Reporting of Community Benefits Programs by Hospitals and Health Plans in Connecticut Calendar Years 2001, 2004 & 2006

Report to the General Assembly, State of Connecticut

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Connecticut Department of Public Health
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INTRODUCTION

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

REPORTING HISTORY

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

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

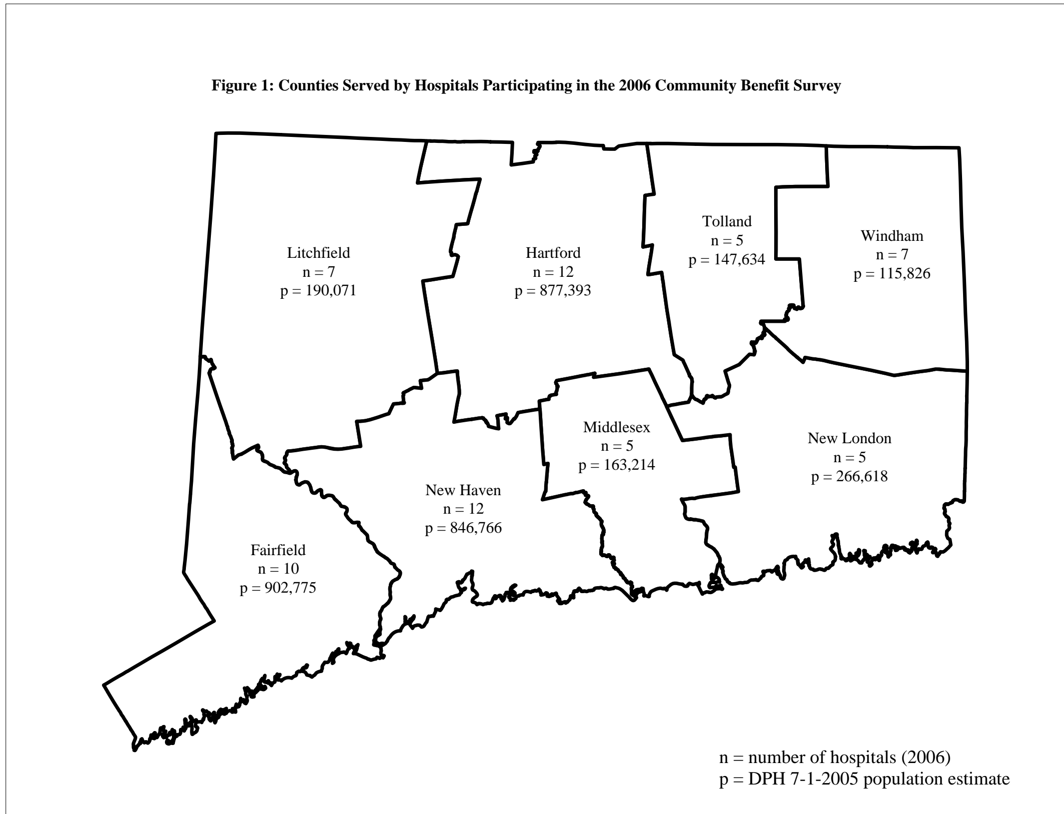
C.G.S. 19a-127k was amended in 2003, changing the reporting requirements from annual to biennial reporting. It also put in place an option for DPH to impose civil penalties of up to $50.00 per day, after the opportunity for a hearing, for failure to report to DPH whether or not an organization has a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

The 2004 survey of information for 2003 and 2004 data had a reduced scope of questions from 149 to 49. All hospitals and MCOs required to report to DPH did so. The first biennial report included information for calendar years 2001 and 2004. Calendar year 2003 data was not included because it was almost identical to 2004. One MCO and the charitable foundation of a MCO submitted completed surveys for the 2003/2004 biennial report.

2006 SURVEY

The 2006 survey questions were virtually identical to those of the previous biennial survey. Hospitals and MCOs were required to submit data for only calendar year 2006 owing to the fact that there appeared to be little change in Community Benefit activity between years. The information on community benefit programs was solicited through a mail survey. The list of organizations required to report their community benefit activities was developed from information provided by the DPH Regulatory Services Branch and the Connecticut Department of Insurance (see Appendix B). Community benefit surveys were sent to 43 acute care inpatient and specialty hospitals and 24 MCOs in November 2006. All hospitals and MCOs responded (see Appendix C).

Figure 1 presents the service areas of the hospitals participating in the 2006 survey. Thirty-five out of forty-three hospitals completed the 2006 Community Benefits Survey. Seventeen hospitals reported they had a Community Benefits Program as defined by state statute and all were required to complete the survey. This represents an increase of eight facilities over the previous report. An additional 18 hospitals indicated they had programs, but their program did not meet the definitions of the statute. These 18 hospitals voluntarily submitted a completed a survey, the results of which are included in this report.



Saint Francis Care submitted a joint survey for St. Francis Hospital and Medical Center & Mount Sinai Rehabilitation Hospital. Saint Vincent's Health Services submitted a single survey for Saint Vincent's Medical Center and Hall Brooke Behavioral Health. Masonic Healthcare Center submitted a survey on behalf of its acute care unit and its geriatric medical/psychiatric components. These facilities represent six of the seventeen hospitals reporting having a Community Benefits Program. Rockville and Manchester Memorial Hospitals each submitted surveys as part of the Eastern Connecticut Health Network and are part of the eighteen hospitals that reported not having a Community Benefits Program, but completed a survey voluntarily.

As in the previous report, although it does not have a Community Benefits Program as defined in statute, Aetna Life Insurance Company and Aetna U.S. Healthcare, Inc. submitted a survey on behalf of the Aetna Foundation. ConnectiCare Inc. and ConnectiCare Insurance Company, Inc. have a community benefits program and also submitted a survey for the 2006 report. No other MCOs reported having a Community Benefits program or completed a survey.

COMMUNITY BENEFIT ACTIVITIES

In 2006, six hospitals supplied information related to their community benefits budget with a median value of $17,763,967. Hospitals reported a median of 4 full-time equivalents (FTEs) involved in Community Benefit activities. The scope of community benefit activities varies widely, ranging from providing a training site for health care professionals or support for family caregivers to targeting communities comprised of low-income neighborhoods.

The reader is reminded that all data are self-reported without independent verification or audit. Although this report lists the information for 2001, 2004 and 2006, strict comparisons are not made between years because of variability in the number of facilities reporting to DPH and under different reporting consequences. However, the information is indicative of trends in community benefit activity statewide. (Please refer to the aggregation of hospital survey data for 2001, 2004

and 2006 in Appendix D.) Lastly, the Community Benefits reporting program has been in place for a number of years now, therefore emphasis is placed on the current information as representing the best view of activities in the community.

1. TARGETING OF COMMUNITY BENEFIT ACTIVITIES TO SPECIAL POPULATION GROUPS

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

The proportion of hospitals targeting special need populations was similar in 2006 for both *Low-Income Neighborhoods and Populations At Risk of a Particular Illness.* This is also true for activities targeted to *Racial Minorities and Medically Underserved Areas.* The proportion of hospitals targeting the various population groups increased for all categories in 2006 over 2004 with the exception of *Immigrant Populations*.

Table1: Hospital Community Benefits Programs Targeted Often or Always to Special Needs Populations in Calendar Years 2001, 2004 and 2006.

Target Areas	2001		2004		2006	
	Number of Responding Hospitals	**Percentage**	**Number of Responding Hospitals**	**Percentage**	**Number of Responding Hospitals**	**Percentage**
Low-Income Neighborhoods	25	68.0%	30	70.0%	33	75.8%
At Risk of Particular Illness	25	60.0%	30	63.3%	33	72.7%
Racial Minorities	24	58.3%	30	63.3%	33	63.6%
Medically Underserved Areas	24	62.5%	31	61.3%	33	63.6%
Immigrant Populations	25	48.0%	30	56.7%	33	48.5%
Inner Cities	24	54.2%	30	53.3%	32	56.3%
Rural Areas	25	24.0%	31	19.4%	34	20.6%

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

Between 2004 and 2006, "Support for Social Service Agencies" changed from the *moderately supported* category to the *most prevalent* category. "Free or Subsidized Health Treatment Services" changed from the *most prevalent* category to the m*oderately supported* category from 2004 to 2006. The activity "Distributing Reports Documenting Community Benefit Activities" changed from the *minimally supported* category to the *moderately supported* category between 2004 and 2006. All other activities fall within the same ranges between 2004 and 2006.

2. MOST PREVALENT COMMUNITY BENEFIT ACTIVITIES

In 2006, Connecticut hospitals were actively involved in the following community benefit activities: a) training sites for health care professionals; b) educational programs for the general public; c) support for safety net agencies; and d) support for social service agencies.

Provide a Training Site for Health Care Professionals: All of the responding hospitals provided a training site for *nursing training* and *other health professional training*. Twenty-nine of the hospitals provided *public health training*. *Graduate medical education* and *medical training* was provided at 26 and 23 of the hospitals responding, respectively (Figure 2).

Health Education in the Community: Thirty-two of the 35 hospitals reported providing some type of health education and screening in the community. Education in the areas of *exercise*, *nutrition, hypertension,* and *diet* were most frequently offered, while education for *safer sexual behavior and alcohol or drug abuse* were offered least often (Figure 3).

Support for Safety-Net Agencies: Thirty out of the 35 hospitals provided support for *health departments or school clinics*. Approximately two-thirds of the reporting hospitals supported *community health centers.* Nineteen of the hospitals supported *community mental health centers* (Figure 4).

Support for Social Service Agencies: Twenty-nine out of the 35 hospitals reported supporting *homeless or victims assistance shelters and social service agencies*. Eighteen hospitals reported supporting *elderly housing projects* (Figure 5).

3. MODERATELY SUPPORTED COMMUNITY BENEFIT ACTIVITIES

In 2006, seven categories of community benefit activities were reported as moderately supported by hospitals. They include: a) support for family care givers of patients; b) working with public safety agencies; c) free or subsidized health services; d) programs to reduce health hazards in homes; e) reducing the transmission of infectious diseases; f) setting community benefit program policy; and g) distributing reports documenting community benefit activities.

Support for Family Caregivers: Thirty-four out of the 35 reporting hospitals have *established support groups for patient families*. Twenty-nine hospitals *provided caregivers with in-kind/financial suppor*t. Approximately two-thirds of the hospitals have *created policies for referring caregivers to support groups*, while approximately one-third *provided respite care* (Figure 6).

Collaboration with Local Public Safety Agencies: Three-quarters of the reporting hospitals promoted *helmet use for bicyclists and motorcycle riders*, while two-thirds of the hospitals *worked to reduce traffic-related injuries*. Sixteen hospitals *worked with police or neighborhood groups to reduce crime* and *to address indoor air quality problems* (Figure 7).

Free or Subsidized Health Treatment Services: Thirty out of 35 hospitals reported providing free or subsidized health services. *Inpatient services* and *other outpatient services* were most frequently provided either free or subsidized, while *dental services,* and *well-child care* were the least frequently provided (Figure 8). According to survey results, free and subsidized services were provided to at least 213,713 residents in Connecticut.

Programs to Reduce Health Hazards in Homes: Nineteen out of 32 responding hospitals participated in or supported programs to reduce *second-hand tobacco exposure*. Seventeen had programs to enhance *poison control* efforts. Thirteen hospitals had programs addressing *lead paint* hazards in the home and ten had programs promoting *fire safety* (Figure 9).

Programs to Reduce Transmission of Infectious Diseases: Twenty-nine hospitals of the thirty-four reporting provided *Immunization programs* to the general public. Half of the hospitals had programs that addressed *sexually transmitted diseases.* Approximately 40% of the hospitals had programs for *tuberculosis identification* or *reducing animal vectored diseases*. Only 3 of the 31 hospitals reported having *clean needle or bleach programs* for substance abusers (Figure 10).

Community Participation in Policy Development for Community Benefit Activities: Twenty-four out of 32 responding hospitals used *community advisory boards* to develop community benefit policies. Approximately 40% of hospitals reported conducting *town meetings* with the public, sending *reports to city/town selectmen*, or *public dissemination of community benefit reports* in policy development. Only six of the hospitals reported involvement at *open board meetings* as a means of policy development (Figure 11).

Distributing Reports Documenting Community Benefit Activities: Fifteen hospitals provided reports to *state/local government officials* while 12 distributed reports to *community groups.* Of the remaining five between ten and eleven hospitals distributed reports to the various groups (Figure 12).

4. Minimally Supported Community Benefit Activities

Community benefit activities found least often among Connecticut hospitals included *direct grants to community agencies* from hospitals.

Direct Grants to Community Agencies: Fifteen hospitals out of thirty-two reported providing grants to *social service agencies*. Fourteen provided grants to the *United Way*. In the balance of the remaining categories of providing grants to community agencies less than 30% of the hospitals indicated they did so (Figure 13).

Summary of the Managed Care Organization Survey Responses

As described above, Aetna Health, Inc. and Aetna Life Insurance Company do not have a formal community benefit program as defined by statute. However the Aetna Foundation (Foundation), described as the independent and charitable arm of Aetna reported it has a community benefit program as defined in statute and completed a survey. Hartford, Fairfield and Middlesex counties encompassed the communities served by the Foundation. The Foundation had community based health education programs in 2006 that addressed: *identifying depression*; *cancer screening*, the *need for prenatal care*; and *encouraging better nutrition*. In 2006, the Foundation provided direct grants to community agencies for all of the categories listed in Figure 13, page 18.

One survey for 2006 information was submitted for ConnectiCare, Inc. and ConnectiCare Insurance Company, Inc. (ConnectiCare). It reports it does have a community benefit program as defined in statute. The ConnectiCare program serves the entire state and has community based health education programs in all of the categories listed in Figure 3 on page 8. ConnectiCare

provided grants to: *hospitals*, *long term care organizations*; *social service agencies*; *primary/ secondary schools*; *United Way or other federated giving programs*; and *arts organizations* in 2006.

OTHER ACTIVITY RELATED TO COMMUNITY BENEFITS

The August 7, 2007 electronic release of CT HEALTH NOTES, issued by the Connecticut Health Policy Project referenced two reports, one from the Internal Revenue Service at http://www.irs.gov/charities/charitable/article/0,,id=172267,00.html and one from the Congressional Budget Office at http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf that referenced uncompensated care as a component of community benefits as it relates to the tax-exempt status of hospitals. CT HEALTH NOTES indicated that the U.S. Senate Finance Committee is considering regulations on hospitals' provision of uncompensated and charity care to qualify for non-profit status.

The Board of Trustees of the Connecticut Hospital Association (CHA) approved a recommendation on March 13, 2006, made by the CHA Board Committee on Hospital Finance to adopt a statewide system to inventory and report on hospital community benefit initiatives. To this end CHA would obtain computer software and coordinate technical implementation and training; centrally house the software and data; and compile reports of community benefit information. Lyon Software in collaboration with the Catholic Health Association and VHA, Inc. developed the "Community Benefit Inventory for Social Accountability (CBISA)" software. CHA hosted two full-day training sessions on the use of CBISA during the week of May 22, 2006. CHA reports, "universal use of the CBISA software by all CHA members will provide the ability to inventory, quantify, and publicly report on all of Connecticut acute care hospitals' community benefit programs."

SUMMARY AND RECOMMENDATIONS FOR THE COMMUNITY BENEFIT REPORTING PROGRAM

This is the fourth report summarizing the community benefit activity in the state and is based upon data submitted by 35 hospitals, one MCO and the charitable foundation of another MCO. Community health benefit activities provided to local communities in the state vary in both scope and type. This variety can be based on the mission and resources of the organization and the perceived needs of the community served.

Full report participation was achieved by both hospitals and MCOs for the second biennial survey. The reader is reminded that the basic requirement is for designated organizations to report whether or not they have a community benefits program, as defined in statute. An organization reporting that it does not have a program "as defined" meets the statutory reporting requirements.

Generally speaking, community benefit activities in the state appeared to increase over the previous reporting period. This is displayed in Figures 3 through 13 on the following pages and Table 1 on page 3. Continued reporting on a biennial basis may allow for increased comparison of information between reporting periods in the future. Consideration may be given to request summary CBISA reports from CHA to supplement the State's understanding of community benefit activity in Connecticut.

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

**Figure 2: Community Benefit Activity -
Providing a Training Site for Health Professionals**

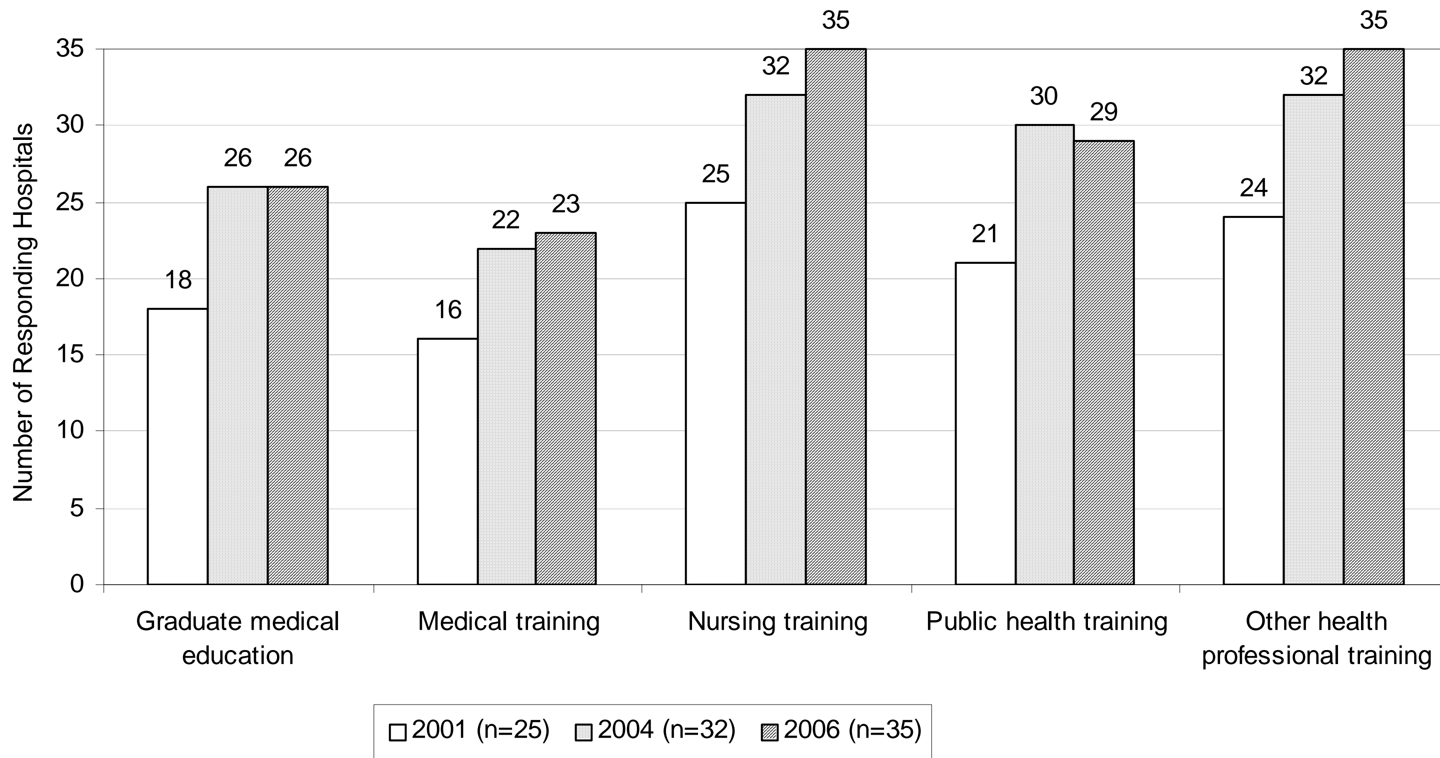


Figure 3: Community Benefit Activity - Health Education in the Community

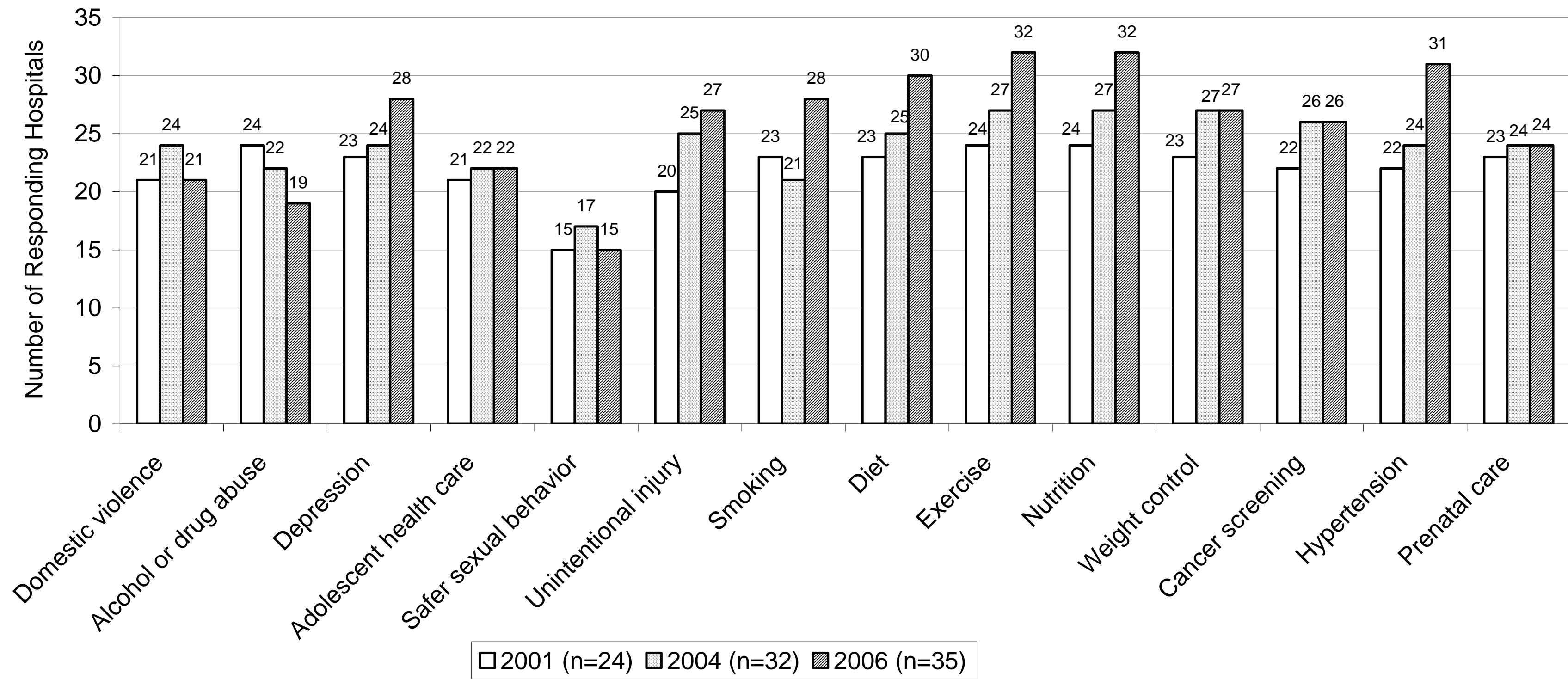


Figure 4: Community Benefit Activity -
Frequency of Support for Safety Net Agencies

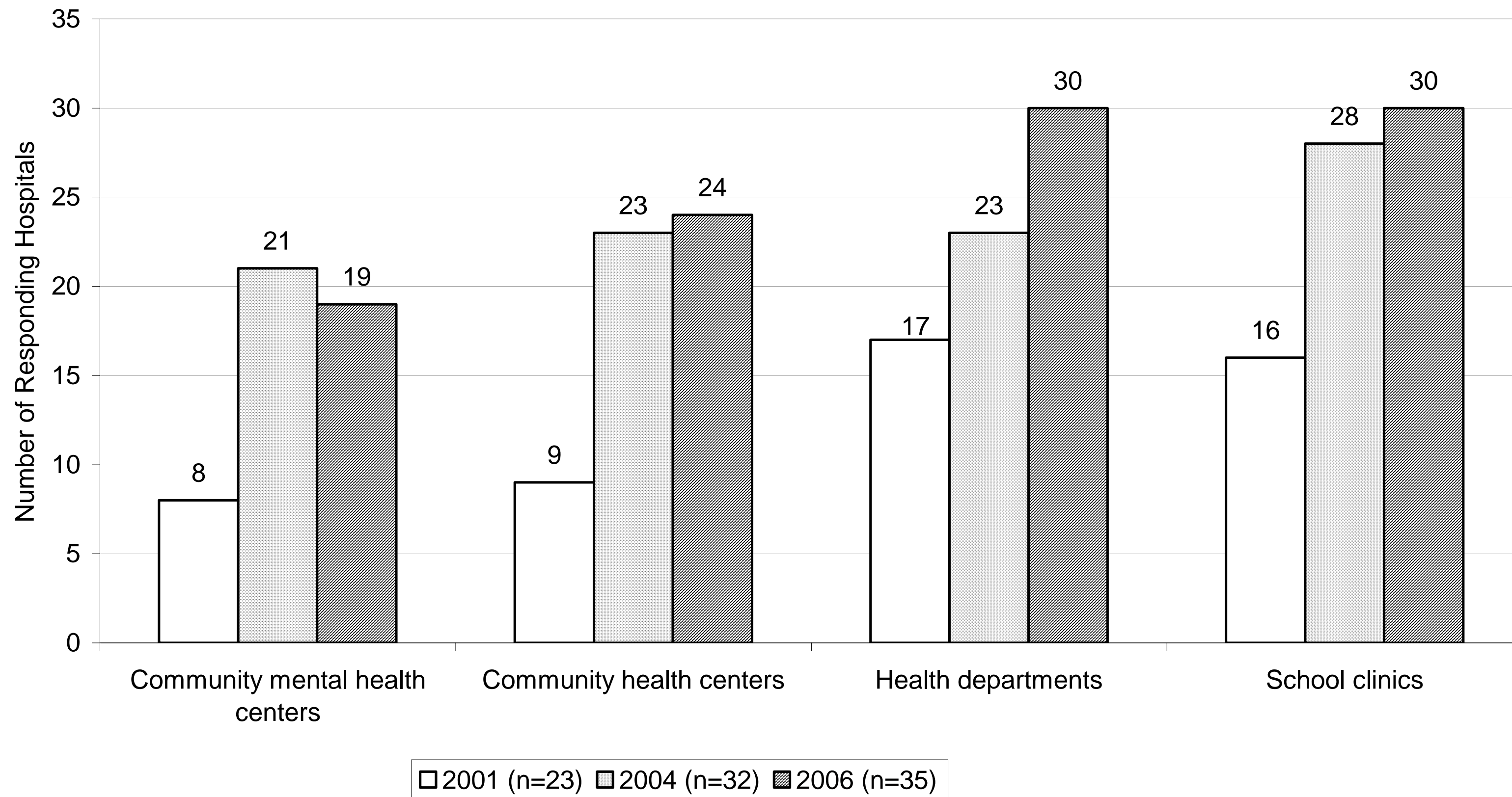


Figure 5: Community Benefit Activity - Support for Social Service Agencies

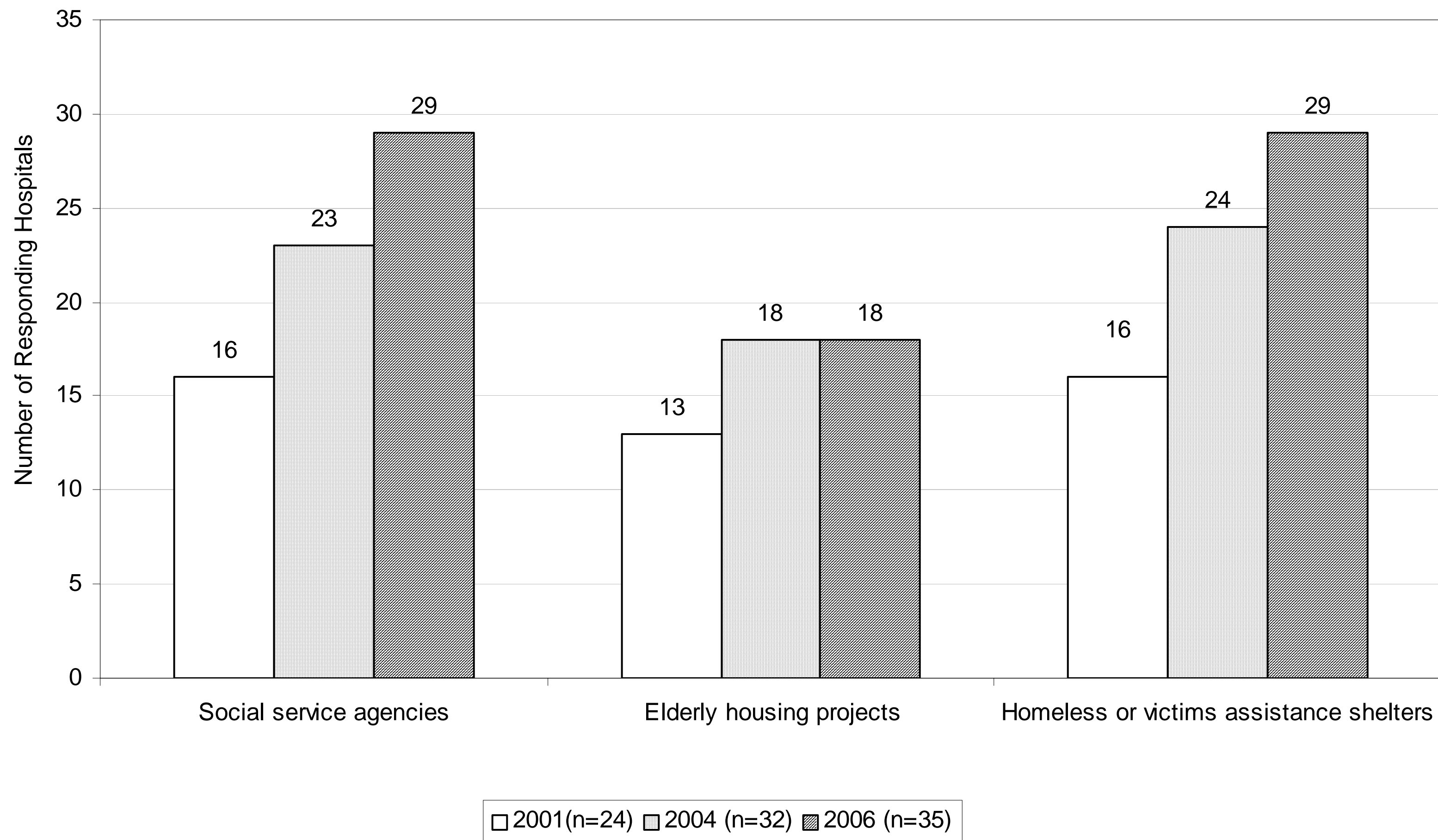


Figure 6: Community Benefit Activity - Support for Family Caregivers

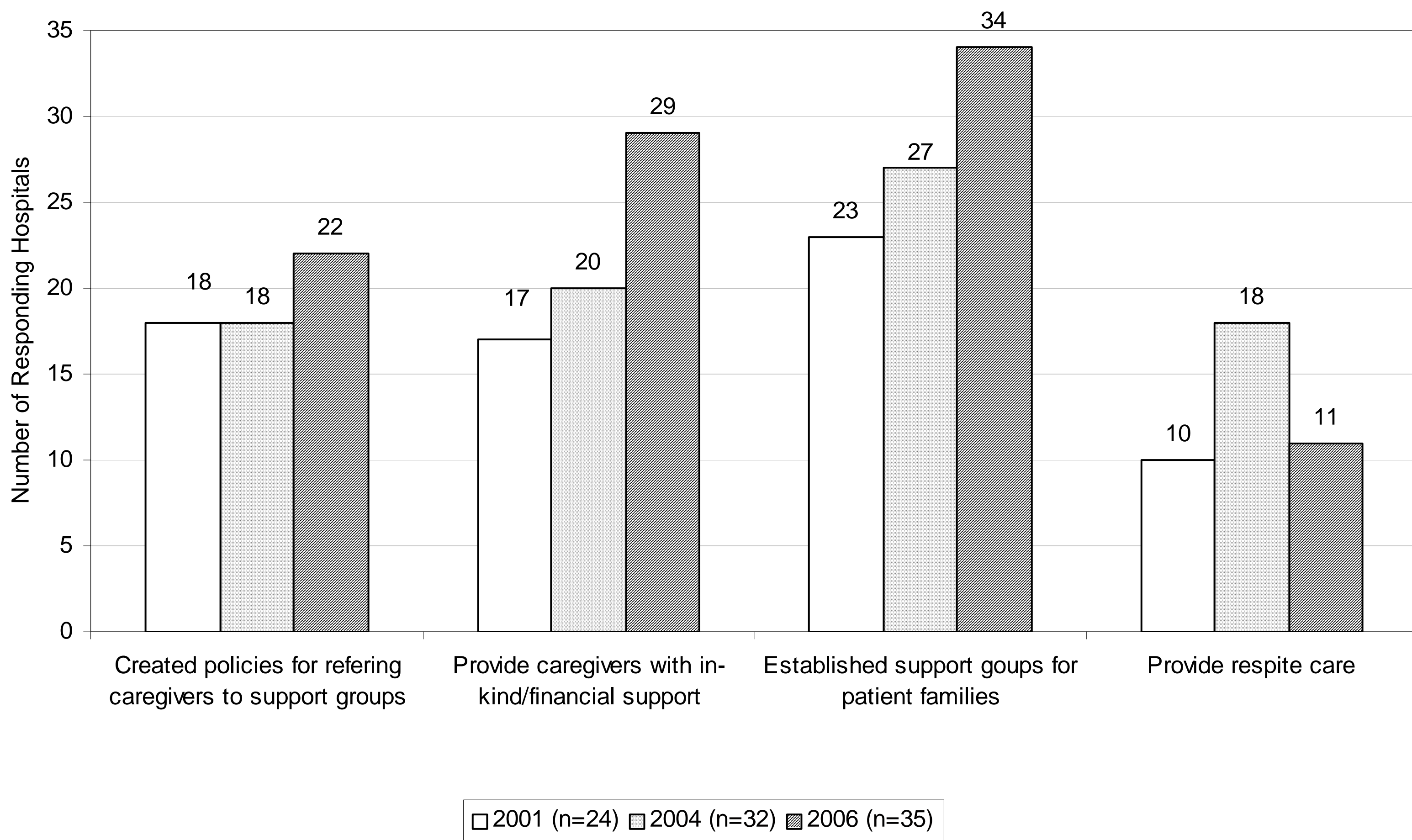


Figure 7: Community Benefit Activity - Collaboration with Local Public Safety Agencies

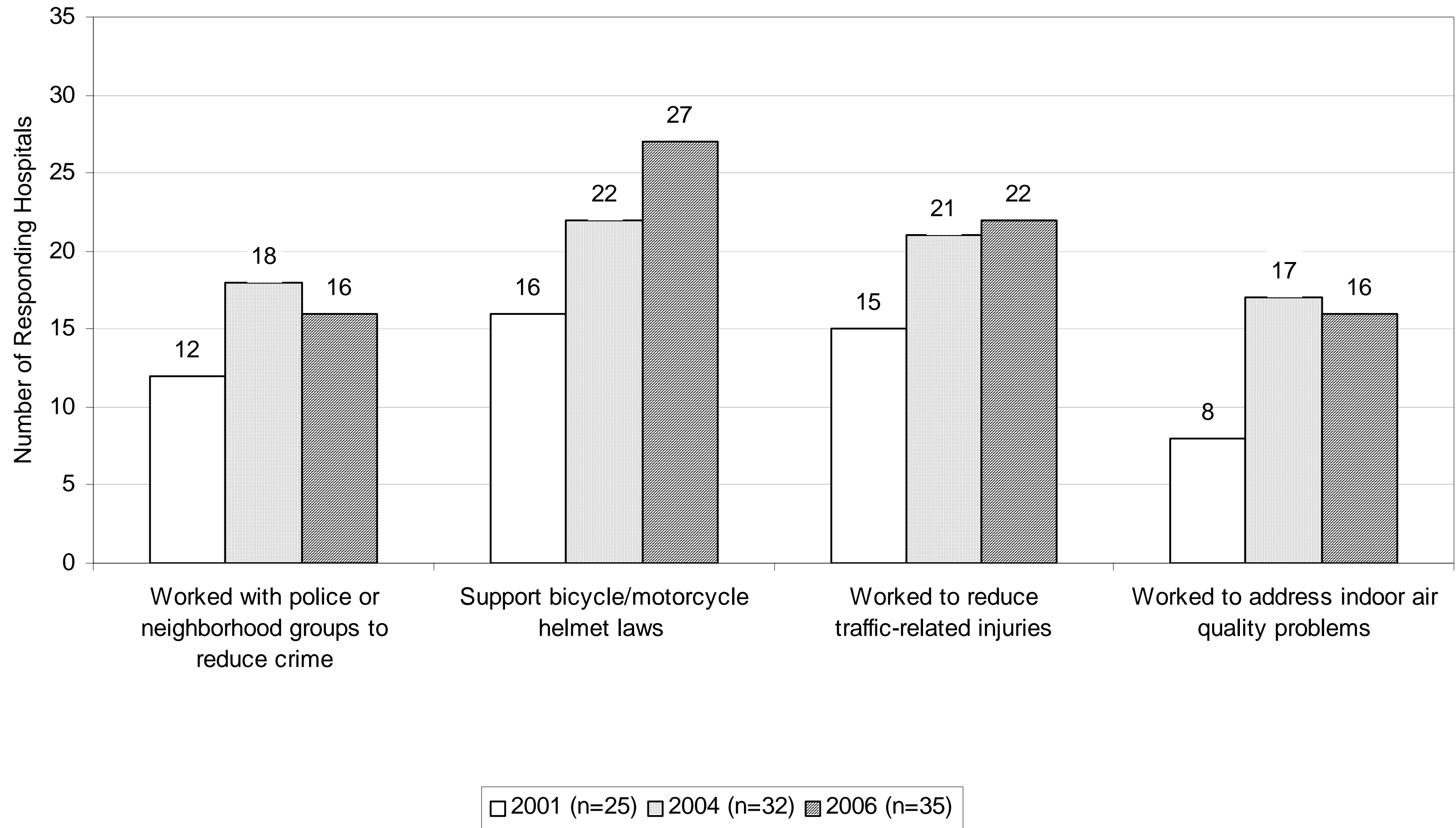


Figure 8: Community Benefit Activity - Free or Subsidized Health Services

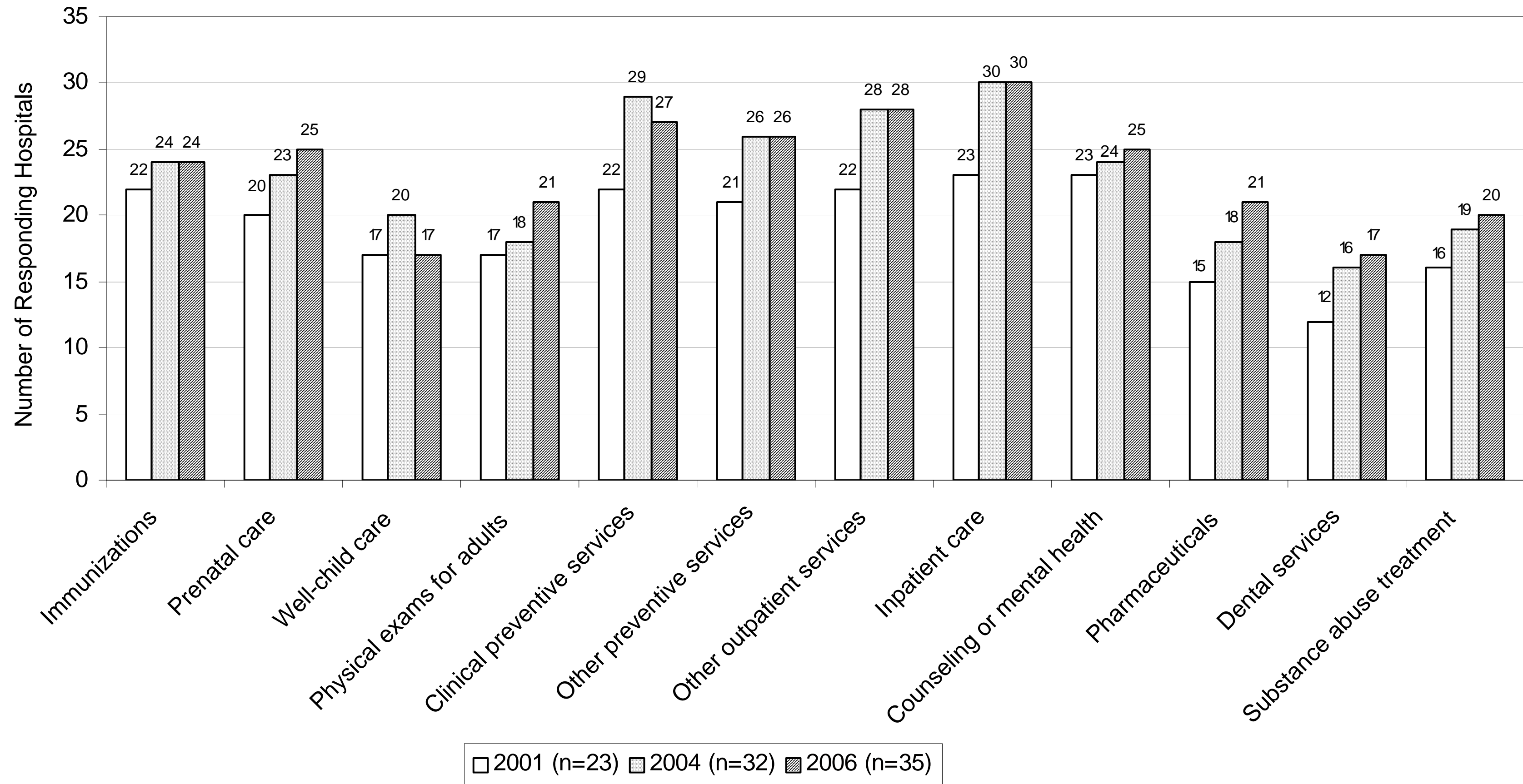


Figure 9: Community Benefit Activity - Programs to Reduce Health Hazards in the Home

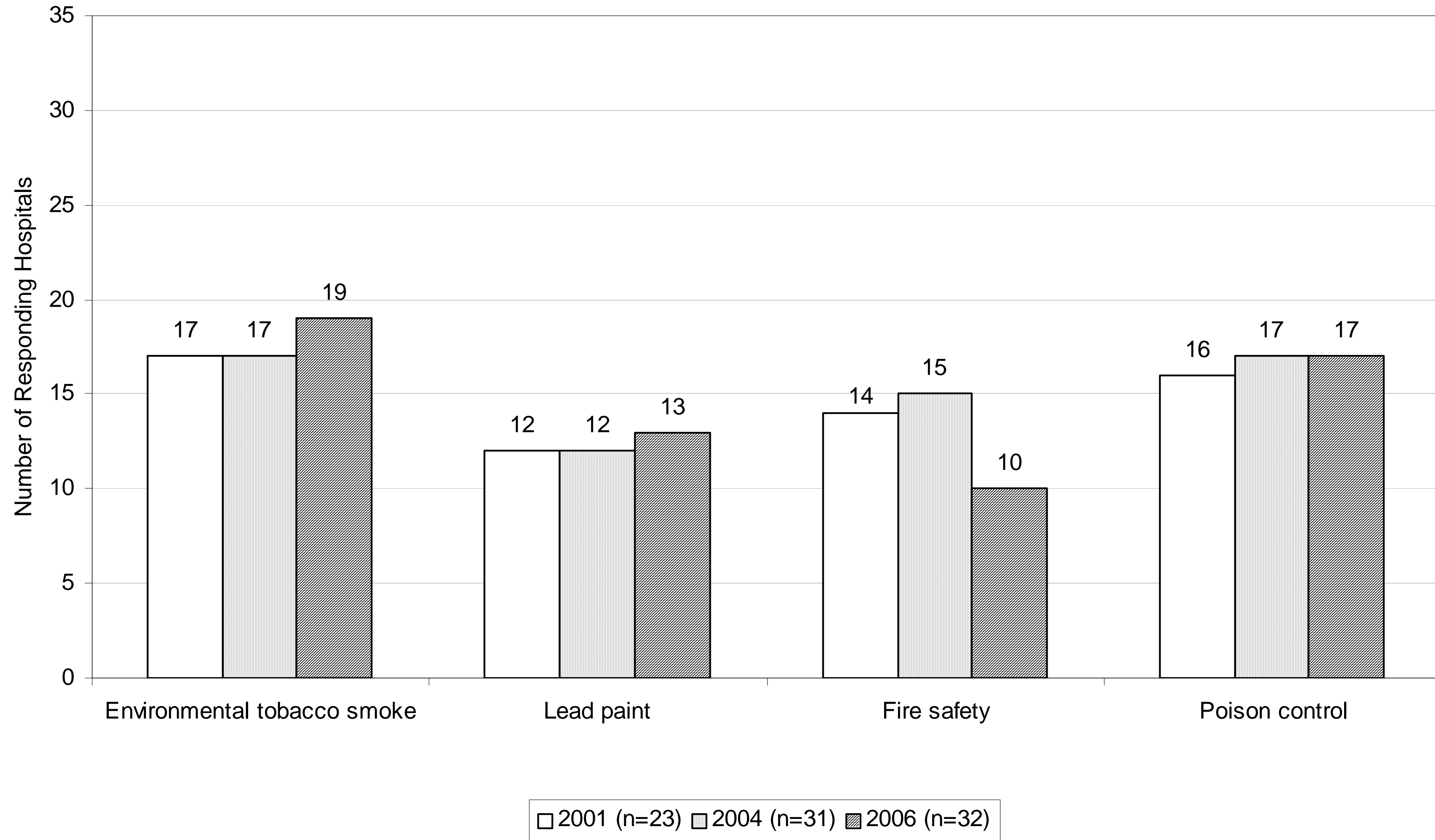


Figure 10: Community Benefit Activity - Programs to Reduce Transmission of Infectious Diseases

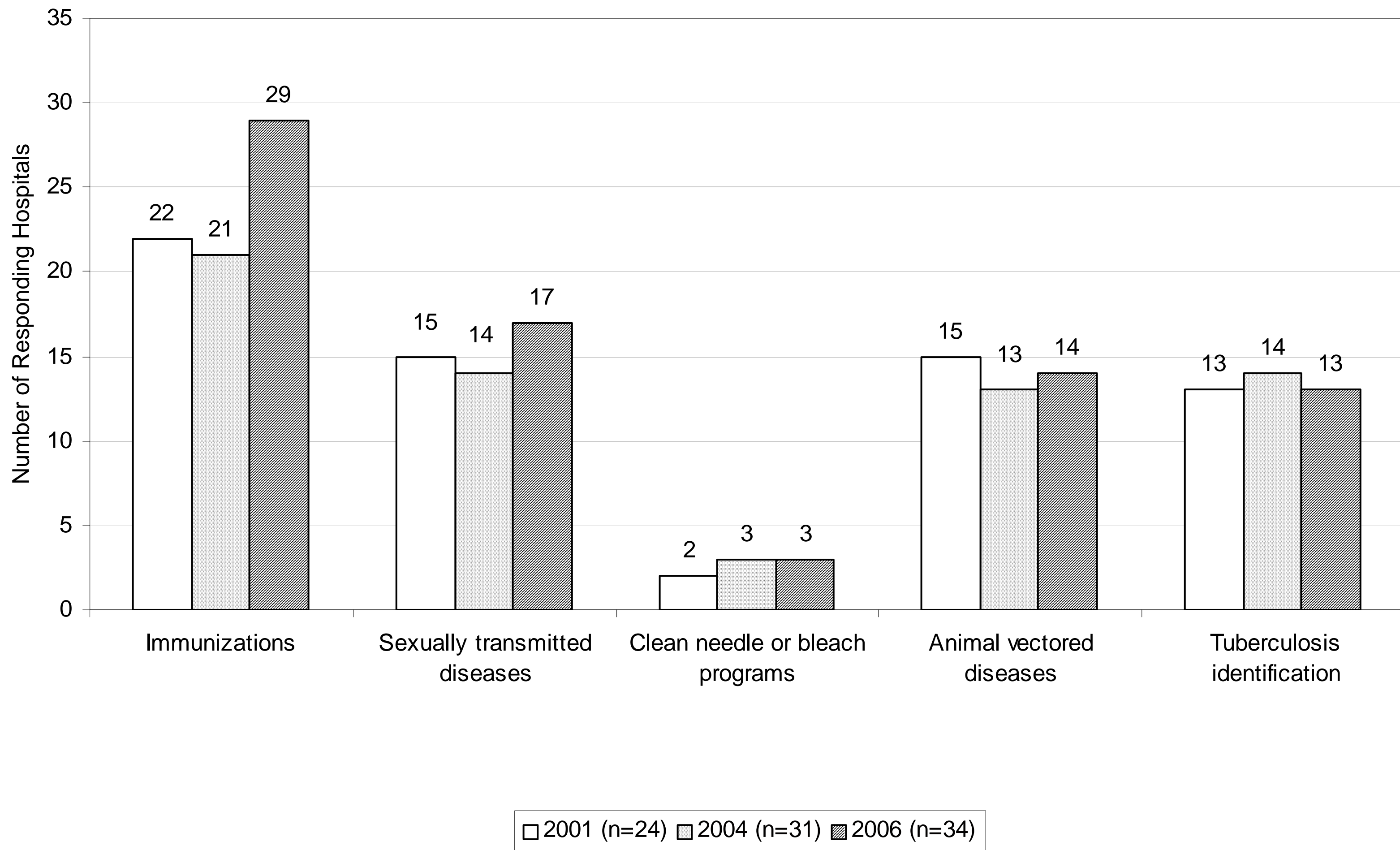


Figure 11: Community Participation in Policy Development for Community Benefit Activities

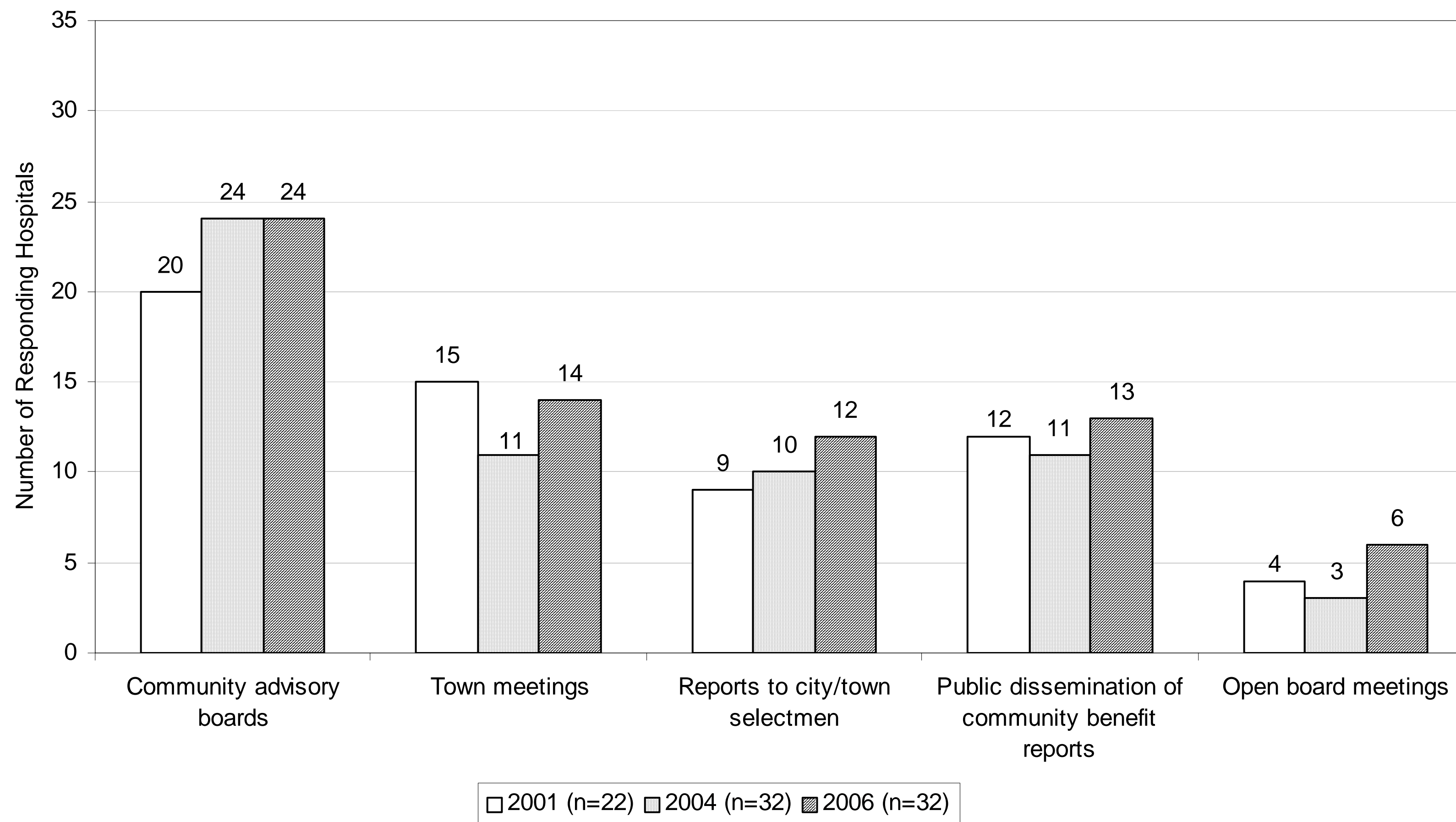


Figure 12: Community Benefit Activity - Distributing Reports Documenting Community Benefit Activities

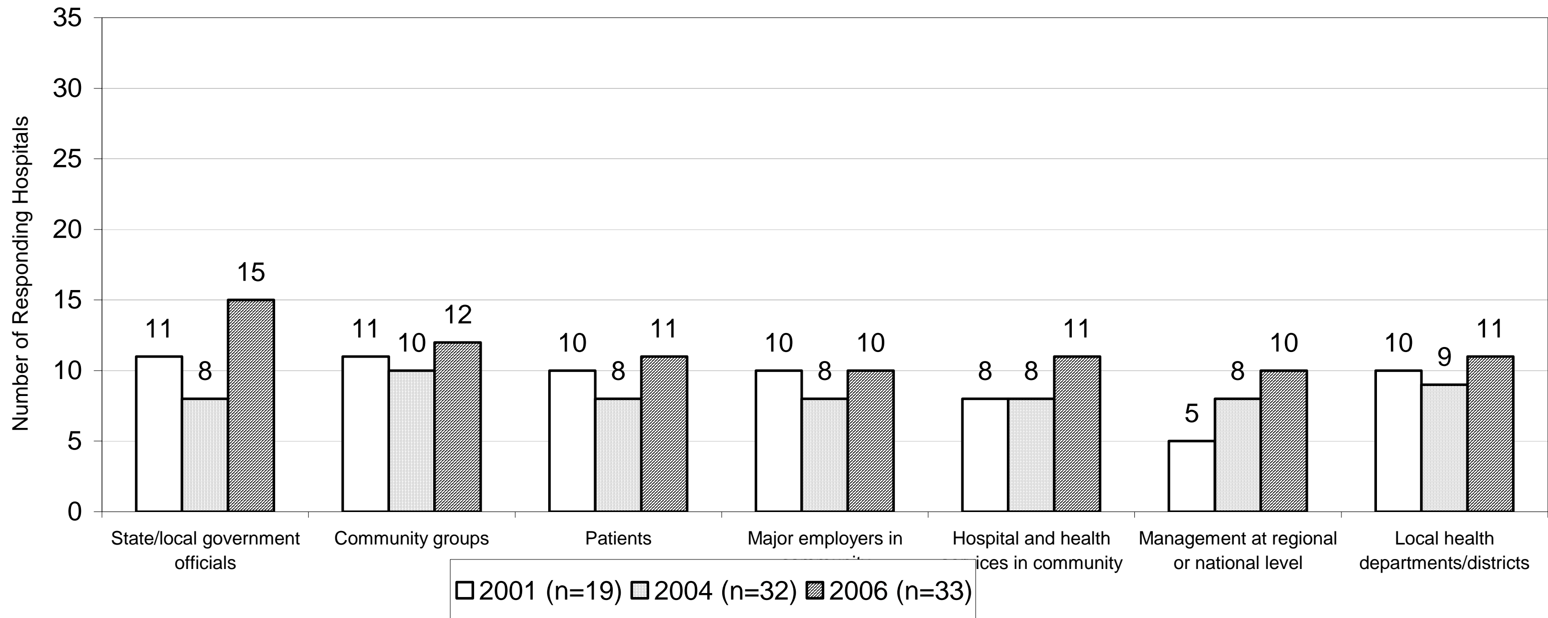
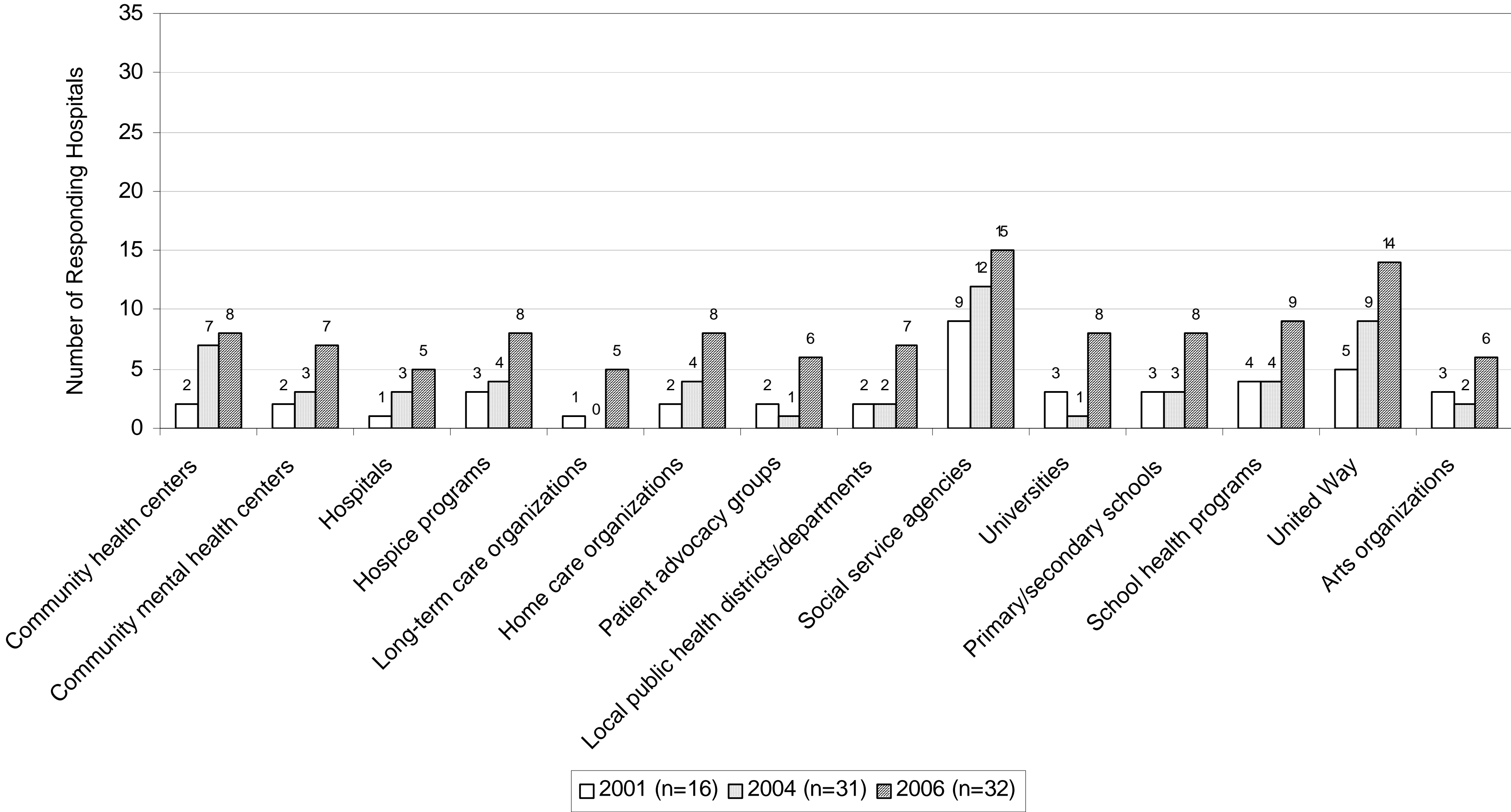


Figure 13: Community Benefit Activity -
Direct Grants to Community Agencies



APPENDICES

Appendix A	Connecticut General Statutes, Section 19a-127k
Appendix B	Hospitals and Managed Care Organizations Subject to Community Benefits Reporting
Appendix C	Year 2006 Community Benefit Survey Respondents
Appendix D	Years 2001, 2004 and 2006 Community Benefit Hospital Survey Responses

APPENDIX A

CONNECTICUT GENERAL STATUTE

SECTION 19A-127K, COMMUNITY BENEFITS PROGRAMS

(a) As used in this section:

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

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

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

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

(b) On or before January 1, 2005, and biennially thereafter, each managed care organization and each hospital shall submit to the commissioner, or the commissioner's designee, a report on whether the managed care organization or hospital has in place a community benefits program. If a managed care organization or hospital elects to develop a community benefits program, the report required by this subsection shall comply with the reporting requirements of subsection (d) of this section.

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

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

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

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

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

(d) Each managed care organization and each hospital that chooses to participate in developing a community benefits program shall include in the biennial report required by subsection (b) of this section the status of the

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

(e) The commissioner, or the commissioner's designee, shall develop a summary and analysis of the community benefits program reports submitted by managed care organizations and hospitals under this section and shall review such reports for adherence to the guidelines set forth in subsection (c) of this section. Not later than October 1, 2005, and biennially thereafter, the commissioner, or the commissioner's designee, shall make such summary and analysis available to the public upon request.

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

APPENDIX B

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

Bridgeport Hospital
Bristol Hospital, Inc.
Charlotte Hungerford Hospital
Connecticut Childbirth & Women's Center
Connecticut Children's Medical Center
Connecticut Hospice
Danbury Hospital
Day Kimball Hospital
Gaylord Hospital
Greenwich Hospital Association
Griffin Hospital
Hall-Brooke Hospital
Hartford Hospital
Hebrew Home and Hospital, Inc.
Hospital for Special Care
Hospital of Saint Raphael
John Dempsey Hospital of the UCONN H.C.
Johnson Memorial Hospital
Lawrence & Memorial Hospital
Manchester Memorial Hospital
Masonic Healthcare Center (chronic)
Masonic Healthcare Center (psychiatric)
Middlesex Hospital
Midstate Medical Center
Milford Hospital
Natchaug Hospital, Inc.
The Hospital of Central Connecticut
New Milford Hospital
Norwalk Hospital
Mount Sinai Rehabilitation Hospital, Inc.
Rockville General Hospital
Saint Francis Hospital and Medical Center
Saint Mary's Hospital
Saint Vincent's Medical Center
Sharon Hospital
Silver Hill Hospital
Stamford Hospital
The Stonnington Institute
Veterans' Home and Hospital
Waterbury Hospital
William W. Backus Hospital
Windham Community Memorial Hospital
Yale New Haven Hospital

*The facilities above meet the definition of a "hospital" as defined in Section 19a-127k, C.G.S. and Section 19a-490 of the Connecticut General Statutes. **Source**: Connecticut Department of Public Health, Bureau of Regulatory Services*

CONNECTICUT MANAGED CARE ORGANIZATIONS SUBJECT TO SECTION 19A-127K, C. G.S.

Aetna Life Insurance Company
Aetna Health, Inc.
Alta Health & Life Insurance Company
American Republic Insurance Company
Anthem Blue Cross & Blue Shield
Celtic Insurance Company
CIGNA HealthCare of Connecticut, Inc.
ConnectiCare, Inc.
ConnectiCare Insurance Company, Inc.
Connecticut General Life Insurance Company
Genworth Life & Health Insurance Company
Golden Rule Insurance Company
Guardian Life Insurance Company
Health Net Insurance of Connecticut, Inc.
Health Net of Connecticut, Inc.
John Alden Life Insurance Company
Oxford Health Insurance, Inc.
Oxford Health Plans (CT), Inc.
Time Insurance Company
Trustmark Insurance Company
Trustmark Life Insurance Company
UniCare Life & Health Insurance Company
Union Security Insurance Company
United HealthCare Insurance Company

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

APPENDIX C

YEAR 2006 COMMUNITY BENEFIT SURVEY RESPONDENTS

	Have CB Program	Submitted CB Survey
Hospitals		
Bridgeport Hospital	X	X
Bristol Hospital, Inc.	X	X
Connecticut Children's Medical Center	X	X
Danbury Hospital	X	X
Greenwich Hospital Association	X	X
Hall-Brooke Hospital*	X	X
Hartford Hospital	X	X
Hebrew Home and Hospital, Inc.	X	X
Masonic Healthvare (chronic)	X	X
Masonic Healthvare (psychiatric)	X	X
Midstate Medical Center	X	X
Milford Hospital	X	X
Mount Sinai Rehabilitation Hospital, Inc.**	X	X
Saint Francis Hospital and Medical Center **	X	X
Saint Vincent's Medical Center*	X	X
Windham Community Memorial Hospital	X	X
Yale New Haven Hospital	X	X
Charlotte Hungerford Hospital		X
Day Kimball Hospital		X
Gaylord Hospital		X
Griffin Hospital		X
Hospital for Special Care		X
Hospital of Saint Raphael		X
John Dempsey Hospital of UCONN HC		X
Johnson Memorial Hospital		X
Manchester Memorial Hospital		X
Middlesex Hospital		X
Natchaug		X
Norwalk Hospital		X
Rockville General Hospital		X
Saint Mary's Hospital		X
Sharon Hospital		X
Stamford Hospital		X
Waterbury Hospital		X
William W. Backus Hospital		X
Managed Care Organizations		
ConnectiCare, Inc.***	X	X
Aetna Foundation, Inc.****	X	X
Total	**19**	**37**

* Saint Vincent's Health Services
** Saint Francis Care
*** ConnectiCare, Inc. / ConnectiCare Insurance Company, Inc.
**** Aetna Life Insurance Company / Aetna Health, Inc.

Appendix D

Year 2001, 2004 & 2006 Hospital Community Benefit Survey Responses

The Community Benefit survey questions and aggregate responses for 2001, 2004 and 2006 are listed below. The "n" for each question represents the number of hospitals responding.

Definitions of terms used in this survey:

Neighborhoods with limited incomes: Greater than 20% of population living in poverty.
Neighborhoods with high immigrant populations: Greater than 20% of residents are recent immigrants.
Rural areas: Areas outside of metropolitan statistical areas.
Neighborhoods with high concentrations of racial minorities: Greater than 20% of population is composed of people of color.
Social services: Services such as family counseling, case management, and information about program benefits.

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

	2001 (n=24)	2004 (n=32)	2006 (n=35)
Yes	7	9	17
No	17	23	18

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

	2001 (N=25)	2004 (n=32)	2006 (n=35)
Yes	4	5	9
No	21	27	26

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

	2001 (N=22)	2004 (n=30)	2006 (n=35)
Yes	20	28	26
No	2	2	5
Not Applicable	--	--	4

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

	2001 (N=25)	2004 (n=31)	2006 (n=35)
Yes	5	6	11
No	20	25	24

5. Does your community benefits program have a formal budget? If yes, please attach the budget and an estimated expenditures report.

	2001 (N=23)	2004 (n=30)	2006 (n=34)
Yes	9	7	8
No	14	22	25
Not Applicable	--	1	1

6. What was the budget for the community benefits program?

	2001 (N=12)	2004 (n=12)	2006 (n=6)
Median	$750,000	$1,523,885	$17,763,967

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

	2001 (N=13)	2004 (n=13)	2006 (n=21)
Median	4.5	19	4

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

	2001 (N=25)	2004 (n=32)	2006 (n=35)
Entire State	2	7	5
Fairfield County	7	10	9
Hartford County	6	12	11
Litchfield County	4	6	6
Middlesex County	3	3	4
New Haven County	9	10	11
New London County	2	4	4
Tolland County	1	4	4
Windham County	3	5	6

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

	2001 (N=25)	2004 (n=30)	2006 (n=33)
Never	1	2	0
Rarely	0	2	1
Sometimes	5	4	6
Often	13	17	18
Always	4	4	7
Unable to Determine	2	1	1

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

	2001 (N=25)	2004 (n=30)	2006 (n=33)
Never	0	2	1
Rarely	1	3	2
Sometimes	7	5	11
Often	10	15	12
Always	2	2	4
Unable to Determine	5	3	3

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

	2001 (N=25)	2004 (n=30)	2006 (n=33)
Never	0	3	1
Rarely	1	0	0
Sometimes	6	6	6
Often	12	17	20
Always	3	2	4
Unable to Determine	3	2	2

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

	2001 (N=24)	2004 (n=30)	2006 (n=32)
Never	4	5	5
Rarely	2	5	1
Sometimes	3	1	7
Often	9	12	13
Always	4	4	5
Unable to Determine	2	3	1

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

	2001 (N=25)	2004 (n=31)	2006 (n=34)
Never	9	8	8
Rarely	5	10	12
Sometimes	3	6	6
Often	3	5	4
Always	3	1	3
Unable to Determine	2	1	1

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

	2001 (N=24)	2004 (n=31)	2006 (n=33)
Never	0	5	2
Rarely	2	2	2
Sometimes	5	2	7
Often	11	15	14
Always	4	4	7
Unable to Determine	2	3	1

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

	2001 (N=24)	2004 (n=30)	2006 (n=33)
Never	1	3	0
Rarely	0	1	2
Sometimes	6	4	7
Often	12	15	16
Always	2	4	5
Unable to Determine	3	3	3

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

	2001 (N=24)	2004 (n=32)	2006 (n=35)
Yes	23	30	34
No	1	2	1

17. Approximately how many residents received free or subsidized services under the auspices of your program?

	2001 (N=20)	2004 (n=26)	2006 (n=27)
Median	4,900	4,137	2,822
Total	--	177,892	213,713

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

	2001 (N=23)	2004 (n=32)	2006 (n=35)
Immunizations	22	24	24
Prenatal or peri-natal care	20	23	25
Physical exams for adults	17	18	21
Counseling or mental health	23	24	25
Substance abuse treatment	16	19	20
Clinical preventive services (e.g., hypertension)	22	29	27
Other preventive services (e.g., colorectal cancer)	21	26	26
Other outpatient medical or surgical services	22	28	28
Other clinical services not mentioned	18	22	22
Well-child care	17	20	17
Dental services	12	16	17
Pharmaceuticals	15	18	21
Inpatient care	23	30	30

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

	2001 (N=24)	2004 (n=31)	2006 (n=34)
Immunization programs	22	21	29
Sexually transmitted disease prevention programs	15	14	17
Clean needle/bleach programs for IV drug users	2	3	3
Animal vectored diseases (rabies, Lyme disease)	15	13	14
Tuberculosis identification programs	13	14	13

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

	2001 (N=22)	2004 (n=32)	2006 (n=35)
Yes	8	21	19
No	14	11	16

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

	2001 (N=23)	2004 (n=32)	2006 (n=35)
Yes	9	23	24
No	14	9	11

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

	2001 (N=23)	2004 (n=32)	2006 (n=35)
Yes	17	23	30
No	6	9	5

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

	2001 (N=24)	2004 (n=32)	2006 (n=35)
Yes	16	23	29
No	8	9	6

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

	2001 (N=24)	2004 (n=32)	2006 (n=35)
Yes	16	24	29
No	8	8	6

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

	2001 (N=24)	2004 (n=32)	2006 (n=35)
Yes	13	18	18
No	11	14	17

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

	2001 (N=23)	2004 (n=32)	2006 (n=35)
Yes	16	28	30
No	7	4	5

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

	2001 (N=24)	2004 (n=32)	2006 (n=35)
Addressing domestic violence and other abuse	21	24	21
Abuse of alcohol or other illicit drugs	24	22	19
Identifying depression	23	24	28
Health promotion for adolescents	21	22	22
Encouraging safer sexual behavior	15	17	15
Reducing unintentional injury	20	25	27
Reducing smoking and other tobacco use	23	21	28
Addressing diet and cholesterol control	23	25	30
Encouraging exercise	24	27	32
Encouraging better nutrition	24	27	32
Encouraging weight control	23	27	27
Cancer screening	22	26	26
Hypertension detection and control	22	24	31
Need for prenatal care	23	24	24

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

	2001 (N=25)	2004 (n=32)	2006 (n=35)
Yes	18	26	26
No	7	6	9

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

	2001 (N=25)	2004 (n=32)	2006 (n=35)
Yes	16	22	23
No	9	10	12

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

	2001 (N=25)	2004 (n=32)	2006 (n=35)
Yes	25	32	35
No	0	0	0

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

	2001 (N=25)	2004 (n=32)	2006 (n=35)
Yes	21	30	29
No	4	2	6

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

	2001 (N=25)	2004 (n=32)	2006 (n=35)
Yes	24	32	35
No	1	0	0

33. What are your organization's practices regarding informal caregivers--that is, friends and family members who provide care to patients?

	2001 (N=24)	2004 (n=32)	2006 (n=35)
Policies for referring caregivers to support groups	18	18	22
Provided financial or in-kind support to groups	17	20	29
Established support groups for patients' families	23	27	34
Provided respite care	10	18	11

34. Has your organization carried out the following types of activities in Connecticut?

2001 (N=25)	Not at all	Sometimes	A great deal
Worked with neighborhood groups to reduce crime	12	9	3
Supported bicycle or motorcycle helmet laws	7	9	7
Worked to reduce traffic-related injuries	10	9	6
Worked to address indoor air quality problems	17	7	1

2004 (n=32)	Not at all	Sometimes	A great deal
Worked with neighborhood groups to reduce crime	14	10	8
Supported bicycle or motorcycle helmet laws	10	10	12
Worked to reduce traffic-related injuries	11	7	14
Worked to address indoor air quality problems	15	13	4

2006 (n=35)	Not at all	Sometimes	A great deal
Worked with neighborhood groups to reduce crime	18	12	4
Supported bicycle or motorcycle helmet laws	8	11	16
Worked to reduce traffic-related injuries	12	11	11
Worked to address indoor air quality problems	18	9	7

35. Does the Community Benefit program have a component that addressed reducing any of the following home-based environmental health hazards?

	2001 (N=23)	2004 (n=31)	2006 (n=32)
Tobacco smoke	17	17	19
Lead paint	12	12	13
Fire safety	14	15	10
Poison control	16	17	17

36. Were grants made available to any of the following types of organizations?

	2001 (N=16)	2004 (n=31)	2006 (n=32)
Community health centers	2	7	8
Community mental health centers	2	3	7
Hospitals	1	3	5
Hospice programs	3	4	8
Long term care organizations	1	0	5
Home care organizations	2	4	8
Patient advocacy groups	2	1	6
Local public health districts or departments	2	2	7
Social service agencies	9	12	15
Universities	3	1	8
Primary/secondary schools	3	3	8
School health programs	4	4	9
United Way or other federated giving programs	5	9	14
Arts organizations (visual or performing)	3	2	6

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

	2001 (N=24)	2004 (n=32)	2006 (n=35)
Yes	20	20	23
No	4	10	10
Not Applicabel	--	2	2

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

	2001 (N=24)	2004 (n=32)	2006 (n=35)
Yes	9	10	11
No	15	20	23
Not Applicable	--	2	1

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

	2001 (N=24)	2004 (n=32)	2006 (n=35)
Yes	18	23	25
No	6	8	9
Not Applicable	--	1	1

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

	2001 (N=24)	2004 (n=32)	2006 (n=35)
Yes	12	13	14
No	12	18	20
Not Applicable	--	1	1

41. Which of the following mechanisms are used by your organization to allow for community involvement?

	2001 (N=22)	2004 (n=32)	2006 (n=32)
Advisory boards drawn from the local community	20	24	24
Town meetings with the public	15	11	14
Reports to city or town boards of selectmen	9	10	12
Public dissemination of community benefit reports	12	11	13
Open board meetings	4	3	6

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

	2001 (N=19)	2004 (n=32)	2006 (n=33)
State regulatory agencies	4	7	11
State or local government officials	11	8	15
Community groups	11	10	12
Patients	10	8	11
Major employers in the community	10	8	10
Hospital and health services in the community	8	8	11
Management at the regional or national level	5	8	10
Local health departments or districts	10	9	11