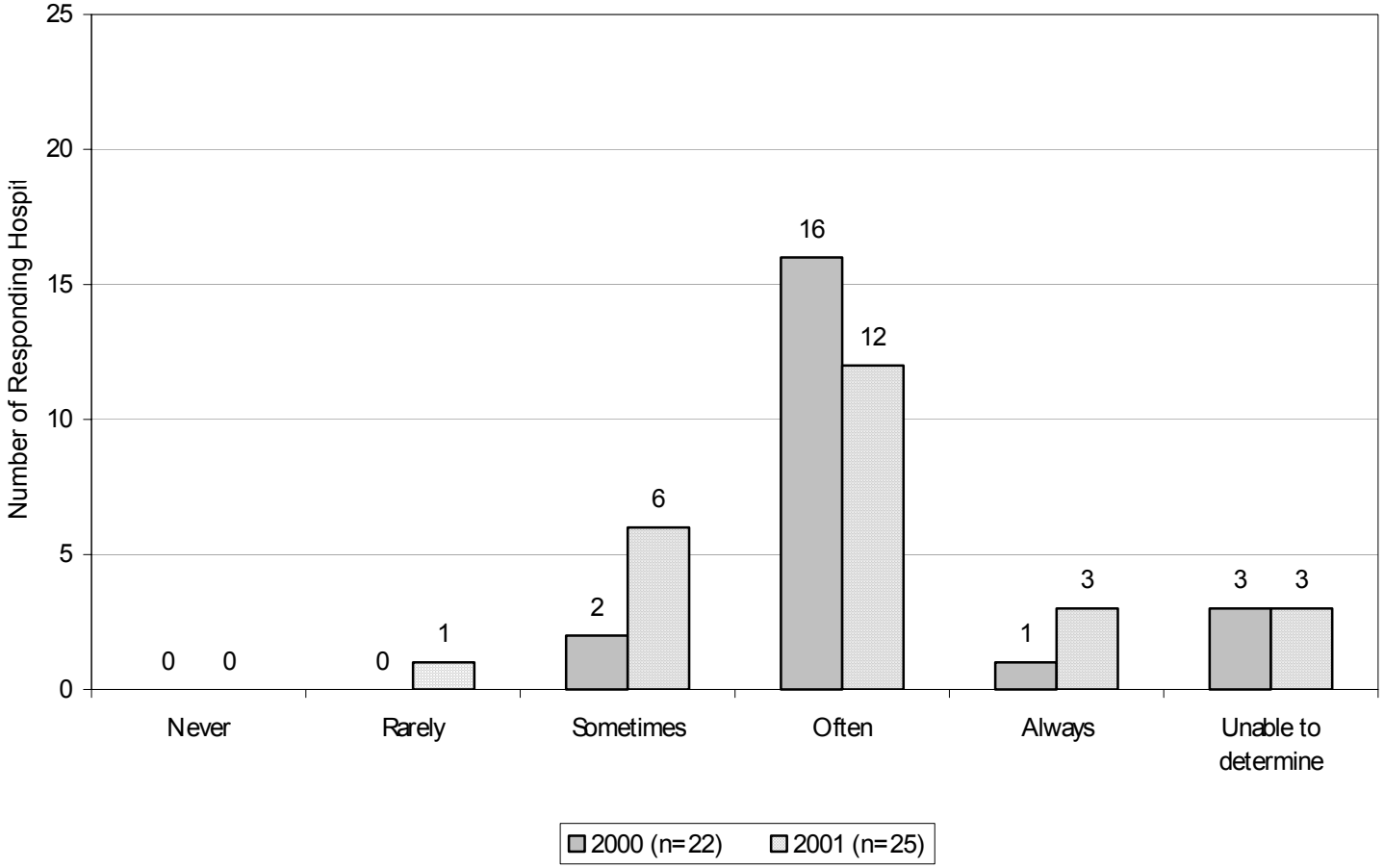


Figure 2E: Community Benefit Activities Targeted to Low Income Neighborhoods

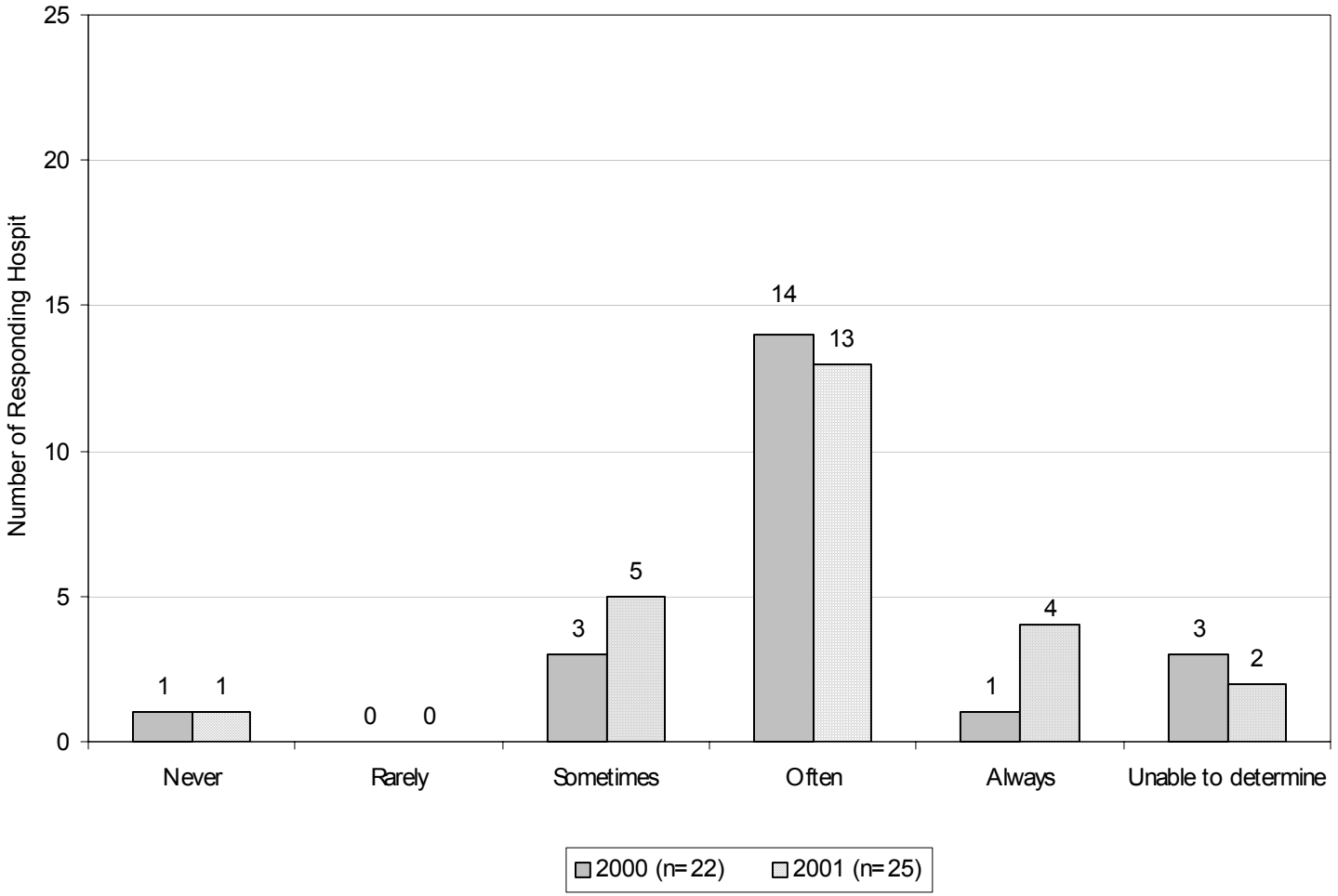


Figure 2F: Community Benefit Activities Targeted to Neighborhoods with High Immigrant Populations

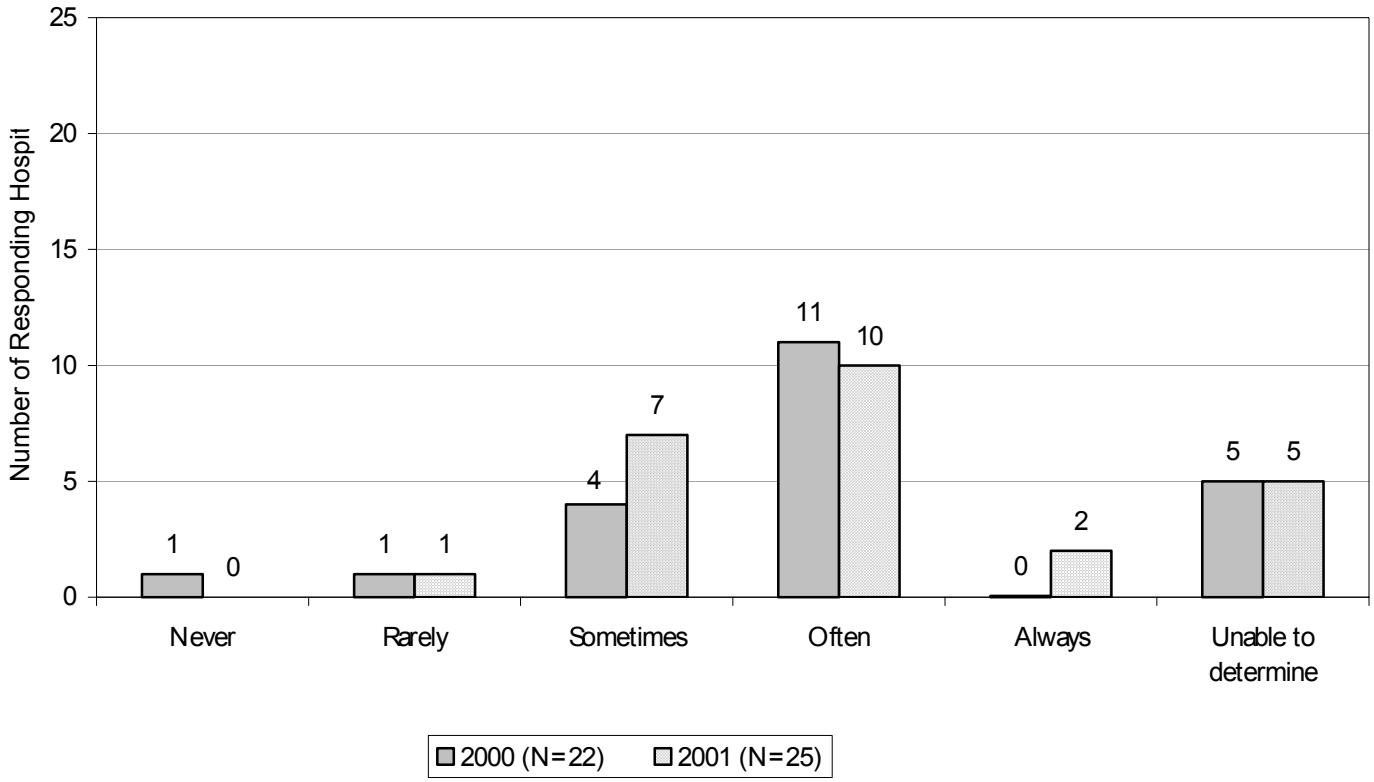


Figure 3: Community Benefit Activities Targeted to Areas with Concentrated Racial Minorities

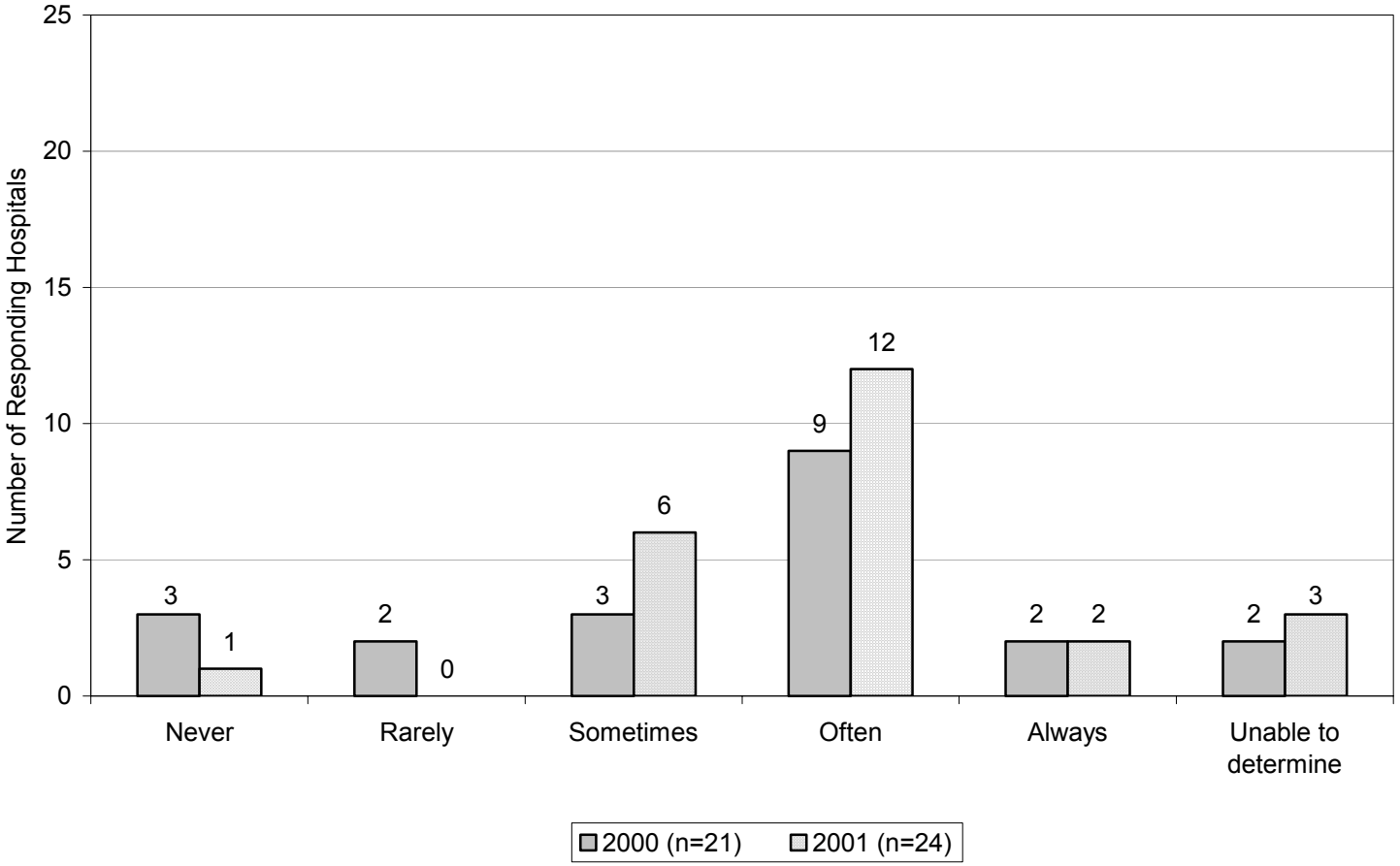


Figure 4: Community Benefit Activity -
Free or Subsidized Health Services

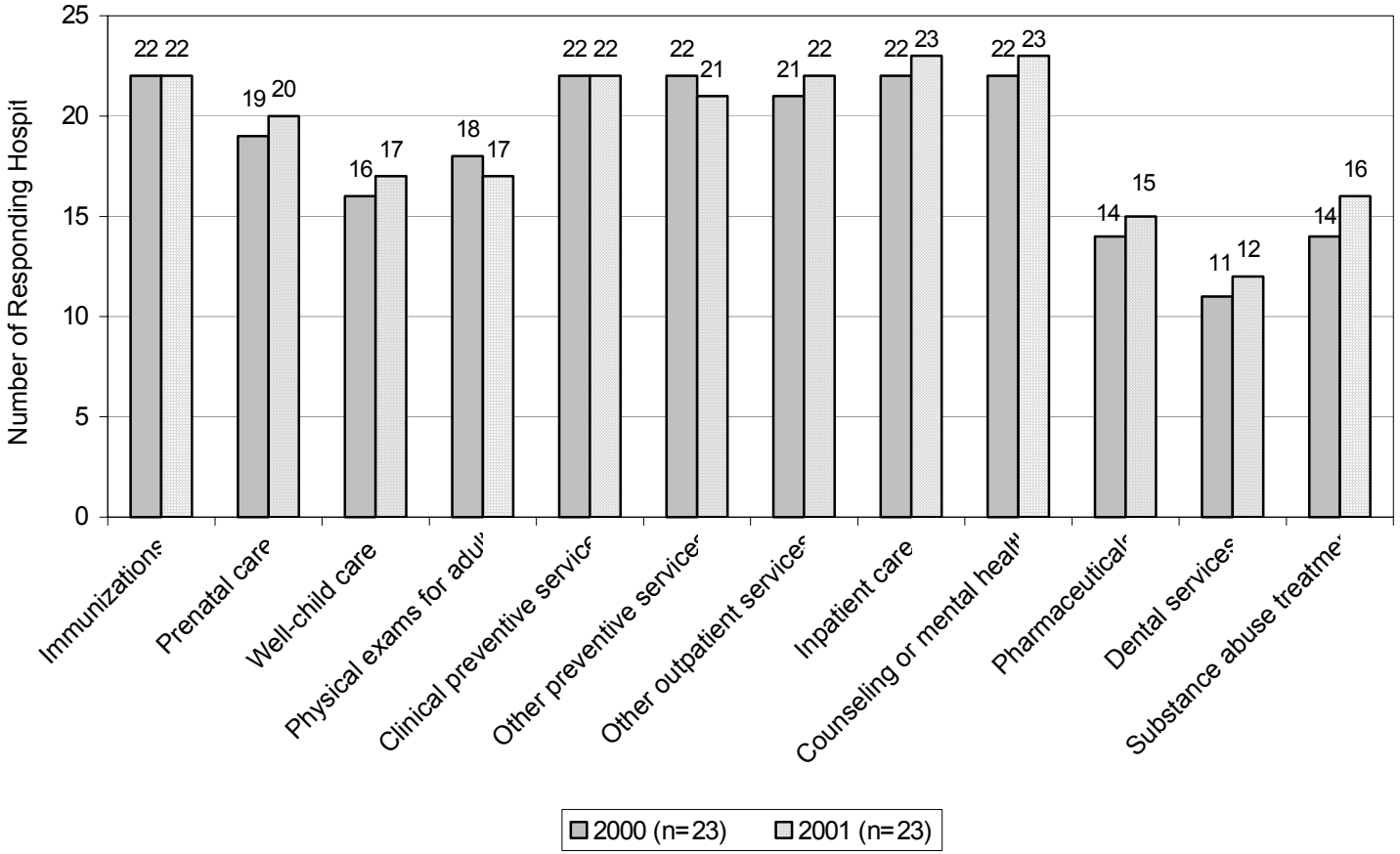


Figure 5: Community Benefit Activity - Health Education in the Community

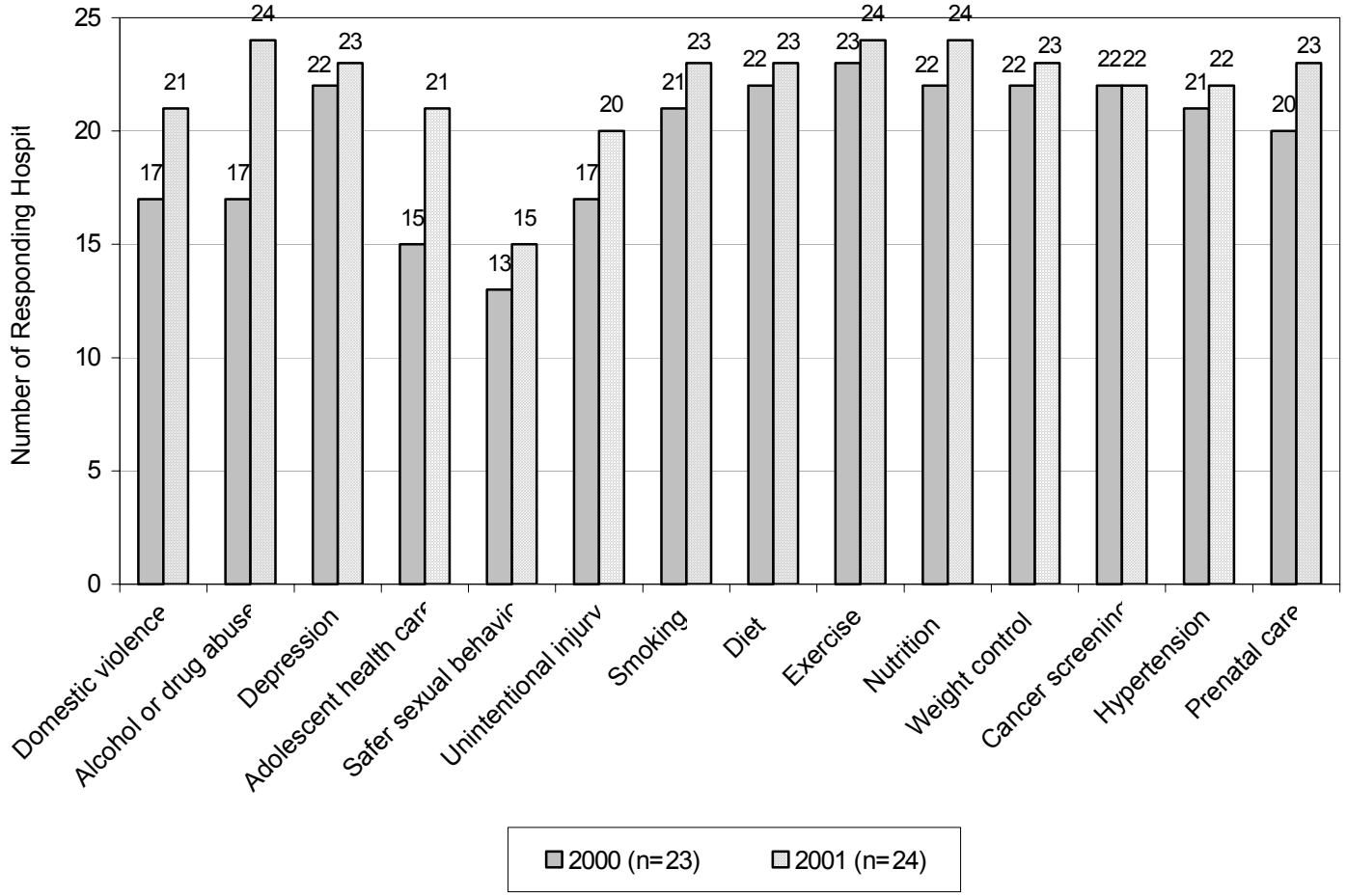


Figure 6: Community Benefit Activity -
Required Training for Affiliated Health Care Providers

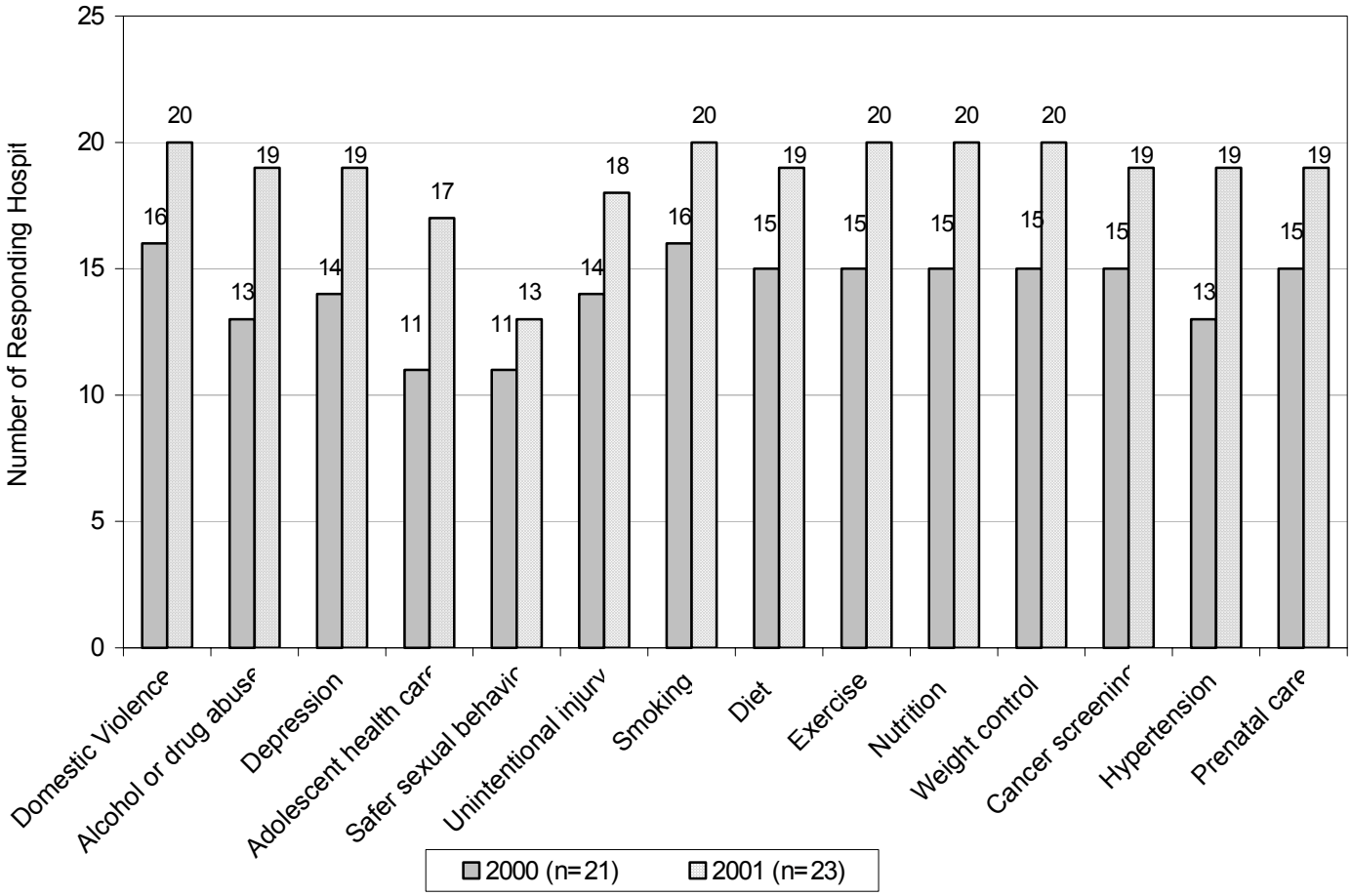


Figure 7: Community Benefit Activity -
Providing a Training Site for Health Professionals

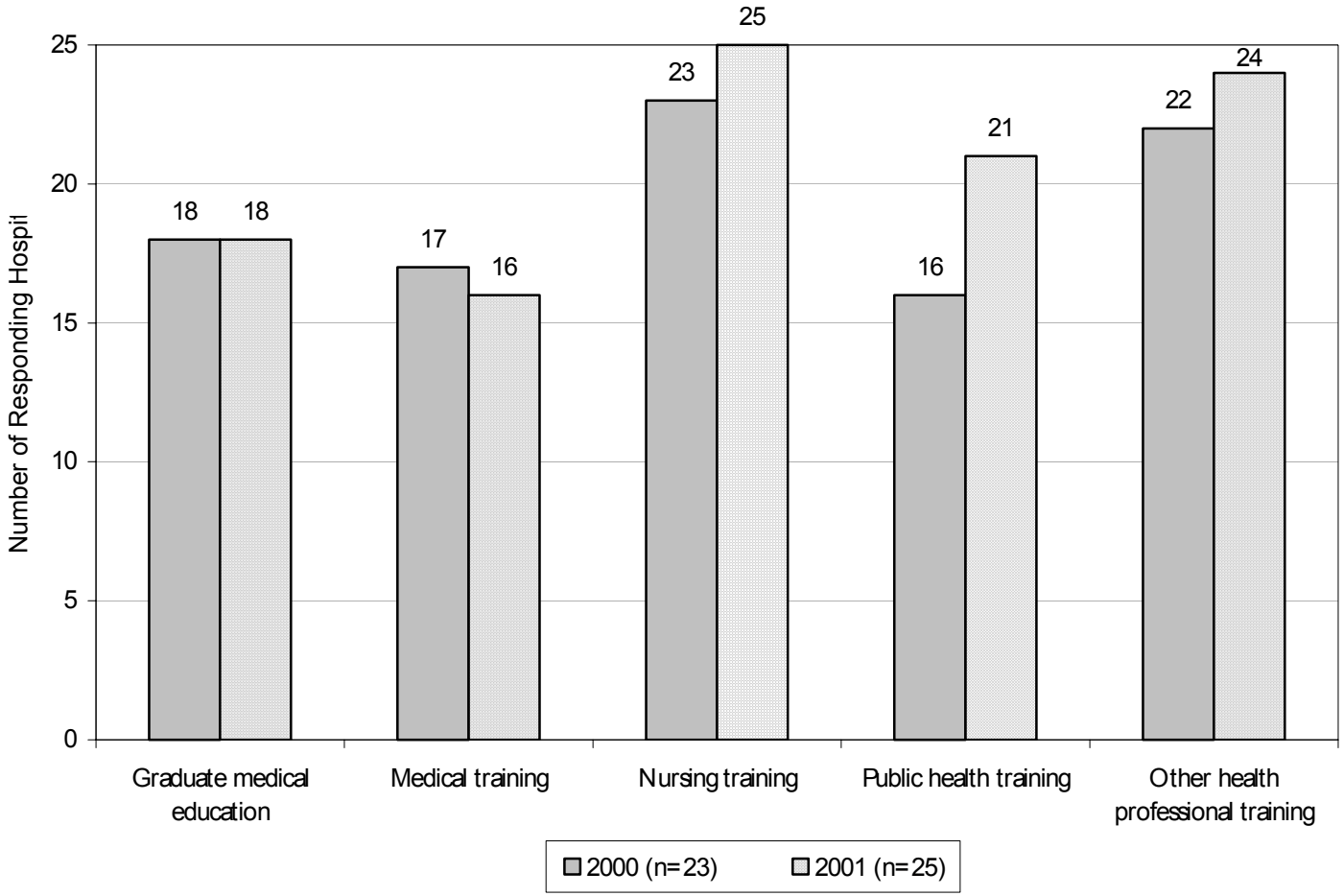


Figure 8: Community Benefit Activity - Stimulating Philanthropy Among Employees

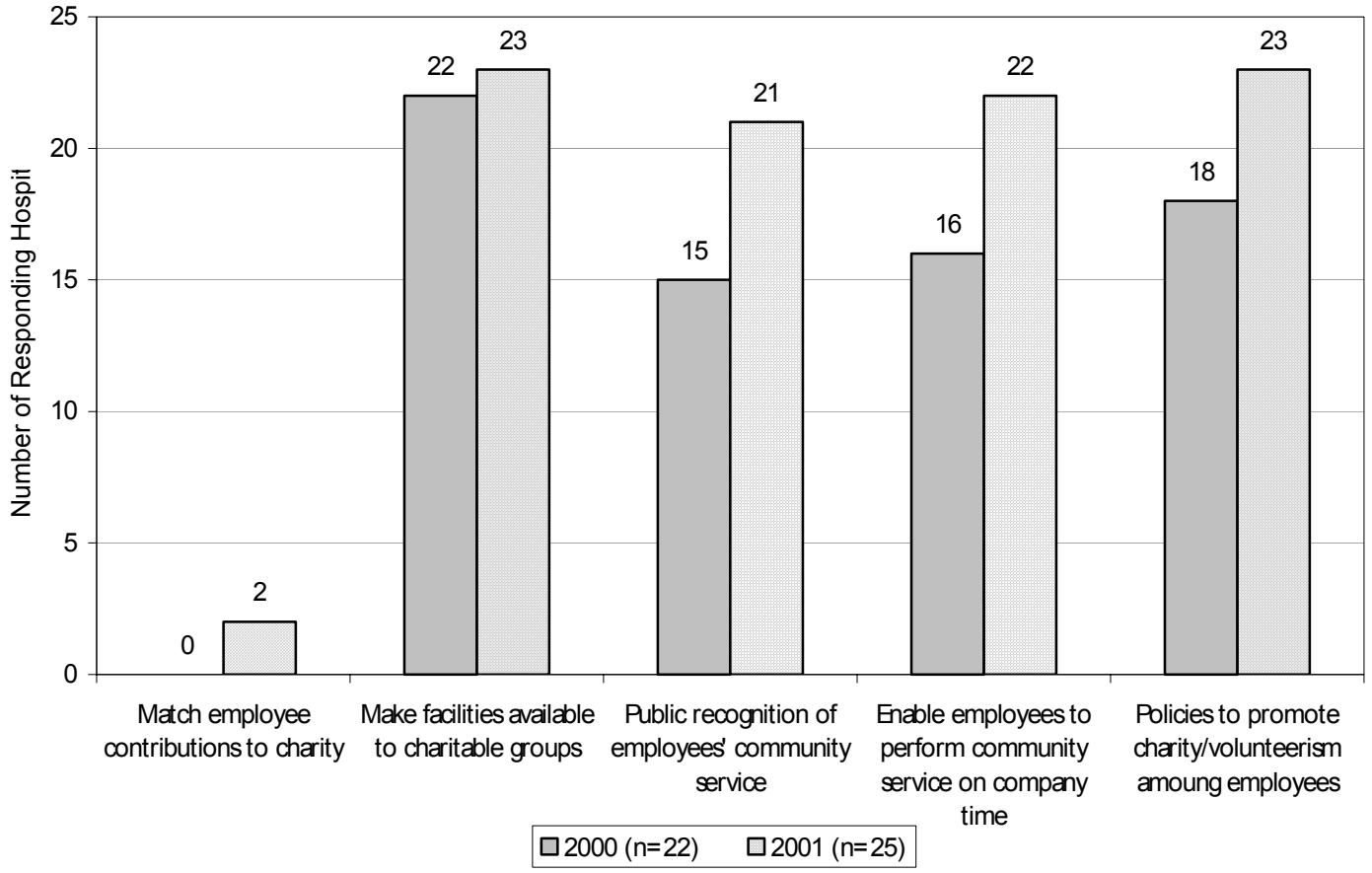


Figure 9: Community Benefit Activity - Programs to Reduce Transmission of Infectious Diseases

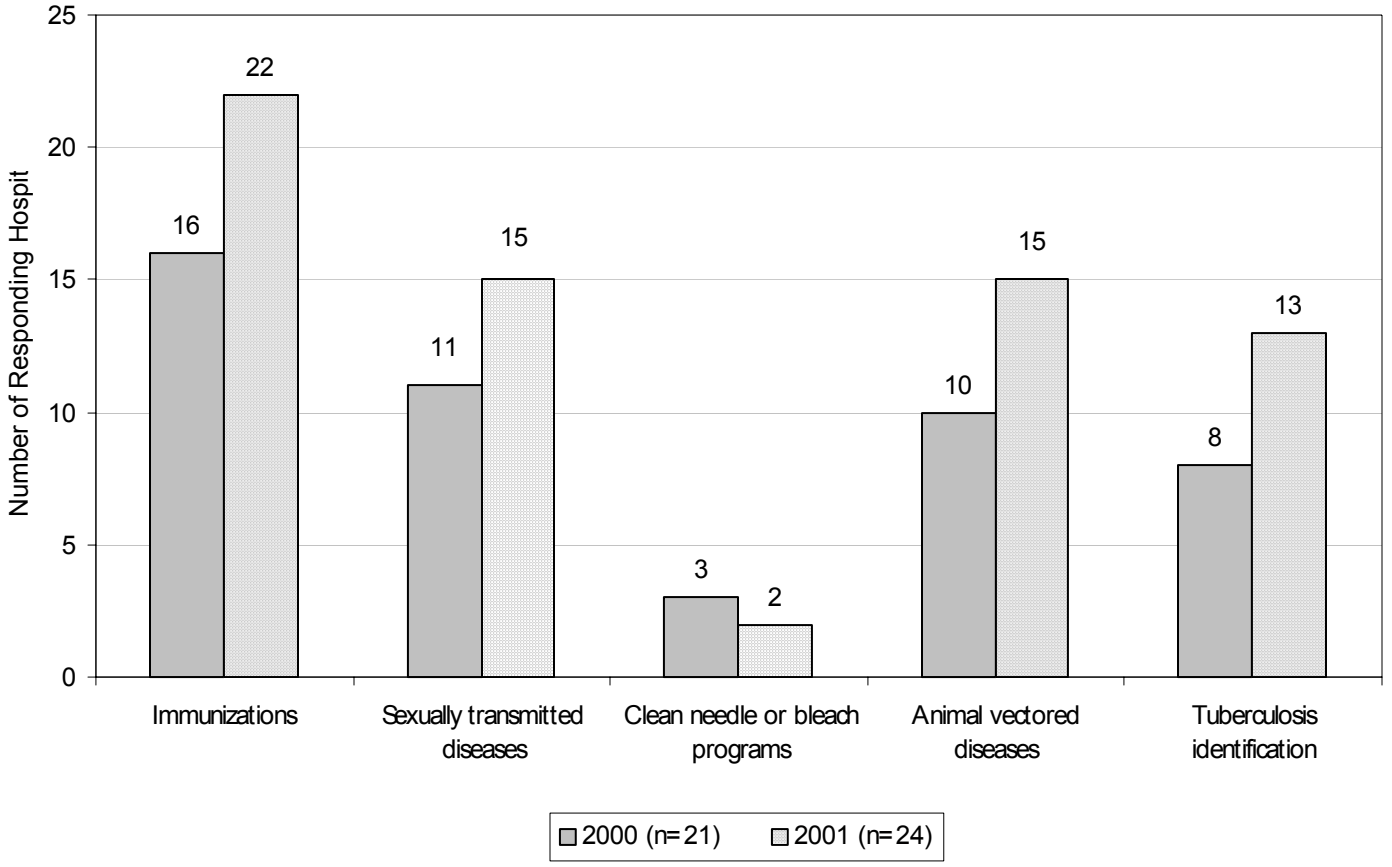


Figure 10: Community Benefit Activity - Frequency of Support for Safety Net Agencies

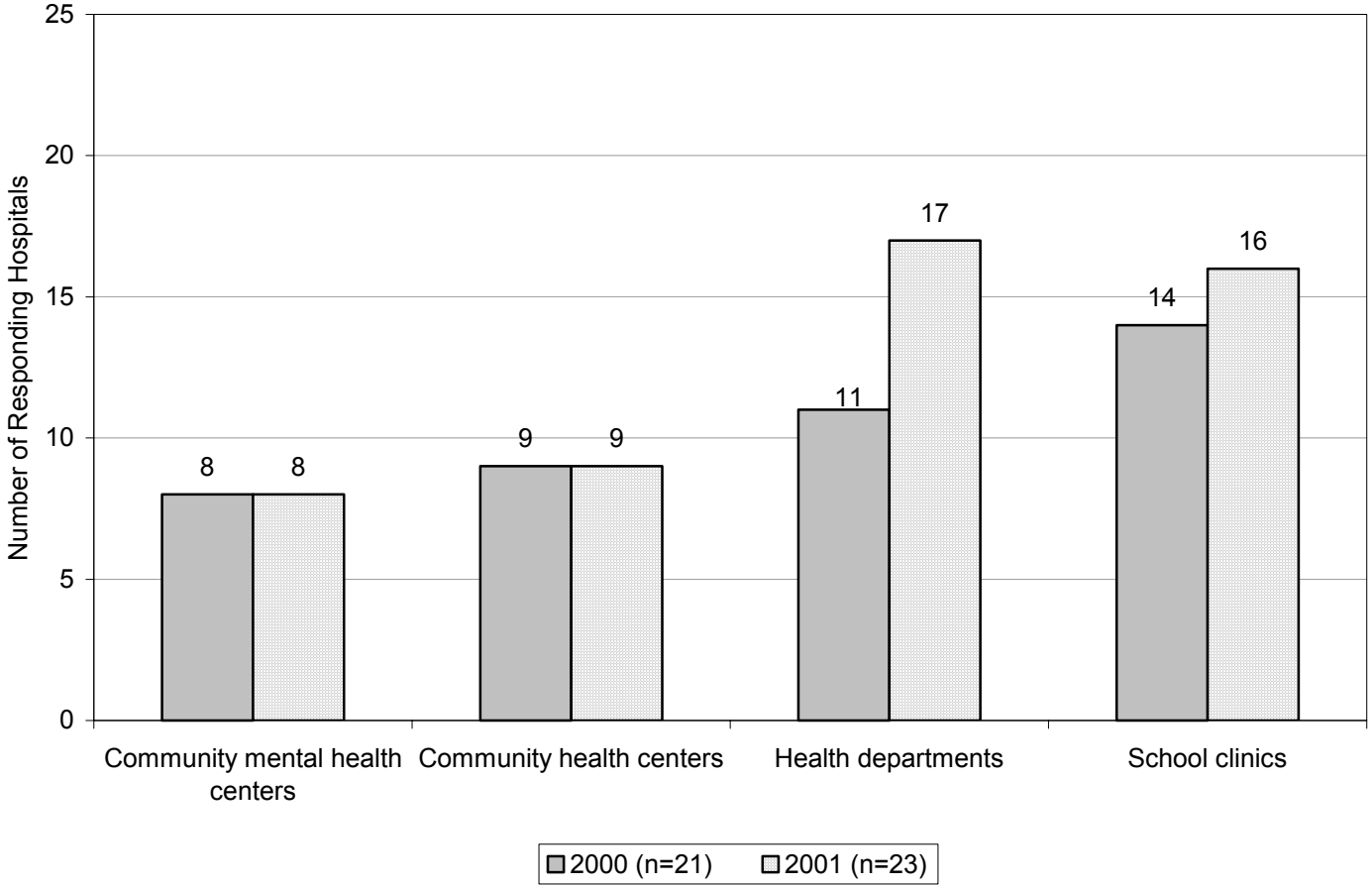


Figure 11: Community Benefit Activity - Support for Social Service Agencies

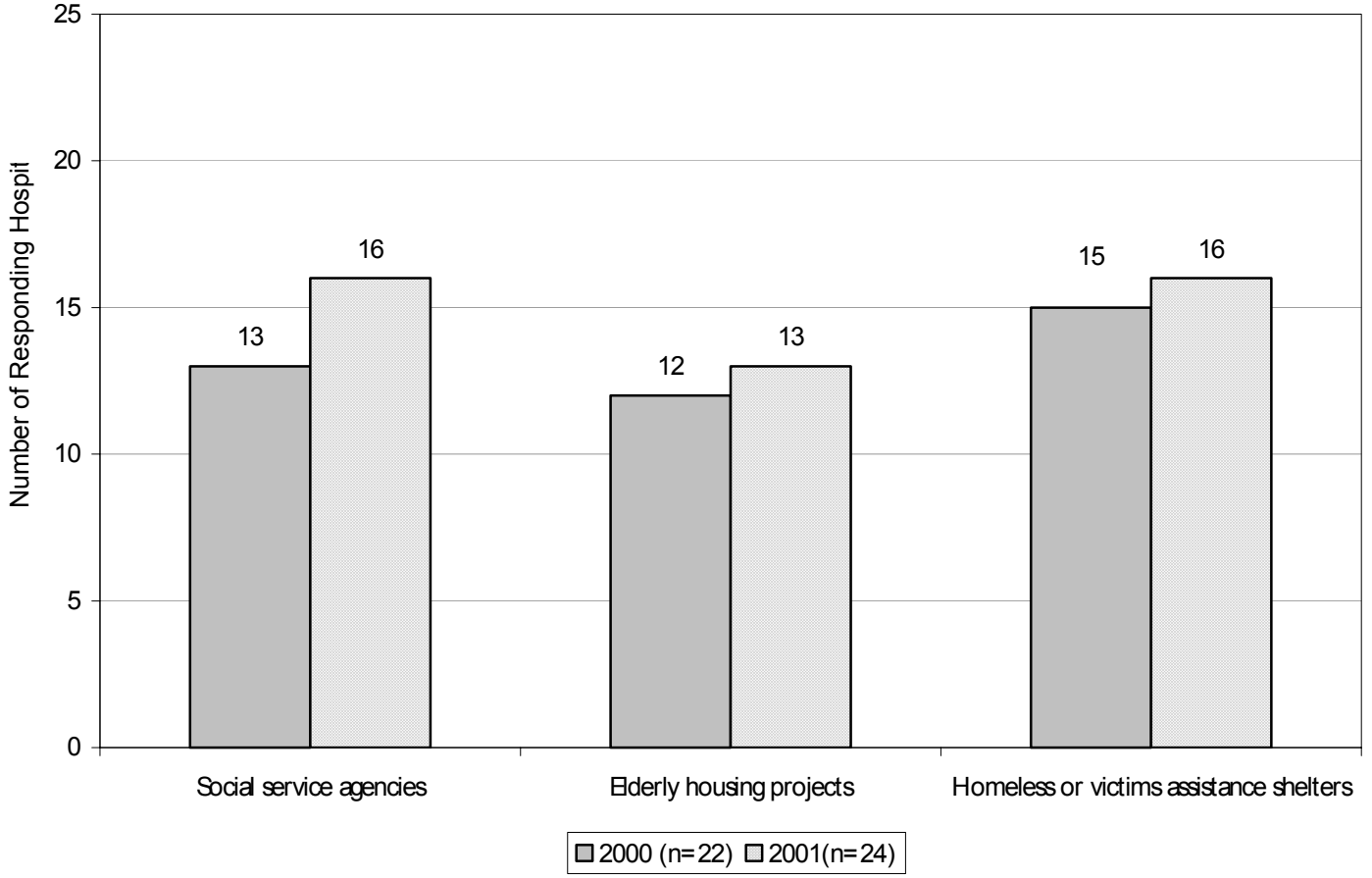


Figure 12: Community Benefit Activity - Support for Family Caregivers

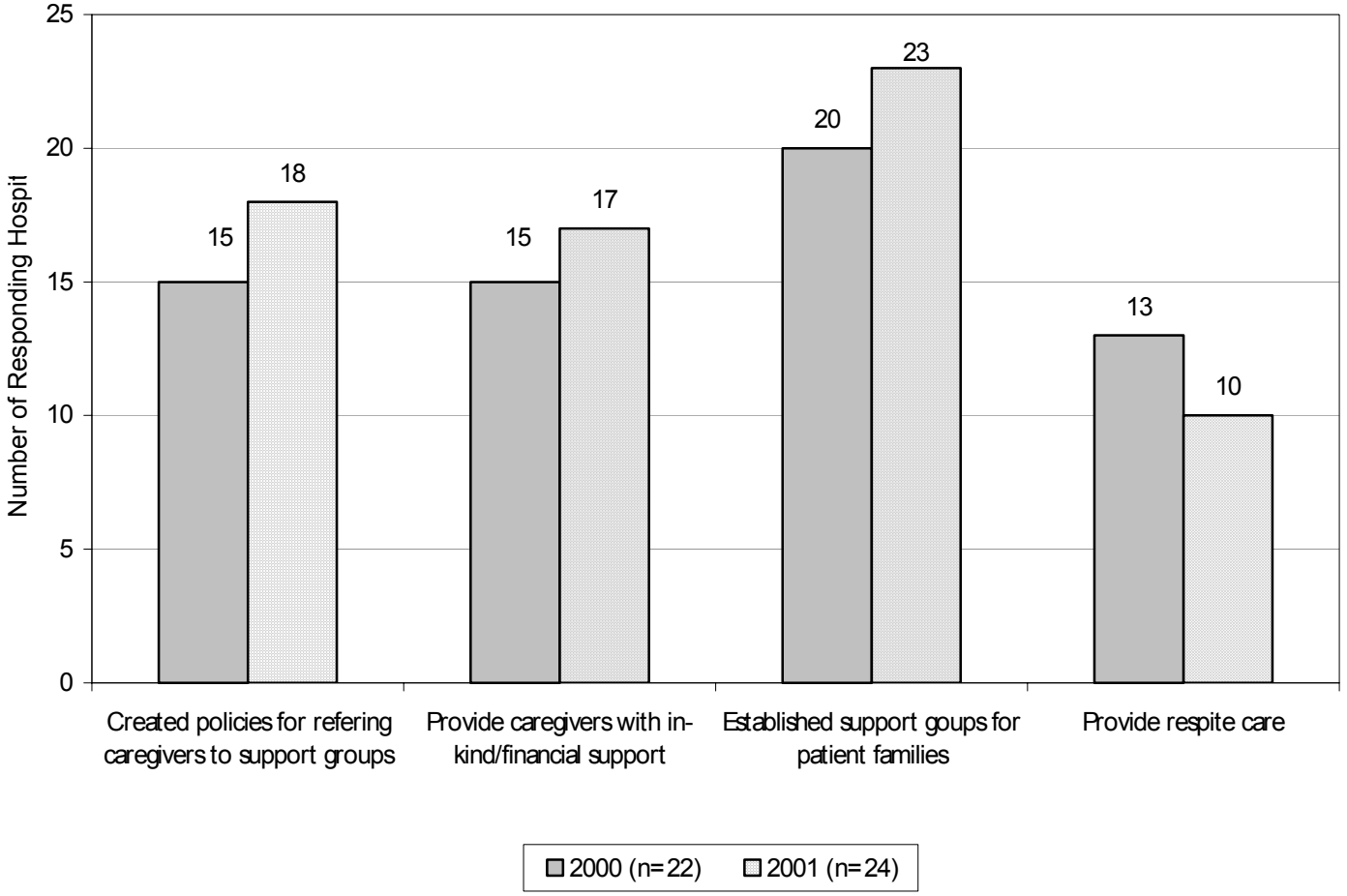


Figure 13: Community Benefit Activity - Distributing Reports Documenting Community Benefit Activities

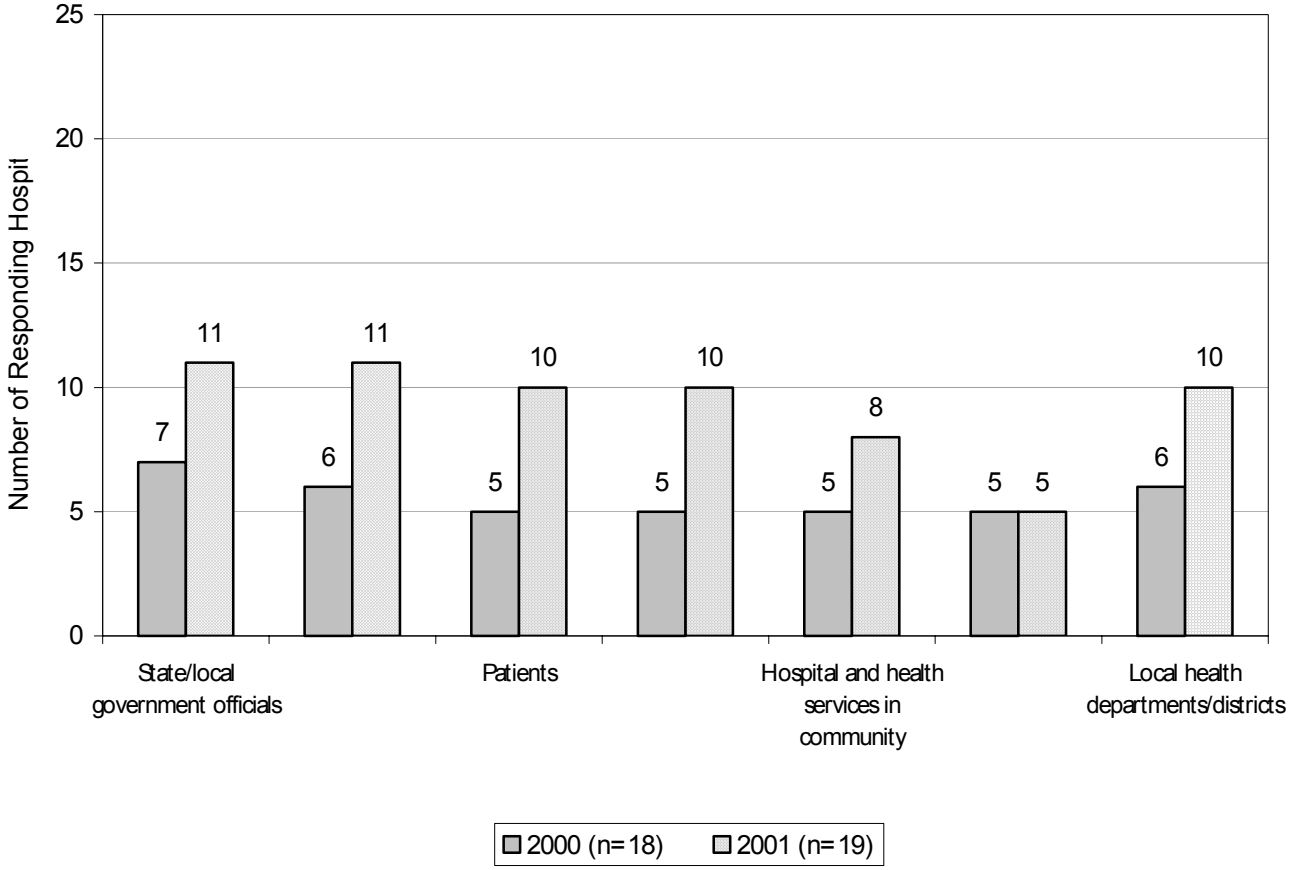


Figure 14: Community Benefit Activity -
Programs to Reduce Health Hazards in the Home

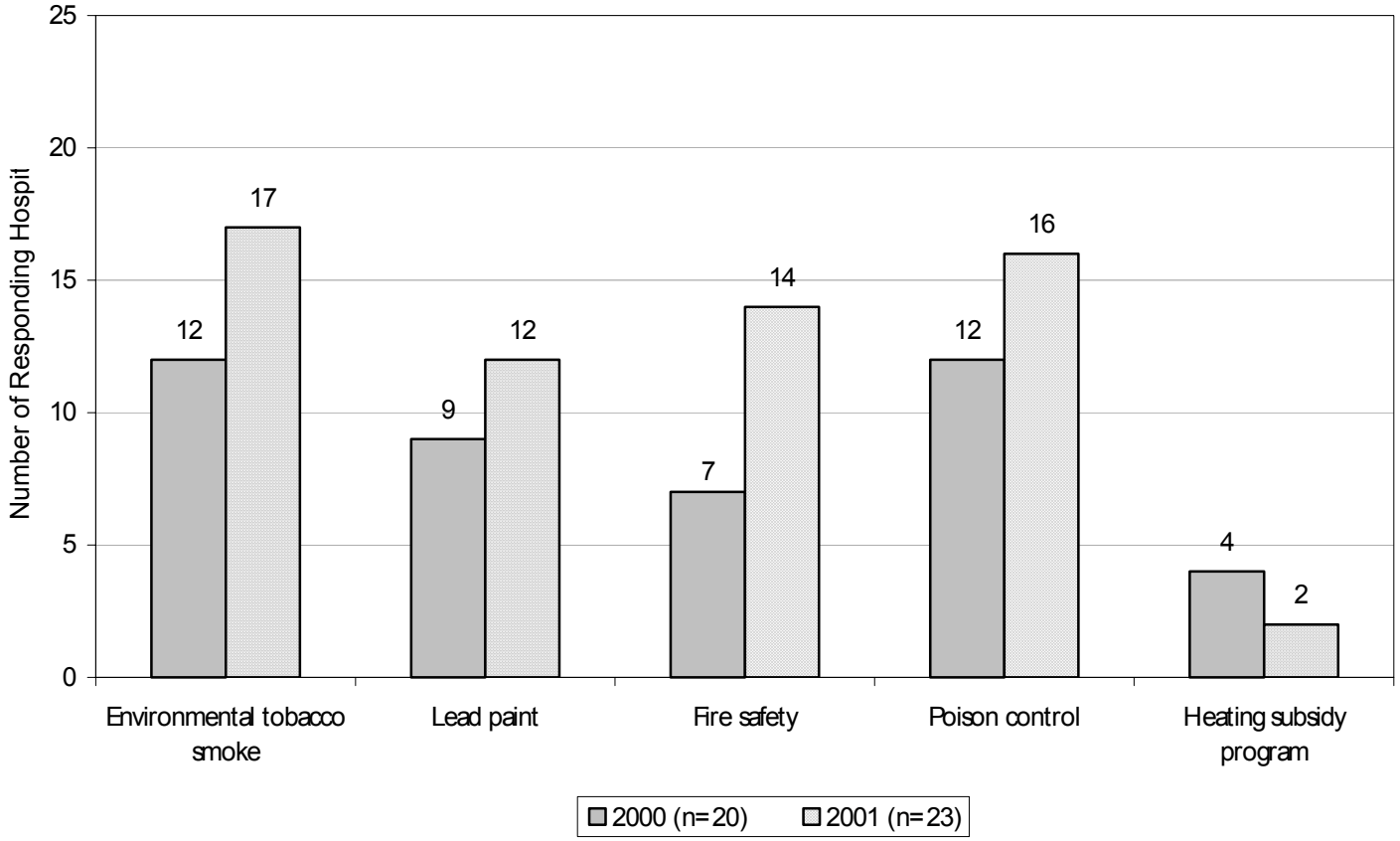


Figure 15: Community Benefit Activity - Collaboration with Local Public Safety Agencies

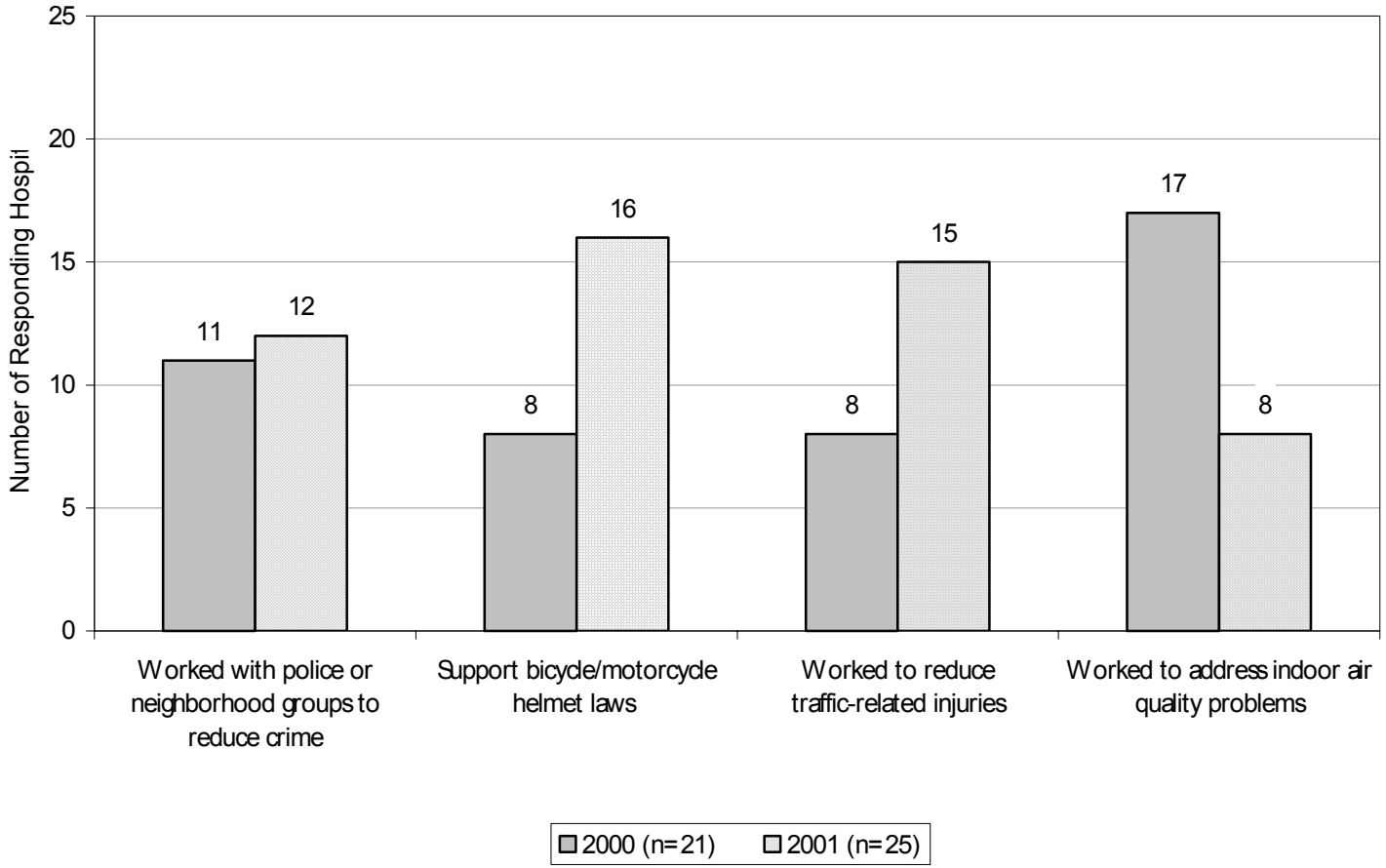


Figure 16: Community Participation in Policy Development for Community Benefit Activities

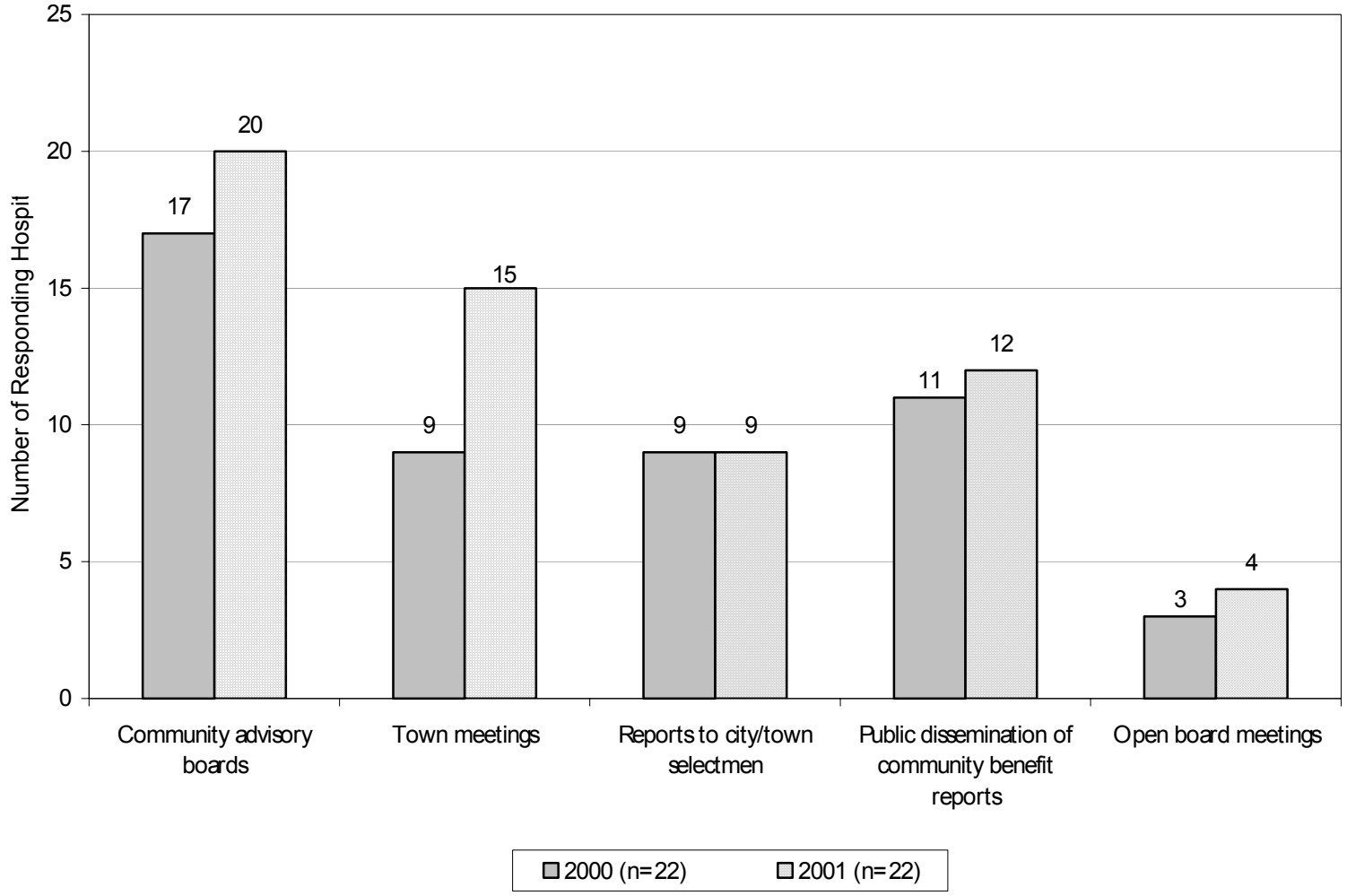


Figure 17: Community Benefit Activity -
Mentoring Programs for Potential Employees from the Community

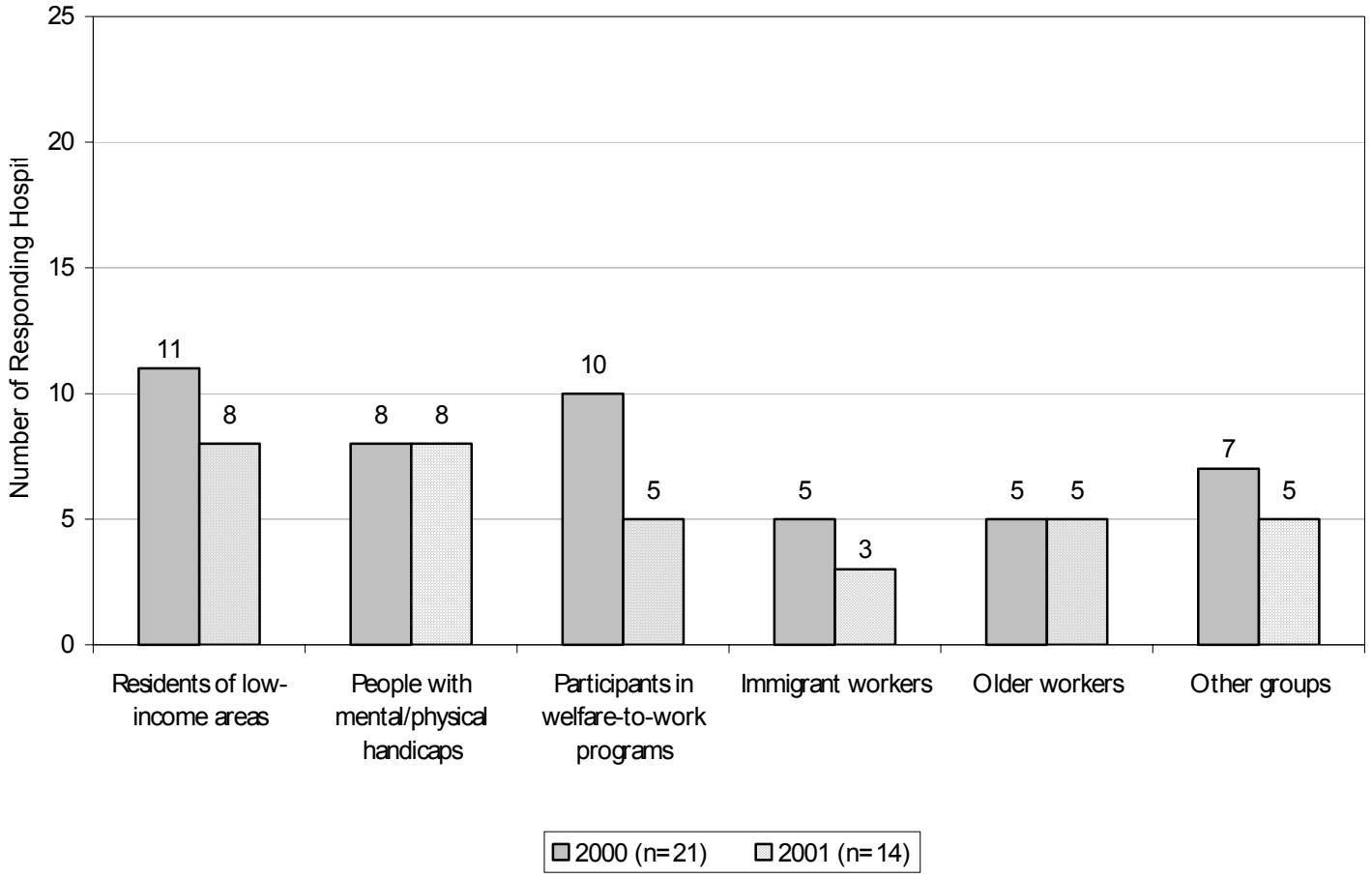


Figure 18: Community Benefit Activity - Addressing Local Environmental Issues

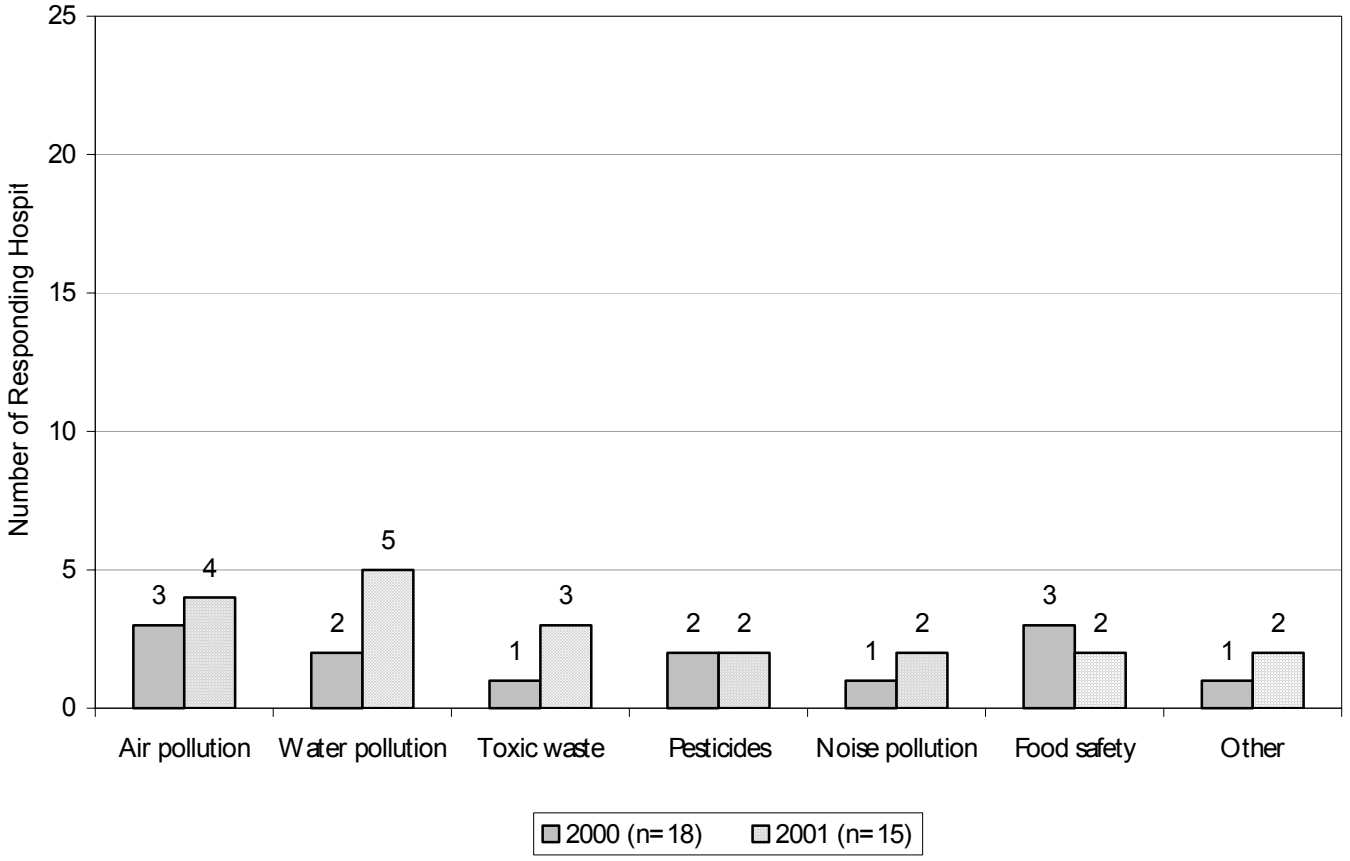
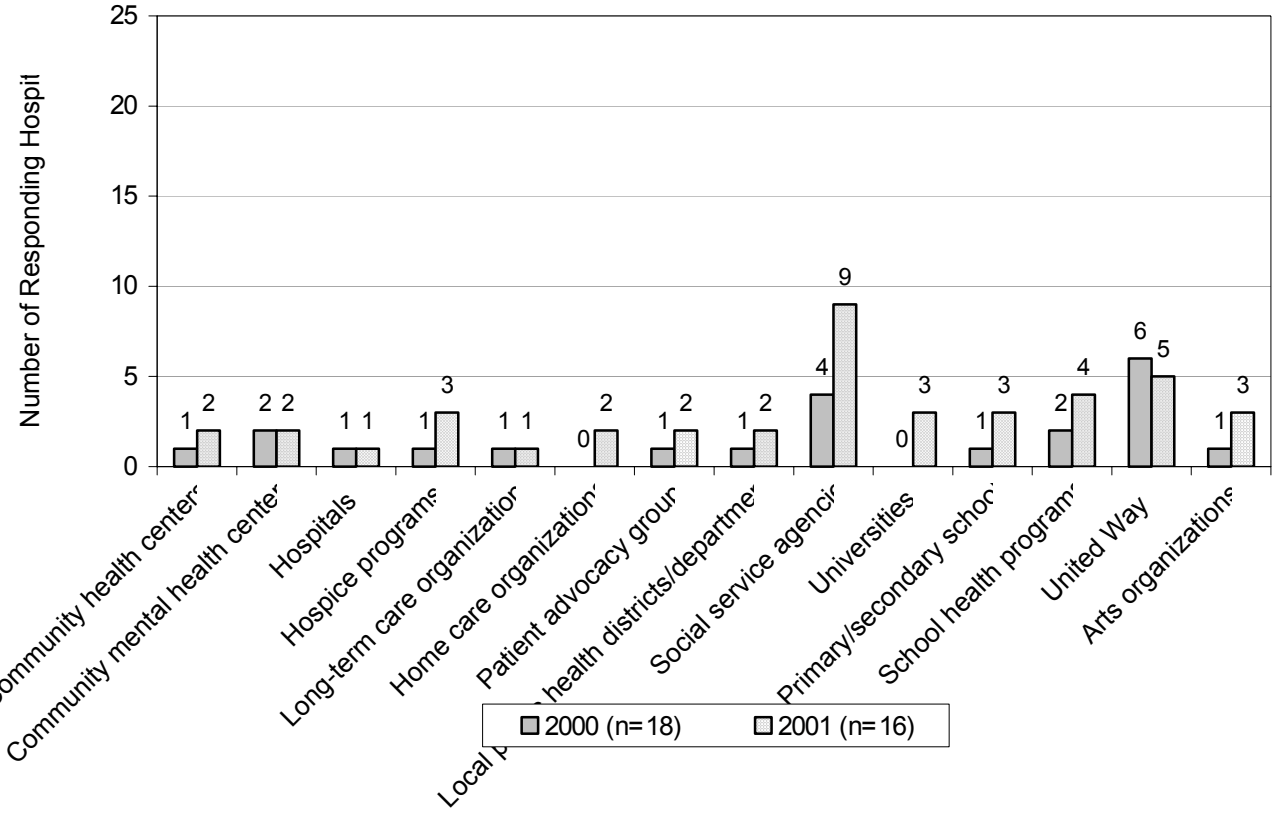


Figure 19: Community Benefit Activity - Direct Grants to Community Agencies



APPENDICES

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 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.

APPENDIX B

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

Bradley Memorial Hospital and Health Center	Middlesex Hospital
Bridgeport Hospital	Midstate Medical Center
Bristol Hospital, Inc.	Milford Hospital
Charlotte Hungerford Hospital	Natchaug Hospital, Inc.
Connecticut Children's Medical Center	New Britain General Hospital
Connecticut Hospice	New Milford Hospital
Danbury Hospital	Norwalk Hospital
Day Kimball Hospital	Rehabilitation Hospital of Connecticut, Inc.
Gaylord Hospital	Rockville General Hospital
Greenwich Hospital Association	Saint Francis Care Behavioral Health
Griffin Hospital	Saint Francis Hospital and Medical Center
Hall-Brooke Hospital	Saint Mary's Hospital
Hartford Hospital	Saint Vincent's Medical Center
Hebrew Home and Hospital, Inc.	Sharon Hospital
Hospital for Special Care	Silver Hill Hospital
Hospital of Saint Raphael	Stamford Hospital
John Dempsey Hospital of the UCONN H.C.	Veterans' Home and Hospital
Johnson Memorial Hospital	Waterbury Hospital
Lawrence & Memorial Hospital	William W. Backus Hospital
Manchester Memorial Hospital	Windham Community Memorial Hospital
Masonic Geriatric Healthcare Center	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.	Health Net Insurance of Connecticut, Inc.
Aetna U.S. Healthcare, Inc.	Health Net of Connecticut, Inc.
Alta Health & Life Insurance Company	John Alden Life Insurance Company
American Republic Insurance Co.	MedSpan Health Options, Inc.
Anthem Blue Cross & Blue Shield	Mutual of Omaha Insurance Company
Celtic Insurance Company	National Health Insurance Company
CIGNA HealthCare of Connecticut, Inc.	New England Life Insurance Company
ConnectiCare, Inc.	Nippon Life Insurance Co. of America
Connecticut General Life Insurance Co.	Oxford Health Plans (CT), Inc.
Conseco Medical Insurance Company	Phoenix Home Life Mutual Insurance Co.
First Allmerica Financial Life Ins. Co.	Principal Life Insurance Company
FirstChoice HealthPlans of CT, Inc.	Protective Life Insurance Company
Fortis Benefits Insurance Company	Sentry Select Insurance Company
Fortis Insurance Company	Trustmark Insurance Company
GE Group Life Assurance Company	UniCare Life & Health Insurance Company
Golden Rule Insurance Company	United HealthCare Insurance Company
Guardian Life Insurance Company	United States Life Insurance Company

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

COMMUNITY BENEFIT MODELS[2]

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

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

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

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

[2] Schlesinger, M., K. Mattocks. *Reporting of Community Benefits by Hospitals and Health Plans in Connecticut for the Calendar Year 2000.* Department of Epidemiology and Public Health, Yale University School of Medicine. September 12, 2001.

APPENDIX D

YEAR 2000 COMMUNITY BENEFIT SURVEY RESPONDENTS

	Have CB Program	Submitted CB Survey
Bridgeport Hospital	X	X
Connecticut Children's Medical Center	X	X
Greenwich Hospital Association	X	X
Midstate Medical Center	X	X
Milford Hospital	X	X
Saint Vincent's Medical Center	X	X
Yale New Haven Hospital	X	X
Bristol Hospital		X
Charlotte Hungerford Hospital		X
Day Kimball Hospital		X
Eastern Connecticut Health Network		X
Hospital of Saint Raphael		X
Johnson Memorial Hospital		X
Lawrence & Memorial Hospital		X
Masonic Geriatric Healthcare Center		X
Middlesex Hospital		X
Norwalk Hospital		X
Saint Francis Hospital and Medical Center		X
Saint Mary's Hospital		X
Sharon Hospital		X
Stamford Hospital		X
Waterbury Hospital		X
William W. Backus Hospital		X
Total	**7**	**23**

APPENDIX E

YEAR 2000 RECOMMENDATIONS

Reporting of Community Benefits by Hospitals and Health Plans

in Connecticut For the Calendar Year 2000

Mark Schlesinger, Ph.D. and Kristin Mattocks, M.P.H.

Excerpted from the Executive Summary: "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."

APPENDIX F

YEAR 2001 COMMUNITY BENEFIT SURVEY RESPONDENTS

	Have CB Program	Submitted CB Survey
Hospitals		
Connecticut Children's Medical Center	X	X
Danbury Hospital	X	X
Greenwich Hospital Association	X	X
Hartford Hospital	X	X
Midstate Medical Center	X	X
Saint Vincent's Medical Center	X	X
Silver Hill Hospital	X	X
Yale New Haven Hospital	X	X
Bridgeport Hospital		X
Bristol Hospital, Inc.		X
Charlotte Hungerford Hospital		X
Day Kimball Hospital		X
Eastern Connecticut Health Network*		X
Griffin Hospital		X
Hospital for Special Care		X
Hospital of Saint Raphael		X
Lawrence & Memorial Hospital		X
Middlesex Hospital		X
Milford Hospital		X
Norwalk Hospital		X
Saint Francis Hospital and Medical Center**		X
Saint Mary's Hospital		X
Sharon Hospital		X
Stamford Hospital		X
Waterbury Hospital		X
William W. Backus Hospital		X
Managed Care Organizations		
ConnectiCare, Inc.	X	X
Total	**9**	**27**

* Rockville General and Manchester Memorial

** Saint Francis Hospital and Medical Center, Rehabilitation Hospital of Conecticut, Inc. and Saint Francis Care Behavioral Health

APPENDIX G

YEAR 2001 HOSPITAL COMMUNITY BENEFIT SURVEY RESPONSES

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

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 Section 19a-127k, C.G.S.?

   (n=24) Yes 7
   No 17
   Don't Know 0

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?

   (n=24) Yes 18
   No 6

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

   (n=25) Yes 4
   No 21

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

   (n=6) _____

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?

   (n=22) Yes 20
   No 2

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.

   (n=14) _____

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

   (n=11) Year .. 1985 median

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

   (n=23) Yes 9
   No 14

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

    (n=15) $ 750,000 median

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

    (n=16) FTEs 4.5 median

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

(n=24)		
	Increase substantially ..	1
	Increase slightly ..	14
	Remain the same	7
	Decrease slightly	1
	Decrease substantially	0
	Unable to determine ...	1

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 any communities in these counties, you should indicate that you are serving that county.

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

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

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

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

(n=25)		
	Never	0
	Rarely	1
	Sometimes	7
	Often	10
	Always	2
	Unable to determine	5

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

(n=25)		
	Never	0
	Rarely	1
	Sometimes	6
	Often	12
	Always	3
	Unable to determine	3

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

(n=24)		
	Never	4
	Rarely	2
	Sometimes	3
	Often	9
	Always	4
	Unable to determine	2

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

(n=25)		
	Never	9
	Rarely	5
	Sometimes	3
	Often	3
	Always	3
	Unable to determine	2

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

(n=24) Never 0
Rarely 2
Sometimes 5
Often 11
Always 4
Unable to determine 2

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

(n=24) Never 1
Rarely 0
Sometimes 6
Often 12
Always 2
Unable to determine 3

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

(n=25) Yes 5
No 20

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

(n=24) Yes 23
No 1

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.)

(n=20) Residents .. 4,900 median

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

(n=24) Yes 12
No 12

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

(n=20) Annual expenditures .. $2,925,000 median

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

(n=23)

	YES	NO
Immunizations	22	1
Prenatal or peri-natal care	20	3
Well-child care	17	6
Physical exams for adults	17	6
Clinical preventive services (e.g. hypertension screening)	22	1
Other preventive services (breast, colorectal cancer)	21	2
Other outpatient medical or surgical services	22	1
Inpatient care	23	0
Counseling or mental health	23	0
Pharmaceuticals	15	8
Other clinical services we haven't mentioned?	18	4
Dental services?	12	11
Substance abuse treatment?	16	7

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

(n=24) Percent .. 5% median

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?
(n=25) Yes 4
No 21

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).
(n=5) Number of patients .. 0-40

30. What was the cost of this premium subsidy over the last year? (Your best estimate is fine).
(n=5) Premium Subsidy .. $0-$175,000

31. Over the past year, how much money did your organization spend on emergency services in Connecticut? (Your best estimate is fine).
(n=15) Annual Expenditures .. $7,500,000 median

32. Does your facility operate as a trauma center?
(n=24) Yes 13
No 11

33. Approximately how many of your patients in Connecticut are enrolled in...
(n=21) Medicare? .. 44 median
Medicaid? .. 13 median
HUSKY? .... 7.3 median

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?
(n=24) Yes 6
No 11
No unusual patterns detected 7

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?
(n=13) Number of times .. 0-2

36. Has your organization operated or subsidized any of the following programs in the past year in this state?
(n=25)

	YES	NO
Health literacy programs?	15	10
Health education programs for immigrants?	8	17
Information programs about eligibility for social welfare	18	7
Health fairs?	24	1

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?
(n=25) Yes 24
No 1

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.
(n=25) Yes 11
No 14

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.
(n=21) $ 400,000 median

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?
(n=17) Percent ..50% median

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

(n=21) Yes 12
No 9

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

(n=20) FTE Staff .. 7 median

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?

(n=21) Percent 35% median

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

(n=24)

	YES	NO
Addressing domestic violence and other abuse?	21	3
Abuse of alcohol or other illicit drugs?	24	0
Identifying depression?	23	0
Health promotion for adolescents?	21	3
Encouraging safer sexual behavior?	15	9
Reducing unintentional injury?	20	4
Reducing smoking and other tobacco use?	23	1
Addressing diet and other forms of cholesterol control?	23	1
Encouraging exercise?	24	0
Encouraging better nutrition?	24	0
Encouraging weight control?	23	1
Cancer screening?	22	2
Hypertension detection and control?	22	2
Need for prenatal care?	23	1

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

(n=25)

	Not at all	Sometimes	A great deal
worked with police or neighbor hood groups to reduce crime?	12	9	3
encouraged employers to provide wellness programs	3	9	13
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

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

(n=23)

	YES	NO
domestic violence and other abuse?	20	3
abuse of alcohol or illicit drugs?	19	4
diagnosing depression?	19	4
health promotion for adolescents?	17	6
encouraging safer sexual behavior?	13	10
prevention of unintentional injury?	18	5
reducing smoking and other tobacco use?	20	3
diet and other forms of cholesterol control?	19	4
encouraging exercise?	20	3
encouraging better nutrition?	20	3
encouraging weight control?	20	3
cancer screening?	19	4
hypertension detection and control?	19	4
prenatal care?	19	4

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

(n=25) Yes 25
No 0

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...
(n=23)

	YES	NO
domestic violence and other abuse?	20	2
abuse of alcohol or illicit drugs?	20	2
diagnosing depression?	21	1
health promotion for adolescents?	16	6
encouraging safer sexual behavior?	13	9
reducing unintentional injury?	19	3
reducing smoking or other tobacco use?	21	1
addressing diet and other forms of cholesterol control?	20	2
encouraging exercise?	19	3
encouraging better nutrition?	19	2
encouraging weight control?	20	2
cancer screening?	21	2
hypertension detection and control?	20	2
prenatal care?	21	2

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?
(n=24) Yes 24
No 0

50. Did your organization provide a site or rotation for graduate medical education?
(n=25) Yes 18
No 7

51. How many positions did you have?
(n=19) Number of positions .. 61 median

52. Did your organization provide a clerkship rotation or site for medical students?
(n=25) Yes 16
No 9

53. Over the past year, how many medical students participated?
(n=18) Number of medical students .. 47.5 median

54. Did your organization participate in or provide a training site for nursing students or graduate nurses in advanced practice nursing or other programs?
(n=25) Yes 25
No 0

55. Over the past year, how many student nurses participated?
(n=23) Number of student nurses .. 86 median

56. Over the past year, how many graduate nurses participated?
(n=22) Number of graduate nurses .. 4.5 median

57. Did your organization provide internship or educational opportunities for students in public health, health administration or health services research programs?
(n=25) Yes 21
No 4

58. Over the past year, how many students participated?
(n=23) Number of students .. 2 median

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)?
(n=25) Yes 24
No 1

60. Over the past year, how many students participated?
(n=24) Number of students .. 14.5 median

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?
(n=23) Yes 8
No 15

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.
(n=17) # of community mental health centers .. 0 median

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?
(n=22) Yes 8
No 14

64. Which of the following forms of support did you provide to community mental health centers in the state?
(n=16)

	YES	NO
Technical assistance	6	10
Other forms of in-kind support (personnel, space, supplies)	3	13
Endorsements in seeking government support	6	10
Grants or direct financial support	2	14
Participation on boards of directors at CMHCs	5	11
Encouraging employees to contribute time to these centers	5	11
Other support we haven't mentioned	5	11

65. In the past year, did your organization have a contract that supported any community health centers in Connecticut for the provision of services?
(n=24) Yes 7
No 17

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.
(n=13) # of community health centers .. 1 median

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?
(n=23) Yes 9
No 14

68. Which of the following forms of support did you provide to community health centers in the state?
(n=18)

	YES	NO
Technical assistance	9	14
In-kind support such as personnel, space, or supplies	4	8
Endorsements in seeking government support	10	14
Financial support that doesn't involve contracts for services	4	13
Participation on boards of directors	3	15
Encouraging employees to contribute their time	3	14
Any other kind of support?	3	13

69. In the past year, did your organization have a contract that supported any local health departments or regional health districts in the state?
(n=24) Yes 11
No 13

70. With how many departments or regional health districts did your organization have such contracts?
(n=15) Number of health departments or districts .. 1 median

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?

(n=23) Yes 17
No 6

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

(n=19)

	YES	NO
Technical assistance	15	4
In-kind support such as space, personnel, or equipment	13	5
Endorsements in seeking government support	13	5
Financial support that doesn't involve contracts for services	6	12
Participation on boards of directors	5	12
Encouraging employees to contribute their time	9	8
Any other support provided?	10	9

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

(n=25) Yes 11
No 14

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

(n=24) Yes 21
No 3

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.

(n=20) $270,000 median (10)
Don't Know .. 10

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

(n=11)

government grants/contracts?	25% median
foundations/nonprofit philanthropy	5% median
commercial companies?	10% median
internal funds/general revenue	33% median

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?

(n=24) Yes 17
No 7

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

(n=23)

	YES	NO
Academic researchers	17	6
Government agencies	17	5
Commercial enterprises	9	13

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?

(n=24) Yes 22
No 2

80. Which of the following prevention activities has your organization made available to the general public...
(n=24)

	YES	NO
immunization programs?	22	2
sexually transmitted disease prevention programs?	15	8
clean needle or bleach programs for IV drug users?	2	20
animal vectored diseases (rabies, Lyme disease)?	15	8
tuberculosis identification programs?	13	10

81. Do you directly employ staff in these programs to reduce infectious diseases?
(n=23) Yes 16
No 7

82. In terms of full-time equivalents, how much staff time is dedicated to the reduction of infectious disease in the community?
(n=18) Number of FTEs 1.4 median

83. Does the program have a formal budget?
(n=23) Yes 8
No 15

84. What was the budget for the past fiscal year?
(n=12) $125,000 median

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.
(n=23) Yes 14
No 9

86. Have these reports been distributed outside the organization, such as to government agencies or community groups?
(n=20) Yes 11
No 9

87. Roughly how many copies of these reports were distributed?
(n=13) 25 median

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?
(n=18) Number of FTEs .. 0.1 median

89. Do these needs assessment efforts have their own budget?
(n=17) Yes 3
No 14

90. Over the past year, how much did your organization spend on needs assessments in Connecticut? Note: Your best estimate is fine.
(n=13) Annual Expenditures .. $500 median

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?
(n=23) Yes 13
No 10

92. Over the past year, has your organization provided financial, technical, or other support for social service agencies in Connecticut?
(n=24) Yes 16
No 8

93. Which of the following forms of support did you provide to social service agencies in the state?
(n=22)

	YES	NO
Technical assistance	13	8
In-kind support such as space, personnel, or equipment	15	7
Endorsements in seeking government support	12	9
Financial support that doesn't involve contracts for services	9	12
Participation on boards of directors	14	8
Encouraging employees to contribute their time	15	7
Any other kind of support?	9	12

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?
(n=25) Yes 19
No 6

95. Which of the following home-based environmental health hazards were addressed by these initiatives?
(n=23)

	YES	NO
Environmental tobacco smoke	17	6
Lead paint	12	11
Fire safety	14	9
Poison control	16	7
Heating subsidy programs	2	20

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?
(n=17) Number of FTEs .. 0.2 median

97. Do these home-based environmental health improvement efforts have their own budget?
(n=21) Yes 5
No 16

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.
(n=14) Annual expenditures .. $7,250 median

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?
(n=24)

	YES	NO
Technical assistance	11	13
In-kind support such as space, personnel, or equipment	5	18
Endorsements in seeking government support	8	15
Financial support that doesn't involve contracts for services	2	21
Participation on boards of directors	6	18
Encouraging employees to contribute their time	8	16
Any other kind of support?	4	19

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?
(n=23) Yes 6
No 17

101. Which of the following environmental threats were addressed through these initiatives?
(n=15)

	YES	NO
Air pollution	4	11
Water pollution	5	10
Toxic waste	3	12
Pesticides	2	13
Noise pollution	2	13
Food safety (or foodborne illnesses)	2	13
Other? Specify_____	2	12

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?
(n=18)

	YES	NO
Technical assistance	4	12
In-kind support such as space, personnel, or equipment	4	12
Endorsements in seeking government support	4	13
Financial support that doesn't involve contracts for services	1	16
Participation on boards of directors	3	14
Encouraging employees to contribute their time	6	12
Any other kind of support	3	14

103. In the past year, has your organization worked with any schools in Connecticut to address or to prevent health problems among children?
(n=23) Yes 21
No 2

104. Does your organization contract with any school-based health clinics?
(n=23) Yes 4
No 19

105. Did your organization operate or staff a school-based health center or clinic?
(n=23) Yes 5
No 18

106. Was your organization paid to operate these centers or clinics?
(n=15) Yes 3
In some cases 1
No 11

107. Did this payment cover your full costs for these services?
(n=12) Yes 0
In some cases 0
No 12

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.
(n=23) Yes 16
No 7

109. Does your organization contract with any organizations providing social services to non-enrollees in elderly housing projects?
(n=24) Yes 5
No 19

110. In the past year, did your organization operate any healthcare programs in elderly housing projects in Connecticut?
(n=24) Yes 13
No 11

111. Was your organization paid to operate these services?

(n=18) Yes 1
In some cases 3
No 14

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

(n=13) Yes 0
No 13

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.

(n=24) Yes 16
No 8

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

(n=23) Yes 9
No 14

115. Was your organization paid to operate these services?

(n=16) Yes 0
In some cases 0
No 16

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

(n=9) Yes 0
In some cases 0
No 9

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

(n=23) Yes 1
No 22

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?

(n=20)

	YES	NO
Technical assistance	4	15
In-kind support such as space, personnel, or equipment	10	10
Endorsements in seeking government support	5	14
Participation on boards of directors	6	13
Encouraging employees to contribute their time	8	11
Any other kind of support?	6	12

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...

(n=24)

	YES	NO
created policies for referring caregivers to support groups?	18	6
provided financial or in-kind support to such groups?	17	7
established support groups for patients' families?	23	1
provided respite care?	10	14

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:

(n=24)

	Never	Rarely	Sometimes	Often	Always
offer counseling to family care givers?	1	0	2	14	7
provide or pay for respite home care for caregivers?	13	2	6	3	0

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.

(n=23) Yes 13
No 10

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

(n=13) Annual expenditures ..$23,530 median

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:

(n=16)

	YES	NO
Community health centers	2	12
Community mental health centers	2	11
Hospitals	1	12
Hospice programs	3	10
Long term care organizations	1	11
Home care organizations	2	11
Patient advocacy groups	2	12
Local public health districts or departments	2	12
Social service agencies	9	7
Universities	3	11
Primary/secondary schools	3	11
School health programs	4	11
United Way or other federated giving programs	5	10
Arts organizations (visual or performing)	3	11

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

(n=25) Yes 23
No 2

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

(n=24) Yes 22
No 2

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

(n=24) q Yes 2
q No 22

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

(n=24) q Yes 23
q No 1

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

(n=24) q Yes 21
q No 3

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

(n=25) q Yes 22
q No 3

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

(n=24) q Yes 23
q No 1

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

(n=24) q Yes 10

q No 14

132. Does this policy or program cover...

(n=14)

	YES	NO
residents of low-income areas?	8	5
people with mental/physical handicaps?	8	6
participants in welfare-to-work training programs?	5	7
immigrant groups?	3	9
older workers?	5	8
some other group?	5	7

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

(n=24) Yes 20

No 4

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

(n=24) Yes 9

No 15

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

(n=24) Yes 18

No 6

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

(n=24) Yes 12

No 12

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

(n=24) Yes 11

No 13

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

(n=24) Yes 12

No 12

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?

(n=24) Yes 17

No 7

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

(n=23) Yes 15

No 8

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

(n=23) Yes 3

No 20

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

(n=24) Yes 3

No 21

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...

(n=20)

	YES	NO
With limited incomes?	14	6
With high immigrant population	12	8
In inner cities?	11	8
In rural areas?	5	13
Medically underserved areas?	15	5
With concentrated racial minorities?	13	7

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?

(n=21)

	Increase focus	Keep the same	Decrease focus
Unprofitable services	1	19	0
Health education programs	11	10	0
Health promotion activities, other than education programs	12	9	0
Health professional education	5	16	0
Health-related research	6	15	0
Programs to limit communicable diseases	2	19	0
Support for local health infrastructure	6	14	0
Collaboration with local public health agencies	9	12	0
Charitable contributions/ volunteer programs	2	19	0
Home-based health initiatives	3	18	0
Environmental health initiatives	2	19	0
Caregiver support programs	5	16	0
Support for schools or social service agencies	6	15	0
Community health needs assessments	8	12	0

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?

(n=15) see survey

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.

(n=25) Yes 17

No 8

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

(n=19)

	YES	NO
State regulatory agencies?	4	15
State or local government officials?	11	8
Community groups?	11	7
Patients?	10	8
Major employers in the community?	10	7
Hospital and health services in the community?	8	9
Management at the regional or national level?	5	12
Local health departments or districts?	10	8

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:

(n=22)

	YES	NO
Advisory boards drawn from the local community	20	2
Town meetings with the public	15	7
Reports to city or town boards of selectmen	9	12
Public dissemination of community benefit reports	12	10
Open board meetings	4	18

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

(n=24)

	No Influence	Limited Influence	Some Influence	Considerable Influence
Local residents	0	1	10	13
City councils or town board of selectmen	0	5	17	2
Local nonprofit organizations	0	1	18	5
Community health centers	0	5	13	3
Community mental health centers	1	7	12	3
Local physicians	0	1	10	13
Local business groups	0	3	19	2
State agencies	0	5	16	3
Local health departments or districts	0	0	15	8
Patients at your hospital	0	0	6	18
Health care providers at your hospital	0	0	4	20