APPENDIX A

STATE HEALTH PLANNING LEGISLATION

STATE OF CONNECTICUT

Sec. 19a-7a. The General Assembly declares that it shall be the goal of the state to assure the availability of appropriate health care to all Connecticut residents, regardless of their ability to pay. In achieving this goal, the state shall work to create the means to assure access to a single standard of care for all residents of Connecticut, on an equitable financing basis and with effective cost controls. In meeting the objective of such access, the state shall ensure that mechanisms are adopted to assure that care is provided in a cost effective and efficient manner.

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

Sec. 19a-7. The Department of Public Health shall be the lead agency for public health planning and shall assist communities in the development of collaborative health planning activities which address public health issues on a regional basis or which respond to public health needs having state-wide significance. The department shall prepare a multiyear state health plan which will provide an assessment of the health of Connecticut's population and the availability of health facilities. The plan shall include: (1) Policy recommendations regarding allocation of resources; (2) public health priorities; (3) quantitative goals and objectives with respect to the appropriate supply, distribution and organization of public health resources; and (4) evaluation of the implications of new technology for the organization, delivery and equitable distribution of services. In the development of the plan the department shall consider the recommendations of any advisory bodies which may be established by the commissioner.

OFFICE OF HEALTH CARE ACCESS

Sec. 19a-613. (a) The Office of Health Care Access shall employ the most effective and practical means necessary to fulfill the purposes of 19a-610 to 19a-622, including but not limited to, performing the duties and functions as enumerated in subsection (b) of this section. (b) The Office shall: (1) Authorize and oversee the collection of data required to carry out the provisions of sections 19a-610 to 19a622 and coordinate with the Connecticut Health Care Data Institute on issues relating to the collection and analysis of health care data described in sections 19a-619 to 19a-622, inclusive; (2) oversee and coordinate health system planning for the state; (3) monitor health care costs; (4) continue the functions and duties of chapter 368z; and (5) implement and oversee health care reform as enacted by the General Assembly.

Sec. 19a-634. (a) The Office of Health Care Access, in consultation with the Department of Public Health, shall carry out a continuing state-wide health care facility utilization study, including a study of existing health care delivery systems; recommend improvements in health care procedures to the health care facilities and institutions; recommend to the commissioner legislation in the area of health care programs; and report annually to the Governor and the General Assembly its findings, recommendations and proposals, as of January first, for improving efficiency, lowering health care costs, coordinating use of facilities and services and expanding the availability of health care throughout the state.

(b) The office shall establish and maintain a state-wide health care facilities plan, including provisions for an ongoing evaluation of the facility utilization study conducted pursuant to subsection (a) of this section to: (1) Determine the availability of acute care, long term care and home health care services in private and public institutional and community-based facilities providing diagnostic or therapeutic services for residents of this state; (2) determine the scope of such services; and (3) anticipate future needs for such facilities and services. The health care facilities plan shall be considered part of the state health plan for purposes of office deliberations pursuant to section 19a-637.

Sec. 19a-637. (a) In any of its deliberations involving a proposal, request or submission regarding rates or services by a health care facility or institution, the office shall take into consideration and make written findings concerning each of the following principles and guidelines: The relationship of the proposal, request or submission to the state health plan; the relationship of the proposal, request or submission to the applicant's long-range plan; the financial feasibility of the proposal, request or submission and its impact on the applicant's rates and financial condition; the impact of such proposal, request or submission on the interests of consumers of health care services and the payers for such services; the contribution of such proposal, request or submission to the quality, accessibility and cost-effectiveness of health care delivery in the region; whether there is a clear public need for any proposal or request; whether the health care facility or institution is competent to provide efficient and adequate service to the public in that such health care facility or institution is technically, financially and managerial expert and efficient; that rates be sufficient to allow the health care facility or institution to cover its reasonable capital and operating costs. Whenever the granting, modification or denial of a request is inconsistent with the state health plan, a written explanation of the reasons for the inconsistency shall be included in the decision.

CONNECTICUT DEPARTMENT OF MENTAL HEALTH & ADDICTION SERVICES

Sec. 17a-451. (h) [The Commissioner] shall develop a state-wide plan for the development of mental health services which identifies needs and outlines procedures for meeting these needs. (j) He shall be responsible for developing and implementing the Connecticut comprehensive plan for prevention, treatment and reduction of alcohol and drug abuse problems to be known as the state substance abuse plan. The plan shall include state-wide, long term planning goals and objectives, and annual revisions of objectives. In the development of the substance abuse plan the commissioner shall solicit and consider the recommendations of the sub-regional planning and action councils established under section 17a-671. (See Appendix C)

CONNECTICUT DEPARTMENT OF MENTAL RETARDATION

Sec. 17a-211. (a) In 1991, and every two years hereafter, the Department of Mental Retardation shall develop and review a five-year plan in accordance with this section. The plan shall: (1) Set priorities; (2) identify goals and objectives and the strategies to be employed to achieve them; (3) define the criteria to be used in evaluating whether the department is making progress toward the achievement of such goals and objectives; (4) identify changes in priorities, goals, objectives and strategies from the prior plan; (5) describe and document progress made in achieving the goals and objectives outlined in the prior plan; and (6) estimate the type and quantity of staff and client services that will be needed over the life of the plan.

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

Sec. 17b-26. (a) The Department of Social Services shall act as the single state agency to coordinate, plan and publish annually the state social services plan for the implementation of social services block grants and community services block grants as required by federal law and regulation. Said department shall furnish copies of said plan to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, and the budgets of state agencies and human services, at least sixty days prior to publication, for their review and recommendations, and shall consult with and furnish to said committees any additional information on such plan which they may request.

APPENDIX B

CONNECTICUT HEALTH DEPARTMENTS AND DISTRICTS

Table B - 1
Local Health Departments and Districts by Municipality

	Municipality [a]	Health Department/District [b]
	Andover	Town of Andover Health Department
✓	Ansonia	Naugatuck Valley Health District
✓	Ashford	Northeast District Dept. of Health
✓	Avon	Farmington Valley Health District
✓	Bantam (b)	Torrington Area Health District
✓	Barkhamsted	Farmington Valley Health District
✓	Beacon Falls	Naugatuck Valley Health District
✓	Berlin	Berlin Health Department
	Bethany	Town of Bethany Health Department
✓	Bethel	Bethel Health Department
✓	Bethlehem	Torrington Area Health District
✓	Bloomfield	West Hartford-Bloomfield Health District
✓	Bolton	Eastern Highlands Health District
	Bozrah	Town of Bozrah Health Department
✓	Branford	East Shore Health District
✓	Bridgeport	Bridgeport Health Department
	Bridgewater	Town of Bridgewater Health Dept.
✓	Bristol	Bristol-Burlington Health District
	Brookfield	Town of Brookfield Health Dept.
✓	Brooklyn	Northeast District Dept. of Health
✓	Burlington	Bristol-Burlington Health District
	Canaan	Town of Canaan Health Department
✓	Canterbury	Northeast District Dept. of Health
✓	Canton	Farmington Valley Health District
	Chaplin	Town of Chaplin Health Department
✓	Cheshire	Chesprocott Health District
	Chester	Town of Chester Health Department
	Clinton	Town of Clinton Health Department
	Colchester	Town of Colchester Health Dept.
✓	Colebrook	Farmington Valley Health District
	Columbia	Town of Columbia Health Department
✓	Cornwall	Torrington Area Health District
✓	Coventry	Eastern Highlands Health District
	Cromwell	Town of Cromwell Health Department
✓	Danbury	Danbury Health And Housing Dept.
✓	Danielson (b)	Northeast District Dept. of Health
	Darien	Town of Darien Health Department
	Deep River	Town of Deep River Health Dept.
✓	Derby	Naugatuck Valley Health District
	Durham	Town of Durham Health Department
✓	East Granby	Farmington Valley Health District
	East Haddam	Town of East Haddam Health Dept.
✓	East Hampton	East Hampton Health Department

	Municipality [a]	Health Department/District [b]
✓	East Hartford	East Hartford Health Department
✓	East Haven	East Shore Health District
	East Lyme	Town of East Lyme Health Dept.
✓	East Windsor	North Central Health District
✓	Eastford	Northeast District Dept. of Health
	Easton	Town of Easton Health Department
✓	Ellington	North Central Health District
✓	Enfield	North Central Health District
	Essex	Town of Essex Health Department
✓	Fairfield	Fairfield Health Department
✓	Farmington	Farmington Valley Health District
	Fenwick (b)	Town of Old Saybrook Health Dept.
	Franklin	Town of Franklin Health Department
✓	Glastonbury	Glastonbury Health Department
✓	Goshen	Torrington Area Health District
✓	Granby	Farmington Valley Health District
✓	Greenwich	Greenwich Health Department
	Griswold	Town of Griswold Health Department
✓	Groton city & town	Ledge Light Health District
	Guilford	Town of Guilford Health Department
	Haddam	Town of Haddam Health Department
✓	Hamden	Quinnipiack Valley Health District
✓	Hampton	Northeast District Dept. of Health
✓	Hartford	Hartford Health Department
✓	Hartland	Farmington Valley Health District
✓	Harwinton	Torrington Area Health District
	Hebron	Town of Hebron Health Department
	Jewett City (b)	Town of Griswold Health Department
✓	Kent	Torrington Area Health District
✓	Killingly	Northeast District Dept. of Health
	Killingworth	Town of Killingworth Health Dept.
	Lebanon	Town of Lebanon Health Department
	Ledyard	Town of Ledyard Health Department
	Lisbon	Town of Lisbon Health Department
✓	Litchfield	Torrington Area Health District
✓	Litchfield (b)	Torrington Area Health District
	Lyme	Town of Lyme Health Department
	Madison	Madison Health Department
✓	Manchester	Manchester Health Department
✓	Mansfield	Eastern Highlands Health District
	Marlborough	Town of Marlborough Health Dept.
✓	Meriden	Meriden Dept. of Health & Human Services
	Middlebury	Town of Middlebury Health Dept.
	Middlefield	Town of Middlefield Health Dept.
✓	Middletown	Middletown Health Department
✓	Milford	Milford Health Department
	Monroe	Town of Monroe Health Department
✓	Montville	Uncas Health District
✓	Morris	Torrington Area Health District
✓	Naugatuck	Naugatuck Valley Health District
✓	New Britain	New Britain Health Department
	New Canaan	Town of New Canaan Health Department
✓	New Fairfield	New Fairfield Health Department
✓	New Hartford	Farmington Valley Health District
✓	New Haven	New Haven Health Department
✓	New London	New London Health Department

	Municipality [a]	Health Department/District [b]
✓	New Milford	New Milford Health Department
	Newington	Town of Newington Health Department
✓	Newtown	Newtown Health District
✓	Newtown (b)	Newtown Health District
✓	Norfolk	Torrington Area Health District
✓	North Branford	East Shore Health District
	North Canaan	Town of North Canaan Health Dept.
✓	North Haven	Quinnipiack Valley Health District
	North Stonington	Town of North Stonington Health Dept.
✓	Norwalk	Norwalk Health Department
✓	Norwich	Uncas Health District
	Old Lyme	Town of Old Lyme Health Department
	Old Saybrook	Town of Old Saybrook Health Dept.
	Orange	Town of Orange Health Department
✓	Oxford	Pomperaug Health District
✓	Plainfield	Northeast District Dept. of Health
	Plainville	Town of Plainville Health Department
	Plymouth	Town of Plymouth Health Department
✓	Pomfret	Northeast District Dept. of Health
	Portland	Town of Portland Health Department
	Preston	Town of Preston Health Department
✓	Prospect	Chesprocott Health District
✓	Putnam	Northeast District Dept. of Health
	Redding	Town of Redding Health Department
	Ridgefield	Town of Ridgefield Health Department
✓	Rocky Hill	Rocky Hill-Wethersfield Health District
	Roxbury	Town of Roxbury Health Department
	Salem	Town of Salem Health Department
✓	Salisbury	Torrington Area Health District
	Scotland	Town of Scotland Health Department
✓	Seymour	Naugatuck Valley Health District
	Sharon	Town of Sharon Health Department
✓	Shelton	Naugatuck Valley Health District
	Sherman	Town of Sherman Health Department
✓	Simsbury	Farmington Valley Health District
	Somers	Town of Somers Health Department
	South Windsor	Town of South Windsor Health Dept.
✓	Southbury	Pomperaug Health District
	Southington	Town of Southington Health Dept.
	Sprague	Town of Sprague Health Department
✓	Stafford	Stafford Health District
✓	Stamford	Stamford Health Department
✓	Sterling	Northeast District Dept. of Health
	Stonington	Town of Stonington Health Dept.
	Stonington (b)	Town of Stonington Health Dept.
✓	Stratford	Town of Stratford Health Department
✓	Suffield	North Central Health District
✓	Thomaston	Torrington Area Health District
✓	Thompson	Northeast District Dept. of Health
	Tolland	Town of Tolland Health Department
✓	Torrington	Torrington Area Health District
	Trumbull	Town of Trumbull Health Department
✓	Union	Stafford Health District
✓	Vernon	North Central Health District
	Voluntown	Town of Voluntown Health Department
	Wallingford	Town of Wallingford Health Dept.

	Municipality [a]	Health Department/District [b]
✓	Warren	Torrington Area Health District
	Washington	Town of Washington Health Department
✓	Waterbury	Waterbury Health Department
	Waterford	Town of Waterford Health Department
✓	Watertown	Torrington Area Health District
✓	West Hartford	West Hartford-Bloomfield Health District
✓	West Haven	West Haven Health Department
	Westbrook	Town of Westbrook Health Department
✓	Weston	Weston/Westport Health District
✓	Westport	Weston/Westport Health District
✓	Wethersfield	Rocky Hill-Wethersfield Health District
	Willington	Town of Willington Health Dept.
✓	Wilton	Wilton Health Department
✓	Winchester	Torrington Area Health District
✓	Windham	North Central Health District
✓	Windsor	Windsor Health Department
✓	Windsor Locks	North Central Health District
✓	Wolcott	Chesprocott Health District
✓	Woodbridge	Quinnipiack Valley Health District
✓	Woodbury	Pomperaug Health District
	Woodmont (b)	Milford Health Department
✓	Woodstock	Northeast District Dept. of Health

(b) Denotes a borough in Connecticut.
✓ Denotes a full-time health department or district.
[a] Connecticut municipalities include 170 cities and towns, and 8 boroughs
[b] Connecticut Department of Public Health, Local Health Administration. *Directory, Local Directors of Health in Connecticut.* Hartford:1997.

Table B - 2
Regional Health Districts and Member Municipalities
Connecticut, 7/1/97

Health District	Municipality[1]
Bristol-Burlington Health District	Bristol, Burlington
Chesprocott Health District	Cheshire, Prospect, Wolcott
East Shore Health District	Branford, East Haven, North Branford
Eastern Highlands Health District	Bolton, Coventry, Mansfield
Farmington Valley Health District	Avon, Barkhamsted, Canton, Colebrook, East Granby, Farmington, Granby, Hartland, New Hartford, Simsbury
Ledge Light Health District	City of Groton, Town of Groton
Naugatuck Valley Health District	Ansonia, Beacon Falls, Derby, Naugatuck, Seymour, Shelton
Newtown Health District	Newtown, Newtown (b)
North Central Health District	East Windsor, Ellington, Enfield, Suffield, Vernon, Windham, Windsor Locks
Northeast District Dept. Of Health	Ashford, Brooklyn, Canterbury, Danielson (b), Eastford, Hampton, Killingly, Plainfield, Pomfret, Putnam, Sterling, Thompson, Woodstock
Pomperaug Health District	Oxford, Southbury , Woodbury
Quinnipiack Valley Health District	Hamden, North Haven, Woodbridge
Rocky Hill-Wethersfield Health District	Rocky Hill, Wethersfield
Stafford Health District	Stafford, Union
Torrington Area Health District	Bantam (b), Bethlehem, Cornwall, Goshen, Harwinton, Kent, Litchfield, Litchfield (b), Morris, Norfolk, Salisbury, Thomaston, Torrington, Warren, Watertown, Winchester
Uncas Health District	Montville, Norwich
West Hartford-Bloomfield Health District	Bloomfield, West Hartford
Weston/Westport Health District	Weston, Westport

1 Municipalities include cities, towns, and boroughs.

APPENDIX C

SUBSTANCE ABUSE AND MENTAL HEALTH

NEEDS ASSESSMENTS

SUBSTANCE ABUSE

Since 1995, the Department of Mental Health and Addiction Services (DMHAS) has been involved in a number of federally funded initiatives focused on measuring the need for substance abuse prevention and treatment services. DMHAS has worked collaboratively with its Academic Partnership, the University of Connecticut Health Center (UCHC) and Yale University, to conduct prevention and treatment research as it applies to the identification, planning and delivery of cost-effective services to Connecticut's residents. The studies described below have benefited policy-makers, program planners and service providers as research findings are translated into applied solutions.

Prevention Needs Assessment: Alcohol and Other Drugs

The Prevention Needs Assessment, awarded to the DMHAS by the federal Center for Substance Abuse Prevention, consists of a family of studies that includes: 1) a School Survey, 2) a Community Resource Assessment, and 3) a Social Indicator Model. These studies will provide information about conditions in the State known to be associated with substance abuse and the related activities that place communities at risk for such problems. The following is a brief description of each study.

Adult Prevention Needs Assessment

Administered as part of the Adult Household Survey (see below – Treatment Needs Assessment), a risk factor module was included in the screening interview instrument. Using this brief questionnaire enabled researchers to assess the prevalence of substance abuse risk factors and to investigate the social and demographic characteristics associated with substance use in Connecticut's adult population.

School Survey

Building upon similar surveys administered in 1989 and 1995, UCHC conducted a representative sample of approximately 15,000 students in grades 5 through 12 to measure youth use of alcohol, tobacco and other drugs (ATOD). New to the 1997/98 school survey was the inclusion of "risk" and "protective" measures designed to provide a better understanding of which factors were most likely to lead to alcohol or drug involvement or conversely, those that are likely to reduce the risk of individuals misusing ATOD. In addition, information was collected on adolescents' knowledge, perceptions and use of available prevention programs.

Community Resources Assessment

Combined with the School Survey, the Community Assessment Survey will measure the availability of prevention services and the unmet need within a community. This leading-edge study, conducted by the

UCHC, will pilot test a series of questionnaires which focus on the delivery of prevention services. Provider information to be collected from both traditional and non-traditional prevention programs includes: 1) description of services provided, 2) number of clients served, 3) service capacity, 4) funding sources and proportion of agency budget for prevention services, 5) risk and protective factors addressed by the program, 6) referrals and linkages with other resources, and 7) perceived prevention needs. By this process, DMHAS will begin to match prevention needs (School Survey) to existing resources (Community Resource Assessment) to identify gaps in services, improve coordination of prevention services and enhance accountability of prevention delivery systems.

Social Indicators Model

Using risk and protective factor theory, social indicator data for all 169 towns were collected for 1992, 1994 and 1996. These data are being analyzed with respect to four domains: the individual and peer, the family, the school and the community. Analysis is being conducted to identify statewide and regional patterns and trends in ATOD-related health status. When fully completed, this study will establish a method: 1) to monitor the conditions within the State that are known to be associated with ATOD-related problems, 2) to predict where in the State future ATOD problems are likely to arise, and 3) to inform program planners of areas requiring services.

Final reports detailing the complete findings of the four Prevention Needs Assessment studies will be available in spring 1999.

Treatment Needs Assessment: Alcohol and Other Drugs

In 1995 and again in 1997, DMHAS won competitive awards from the federal Center for Substance Abuse Treatment (CSAT) to conduct statewide assessments to determine the need for treatment services in Connecticut. Both assessments contained a "family of studies" designed to provide a comprehensive approach to understanding the prevalence of alcohol and other drug use, abuse and dependence. Reports from the 1995 assessment are currently available while the 1997 assessment is in final stages of development. Findings from the 1995 "family of studies" have been widely disseminated and have formed the basis for policy and program initiatives throughout the State. Below is a brief description of each needs assessment process.

1995 Family of Studies

School Survey

In 1995, UCHC conducted for DMHAS a school survey of 7th to 12th graders in public schools in Connecticut as a follow-up to the 1989 school survey. Major objectives included: 1) to estimate the prevalence of ATOD use in Connecticut's school population as well as problems associated with substance use; 2) to examine changing trends in adolescent substance abuse since the 1989 school survey; 3) to identify social and demographic characteristics of adolescents with ATOD abuse; and 4) to assist State and regional planning efforts for treatment and prevention services. Results of the survey were published in 1996 in a report entitled: *Adolescent Substance Abuse Treatment Needs Assessment: The 1995 Adolescent Alcohol and Drug Use School Survey*. Several key findings from that study include: a significant rise in the use of marijuana and inhalants especially for 7th and 8th graders, and a decrease of one full year in the age of first use for alcohol, marijuana and inhalants for junior high school students since the 1989 survey.

Youth at Risk Survey

In order to fully assess the prevalence of AOD use and the need for treatment among adolescents in the State, the University of Connecticut Health Center conducted, for DMHAS and the Department of Children and Families, the Youth At Risk (YAR) Survey. This study targeted those youth missed in the 1995

School Survey and included chronic truants and dropouts, alternative school students and committed juveniles. The objectives of this study included: a) to determine the prevalence of alcohol and other drug use among at-risk adolescents not in regular schools; b) to provide more accurate estimates of prevalence of use among the State's school-age population by integrating data from youth-at-risk and in-school data; c) to estimate the need for intervention and treatment among this population; and d) to describe the social, vocational, legal and psychological problems associated with these youths' substance abuse. Findings from the YAR study provided a unique insight to the differences between these two populations regarding substance use and abuse and the need for treatment. Particularly, 52% of committed juveniles, 25% of alternative school students and 18% of dropouts are determined to be in need of treatment as opposed to 5% of high school students. In addition to their substance abuse, the out-of-school population exhibits high levels of family, intrapersonal and environmental risk factors requiring an integrated and coordinated approach to their social and substance abuse needs.

Substance Abuse Need for Treatment among Arrestees (SANTA)

As part of the "family of studies", designed to complement the Adult Household Survey, Yale University's School of Medicine conducted for DMHAS a survey of the criminal justice population. This study of recent arrestees had two objectives: first, to determine the prevalence of alcohol and other drug use among samples of arrestees in Connecticut; and second, to estimate the need for substance abuse treatment within this population. The Substance Abuse Need for Treatment among Arrestees (SANTA) survey for adult arrestees was conducted between August 1995 and February 1996 at the Hartford and New Haven detention centers. A total of 478 adults were interviewed at the time of their arrest to assess substance use patterns and social, family, vocational and psychiatric issues. Findings from the SANTA study indicated that the rate of substance dependence was extraordinarily higher for recent arrestees than in the general population. Focusing on current dependence, 57.2% of male and 60.8% of female arrestees are dependent on any substance compared to 12.9% of men and 4.3% of women in the general population.

Adult Household Survey

The Adult Household Survey (ADH) was a collaborative effort of researchers at the University of Connecticut Health Center and the Institute for Social Inquiry (ISI) at the Storrs campus and conducted for DMHAS. Objectives for this study were: to determine the prevalence of alcohol and other drug use in the adult population for the state and regional planning areas; to estimate the prevalence of substance use disorders in Connecticut's adult population, and to estimate the need and demand for substance abuse treatment at the State and regional levels. The survey was conducted between March 1995 and March 1996 and contained two components: 1) a screening interview which collected information for all respondents, and 2) a diagnostic interview for respondents who met specific screening criteria.

Major findings from the AHS regarding alcohol and other drug (AOD) rates include the following:

- Alcohol continues to be the most widely used substance with 95% of adults having ever used and 59% currently using;
- Marijuana is the second most commonly reported substance with 32% of Connecticut adults reporting lifetime use and 3% reporting use in the past 30 days;
- Cocaine lifetime use is approximately 9% while less than 1% report current use;
- Other substances such as hallucinogens, stimulants and sedatives have low lifetime rates, at 6%, 6% and 4% respectively, and current use rates under 1%; and
- Heroin had the lowest lifetime use at 1.8% and a current use rate of less than 0.1%.

The AHS found that the prevalence of diagnosable and treatable psychiatric and medical conditions (abuse and dependence) associated with substance use varies in the following ways:

- Overall 8.3% of those populations included in the AHS meet the criteria for current abuse and dependence of any substance (alcohol or any illicit drug).
- Alcohol abuse and dependence accounts for the greatest percentage (7.8%) of those currently needing treatment in the general population.
- Marijuana is next with 1.2%, followed by cocaine (0.6%) and heroin or opiates (0.3%).

Social Indicators Model

The Social Indicator study focused on the social, economic and demographic conditions of the State that were thought to be associated with AOD-related problems. Study objectives included: to evaluate the availability of the indicators; to analyze the reliability, validity and generalizability of these indicators, to establish a database that identifies conditions within the State that reflect increases or decreases in the need for treatment; to assess the efficacy of these indicators as predictors of treatment utilization; to inform planners and policy makers within DMHAS and other State departments of problem indicators that should be considered in the development of treatment responses.

TREATMENT NEEDS ASSESSMENT II

In October 1997, DMHAS received a federal award from the Center for Substance Abuse Treatment (CSAT) to conduct a second "family of studies" designed to build upon the methodologies and findings of Connecticut's first substance abuse treatment needs assessment. The major objectives of the proposed study are: 1) to enhance previous data collection efforts, 2) to develop new methodologies to estimate treatment demand, 3) to provide new prevalence data from critical populations, and 4) to integrate the prevalence and demand estimates from the first treatment needs assessment with those obtained from special adult populations targeted in the second study. The three complementary studies include:

Study of Temporary Assistance to Needy Families (TANF) and General Assistance (GA) Populations

The main goals of the study are: 1) to provide the State with reliable estimates of need and demand for alcohol and drug treatment among adult and adolescent TANF enrollees and GA recipients, 2) to evaluate access, availability and effectiveness of substance abuse treatment services for TANF enrollees and GA recipients, and 3) to identify barriers to substance abuse treatment and service gaps for this population. The study will also provide data regarding medical (e.g., risk of HIV and other infectious illness) and psychiatric comorbidity (including depression, anxiety and psychotic disorders) associated with alcohol and other drug use, abuse and dependence in this population.

Social Indicator Analysis

This research project builds upon the Social Indicators Model from the first Treatment Needs Assessment which demonstrated that substance abuse treatment need in Connecticut varies according to region, community-type, and population characteristics. Multivariate analyses of the data to date have examined the interrelationships among the indicators and showed that indicators of poverty, urbanicity, crime and substance abuse "help-calls" contributed independently to a predictive model of substance abuse treatment demand.

Integration of Surveys, Social Indicators, and Treatment Utilization Findings

The purpose of the above studies is to enable Connecticut to estimate the prevalence of substance use and abuse, and to develop a demand model for prevention and treatment services that can guide the process of resource allocation. The aim to provide Connecticut's citizens with the most cost effective substance abuse prevention and treatment services available requires that the following be identified: 1) the number of people in need of services be quantified (prevalence estimates), 2) the number of those in need

who would actually use services be determined (demand estimates); and 3) the number and type of services to be utilized, planned and provided (resource allocation). To this end, information from the Treatment Needs Assessment I and II studies will be integrated to derive a comprehensive demand and resource allocation model.

MENTAL HEALTH

Over the course of the past several years, the federal Center for Mental Health Services (CMHS) in collaboration with a group of technical experts has developed a model for estimating the number of individuals with mental illness. Data from two national studies, the National Comorbidity Survey (NCS) and the Epidemiological Catchment Area (ECA) Study, were used to determine the 12-month prevalence for those with a mental illness. Applying this model, DMHAS extrapolated the number of adults within the State having a mental illness as follows:

- of Connecticut's adult population, 5.1% has a serious mental illness (SMI)
- approximately half of those with SMI or 2.6% of the total adult population have a severe and prolonged mental illness (SPMI)

An estimate of the prevalence of serious and prolonged mental (SPMI) illness used lifetime prevalence rates for schizophrenia, bipolar disorder and serious depression. The prevalence rates for these diagnostic groups were derived from the Epidemiological Catchment Area Study pooled rates for the six sites (one of which was New Haven, Connecticut). To each of these rates, a fixed value was applied representing DMHAS' estimate of the percentage of persons within each diagnostic group who have been seriously disabled by mental illness for a prolonged period of time. DMHAS estimate that 98% of all persons with schizophrenia, 50% of persons with bipolar disorder and 10% of persons with serious depression are reasonable estimates of "chronicity".

APPENDIX D

YEAR 2000 PLANNING EFFORTS

HEALTHY PEOPLE 2000

The U.S. Department of Health and Human Services designated various agencies within the Public Health Service to coordinate activities to achieve the objectives in each of the *Healthy People 2000* priority areas.

Table D - 1
***Healthy People 2000* Priority Areas and Lead Agencies**[2]

DHHS, PHS Lead Agencies	*Healthy People 2000* Priority Areas
Substance Abuse and Mental Health Services Administration	Alcohol and other drugs Mental health and mental disorders
Centers for Disease Control	Clinical preventive services Diabetes and chronic disabling conditions Educational and community-based programs Environmental health HIV infection Immunization and infectious diseases Occupational safety and health Oral health Sexually transmitted diseases Surveillance and data systems Tobacco Unintentional injuries Violent and abusive behavior
Food and Drug Administration	Food and drug safety
Health Resources and Services Administration	Educational and community-based programs Clinical preventive services Maternal and infant health
National Institutes of Health	Cancer Diabetes and chronic disabling conditions Environmental health Heart disease and stroke Mental health and mental disorders Nutrition Oral health
Office of Population Affairs	Family planning
President's Council on Physical Fitness and Sports	Physical activity and fitness

CDC HEALTH STATUS INDICATORS

The DHHS Centers for Disease Control and Prevention (CDC) was delegated responsibility for the priority area concerning health surveillance and to develop supporting data systems. As part of this responsibility, CDC

[2] U.S. Dept of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention. *Healthy People 2000 Review 1997*. Washington: 1997, p. 216.

developed a set of 18 health status indicators[3] to track the general health status of the population for each indicator. The indicators, listed below, were chosen in an effort to facilitate national, state, and local efforts in tracking the *Healthy People 2000* objectives and to help communities assess the general health status of their population.

Table D-2
Health Status Indicators

Mortality

- Total mortality
- Lung cancer deaths
- Motor vehicle crash deaths
- Homicide
- Cardiovascular disease
- Breast cancer deaths
- Suicides
- Infant mortality
- Work injury-related deaths

Disease Incidence

10. Acquired immunodeficiency syndrome (AIDS)
11. Syphilis
12. Tuberculosis
13. Measles

Risk Factors

14. Poor air quality, as measured by the proportion of people living in counties exceeding U.S. Environmental Agency standards for air quality during the previous year
15. Prenatal care, as measured by the percentage of mothers delivering live infants who did not receive prenatal care during the first trimester
16. Childhood poverty, as measured by the proportion of children less than 15 years of age living in families at or below the poverty level
17. Low birthweight-as measured by the percentage of live-born infants weighing less than 2,500 grams at birth
18. Births to adolescents (females aged 10-17 yrs.) as a percentage of total live births

[3] U.S. Dept of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention. Health objectives for the nation. *Morbidity and Mortality Weekly Report* 1991; Vol. 40, No. 27:1-3.

HEALTHY CONNECTICUT 2000

Healthy People 2000[4] and *Healthy Connecticut 2000 Baseline Assessment Report*[5] established priority areas for year 2000 objectives. The national priority area of Clinical Preventive Services was not covered in either the Connecticut 1992 or 1997 documents but may be included in future updates of the report. The 1997 revision covers two national priority areas that were not addressed in 1992: Educational/Community-based Programs, and Oral Health. The two national priority areas, Alcohol and Other Drugs, and Mental Health and Mental Disorders, are not addressed in DPH documents since these areas are under the jurisdiction of DMHAS.

Table D-3
Healthy People 2000 and Healthy Connecticut 2000 Priority Areas

	Healthy Connecticut 2000 Priority Areas	
Healthy People 2000 Priority Areas	1992	1997[6]
Health Promotion		
1/ Physical Activity and Fitness	✓[7]	✓
2/ Nutrition	✓	✓
3/ Tobacco	✓	✓
4/ Alcohol and Other Drugs	--[8]	--
5/ Family Planning	✓	✓
6/ Mental Health and Mental Disorders	--	--
7/ Violent and Abusive Behavior	✓	✓
8/ Educational / Community-Based Programs	--	✓
Health Protection		
9/ Unintentional Injuries	✓	✓
10/ Occupational Safety and Health	✓	✓
11/ Environmental Health	✓	✓
12/ Food and Drug Safety	✓	✓
13/ Oral Health	--	✓
Preventive Services		
14/ Maternal and Infant Health	✓	✓
15/ Heart Disease and Stroke	✓	✓
16/ Cancer	✓	✓
17/ Diabetes & Chronic Disabling Conditions	✓	✓
18/ HIV Infection	✓	✓
19/ Sexually Transmitted Diseases	✓	✓
20/ Immunization and Infectious Diseases	✓	✓
21/ Clinical Preventive Services	--	--
Surveillance and Data Systems		
22/ Surveillance and Data Systems	✓	✓

4 U.S. Dept of Health and Human Services. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*., 1990:

5 Connecticut Dept of Public Health. *Healthy Connecticut 2000 Baseline Assessment Report.* Hartford, CT. 1992:250pp.

6 Connecticut Dept of Public Health. *Healthy Connecticut 2000 Baseline Assessment Report Replacements and Additions.* 1997.

7 Indicates that the document contains objectives related to the priority area.

8 Indicates that the priority area is not addressed in the document.

APPENDIX E

SELECTED HEALTHY COMMUNITY INITIATIVES

Danbury Healthy 2000 (1994)

Area Served:	Greater Danbury
Participants:	Danbury Hospital, Danbury Visiting Nurse Association, Danbury Public Schools, Housatonic Valley Coalition Against Substance Abuse, AIDS Project Greater Danbury, Community Action Committee of Danbury, Danbury Department of Health.
Goals:	To increase the span of a healthy life, reduce health disparities, and increase access to preventive services.
Priorities:	• Depression/suicide • HIV/AIDS • Immunizations • Substance abuse • Teen pregnancy • Violence
Of Note:	Medical Town Meetings are free public forums held periodically to provide an opportunity to town discussion about health issues.

Greater New Haven Partnership for a Healthy Community

Area Served:	New Haven, East Haven, West Haven, North Haven, Hamden, North Branford, Orange, Woodbridge, and Bethany
Participants:	Initiating Partners: Community Foundation, Fair Haven and Hill Health Community Centers, Saint Raphael Healthcare System and Yale-New Haven Hospital, New Haven Health Dept., United Way, Visions for a Greater New Haven, and Yale University School of Medicine - Department of EPH. Community Partnership: represents the diversity of the community - politically, racially, geographically, ethnically, and economically.
Goals:	To improve the health status of all residents in Greater New Haven; to gain a comprehensive understanding of the community's health status and potential; to marshal community resources to improve quality of life; to encourage people to take greater responsibility for their own health; and to promote wellness and improve access for all to basic and preventive health care.
Priorities:	• Community needs assessment • Community outreach
Of Note:	Aiming to create a model of collaboration for continuum of care.

Healthy Connecticut Initiative - Regional Public Health Needs Assessment (1994)

Area Served:	Andover, Chaplin, Columbia, Coventry, Lebanon, Mansfield, Scotland, Sprague, and Windham representing over 71,000 residents.
Participants:	Andover, Chaplin, Columbia, Coventry, Lebanon, Mansfield, Scotland, Sprague, and Windham representatives and staff of The Healthy Connecticut Initiative.
Goals:	To improve access to local public health services by encouraging health policy decision-making at the community level to improve their quality of life.
Priorities:	• Infectious diseases • Municipal and interagency coordination, collaboration, and cooperation • Regional health district to enhance efficiency and coordination of services • Substance abuse • Violence prevention
Of Note:	Windham has since joined the North Central Health District but no formal action has taken place in the other communities. Discussions are continuing regarding consolidation and formation of a health district..

Hartford Community Health Partnership (1995)

Area Served:	City of Hartford
Participants:	DPH, Hartford Health Department, Hartford Hospital and St. Francis Medical Center, Hispanic Health Council, United Way, CT Children's Medical Center, and community representatives.
Goals:	To collaboratively assess and improve the health status of the City's residents by mobilizing the different community sectors.

Priorities:	• Collaboration and the role of the public health department • Health status data base • Economics • Health service delivery • Cultural diversity
Of Note:	Utilizing the partnership approach as a strategy to plan, develop, implement, monitor, maintain, and evaluate a community's shared visions for the production of health.

Healthy Living 2000 (1994)

Area Served:	Greenwich
Participants:	Greenwich Hospital, Greenwich Department of Health, media, community agencies, businesses, and residents.
Goals:	To help the people of Greenwich improve their health and to prevent major illnesses and chronic disease.
Priorities:	• Alcohol abuse and misuse • High cholesterol • Hypertension • Life dissatisfaction • Overweight • Unintentional injuries and safety

Healthy Meriden 2000 (1994)

Area Served:	City of Meriden
Participants:	The Veterans Memorial Medical Center, the Meriden Health Department, and the Easter Seal Rehabilitation Center and stakeholders groups with 150+ volunteers.
Goals:	Measurably improve the health status of Meriden's citizens.
Priorities:	• Chronic Disease & Leading causes of death • Crime • Elderly Issues • Health care resource utilization • Substance abuse/tobacco • Teen pregnancy
Of Note:	Published an inventory of community services as a collaborative effort among Healthy Meriden 2000, Meriden's Children First Initiative, and the Meriden Clergy Association.

Hartford New London 2000 (1996)

Area Served:	City of New London
Participants:	New London Health Dept, Lawrence & Memorial Hospital, various churches, schools, neighborhood alliances.
Goals:	Improve the overall health of New London residents
Priorities:	• Teenage pregnancy • Drug and alcohol dependence • Breast cancer • Communicable diseases
Of Note:	Community survey and task forces in place to move forward with intervention strategies.

Healthy Valley 2000 (1993)

Area Served:	Ansonia, Beacon Falls, Derby, Oxford, Seymour, and Shelton
Participants:	Griffin Hospital has taken the coordinating lead with a stakeholder group of 200 community members.
Goals:	To improve the health and quality of life of residents and the community by making the Valley a better place to live, work, raise a family, and enjoy life.
Priorities:	• Substance Abuse • Economic Development • Crime • AIDS • Education
Of Note:	Nationally recognized as a community model by The Presidents' Summit for America's Future.

Neighborhood Health Improvement Partnership (1995)

Area Served:	Bridgeport's East Side and East End
Participants:	35 Bridgeport community agency representatives. A Coordinating Committee represents healthcare providers, consumers, legislators, policy makers, law enforcement officials, and major employers. Bridgeport Hospital is the primary health care provider.
Goals:	To improve the well-being of the neighborhood's residents through education of healthy choices and the promotion of living healthier and longer.
Priorities:	• Access to health care • Economic development • Substance abuse and mental health • Teenage pregnancy and parenting
Of Note:	A special liaison has been set up to assure parental involvement in the development of the final action plan. The NHIP emphasizes that parents are key to improving and maintaining the health of a community.

Northeast District "Building Healthier Communities" (1995)

Area Served:	Ashford, Brooklyn, Canterbury, Eastford, Hampton, Killingly, Plainfield, Pomfret, Putnam, Sterling, Thompson, and Woodstock
Participants:	Community Health Coordinating Council (health, social services, and provider organizations within the district) and the Northeast District Department of Health.
Goals:	To fulfill two core public health functions: monitoring the health status of the population, and leading the development of health policy and planning.
Priorities:	• Alcohol and Drug Use (Particularly Involved In Motor Vehicle Fatalities) ▪ Smoking (Particularly Among Teens And Pregnant Women). • Teenage Pregnancy • Violence And Abusive Behavior
Of Note:	In June 1996, the NDDH, for the Coordinating Council, published *"Health Highlights: Selected Health Status Indicators and Objectives for Northeastern Connecticut"* which compared district health status data with state and national data and *Healthy People 2000* target objectives.

PATCH - Planned Approach to Community Health (1984)

Area Served:	Middletown, Middlefield, Portland, Durham, Haddam, Cromwell, East Hampton, and East Haddam
Participants:	Representatives from the communities, the Connecticut DPH, Middlesex Hospital, and the Centers for Disease Control and Prevention.
Goals:	Engage a broad-based group of community participants which actualizes a shared visions for a healthy community.
Priorities:	• Community needs assessments • Health improvement plan • Coalition with nontraditional partners to establish an effective public/private partnership for community health.

SPARC : Sickness Prevention Achieved Through Regional Collaboration	
Area Served:	Litchfield County in Connecticut
Participants:	CT AARP, DPH, legislators, CT Peer Review Organization, Centers for Disease Control & Prevention, New Milford Visiting Nurse Association, Salisbury Public Health Nursing Association, Sharon Hospital, Torrington Area Health District, Visiting Nurse and HomeCare, Washington-Warren Visiting Nurse Association.
Goals:	To improve the health status of residents by increasing access to clinical preventive services.
Priorities:	• Develop a regional network of providers • Provide a means of tracking clinical prevention activities • Increase the utilization of preventive services
Of Note:	The region is a three-state, four-county area that includes Duchess and Columbia Counties, New York and Berkshire County, Massachusetts.

Stratford Health Advisory Council - “Building a Healthy Community” (1994)	
Area Served:	Stratford
Participants:	Stratford Health Department assumed the leadership role among the members representing health, business, education, social service, and community sectors in town. Includes DPH, Bridgeport Hospital, Chamber of Commerce, Council of Churches, Board of Education, and the Stratford Youth and Family Advisory Board.
Goals:	To assist the Town Manager and Health Director in formulating public health policies, identifying priorities, and advancing services that truly reflect the needs of the community.
Priorities:	• Cancer and Heart disease • Diet • Maternal and child health • Mental/emotional health • Substance abuse • Youth risk behaviors
Of Note:	The Council is focusing on heart disease and cancer for its initial community health action plan that emphasizes reducing tobacco and alcohol negative outcomes, increasing medical screening services, promoting fitness and nutrition.

APPENDIX F

CONNECTICUT'S MEDICAID MANAGED CARE PLANS

Enrollment and Market Share of Medicaid Managed Care Plans
Connecticut, as of 1/1/98

Participating Plans[9]	Description	Enrollment[10]	Market Share
Blue Cross/Blue Shield of Connecticut	Traditional plan	64,922	30%
Community Health Network	Fully capitated/FQHC model/serve Medicaid only	20,141	9%
HealthRight	Fully capitated/FQHC models/serve Medicaid only	29,542	14%
Kaiser Permanente	Traditional plan	4,815	2%
MD Health Plan	Traditional plan	24,706	11%
Oxford Health Plan	Traditional plan	33,069	15
Physicians Health Services	Traditional plan	21,533	10%
Yale Preferred One, Inc.	Serve Medicaid only	19,554	9%
Total		218,282	

Source: DSS, Benova, Inc. Monthly Enrollment Report,
These numbers represent the enrollment and eligibility activity as of the month end cut off data of 11/25/97. These numbers fluctuate daily as retroactive changes are made in eligibility status.

9 Since initial publication of the *Assessment* in January, 1998, Oxford has left the program bringing the total number of participating plans to seven.

10 As of November 1998, total enrollment has increased to 223,808 with the market shares increasing 2-3% for all plans except for Kaiser.

APPENDIX G

SAFETY NET PROVIDERS IN CONNECTICUT

A Report to the Public Health Subcommittee of the Medicaid Managed Care Council of the Connecticut State Legislature
by the Connecticut Department of Public Health, January, 1998

Contents

EDITOR'S NOTE:
The "Safety Net Providers in Connecticut" was developed independently, and published separately from the State Health Assessment. The report is an important planning document and supports the State Health Assessment. Therefore, the entire document, including Appendices, is included as Appendix G of the State Health Assessment.

EXECUTIVE SUMMARY

With the advent of managed care and other major shifts in the health care funding environment, municipal health departments and voluntary or nonprofit sector health care agencies in Connecticut, which make up the state's health care "safety net," faced a shifting client base, increased administrative costs, and decreased revenues. Reportedly this had forced some providers to consolidate operations, curtail services or close down entirely. Weakening of this infrastructure threatens not only the state's capacity to care for its uninsured and for its populations at risk but also its ability to meet its overall public health obligations to promote health and prevent disease and injury.

At the request of the Public Health Subcommittee of the State Legislature's Medicaid Managed Care Council, an inventory of "safety net" health care providers in Connecticut was undertaken by DPH. The study also included information about: personal care services versus population-based services, both of which these providers deliver; gaps where requested information is not available to DPH; fiscal constraints and limitations on statutory authority that prevent DPH from carrying out monitoring as requested by the Subcommittee; considerations in establishing a monitoring and surveillance system for safety net providers in Connecticut; and suggestions for further research.

The study defined as safety net providers: community health centers, school-based health centers, local health departments, visiting nurses associations (VNAs), family planning clinics, and public health dental service sites. Nearly 300 safety net providers in these six categories were identified. Background information on each of the six groups of providers was provided along with legal mandate, regulatory or licensure requirements, funding, and the kind of data DPH collects on each group.

Aggregate data rather than client-based data were generally collected from each group of safety net providers. Licensure requirements and grant administration requirements formed the basis for the kind of data that DPH collects. However, statutory authority for data requirements and data collection by DPH is limited (the exception is a broad statutory reporting requirement to DPH for local health departments).

DPH has gaps in data about the fiscal status and performance of safety net providers due to lack of timeliness of such data; fragmentation in its collection and in its handling due to the categorical nature of most DPH programs; lack of adequate staff and resources to handle the design, collection, and analysis of the data system; and limitations on data requirements from the laws themselves. The capacity of many of the providers to supply detailed information and specific kinds of data is a problem. Also, health care providers are reluctant to provide certain kinds of information considered proprietary such as fiscal well-being or service delivery patterns.

To effectively monitor the status, performance, and fiscal solvency of safety net providers, a monitoring and surveillance system very different from what DPH currently has in place would be needed. This system would require access to: timely information from the agencies on a regular basis; data that is uniform from provider to provider; client specific data on service delivery including demographics, diagnosis, units of service by provider, and payer; data on performance, client services and quality of care, especially changes in any of these areas; and information on the fiscal status and financial solvency of the provider. Lastly, it requires appropriate statutory authority to carry out these functions.

Suggested areas for further study were: the design of a surveillance system for monitoring the status of safety net providers; and the identification and validation of performance indicators for safety net providers in the community.

1 INTRODUCTION AND PURPOSE

This report is in response to a request from the Subcommittee on Public Health of the Medicaid Managed Care Council. The Subcommittee was concerned about the impact of the current health care delivery environment, particularly the advent of the state's Medicaid Managed Care Program, on safety net health care providers in the state. The report provides information on what data DPH normally collects on these providers. Also provided is information on legal, resource or other limitations in carrying out the Subcommittee's request from last legislative session for a monitoring and surveillance system.

2 BACKGROUND

With the advent of managed care and other major shifts in the health care funding environment, municipal health departments and voluntary or nonprofit sector health care agencies in Connecticut, which make up the state's health care "safety net," faced a shifting client base, increased administrative costs, and decreased revenues. Reportedly this has forced some providers to consolidate operations, curtail services or close down entirely. Weakening of this infrastructure threatens not only the state's capacity to care for the uninsured and populations at risk, but also its ability to meet its overall public health obligations to promote health and prevent disease and injury.

In March, 1997, the Public Health Subcommittee of the State Legislature's Medicaid Managed Care Council completed a study of Connecticut's safety-net providers, as "providers of last resort," and their participation in the state's Medicaid Managed Care Program (known as "Connecticut Access[11]"). The study, entitled, *The Status of Safety Net Providers in Connecticut*, provided information about the experiences of these providers one year after implementation of the Connecticut Access Program.

As a result of this initial study, the Subcommittee recommended that the Connecticut Department of Public Health (DPH):

1. Provide an inventory of safety net providers in the state. (The original definition from the Subcommittee included: community health centers, child guidance clinics, school-based health centers, local health departments, nonprofit VNAs, family planning clinics, and public health dental services.)
2. Include in the inventory (a) a catalog of direct and population-based services provided to both insured and uninsured clients at each site; (b) the number of services provided at each site; and (c) the payer mix of clients.
3. Develop an ongoing monitoring system to identify safety net provider reductions in services including, but not limited to, medical social work, outreach, psychological testing and home visitation.
4. Be authorized to convene a public hearing to discuss and plan for the impact of a reduction in services when a safety net provider is at risk of closing or reducing services.

These recommendations were included in Public Act 97-240, *An Act Concerning Medicaid Managed Care*, which was passed by the State Legislature in 1997 but later vetoed by the Governor.

The Subcommittee subsequently asked DPH to carry out these activities despite the absence of a statutory mandate. DPH agreed to provide the Subcommittee in January, 1998, the following information, where it was available *in-house* and could be obtained with current resources:

[11] Since publication of this report in January, 1998, the Medicaid managed care program is now referred to as HUSKY Part A (formerly know as "Connecticut Access").

1. An *inventory* of safety net providers as could be determined from DPH regulatory and grant administration activities. (A modified definition was agreed upon: community health centers, school-based health centers, local health departments, nonprofit VNAs, family planning clinics, and public dental service sites. Child guidance clinics were deleted).
2. Clarification of *personal care services* versus *public health/ population-based services*, both of which these providers deliver.
3. Identification of *gaps* where information previously requested is not available to DPH.
4. Identification of *fiscal constraints and limitations* on statutory authority that prevent DPH from carrying out such a monitoring system.
5. *Considerations* in establishing a monitoring and surveillance system.
6. *Suggestions* for further study.

3 PUBLIC HEALTH AND PUBLIC HEALTH SERVICES

DPH acknowledges the importance of these health care providers and the critical role they play in public health and health care delivery in Connecticut.

The *mission* of agencies serving the public's health is to assure conditions in the community in which people can be healthy. The *substance* of public health is organized community efforts aimed at the prevention of disease and injury and the promotion of health.

When looking at these safety net providers and their roles, it is important to keep in mind the different kinds of services that are provided -- *personal health care* services versus those that are *population-based*.

POPULATION-BASED SERVICES

The provision of population-based services is directly related to the provision of essential public health services. Population-based services are identified as interventions to alter the social and physical environment, to change health-related behaviors, or to reduce directly the risk of causing a health problem. These services are generally developed and available for an entire population of a community or the state rather than just for individuals. They may include the following:[12]

- Diagnose and investigate health problems and health hazards in the community.
- Inform, educate, and empower people about health issues.
- Mobilize community partnerships and action to identify and solve health problems.
- Develop policies and plans that support individual and community health efforts.
- Enforce laws and regulations that protect health and ensure safety.
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- Assure a competent public health and personal health care workforce.
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
- Conduct research for new insights and innovative solutions to health problems.

PERSONAL HEALTH SERVICES

In contrast to population-based services, personal or direct health services involve a one-on-one interaction between a health care professional and a patient. Direct services address physical, mental, or social functioning of the individual and may be performed by health care professionals for the purpose of promoting, maintaining, and restoring health. These services include what most consider ordinary medical care, including inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-rays, and dental care. In Connecticut they are delivered primarily by private sector organizations, such as community health centers and VNAs, but in many communities, municipal health departments may provide many of these services, especially for disadvantaged populations.[13]

The delivery of personal health services is separate but complementary to the delivery of population-based services. When looking at safety net health care providers and their importance to health in this state, we must keep in mind that these providers contribute to both, and that both are critical to the well-being of people in Connecticut. Both personal and population-based services need careful monitoring when agencies go into crisis, and both need careful attention in the current health care environment.

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12 U.S. Public Health Service, Essential Public Health Services Work Group. 1994.

13 U.S. Public Health Service, Essential Public Health Services Work Group. 1994.

4 IMPORTANCE OF SAFETY NET PROVIDERS

Connecticut lacks a county structure and the formal regional systems of public health and health care delivery found in other parts of the United States. As identified by the Subcommittee on Public Health in its 1997 study, the state has traditionally relied on the voluntary or nonprofit sector to provide to its cities and towns many of the services and functions that are considered "public health" and would normally be delivered by the public sector.

Further, *safety net providers* in Connecticut have the following important characteristics:

1. Their services and role are seen as essential and critical to the well-being of the community and/or state. Therefore, their presence and activities are often mandated, authorized, or in some way sanctioned by state public health laws, municipal charter, or local public health ordinances.
2. The providers are substantially funded through public moneys (federal, state, local) to carry out certain public health functions or meet the health needs of certain populations that are underserved or at risk.
3. The providers' service histories evolved in response to defined public health needs within their communities. The providers are now recognized by state/local government as providing essential services to meet specific needs in the communities they serve.
4. The focus of service is population-based, not just client-based, and has an impact on the entire population or a significant subset of it.

Based on the preceding criteria, the following types of providers were included in the Subcommittee's definition of a safety net provider:

- Community Health Centers
- Family Planning Clinics
- Public Health Dental Service Sites
- School-based Health Centers
- Visiting Nurse Associations Local Health Departments/Health Districts

The role of the state's safety net providers is especially important in this period of transition in health care financing and service delivery, for experience has shown the following:

1. These providers bring to the health care delivery system a *grassroots* understanding of community needs and community priorities.
2. They often serve as *points of entry* into a system of care that is culturally and linguistically competent and provides comprehensive primary care that is responsive to consumers' specific needs.
3. Many provide the important *enabling services* required by vulnerable populations to assure access to health care, including outreach, transportation, interpreter services, child care and community health awareness.
4. Some are very effective as *buffers* for consumers in negotiating health plan enrollment and obtaining authorization for needed services in an evolving managed care environment.

5 INVENTORY OF SAFETY NET PROVIDERS

As requested, an inventory was performed to identify the following kinds of safety net providers:

- Community Health Centers
- Family Planning Clinics
- Public Health Dental Service Sites
- School-Based Health Centers and Clinics
- Visiting Nurse Associations
- Local Health Departments and Health Districts

The community health centers, family planning clinics, school-based health centers and clinics, visiting nurse associations and their well-child clinics, and local health department-sponsored clinics were identified through use of Department of Public Health licensure files. Public health dental service sites were identified by DPH's Oral Health Program, through program files, licensure files, and a recent survey of providers. The local health departments and health districts were identified by DPH's Local Health Administration Program through its grants-in-aid program and administrative files.

A summary of DPH's authority for, jurisdiction over, oversight of, and relationship to the six kinds of safety net providers is provided below. Information is given on the kinds of data DPH collects on these providers. Listings of providers in each category and maps showing their locations in the state are given in the *Appendices A-F*.

COMMUNITY HEALTH CENTERS

Introduction

For almost 30 years, community health centers (CHCs) have been a critical source of health care for the poor, underserved, and vulnerable populations at risk in many communities throughout Connecticut. They have provided a consistent "medical home" for hundreds of thousands of uninsured and underinsured people, assured access to cost-effective, high quality preventive and primary care services, and have contributed to the improvement of overall health status in the communities they serve. Community health centers are private, non-profit corporations that provide a wide range of primary care services to the communities they serve. Depending on community need, many also offer dental services, addiction services, and social and outreach programs. The structure, organization, and operation of the centers is defined in state law. There were 14 community health center corporations in Connecticut in state fiscal year (SFY) 1996-1997, 12 of which are currently operational. Meri-Care, Inc. in Meriden, CT merged with The Community Health Center of Meriden, Inc. in early 1997, bringing the number to 13. The Norwalk Community Health Center, which is in its fourth year of planning, has a board and administrative staff, but is not yet operational. The 12 remaining corporations currently run a network of 55 clinical sites. The sites include school based health centers, dental service sites, shelters for the homeless, senior center clinics, and general primary care clinics. The two aforementioned transitional sites are included in *Appendix A*; Meri-care continues to run its dental clinic, but has closed its community health center operations.

Legal Mandate

There is no legal mandate for community health centers in Connecticut. Their formation is the result of longtime voluntary community efforts in response to local community needs.

Community health centers are defined under Section 19a-490(a) of the *Connecticut General Statutes* for funding purposes. All community health centers must be located in federally designated medically underserved areas or serve medically underserved populations, have a board composition that is predominantly community users, have certain staffing and hours of service, provide a sliding fee schedule, and meet other criteria defined in law.

Regulatory Requirements

Community health centers are subject to licensure as outpatient clinics under Section 19a-493 of the *Connecticut General Statutes*. CHCs are licensed by DPH biennially. The process for licensure includes filing of application materials with DPH and unannounced on-site inspections by DPH of each site run by the CHC. The licensure inspection process reviews compliance with the regulations identified in the State Public Health Code, which address minimum care standards, including administration of the clinic, governing authority, physical plan, personnel, clinical services and quality of care.

When CHCs are not in compliance with the requirements of the Public Health Code, DPH issues findings which require the provider to submit a written plan of correction. The plan of correction submitted to DPH reflects the mechanisms the provider will implement to correct the situation. Department staff validate that the provider has implemented its plan of correction. A variety of disciplinary actions as defined in Section 19a-494 of the *Connecticut General Statutes* may be pursued for adverse findings that have a significant impact on the care and services provided to clients. Disciplinary actions may include consent orders, reprimands, licensure suspension or revocation.

Data

Based on SFY 1997 fiscal information, the community health centers had the following payer mix (percentages are approximate):

Title XIX/Medicaid	42%
Uninsured	24%
Private insurance (complete/partial)	18%
City welfare	13%
Medicare	3%
Total:	**100%**

From SFYs 1991 through 1997, DPH funded the Connecticut Primary Care Association (CPCA) to subcontract with all the community health centers in the state for operational and expansion services and to collect and provide data to DPH. Information included utilization, payer mix, and demographic data by center.

Data reported to DPH by CPCA showed that utilization of CHC services from SFYs 1991 to 1996 more than doubled. During this same period, the number of unduplicated clients served nearly doubled as well. In SFY 1996-1997, community health centers served nearly 160,000 people through 56 clinical sites. Forty percent of the clients served, or 64,000, were under age 19 years, and 24% of all clients were uninsured.

Effective July 1, 1997, DPH began directly administering its contracts to the CHCs in the state. DPH collects the following information on community health centers through its annual/biennial contracts: client demographics; numbers of users, visits, and encounters; types of services; visit payment sources; use of grant moneys and expenditures; and compliance with the Office of Policy and Management (OPM) performance measures. Although the centers collect information on individual clients, it is reported in the aggregate to DPH.

Funding

Community health centers are funded by DPH for general operations, expansion activities, and specific programs (e.g. sexually transmitted diseases (STD) screening, HIV/AIDS testing and counseling, and immunization tracking); by the State Bonding Commission for capital projects; and by federal grants such as 330 funds from the U.S. Public Health Service (federal moneys for start up and general operations). They also receive private donations, some municipal moneys, and collect fees through private pay, Title XIX, and private insurers.

Community health centers are also supported financially through several state and federal programs: the State Loan Repayment Program, which helps to attract qualified health care professionals to community health centers by paying for their educational loans; the placement of National Health Service Corps (NHSC) professionals in qualified community health centers; the recommendation of qualified foreign physicians for 2-year federal immigration waivers (under the J-1 Visa Program) so that they can work in primary care settings in federally designated underserved areas; and the federal Primary Care Fellowship Program, which funds the placement of medical students and nurse practitioner students in community health centers as part of their graduate education.

Funding for community health centers in Connecticut in SFY 1996-1997:

State funding (general operations and expansion)	$4,830,557
State funding (bonding)	210,000
Federal funding (330 funds, NHSC, Loan Repayment)	410,200
Total:	**$5,450,757**

FAMILY PLANNING CLINICS

Introduction

For decades, the network of family planning clinics in Connecticut has provided comprehensive reproductive health services to men and women of all ages. Services include: contraceptive counseling; preconceptual counseling; pregnancy screening and options counseling; STD screening; HIV/AIDS testing and counseling; and health promotion activities such as influenza immunizations and nutrition counseling. Special outreach is provided to adolescents, minorities, and homeless women.

In SFY 1997 there were 27 licensed family planning clinic sites in the state. Planned Parenthood of Connecticut closed its Middletown facility in the fall of 1997, bringing the number to 26. Locations of family planning clinics are listed in *Appendix B.*

Legal Mandate

There is no legal mandate for family planning clinics in Connecticut. Their development is the result of voluntary community effort in response to local community needs and changing technology.

Regulatory Requirements

Family planning clinics (FPCs) may be a singular service or a component of multiple health services provided by a community health center, a hospital, or a local health department. Such services are subject to licensure under Section 19a-493 of the *Connecticut General Statutes*. FPCs are licensed by DPH biennially. However, service sites operated by a hospital are subject to the same licensing requirements governing the hospital. The process for licensure includes filing of application materials with DPH and unannounced on-site inspections of the family planning clinic site by DPH. The licensure inspection process reviews compliance with the regulations identified in the State Public Health Code, which address minimum care standards including administration of the clinic, governing authority, physical plan, personnel, clinical services and quality of care.

When a clinic is not in compliance with the requirements of the Public Health Code, DPH issues findings which require the provider to submit a written plan of correction. The plan of correction submitted to DPH reflects the mechanisms the provider will implement to correct the situation. Department staff validate that the provider has implemented its plan of correction. A variety of disciplinary actions as defined in Section 19a-494 of the *Connecticut General Statutes* may be pursued for adverse findings that have a significant impact on the care and services provided to clients. Disciplinary actions may include consent orders, reprimands, licensure suspension or revocation.

Data

DPH collects the following information on family planning clinics through its contracts: numbers, gender, and ages of patients served; services provided; number of educational programs presented and number of clients in attendance; use of grant moneys and expenditures; and compliance with OPM performance measures. While the centers collect information on individual clients, it is reported in the aggregate to DPH.

In SFY 1997, nearly 18,000 people were served in the 19 sites funded by DPH. Of these, 6,200 (about 31%) were under 19 years of age.

Funding

Family planning clinics are funded by DPH for general operations and for specific programs (such as STD and HIV/AIDS testing and counseling), and with federal grants through Title X. They also receive private donations, some municipal moneys, and collect fees through private pay, Title XIX, and private insurers. DPH contracts for services with Planned Parenthood of Connecticut, which then subcontracts with 19 family planning affiliates. DPH funding to family planning clinics in SFY 1997 is shown below.

State funding (general operations and expansion)	$1,172,644
State funding (STD, breast/cervical cancer screening, etc.)	108,845
Federal funding (Title X)	1,690,905
Total	**$2,972,394**

Information on payer mix is shown below for SFY 1997.

Funding source	No. clients served	Percent of total
Title XIX/Medicaid	16,972	41%
Private insurance (complete/partial)	1,216	3%
Self pay: (all or part expected)	10,696	25%
No source - free (no charge/no third party)	1,579	4%
All other sources*	11,224	27%
Total	**41,687**	**100%**

* Other sources = number of visits by individuals whose care was paid for, billed to, or supported by other federal, state, or local sources such as Title X, Title XX, CHAMPUS, special State appropriations, town/local moneys, private charities, Title V funds, State matching funds, or local matching funds.

PUBLIC HEALTH DENTAL SERVICE SITES

Introduction

For nearly a century, preventive dental care has been provided through Connecticut's schools. Largely responding to a growing recognition of the importance of good oral health to overall health and to the need to assure oral health care access for all, Connecticut has witnessed a significant increase in the number of community health centers, school-based health centers, hospitals and other community public health facilities that offer preventive and primary oral health services. These facilities have proven to be a critical source of oral health care for uninsured, underinsured and otherwise vulnerable populations. The community-based public health facilities have been able to provide cost-effective, high quality preventive and primary oral health care services, thereby improving the overall health status of Connecticut's residents.

Legal Mandate

There is no legal mandate in Connecticut for public health dental service sites. Their development has often been the result of voluntary efforts based on community need.

Regulatory Requirements

Public health dental services may be a singular service or a component of multiple health services provided by a community health center, a school-based health center, a hospital or a local health department. Such services are subject to licensure under Section 19a-493 of the *Connecticut General Statutes* and are licensed biennially by DPH. However, dental service sites operated by a hospital are subject to the same licensing requirements governing the hospital. The process for licensure includes filing of application materials with DPH and unannounced on-site inspections of each facility by DPH. The licensure inspection process reviews compliance with the regulations identified in the State Public Health Code, which address minimum care services including administration of the clinic, governing authority, physical plan, personnel, clinical services and quality of care.

When dental service sites are not in compliance with the requirements of the Public Health Code, DPH issues findings which require the provider to submit a written plan of correction. The plan of correction submitted to DPH reflects the mechanisms the provider will implement to correct the situation. Department staff validate that the provider has implemented its plan of correction. A variety of disciplinary actions as defined in Section 19a-494 of the *Connecticut General Statutes* may be pursued for adverse findings that have a significant impact on the care and services provided to clients. Disciplinary actions may include consent orders, reprimands, licensure suspension or revocation.

Data

There are currently 43 sites where public health dental services are provided (*Appendix C*). The sites are run by the following:

Community health center	13 sites
School-based health center	18 sites
Local health department	1 site
Hospital	11 sites
Total	43 sites

Several public health dental sites are currently funded by DPH to support their general operations. DPH is actively collecting and updating available information on public health dentistry in Connecticut through surveys by its Oral Health Program including: preventive and primary dental care services provided; site capacity, staffing and utilization; and oral health status and needs assessment. A survey was completed in 1997 and a report will be available in the near future.

In addition to the above, data for each dental site was recently collected and is currently being analyzed to determine the number and percent of age groupings receiving dental treatment, and the funding, revenue sources, and payer mix for dental services.[14]

SCHOOL-BASED HEALTH CENTERS AND CLINICS

Introduction

For more than two decades, schools in the state have attempted to bring health care services closer to students in need by providing these services on site. In 1985, a highly effective strategy for improving the health status of children and adolescents at health risk was introduced in Connecticut--the school-based health center model for the provision of primary health care and mental health services within the school setting. School-based health centers (SBHCs) provide a wide range of health care services, including dental health, mental health and social services through an interdisciplinary team. SBHCs are an important source of health care and provide a "medical home" for thousands of uninsured and underinsured children and youth in the state. A 1996 study of students in Connecticut at the time of their first visit to an SBHC revealed that nearly 32% had no regular source of health care.[15]

In SFY 1996-1997, there were 64 licensed clinics providing school health services in Connecticut. Of these, 46 met the criteria for a SBHC as established by DPH (see listing and map of locations in *Appendix D*). Eighteen provided dental services.

Legal Mandate

There is no legal mandate in Connecticut for school-based health centers or school health clinics. Their development has often been the result of voluntary efforts based on community interest and need.

Regulatory Requirements

School-health clinics, including school-based health centers may be a singular service provided by a board of education or local health department, or a component of multiple health services provided by a community health center or a hospital. Such services are subject to licensure under Section 19a-493 of the *Connecticut General Statutes*. SBHC's are licensed by DPH biennially. However, if the service site is operated by a hospital, it is subject to the same licensing requirements governing the hospital. The process for

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14 Stanton Wolfe, Oral Health Program, Connecticut Department of Public Health. Personal communication. 1997.

15 Connecticut Dept of Public Health. *Voice of Connecticut Youth.* 1996.

licensure includes filing of application materials with DPH and unannounced on-site inspections of the SBHC by DPH. The licensure inspection process reviews compliance with the regulations identified in the State Public Health Code, which address minimum care standards including administration of the clinic, governing authority, physical plan, personnel, clinical services and quality of care.

When a SBHC is not in compliance with the requirements of the Public Health Code, DPH issues findings which require the provider to submit a written plan of correction. The plan of correction submitted to DPH reflects the mechanisms the provider will implement to correct the situation. Department staff validate that the provider has implemented its plan of correction. A variety of disciplinary actions as defined in Section 19a-494 of the *Connecticut General Statutes* may be pursued for adverse findings that have a significant impact on the care and services provided to clients. Disciplinary actions may include consent orders, reprimands, licensure suspension or revocation.

Data

DPH collects the following client-specific information from all school-based health centers through its School Healthcare ONLINE!!!™ (SHO) data system: demographics, income, payment source, source of care, dates of visits, purpose of visits, services provided, ICD-9 codes, and referrals.

Through its grants administration process, DPH also collects the following information on school-based health centers that are funded through its annual/biennial contracts: client demographics; numbers of users, visits, and encounters; types of services; visit payment sources; use of grant moneys and expenditures; and compliance with OPM performance measures. While the centers collect information on individual clients, it is reported in the aggregate to DPH.

Funding

The SBHCs are funded by municipal moneys for general operations; state grants for planning, expansion and for specific programs (such as immunizations or AIDS); federal moneys; and private funds as outlined below.

Municipal appropriations	(Must be 25% of DPH grant)
State grants	$3,837,129
Federal grants	$ 392,218
Private foundation moneys	$ 725,270

No information on the SBHC's payer mix is available at this time. In SFY 1996-1997 the centers began to enter into contracts with managed care organizations for participation as providers in Medicaid Managed Care and with other private insurers. Under the Connecticut Access Program[16], school-based health centers are deemed *essential providers*.

VISITING NURSE ASSOCIATIONS

Introduction

Visiting nurse associations (VNAs), which are traditional, nonprofit public health nursing organizations, were established in communities throughout the state in the early part of this century to care for the sick in their homes and to carry out many kinds of community activities to promote health and to

[16] Since publication of this report in January, 1998, the Medicaid managed care program is now referred to as HUSKY Part A (formerly know as "Connecticut Access").

prevent the spread of disease. Most of the early organizations were private, nonprofit entities supported by communities. Some were incorporated directly under town charter (nine are still under town charter).

Public health nurses and visiting nurses have a long history of serving and supporting communities across the United States. The value of their service is not just in the care of the sick, but involves assessment of living conditions and social support. Patient needs essential for independent living may not be apparent in inpatient settings. Nurses visiting homes identify and resolve issues that interfere with safe, healthy living.

The first organized home care nursing services were established to aid the poor in crowded urban tenements and isolated rural areas. The first visiting nurses focused on caring for the sick, educating mothers regarding childbirth and child health, and promoting basic public health like sanitation and nutrition. Today, visiting nurse associations continue to provide a wide range of home care services as well as services to mothers and children, screening programs for various health problems in the community, and infectious disease follow-up. Of the 40 VNAs in Connecticut, 39 currently run well-child clinics. Locations of VNAs in Connecticut are listed in *Appendix E*. In Connecticut, VNAs may serve one town (as in the case of the nine VNAs that are under their respective town charters) or multiple towns in whole regions of the state.

In the 1970's, the importance of the care of the sick expanded as shortened hospital stays and changes in technology created new markets, and home health care emerged as a distinct service. With the advent of better health insurance benefits, proprietary agencies began to compete with VNAs for paying clients. Despite the growth in the industry of for-profit home care agencies, visiting nurse associations have persevered as providers of home care to thousands of uninsured or underinsured people.

Legal Mandate

There is no legal mandate in Connecticut for either visiting nurse associations or home health agencies. Their development is the result of voluntary community effort in response to local community needs.

Regulatory Requirements

Visiting nurse associations are subject to state licensure as home health care agencies under Section 19a-493 of the *Connecticut General Statutes.* If an agency also has a well child clinic, as 39 of the 40 still do, the clinic is subject to licensure as an outpatient clinic under Section 19a-493 of the *Connecticut General Statutes.*

Each home health care agency and each well child clinic is licensed by DPH biennially. The process for licensure includes filing of application materials with DPH and unannounced on-site inspections by DPH. The licensure inspection process reviews compliance with the regulations identified in the State Public Health Code, which address minimum care standards including administration of the clinic, governing authority, physical plan, personnel, clinical services and quality of care. In the case of home health agencies, safety of patient care in the home is reviewed.

When a licensed home health agency or a licensed well child clinic is not in compliance with the requirements of the Public Health Code, DPH issues findings which require the provider to submit a written plan of correction. The plan of correction submitted to DPH reflects the mechanisms the provider will implement to correct the situation. Department staff validate that the provider has implemented its plan of correction. A variety of disciplinary actions as defined in Section 19a-494 of the *Connecticut General Statutes* may be pursued for adverse findings that have a significant impact on the care and services provided to clients. Disciplinary actions may include consent orders, reprimands, licensure suspension or revocation.

Data

DPH collects information from all licensed home care agencies as part of their annual licensure renewal applications. While the centers collect information on individual clients, it is reported in the

aggregate to DPH. The data provide a rich resource for examining characteristics of the population utilizing services, how services are paid, and other trends in utilization. Information collected includes:

- Agency staffing and contracts for staffing
- Services provided and hours of availability
- Client functional status
- Age, gender and racial characteristics of clients
- Sources of payment
- Client status: new, continued and readmitted
- Primary diagnosis at admission
- Reason for discharge
- Client living conditions (support)
- Number and hours of visits made (by service)
- Number Spanish speaking clients served
- Referral source.

There are 114 licensed home health care agencies in Connecticut. Of these, 40 (35%) are the traditional, not-for-profit VNAs. In SFY 1996-1997, VNA nurses and their ancillary staff made nearly 3 million visits to over 75,000 Connecticut residents. Of those served, 7.5% were under 19 years of age. The majority (65%) were over 65 years of age.

Funding

In addition to traditional reimbursement sources, VNAs are funded by state grants for specific prevention programs (such as immunization awareness and outreach, Healthy Start or WIC); state and federal grant moneys to support home health services; some municipal funds; patient fees; and private funds and donations. Information on data collected from these sources is not available to DPH at this time. The payer mix for Connecticut VNAs for SFY 1995-1996 is shown below.

Payer	Percent
Medicare	71%
Medicaid	16%
Self pay	2.9%
VA	0.06%
Other federal	1.2%
State and local	3.0%
BC Home Care	1.5%
Other insurance	3.6%
Other sources (gratis)	1.2%

As the number of uninsured and underinsured persons grows, so will the number of persons at home without care or support. Changes in Medicare and Medicaid benefits, the largest source of payment for home care, may result in a growing population of people without resources for care at home. VNAs are challenged to continue providing high quality, effective care for those people in need.

LOCAL HEALTH DEPARTMENTS AND HEALTH DISTRICTS

Introduction

Local health departments (LHDs) are critical providers of population-based essential public health services at the local level in Connecticut. These departments are governmental entities separate from the State Department of Public Health, but are linked by statute in several important ways: approval of appointments of directors of health by the Commissioner of Public Health; mandates to carry out critical public health functions in the areas of infectious disease control in the community, environmental health, etc.; legal authority to levy fines and penalties for public health code violations, and to grant and rescind license permits (such as for food services establishments or septic systems); and funding to carry out the full area of public health activities to improve the health of people in their jurisdictions. Municipal health authorities and districts must include in their responsibilities the enforcement of the state public health code as required by DPH. Often this is a difficult task given the wide variety of public health services needed by communities and the limited municipal budgets to pay for those services.

Over the years, Connecticut's local health departments have moved away from direct service delivery programs, such as running clinics, home health services, and school health, and have focused more on programs that benefit the broader population, such as infectious disease control in the community and environmental health. Local health departments are the main provider agencies for population-based public health services in the state. Data from a 1991-1992 national survey of local health departments in the country showed that local health departments in Connecticut carried out a wide variety of population-based functions.[17] (See *Appendix G* on how Connecticut's local health departments conform with *Healthy Connecticut 2000* objective 8.14 and provide core public health services.)

Local public health services to Connecticut's 169 municipalities and 7 boroughs are delivered through either municipal (city, borough or town health departments) or through regional health departments called district health departments**.** (Locations of local health departments/districts in Connecticut are listed in *Appendix* F.) There are 95 municipal health departments in the state: 26 of these are full-time and 69 are part-time. There are 18 district health departments in the state for a total of 113 local health departments.

Municipal health departments in Connecticut date back to nearly the turn of the century, whereas regional health departments or health districts were first formed in Connecticut in 1966. The health districts

[17] National Association of County and City Health Officials. *1992-1993 National Profile of Local Health Departments.* Washington, D.C., 1995. 116pp.

are all full-time and range in size from two towns with a population of over 12,000 people, to 16 towns serving a population of over 107,000 people. More than one-third of the state's population receives its local public health services through a health district.

In the last three years (1995-97), three separate new health districts were formed by seven towns, and an eighth town joined an existing health district. Five of these eight towns dismantled full-time city or town health departments to form the regional health department. State law requires that a public hearing on the proposal to join a health district be held by the governing body of each municipality before a vote is taken (Section 19a-241(a), *Connecticut General Statutes*).

Legal Mandate

Local health departments are the only safety net providers for which there is a legal mandate in the state (Section 19a-200, *Connecticut General Statutes*). State law requires the services of a local health director in each town. Cities and towns may either establish their own municipal health departments or they may form a regional health department, or *health district*, with one or more other towns.

Regulatory Requirements

If a local health department or health district runs one or more clinics, as 18 of them do, the clinic is subject to licensure as an outpatient clinic under Section 19a-493 of the *Connecticut General Statutes*. Eleven local health departments run well child clinics, eight run municipal clinics that provide STD services, immunizations, etc., and one municipal health department (Waterbury) runs both kinds of clinics.

Each clinic is licensed by DPH biennially. The process for licensure includes filing of application materials with DPH and unannounced on-site inspections of the clinic by DPH. The licensure inspection process reviews compliance with the regulations identified in the State Public Health Code, which address minimum care standards including administration of the clinic, governing authority, physical plan, personnel, clinical services and quality of care.

When a clinic is not in compliance with the requirements of the Public Health Code, DPH issues findings which require the provider to submit a written plan of correction. The plan of correction submitted to DPH reflects the mechanisms the provider will implement to correct the situation. Department staff validate that the provider has implemented its plan of correction. A variety of disciplinary actions as defined in Section 19a-494 of the *Connecticut General Statutes* may be pursued for adverse findings that have a significant impact on the care and services provided to clients. Disciplinary actions may include consent orders, reprimands, licensure suspension or revocation.

Data

DPH collects data on local health departments through its grants in aid, or per capita funding, and other state administered funding. No information is collected at this time for part-time departments, unless they are grant funded. DPH does have broad authority to collect data from local health departments under Section 19a-200 of the *Connecticut General Statutes*. Full-time departments and health districts annually apply for state grants in aid. They must present a program plan for moneys, budget, and evidence of matching municipal funds (as required by law).

Further they must demonstrate compliance with the funding regulations, show that they are in compliance with state law in provision of services, and that eight basic local public health services are in place. These eight essential public health services are: public health planning, communicable and chronic disease control, health education, environmental health services, community nursing services, nutrition services, maternal and child health services, and emergency medical preparedness.

The data provide a resource for examining how local health departments are organized, what services they provide, how these are funded, population served, other trends, use of grant moneys, and expenditures.

Funding

The local health departments are funded primarily with municipal appropriations, but they also receive state grants, federal grants, and private foundation moneys. In addition, they generate revenues from fees and licenses and the imposition of fines and penalties. In SFY 1997, the following state-administered moneys were given to local health departments/districts:

Per capita grants in aid to LHDs	$ 2,526,782
DPH grants and contracts	8,082,481
Total	**$10,609,263**

SUMMARY OF INVENTORY

As demonstrated in the foregoing inventory, about 340 providers make up the public health safety net in Connecticut. These include:

Community Health Centers	12 corporations; 55 clinic sites
Family Planning Clinics	26 sites
Public Health Dental Service Sites	43 sites
School-based Health Clinics	64 school clinics; 46 are SBHCs
Visiting Nurse Associations	40 agencies
Local Health Departments/Health Districts	113 departments, including 18 health districts.

When overlap is eliminated (e.g., community health centers that run school-based health centers, school-based health centers that run dental service sites), the unduplicated count of safety net providers is about 300. Most safety net providers deliver personal care services, and most provide population-based services to some extent as well. All serve significant numbers of the uninsured and underinsured.

All have funding bases that are dependent on state, federal, and local moneys, grants and donations, and fees in varying amounts. These providers, who care for some of society's most vulnerable, are themselves vulnerable through their dependency on "soft" sources of moneys, and hence are vulnerable to the economy and policy shifts.

6 MONITORING SAFETY NET PROVIDERS

JURISDICTION

DPH has jurisdiction for monitoring the status and performance of safety net providers in a variety of ways, depending on the kind of provider and the intent of DPH's oversight.

DPH may have ***statutory authority*** to mandate that certain kinds of data be filed, such as in the case of local health departments, which are required to file an annual report of their activities according to guidance from the DPH. The limitation here is timing, as this filing occurs in the fiscal year following the year in which the activities actually occurred.

DPH may be authorized by law to take **r*egulatory action***, such as licensure. Here, the public health goal is to assure that minimum safe standards for care are met, and that safe care is being provided. Through initial award of and periodic renewal of a license, the performance of a provider is monitored. If minimum standards are not consistently met, a license can be revoked. A disadvantage in provider monitoring is the infrequency of inspection (annually or biennially), unless a complaint is filed or there is cause to do a special inspection.

DPH may be authorized to do ***funding and grant administration***. Here a set of expectations for service delivery is specified in contract, and performance is monitored periodically. Standards are often above those set for licensure (if the provider is subject to licensure). If terms and expectations of the contract are not met, then funding can be withdrawn. Depending on the reasons for the funding and its cycle, frequent technical assistance and consultation as well as monitoring may be provided, and can produce important information on a provider's general status. However, fiscal information is limited to the grant and the terms of the contract. Information on actual patient load or census, cash flow, debts, profit margins, etc., are not available. Further, expenditure reports are made quarterly, but annual financial audits do not come in for nearly 6 months after the close of the contract year.

GAPS IN INFORMATION

The kind of information available at DPH about the status and fiscal solvency of safety net providers is limited:

Mandates

DPH information is limited by the kind of mandates under which DPH collects that information. When the purpose is to assure that minimum safe standards for licensure are met, that becomes the focus of the data collected by DPH programs. When the purpose is assurance to the state that standards of performance for funding are reached, and rules for the use of state and federal moneys are followed, those areas dictate the kind of data collected.

Timeliness

There are gaps in the timeliness of the data. In most reports the data are at least 3 months old, and in some reports data are a year or more old at the time of receipt.

Categorical Funding

Information is further limited by fragmentation in both data collection and handling, due to the categorical nature of most DPH programs.

Provider Cooperation

The capacity of many of the providers to supply detailed information and data of specific kinds is limited. Moreover, health care providers have historically been reluctant to provide certain kinds of information about their fiscal well-being or service delivery patterns or trends over several years. For example, two kinds of data that would be most valuable--data on utilization and data on cost of health care services--are also among the most sensitive for many providers to make available. It begs the question: what kind of information are safety net providers willing to provide, so that DPH could effectively monitor performance and detect serious service delivery problems or fiscal changes indicating that a provider agency is in crisis?

CONSTRAINTS

The kind of information available at DPH is also influenced by the following constraints.

Fiscal Constraints

A serious limitation at DPH is inadequate staff and resources to handle the full cycle from conceptualization of design to collection, analysis, and publication of data. Most areas of DPH currently lack the resources to put adequate data collection and analysis systems in place.

Legal Constraints

Some limitations on information result from the laws, themselves. For example, with the advent of the state's *Single Audit Act*, less fiscal reporting and fewer kinds of financial data are required of state contractors, including cities and towns.

Finally, DPH's authority under Section 19a-2a of the *Connecticut General Statutes* to require providers to report certain kinds of data may be limited. This is especially true of those data considered proprietary in nature, and that requested by the Subcommittee as part of a monitoring and surveillance system.

SUMMARY OF DPH INFORMATION

DPH has jurisdiction for monitoring the status and performance of safety net providers in a variety of ways: through licensure functions, statutory authority, and grants administration and funding activities. Licensure requirements and grant administration requirements form the basis for the kind of data that DPH collect, but statutory authority for data collection and data requirements appear limited in these areas (the exception is a broad statutory reporting requirement for local health departments). Generally, aggregate data rather than client-based data are collected.

The kinds of information available at DPH about the fiscal status and performance of safety net providers is limited by the timeliness of receipt of such data; fragmentation in its collection and handling due to the categorical nature of most DPH programs; lack of adequate staff and resources to handle the design, collection, and analysis of the data; and limitations on data collection from the laws, themselves. The capacity of many of the providers to supply detailed information and specific kinds of data is a problem. Also, health care providers are reluctant to provide certain kinds of information about their fiscal well-being or service delivery patterns, or other data that is considered proprietary.

7 RESEARCH AREAS

Two areas for further study are suggested:

1. The design of a surveillance system for monitoring the status of safety net providers.
2. The identification and validation of performance indicators for safety net providers in the community.

8 CONSIDERATIONS

A monitoring and surveillance system very different from what DPH currently has in place is needed to adequately monitor the status and performance of the state's safety net health care providers, and to determine their effectiveness and fiscal solvency. To become more comprehensive, the system would require access to:

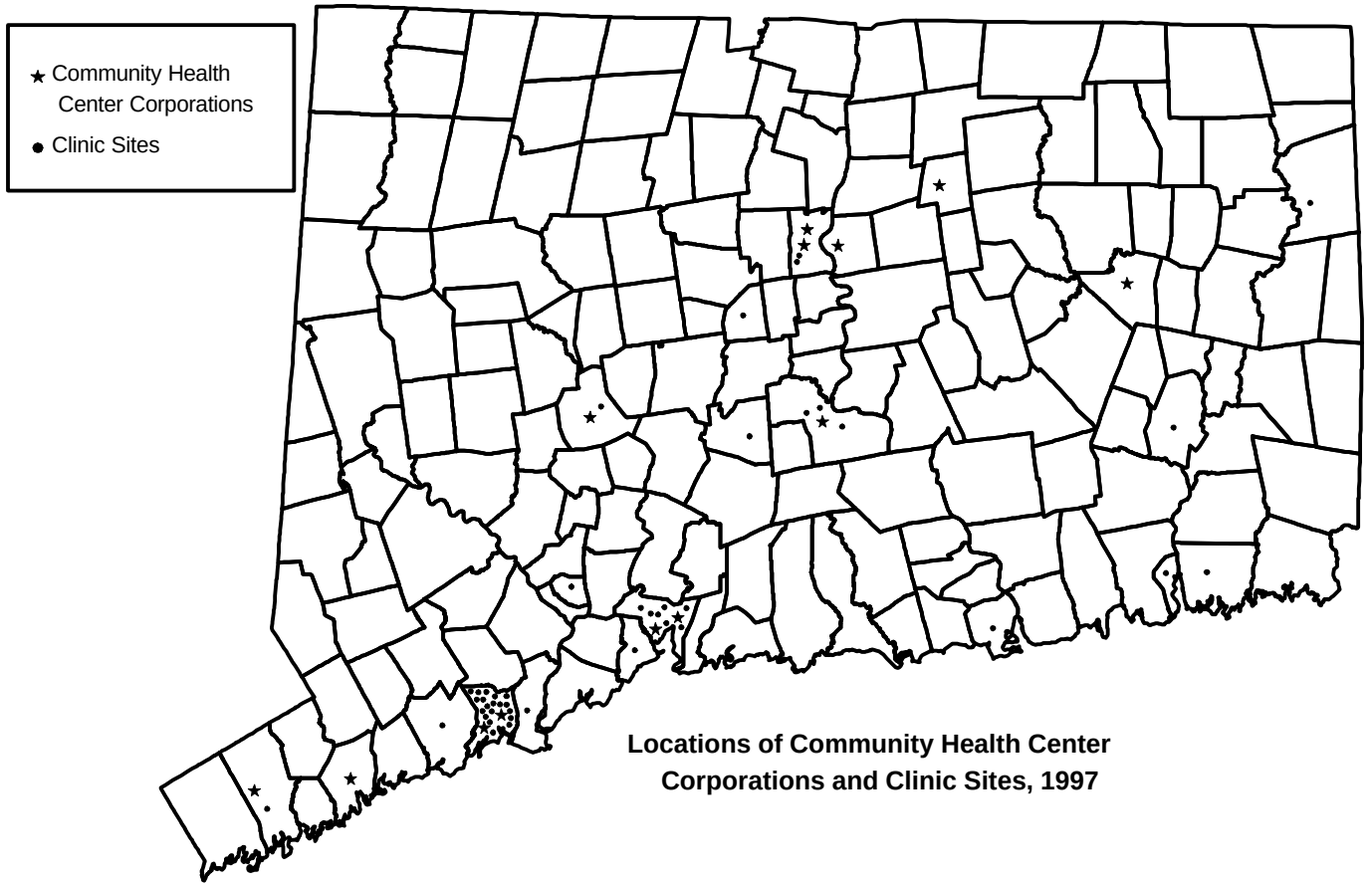
- timely information from the agencies on a regular basis.
- data that is uniform from provider to provider.
- client specific data on service delivery including demographics, diagnosis, units of service by provider, and payer.
- data on performance, client services and quality of care, especially significant changes in any of these areas; and
- information on the fiscal status and financial solvency of the provider.

Lastly, appropriate statutory authority is needed to carry out these functions. Overall, a greatly enhanced capacity for data collection and analysis, and appropriate resources, would be required.

SAFETY NET PROVIDERS REPORT

APPENDIX A COMMUNITY HEALTH CENTERS

Community Health Centers	Address	City	ST	Zip
Aequus House - Southwest Community Health Ctr	1108 Fairfield Ave	Bridgeport	CT	06605
Bridgeport Community Health Ctr, Inc	982-988 East Main St	Bridgeport	CT	06608
Bridgeport Community Health Ctr, Inc *	471 Barnum Ave	Bridgeport	CT	06608
Brooke St Shelter - Southwest Comm. Hlth Ctr, Inc	309 Brook St	Bridgeport	CT	06608
C.A.S.A - Southwest Comm. Hlth Ctr, Inc	690 Artic St	Bridgeport	CT	06608
Clinton St Shelter - Southwest Comm. Hlth Ctr, Inc	90-95 Clinton Ave	Bridgeport	CT	06604
Helping Hands of CT-Southwest Comm Hlth Ctr	1124 Iranistan Ave	Bridgeport	CT	06604
Horizons - Southwest Community Hlth Ctr, Inc	1635 Fairfield St	Bridgeport	CT	06605
Hosanna Christian Min.-Southwest Comm Hlth Ctr	1416 Fairfield Ave	Bridgeport	CT	06604
Janus House - Southwest Comm Hlth Ctr, Inc	385 Barnum Ave	Bridgeport	CT	06605
Main St Med Care Southwest Comm Hlth Ctr, Inc	779 Main St	Bridgeport	CT	06605
Mary Magdalene House Southwest Comm Hlth Ctr	1986 North St	Bridgeport	CT	06601
North End Clinic Bridgeport Comm Hlth Ctr, Inc	1381 Reservoir Ave	Bridgeport	CT	06606
Pivot Ministries Southwest Comm Hlth Ctr, Inc	495 Jane St	Bridgeport	CT	06608
Prospect House Southwest Comm. Hlth Ctr, Inc	392 Prospect St	Bridgeport	CT	06604
Ralphola Taylor Com Ctr Bridgeport Com. Hlth Ctr	790 Central Ave	Bridgeport	CT	06607
Re-Entry Ministries Southwest Comm Hlth Ctr, Inc	204 Hollister Ave	Bridgeport	CT	06607
SWCHC at Marina Vill Southwest Comm Hlth Ctr	743 South Ave	Bridgeport	CT	06604
SW Community Health Ctr, Inc*	361 Bird St	Bridgeport	CT	06605
YMCA of Greater Bridgeport-SW Comm Hlth Ctr	651 State St	Bridgeport	CT	06604
YWCA - SW Comm Hlth Ctr, Inc	753 Fairfield Ave	Bridgeport	CT	06605
Healthfirst of Killingly - Healthfirst, Inc	231 Broad St	Danielson	CT	06239
E Hartford Comm. Hlth Ctr, Inc*	94 CT Blvd.	E Hartford	CT	06108
Operation Hope Southwest Comm Hlth Ctr, Inc	50 Nichols St	Fairfield	CT	06430
Community Hlth Care Ctr of Groton	333 Long Hill Rd	Groton	CT	06340
Charter Oak Terrace-Rice Hts Hlth Ctr*	81 Overlook Terrace	Hartford	CT	06106
Community Hlth Services, Inc *	500 Albany Ave	Hartford	CT	06120
Family Hlth Ctr Charter Oak Terr/Rice Hgts Hlth Ctr	21 Grand St	Hartford	CT	06106
A.I. Prince Reg Voc-ChartOak Ter/Rice Hts CHC	500 Brookfield St	Hartford	CT	06106
Meri-Care Dental Clinic Community Hlth Ctr, Inc	165 Miller St	Meriden	CT	06450
The Comm Hlth Ctr of Meriden-Comm Htlh Ctr, Inc	134 State St	Meriden	CT	06450
Community Hlth Ctr, Inc *	635 Main St	Middletown	CT	06457
Eddy Home Comm Hlth Ctr, Inc	Labella Circle	Middletown	CT	06457
Rita Hayes Wellness Ctr Comm Hlth Ctr, Inc	66 Spring St	Middletown	CT	06457
Woodrow Wilson Middle Bsed Cli-Comm Hlth Ctr	Wilderman's Way	Middletown	CT	06457
Comm. Hlth Ctr Comm. Hlth Ctr, Inc	One Washington St	New Britain	CT	06457
Columbus House Hill Health Clinic	200 Columbus Ave	New Haven	CT	06519
Dixwell Health CtrHill Health Corp.	226 Dixwell Ave	New Haven	CT	06510
Fair Haven Community Health Clinic *	374 Grand Ave	New Haven	CT	06513
Fair Haven Community Health Clinic	339 Eastern St	New Haven	CT	06513
Fair Haven Community Health Clinic	181 Mitchell Dr	New Haven	CT	06513
Hill Health Ctr, Hill Health Corp *	400-428 Columbus Ave	New Haven	CT	06519
Jackie Robinson Mid Sch Body Shop-Hill Hlth Ctr	Hillhouse HS	New Haven	CT	06519
Lincoln-Bassett School- Hill Hlth Ctr, Corp	130 Bassett St	New Haven	CT	06511
Roberto Clemente Middle Sch Body Shop	360 Columbus Ave	New Haven	CT	06519
Comm Hlth Ctr of New London - Comm Hlth Ctr	One Shaws Cove	New London	CT	06320
Norwalk Community Health Ctr*	137 East Ave	Norwalk	CT	06851
Healthfirst/Norwich Comm Hlth Ctr-Healthfirst, Inc	112 Lafayette St	Norwich	CT	06360
Comm Hlth Ctr of Old Saybrook-Comm. Hlth Ctr	263 Main St	Old Saybrook	CT	06475



Locations of Community Health Center Corporations and Clinic Sites, 1997

Note: The stars and dots denoting the center corporations and clinics fall randomly within a town's border and are not actual site locations.

Source: DPH, BCH & HRSD, 1998

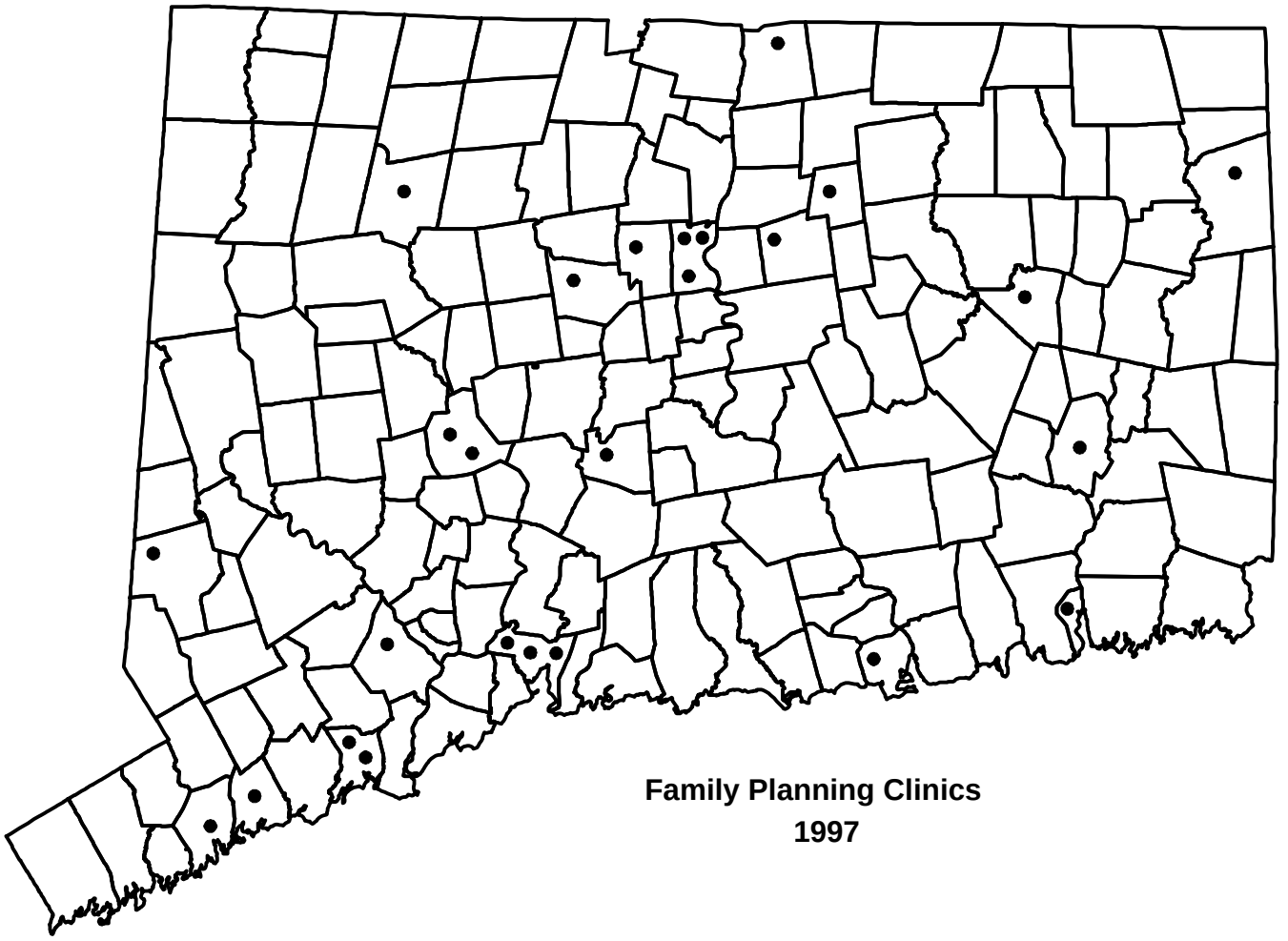
APPENDIX A COMMUNITY HEALTH CENTERS (CONTINUED)

Community Health Centers	Address	City	ST	Zip
Stamford Comm Hlth Ctr/West Side	245 Selleck St	Stamford	CT	06902
Stamford Community Health Ctr*	137 Henry St	Stamford	CT	06902
Stratford Com Hlth Ctr-Bridgeport Comm Htlh Ctr	727 Honey Spot Rd	Stratford	CT	06497
Vernon Area Community Htlh Ctr, Inc*	43 West Main St	Vernon	CT	06066
Berkeley Heights - Staywell Hlth Care, Inc	354 Longhill Rd	Waterbury	CT	06704
Staywell Health Ctr-Staywell Healthcare, Inc*	232 North Elm St	Waterbury	CT	06702
West Haven Health Ctr-Hill Hlth Corp.	285 Main St	West Haven	CT	06516
Healthfirst, Inc *	1315 Main St	Willimantic	CT	06226

SAFETY NET PROVIDERS REPORT

APPENDIX B FAMILY PLANNING CLINICS

Family Planning Clinic	Address	City	ST	Zip
Planned Parenthood of CT, Inc, Bpt	753 Fairfield Ave	Bridgeport	CT	06604
Planned Parenthood of CT, Inc	779 Main St	Bridgeport	CT	06604
Planned Parenthood of CT, Inc, Danbury	44 Main St	Danbury	CT	06810
Planned Parenthood of CT, Inc, Danielson	87 Westcott Rd	Danielson	CT	06239
Planned Parenthood of CT, Inc, Enfield	76 Palomba Dr	Enfield	CT	06082
Family Planning Program	UCONN Health Ctr	Farmington	CT	06032
Clinica Atabex - Hispanic HC	175 Main St	Hartford	CT	06106
Harford H.D. Planned Family Planning Project	80 Coventry St	Hartford	CT	06112
PPC - Family Planning Program	66 Hampton St	Hartford	CT	06112
Planned Parenthood of CT, Inc Manchester	419 West Middle Turnpike	Manchester	CT	06040
Planned Parenthood of Conn., Inc Health Stop	26 Woman's Way	Meriden	CT	06451
Fair Haven Comm. Hlth Ctr	374 Grand Ave - Finch	New Haven	CT	06513
Hill Health Ctr	911 Stone St	New Haven	CT	06511
Planned Parenthood of CT	129 Whitney Ave	New Haven	CT	06510
Planned Parenthood of CT, New London	45 Franklin St	New London	CT	06320
Planned Parenthood of CT, Inc, South Norwalk	50 Washington St	Norwalk	CT	06854
Planned Parenthood of CT - Norwich	12 Case St	Norwich	CT	06360
Planned Parenthood of CT., Inc, Old Saybrook	263 Main St	Old Saybrook	CT	06475
Planned Parenthood of CT., Inc, Shelton	415 Howe Ave	Shelton	CT	06484
Planned Parenthood of CT., Inc, Torrington	249 Winsted Rd	Torrington	CT	06790
Rockville General Hospital	31 Union St	Vernon	CT	06066
Planned Parenthood of CT, Inc, Waterbury	72 East Main St	Waterbury	CT	06702
Stay Well Health Ctr	232 North Elm St	Waterbury	CT	06702
PPC - Hartford - Hilda Standish Clinic	102 New Britain Ave.	W Hartford	CT	06033
Partnership Health Program	180 Bayberry La	Westport	CT	06880
Planned Parenthood of CT., Inc, Willimantic	872 Main St	Willimantic	CT	06226



Family Planning Clinics
1997

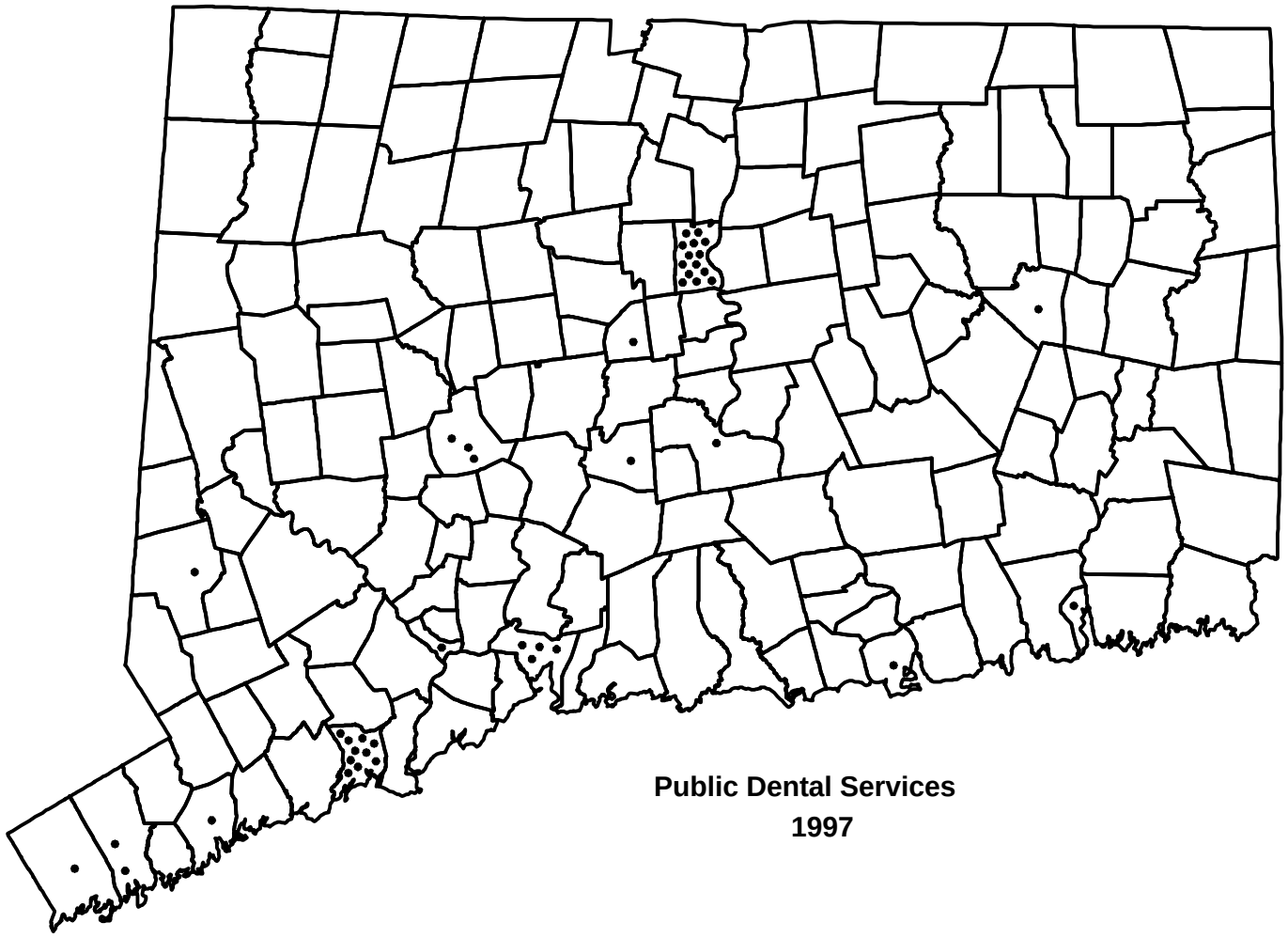
Note: The dots denoting the clinics fall randomly within a town's border and are not actual clinic locations.

Source: DPH, BCH, 1998

SAFETY NET PROVIDERS REPORT

APPENDIX C PUBLIC HEALTH DENTAL SERVICE SITES

Public Health Dental Service Sites	Address	City	ST	Zip
Roosevelt Elementary School	680 Park Ave	Bridgeport	CT	06604
Columbus Elementary School	275 George St	Bridgeport	CT	06604
Bassick High School	1181 Fairfield Ave	Bridgeport	CT	06605
Southwest Community Health Ctr	361 Bird St	Bridgeport	CT	06605
Central High School	1 Lincoln Blvd.	Bridgeport	CT	06606
Blackhum Elementary School	425 Throne St	Bridgeport	CT	06606
Munoz-Marin Elementary School	479 Helen St	Bridgeport	CT	06608
Bridgeport Health Dept.	752 East Main St	Bridgeport	CT	06608
Bridgeport Community Health Ctr	471 Barnum Ave	Bridgeport	CT	06608
Harding High School	1734 Central Ave	Bridgeport	CT	06610
Dental Services, Danbury Hospital	24 Hospital Ave	Danbury	CT	06810
Dental Clinic, Griffin Hospital	2 Mountain St	Derby	CT	06418
Dental Clinic, Greenwich Hospital	5 Perry Ridge Rd	Greenwich	CT	06830
Barnard Brown Elementary School	1304 Main St	Hartford	CT	06103
Community Dental Ctr, St. Fran/Mt Sinai Hosp	140 Woodland St, 3rd Fl.	Hartford	CT	06105
Betances Elementary School	42 Charter Oak Ave.	Hartford	CT	06106
Moylan Annex (McDonough Elem School)	100 Wilson St	Hartford	CT	06106
Charter Oak/Rice Heights Health Ctr	21 Grand St	Hartford	CT	06106
Burns Elementary	95 Putnam St	Hartford	CT	06106
Mary Hooker Elementary School	200 Sherbrooke Ave	Hartford	CT	06106
Maria Sanchez Elementary School	176 Babcock St	Hartford	CT	06106
Martin Luther King Elementary School	25 Ridgefield St	Hartford	CT	06112
Univ. of CT Burgdorf School of Dental Need	131 Coventry St	Hartford	CT	06112
Dental Services, Hartford Hospital	80 Seymour St	Hartford	CT	06115
Clark Elementary School	75 Clark St	Hartford	CT	06120
SAND Elementary School	1700 Main St	Hartford	CT	06120
Community Health Services, Inc	520 Albany Ave	Hartford	CT	06120
Mericare Dental Clinic/CHC Meriden	165 Miller St	Meriden	CT	06450
Community Health Ctr, Inc	635 Main St	Middletown	CT	06457
CHC of New Britain	One Washington Square	New Britain	CT	06051
Dept of Dentistry, Yale-New Haven Hos	20 York St	New Haven	CT	06504
Dept. of Oral & Maxilofacial Surg, St. Raphaels	1450 Chapel St	New Haven	CT	06511
Katherine Brennan Elementary School	200 Wilmot Rd	New Haven	CT	06511
Hill Health Ctr	400-428 Columbus Ave	New Haven	CT	06519
Dental Clinic, CHC of New London	1 Shaw Cove	New London	CT	06320
Dental Services, Norwalk Hospital	11 Maple St	Norwalk	CT	06856
Community Health Ctr of Old Saybrook	263 Main St	Old Saybrook	CT	06475
Westhill High School	125 Roxbury Rd	Stamford	CT	06902
Student Health Services of Stamford, Inc	888 Washington Blvd	Stamford	CT	06904
Stay Well Health Ctr	232 North Elm St	Waterbury	CT	06702
Dental Services, St. Mary's Hospital	56 Franklin Ave	Waterbury	CT	06702
Chase Clinic, Dental Svcs, Waterbury Hosp	64 Robbins St	Waterbury	CT	06721
Health First, Inc	1315 Main St	Willimantic	CT	06226



Public Dental Services
1997

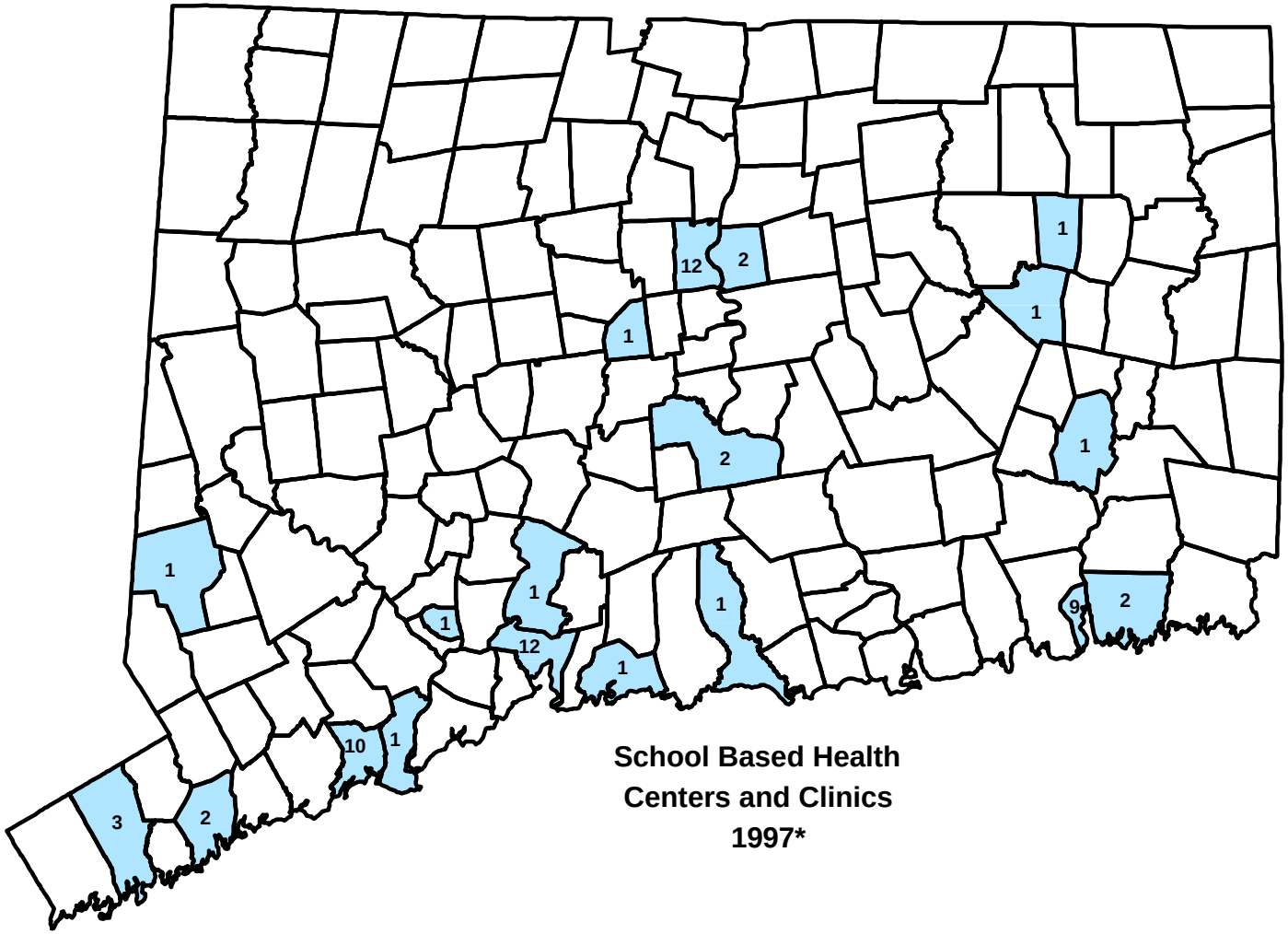
Note: The dots denoting the clinics fall randomly within a town's border and are not actual clinic locations.

Source: DPH, BCH, 1998

SAFETY NET PROVIDERS REPORT

APPENDIX D SCHOOL-BASED HEALTH CENTERS* AND CLINICS

School Based Health Ctr or Clinic	Address	City	ST	Zip
Ansonia High School*	111 Howard Ave	Ansonia	CT	06415
Walsh Intermediate, Branford Public*	185 Damascus Rd	Branford	CT	06405
Bassick High*	1181 Fairfield Ave	Bridgeport	CT	06605
Blackham Elementary*	425 Thorme St	Bridgeport	CT	06606
Central High School*	1 Lincoln Blvd.	Bridgeport	CT	06606
Columbus Elementary School*	275 George St	Bridgeport	CT	06608
Dunbar Elementary School*	790 Central Ave	Bridgeport	CT	06607
Harding High School*	1734 Central Ave	Bridgeport	CT	06610
JFK Campus)	700 Palisade Ave.	Bridgeport	CT	06610
Luis Munoz Marin School	479 Helen St	Bridgeport	CT	06608
Read Elementary School*	130 Ezra St	Bridgeport	CT	06606
Roosevelt Elementary School*	680 Park Ave	Bridgeport	CT	06604
Parish Hill High School Reg Dist 11	PO Box 277	Chaplin	CT	06235
Danbury High School*	43 Clapboard Ridge Rd	Danbury	CT	06811
E Hartford High School*	869 Forbes St	E Hartford	CT	06118
E Hartford Middle*	777 Burnside Ave	E Hartford	CT	06108
Fitch High School*	10 Groton Long Point Rd	Groton	CT	06340
West Side Middle School*	250 Brandegee Ave	Groton	CT	06340
Hamden High School*	1141 Dixwell Ave	Hamden	CT	06514
A.I. Prince Technical School	500 Brookfield St	Hartford	CT	06106
Betances Elementary School	42 Charter Oak Ave.	Hartford	CT	06106
Bulkeley High School	300 Wethersfield Ave.	Hartford	CT	06114
Dental Div of Health Svcs/Health Educ	1305 Greenfield St	Hartford	CT	06112
Hartford Public High School*	55 Forest St	Hartford	CT	06105
Lewis Fox Middle	305 Greenfield St	Hartford	CT	06112
M.D. Fox Elementary School	470 Maple Ave	Hartford	CT	06106
Maria Sanchez Elementary	176 Babcock St	Hartford	CT	06106
Martin Luther King Elementary	25 Ridgefield St	Hartford	CT	06120
Parkville Elementary	1755 Park St	Hartford	CT	06106
Quirk Middle School*	85 Edwards St	Hartford	CT	06120
Weaver High School*	415 Granby St	Hartford	CT	06112
Madison Public Schools	10 Campus Dr	Madison	CT	06443
Macdonough Elemen. School*	66 Spring St	Middletown	CT	06457
Woodrow Wilson Middle School*	Wilderman's Way	Middletown	CT	06457
New Britain Consolidated Dist School	1 Liberty Square	New Britain	CT	06051
Clinton Ave Elementary School*	293 Clinton Ave	New Haven	CT	06511
Fair Haven Middle*	164 Grand Ave	New Haven	CT	06513
Jackie Robinson Middle School*	150 Fournier St	New Haven	CT	06511
James Hillhouse High School*	480 Sherman Parkway	New Haven	CT	06511
Katherine Brennan Elementary School	200 Wilmot Rd	New Haven	CT	06511
Lincoln-Bassett Elementary School*	130 Bassett St	New Haven	CT	06511
Roberto Clemente Middle School*	360 Columbus Ave	New Haven	CT	06519
Sheridan Middle School*	191 Fountain St	New Haven	CT	06511
Troup Science Academy Middle School*	259 Edgewood Ave	New Haven	CT	06511
Truman Elementary	114 Truman St	New Haven	CT	06519
Vincent Mauro Elementary School	130 Orchard St	New Haven	CT	06511
Wilbur Cross High School*	181 Mitchell Dr.	New Haven	CT	06511
Bennie Dover Jackson Middle School*	36 Waller St	New London	CT	06320

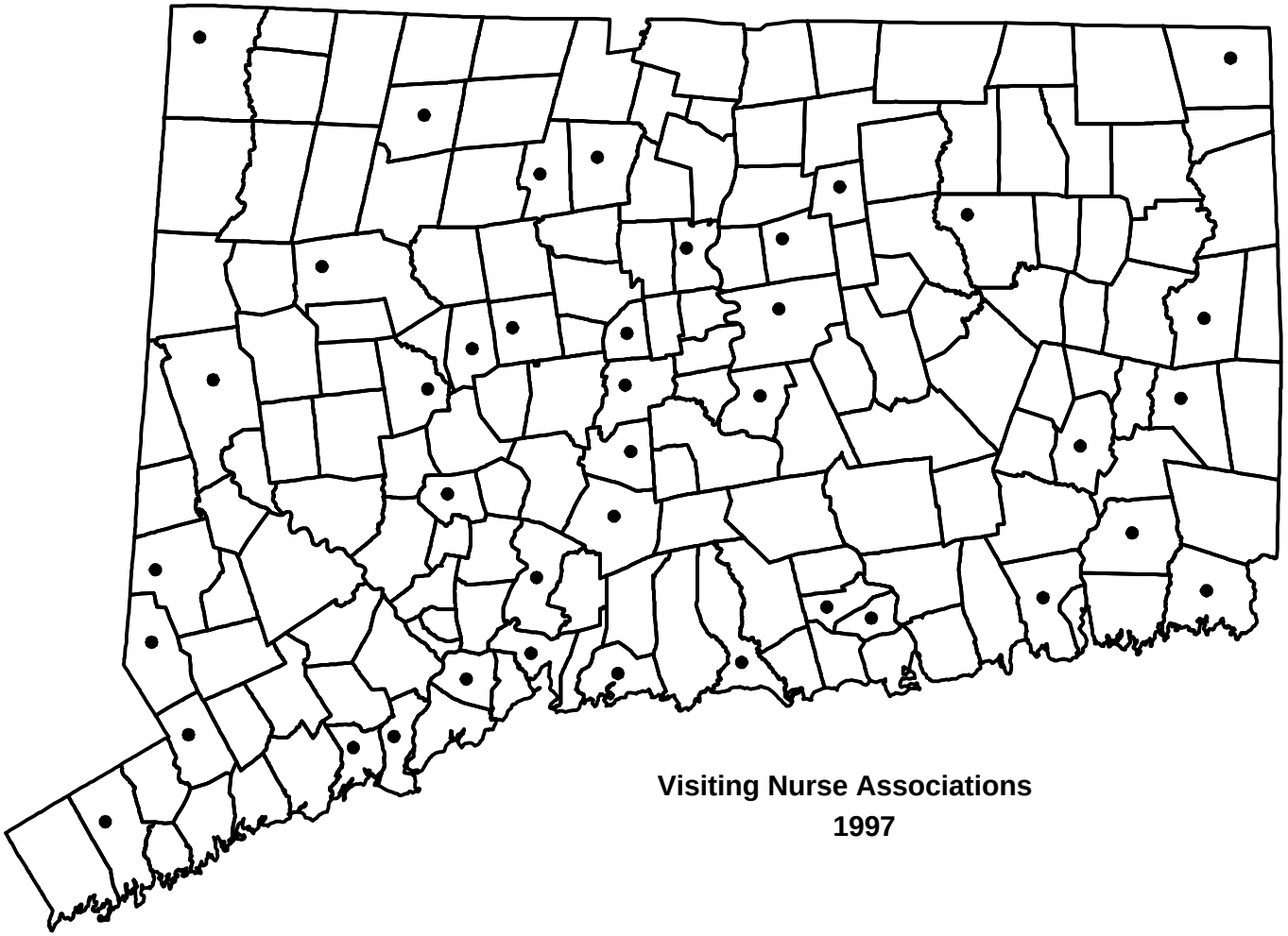


School Based Health Centers and Clinics 1997*

The number of centers or clinics is indicated in each town.
Source: DPH, 1998

APPENDIX D SCHOOL-BASED HEALTH CENTERS* AND CLINICS (CONTINUED)

School Based Health Ctr or Clinic	Address	City	ST	Zip
Edgerton Elementary*	120 Cedar Grove Ave.	New London	CT	06320
Harbor School*	432 Montauk Ave	New London	CT	06320
Jennings Elementary School*	50 Mercer St	New London	CT	06320
Magnet Elementary School*	200 Hempstead St	New London	CT	06320
Nathan Hale Elementary*	37 Beech Dr	New London	CT	06320
New London High School*	490 Jefferson St	New London	CT	06320
Winthrop and Smith Bent Ctr*	7 Bauxhall St	New London	CT	06320
Winthrop Elementary School*	74 Grove St	New London	CT	06320
Brien McMahon High School*	300 Highland Ave	Norwalk	CT	06854
Norwalk High School*	23 Calvin Murphy Dr	Norwalk	CT	06851
Norwich Free Academy	305 Broadway	Norwich	CT	06360
Dolan Middle School*	51 Toms Rd	Stamford	CT	06906
Stamford High School*	55 Strawberry Hill Ave	Stamford	CT	06901
Westhill High School*	125 Roxbury Rd	Stamford	CT	06902
Wooster Middle School*	150 Lincoln St	Stratford	CT	06497
Windham High School*	355 High St	Willimantic	CT	06226



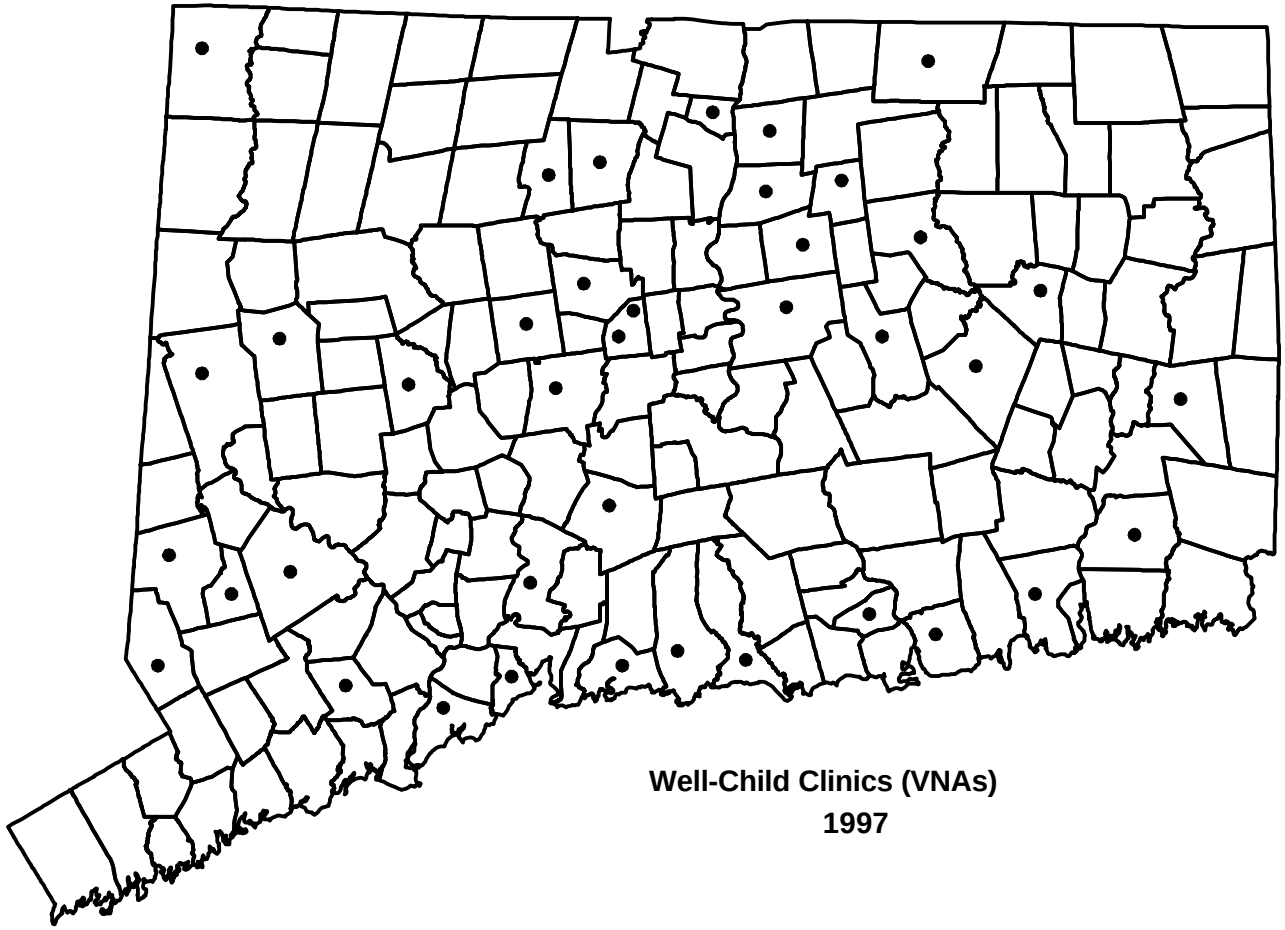
Visiting Nurse Associations
1997

Note: The dots denoting the VNAs fall randomly within a town's border and are not actual site locations.
Source: DPH, BCH, 1998

SAFETY NET PROVIDERS REPORT

APPENDIX E VISITING NURSES ASSOCIATIONS

VNA	Address	City	ST	Zip
Berlin Public Health Nursing Service	240 Kensington Rd	Berlin	CT	06037
VNA Community Healthcare, Inc	40 Kirkham St	Branford	CT	06405
Visiting Nurse Services of CT, Inc	4380 Main St	Bridgeport	CT	06604
The Greater Bristol VNA, Inc	10 Malby St.	Bristol	CT	06011
Canton VNA, Inc	220 Albany Tpke	Canton	CT	06019
Danbury VNA, Inc	4 Liberty St	Danbury	CT	06810
Deep River Public Health, Nursing Service	8 Elm St	Deep River	CT	06417
Visiting Nurses of the Lower Valley, Inc	8 Essex Plaza	Essex	CT	06426
Glastonbury VNA, Inc	969 Hebron Ave	Glastonbury	CT	06033
Regional Visiting Nurse Agency, Inc	1100 Sherman Ave	Hamden	CT	06514
E Hartford VNA I	60 Hartland St., Founders Plz	Hartford	CT	06108
Griswold Public Health, Nursing Service	32 School St	Jewett City	CT	06351
Ledyard Public Health Nursing Service	741 Colonel Ledyard Hwy	Ledyard	CT	06339
Visiting Nurse and Home Care, NW	24 Village Green Dr	Litchfield	CT	06675
VNA Community Care Inc	560 Durham Rd	Madison	CT	06443
Visiting Nurse & Home Care of Manch	545 North Main St	Manchester	CT	06040
Visiting Nurse & Community Hlth of Eastern CT	Box 716, 34 Ledgebrook Dr	Mansfield	CT	06250
Meriden Public Health & VNA	658 Broad St	Meriden	CT	06450
Naugatuck Visiting Nurses Association	16-20 Park Place	Naugatuck	CT	06770
VNA of Central CT, Inc	205 West Main St,Box 1327	New Britain	CT	06050
VNA of South Central CT	One Long Wharf	New Haven	CT	06511
New Milford VNA, Inc	68 Park La Rd	New Milford	CT	06776
United Community Svcs - Community Nursing	77 East Town St	Norwich	CT	06360
Orange VNA	525 Orange Ctr Rd	Orange	CT	06477
Stonington VNA, Inc	20 S. Anquilla Rd	Pawcatuck	CT	06379
Visiting Nurse and Home Care, Inc	146 New Britain Ave	Plainville	CT	06062
Portland Visiting Nurses Association, Inc	309 Main St	Portland	CT	06480
VNA of Southern Worchester	148 Old Turnpike, Route 131	Quinebaug	CT	06262
VNA of Ridgefield, Inc	90 East Ridge	Ridgefield	CT	06877
Salisbury Public Health Nursing Assoc	30 Salmon Kill Rd	Salisbury	CT	06068
VNA Valley Care, Inc	8 Old Mill La	Simsbury	CT	06070
VNA Care, Inc	129 East Main St	Stamford	CT	06911
Stratford VNA, Inc	88 Ryder's Landing	Stratford	CT	06497
Plymouth Public Health Nursing Service	Town Hall, 19 East Main St	Terryville	CT	06786
Visiting Nurse and Community Care, Inc	8 Keynote Dr	Vernon	CT	06066
VNA of Wallingford, Inc	701 Ctr St, PO Box 657	Wallingford	CT	06492
VNA of Southeastern CT	200 Boston Post Rd	Waterford	CT	06385
VNA Health at Home, Incorporated	27 Princeton Rd	Watertown	CT	06795
Nursing Home and Home Care, Inc	180 School Rd, PO Box 489	Wilton	CT	06897
Foothills Visiting Nursing & Home Care	32 Union St	Winsted	CT	06098

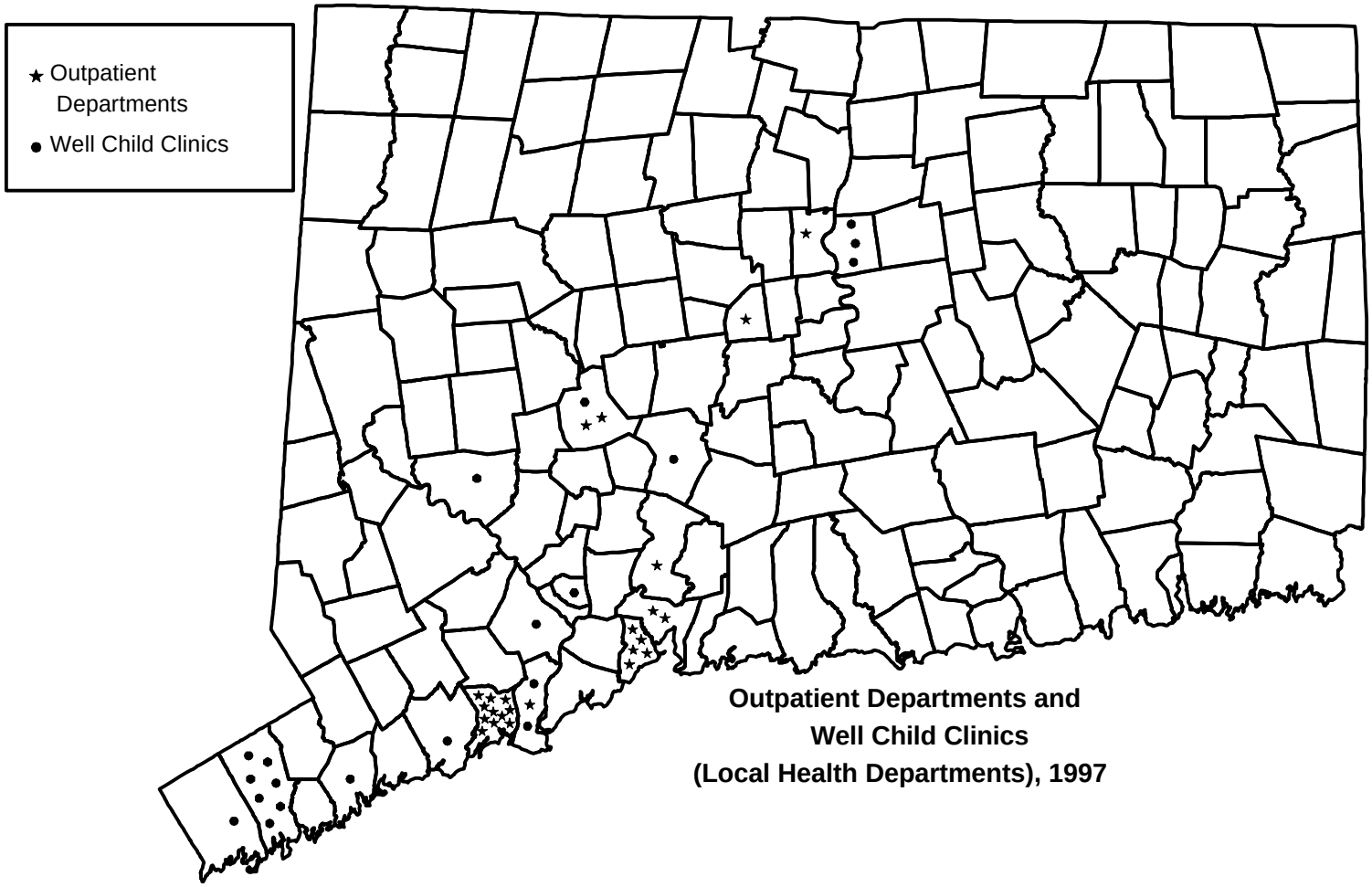


Well-Child Clinics (VNAs)
1997

Note: The dots denoting the clinics fall randomly within a town's border and are not actual clinic locations.
Source: DPH, BCH, 1998

WELL-CHILD CLINICS (VNAS)

VNA	Well-Child Clinic	Address	City	ST	Zip
Bethel VNA	Bethel WCC	Plumtrees Rd	Bethel	CT	06801
Visiting Community Healthcare	Branford WCC	40 Kirkham St	Branford	CT	06405
Bristol VNA	Bristol VNA	10 Maltby St,	Bristol	CT	06010
Canton VNA of CT	Canton WCC	220 Albany Ave	Canton	CT	06016
Visiting Nurse & Community Care, Inc	Visiting Nurse & Community Care	First Cong Church	Coventry	CT	06066
Danbury VNA Inc	Danbury WCC	4 Liberty St	Danbury	CT	06810
Visiting Nurse & Community Care, Inc	East Windsor WCC-	School St-	East Windsor	CT	06088
Visiting Nurse of the Lower Valley, Inc	Essex WCC	8 Essex Plaza	Essex	CT	06424
VNA Farmington Valley	Farmington WCC	2 Monteith Dr	Farmington	CT	06032
VNA Health Care, Inc	Glastonbury VNA -WCC	969 Hebron Ave	Glastonbury	CT	06033
Visiting Community Healthcare	Guilford WCC	669 Boston Post Rd	Guilford	CT	06437
Regional VNA, Inc	Hamden WCC	1100 Sherman Ave	Hamden	CT	06514
Visiting Nurse & Community Hlth of Eastern CT, Inc	Hebron WCC-Hebron Public Safety Bldg.	Route 66	Hebron	CT	06248
Griswold Public Health Nursing Services	Griswold Public Health Nursing Services	32 School St	Jewett City	CT	06351
Visiting Nurse & Community Hlth of Eastern CT, Inc	Lebanon WCC-Lebanon Public Safety Bldg.	Goshen Hill Rd	Lebanon	CT	06249
Ledyard PHNS	Ledyard WCC	741 Col Ledyard Hwy	Ledyard	CT	06339
VNA and Community Care	Madison WCC	560 Durham Rd	Madison	CT	06443
Visiting Nurse & Home Care	Manchester WCC	585 East Ctr St	Manchester	CT	06404
VNA of South Central CT	VNA of SC CT WCC	2051 Bridgeport Ave	Milford	CT	06460
Visiting Nurse & Home Care	New Britain WCC	100 Grand St	New Britain	CT	06050
Visiting Nurse & Home Care	New Britain WCC	147 West Main St	New Britain	CT	06052
New Milford VNA	New Milford WCC	68 Park La Rd	New Milford	CT	06776
Visiting Nurse & Homecare	Northwest	131 Route 202	NewPreston	CT	06777
Danbury VNA, Inc	Newtown WCC.	Riverside Rd	Newtown	CT	06482
Old Lyme VNA, Inc	Old Lyme WCC	52 Lyme St	Old Lyme	CT	06371
VNA of Ridgefield, Inc	Ridgefield WCC	90 East Ridge	Ridgefield	CT	06877
Salisbury PHNA, Inc	Salisbury PHNA, Inc	30A Salmon Kill	Salisbury	CT	06068
VNA Farmington Valley, Inc	Simsbury WCC	8 Old Mill La	Simsbury	CT	06070
Visiting Nurse & Community Care, Inc	So Windsor WCC	1790 Ellington Ave	So Windsor	CT	06074
Southington VNA, Inc	Southington WCC	8 Meriden Ave	Southington	CT	06489
Visiting Nurse & Community Care	Stafford Springs WCC	W Main & Church St	Stafford Springs	CT	06076
Trumbull PHNS	Trumbull WCC	4632 Madison Ave	Trumbull	CT	06611
Visiting Nurse & Community Care, Inc	Vernon WCC	Union & Elm St	Vernon	CT	06066
VNA of Wallingford, Inc	Wallingford WCC	701 Ctr St	Wallingford	CT	06492
PHNS, Inc	Waterford WCC	1000 Hartford Rd	Waterford	CT	06385
VNA Health at Home, Inc	Watertown WCC	27 Princeton Rd	Watertown	CT	06795
VNA of South Ctrl CT, Inc	VNA of SC CT, WCC	355 Main St	West Haven	CT	06516
Visiting Nurse & Comm. Hlth of Eastern CT, Inc	Willimantic WCC	132 Mansfield Ave	Willimantic	CT	06226
Visiting Nrse & Home Care	Windsor Locks WCC	50 Church St	Wind Locks	CT	06096



Outpatient Departments and Well Child Clinics (Local Health Departments), 1997

Note: The stars and dots denoting the center corporations and clinics fall randomly within a town's border and are not actual site locations.

Source: DPH, BCH, 1998

SAFETY NET PROVIDERS REPORT

APPENDIX F LOCAL HEALTH DEPTS AND HEALTH DISTRICTS

Local Health Dept	Director's Mailing Address	City	ST	Zip
Town of Andover	269 Church St.	Amston	CT	06231
Town of Hebron	269 Church St.	Amston	CT	06231
Farmington Valley Health Dist	50 Simsbury Rd	Avon	CT	06001
Town of Sprague	POB 677	Baltic	CT	06330
Berlin Health Dept	240 Kensington Rd	Berlin	CT	06037
Bethel Health Dept	1 School St	Bethel	CT	06801
East Shore Health Dist	29C Business Park Dr	Branford	CT	06405
Bridgeport Health Dept	752 East Main St	Bridgeport	CT	06608
Bristol-Burlington Health Dist	240 Stafford Ave	Bristol	CT	06010
Town of Brookfield	60 Old New Milford Rd	Brookfield	CT	06804
Northeast Dist Dept of Health	182 South Main St, POB 145	Brooklyn	CT	06234
Town of Canaan	7 Main St, POB 970	Canaan	CT	06018
Chesprocott Health Dist	1247 Highland Ave	Cheshire	CT	06410
Town of Chester	150 Main St	Chester	CT	06412
Town of Colchester	127 Norwich Ave, Suite 108	Colchester	CT	06415
Town of Salem	127 Norwich Ave, Suite 108	Colchester	CT	06415
Town of Cromwell	26 Shunpike Rd	Cromwell	CT	06416
Danbury Health & Housing Dept	20 West St	Danbury	CT	06810
Town of Redding	24 Hospital Ave	Danbury	CT	06810
Town of Darien	2 Renshaw Rd	Darien	CT	06820
Town of Durham	POB 428	Durham	CT	06422
East Hampton Health Dept	20 East High St	East Hampton	CT	06424
E Hartford Health Dept	740 Main St	E Hartford	CT	06108
Town of Easton	94 Burr St	Easton	CT	06612
North Central Health Dist	47 North Main St POB 1222	Enfield	CT	06083
Town of Somers	115 Elm St	Enfield	CT	06082
Town of Essex	One Wildwood Medical Ctr	Essex	CT	06426
Fairfield Health Dept	725 Old Post Rd	Fairfield	CT	06430
Glastonbury Health Dept	2155 Main St	Glastonbury	CT	06033
Greenwich Health Dept	101 Field Point Rd POB 2540	Greenwich	CT	06836
Borough of Stonington	Gold Star Office Park, Suite 120	Groton	CT	06340
Ledge Light Health Dist	1 Fort Hill Rd	Groton	CT	06340
Town of Stonington	Gold Star Office Park Suite 120	Groton	CT	06340
Town of Guilford	31 Park St	Guilford	CT	06437
Hartford Health Dept	131 Coventry St	Hartford	CT	06112
Town of Haddam	High St	Higganum	CT	06441
Borough of Jewett City	32 School St	Jewett City	CT	06351
Town of Griswold	32 School St	Jewett City	CT	06351
Town of Lisbon	32 School St	Jewett City	CT	06351
Town of Preston	32 School St	Jewett City	CT	06351
Town of Voluntown	32 School St	Jewett City	CT	06351
Town of Ledyard	743 Col Ledyard Hwy	Ledyard	CT	06339
Borough of Fenwick	22 Cove Rd	Lyme	CT	06371
Town of Old Saybrook	22 Cove Rd	Lyme	CT	06371
Madison Health Dept	Campus Dr	Madison	CT	06443
Town of Clinton	1353 Boston Post Rd	Madison	CT	06443
Town of Killingworth	1353 Boston Post Rd	Madison	CT	06443
Manchester Health Dept	479 Main St POB 191	Manchester	CT	06045
Eastern Highlands Health Dist	4 South Eagleville Rd	Mansfield	CT	06268
Town of Columbia	10 Higgins Highway - Suite 4	Mansfield Ctr	CT	06250
Town of Lebanon	10 Higgins Highway Suite 4	Mansfield Ctr	CT	06250
Town of Marlborough	Independence Dr POB 269	Marlborough	CT	06447
Meriden Dept of HHS	165 Miller St	Meriden	CT	06450
Town of Middlebury	White Deer Rock Rd	Middlebury	CT	06762
Town of Middlefield	405-1 Main St	Middlefield	CT	06455
Middletown Health Dept	245 DeKoven Dr	Middletown	CT	06457

Local Health Dept	Director's Mailing Address	City	ST	Zip
Town of Deep River	520 Saybrook Rd	Middletown	CT	06457
Borough of Woodmont	2051 Bridgeport Ave	Milford	CT	06460
Milford Health Dept	2051 Bridgeport Ave	Milford	CT	06460
Town of Monroe	838 Main St	Monroe	CT	06468
New Britain Health Dept	31 High St	New Britain	CT	06051
Town of New Canaan	11 Garibaldi La	New Canaan	CT	06840
New Fairfield Health Dept	4 Brush Hill Rd	New Fairfield	CT	06812
New Haven Health Dept	54 Meadow St 9th Floor	New Haven	CT	06519
New London Health Dept	120 Broad St	New London	CT	06320
Town of Waterford	488 Montauk Ave	New London	CT	06320
New Milford Health Dept	10 Main St	New Milford	CT	06776
Town of Bridgewater	41 South Main St	New Milford	CT	06776
Town of Roxbury	41 South Main St	New Milford	CT	06776
Town of Newington	Town Hall, 131 Cedar St	Newington	CT	06111
Newtown Health Dist	3 Main St	Newtown	CT	06470
Town of East Lyme	22 West Main St	Niantic	CT	06357
Town of Lyme	22 West Main St	Niantic	CT	06357
Town of North Canaan	POB 817	North Canaan	CT	06018
Town of Franklin	7 Meetinghouse Hill Rd	North Franklin	CT	06254
Quinnipiack Valley Health Dist	1151 Hartford Turnpike	North Haven	CT	06473
Norwalk Health Dept	137-139 East Ave	Norwalk	CT	06851
Town of Bozrah	130 New London Turnpike	Norwich	CT	06360
Uncas Health Dist	401 West Thames St, #2301	Norwich	CT	06360
Town of Old Lyme	POB 160, 52 Lyme St.	Old Lyme	CT	06371
Town of Orange	525 Orange Ctr Rd	Orange	CT	06477
Town of Plainville	7 North Washington St POB 40	Plainville	CT	06062
Town of Portland	259 Main St	Portland	CT	06480
Town of Ridgefield	66 Prospect St	Ridgefield	CT	06877
Town of Scotland	Gager Hill Rd, Box 4	Scotland	CT	06264
Town of Sharon	Sharon Medical Arts Building	Sharon	CT	06069
Naugatuck Valley Health Dist	470 Howe St	Shelton	CT	06484
Town of Sherman	Mallory Town Hall, POB 39	Sherman	CT	06784
Town of East Haddam	90 Garnet La	So Windsor	CT	06074
Pomperaug Health Dist	800 Main St Suite 130	Southbury	CT	06488
Town of Southington	93 Main St	Southington	CT	06489
Stafford Health Dist	One Main St	Stafford Springs	CT	06076
Stamford Health Dept	888 Washington Blvd, 8th fl.	Stamford	CT	06901
Stratford Health Dept	2730 Main St	Stratford	CT	06497
Town of Plymouth	27 Main St	Terryville	CT	06786
Torrington Area Health Dist	1116 Litchfield St	Torrington	CT	06790
Town of Trumbull	4632 Madison Ave	Trumbull	CT	06611
Town of So Windsor	351 Merline Rd Suite 103	Vernon	CT	06066
Town of Tolland	351 Merline Rd Suite 103	Vernon	CT	06066
Town of Willington	351 Merline Rd, Suite 103	Vernon	CT	06066
Town of Wallingford	45 South Main St.	Wallingford	CT	06492
Town of Washington	1 Kirby Rd	Washington	CT	06793
Town of Bethany	171 Grandview Ave	Waterbury	CT	06708
Waterbury Health Dept	402 East Main St	Waterbury	CT	06702
W Htfd-Bloomfield Health Dist	50 South Main St	W Hartford	CT	06107
West Haven Health Dept	355 Main St	West Haven	CT	06516
Town of Westbrook	POB 502	Westbrook	CT	06498
Town of North Stonington	3 Crestview Dr	Westerly	RI	02891
Weston/Westport Health Dist	180 Bayberry La	Westport	CT	06880
Rocky Hill/Wethfld Health Dist	505 Silas Deane Highway	Wethersfield	CT	06109
Town of Chaplin	14 Quarry St	Willimantic	CT	06226
Wilton Health Dept	238 Danbury Rd	Wilton	CT	06897
Windsor Health Dept	Town Hall 275 Broad St	Windsor	CT	06095

LOCAL HEALTH OUTPATIENT DEPTS

Local Health Dept	Outpatient Dept	Address	City	ST	Zip
Bridgeport Dept of Health	Blackham SBHC	425 Throme St	Bridgeport	CT	06606
Bridgeport Dept of Health	City Health Svcs of Bpt	752 East Main St	Bridgeport	CT	06606
Bridgeport Dept of Health	Columbus SBHC	275 George St	Bridgeport	CT	06608
Bridgeport Dept of Health	Eisenhower Health Ctr	263 Golden Hill St	Bridgeport	CT	06604
Bridgeport Dept of Health	Harding High School	1734 Central Ave.	Bridgeport	CT	06607
Bridgeport Dept of Health	JFK Campus Health Ctr	700 Palisades Parkway	Bridgeport	CT	06608
Bridgeport Dept of Health	Luis Munoz Marin School	479 Helen St	Bridgeport	CT	06608
Bridgeport Dept of Health	No. End Clinic	1381 Reservoir Ave	Bridgeport	CT	06606
Bridgeport Dept of Health	Read Elem. SBHC	130 Ezra St	Bridgeport	CT	06608
Bridgeport Dept of Health	Roosevelt SBHC	680 Park Ave	Bridgeport	CT	06604
Bridgeport Dept of Health	Central High School	1 Lincoln Blvd.	Bridgeport	CT	06606
Quinnipiack Valley Health Dist	Hamden High School	2040 Dixwell Ave	Hamden	CT	06514
Hartford Health Dept	Burgdorf Ctr.	80 Coventry St	Hartford	CT	06112
New Britain Health Dept	New Britain Health Dept	31 High St	New Britain	CT	06051
New Haven Health Dept	K. Brennan School	200 Wilmot Rd	New Haven	CT	06515
New Haven Health Dept	New Haven Health Dept	54 Meadow St	New Haven	CT	06519
Stratford Health Dept	Wooster Middle SBHC	150 Lincoln St	Stratford	CT	06497
Waterbury Health Dept	Tri Project Health Van	232 N. Elm St	Waterbury	CT	06702
Waterbury Health Dept	Wtby Health Dept	402 E. Main St	Waterbury	CT	06702
West Haven Health Dept	Allington Sr. Ctr	One Forest Rd	West Haven	CT	06516
West Haven Health Dept	J Prete Senior Housing	1187 Campbell Ave	West Haven	CT	06516
West Haven Health Dept	Morrissey Manor Housing	Bayshore Dr	West Haven	CT	06516
West Haven Health Dept	Surfside Housing	200 Oak St	West Haven	CT	06516
West Haven Dept of Health	West Haven Health	355 Main St	West Haven	CT	06516

SAFETY NET PROVIDERS REPORT

APPENDIX G LOCAL HEALTH PROVISION OF CORE PUBLIC HEALTH FUNCTIONS

***Healthy People* and *Healthy CT* Priority Area**: Educational and Community-Based Program.
Objective Number 8.14: Increase to at least 90 percent the proportion of people who are served by a local health department that is effectively carrying out the core functions of public health.
Rationale: The Institute of Medicine Report *The Future of Public Health* defined necessary steps to strengthen the public health system. The desired outcome is a public health system effectively performing the core functions identified as assessment, policy development and assurance.

Objective Parameters	US Baseline	US Yr. 2000 Target	CT Baseline	CT Yr. 2000 Target
I. *Assessment activities*				
A. Data collection/analysis				
1. Behavioral risk assessment	33%	90%	20.0%	100%
2. Morbidity data	49	90	34.3	100
3. Reportable diseases	87	90	90.0	100
4. Vital records and statistics	64	90	25.7	100
B. Epidemiology/surveillance				
1. Chronic diseases	54	90	31.4	100
2. Communicable diseases	91	90	87.1	100
II. Policy development				
A. Health code development and enforcement	59	90	82.9	100
B. Health planning	57	90	50.0	100
C. Priority setting	51	90	42.9	100
III. Assurance activities				
A. Inspection				
1. Food and milk control	72	90	82.9	100
2. Health facility safety/quality	47	90	45.7	100
3. Recreation facility safety/quality	54	90	65.7	100
4. Other facility safety/quality	32	90	45.7	100
B. Licensing		90		
1. Health facilities	22	90	24.3	100
2. Other facilities	71	90	87.1	100
C. Health education	74	90	61.4	100
D. Environmental				
1. Air quality	33	90	37.1	100
2. Hazardous waste management	46	90	61.4	100
3. Individual water supply/safety	77	90	81.4	100
4. Noise pollution	20	90	35.7	100
5. Occupational health and safety	23	90	32.9	100
6. Public water supply safety	58	90	48.6	100
7. Radiation control	21	90	28.6	100
8. Sewage disposal systems	79	90	94.3	100
9. Solid waste management	55	90	44.3	100
10. Vector and animal control	70	90	60.0	100
11. Water pollution	60	90	87.1	100

Objective Parameters	US Baseline	US Yr. 2000 Target	CT Baseline	CT Yr. 2000 Target
E. Personal health services	60	90		
1. AIDS testing and counseling	57	90	25.7	100
2. Alcohol abuse	16	90	11.4	100
3. Child health	84	90	48.6	100
4. Chronic diseases	69	90	31.4	100
5. Dental health	38	90	21.4	100
6. Drug abuse	17	90	15.7	100
7. Emergency medical services	13	90	22.9	100
8. Family planning	59	90	11.4	100
9. Handicapped children	47	90	11.4	100
10. Home health care	50	90	21.4	100
11. Hospitals	3	90		
12. Immunizations	92	90	75.7	100
13. Laboratory services	43	90	15.7	100
14. Long term care facilities	6	90	7.1	100
15. Mental health	14	90	15.7	100
16. Obstetrical care	20	90	5.7	100
17. Prenatal care	59	90	11.4	100
18. Primary care	22	90	7.1	100
19. Sexually transmitted diseases	73	90	47.1	100
20. Tuberculosis	81	90	45.7	100
21. WIC	69	90	25.7	100

Source of Data: U.S. Dept of Health and Human Services. Public Health Service. Centers for Disease Control, Atlanta, GA. *Profile of State and Territorial Public Health Systems: United States, 1990.* Public Health Program Office Publication, 1991. Data is limited due to self reporting by local health departments.

APPENDIX H

HEDIS MEASURES

The Health Plan Employer Data and Information Set, *HEDIS 3.0*[18], builds on the earlier versions for both the commercial (HEDIS 2.5) and Medicaid populations.[19] Notable changes include the addition of more outcome measures, a standardized satisfaction survey, more measures related to high prevalence diseases, the addition of a testing set, and the integration of public and private reporting requirements.

HEDIS 3.0 Reporting and Testing Set Measures

Effectiveness of Care	***Access/Availability of Care***
Reporting Set	*Reporting Set*
Childhood Immunization Status	Adults' Access to Prevention/Ambulatory Services
Adolescent Immunization Status	Children's Access to Primary Care Providers
Advising Smokers to Quit	Availability of Primary Care Providers
Flu Shots for Older Adults	Availability of Obstetrical and Prenatal Care
Breast Cancer Screening	Initiation of Prenatal Care
Cervical Cancer Screening	Low Birthweight Deliveries at Facilities for High-Risk Deliveries & Neonates
Check-ups After Delivery	Annual Dental Visit
Treating Children's Ear Infections	Availability of Dentists
Beta Blocker Treatment After a Heart Attack	Availability of Language Interpretation Services
Eye Exams for People with Diabetes	*Testing Set* - Problems with Obtaining Care
The Health of Seniors	***Satisfaction with the Experience of Care***
Follow-up after Hospitalization for Mental Illness	*Reporting Set*
Testing Set	Satisfaction Survey
Substance Counseling for Adolescents	Descriptive Information
Number of People in the Plan Who Smoke	*Testing Set*
Smokers Who Quit	Consumer Assessments of Health Plans Study
Flu Shots for High-Risk Adults	Disenrollment Survey
Stage at which Breast Cancer was Detected	Satisfaction with Breast Cancer Treatment
Chlamydia Screening	***Health Plan Stability***
Colorectal Cancer Screening	*Reporting Set*
Aspirin Treatment after a Heart Attack	Disenrollment
Follow-up after an Abnormal Pap Smear	Provider Turnover
Follow-up after an Abnormal Mammogram	Years in Business/Total Membership
Use of Appropriate Medications for People with Asthma	Indicators of Financial Stability
Prevention of Stroke in People with Arial Fibrillation	Narrative Information on Race Trends, Financial Stability and Insolvency Protection
Monitoring Diabetes Patients	***Cost of Care***
Outpatient Care of Patients Hospitalized for Heart Failure	*Reporting Set*
Cholesterol Management of Patients Hospitalized for Coronary Artery Disease	Rate Trends High-Occurrence/High Cost DRGs
Controlling High Blood Pressure	*Testing Set* -Health Plan Costs Per Member Per Month
Assessment of How Breast Cancer Therapy Affects the Patient's Ability to Function	***Use of Services***
Failure of Substance Abuse Treatment	*Reporting Set*
Screening for Chemical Dependency	Frequency of Ongoing Prenatal Care
Continuity of Care for Substance Abuse Patients	Well-Child Visits in the First 15 Months of Life

[18] National Committee for Quality Assurance. *HEDIS 3.0 - Health Plan Employer Data and Information Set.* Washington, D.C: 1997.

[19] National Committee for Quality Assurance. *HEDIS 3.0 Draft for Public Comment.* Washington, D.C. July, 1996:iii.

Prescription of Antibiotics for the Prevention of HIV-Related Pneumonia
Continuation of Depression Treatment
Availability of Medication Management and Psychotherapy for Patients with Schizophrenia
Appropriate Use of Psychotherapeutic Medications
Family Visits for Children aged 0-12
Patient Satisfaction with Mental Health Care

Health Plan Descriptive Information

Reporting Set
Board Certification/Residency Completion
Provider Compensation
Physicians Under Capitation
Case Management
Utilization Management
Risk Management Quality Assessment and Improvement
Recredentialing
Preventive Care and Health Promotion
Arrangements with Public Health, Educational and Social Service Organizations
Pediatric Mental Health Network
Chemical Dependency Services
Family Planning Services
Total Enrollment
Enrollment by Payer (Member Years/Months)
Unduplicated Count of Medicaid Members
Cultural Diversity of Medicaid Membership
Weeks of Pregnancy at Time of Enrollment in Health Plan
Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life
Adolescent Well-Care Visit
Frequency of Selected Procedures
Inpatient Utilization - General Hospital/Acute Care
Ambulatory Care
Inpatient Utilization - Non-Acute Care
Discharge and Average Length of Stay - Maternity Care
Births and Average Length of Stay, Newborns
Cesarean Section & Vaginal Birth/After Cesarean Rate
Mental Health Utilization - Inpatient Discharge and Average Length of Stay
Mental Health Utilization - % of Members Receiving Inpatient, Day/Night and Ambulatory Services
Readmission for Specified Mental Health Disorders
Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay
Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services
Readmission for Chemical Dependency
Outpatient Drug Utilization

Testing Set
Use of Behavioral Health Services

Informed Health Care Choices

Reporting Set
New Member Orientation/Education
Language Translation Services

Testing Set -
Counseling Women About Hormone Replacement Therapy

APPENDIX I

QUALITY ASSURANCE OVERSIGHT

Comparison of Public Quality Assurance Oversight with a Model Quality Monitoring Program (9/97)

Elements of a Model Quality Assurance Program	HCFA Medicare Manage Care	HCFA QARI Medicaid Managed Care	CT Medicaid Managed Care	CT State Employee Health lan	CT Public Act 97-99
Certificate of Authority	✓[a]	✓	✓		
Provide Consumers with Info					
Plan's benefits/procedures	✓[b]	✓	✓	✓	✓
Comparative Information	✓[b]	✓	✓		✓
Monitor Grievance Procedures					
Internal	✓[c]	✓	✓	✓	✓
External	✓	✓	✓		✓
Improve System Performance					
Require NCQA Accreditation HEDIS Reporting	✓	✓[d]	✓[d]		✓
Tracer Conditions	✓[e]	✓	✓[f]		
Consumer/Provider Surveys	✓[g]	✓[g]	✓[g]	✓[g]	
Promoting Public Health					
Community-Based measures	[h]				
Other Quality Activities Implemented					
Clinical Mandates	✓[i]		✓	✓[j]	✓[j]
Regulation of Utilization Review			✓	✓	✓
Choice of Provider	✓[k]	✓[k]		✓[k]	
Banning "Gag Clauses"	✓	✓	✓	✓	✓

Sources: HCFA Office of Managed Care, State Comptroller's Office, and the Connecticut Department of Social Services.

[a] HCFA does not issue a certificate of authority per se, but under its "HMO Qualification Program", HCFA personnel assess whether health plans meet Medicare standards similar to those for fee-for-service providers.

[b] HCFA has announced a consumer information program to provide beneficiaries information to compare plans. The types of information will include basic benefit and cost comparisons, consumer satisfaction ratings, and performance indicators on flu shots, mammograms, etc. Comparisons on benefits and cost comparisons will be released in July, comparisons of performance measures by the end of the year, followed by the results of satisfaction surveys.

[c] HCFA specifies that each plan must specify an appeals process for beneficiaries. HCFA employs a medical peer review organization in each state to review complaints by beneficiaries involving the quality and denials of care. Members can appeal directly to the PRO.

[d] The HCFA Quality Assurance Reform Initiative recommends, but does not require, NCQA accreditation and HEDIS reporting. The CT Medicaid managed care program, which utilizes the QARI framework, also recommends NCQA accreditation and HEDIS reporting.

[e] The HCFA Diabetes Project is a pilot project to evaluate and improve diabetes care for Medicare beneficiaries. Using medical record review, the project has identified opportunities to improve care. Interventions to improve care have been developed and implemented and the last phase will evaluate the effectiveness of the interventions.

[f] CPRO will focus on three areas, beginning with pediatric asthma.

[g] Only consumers are surveyed.

[h] While HCFA has several public health improvement projects underway, participation by health plans is voluntary. Pneumonia/Flu 2000 promotes influenza and pneumonia vaccinations, and a Preventive Screening Services Project includes an office reminder intervention system that identifies patients in need of services, reinforces positive patient behavior, and provides feedback on practice performance).

[i] The Medicare program has only specified mandated length of stays for mastectomy procedures.

[j] In Connecticut, a clinical mandate exists for maternity and mastectomy hospital stays.

[k] Health plans in these programs offer "out-of network" options for beneficiaries.

APPENDIX J

COMMUNITY BENEFIT GUIDELINES FOR HMOs

Massachusetts Community Benefit Guidelines for Health Maintenance Organizations[20]

- The governing body of each HMO should adopt and make public a Community Benefits Policy Statement setting forth its commitment to a formal Community Benefits Program.
- The governing body and senior management of the HMO should be responsible 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.
- The governing body and senior management of the HMO should seek assistance and participation from HMO members and the community in developing and implementing the HMO's Community Benefits Program, and in defining the targeted population and the specific health care needs to be addressed by the Community Benefits Program.
- Each HMO should develop its Community Benefits Program based upon an assessment of the health care needs and resources of the identified populations, particularly lower and moderate-income communities. The Program should consider the health care needs of a broad spectrum of age groups and health conditions.
- The HMO should develop and market products which would attract all segments of the population.
- The HMO should strive to offer and promote, consistent with existing laws and regulations, direct enrollment for non-group coverage and continue to work toward insurance market reform so that managed care will be an option for all working families and individuals.
- The HMO should take steps to reduce cultural, linguistic, and physical barriers to accessible health care at key points of patient contact.
- The HMO should strive to help Massachusetts consumers who are about to lose coverage or who are uninsured, to maintain or obtain, as applicable, health care coverage, at least for limited periods of time, at reduced or subsidized rates.
- The HMO should make an Annual Community Benefits Report available upon request to the public at the HMO and through the headquarters of the Massachusetts Association of HMOs (MAHMO), where the Report will also be available upon request to the public and to the Office of the Attorney General. The Report should describe the HMO's level of community benefits expenditures and describe the HMO's approach to establishing those expenditures.

[20] State of Massachusetts, Attorney General's Office, February, 1996.

APPENDIX K

ACCESS TO HEALTH INSURANCE AND HEALTH CARE

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

This Act is most generally referred to as the Kassebaum/Kennedy bill and was signed into law on August 21, 1996. Its provisions are designed to help individuals and families keep insurance when changing jobs by limiting preexisting condition exclusions, guarantee issue and renewability for small businesses, portability of insurance coverage for individuals leaving jobs, and increases in the tax deductability of health insurance premiums for the self-employed.

States are required to reform their private insurance markets to comply with the law by July 1, 1997. Like welfare reform, states are given some flexibility in terms of shaping their program to meet the federal provisions. For example, existing state laws which are more stringent regarding guarantee issue or high risk pools will take precedence. For this reason, the impact of this legislation will vary widely across the nation.

Table K- 1
Provisions of the Health Insurance Portability and Accountability Act

Main Provisions	Explanation
Pre-Existing Condition Exclusions	Under the law, insurers may only impose one 12 month exclusion period for any preexisting condition treated or diagnosed in the previous six months. A 12 month exclusion can never be imposed again on any employee who maintains continuous health coverage without a break for more than 62 days. Pregnancy cannot be considered a preexisting condition.
Group to Individual Portability	Under certain conditions, the law allows individuals to obtain health insurance if they leave their job and seek coverage in the individual market. To qualify, an individual must have been insured for 18 months or longer, covered under a group plan, have exhausted available COBRA coverage, and is not eligible for an employment based plan, Medicare, or Medicaid.
Guaranteed Issue and Renewability	This provision requires that insurers which sell policies to small businesses, must sell their products to all small businesses (defined as 2-50 employees). While the provision in a way guarantees access to insurance products for small businesses, it does not address limits on what insurers can charge so affordability is an issue. Additionally, the law bans insurers from dropping group coverage due to health status of the group's members.
Tax Deductibility for the Uninsured	Currently, the self employed can deduct 30% of their health insurance premiums from their income when filing federal tax returns. Under the Kassebaum/Kennedy bill, this is increased to 80% over a ten year period.
Other Provisions	Tax treatment of long term care insurance. The treatment of long term care insurance is designed to provide incentives for individuals and employers to purchase long term care insurance. Medical savings account demonstration program. The MSA demonstration will be available to 750,000 people for four years. The accounts will be used to pay for medical expenses by people with high deductible health insurance plans with tax deductible contributions by workers and employers.

Source: Families USA, Dec. 1996

UNCOMPENSATED CARE PROGRAM

Connecticut ensures, by statute, that emergency health care services are provided by hospitals regardless of an individual's ability to pay. Uncompensated care is generally defined as a hospital's bad debt (uncollected amounts for services for which the hospital is expected to receive payment) and free care (services to the indigent provided at either a reduced rate or free of charge). Hospitals incur unreimbursed costs from uncompensated care and government underpayments for publicly insured clients. Hospitals may offset these costs through higher charges to private payers or "cost shifting". Depending upon a hospital's

case-mix, cost-shifting can put it at a competitive disadvantage for paying patients. The broader implication is that cost control techniques used by the public sector which limit payments, can have a limited effect on total health spending due to the cost-shift phenomenon.[21]

In order to level the playing field and address the cost-shifting issue**,** the state established the uncompensated care program in 1991 for all its acute care general hospitals. In addition, the program allowed the State to take advantage of a 1991 federal amendment to obtain federal matching payments on provider taxes. The program is funded by a 9.25% tax on hospital gross earnings and according to current state law, will decrease by 1% each fiscal year until 1999. The amount of uncompensated care varies among Connecticut's 34 acute care general hospitals and depends upon community demographics, the availability of health care programs offered to needy populations in a community, and the enforcement of hospital collections. The majority of uncompensated care is provided by urban hospitals.[22] In total, uncompensated care has generally risen since FY 1994 and accounts for about 4% of hospital gross revenues on average.[23]

Since the money received by hospitals is not paid on a claims basis, it is not entirely certain how much of this money pays specifically for services to the uninsured and underinsured. OHCA, responsible for administration of the program, estimates about 65% of gross uncompensated care is attributed to services for the uninsured.[24] On the national level, estimates of uncompensated care vary greatly. The American Hospital Association estimated that hospitals provided over $13 billion in uncompensated care in 1991 while the Congressional Budget Office estimated the value at $25 billion. A study done by Long and Marquis, estimated the cost of care for uninsured individuals at $40.6 billion in 1993.

While the program helps maintain financial stability for the state's hospital infrastructure, funding health services for the uninsured through this mechanism does not encourage the use of primary and preventive care and it also perpetuates the use of higher cost hospital emergency rooms. Coordination and continuity of care is also a problem with this system as each patient encounter may be with a different provider. For this reason as well as for fiscal considerations, many states have shifted from uncompensated care pools to insurance-based approaches. Thirty-six states have programs that target uninsured adults or children that do not qualify for Medicaid. Of these, fifteen use insurance subsidy programs which may be financed by managed care savings, diverted pool funds, and cigarette or other taxes.[25]

Welfare Reform

Enacted in August, 1996, the Personal Responsibility and Work Opportunity Act of 1996 (PRA) will begin implementation by states in 1997. The law includes several provisions which will effect financial support and access to health services for Connecticut's most vulnerable citizens. The major health-related provisions are summarized in the table below.

Table K- 2
Health Related Provisions of PRA

Population Affected	New Provision Under HR 3737
Medicaid AFDC Recipients	Replaces AFDC program with Temporary Assistance to Needy Families block grant. ■ States now receive a finite amount of money to cover eligibles. Assistance can no longer be guaranteed to all who are eligible. ■ Cash assistance recipients are no longer automatically enrolled in Medicaid.
Immigrants	Legal immigrants entering the country after Aug. 22, 1996 remain ineligible for any federal means-tested public benefit for a period of five years from the date of entry into the country. Supplemental Security Income is reinstated for legal immigrants under certain guidelines.

21 Congressional Budget Office. Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals Cost Shift? Washington, D.C. 1993.

22 Connecticut Office of Health Care Access. *Report on the Financial Stability of Connecticut's Short-Term Acute Care General Hospitals in a Competitive Market.*, Hartford, CT. 1996.

23 Connecticut Office of Health Care Access. Uncompensated Care Analysis for FY 1997 (Schedule E). Hartford, CT. 1998.

24 Connecticut Office of Health Care Access. *Uncompensated Care Analysis for Year Ending September 30, 1996*. Hartford, CT. 1997.

25 Alpha Center. State programs to expand coverage reach more than a million people. *State Initiatives in Health Care Reform*. 1996 Oct;(20):1-4.

Family and Child Nutrition	■ Changes to the food stamp program is expected to account for half of the total savings the new law will achieve. Legal immigrants and employable individuals between 18-50 who are not caring for children will be most affected.[26] ■ Some restrictions placed on the WIC program through the TANF block grant include removing funding for outreach and materials, prohibiting WIC benefits to incarcerated women, and requiring citizenship to receive WIC.[27]
Supplemental Security Income	Establishes a new definition of childhood disability which does not include benefits for emotional or developmental delays. SSI is now limited to children who are determined to have a physical or mental impairment resulting in severe functional limitation.
Teenage Pregnancy	The law allocates more money for teenage abstinence education and establishes national goals to prevent teenage pregnancies out of wedlock by requiring at least 25% of communities in the U.S. to have teenage pregnancy programs in place by 1/1/97.[28]

States have some flexibility in revising their program to be consistent with the law. Connecticut has initiated changes to its welfare program to comply with the federal law through Public Act 97-2 of the June Special Session. To address the potential loss of Medicaid benefits, it maintains current law of a two year Medicaid extension for families that lose welfare benefits while employed and other families under guidelines. It also extends Medicaid eligibility to children under the age of 19 and up to 185% of poverty and allows eligibility to Medicaid for qualified aliens under certain guidelines.[29] Even with these changes, there is concern over the effects of this reform initiative and its potential to create more uninsured citizens that could cause an increasing strain of safety-net providers.

[26] *The New Welfare Law: Issues and Options for Connecticut, 1997.* Edited and compiled by the Legal Assistance Resource Center of Connecticut and the Center on Budget and Policy Priorities. Washington, D.C. 1997.

[27] Mullins C, Sementilli-Dann, L. *Federal Welfare Reform and Maternal and Child Health in Connecticut.* CAHS. 1996.

[28] Mullins and Sementilli-Dann, p. 7.

[29] Connecticut Office of Legislative Research. *Amended Bill Analysis for Public Act 97-2*. Hartford, CT. 1997.

APPENDIX L

CAUSES OF HOSPITALIZATION

Causes of Hospitalization
Category Descriptions[a]

Category Description	Coding Definition
Heart Disease	390-398, 402, 404-429
Digestive System Disorders	530-579
Mental Health	290-319
Alcohol/Drug Abuse or Dependence	291-292, 302-305
Cancer	140-239
Injuries	800-959
Pneumonia	480-486
Cerebrovascular Disease	430-438
Chronic Obstructive Pulmonary Disease	490-496
Asthma	493
Infectious & Parasitic Diseases	001-139
Septicemia	038
HIV/AIDS	042-044
Diabetes	250
Central Nervous System Disorders	320-336, 340-349
Birth-related	
Mothers	DRGs 370-384
Infants	DRGs 385-391
Other	All Other Not Included in Above

[a] The first three digits ICD-9-CM code of the Principal Diagnosis were used unless otherwise specified.

APPENDIX M

ACUTE CARE PROJECTION METHODOLOGY[30]

DATA SOURCES AND DATA ELEMENTS

Hospital data submitted in the Annual Reporting Schedule 500 reports to the Connecticut Office of Health Care Access (OHCA) were utilized to determine the current inventory and capacity of acute care facilities in the state. In order to develop detailed utilization rates, however, data records from OHCA's hospital discharge abstract and billing data base were used. These records include information such as patient age, patient gender, town of residence, patient days, hospital, and one of six assigned services: (1) newborn; (2) maternity; (3) psychiatric; (4) rehabilitation; (5) pediatric; and (6) adult medical/surgical.

These services were expanded to include the intensive care unit/critical care unit (ICU/CCU) and neonatal ICU (NICU) services. To obtain utilization data on these services, revenue code data from the hospital discharge abstract and billing data base were used. Revenue codes that apply to ICU/CCU and NICU services were identified as were the respective patient days. The days associated with the original six services were then reduced by the number of days assigned to the two additional services to avoid duplication. The days designated as “Post ICU” and “Post CCU” were also identified by their revenue codes. They represent days intermediate between ICU/CCU and medical/surgical. Because no separate beds for these services are reported in the Schedule 500 reports, these step-down days were assigned to the medical/surgical service for analysis purposes.

The two sources of data on acute care utilization basically provide similar information regarding patient days by hospital. However, there are discrepancies at the service level. Discharge data were used to extract hospital days by service because this data base also provides the patient town-of-residence data needed to calculate the utilization rates within USRs. The Schedule 500 Reports were used to extract information pertaining to hospital beds and their occupancy. Some of the bed data was modified to reflect more accurate data found in "Attachment 16-17-18" of a hospital's Annual Reporting to OHCA or provided by the DPH Licensure Unit.

[30] This methodology is similar to that previously used by Arthur D. Little, Inc. in their June 11, 1993 report to the State of Connecticut, Commission on Hospitals and Health Care, entitled *Assessment of Current Health Care Facilities and Future Requirements.*

UTILIZATION RATES

Using the discharge data, current statewide utilization rates were calculated for all services by patient gender and the following age groups:

- 0 - 4 years
- 5 - 19 years
- 20 - 44 years
- 45 - 64 years
- 65+ years

POPULATION PROJECTIONS

Connecticut's OPM population projections were used to estimate the Connecticut population by age and sex for April 1995, 2000, and 2005. (April is the midpoint of the federal fiscal year.) Population data as of April were calculated using interpolation of OPM's July estimates.

Connecticut's population is projected to increase by 0.8% from 1995 to 2000 and 1.4% from 2000 to 2005. That is, the population of Connecticut is projected to be virtually static for the period 1990 to 2000 with a slight increase in the beginning of the twenty-first century. Most notable is the increase in the 45-64 age group -- 12% between 1995 and 2000 and 14% between 2000 and 2005. Also of significance is the fact that the over-75 segment of the population will increase by 12% from 1995 to 2000 and 6.2% from 2000 to 2005. This latter group in particular has significance for medical service requirements because they are major users of acute care services.

PROJECTED UTILIZATION AND BED NEED

Utilization rates were multiplied by the projected population cohorts for the years 2000 and 2005 by USR to obtain the expected number of patient days for each USR in the years 2000 and 2005. This assumes that 1995 acute care utilization rates will not change over time. The average daily census by USR and service was then obtained by dividing the patient days by 365.

The projections were then adjusted for out-of-state resident utilization. Discharges, whose zip codes were invalid but which resemble a Connecticut zip code by having a prefix "06," were also included in this adjustment. The out-of-state patient days were allocated to each USR and service according to the location of the hospital from which the patients were discharged. The out-of-state adjustment is the percentage of the "out-of-state patient days" to the "Connecticut residents' patient days" for each USR and service. This adjustment was then applied to the projected average daily census to produce the target daily census. Adjustments assume that 1995 percentages for out-of-state utilization, by service and USR, will prevail in the future.

The target census projections were then adjusted for "target occupancies" to arrive at year-2000 and 2005 estimates of bed need by service, within USR, and for the total state. Target occupancy adjustments are necessary to account for the daily fluctuations that occur in the use of hospital beds. That is, hospitals must provide additional bed capacity over their average census to handle the random fluctuations in their day-to-day census.

To develop a final projected bed need, the year 2000 and 2005 estimates were adjusted for potential changes in service delivery and other factors that might affect future acute care bed utilization.

ANALYTIC FORMULATION OF PROJECTION METHODOLOGY

Subscript notation is as follows:

i = USR
j = age group
k = gender
l = medical service

Statewide patient days by age-gender cohort for each service is denoted by: D_{jkl}

Current statewide population by age-gender cohort is: P_{jk}

Projected USR population (i.e., summed over towns in the USR) is: P'_{ijk}

Projected patient days by USR are calculated as:

$$D'_{il} = \sum_{jk} \frac{D_{jkl}}{P_{jk}} P'_{ijk}$$

The statewide projected utilization by service is:

$$D'_{l} = \sum_{i} D'_{il} = \sum_{ijk} \frac{D_{jkl}}{P_{jk}} P'_{ijk}$$

Average Daily Census by USR and service becomes:

$$ADC_{il} = \frac{D'_{il}}{365}$$

Out of state patients (including those whose town of residence is "Unknown CT") are assigned to a USR according to the USR location of the hospital from which the patients are discharged. Patient days are then summed by USR within service. It is denoted by $OOSD_{il}$. The adjustment becomes:

$$ADJ_{il} = \frac{OOSD_{il}}{D_{il}}$$

where D_{il} represents the patient days of Connecticut residents only within USR and service. Target Daily Census is Average Daily Census adjusted for the out of state patient usage.

$$TDC_{il} = ADC_{il} (1+ADJ_{il})$$

Target Occupancy (TO) is the daily occupancy needed to account for the intrinsic random nature of hospital patient visits. The detailed discussion of the calculation of TO follows below. The number of beds needed is: $B_{il} = TDC_{il}/TO_{il}$

Target Occupancy

The following formula was used to calculate a "target occupancy" on a service-by-service basis:

Target Occupancy		=	$\frac{N}{N+2\sqrt{N}}$
Where:	N	=	Average expected census in the unit
	$\sqrt{N}$	=	Standard deviation of unit census, assuming random arrival of patients and therefore a "Poisson" distribution of census
	$2\sqrt{N}$	=	Additional beds required to handle fluctuation in daily census approximately 98% of the time.

This equation is based on a Poisson probability distribution. The Poisson process is appropriate for processes with approximately random arrivals and occupancies, and has the statistical advantage of being a single-parameter probability distribution (the standard deviation is equal to the square root of the mean). As a result, additional assumptions do not have to be made about the standard deviation. In previous hospital-based work, health care researchers such as Arthur D. Little, have found the Poisson to be a good probability distribution to describe the occupancy distribution in short length-of-stay units.

The "target occupancy adjustment" reflects the variation in the daily occupancy of beds for each hospital in a USR for a particular service. It is obtained in the following way. The projected average daily census is the average number of beds projected to be needed for the USR and service. Because of the daily

fluctuations in the occupancy of beds, the actual number of beds needed could be less than or greater than the average census. The fluctuation of the need for hospital beds happens at the hospital level, not at the USR level, because the USR itself does not have a single regional hospital. Therefore, the projected average daily census by USR needs to be divided by the total number of hospitals that provide the service in that USR to obtain the base need for beds at a hospital. Although in reality, not all the hospitals in the USR are of the same size, the method is valid for projection purposes. The base need for beds in each hospital is assumed to be the mean, and denoted by **N**. The Poisson probability distribution is used to predict the daily fluctuation in the demand of hospital beds. The ratio $\frac{\mathbf{N}}{\mathbf{N}+2\sqrt{\mathbf{N}}}$ is used as the indication of daily occupancy regarding the fluctuation for the hospitals in the USR for the service.

This formula results in a target occupancy of about 90 percent for a large service with an average census of 200, compared with an occupancy of about 70 percent for a service with an average census of 20.

APPENDIX N

ABBREVIATIONS USED IN TEXT

Abbreviations	Meaning
	A
AAMR	Age-Adjusted Mortality Rates
AAP	American Academy of Pediatrics
ADL	Activities of Daily Living
ADS	Alternative Delivery Systems
AFDC	Aid to Families with Dependent Children
AIDS	Acquired Immunodeficiency Syndrome
ALOS	Average Length of Stay
APN	Advanced Practice Nurse
ASO	Administrative Services Only
APP/YPP	Adolescent Pregnancy Prevention/Young Parents' Program
AZT	Azidothymidine (Zidovudine - Anti-viral agent)
	B
BAC	Blood Alcohol Concentration
BBTD	Baby Bottle Tooth Decay
BCH	DPH Bureau of Community Health
BDMP	Birth Defects Monitoring Program
BMI	Body Mass Index
BNH	Black-non-Hispanic
BOC	U.S. Bureau of the Census
BRFSS	Behavioral Risk Factor Surveillance System
BRS	DPH Bureau of Regulatory Services
	C
CAES	Connecticut Agricultural Experiment Station
CBCCEDP	Connecticut Breast and Cervical Cancer Early Detection Program
CCNH	Chronic and Convalescent Nursing Homes
CCU	Critical Care Unit
CDC	Centers for Disease Control and Prevention
CGS	Connecticut General Statutes
CHC	Community Health Centers
CHCP	Connecticut Home Care Program
CHD	Chronic Heart Disease
CIRTS	Connecticut Immunization Registry and Tracking System
CLPPP	Connecticut Lead Poisoning Prevention Program
CLPSC	Connecticut Lead Poisoning Screening Committee
CNS	Central Nervous System
CON	Certificate of Need
COGME	Council on Graduate Medical Education
COPD	Chronic Obstructive Pulmonary Disease
CPLTC	Connecticut Partnership for Long Term Care
CPI	Consumer Price Index
CPR	Cardio-Pulmonary Resuscitation
CPRO	Connecticut Peer Review Organization

Abbreviations	Meaning
CPWS	Community Public Water Supplies
CVD	Cardiovascular Disease
	D
DCF	Connecticut Department of Children and Families
DEP	Connecticut Department of Environmental Protection
DHHS	U.S. Department of Health and Human Services
DMHAS	Connecticut Department of Mental Health and Addiction Services
DMR	Connecticut Department of Mental Retardation
DOC	Connecticut Department of Corrections
DOI	Connecticut Department of Insurance
DPH	Connecticut Department of Public Health
DRG	Diagnostic Related Group
DRSP	Drug-resistant *Streptococcus pneumoniae*
DSS	Connecticut Department of Social Services
DUI	Driving Under the Influence
DWSRF	Drinking Water State Revolving Fund
	E
EBRI	Employee Benefit Research Institute
EEOH	DPH Division on Environmental Epidemiology and Occupational Health
EMS	Emergency Medical Services
EPA	U.S. Environmental Protection Agency
EPO	Exclusive Provider Organization
EPSDT	Early Periodic Screening, Diagnosis, and Treatment Program
ESRD	End Stage Renal Disease
ETS	Environmental Tobacco Smoke
	F
FAS	Fetal Alcohol Syndrome
FDA	U.S. Food and Drug Administration
FY	Fiscal Year
FFY	Federal Fiscal Year
FPP	Food Protection Program
FTE	Full-time Equivalent
	G
GPRA	Government Performance and Results Act of 1993
	H
HAV	Hepatitis A Virus
HCFA	U.S. Health Care Financing Administration
HDL	High-density Lipoprotein
HEDIS	Health Plan Employer Data and Information Set
HCQIS	Health Care Quality Information System
HMO	Health Maintenance Organization
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HPSA	Health Professional Shortage Area
HUSKY	Healthcare for Uninsured Kids and Youth
	I
IADL	Instrumental Activities of Daily Living
ICU	Intensive Care Unit
IDU	Injection Drug Users
IGT	Impaired Glucose Tolerance
IMAP	Infant Mortality Action Plan
IOM	Institute of Medicine

Abbreviations	Meaning
IPA	Individual Practice Association
ISN	Integrated Service Networks
	J
JCAHO	Joint Commission on Accreditation of Health Care Organizations
	L
LEA	Lower Extremity Amputation
LDL	Low-density Lipoproteins
LHD	Local Health Department or District
LIS	Less Invasive Surgery
LRI	Lower Respiratory Infection
	M
MCH	Maternal and Child Health
MCO	Managed Care Organization
MDC	Major Diagnostic Categories
MIH	Maternal and Infant Health
MMC	Medicaid Managed Care
MMR	Mumps, Measles, and Rubella
MOA	Memorandum of Agreement
MQA	Medical Quality Assurance
MSAFP	Maternal Serum Alpha-Fetoprotein
MSM	Men who have Sex with Men
MSO	Management Service Organization
	N
NCHS	National Center for Health Statistics
NCI	National Cancer Institute
NCQA	National Committee for Quality Assurance
NHANES	National Health and Nutrition Examination Survey
NHIS	National Health Interview Study
NHLBI	National Heart Lung and Blood Institute
NICU	Neonatal Intensive Care Unit
NIS	National Immunization Survey
NNRTI	Non-nucleoside Reverse Transcriptase Inhibitors
NTD	Neural Tube Defect
NTNC	Non-transient Non-community System
	O
OEMS	DPH Office of Emergency Medical Services
OHCA	Connecticut Office of Health Care Access
OHSP	Occupational Health Surveillance Program
OPPE	DPH Office of Policy, Planning and Evaluation
OPM	Connecticut Office of Policy and Management
	P
P&S	Primary and Secondary Syphilis
PA	Physician's Assistant
PACE	Program for All-inclusive Care for the Elderly
PAH	Polyaromatic Hydrocarbons
PFD	Personal Flotation Device
PHHS	U.S. Preventive Health and Health Services
PHO	Physician Hospital Organization
PM	Particulate Matter
POS	Point of Service Plan
PPO	Preferred Provider Organization
PSO	Provider Sponsored Organization

Abbreviations	Meaning
	Q
QARI	Quality Assurance Reform Initiative
QISMC	Quality Improvement System for Managed Care
	R
RHNS	Rest Home with Nursing Supervision
	S
SEER	Surveillance, Epidemiology, and End Results
SES	Socio-economic Status
SBHC	School-based Health Center
SCBW	Survey of Childbearing Women
SFY	State Fiscal Year
SIR	Standard Incidence Ratios
STD	Sexually Transmitted Disease
	T
TB	Tuberculosis
TNC	Transient Non-community
	U
UCONN CES	University of Connecticut Cooperative Extension System
UR	Utilization Review
USPHS	U.S. Public Health Service
USR	Uniform Service Region
	W
WIC	DPH Special Supplemental Food Program for Women, Infants and Children
	Y
YPLL	Years of Potential Life Lost

APPENDIX O

GLOSSARY

Access An individual's ability to obtain appropriate health care services. Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers) and sociological (e.g., discrimination, language barriers). Efforts to improve access often focus on providing or improving health coverage.

Accessibility The degree to which the health care system inhibits or facilitates the ability of an individual to gain entry and to receive services. Accessibility involves geographic, architectural, transportation, social, time, and economic consideration. It may be measured either by utilization, non-utilization or the relative strength and absence of barriers to utilization.

Accreditation A process whereby a program of study or an institution is recognized by an external body as meeting certain predetermined standards. For facilities, accreditation standards are usually defined in terms of physical plant, governing body, administration, and medical and other staff. Accreditation is often carried out by organizations created for the purpose of assuring the public of the quality of the accredited institution or program. State or Federal governments can recognize accreditation in lieu of, or as the basis for licensure or other mandatory approvals. Public or private payment programs often require accreditation as a condition of payment for covered services. Accreditation may either be permanent or may be given for a specified period of time.

Acute Care *M*edical treatment given to individuals whose illnesses or health problems are short-term (usually under 30 days) or episodic. Acute care facilities are those hospitals that mainly serve persons with short-term health problems.

Adequacy of Prenatal Care See Kessner Index.

Administrative Services Only A service requiring a third party to deliver administrative services to an employer group and requiring the employer to be at risk for the cost of health care services provided. This is a common arrangement when an employer sponsors a self-funded health care program.

Affiliation An agreement, usually formal, between two or more otherwise independent entities or individuals which defines how they will relate to each other. Affiliation agreements between hospitals may specify procedures for referring or transferring patients from one facility to another, joint faculty, and/or medical staff appointments, teaching relationships, sharing of records or services, or provision of consultation between programs.

Age-adjusted Death Rate (Direct method) A summary of age-specific death rates, applied to a standard population to calculate what rate would be expected if the selected population had the same distribution as the standard population. The total of expected deaths divided by the total of the standard population and multiplied by 100,000 yields the age-adjusted death rate per 100,000.

Age-specific Rate The number of events to individuals in a specific age group per 100,000 individuals in the population in the same age group.

Alternative Delivery Systems A catch-all phrase used to cover all forms of health care delivery except traditional fee-for-service, private practice. The term includes HMOs, PPOs, IPAs, and other systems of providing health care.

Ambulatory Care All types of health services that are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usual implies that the patient must travel to a location to receive services that do not require an overnight stay. See also "ambulatory setting" and "outpatient".

Ambulatory Setting A type of institutional organized health setting in which health services are provided on an outpatient basis. Ambulatory care settings may be either mobile (when the facility is capable of being moved to different locations) or fixed (when the person seeking care must travel to a fixed service site).

Ambulatory Surgery Centers Surgical facilities that provide outpatient (same day) surgery, including single and multi-specialty centers, and independent, corporate or hospital owned centers. Procedures performed in ambulatory surgical centers include ophthalmology, gynecology, gastroenterology, ear/nose/throat, orthopedics, general, reconstructive and cosmetic and podiatry.

Ancillary Service Diagnostic and therapeutic services generally provided by hospitals and consisting of specific departments such as x-ray and laboratory.

Any Willing Provider Laws that require managed care plans to contract with all health care providers that meet their terms and conditions.

Appropriateness Appropriate health care is when the expected health benefits exceeds the expected negative consequences by a wide enough margin to justify treatment.

Assessment A surveillance process for identifying public health threats and trends.

Assurance The pledge that necessary services, including personal health services for the protection of public health in the community will be available and accessible to all persons.

Average Length of Stay The average stay, in days, of inpatients in a given time period. This can be calculated by dividing the number of patient days by either the number of admissions or the number of discharges and death.

Behavioral Risk Factors Actions or habits (e.g., smoking, use of seat belts, exercise) that contribute to a person's health.

Benchmark A term meaning a measurement taken at the outset of a series of measurements of the same variable, sometimes meaning the best or most desirable value of the variable.

Birthweight The first weight of a fetus or infant at time of delivery. This weight is usually measured during the first hour of life, before postnatal weight loss occurs.

Burden of Disease A general term used in public health and epidemiological literature to identify the cumulative effect of a broad range of harmful disease consequences on a community, including the health, social, and economic costs to the individual and to society. Since the broad range of information is not consistently available for many of the conditions described in this report, measures of mortality were used in making comparative assessments of disease burden, allowing a contrast the variety of conditions using a common unit of measure.

Capitation A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person insured, regardless of actual use or expense. Capitation is the characteristic payment method for certain health maintenance organizations.

Carve Out An arrangement whereby an employer eliminates coverage for a specific category of services (e.g., vision care, mental health/psychological services, or prescription drugs) and contracts with a separate set of providers for those services according to a predetermined fee schedule or capitation arrangement. May also refer to a method of coordinating dual coverage for an individual.

Case Mix A measure of the types of cases being treated by a particular health care provider that is intended to reflect the patients' different needs for resources. Case mix is generally established by estimating the relative frequency of various types of patients seen by the provider during a given time period, and may be measured by factors such as diagnosis, severity of illness, utilization of services and provider characteristics.

Cause of Death The underlying cause of death determined to be the primary condition leading to death, based on the international rules and sequential procedure set forth for manual classification of the underlying causes of death by the National Center for Health Statistics and the World Health Organization (*International Classification of disease, Ninth Revision*). See also "Underlying cause of death".

Certificate of Need A certificate issued by a governmental body to an individual or organization proposing to construct, modify, or close a health facility, acquire major new medical equipment, modify a health facility, or offer a new or different health service or discontinue a service. Such issuance recognizes that a facility or service, when available, will meet the needs of those for whom it is intended. CON is intended to control expansion of facilities and services by preventing excessive or duplicative development of facilities and services.

Chronic Care Treatment and care given to individuals whose health problems are long term and continuing. Rehabilitation facilities, nursing homes, and mental hospitals may be considered chronic care facilities.

Chronic Disease A disease with one or more of the following characteristics: permanence, leaves residual disability, caused by non-reversible pathological alternation, requires special training of the patient for rehabilitation, or may require a long period of supervision, observation, or care.

Continuum of Care A comprehensive set of services ranging from preventive and ambulatory services to acute care to long term and rehabilitative services. By providing continuity of care, the continuum focuses on prevention and early intervention for those who have been identified as high risk and provides easy transition from service to service as needs change.

Cost The total level of economic investment required for the provision of health services. This level of investment includes all financial expenditures, especially expenditures for capital and operating requirements. Charges, the price of a service or amount billed to an individual or third party, may or may not be equal to service costs.

Cost Containment A wide variety of strategies or methods whose primary goal is to control the rising cost of health care, thus making health care more affordable. These strategies and methods may include, but are not limited to government regulation, managed care programs, payment policies, global budgets, rate setting, consumer education, and utilization management.

Cost Sharing Provisions in a health insurance plan that require the insured to pay some portion of the covered medical expenses. Typical forms of cost sharing include coinsurance, co-payments, and deductibles.

Cost Shifting The practice of increasing revenues from one type of payer (e.g., privately insured patients) in order to cover the costs of uncompensated care or other shortfalls in reimbursements from other payers.

Crude Rate: The number per 100,000 population. This rate should not be used for making comparisons between different populations when the age, race, and sex distributions of the populations are different.

Demand The amount of a given service sought by consumers in response to their perceived need for that service. Demand is influenced by availability of services, by accessibility of the service and by ability to pay for the service.

Diagnostic Related Groups A patient classification scheme that categorizes patients who are medically related with respect to diagnoses and treatment, and are statistically similar in their length of stay. The classification system is generally used to set uniform rates for the payment of hospital care. The DRG system was adopted by the Medicare program in 1983 to create incentives for hospitals to provide more cost-effective care.

Direct Medical Services Services delivered by a health professional to a patient in an office, clinic, or emergency room. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products, and services.

Disability Any temporary or long term condition (physical and/or mental) that results from an acute or chronic condition that may prevent the performance of regular duties.

Disease Burden See Burden of Disease

Disproportionate Share A program that provides additional financial aid to hospitals having excessive numbers of indigent patients.

Early and Periodic Screening Diagnosis and Treatment Program A program mandated by law as part of the Medicaid program. The law (section 1905(a)(4)(B) of the Social Security Act) requires that all States have in effect a program for eligible children under age 21 to ascertain their physical or mental defects, and to provide such health care treatments, and other measures to correct or ameliorate defects and chronic conditions discovered.

Emergency Medical Services The services provided to accident victims and patients suffering from severe acute illness and psychiatric emergencies. Services include the detection and reporting of medical emergencies, initial care, transportation and care for patients in route to health care facilities, medical treatment for the acutely ill and severely injured within emergency departments, and the provision of linkages to continued care or rehabilitation services.

Employee Retirement Income Security Act A federal law enacted in 1974 that set minimum standards of information disclosure and fiduciary responsibilities in the establishment, operation, and administration of employee benefit plans, including group life, pensions, and health plans. Employers who operate their own insurance plans for employees, or "self-insure" under ERISA, are exempt from state insurance regulation.

Environmental Health Characteristics of health that result from the aggregate impact of both natural and man-made surroundings, including health effects of air pollution, water pollution, noise pollution, solid waste disposal, and housing; occupational disease and injuries; and those diseases related to unsanitary surroundings.

Epidemiology A branch of medical service that deals with the incidence, distribution, and control of disease in a population, or the sum of the factors controlling the presence or absence of a disease.

Exclusive Provider Organization An organization that provides coverage only for contracted providers.

Fee-for-Service A method of payment in which each service provided to the patients is associated with a corresponding fee to be paid to the provider. It is the method of billing used by the majority of U.S. physicians.

Fetal Death Death prior to the complete expulsion or extraction from the mother of a product of conception, which has passed through at least the 20th week of gestation. The fetus shows no signs of life such as heartbeat, pulsation of the umbilical cord, or movement of voluntary muscles.

Freestanding An independent facility without financial or administrative attachment or support from another facility.

Gatekeeper A healthcare professional, who coordinates, manages, and authorizes all healthcare services provided to a covered beneficiary. May be a nurse, a social worker, a physician's assistant, or a physician (e.g., internist, family/general

practitioner, pediatrician, and in some cases, OB/GYN). Gatekeepers are frequently used by managed care plans to control costs by limiting unnecessary utilization of services.

Gestational Age The number of completed weeks elapsed between the first day of the last normal menstrual period and the date of delivery.

Group Model Health Maintenance Organization A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.

Group Practice The provision of medical services by three or more physicians formally organized to provide medical care, consultation, diagnosis, and/or treatment through the joint use of equipment and personnel, and with income from the medical practice distributed in accordance with methods previously determined by members of the group. Group practices have a single-specialty or multi-specialty focus.

Group Practice Without Walls Typically a network of physicians who have formed a single legal entity, but maintain their individual practices. The assets of individual practices may be acquired by the larger entity, but some autonomy is retained at each site. The central management provides administrative support. See Integrated Delivery System.

Health A state of physical, mental, and social well-being and productive functioning, not merely the absence of disease or infirmity.

Health Alliances or Regional Health Alliances Purchasing pools responsible for negotiating health insurance arrangements for employers and/or employees. Alliances would use their leverage to negotiate contracts that would ensure care is delivered in economical and equitable ways. (Also referred to as health insurance purchasing cooperatives or health plan purchasing cooperatives.)

Health Care Financing Administration An agency of the U.S. Department of Health and Human Services responsible for administrating the Medicare program and overseeing the administration of state Medicaid programs.

Health Delivery System A coordinated complex of resources, including manpower, facilities, equipment, etc. that provides health care to the populace of a given area.

Health Education A continuing process of informing people how to achieve and maintain good health; of motivating them to do so; and of promoting environmental and lifestyle changes to facilitate their objective.

Health Maintenance Organization An entity that provides, offers, or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. There are four basic models of HMOs: group models, individual practice association, network model, and staff model. Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO: 1) an organized system for providing health care or otherwise assuring health care delivery in a geographic area; 2) an agreed upon set of basic and supplemental health maintenance and treatment services; and 3) a voluntarily enrolled group of people.

Health Plan *A* health maintenance organization, preferred provider organization, insured plan, self-funded plan, or other entity that covers health care services.

Health Professional Shortage Area An area or group that the U.S. Department of Health and Human Services designates as having an inadequate supply of health care providers. It can be an urban or rural geographical area, a population group for which access barriers can be demonstrated that prevent members from using local providers, or medium- and maximum-security correctional institutions, and public or non-profit private residential facilities.

Health Status The level of illness or wellness of a population at a particular time.

Health Systems All services, functions and resources in a geographic area whose primary purpose is to affect the state of health of the population.

Health Plan Employer Data and Information Set A core set of comparable performance measures of managed care plans on quality, access, patient satisfaction, membership, utilization, finance, and descriptive information on health plan management and activities.

Hispanic Ethnicity Refers to people whose origins are from Spain, the Spanish-speaking countries of Central America, South America, and the Caribbean, or persons of Hispanic origin identifying themselves as Spanish, Spanish-American, Hispanic, Hispano, Latino, and so on. In Connecticut, the birth, death, and fetal death certificates have a separate line item for the individual's Hispanic status, to attempt to distinguish Hispanic ethnicity from race. Individuals identifying themselves as "Hispanic" can be of any race.

Home Health Care A broad spectrum of services (physical health, psycho-social, and environmental support) provided to persons living at home for the purpose of promoting, maintaining, or restoring health; or minimizing the effects of illness

and disability. Services are delivered by a variety of professional and non-professional personnel, generally through a provider agency which may be voluntary (non-profit) or proprietary (for profit); or through the efforts of an assessment and coordinating program or group.

Hospice A multi-disciplinary service program for the dying person and his/her family which provides the supports needed to keep the dying person comfortable and free from pain until the time of death.

Incidence The number of new cases of a specific disease occurring during a certain period of time.

Indemnity Plans Protection against loss. An indemnity policy pays money to an insured in the event of hospitalization or illness, or a predetermined amount for the medical or surgical procedures incurred.

Indicator A measurable factor which reflects or is highly correlated with either a health problem or outcome (e.g., infant mortality or disability days) or particular characteristics of health systems service delivery (e.g., cost per patient day, percent of area residents with a regular control course of care, or time or distance from primary care). A proxy indicator can be used to bring to light social or environmental conditions, values, interests and concerns.

Individual Practice Association Model HMO A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.

Infant Death Death occurring to an individual of less than one year (365 days) of age, comprising the sum of *neonatal death* and *postneonatal death.*

Infant Mortality Rate The number of deaths reported among infants under one year of age in a calendar year per 1,000 live births reported in the same year and place.

Inpatient A person who must stay overnight in a health facility (usually a hospital) for medical treatment.

Integrated Delivery The ability to provide comprehensive healthcare services through a coordinated, person-centered continuum designed to improve the health of people in a specified community within economic limits.

Integrated Delivery System A group of health care service units that typically includes hospitals, physicians (for example, medical groups and independent practice associations), and other non-hospital providers) for example, ambulatory surgery centers, home health providers, skilled nursing facilities). These units are coordinated in their efforts to service one or more target markets. The integration may take a variety of forms, including joint venture, merger, or contract.

Integrated Service Networks Any plan that incorporates a network of providers that can provide the full continuum of necessary medical and social service needs for enrollees, and accepts financial risk for that care.

Intentional Injury Injuries and deaths that are self-inflicted or perpetrated by another person. Intentional injuries can be caused by homicide, suicide, assault, domestic violence, and intentional use of firearms.

Kessner Index (Modified) The Kessner Index is a composite indicator of the adequacy of prenatal care a mother receives during her pregnancy. Prenatal care is categorized as *adequate, intermediate*, or *inadequate* based on three items from the birth certificate: timing of the first prenatal visit; total number of prenatal visits; and length of gestation.

Licensure A form of business licensure in which an applicant is granted a license or permit to conduct or engage in the provision of health services within a specific type of institution or setting. Inpatient, outpatient, and non-patient health facilities are licensed by State regulatory agencies with statutory authority to license, certify, inspect, or otherwise approve or disapprove the operation of specific types of health facilities.

Linkages A set of relationships between two or more providers for purposes of providing continuous care, avoiding duplication of services, assuring appropriate placement, expanding the range of services available, or assuring the most economical use of available resources.

Live Birth The complete expulsion or extraction from the mother of a product of conception, regardless of the duration of pregnancy; after such separation, shows signs of life (e.g., heartbeat, pulsation of the umbilical cord, or movement of voluntary muscles).

Local Health Department A governmental public health agency, which is in whole or in part responsible to a sub-state governmental entity or entities (e.g., a city, county, borough, township). A local health department employs one or more full-time professional public health employees (e.g., public health nurse, sanitarian), delivers public health services (e.g., immunization, food inspection), serves a definable geographic area, and has identifiable expenditures and/or budgets in the political subdivision(s) it serves.

Local Health District A local governmental entity consisting of two or more towns that is responsible for the public health of its constituent towns.

Local Public Health Authority The agency charged with responsibility for meeting the health needs of the community. Usually this is the Board of Health, a city/county/regional authority, and its administrative arm, the local health department.

Long Term Care A continuum of broad-ranged maintenance and health services delivered to the chronically ill, disabled, and others. Services may be provided on an inpatient, outpatient, or at-home basis.

Low Birthweight A birthweight of less than 2,500 grams (approximately 5 lbs., 8 oz.).

Managed Care A system of health care delivery that influences utilization and cost of services and measures performance. The goal is a system that delivers value by giving people access to quality, cost-effective health care.

Managed Health Care Plan One or more products which integrate financing and management with the delivery of health care services to an enrolled population; employ or contract with an organized provider network which delivers services and which (as a network or individual provider) either shares financial risk or has some incentive to delivery quality, cost-effective services; and use an information system capable of monitoring and evaluating patterns of covered persons' use of medical services and the cost of those services.

Management Service Organization A legal entity that provides practice management, administrative, and support services to individual physicians or group practices. It may be a direct subsidiary of a hospital or may be owned by investors.

Maternal and Child Care Services for the prevention, diagnosis, and treatment of diseases and conditions which are specific to mothers and children or for which mothers and children are considered particularly vulnerable populations with special needs.

Medicaid (Title XIX) A Federally aided, State-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all of the poor, however, but only persons who meet specified eligibility criteria. Subject to broad Federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

Medicaid HEDIS A set of health plan performance measures specially targeted to meet the needs of programs that serve Medicaid beneficiaries with particular focus on women and children.

Medicaid Waivers A waiver of current federal Medicaid law obtained from the HCFA that exempts states from a number of federal Medicaid statutes and regulations that would otherwise hinder their efforts to create Medicaid managed care programs. The two most common types of waivers obtained for this purpose are:

> ***1115 waiver*** 1115 waivers allow states to use federal funds in ways that are not otherwise permitted under federal law to implement and test innovations in their Medicaid programs. These programs, often known as demonstrations, usually include the creation of capitated managed care programs that alter eligibility requirements and benefit packages.
>
> ***1915(b) waiver*** 1915 (b) waivers exempt states from the freedom-of-choice requirements that allow Medicaid beneficiaries the same liberty to select among providers as the privately insured. By waiving this requirement, states are able to mandate the enrollment of certain Medicaid recipients into a managed care program. They also allow states to waive requirements of uniform statewide operation (statewide effectiveness) and identical benefits for different types of beneficiaries (comparability).

***Medically Indigen*t** Individuals with little or no health insurance and who are without sufficient resources to pay for essential health care.

Medically Underserved Area An urban or rural geographic area designated by the federal Department of Health, Education and Welfare as having a shortage of personal health services, or a population group designated by the Secretary as having a shortage of such services.

Medicare A federally funded nationwide hospital and medical-care insurance program for the elderly (over age 64) and some people with disabilities.

Medigap Private insurance policies that supplement Medicare coverage.

Mental Health The capacity of an individual to form harmonious relations with his/her social and physical environment, and to achieve a balanced satisfaction of his/her own drives.

Morbidity The extent of illness, injury, or disability in a defined population, expressed in general or specific rates of incidence or prevalence. Sometimes used to refer to any episode of disease.

Mortality Rate The mortality rate (death rate) expresses the number of deaths in a unit of population within a prescribed time and may be expressed as crude death rates (e.g., total deaths in relation to total population during a year) or as rates

specified for disease and, sometimes, for age, sex, or other attributes (e.g., number of deaths from cancer in white males in relation to the white male population during a year).

National Health Care A system of health insurance administered by the government that insures all citizens. The government serves as the single insurer (single-payer) and sets all fees for hospitals, physicians, and other health providers.

Neonatal Death Death occurring to an infant less than 28 days of age.

Network A defined group of providers, typically linked through contractual arrangements, which provide either specific benefits or a full range of acute and long term care services.

Network Model HMO An HMO type that contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his/her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.

Non-Community Water System A public water system which serves at least twenty-five (non-residents) persons at least sixty days out of the year and is not a community or a seasonal water system.

Non-Transient Non-Community Water System A public water system that is not a community system and that regularly serves at least twenty-five of the same persons over six months per year.

Nursing Homes A wide range of licensed health facilities, other than hospitals, that provide various levels of maintenance and personal or nursing care to people who are unable to care for themselves and who may have health problems which range from minimal to very serious. The term includes free-standing institutions, or identifiable components of other health facilities that provide nursing care and related services, personal care, and residential care.

Organized Delivery Systems Networks of providers and payers that provide care and compete with other systems for enrollees in regions. Systems include hospitals, primary care physicians, specialty care physicians, and other providers and sites that offer a full range or preventive and treatment services. Also refers to accountable health plans, coordinated care networks, community care networks, integrated health systems, and integrated service networks.

Outpatient A patient who receives ambulatory care at a hospital or other facility without being admitted to the facility. Usually, it does not mean people receiving services from a physician's office or other program that does not provide inpatient care.

Physician-Hospital Organization A legal entity formed and owned by one or more hospitals and physician groups in order to obtain payer contracts and to further mutual interests. Physicians maintain ownership of their practices while agreeing to accept managed care patients under the terms of the agreement. The PHO serves as a negotiating, contracting and marketing unit. (See integrated delivery system).

Point-of-Service Plan A health plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers. Point-of-service can be provided in several ways: 1) an HMO may allow members to obtain limited services from non-participating providers; 2) an HMO may provide non-participating benefits through a supplemental major medical policy; 3) a PPO may be used to provide both participating and non-participating levels of coverage and access; or 4) various combinations of the above may be used.

Policy Development The process of selecting the most appropriate response to public health threats and trends.

Population Based Services Preventive interventions and personal health services, developed and available for the entire population rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are immunization campaigns, injury prevention, lead poisoning prevention and screening programs, outreach and public education, newborn metabolic screening, and counseling for a family who infant has died from Sudden Infant Death Syndrome.

Postneonatal Death Death occurring to an infant aged 28 days to 364 days.

Preferred Provider Organization A program in which contracts are established with providers of medical care. Providers under such contracts are referred to as preferred providers. Usually, the benefit contract provides significantly better benefits (fewer co-payments) for services received from preferred providers, thus encouraging covered persons to use these providers. Covered persons are generally allowed benefits for non-participating providers' services, usually on an indemnity basis with significant co-payments. A PPO arrangement can be insured or self-funded. Providers may be, but are not necessarily, paid on a discounted fee-for-service basis.

Premature A live birth or fetal death that occurs before the completion of the 37th week of gestation.

Prenatal Existing or taking place prior to birth.

Prepayment Usually refers to any payment to a provider for anticipated services (such as an expectant mother paying in advance for maternity care). Sometimes prepayment is distinguished from insurance as referring to payment to organizations which, unlike an insurance company, take responsibility for arranging for and providing needed services as well as paying for them (such as health maintenance organizations, prepaid group practices, and medical foundations).

Prevalence The number of cases of a disease, infected persons, or persons with some other attribute present during a particular interval of time. Prevalence is often expressed as a rate.

Preventive Care Comprehensive care emphasizing patients' behaviors that encourage health promotion and disease prevention, early detection, and early treatment of conditions, generally including routine physical examinations, immunization, and well-person care.

Preventive Health Services Refers to the extensive array of procedures and services provided to the individual by medical providers and other practitioners which are designed to prevent disease or arrest its development. Services such as immunization, screening tests, chemoprophylaxis and contraception are included.

Primary Care Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Primary care is considered comprehensive when the primary provider enters into a sustained partnership with the patient to take responsibility for the overall coordination for the care of the patient's health problems; biological, behavioral, or social. Physicians have traditionally provided the care, but, increasingly, it is provided by other personnel such as nurse practitioners or physician assistants.

Primary Care Case Management A Medicaid managed care arrangement in which the State Medicaid agency contracts directly with primary care providers to act as "gatekeeper," approving and monitoring all covered services for the patient. For this case management service, the primary care providers are paid a per patient per month case management fee (usually between three and five dollars). In addition, the providers are reimbursed by the state on a fee-for-service basis for all services provided.

Primary Care Physicians Internists or general/family practitioners who treat a variety of medical problems across all patient age groups and who frequently serve as the patient's first point of contact with the healthcare system. In some cases, obstetricians, gynecologists, and pediatricians are considered primary care physicians.

Provider Sponsored Organization Within the Medicare program, HCFA allows hospitals and doctors to group together to form this entity for the Medicare program. Similar to HMOs except the entity is run by medical providers.

Public Health One of the efforts organized by society to protect, promote, and restore the people's health. The combination of sciences, skills, and beliefs directed to the maintenance and improvement of the health of all the people through collective or social actions. A social institution, a discipline, and a practice with the goal to reduce the amount of disease, premature death, and disease-produced discomfort and disability in the population.

Quality of Care A measure of the degree to which delivered health care services meet established professional standards and judgments of value by the consumer. Quality may also be seen as the degree to which actions taken or not taken maximize the probability of beneficial health outcomes and minimize risk and other untoward outcome, given the existing state of medical science and art. Quality is frequently described as having three dimensions: quality of input resources, (certification, and/or training of providers); quality of the process of services delivery (the use of appropriate procedures for a given condition), and quality of outcome of service use (actual improvement in condition or reduction of harmful effects).

Race A population of individuals who identify themselves from a common history, nationality, or geographical place. When responses in the "race" line item on vital records are associated with the definition of Hispanic origin, they are re-coded to "white race," as described in the National Center for Health Statistics instruction manuals for coding vital records. Individuals identifying themselves as either "white," "black," or "other" race can be of any ethnic group.

Rehabilitation The combined and coordinated use of medical, social, educational, and vocational measures used for training or re-training individuals disabled by disease or injury to the highest possible level of functional ability.

Residence The usual place of abode of the person to whom the vital event occurred. For births and fetal deaths, residence is defined as the mother's usual place of residence.

Risk Sharing The distribution of financial risk among parties furnishing a service. For example, if a hospital and a group of physicians from a corporation provide health care at a fixed price, a risk-sharing arrangement would entail both the hospital and the physician group being held liable if expenses exceed revenues.

Surveillance The systematic collection, analysis, interpretation, and dissemination of health data to assist in the planning, implementation, and evaluation of public health interventions and programs.

Technology Mechanical devices, pharmaceuticals, and techniques used in medical and surgical diagnostic and therapeutic procedures. These devices and techniques are often related to innovations in treatment methods and advances in patient care.

Teenage Mother A woman under 20 years of age on the date of delivery.

Third-Party Payer Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. An individual pays a premium for such coverage in all private and in some public programs; the payer organization then pays bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (the third party).

Transient Non-Community Water System A non-community water system that does not meet the definition of a non-transient non-community water system.

Trimester of pregnancy One-third of the total gestation period of a full-term pregnancy, or 13 weeks per trimester. The "third trimester" classification comprises pregnancies of 27 or more weeks gestation. The weekly count begins on the first day of last menstrual period.

Underinsured People with public or private insurance policies that do not cover all necessary medical services, resulting in out-of-pocket expenses.

Underlying Cause of Death The disease or injury that initiated the sequence of events leading directly to death, or the circumstances of the accident or violence that produced the fatal injury.

Uninsured People who lack public or private health insurance.

Unintentional Injury Injuries and deaths that are considered accidental. Unintentional injuries can be a result of residential fires, falls, motor-vehicle-related, and drownings.

Universal Access/Coverage The provision of a standard minimum level of healthcare benefits to all individuals residing in an area (may be a region, state, or the U.S. as a whole).

Utilization Patterns or rates of use of a single service or type of service, (e.g., hospital care, physician visits, prescription drugs). Use is also expressed in rates per unit of population at risk for a given period.

Utilization Review A cost-control mechanism used by some insurers and employers that evaluate health care on the basis of appropriateness, necessity, and quality.

Very Low Birthweight A birthweight of less than 1,500 grams (approximately 3 lbs., 5 oz.).

Years of Potential Life Lost A measure of the relative impact of various diseases and lethal forces on society. It highlights the loss to society as a result of youthful or early deaths. The figure for potential years of life lost due to a particular cause is the sum, over all persons dying from that cause, of the years that these persons would have lived had they experienced normal life expectation.

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APPENDIX P

MAPS