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Access to Primary Care For Hartford Children in HUSKY A: 2005

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INTRODUCTION

A medical home, as defined by the American Academy of Pediatrics (AAP), is an ongoing source of care that is “accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.”¹ Ensuring that all children have a medical home is a national child health care reform priority. The United States Department of Health and Human Services’ *Healthy People 2010* program includes the goal that all children with special health care needs will receive regular ongoing comprehensive care within a medical home.² Further, several federal programs require that children have a continuously available source of care. For example, the Title V Maternal and Child Health Services Block grantees are required to report on the medical home among children with special health care needs.³ The AAP recommends that ALL children have a medical home for ensuring healthy growth and development.

Assessing the extent to which children do in fact have medical homes is methodologically challenging, given the many dimensions that define a medical home. The AAP definition of medical home, for example, includes seven different domains and 37 conceptual measures. Tools such as the Medical Home Index⁴ have been developed and widely disseminated to facilitate the measurement of the medical home; however, the data collection process is both resource-intensive and time-consuming. Population-based data from the Medical Expenditure Panel Survey or the National Survey of Children with Special Health Care Needs, for example, can be used to measure medical home, but offer only limited information about the medical home at the state level and may be inconsistent in assessment of medical home criteria.⁵

In the absence of a national provider identification system, it is not possible to use Medicaid claims data to assess the degree to which children see an individual provider consistently over time. It is, however, possible to determine whether children receive care in a single primary care site where providers would presumably have access to records for previous visits. Assessing primary care site utilization using administrative data is therefore an efficient, cost-effective alternative to surveys and medical record reviews aimed at assessing patterns of primary care for children in a Medicaid program. This approach to investigating “medical home” is quantitative rather than qualitative. Developing a methodology for mining Medicaid claims data to assess patterns in primary care site utilization allows for monitoring the primary care delivery system as part of ongoing state-level performance monitoring.

¹ American Academy of Pediatrics. 2002. Medical Home Initiatives for Children with Special Needs Project Advisory Committee. “Medical Home.” *Pediatrics* 110(1): 184-186.

² U.S. Department of Health and Human Services. *Healthy People 2010*. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000. Goal 16-2. Available at: <http://www.healthypeople.gov/Document/tableofcontents.htm#Volume2>.

³ Performance indicators reported by Title V Maternal and Child Health Services Block grantees may be found at: <ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf>.

⁴ Center for Medical Home Improvement. The Medical Home Index 2006: A Measure of Medical “Homeness.” Greenfield, NH: CMHI, 2006. Available at: <http://www.medicalhomeimprovement.org/outcomes.htm>.

⁵ Bethell, C.D., et al. Using Existing Population-based Data Sets to Measure the American Academy of Pediatrics definition of medical home for all children and children with special health care needs. *Pediatrics* 113(5 Suppl): 1529-1537.

PURPOSE

The purpose of this study was to determine whether children in a Medicaid managed care program have access to ongoing care in a primary care site. This study was conducted as part of an overall program of independent performance monitoring in Connecticut's HUSKY Program.⁶

- To describe general patterns of primary care utilization by Hartford children who were continuously enrolled in HUSKY A in 2005;
- To estimate the proportion of Hartford children who had access to a primary care site in 2005; and
- To investigate the association between having access to a primary care site and having emergency care for ambulatory care sensitive conditions.

METHODS

Design & Data

This study describes access to a primary care site among Hartford children who were continuously enrolled in HUSKY A in calendar year 2005. Three datasets were linked to analyze site of primary care in HUSKY A: (1) HUSKY A enrollment files; (2) HUSKY A encounter data files; and (3) provider data files maintained by a data vendor for the Connecticut Department of Social Services.

Using HUSKY A enrollment data, children aged 0 to 20 years who were residents of Hartford and continuously enrolled (any plan) between January 1 and December 31, 2005 were identified. The scope of this investigation was limited to care received by children living in Hartford in 2005 for the following reasons: 1) a relatively large proportion of all children enrolled in HUSKY A reside in Hartford; 2) the health care delivery system in Hartford is largely hospital- and clinic-based; and 3) provider data used to study primary care site had to be manually sorted. HUSKY A encounter data for Hartford children were searched for records corresponding to ambulatory care received during that one-year period.⁷ Encounter records were then matched with the provider file using billing provider identification numbers.

A significant proportion of service provider records were either missing the provider identification number or the identification number was the same as the billing provider identification number. Therefore, billing provider, as reported on all encounter records, was used to determine the service

⁶ Connecticut Voices for Children is a non-profit organization that conducts research and policy analysis on children's issues. This report on medical home was prepared under a contract between the Connecticut Department of Social Services and the Hartford Foundation for Public Giving, with a grant to Connecticut Voices from the Hartford Foundation. Connecticut Voices for Children contracts with MAXIMUS, Inc. for data management data analysis. This report was prepared by Mary Alice Lee, Ph.D., Senior Policy Fellow, with assistance from Karen M. Sautter, M.P.H., and Amanda Learned, B.A. This publication does not express the views of the Department or the State of Connecticut. The views and opinions expressed are those of the authors.

⁷ Well-child care (EPSDT screening exams): Encounter records with CPT-4 codes for preventive care (99381-5, 9938R, 9938T, 99382, 99391-5, 9939R, 9939T, 99431, 9943R, or 9943T) when accompanied by any diagnosis code; UB-92 revenue codes (092, 093, 094) when accompanied by any diagnosis code; CPT-4 codes for evaluation and management (99201-5, 99211-5, 99432) and clinic codes (510, 515) when accompanied by well-child diagnosis (v20 series, v70, v70.0, v70.3-v70.9); outpatient care: CPT-4 codes (99201-5, 99211-99205, 99432-3), clinic codes (510, 514, 515, 516, 519, 3000Y), or UB-92 revenue codes (450, 456, 459) with any diagnosis other than well-child.

provider site. Records for billing provider were aggregated and grouped by site using information found in the Medicaid provider files, the Connecticut Medical Assistance Program provider search engine,⁸ the Connecticut Department of Public Health physician licensure database,⁹ review by a Hartford pediatrician,¹⁰ and search of the Yellow Pages. These steps were taken because single billing providers (e.g., Connecticut Children’s Medical Center) may be associated with different types of providers and provider entities (e.g., emergency care physicians, professional physician services, hospital care units) using different provider site identification numbers. Encounter records with billing provider site identification numbers that did not match to any found in provider files were labeled “unknown.”¹¹ The limitation of choosing to use billing provider site as a means of approximating service provider is discussed later in this section.

Measures

“Access to a primary care site” was operationally defined as summarized in Table 1. Children were counted as having had access to a primary care site if they met one of the following five criteria: (1) had one well child visit; OR (2) if two or more well-child visits were received, had all well-child visits with a single (billing) provider; OR (3) had at least one well-child visit and at least one office or clinic visit with a single (billing) provider; OR (4) if only two office/clinic visits were received, both occurred with a single (billing) provider; OR (5) if three or more office/clinic visits were received, at least half occurred with a single (billing) provider.

Table 1. Operational Definition of Access to a Primary Care Site

	Evidence of a primary care site?
Had one well-child visit with single provider^a	YES
If two or more well-child visits, had all visits with a single provider	YES
Had well-child visit + at least one office/clinic visit with single provider	YES
If two office/clinic visits only, had all visits with a single provider^b	YES
If three or more office/clinic visits, had at least half of those visits at a single site of care	YES
Had one office/clinic visit only	NO
Had more than one office or clinic visit with fewer than half of all visits with a single provider	NO
Had emergency care only	NO
Did not have any office/clinic visits	NO

^a Including well-baby visits every 3 or 6 months with single provider

^b Including children 6-10 who may not have annual well-child visit.

Children who had just one office/clinic visit were not counted as having had access to a primary care site. Children who had emergency care only and those without office/clinic visits for any diagnosis were not counted as having had access to a primary care site.

⁸ The Connecticut Medical Assistance Program provider search engine is available at: <http://www.ctmedicalprogram.com/webApps/providerSearchAdvanced.do>.

⁹ The Connecticut Department of Public Health physician licensure database is available at: http://www.dph.state.ct.us/MD_Profile/hlthprof.htm.

¹⁰ List reviewed with Richard Antonelli, MD, MPH, Chief, Division of Primary Care and Director, Department of General Pediatrics, Connecticut Children’s Medical Center.

¹¹ 972 of 81,238 encounter records (1.2%) had unknown billing providers.

Analysis

The sociodemographic characteristics of the sample (i.e., age, gender, race/ethnicity, primary language, and health plan) were described. Utilization patterns of the sample population were tabulated. Utilization rates for any care, any well-child care, any outpatient care (office or clinic visits), any emergency care, and no care were determined by comparing the number of children who had (or did not have) care to the number who were continuously enrolled during the study period. Health care utilization rates were stratified by age, gender, race/ethnicity, primary language, and health plan.

The proportion of children with a primary care site was calculated overall, and for each operational definition category described in Table 1, by age group (<6, 6-10, 11-15, 16-20), gender, race/ethnicity, primary language, and managed care plan. The proportion of children who had a primary care site was determined by comparing that number of children with a primary care site to both the number of children who (1) received primary care (well-child care and/or office or clinic visits), or (2) were enrolled during the study period. Chi-square analysis (χ^2) was employed to determine the association between sociodemographic variables of interest (i.e., age, gender, race/ethnicity, primary language, and health plan) and having a primary care site (that is, across all categories of primary care site in Table 1). Statistically significant relative risk values at the $p < 0.05$ level are reported.

In theory, children with access to primary care should be less likely to use the emergency room for non-urgent conditions that can be treated in a primary care setting. To determine whether having a primary care site affected the rate at which children seek care for ambulatory care sensitive conditions¹² (ACSC), emergency care utilization by children who did and did not have primary care site was compared (χ^2).

Limitations

The results of this study should be interpreted with caution for the following methodological reasons:

- This study estimates the proportion of children who had access to a primary care site in 2005. Having an actual medical home, as defined by professional medical organizations such as the AAP, involves study of components of care far beyond what can be analyzed using administrative data alone—for example, non-billable services such as care coordination, trust between family and provider, and provider cultural competence. The study approximates the universe of Hartford children enrolled in HUSKY A who *may* have had an ongoing source of care.
- In the absence of a unique provider identification number for each service provider, this study used the billing provider identification number to approximate the actual service provider for

¹² Emergency care: CPT-4 codes (99281, 99282, 99283, 99284, 99285) and UB-92 revenue codes (450, 456, 459). Ambulatory-care sensitive conditions were defined by the following ICD-9-CM codes: 090 (congenital syphilis); 033, 037 (immunization preventable conditions); 345, 780.3 (grand mal status and other epileptic convulsions); 493 (asthma); 382, 462, 463, 465, 472.1, 20.01 (severe ear, nose, and throat infections); 481, 482.2, 482.3, 482.9, 483, 485, 486 (bacterial pneumonia); 011-018 (tuberculosis); 250.0-250.3, 250.8, 250.9 (diabetes A, B, and C); 251.2 (hypoglycemia); 681-683, 686 (cellulitis); 558.9 (gastroenteritis); 590, 599.0, 599.9 (kidney or urinary infection); 276.5 (dehydration); 280.1, 280.8, 280.9 (iron deficiency anemia); 260-262, 268.0, 268.1 (nutritional deficiencies); and 783.4 (failure to thrive).

each encounter. Using the administrative site (i.e., specific payer) as a proxy for the individual service provider or site of care is imperfect, at best. For example, children may utilize several service providers who have the same billing provider identification number, leading to an overestimate of the proportion of children who had a true primary care site (i.e., a single primary care provider).

- The billing provider site identification number did not always match to an existing provider or billing identification number in the Mercer provider file, creating missing values. Since unmatched encounter records and associated enrollees were excluded from the analysis, this study may not offer a complete picture of children with a primary care site in Hartford.
- The billing provider site was identified through review of current databases on the Internet. In some cases, it was not possible to determine the actual billing provider site because some providers had not remained in the same practice situation since the 2005 study period. Further, providers who practiced in Hartford in 2005 may have left the area in the middle of the year, causing some children to switch providers during the year. This may exclude some children from being classified as having evidence of a primary care site.
- This study does not represent the experiences of all children enrolled in HUSKY A, as children who were not continuously enrolled or live outside of Hartford are not represented.
- Data were not available for primary care visits that were delivered by providers who do not participate in the HUSKY managed care program or whose services were paid for by other insurance; the result may be an underestimate of the number of children with access to a primary care site.
- Children with special healthcare needs may have ongoing, continuous access to a specialty care site that also meets their primary care needs, but specialty care was not examined in this study.
- Encounter data were not audited for reliability prior to being studied.

RESULTS

Profile of Hartford Children in 2005

In 2005, 19,963 children residing in Hartford were continuously enrolled in HUSKY A.¹³ The majority of children was Hispanic (56.2%), enrolled in Blue Care (63.4%), English speaking (80.9%), and 9.3 years of age on average. Sociodemographic characteristics did not vary widely by managed care plan. Sociodemographic and enrollment characteristics of all Hartford children who were continuously enrolled in HUSKY A in 2005 are shown in **Table 2**.

Ambulatory Care Utilization

Most Hartford children had some primary care in 2005. Among the 19,963, 16,105 or 81 percent of Hartford children received primary care—that is they had well-child care and/or office or clinic visits for diagnoses other than well care (**Table 3**). One in six Hartford children did not receive any primary care during 2005, despite continuous coverage.

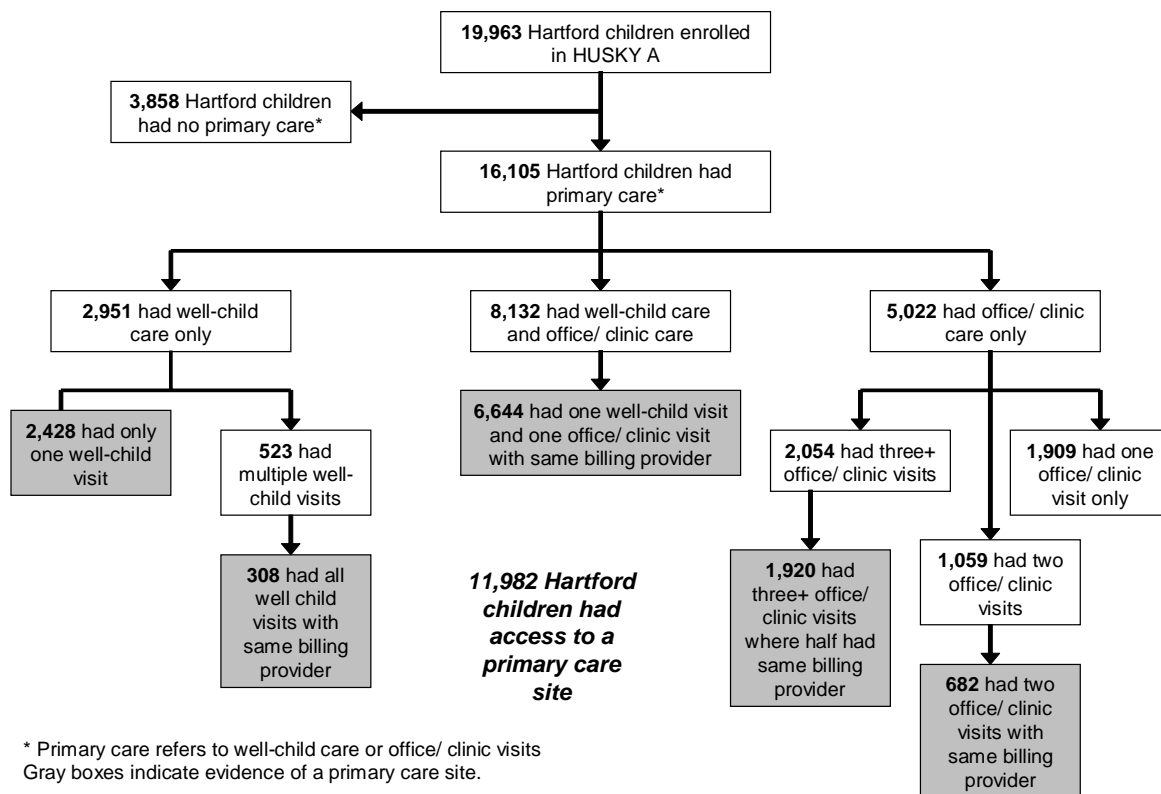
¹³ Hartford children=12 percent of all HUSKY A enrollees aged 0 to 20 years who were continuously enrolled that year (169,580).

Among the 16,105 children who received any primary care, 18 percent had only well-child care, 50 percent had only office or clinic visits for diagnoses other than well care, and 31 percent had both well-child care and office or clinic care. Hartford children made an average of 1.4 well-child visits, compared to 3.3 office/clinic visits for any diagnosis (**Table 4**).

Access to a Primary Care Site

Figure 1 presents the algorithm used to identify children with evidence of access to a primary care site and the number of children with evidence of access to a primary care site by the criteria described in Table 1. Sixty percent of all Hartford children continuously enrolled in HUSKY A in 2005 had evidence of access to a primary care site. Among the 16,105 Hartford children who had any primary care during 2005, 74 percent (11,982) had evidence of having access to a primary care site (**Table 5**). Among the 2,951 children who received *only* well-child care, 93 percent had evidence of a primary care site according to the criteria in Table 1, compared to 82 percent who had both well-child care and office/clinic visits, and just 52 percent of children with *only* office/clinic visits.

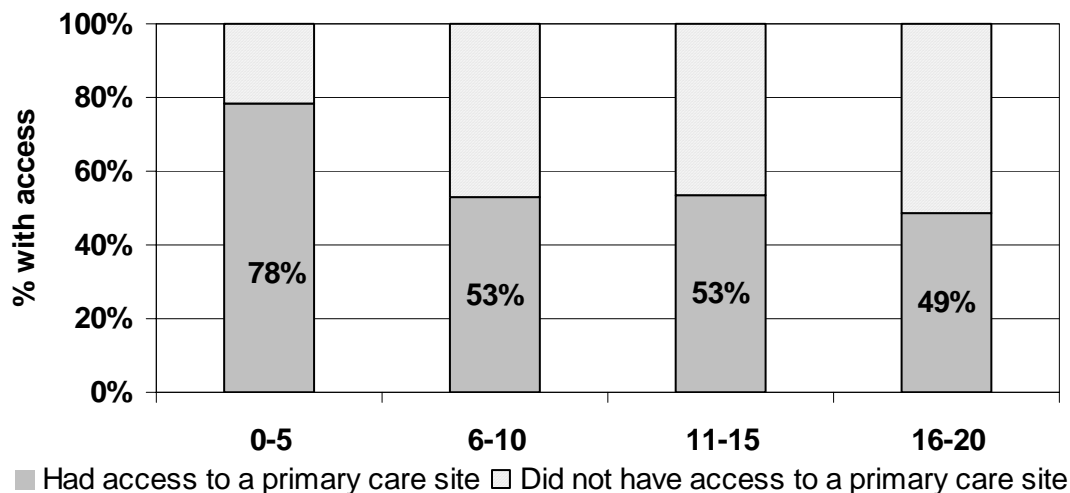
Figure 1. Access to a Primary Care Site Among Hartford Children Continuously Enrolled in HUSKY A, 2005



Several sociodemographic factors were predictive of children in Hartford having access to a primary care site:

- **Age:** Younger children were more likely to have access to a primary care site than older children.¹⁴ Children aged 5 years or younger were 50 percent more likely to have access to a primary care site than all other children (**Figure 2**).

Figure 2. Access to a Primary Care Site by Age, Hartford 2005



- **Gender:** Female children were more likely to have access to a primary care site than male children (61.4% female children compared to 58.7% of male children).¹⁵
- **Race/ethnicity:** Compared with all other Hartford children, Black children were slightly more likely and Hispanic children were slightly less likely to have access to a primary care site. There was no difference in access to a primary care site for White children and children belonging to other racial/ethnic groups.¹⁶
- **Primary language:** Children in English-speaking households were more likely and children in Spanish-speaking households were less likely to have access to a primary care site.¹⁷
- **Health plan:** Compared with all other children, children enrolled in BlueCare were slightly less likely and children enrolled in HealthNet were slightly more likely to have access to a primary care site.¹⁸

¹⁴ RR_{0-5: all other} = 1.50 (1.47-1.53); RR_{6-10: all other} = 0.85 (0.82-0.87); RR_{11-15: all other} = 0.86 (0.83-0.88); RR_{16-20: all other} = 0.79 (0.76-0.82).

¹⁵ RR_{female: male} = 1.05 (1.02-1.07).

¹⁶ RR_{Black, non-Hispanic: all other} = 1.06 (1.04-1.08); RR_{White, non-Hispanic: all other} = 1.05 (1.00-1.10); RR_{Hispanic: all other} = 0.93 (0.91-0.96); RR_{Other groups: all other} = 1.06 (0.94-1.18).

¹⁷ RR_{English: all other} = 1.05 (1.02-1.08); RR_{Spanish: all other} = 0.95 (0.92-0.98); RR_{Other languages: all other} = 0.99 (0.85-1.14).

¹⁸ RR_{BlueCare: all other} = 0.96 (0.94-0.99); RR_{CHNCT: all other} = 1.02 (0.98-1.06); RR_{HealthNet: all other} = 1.06 (1.02-1.11); RR_{Preferred One: all other} = 1.02 (0.98-1.07); RR_{Changer: all other} = 1.01 (0.97-1.04).

Emergency Care for Ambulatory Care Sensitive Conditions

Contrary to expectations, children with access to primary care were over 60 percent more likely to have sought emergency care for ambulatory care sensitive conditions than children without access to a primary care site (Table 6).¹⁹

Table 6. Access to a Primary Care Site and Emergency Care for Ambulatory Care Sensitive Conditions

Had a access to a primary care site?	Had emergency care?		TOTAL	Percent with emergency care
	YES	NO		
YES	2,060	9,922	11,982	17.2%
NO	826	7,155	7,981	10.3%
TOTAL	2,886	17,077	19,963	14.5%

RR_{access to a primary care site: no access to a primary care site} = 1.66 (1.54-1.79)

DISCUSSION

This study demonstrated that while methodologically challenging, it is feasible to use Medicaid administrative data to operationalize a definition of access and to identify children who have access to a primary care site. While the strategy employed in this study does not identify children who have a *true* medical home in any qualitative sense, it perhaps more importantly helps identify children who do not appear to have had access to a primary care site. Assuming that Medicaid is the only source of coverage for children included in our study, there is evidence that 40 percent of Hartford children did not have access to a primary care site. The good news is that among children who had any primary care, 74 percent had evidence of access to a primary care site. Compared to findings from Peterson et al. (2002) in which 50 percent of children saw an individual primary care provider (vs. group provider or provider site) and had at least one well-child visit, Hartford children may be better connected to primary care sites.

Age clearly plays a role in whether children have access to or seeks care at a primary care site. As one might expect, the younger a child, the more likely the child was to have access to a primary care site: 78 percent of children under 6 who had any primary care met the criteria for access to a primary care site, probably due to the intensity of care that is promoted during early childhood. This finding indicates that the program challenge may lie in keeping parents engaged in primary care as their children age. Families in Medicaid risk discontinuity in health care services due to factors such as changing socioeconomic circumstances, disrupted living arrangements, and gaps in coverage, so establishing access to a primary care site is an even more challenging prospect.

Many children with access to primary care sites also obtained emergency care for ambulatory care sensitive conditions. These results are consistent with results from an earlier study showing that two in five children in HUSKY A had emergency care for an ambulatory care sensitive condition in a one-year period.²⁰ One in four emergency visits were for ambulatory care sensitive conditions, with the largest percentage (62%) for treatment of severe ear, nose and throat conditions. Among

¹⁹ RR_{access to a primary care site: no access to a primary care site} = 1.66 (1.54-1.79).

²⁰ Connecticut Voices for Children. Emergency care for children in HUSKY A: 2005. New Haven, CT: CT Voices, 2007.

children with any emergency care, younger children and Hispanic children were most likely to have had emergency care for ambulatory care sensitive conditions. Findings in both these studies may be due to any number of explanations that warrant further investigation. For one, children who are most likely to have access to primary care may be those children with ongoing needs or those whose families are generally more inclined to seek care. It is also possible that the conditions for which they obtained emergency care may not have been entirely preventable in the context of well-child visits or primary care for other, even related diagnoses. Perhaps more intensive or frequent primary care visits might have averted the need for emergency care. Another possible explanation is that families of children seen in hospital clinics may not distinguish between the hospital clinic for daytime care and the emergency department for after-hours services. This finding warrants further investigation into the relationship of access to a primary care site and emergency care for ambulatory care sensitive conditions.

In addition to the methodological limitations previously outlined, this study has other significant limitations. First, the operational definition of “access to primary care” is heavily dependent on having had well-child care. For children 6 to 10 for whom well-child visits are recommended every other year, the definition may not adequately capture children’s relationships to primary care sites and providers. Second, the counterintuitive finding about emergency care utilization casts doubt on the adequacy of the measure used in this report to estimate access to a primary care site.

A primary care site is not necessarily a medical home. Even children who receive regular care from a single provider may never get care that is truly “comprehensive, family centered, coordinated, compassionate, and culturally effective.”²¹ These aspects of care cannot be studied using administrative data alone. In fact, the quality of care received in any primary care setting is most likely to have the greatest impact on health and health care utilization.

CONCLUSIONS

- **There is evidence that many but not all Hartford children who were continuously enrolled in HUSKY A in 2005 had access to a primary care site.**
- **Children who had access to a primary care site were more likely to use emergency care for ambulatory care sensitive conditions than children without access to a primary care site.**
- **Timely implementation of the national provider identification number will improve Connecticut’s ability to monitor care for children with access to primary care sites.**

RECOMMENDATIONS

- **Once the national provider identification system has been adopted in Connecticut’s Medicaid program, revise methods and investigate access to care and continuity of care with individual providers in a variety of practice setting (hospital clinic, community clinic, private office).**

²¹ American Academy of Pediatrics. 2002. Medical Home Initiatives for Children with Special Needs Project Advisory Committee. “Medical Home.” *Pediatrics* 110(1): 184-186.

- **Investigate “medical home” using other research methods (survey, medical record review).**

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Table 2. Hartford Children in HUSKY A by Health Plan, 2005

	All Enrollees		BlueCare		CHNCT		HealthNet		Preferred One		Changed Plans	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	19,963	--	12,658	63.4%	2,307	11.6%	1,605	8.0%	1,484	7.4%	1,909	9.6%
Average Age	9.3	--	9.4	--	9.6	--	9.7	--	8.6	--	9.0	--
Age:												
<6	6,015	30.1%	3,758	29.7%	681	29.5%	463	28.8%	509	34.3%	604	31.6%
6-10	5,349	26.8%	3,424	27.1%	575	24.9%	394	24.6%	424	28.6%	532	27.9%
11-15	5,402	27.1%	3,463	27.4%	631	27.6%	434	27.0%	360	24.3%	514	26.9%
16-20	3,197	16.0%	2,013	15.9%	420	18.2%	314	19.6%	191	12.9%	259	13.6%
Gender:												
Female	9,885	49.5%	6,195	48.9%	1,177	51.0%	779	48.5%	768	51.8%	966	50.6%
Male	9,832	49.3%	6,289	49.7%	1,106	47.9%	801	49.9%	709	47.8%	927	48.6%
Unknown	246	1.2%	174	1.4%	24	1.0%	25	1.6%	7	<1.0%	16	<1.0%
Race/ethnicity:												
Black	7,515	37.6%	4,175	33.0%	711	30.8%	910	56.7%	887	59.8%	832	43.6%
White	1,055	5.3%	722	5.7%	107	4.6%	117	7.3%	59	4.0%	50	2.6%
Hispanic and other groups ^a	11,393	57.1%	7,761	61.3%	1,489	64.5%	578	36.0%	538	36.3%	1,027	53.8%
Primary language:												
English	16,158	80.9%	9,987	78.9%	1,788	77.5%	1,453	90.5%	1,348	90.8%	1,582	82.9%
Spanish and other languages ^b	3,559	17.8%	2,497	19.7%	495	21.5%	127	7.9%	129	8.7%	311	16.3%
Unknown	246	1.2%	174	1.4%	24	1.0%	25	1.6%	7	<1.0%	16	<1.0%

^a Number of children in other racial/ethnic groups was 175; not reported separately in order to minimize the risk of revealing protected health information.

^b Number of children in households with languages other than English or Spanish was 125; not reported separately in order to minimize the risk of revealing protected health information.

Source: CT Voices analysis of HUSKY A enrollment data for continuously enrolled children, obtained from the Connecticut Department of Social Services.

Table 3. Hartford Children in HUSKY A by Type of Care Received, 2005

	All Enrollees		Any Primary Care		HAD PRIMARY CARE					
					Well-Child Care Only		Well-Child Care and Office/Clinic Visits		Office/Clinic Visits Only	
					#	%	#	%	#	%
Total	19,963	--	16,105	80.7%	2,951	17.2%	8,132	47.5%	5,022	29.3%
Average Age	9.3	--	9.1	--	8.1	--	7.8	--	11.3	--
Age:										
<6	6,015	30.1%	5,515	91.7%	1,113	20.2%	3,753	68.1%	649	11.8%
6-10	5,349	26.8%	3,914	73.2%	790	20.2%	1,488	38.0%	1,636	41.8%
11-15	5,402	27.1%	4,364	80.8%	813	18.6%	1,976	45.3%	1,575	36.1%
16-20	3,197	16.0%	2,312	72.3%	235	10.2%	915	39.6%	1,162	50.3%
Gender:										
Female	9,885	49.5%	8,163	82.6%	1,493	18.3%	4,064	49.8%	2,606	31.9%
Male	9,832	49.3%	7,750	78.8%	1,418	18.3%	3,969	51.2%	2,363	30.5%
Unknown	246	1.2%	192	78.0%	40	20.8%	99	51.6%	53	27.6%
Race/ethnicity:										
Black	7,515	37.6%	6,002	79.9%	1,178	19.6%	3,091	51.5%	1,733	28.9%
White	1,055	5.3%	861	81.6%	165	19.2%	474	55.1%	222	25.8%
Hispanic and other groups ^a	11,393	57.1%	9,242	81.1%	1,608	17.4%	4,567	49.4%	3,067	33.2%
Primary language:										
English	16,158	80.9%	13,022	80.6%	2,410	18.5%	6,629	50.9%	3,983	30.6%
Spanish and other languages ^b	3,559	17.8%	2,891	81.2%	501	17.3%	1,404	48.6%	986	34.1%
Unknown	246	1.2%	192	78.0%	40	20.8%	99	51.6%	53	27.6%
Health plan										
Blue Care	12,658	63.4%	10,247	81.0%	1,836	17.9%	5,191	50.7%	3,220	31.4%
CHNCT	2,307	11.6%	1,842	79.8%	322	17.5%	912	49.5%	608	33.0%
Health Net	1,484	8.0%	1,260	84.9%	197	15.6%	643	51.0%	420	33.3%
Preferred One	1,605	7.4%	1,208	75.3%	304	25.2%	615	50.9%	289	23.9%
Changed plans	1,909	9.6%	1,548	81.1%	292	18.9%	771	49.8%	485	31.3%

^a Number of children in other racial/ethnic groups was 175; not reported separately in order to minimize the risk of revealing protected health information.

^b Number of children in households with languages other than English or Spanish was 125; not reported separately in order to minimize the risk of revealing protected health information.

Source: CT Voices analysis of HUSKY A enrollment data for continuously enrolled children, obtained from the Connecticut Department of Social Services.

Table 4. Ambulatory Care Visit Rates for Hartford Children in HUSKY A, 2005

Number of Visits (any type)	Any Well-Child Care		Any Office/Clinic Care	
	Number of children	Percent	Number of children	Percent
1	8,359	75.4%	4,381	33.3%
2	1,583	14.3%	2,785	21.2%
3	603	5.4%	1,863	14.2%
4	325	2.9%	1,188	9.0%
5	134	1.2%	777	5.9%
6+	79	<1.0%	2,160	16.4%
Total	11,083	100.0%	13,154	100.0%
Average number of visits	1.4		3.3	

Source: CT Voices analysis of HUSKY A enrollment data for continuously enrolled children, obtained from the Connecticut Department of Social Services.

Table 5. Hartford Children in HUSKY A with Access to a Primary Care Site, 2005

	All Enrollees		Access to a Primary Care Site Total		Had Access to a Primary Care Site									
					Well-child Care Only				Well-child Care & Office/ Clinic Visits		Office/Clinic Visits Only			
					One well-child visit only		Two or more well-child visits, all with same provider ^c		At least one well child visit and one office/clinic visit with same provider ^c		Two office/clinic visits, both with same provider ^c		Three or more office/clinic visits, at least half with same provider ^c	
#	%	#	%	#	%	#	%	#	%	#	%	#	%	
Total	19,963	--	11,982	60.0%	2,428	20.3%	308	2.6%	6,644	55.4%	682	5.7%	1,920	16.0%
Age:														
<6	6,015	30.1%	4,701	78.2%	779	16.6%	200	4.3%	3,358	71.4%	118	2.5%	246	5.2%
6-10	5,349	26.8%	2,832	52.9%	741	26.2%	34	1.2%	1,218	43.0%	248	8.8%	591	20.9%
11-15	5,402	27.1%	2,886	53.4%	696	24.1%	56	1.9%	1,375	47.6%	168	5.8%	591	20.5%
16-20	3,197	16.0%	1,563	48.9%	212	13.6%	18	1.2%	693	44.3%	148	9.5%	492	31.5%
Gender:														
Female	9,885	49.5%	6,073	61.4%	1,216	20.0%	155	2.6%	3,319	54.7%	333	5.5%	1,050	17.3%
Male	9,832	49.3%	5,773	58.7%	1,178	20.4%	151	2.6%	3,251	56.3%	344	6.0%	849	14.7%
Unknown ^d	246	1.2%	136	55.3%	34	25.0%	3	2.2%	74	54.4%	5	3.7%	21	15.4%
Race/ethnicity:														
Black	7,515	37.6%	4,676	62.2%	977	20.9%	155	3.3%	2,663	57.0%	245	5.2%	636	13.6%
White	1,055	5.3%	662	62.7%	135	20.4%	18	2.7%	395	59.7%	34	5.1%	80	12.1%
Hispanic and other groups ^a	11,393	57.1%	6,644	58.3%	1,316	19.8%	135	2.0%	3,586	54.0%	403	6.1%	1,204	18.1%
Primary language:														
English	16,158	80.9%	9,795	60.6%	1,983	20.2%	266	2.7%	5,499	56.1%	546	5.6%	1,501	15.3%
Spanish and other languages ^b	3,559	17.8%	2,051	57.6%	411	20.0%	40	2.0%	1,071	52.2%	131	6.4%	398	19.4%
Unknown ^e	246	1.2%	136	55.3%	34	25.0%	2	1.5%	74	54.4%	5	3.7%	21	15.4%
Health plan														
Blue Care	12,658	63.4%	7,496	59.2%	1,497	20.0%	186	2.5%	4,133	55.1%	407	5.4%	1,273	17.0%
CHNCT	2,307	11.6%	1,408	61.0%	266	18.9%	35	2.5%	775	55.0%	107	7.6%	225	16.0%
Health Net	1,484	8.0%	942	63.5%	167	17.7%	21	2.2%	542	57.5%	55	5.8%	157	16.7%
Preferred One	1,605	7.4%	985	61.4%	257	26.1%	35	3.6%	553	56.1%	52	5.3%	88	8.9%
Changed plans	1,909	9.6%	1,151	60.3%	241	20.9%	31	2.7%	641	55.7%	61	5.3%	177	15.4%

^a Number of children in other racial/ethnic groups was 175; not reported separately in order to minimize the risk of revealing protected health information.

^b Number of children in households with languages other than English or Spanish was 125; not reported separately in order to minimize the risk of revealing protected health information.

^c “Same provider” refers to same billing provider.

Source: CT Voices analysis of HUSKY A enrollment data for continuously enrolled children, obtained from the Connecticut Department of Social Services.