SECTION 3 CHAPTER 7
PERSONS AT RISK AND VULNERABLE POPULATIONS

7.0 PERSONS AT RISK AND VULNERABLE POPULATIONS

The Plan's mandate includes an assessment of the availability of certain health care services and an evaluation of unmet needs of persons at-risk and vulnerable populations.

The DPH has identified 25 health priorities for increasing the life expectancy and quality of life of Connecticut residents. See Appendix R for details.

Since January 2012, DPH has been developing a State Health Assessment that will: evaluate the health care delivery system; identify priority populations and areas; determine the need for services and programs; and inform policymakers and the public about the health of Connecticut residents. Subsequently, DPH will develop a State Health Improvement Plan in response to the findings of the assessment, to guide policy and program changes that will lead to improved access to care, improved outcomes and health equity for the state's residents. The Department will release the health assessment and improvement plan in 2013. DPH is working with representatives of other State agencies, local health departments, community organizations, educational institutions, complementary services providers, business and industry, and health care providers to develop the assessment and improvement plan.

7.1 IDENTIFYING PERSONS AT RISK AND VULNERABLE POPULATIONS

In the last few years, national efforts have been focused on reducing health inequalities or disparities for certain populations.[115] Such inequalities gauge the health of the community and guide efforts to identify and implement solutions to improve health status in general. Although racial and ethnic minorities tend to have poorer health outcomes, they are not the only populations that experience inequities. The federal government has provided leadership in identifying health disparities and the priority populations that are at risk or vulnerable.

DPH has developed a working definition of health disparities and priority populations for Connecticut based on federal guidelines and evidence-based research for its monitoring and surveillance activities. *"Health disparities refer to the differences in disease risk, incidence, prevalence, morbidity, mortality and other adverse conditions, such as unequal access to quality care, that exist among specific population groups in Connecticut. Population groups may be based on race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness and geographic area of residence. Specifically, health disparities refer to those avoidable differences in health that result from cumulative social disadvantages."* [116]

Priority, at risk or vulnerable populations in Connecticut have at least one of the following characteristics: they are elderly; residents of towns with the lowest income, highest poverty and extremely high population density (or urban core cities) that is, Bridgeport, New Britain, New London, West Haven, Hartford, New Haven and Waterbury[117]; residents with household income at or below 200% of the federal poverty level; racial/ethnic minorities such as blacks, Hispanics and other non-whites; residents of rural areas with average income, below average poverty and the lowest population density in Connecticut; uninsured population under age 65; people with chronic medical conditions; the disabled; the homeless; non-English speakers; lesbian, gay, bisexual, and transgender population; and immigrants.[118]

Estimates of Connecticut residents vulnerable or at-risk are shown in Table 7.1.

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[115]Centers for Disease Control and Prevention. (2011, January). CDC Health Disparities and Inequalities Report, United States 2011. *U.S. Department of Health and Human Services. Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report. Supplement Vol. 60.*

[116]Stratton, A., Hynes, M., Nepaul, A. (2007). *Defining Health Disparities*. The Connecticut Health Disparities Project. Connecticut Department of Public Health.

[117]University of Connecticut College of Liberal Arts & Sciences, Connecticut State Data Center. *The Five Connecticuts*.

[118]U.S Department of Health and Human Services, Agency for Healthcare Research and Quality priority populations, specified by Congress in the Healthcare Research and Quality Act of 1999 (Public Law 106-129).

Table 7.1 Connecticut's At Risk or Vulnerable Populations

Priority Group	Description	Number[k]	% of Population
Seniors[a]	Residents 65 years of age and older	506,559	14%
Low income[b]	Residents with household income at or below 200% of the federal poverty level	752,631	21%
Racial/ethnic	Blacks, Hispanics and other non-whites	1,027,835	29%
Rural areas[d]	Residents of rural areas such as Sterling, with average income, below average poverty and the lowest population density in Connecticut	489,316	14%
Urban towns[e]	Residents of core urban areas such as Hartford, with lowest income, highest poverty and highest population density in Connecticut	665,539	19%
Uninsured[f]	Population under age 65 that is uninsured	377,900	13%
Chronically ill[g]	People with chronic medical conditions. The seven most common conditions are:		
	(1) Cancer	136,000	4.0%
	(2) Diabetes	147,000	4.4%
	(3) Heart Disease	224,000	6.6%
	(4) Hypertension	434,000	12.9%
	(5) Stroke	30,000	0.9%
	(6) Mental Disorders	408,000	12.1%
	(7) Pulmonary Conditions	611,000	18.1%
Homeless[h]	People who used residential programs for the homeless	4,316	0.1%
Non-English speaking[i]	People who speak English less than "very well"	293,656	9%
Disabled[j]	People living with a disability	367,557	10%

[a]U.S. Census Bureau Census 2010.

[b]U.S. Census Bureau, 2008-2010 American Community Surveys.

[c]U.S. Census Bureau Census 2010.

[d]University of Connecticut, Connecticut State Data Center Five Connecticuts town grouping of Census Bureau Census 2010 Estimates. Sixty-three towns fall into this category.

[e]University of Connecticut, Connecticut State Data Center Five Connecticuts town grouping of Census Bureau Census 2010 Estimates. Seven towns fall into this category.

[f]The Henry J. Kaiser Foundation State Health Facts, Connecticut: Health Insurance Coverage of Nonelderly 0-64, States (2009-2010), U.S. (2010).

[g]As defined by U.S. Centers for Disease Control and Prevention. 2003 estimates from DeVol, Ross and Armen, Bedroussian. October, 2007. An Unhealthy America: The Economic Burden of Chronic Disease. Milken Institute.

[h]U.S. Department of Housing and Urban Development, Office of Community Planning and Development. The 2010 Annual Homeless Assessment Report to Congress. Appendix C-2 Changes in Point in Time Estimates of the Homeless Population by State, 2007-2010. Page 131.

[i]U.S. Census Bureau, 2010 American Community Survey 1-Year Estimates.

[j]U.S. Census Bureau, 2010 American Community Survey 1-Year Estimates.

[k]Numbers do not add up and represent different years; some residents have been counted in more than one group.

7.2 DEFINITION OF UNMET HEALTH CARE NEED

Unmet health care need can result from a lack of availability of services or lack of affordability of available services. For the purposes of this plan, two definitions of unmet health care need are used. First, unmet need is defined as *inadequate availability of health care services deemed necessary to deal with a particular health problem*.[119, 120] When this definition is utilized, the barriers to accessing care may be one or more of the following:

- Physical unavailability of service or professional shortage;
- Mismatched services for the needs of the people -- that is, the health care system is unresponsive;
- Inferior available services as compared to the norm;
- Lack of knowledge regarding what services are available locally or how to access them;
- Lack of enabling services such as translation services to non-English speaking immigrants or transportation to facilitate access, especially in rural areas;
- Insufficient coordination between different providers of different levels and types of services;
- Complex health insurance payer rules such as eligibility for Medicare and/or Medicaid and for accessing services; and
- Inadequate collaboration among governmental agencies and/or community providers.

Second, unmet need is defined as *when individuals of a distinct socio-demographic group, such as the uninsured or people with low income, forgo or delay accessing needed available health care services because the associated costs are unaffordable*. The Institute of Medicine's (IOM) has identified lack of insurance as a significant driver of health disparities.[121]

Both definitions presume an adverse impact on health status from lack of or delayed care, or disparities in access. Whichever definition is used, unmet need has to be quantified to determine the appropriate intervention(s) or policy change. The expected result is a more integrated healthcare delivery system in which resources are allocated efficiently based on agreed priorities to improve health status and eliminate inequalities.

7.3 METHODS FOR EVALUATING UNMET NEED AND GAPS IN SERVICES

Three methods are used to evaluate unmet need for primary care services in Chapter 9: 1) Federal designation approach; 2) Population-based relative availability approach; and 3) Proxy approach.

7.3.1 FEDERAL DESIGNATION APPROACH

The first approach uses Medically Underserved Areas or Populations (MUA/P) or Health Professional Shortage Areas (HPSA) designations in comparison with uninsured rates to determine potential future demand for primary care-related services. The DPH Primary Care Office works with the Office of Shortage Designation of the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, to identify medically underserved areas in Connecticut that may qualify for these federal designations as underserved areas for primary care, dental or mental health care.

Each of the three HPSA designations - primary care, dental and mental health - is subcategorized to enable demonstration of provider shortage(s) by:

- Geographic area for the area's total population;
- Population group in which over 30% have incomes at or below 200% of federal poverty levels and are migrant/seasonal farmworkers and families, Medicaid eligible, Native Americans/Native Alaskan, homeless, or isolated from access because of language and cultural/physical barriers; or
- Facility such as community health centers, rural health clinics, federal correctional facilities, and state hospitals utilizing factors such as the facility's outpatient population, wait times, patients' residences, and in-house faculty.

[119]DeCesaro, A., Hemmetter, J. (2009, February). Unmet Health Care Needs and Medical Out-of-Pocket Expenses for SSI Children. *Journal of Vocational Rehabilitation 30 (2009) 177-199*.

[120]Marshall, E.G., Wong, S. T., Haggerty, J.L., & Levesque, J. (2010, February). Perceptions of unmet healthcare needs: what do Punjabi and Chinese-speaking immigrants think? A qualitative study. *BioMed Central BMC Health Services Research 2010, Vol 10:46*. Retrieved from http://www.biomedcentral.com/1472-6963/10/46

[121]Institute of Medicine. (2002). *Unequal Treatment Confronting Racial and Ethnic Disparities in Health Care*. Edited by B. D. Smedley, A. Y. Stith, and A. Nelson. Board on Health Sciences Policy. Washington, DC: The National Academies Press.

7.3.2 POPULATION-BASED RELATIVE AVAILABILITY APPROACH

The second approach compares the geographic availability and accessibility of inpatient services between regions.[122] Use rates are also calculated for certain at-risk populations and compared to rates for the general population. Comparisons with availability per 1,000 of general populations for specific subpopulations, are included where relevant and available.

7.3.3 PROXY APPROACH

The third approach utilizes proxies in identifying gaps in outpatient services for at-risk populations. Proxies include mortality rates, ED utilization for non-urgent care as a gauge of wait times for primary care visits (e.g., obstetrics / gynecology, well child, and adult medicine) and preventable hospitalizations derived from acute care discharge data.[123]

7.4 PROGRAMS/PLANS TO MITIGATE UNMET NEED AND GAPS IN SERVICES

This section identifies any plans or programs in development, already developed and/or being implemented by DPH or other State agencies to mitigate unmet need in at risk-persons and vulnerable populations. (Appendix S includes additional information on DPH programs.)

7.4.1 FEDERAL MEDICALLY UNDERSERVED AREAS AND HEALTH PROFESSIONAL SHORTAGE AREAS[124]

The federal HPSA designations, reviewed periodically, are a first step for the state and local communities to obtaining resources to improve access to health care services to vulnerable or at-risk populations and areas. Since 1982, when the Federal Bureau of Primary Health Care granted the state four MUA designations to cover areas served by Charter Oak Health Center and Community Health Services of Hartford, Cornell Scott-Hill and Fair Haven Community Health Centers of New Haven, to date, 29 more towns have applied for and been designated MUAs. Benefits include National Health Service Corps (NHSC) placements of qualified medical staff, improved facilities and laboratory services, enhanced Medicare reimbursements, Community Health Center Grants and other federal or State programs.

HPSAs are also designated, mostly in poorer communities. Currently, the state has 104 designations covering 94 towns in the eight counties. DPH works with NHSC, which provides employment or financial incentives, to place both U.S. and non-U.S. citizen health professionals in the underserved and professional shortage areas. Non-citizen physicians who meet all the State licensing and U.S. Citizenship and Immigration Services (UCSIS) requirements may apply and be considered to practice in a shortage area through 1) the National Interest Waiver (NIW) program[125], 2) the Conrad 30 J-1 or 3) HHS J-1 visa programs.

Additional information on how these designations have been utilized to improve access to health care services in the state is provided in Chapter 9.

7.4.2 THE SAFETY NET SYSTEM

"Safety net providers" are those who either by mandate offer health care services regardless of patients' ability to pay, or by mission have a patient mix that consists mostly of the uninsured, Medicaid beneficiaries, inner city and rural poor and other vulnerable populations.[126] Public hospitals and clinics are widely accepted as safety net providers, the description

[122]Mellow, J., Hoge, S.K., Lee, J.D., Natarajan, M., Yu, Sung-suk, V., Greifinger, R.B., Belkin, G. (2008, May). *Mapping the Innovation in Correctional Health Care Service Delivery in New York City*. Robert Wood Johnson Foundation for New York City Department of Correction. Retrieved from http://www.jjay.cuny.edu/NYCMappingHeathCare.pdf

[123]DeCesaro, A., & Hemmetter, J. (2009, February). Unmet Health Care Needs and Medical Out-of-Pocket Expenses for SSI Children. *Journal of Vocational Rehabilitation 30 (2009)*, 177-199.

[124]Connecticut Department of Public Health. (2011, October). *Health Care for Connecticut's Underserved Population, Identifying and Assisting the Medically Underserved in Connecticut*. Retrieved from http://www.ct.gov/dph/lib/dph/hisr/pdf/medically_underserved_issuebrief2011.pdf

[125]Interested physicians and employers may visit www.uscis.gov or federal requirements and contact the DPH Planning Branch at (860) 509-7658 for a form to obtain a letter from DPH attesting to licensure, to shortage practice location, and that granting this visa is "in the public interest."

[126]Institute of Medicine. (2000). *American's Health Care Safety Net: Intact but Endangered*. M. E. Lewin, & S. Altman (Eds.). Health Policy Programs and Fellowships. Washington, DC: National Academy Press.

is more inclusive, though many private health care providers opt out of serving Medicaid recipients, disadvantaged or uninsured patients.[127] Even with the planned coverage expansion in the PPACA, it is expected that some people may remain uninsured and continue to rely on the safety net system for their health care needs. Additionally, the expansion is expected to increase the number of Medicaid beneficiaries, creating additional strain on existing capacity from people seeking care once they have coverage. It is therefore important that the safety net system is effective and remains financially viable.

7.4.2.1 Safety Net Hospitals

By federal law, all emergent, non-elective patients at Connecticut's general hospitals must receive treatment, regardless of ability to pay. Sometimes hospitals are not reimbursed or compensated for the care they provide. This uncompensated care is either charity care, when the hospital knows in advance that the care provided will not be reimbursed, or bad debt incurred after the service has been provided, with no forewarning of non-payment. Bad debt and charity care were two-thirds and one-third, respectively, of $647.3 million in uncompensated care charges in hospital fiscal year (FY) 2010.[128] The State and federal government jointly fund the Disproportionate Share Hospital (DSH) programs. These programs are designed to assist hospitals financially with their uncompensated and undercompensated[129] care costs. The DSH programs provide supplemental reimbursement to offset these shortfalls to help hospitals continue in their role as a safety net to patients with limited access to health care. The Connecticut Department of Social Services (DSS) administers uncompensated care related programs including the Connecticut Medicaid DSH programs, in accordance with an approved State plan.

7.4.2.2 Safety Net Community-Based Providers

7.4.2.2.1 Community Health Centers (CHCs)

Services CHCs provide include general primary medical care, preventive dental care, screenings and behavioral health treatments and counseling. Additional details on community health centers are provided in Chapter 9.

7.4.2.2.2 School-Based Health Centers

School-based health centers (SBHCs) are licensed outpatient facilities that offer comprehensive services to address medical, mental and oral health needs of students in grades pre-K through 12 during the academic year. Additional details on school based health centers are provided in Chapter 9.

7.4.2.2.3 Local Health Departments

Local health departments (LHDs) are State-funded government entities that provide population-based essential public health services in their local areas. These public health activities include disease prevention and control, infectious disease control and environmental health in the community.

There are 50 full-time LHDs in 29 individual towns and 21 districts of two to 18 towns, serving 144 Connecticut towns and 95% of the state's residents; additionally, 25 LHDs are part-time and serve the remaining 25 towns and 5% of the population.

LHDs, other health care providers and refugee settlement agencies, assist DPH in its Refugee and Immigrant Health Program. Upon entry into Connecticut, each refugee[130] receives an initial health assessment, medical care for conditions that are potentially significant for public health, treatment for chronic conditions, and referrals for other health care services such as mental health and family planning.

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[127]Jones, A.S., & Sajid, P.S. (2010, June). A Primer on Health Care Safety Nets. *Robert Wood Johnson Foundation*.

[128]Connecticut Department of Public Health. (2011, September). *Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2010*. Retrieved from http://www.ct.gov/dph/lib/dph/ohca/publications/2011/fsreport2010.pdf

[129]Undercompensated care generally refers to government programs, like Medicaid, which tend to provide lower rates of reimbursement.

[130]U.S. Department of Health and Human Services, Office of Refugee Resettlement (ORR) defines a refugee as "Any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion…"

Twelve LHDs operate licensed outpatient clinics authorized to provide ambulatory medical or dental care for local residents with chronic or acute medical conditions; these outpatient clinics also provide preventive and health maintenance care services. Additional details on LHD or municipality clinics are provided in Chapter 9.

7.4.3 PHYSICIAN NETWORKS AND SPECIAL SERVICE PROVIDERS

Many private health care practitioners opt out of providing care to the uninsured or participating in government funded programs, especially Medicaid. Only a few physicians, nurses and other specialty care providers donate time or discounted services in their own settings or at a free clinic to disadvantaged patients, the underinsured, the uninsured and /or Medicaid beneficiaries who lack access to care.

In 2010, uncompensated or charity care for private office-based physician visits in the U.S. was estimated at $5.1 billion. The aggregate associated costs, number of health care providers that fall in this category, and state residents that benefit from such services in Connecticut is not known. In 2010, eight free clinics provided approximately $7.3 million of free medical, behavioral and dental services.[131] These clinics provide at least one basic health care service that may be primary care, reproductive health, pharmaceutical, specific health condition or medication arrangement related. Generally free clinics are funded through private charitable donations from civic groups, churches, foundations and business organizations.[132] Chapter 9 provides more information on free clinics.

7.4.4 NEWBORN SCREENING PROGRAM[133]

Newborn screening identifies infants at increased risk for diseases that timely medical treatment can avert complications and prevent irreversible problems and death. Connecticut State law mandates screening newborns within the first 4 days of life for selected genetic and metabolic disorders. Specimens are tested at the DPH State Laboratory; all abnormal results are reported to the DPH Tracking Unit, which reports the results to the primary care providers; and assures referrals are made to the State-funded Regional Treatment Centers for confirmatory testing and treatment.

Regional Treatment Centers provide comprehensive testing, counseling, education, treatment, and follow-up services. The Tracking Unit coordinates and provides educational programs, guidelines, protocols, materials, technical assistance for birthing facilities staff, primary care providers, and health professionals; and provides telephone technical assistance for families and the general public.

7.4.5 CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

The Children and Youth with Special Health Care Needs (CYSHCN) program is for residents under age 22 who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and require health and related services beyond those required for other children.[134]

Approximately 139,453 CYSHCN reside in Connecticut. DPH conducts statewide assessments of the needs of families with such children and providers who serve them, to identify the unmet needs and to assess capacity and performance.

In Connecticut, 16% of children and youth have special needs compared to 13.9% nationally. Four out of five were predominantly racial/ethnic minorities or multi-racial; approximately 6.2% were uninsured sometime in the year, and more than one-third of the insured had inadequate health insurance coverage.[135] With respect to access to care, about 12% of the children experienced an unmet need for a specific health care service; 25% had difficulty in receiving a needed health service referral; almost 4% did not have a personal doctor or nurse, with 4% relying on the emergency room as a usual source of care. More than one in five CYSHCN families paid over $1,000 out-of-pocket in medical expenses annually for the child; as a result a family member had to cut back or stop working to care for the child causing financial difficulties.

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[131]Potteiger, J.L. & Munson, H. (2011, April). CT Free Clinics. *2011 Policymaker Briefing Book. CT Health Policy Project*. Retrieved from http://www.cthealthpolicy.org/cthealthbook/papers/ct_free_clinics.pdf

[132]Darnell, J.S., (2010, June). Free Clinics in the United States: A Nationwide Survey. *Archives of Internal Medicine. Vol. 170 No. 11*. Retrieved from http://www.wafreeclinics.org/admin/mod-cms/viewattachment.php?id=498

[133]Connecticut Department of Public Health Newborn Screen Program. Retrieved from http://www.ct.gov/dph/cwp/view.asp?a=3122&q=387742&dphNav_GID=1601

[134]Connecticut Department of Public Health. Retrieved from http://www.ct.gov/dph/cwp/view.asp?a=3138&Q=387702&PM=1

[135]U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.(2007). *The National Survey of Children with Special Health Care Needs Chartbook 2005–2006*. Rockville, Maryland.

The Connecticut Medical Home Initiative for children and youth with special health care needs builds on policies and programs to provide a system of care that ensures coordinated access to family-centered quality care, adequately trained providers and insurance coverage.[136] The initiative attempts to improve community-based services for these children and their families by facilitating connections among families, agencies and medical homes that are accessible, compassionate, comprehensive, continuous, coordinated, culturally competent and family-centered; and to promote and sustain the medical home model.

7.4.6 HIV/AIDS SERVICES IN CONNECTICUT

DPH administers a program working with various HIV/AIDS service- and community-based organizations to provide free core medical and supportive services to people living with HIV or AIDS (PLWHA) and their families. Services include: medical case management, primary medical care, oral health, mental health, substance abuse-outpatient, medical nutrition therapy, HIV-related medications sponsored temporarily by the DSS Connecticut AIDS Drug Assistance program, health insurance premium and cost sharing assistance, home health care, home-and-community based services, hospice care, medical transportation, housing-related services, food bank/meals, psychosocial support, linguistic services and related emergency financial assistance.

As of December 2010, more than 10,500 people in Connecticut were living with HIV/AIDS with more than 400 newly diagnosed in the same year. HIV/AIDS occurs disproportionately among racial/ethnic minorities, with non-Hispanic blacks and Hispanics accounting for two-thirds of the cases but only one-quarter of the population. PLWHA are twice as likely to be male as female, and seven in ten are between 40 and 59 years of age. Bridgeport, New Haven and Hartford, which are the state's three largest cities with the most Hispanic and non-Hispanic black residents, account for about one-half of the PLWHAs in Connecticut.[137]

The gaps in core medical services to PLWHA are dental care, continuous health insurance coverage, outpatient substance abuse services, mental health services and financial assistance with purchasing AIDS-related medication. Other needs include assistance with support services such as food, housing and medical transportation. Some of the barriers faced by this subpopulation are the fear of their status being revealed, inability to pay for services, housing, and case management.[138]

7.4.7 CONNECTICUT CHRONIC DISEASE PREVENTION PLAN

DPH and its partners are developing a chronic disease prevention plan for cardiovascular disease, cancer, diabetes and asthma. The Plan is expected to be released in December 2012.

It focuses on four modifiable risk factors-- poor nutrition, inadequate physical activity, tobacco use and excessive alcohol use, that are common to these chronic diseases-- and three intermediate risk factors-- high blood pressure, high blood cholesterol, and obesity.

The goal of the plan is to reduce significantly the social and economic impact of chronic disease by targeting the modifiable risk factors the four diseases share. The plan prioritizes prevention and wellness, promotes cost-effective preventive care practices, advances health equity, and specifies goals, outcomes and measures to enable evaluation.

7.4.8 VULNERABLE POPULATION EMERGENCY RESPONSE PROGRAM

DPH's Vulnerable Population Emergency Response Planning program provides an integrated database of the type and scope of care, monitoring, and human services necessary to enable populations with functional disabilities to remain in their homes and communities.

The program goal is to build community resilience, by creating an accessible inventory of services that support non-institutionalized residents of each community with functional needs. Efforts to minimize adverse outcomes related

[136]Connecticut Department of Public Health. *Connecticut Medical Home Initiative for Children & Youth with Special Health Care Needs*. Retrieved from http://www.ct.gov/dph/lib/dph/family_health/children_and_youth/pdf/cmhi_contractor_contact_sheet_072209.pdf

[137]Connecticut Department of Health HIV Surveillance Program. *HIV Infection Cases Diagnosed in 2010 by Sex, Race, and Age*. Retrieved from http://www.ct.gov/dph/lib/dph/aids_and_chronic/surveillance/statewide/ct_hivaids_currentyear_table.pdf

[138]Connecticut HIV Planning Consortium. (2009, October). *Connecticut Comprehensive HIV Care and Prevention Plan: 2009-2012*.

to a disruption of support networks, inaccessible supplies and durable medical equipment, and interruptions of services due to a disaster or public health emergency begin with an assessment of the communities' health and safety needs, and the community-based service providers that provide support and health care.

7.4.9 RURAL COMMUNITY HEALTH PLANNING[139]

Public transportation is one of the top barriers to care in rural areas. Moreover, community health centers and rural hospitals experience difficulty in recruiting and retaining professional staff.[140] The 61 rural communities in Connecticut are well serviced by a network of community based primary care providers, mental health and substance abuse providers, and hospitals. Primary care providers are based closer to hospitals and therefore are not easily accessible to rural residents, most of whom have no private transportation. Residents have to travel out of their local areas to major medical centers to obtain specialty services. Although specialty care providers have opened satellite locations in suburban towns close to some rural towns, most providers are either not accepting new patients or Medicaid patients, making specialty medical care inaccessible to low-income residents of rural towns. Health care providers in rural towns have identified transportation, substance abuse, domestic violence, and translation services as the top five health care related services needed.

As part of rural community health planning activities involving DPH, several towns bordering rural areas have been designated HPSAs to assist with health care professional related capacity issues. The Connecticut State Office of Rural Health (CT-ORH) has recommended interfacing with DPH to ensure that public health planning activities take into account the needs of rural areas. CT-ORH assists rural communities to locate funding sources and partners with philanthropic funders to help develop and implement plans that promote healthy communities. For example in 2011, CT-ORH assisted Northwestern Connecticut Community College in establishing a new associate nursing degree program; through the Community Health Centers Association grant, the office participated in the Student Experiences And Rotations Health (SEARCH) program to offer students clinical experience and placement in the area; and also offered competitive grants for preventive health care, behavioral health and emergency medical services training. To improve transportation-related barriers in rural communities over time, the Connecticut Department of Transportation (DOT) has implemented two initiatives, the Locally-Coordinated Public Transit Human Services Transportation Plan, which identifies transportation types, destinations, funding sources and gaps in services in these communities; and United We Ride, which is a federal initiative to coordinate transportation services in the state.

7.5 DEPARTMENT OF SOCIAL SERVICES PROGRAMS

The Department of Social Services (DSS) provides and administers a broad range of health care-related services to the elderly, persons with disabilities, families, and individuals through programs authorized by State and federal legislation. Some of the programs and the populations they serve are described below.

7.5.1 CONNECTICUT MEDICAID PROGRAM[141]

DSS funds and provides a free or low-cost health insurance coverage program for low-income elderly, blind, or disabled persons, and families with children. The Medicaid program is administered by DSS in adherence to Title XIX of the Social Security Act, the federal Medicaid law, to qualify for 50% reimbursement from the federal government. The program provides different plans and benefits to low-income subpopulations. Payments for health care services provided under each plan are made directly to providers.

The Healthcare for UninSured Kids and Youth (HUSKY) plan provides coverage for children and teenagers less than 20 years of age, based on family income, and pays for services such as doctor visits, prescriptions, and vision and dental care. Children under 19, their parents or relative caregivers and pregnant women with family income up to 185% of federal poverty level (FPL) receive coverage under HUSKY A; uninsured children in families with incomes between 185% and 300% and their families may qualify for coverage under HUSKY B on a sliding scale.

The plan for the aged, the blind or disabled individuals between ages 18 and 65, HUSKY C or Title 19, is based on

[139]Connecticut Office of Rural Health. (2011, November). *Annual Report*. Retrieved from http://ruralhealthct.org/assets/Annual_Report_2011.pdf

[140]State of Connecticut Office of Rural Planning. (2006, June). *Rural Community Health in Connecticut: Challenges and Opportunities*. Prepared by Holt, Wexler & Farnam, LLP.

[141]Connecticut Department of Social Services. (2012). *HUSKY and Medicaid*. Retrieved from http://www.ct.gov/dss/cwp/view.asp?a=2353&q=490478

income and asset limits.[142] Benefits under the plan include approved medical goods and services; outpatient, hospital and nursing home care; prescriptions; and private health insurance premium assistance, if cost effective.

In 2010, Connecticut was the first state to expand the Medicaid program to cover recipients of State Administered General Assistance (SAGA) under PPACA. This program, HUSKY D or Medicaid for low-income adults, provides health insurance coverage for single adults or married adults between ages 19 and 64, who are not pregnant and do not receive federal Supplemental Security Income or Medicare, with incomes below 56% of federal poverty levels.[143] Beneficiaries receive full Medicaid benefits, long term care, home health care and non-emergency transportation.

7.5.2 CONNECTICUT PRE-EXISTING CONDITION INSURANCE PLAN[144]

DSS contracts with the Health Reinsurance Association to operate Connecticut's Pre-Existing Condition Insurance Plan (CT PCIP). Formerly the temporary high-risk pool program, CT PCIP currently provides federal subsidies available through the PPACA. CT PCIP is open to Connecticut residents who have qualified, diagnosed medical conditions and have been uninsured for 6 months. The plan premium is a flat rate pre-approved by the federal government and provides comprehensive medical benefits coordinated through the UnitedHealthcare provider network.

7.5.3 CHARTER OAK HEALTH PLAN[145]

The Charter Oak Health Plan is a State-funded health insurance program administered by DSS since 2008 and offered to uninsured adults of all incomes, from ages 19 through 64 who do not qualify for the pre-existing condition insurance plan or HUSKY Health. Charter Oak offers a full range of coverage, including preventive care, emergency room and hospital visits, primary care and specialist physicians, pharmacy, behavioral health services, prescription medications and a total lifetime benefit of $1 million. By statute, Charter Oak enrollees cannot have been covered by health insurance during the preceding six months. However, applicants can request an exception to this waiting period for factors such as job loss, financial hardship or loss of HUSKY Plan eligibility due to age or income. Premiums are subsidized based on income levels and family size.

7.6 HEALTH INSURANCE EXCHANGE

The PPACA enabled creation of health insurance exchanges (HIE) by states for individuals and small employers with fewer than 100 employees to purchase health insurance coverage in an organized and competitive market. HIEs will provide consumers a choice of health plans at competitive rates developed with a set of rules for offering and pricing in this market; accessible easy to understand information on and how to enroll in plans; make the plans portable so that an individual will continue to have coverage even when he/she changes jobs; and reform the insurance market with respect to ensuring non-denial of coverage for pre-existing conditions and minimizing arbitrary premium increases.[146]

Since September 2010, Connecticut has received nearly $115 million in federal funding for activities related to establishing a State HIE to increase access to affordable health coverage and reduce Connecticut's almost 378,000 underinsured and uninsured. Funded activities include background research, consulting with stakeholders, making legislative and regulatory changes, establishing the administrative structure, staff and a customer support program for the exchange, and developing an IT system and a system for ensuring program oversight and integrity by December 2014.

Through the Governor's Office of Health Reform and Innovation, as part of PPACA implementation, the State is also receiving technical support from the National Academy of State Health Policy to educate health reform leaders on health equity issues, strategies to address disparities, and to measure effectiveness; to create a system to maximize participation of rural and, low-income and minority populations in Medicaid and HIE; and to improve Medicaid clients' transition to a person-centered system of service delivery.[147]

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