

Report to the Connecticut General Assembly

From the Sustinet Health Partnership Board of Directors

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Sustinet Health Partnership

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Nancy Wyman (Co-Chair) • Kevin Lembo (Co-Chair)
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Estela Lopez • Sal Luciano • Joseph McDonagh • Jamie Mooney*

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Health Disparities and Equity Advisory Committee
Health Information Technology Advisory Committee
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Preventive Healthcare Advisory Committee
Healthcare Quality and Provider Advisory Committee
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This report is hereby submitted to the Connecticut General Assembly on January 7, 2011:

Nancy Wyman, Lt. Governor

Kevin Lembo, State Comptroller

* Jamie Mooney recently resigned her Board post; we thank her for her contributions.

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Executive Summary

Connecticut residents, businesses, and state government face deep and growing problems with health care and coverage. Costs are rising to unsustainable levels, hundreds of thousands of people lack insurance, quality is inconsistent, purchasers are unsure of the value they receive for their premium dollar, and disparities along racial and ethnic lines affect both health status and access to essential care. If policymakers do nothing and recent trends in Connecticut continue unabated, the end of this decade will see private employers spending \$14.8 billion a year on insurance premiums, and nearly 390,000 people will be uninsured.

Fortunately, two developments now put Connecticut's leaders in a strong position to address these longstanding problems, despite the state's daunting budget deficit. First, the federal government passed the Patient Protection and Affordable Care Act (Affordable Care Act or ACA). Among its features, this legislation offers substantial new federal resources to states that aggressively tackle issues of coverage, cost, and quality. Second, the General Assembly's 2009 SustiNet legislation laid the foundation for using these new federal resources to effectively address the state's health care problems by applying innovative strategies that will place Connecticut in the front ranks of American states.

The SustiNet law embodied a distinctive vision. Uninsured, low-income residents will get the help they need to afford coverage, and insurers will no longer be permitted to discriminate against consumers with preexisting conditions. At the same time, a new, publicly-administered health plan—dubbed “SustiNet,” from the state motto—will implement the country's best thinking about reforming health care delivery to slow cost growth while improving quality. SustiNet will begin with existing state-sponsored populations, state employees and retirees as well as Medicaid and HUSKY beneficiaries. SustiNet will then become a new health coverage option for municipalities, private employers, and families.

To flesh out this vision in detail, the 2009 law established the SustiNet Health Partnership Board of Directors (Board), requiring the Board to develop recommendations for further legislative action. After twenty open meetings, two public briefings, a legislative briefing, and numerous meetings of advisory committees and task forces staffed by nearly two hundred volunteer citizen/experts, we are proud to present our recommendations to the Connecticut General Assembly and the Governor. Thanks to the Affordable Care Act, the Legislature's vision of SustiNet can now be implemented without increasing state spending. In fact, the combination of federal reforms and our proposal for expanding coverage, slowing cost growth, and improving quality will reduce state budget deficits, according to estimates from Dr. Jonathan Gruber of the Massachusetts Institute of Technology, one of the country's leading health economists.

We recommend a policy with the following features:

- **The SustiNet health plan will implement delivery system and payment reforms** that move towards a more coordinated, patient-centered, evidence-based approach to health care.
- **The plan will be administered by a quasi-governmental agency** governed by a board of directors appointed by the Governor and the Legislature. Initially, staff and administrative support will be provided by the Office of the Comptroller.
- **SustiNet will begin by serving state employees and retirees along with Medicaid and HUSKY beneficiaries**, none of whom will see reduced benefits or increased costs because of the shift to SustiNet. However, SustiNet's delivery system and payment reforms will immediately seek to achieve savings for state taxpayers while improving quality of care and health outcomes for consumers.
- **SustiNet will become a new health insurance choice for municipalities, private employers, and households.** Connecticut's cities and towns will quickly gain the ability to enroll their



workers in Sustinet. Sustinet will then gear up to offer commercial-style insurance to small employers and non-profits, if possible before 2014. Effective on January 1, 2014, when most federal reforms become operational, Sustinet will offer comprehensive, commercial benefits to all of the state's employers and households. This new health insurance choice will be available both inside and outside Connecticut's new health insurance exchange, established under the ACA. Sustinet will undertake feasibility studies, develop business plans, conduct a risk assessment, and take any other steps needed to ensure that the new competitive option is viable and adds value in the marketplace.

- **HUSKY will expand to cover all adults with incomes up to 200 percent of the Federal Poverty Level.** By drawing down the maximum possible amount of federal funding, the state can extend HUSKY's current safeguards to additional vulnerable adults while reducing the amount state taxpayers must spend to cover low-income residents.

As HUSKY expands to cover the lowest-income uninsured, Sustinet will play two distinct roles. First, Sustinet will seek to lower the cost and improve the quality of services provided to state-sponsored populations. Second, Sustinet will offer all employers and families a new, competitive health insurance option that reforms health care delivery and payment to improve value and slow premium growth.

These reforms will spark broader change throughout Connecticut. Leading by example, Sustinet's innovations will make it easier for others to follow a similar path. Our proposal harnesses the power of competition, ensuring that successful Sustinet reforms will be replicated by private insurers seeking to preserve their market share. Sustinet will also work collaboratively to implement multi-payer reforms that help the state's providers give their patients high-value, quality care. And by enrolling a large number of consumers, Sustinet will gain the leverage it needs to reform health care delivery and payment.

Even if Sustinet fails to slow cost growth, implementing national reform in the way that we propose will still save Connecticut taxpayers between \$226 million and \$277 million a year, starting in 2014. Such savings will result from substituting newly available federal dollars for current state spending on health coverage for low-income residents. And if Sustinet slows cost growth by just one percentage point per year, the state budget will improve by \$355 million in 2014, with gains reaching more than \$500 million a year, starting in 2019.

To support these efforts, we recommend that the Legislature work with state officials to find the resources needed for vigorous campaigns to reduce obesity and tobacco use, improve the state's infrastructure for furnishing preventive care and promoting healthy behaviors, eliminate health-related racial and ethnic disparities, and develop Connecticut's health care workforce. To address the access problems that result from low reimbursement rates for HUSKY providers, we recommend that the state comprehensively realign Medicaid and HUSKY payment, allowing targeted, budget-neutral payment increases that address particularly serious access problems. After that realignment, we urge the Legislature and the Administration to implement a multi-year initiative that gradually raises HUSKY payments to at least Medicare levels.

The baton now passes to the Legislature for further progress down the path it began in 2009. We are confident that 2011 will see Connecticut enact some of America's most thoughtful and strategic health reforms, benefiting the state's taxpayers, employers, and families for years to come.

Background

2009 SUSTINET LEGISLATION

The SustiNet Health Partnership Board of Directors (Board) was established in 2009 by the Connecticut General Assembly (Public Act No. 09-148) and tasked with the responsibility of proposing to the Legislature a “SustiNet Plan ... designed to (1) improve the health of state residents; (2) improve the quality of health care and access to health care; (3) provide health insurance coverage to Connecticut residents who would otherwise be uninsured; (4) increase the range of health care insurance coverage options available to residents and employers; (5) slow the growth of per capita health care spending both in the short-term and in the long-term; and (6) implement reforms to the health care delivery system that will apply to all SustiNet Plan members...”

The 2009 law provided the broad outline for the SustiNet plan, but left many details open. The General Assembly charged the Board with addressing these details, including how to:

- Structure and govern the plan;
- Launch plan operations;
- Integrate SustiNet with existing state coverage programs;
- Equip SustiNet to function effectively and add value within the private insurance marketplace;
- Reduce the number of state residents without insurance coverage; and
- Integrate SustiNet with the structures to be created under federal health care reform.

The General Assembly had a clear vision that SustiNet would offer publicly-sponsored insurance coverage to many Connecticut residents and embed in that insurance coverage health care delivery system reforms that could improve health, reduce disparities, and slow cost growth. The goal of this new health insurance option would be to lead by example, implementing the country’s best thinking about how to restructure health care delivery and financing.

THE WORK OF THE SUSTINET BOARD AND ITS COMMITTEES AND TASK FORCES

Beginning its work in September 2009, the Board is co-chaired by Nancy Wyman, State Comptroller, and Kevin Lembo, State Healthcare Advocate. The Board includes a physician, representatives of allied health professions, organized labor, small business, the faith community, and individuals with expertise in employee benefit plans, health economics, health information technology, actuarial science, and racial and ethnic disparities in health care. To carry out its charge, the Board appointed advisory committees related to health disparities and equity, health information technology, patient-centered medical homes, preventive health care, and health care quality and providers. The Board likewise appointed task forces to develop comprehensive plans to strengthen the state’s health care work force, prevent tobacco use and increase effective smoking cessation, and combat obesity. Embodying an extraordinary breadth of background and expertise, more than 160 Connecticut residents volunteered countless hours to serve on these advisory committees and task forces, which communicated detailed recommendations to the SustiNet Board and the General Assembly on July 1, 2010. These reports were invaluable, and we are grateful for the hard work of our committees and task forces.

The Board itself held 20 open meetings, each with advance public notice as well as agendas, background materials, minutes, and presentations posted on the internet. We also held two briefings in which we invited public testimony, and we conducted an additional briefing for state legislators. Dr. Jonathan Gruber of the Massachusetts Institute of Technology (MIT), one of the country’s most respected health economists, estimated the cost and coverage effects of policy options under consideration.

Within 60 days of the federal government’s enactment of the Patient Protection and Affordable Care Act (Affordable Care Act or ACA), we

issued a report analyzing the impact of this federal legislation on Sustinet.¹ We noted the many common elements shared by Sustinet and federal reform. At the same time, we raised important questions for further discussion.

Answering both these and other questions, this final report contains our specific recommendations to the General Assembly on some, but not all, of the issues involved in launching and operating Sustinet. We recommend further analysis to guide decisions on the remaining issues.

The Board was assisted by consultants who included, in addition to Jonathan Gruber, Stan Dorn of the Urban Institute, Anya Rader Wallack of Arrowhead Health Analytics, Katharine London of the University of Massachusetts Medical School Center for Health Law and Economics, and Linda Green of Goddard Associates. Their work was funded by the Connecticut Health Foundation, the Jesse B. Cox Charitable Lead Trust, the State Coverage Initiatives program of AcademyHealth, which is a program office of the Robert Wood Johnson Foundation, and the Universal Health Care Foundation of Connecticut. We appreciate the generous financial support of these funders.

WHY ACTION IS NECESSARY

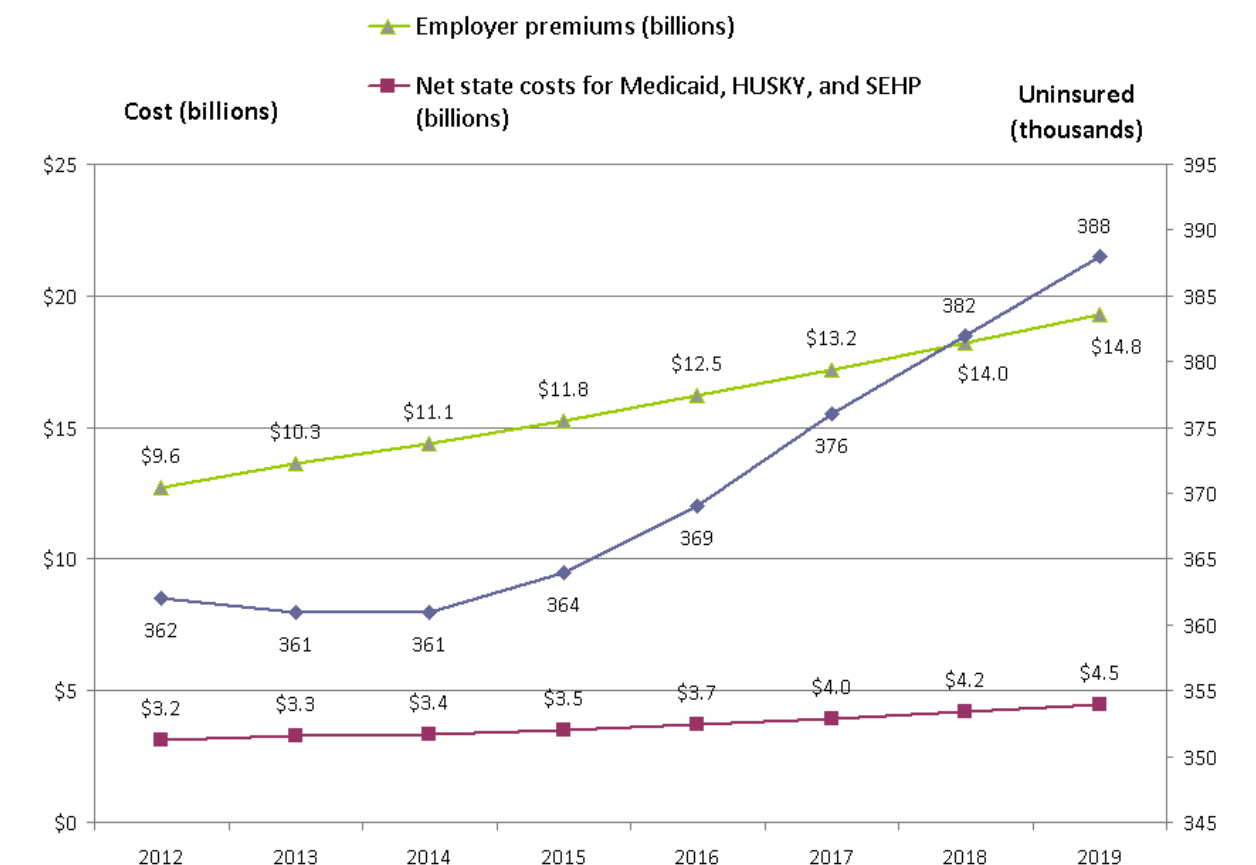
Sustinet was conceived in the context of an ever-worsening health care cost and access crisis. Employers cannot afford double-digit cost increases even when economic growth is hardy, much less when it is negligible. State governments, including Connecticut's,

are likewise struggling under the weight of burgeoning costs for Medicaid and coverage for state employees and retirees. At the same time, the number of uninsured residents, in Connecticut and elsewhere, has steadily increased, in good economic times and bad. If recent trends continue, by the end of this decade, among Connecticut residents under age 65:

- Nearly 390,000 people will be uninsured;
- Net state costs for Medicaid, HUSKY, and state employee/retiree insurance will climb from \$3.2 billion in 2012 to \$4.5 billion in 2019; and
- Premiums for private employers will increase from \$9.6 billion a year in 2012 to \$14.8 billion (Figure 1)—a 55 percent rise.

Figure 1.

Projected number of uninsured, net state health coverage costs, and private employer premiums for Connecticut residents under age 65: 2012-2019, without reform



Source: Gruber Microsimulation Model 2010. Notes: State costs shown here are net General Fund outlays. They do not include federal matching funds that are subject to the state's spending cap. "SEHP" refers to state employee and retiree coverage. All costs are for residents under age 65 and shown in 2010 dollars.

These problems are not unique to Connecticut, of course. But given the resources and talent in this state, the Board believes that Connecticut can and should be a national leader in providing consumers with high quality, affordable health coverage. To achieve this goal, state government's health care functions need to be reorganized and refocused. Our vision is that Sustinet will help lead the way, galvanizing the state's efforts to become a national frontrunner in reforming health care to slow cost growth, improve quality, and make affordable, high-value coverage available to all.

Counting both federal and state dollars, and including services provided to residents of all ages, Connecticut state government currently oversees approximately

\$8 billion a year in health care spending on state employees and retirees, public program beneficiaries, and others. By improving how we manage these funds and the coverage we provide, fully implementing federal health care reform and making Sustinet broadly available, we can achieve several goals:

- 1 Slowing the growth of public and private health care spending in Connecticut;
- 2 Ensuring that all residents have access to affordable, high-quality, comprehensive coverage;
- 3 Implementing delivery system and payment reforms that benefit all residents;

4 Providing Connecticut's employers and families with a new health plan option—namely, an independent, transparently managed plan for Connecticut consumers, health care providers, and employers;

5 Improving access to care among low-income residents; and

6 Reducing racial and ethnic disparities related to health care access and quality.

Like nearly all states, Connecticut is suffering tremendous fiscal stress. It is our belief that we can and should achieve Sustinet's goals without calling for substantial new infusions of General Fund dollars. This can be done by making prudent investments that reap both short- and long-term dividends, maximizing the state's utilization of available federal resources, and carefully managing the state's health care expenditures.

HOW THIS REPORT IS ORGANIZED

The body of this report covers the following topics:

- Key features of federal health care reform;
- Our findings and general recommendations;
- The coverage and cost effects of our recommended policy direction, based on the research conducted by Dr. Gruber;
- Our policy recommendations in detail; and
- Our suggested timeline for implementation.

The appendix to this report includes the full recommendations of the Board's advisory committees and task forces; a "cross-walk" comparing our recommendations to the relevant provisions of the 2009 Sustinet law; and a brief description of the model Dr. Gruber used to project cost and coverage effects.²

Federal Health Care Reform

Sustinet was envisioned prior to the passage of the ACA, but state legislators were well aware in 2009 that federal legislative efforts were under way. Sustinet's goals and structure are thus consistent with the framework established by the ACA.

The ACA allows each state to either create a state-based health insurance exchange or join a federal exchange. Beginning on January 1, 2014, the exchange will facilitate comparison-shopping for health insurance. New federal tax credits and cost-sharing subsidies will be offered to low-income individuals who purchase insurance through the exchange. At the same time, Medicaid coverage of adults will expand to 138 percent of the federal poverty level (FPL).³ During 2014-2016, the federal government will pay all the costs of Medicaid's newly eligible adults. Beginning in 2017, the federal share of these expenses will begin falling, reaching 90 percent in 2020 and staying at that level thereafter. One important source of new federal dollars is an increase in the Medicare payroll tax for families earning more than \$250,000 a year.

In addition to new federal subsidies and expanded Medicaid, the ACA's mandate for individuals to obtain and incentives for firms to offer coverage will reduce the number of uninsured. The latter incentives include tax credits for small employers that insure their workers and penalties for larger firms that do not. The ACA also reforms insurance markets by requiring insurers to devote at least a minimum percentage of premiums to health care costs, forbidding discrimination against consumers based on preexisting conditions, strengthening review mechanisms for premium increases, etc. In addition, the Affordable Care Act includes numerous initiatives to reform health care delivery and payment, including grants and demonstration projects.

As explained in our earlier report, the General Assembly's 2009 vision of a substantial increase in coverage, accompanied by a new, publicly administered health insurance option offered to the state's residents and employers, can now be implemented more effectively and with much more favorable fiscal effects than was anticipated in 2009. The combination of newly available federal funds to cover low-income consumers and the potential impact of delivery system and payment reforms could allow substantial savings to the state General Fund, as we explain later.

Our Findings and Central Recommendations

The Board organized its effort to understand options for Sustinet design into six major subject areas: covered populations; covered benefits; delivery system and payment reform; governance and administration; coverage and access to care; and public health investments. To examine each subject area, we conducted major policy meetings at which our consultants outlined policy options and applicable trade-offs.

In this section, we describe the policy options we considered and our central recommendations. Our full recommendations are detailed in a later portion of the report.

“

Sustinet represents a unique opportunity to develop and nurture a coordinated, cost-effective health care delivery system for the state...all possible efforts should be made to assure its success and move it forward.

Sustinet Board Member

”

COVERED POPULATIONS

We envision that the Sustinet health plan will provide a common platform for reforming health care delivery and payment. The plan will begin by covering those

for whom the state is currently responsible—that is, state employees and retirees as well as Medicaid and HUSKY beneficiaries. The initial focus of our recommended proposal will thus involve slowing cost growth, rather than increasing coverage. However, as eligibility for Medicaid and HUSKY expands, so too will Sustinet enrollment.

As an interim step in moving beyond state-sponsored populations, Sustinet will be offered as an option for small firms, municipalities, and non-profit corporations. Municipalities will be the first employer group outside state agencies to gain access to Sustinet, allowing cities and towns to purchase the same coverage received by state employees and retirees. Local taxpayers could thus benefit from economies of scale and leverage already exerted by state government. At the same time, we propose that a municipality and Sustinet should be allowed to negotiate covered benefits that differ from those offered to state workers, such as the more commercial-style coverage that Sustinet will offer to private firms and individuals.

We recognize that gearing up to offer such commercial coverage will not be a quick and easy task. Accordingly, we recommend that Sustinet’s governing entity should move forward as feasible to serve small firms and non-profits during the interim stage before 2014, without statutorily imposed deadlines.

By contrast, we recommend that the Legislature create a clear statutory deadline for the final stage of offering Sustinet as an option to all Connecticut employers and residents outside state government. Under our suggested approach, Sustinet will be available for any state resident or employer to purchase beginning on January 1, 2014—the date when the main provisions of the Affordable Care Act go into effect, including operation of the health insurance exchange. Under our proposal, Sustinet would be offered both inside and outside Connecticut’s exchange.⁴



In serving employers and individuals outside state government, Sustinet will offer the option of commercial-style benefits, as explained below. Sustinet will thus need to meet legal standards that apply to commercial coverage, including benefit requirements under state and federal law. To prevent Sustinet from becoming a magnet for high-risk enrollees, it will follow the same rules that apply to other plans in the applicable market, whether group or individual, including rules that govern premium variation. With public and private employers large enough to self-insure, Sustinet will avoid such adverse selection through steps that could include experience-rating premiums.

Of course, we understand that work will be required before offering commercial coverage. A state insurance license will be needed to offer coverage in the exchange, for example, but we are convinced that this should not create an insuperable obstacle. Publicly administered health plans at the county level in California have operated with insurance licenses for many years, even though capital requirements for licensure are much higher in that state than here. And Sustinet will need to develop a business plan, with a feasibility study and risk assessment, to ensure that it offers a competitive option that adds value, compared to other choices available to firms and individuals. For Sustinet to commit to this work and succeed, we believe the Legislature needs to lay down clear markers in statute.

We value the role that employers play in offering health insurance to workers and their families. Our goal is to strengthen rather than undermine that role by offering Connecticut businesses a new option for insuring their employees. We believe that increasing competitive choices in this way could improve the Connecticut business climate, particularly if Sustinet slows cost growth and shares those savings with employers.

Table 1.**Provisions of Sustinet Law Regarding Populations in Sustinet**

POPULATION	DATE OF POTENTIAL COVERAGE IN SUSTINET	BOARD MAY OR SHALL DEVELOP RECOMMENDATIONS	RESTRICTIONS OR OTHER SPECIFICATIONS
State employees, retirees and dependents	Not specified	May	Any changes in benefits subject to collective bargaining agreements
Non-state public employees	On or after July 1, 2012	May	
HUSKY Plan Part A and B	Not specified	Shall	
Medicaid	Not specified	Shall	
Enrollees in state-administered general assistance (SAGA)	Not specified	Shall	
State residents not offered ESI and not eligible for Medicaid, HUSKY or SAGA	On or after July 1, 2012	Shall	Premium variation limited to that allowed under small group law
Employer groups	On or after July 1, 2012, for small firms. No date specified for larger firms.	Shall	
State residents offered ESI, whose incomes are below 400% FPL	Not specified	Shall	The Board may recommend mechanism for collecting payments from employers



Coordinating the design of health insurance coverage and procurement of services across these populations offers many potential advantages, including the following:

- When applied to a larger population, synchronized efforts at delivery system and payment reform can have a greater influence on provider behavior and the diffusion of innovation;
- A larger population may give the state added leverage to lower prices and improve value in purchasing goods and services; and
- The system will be simplified for both providers and consumers if reforms are consistent across multiple populations.

On the other hand, there are major differences between potential Sustinet populations, including covered benefits, health care needs, and applicable legal requirements. Connecticut's Medicaid and HUSKY programs cover in excess of 530,000 people, more than half of whom are children.⁵ Medicaid benefits, cost-sharing, eligibility, and administration are governed by federal statutes and regulations as well as the decisions of the Centers for Medicare and Medicaid Services (CMS). Medicaid is also shaped by Connecticut statutes and judicial decisions that interpret both federal and state law.

The State Employees Health Plan (SEHP) covers over 200,000 active employees, retirees, and their dependents. This coverage is governed by collective bargaining agreements between the state and public employee unions.

When Sustinet becomes an option in the group and individual markets, which currently include approximately 2.1 million and 150,000 non-elderly residents, respectively,⁶ the above constraints will not apply. Sustinet will still need to follow applicable state and federal laws, however, including state benefit requirements.

The Board considered a range of options for integrating Sustinet populations. We learned about examples from

other states, including Washington and Massachusetts, where joint procurement processes are in place for multiple state-covered populations.

The Board also considered the advice of our Advisory Committees on the issue of integration, which included the following recommendations:

- Sustinet should use common quality measurement, payment innovations, public health initiatives, and delivery system reforms across all populations, to the greatest extent possible, to achieve maximum impact.
- Sustinet should pursue an integrated approach to reducing or eliminating health disparities across all populations.

Put simply, much of the coverage received by these different groups will continue to differ under Sustinet, including applicable legal requirements, funding sources, population characteristics, provider networks and payment levels, cost-sharing, and covered benefits. At the same time, key elements of health care delivery can and, in our view, should be addressed using a common platform across all of Sustinet's membership groups. As later sections of this report make clear, this common platform will seek to add value and slow cost growth for both publicly and privately funded health coverage. And we urge that, as our recommendations (described below) for increasing HUSKY and Medicaid payment go into effect, Sustinet should commit to the goal of eliminating any differential between groups of Sustinet members in their access to participating health care providers.

BOARD RECOMMENDATION:

We recommend that the future Sustinet governing board (which will be described later) should immediately begin working with the State Comptroller and the Department of Social Services to reform health care delivery and payment for state employees and retirees as well as individuals receiving coverage under Medicaid and HUSKY.

We further recommend that the Sustinet governing board should take all necessary actions (which may include conducting a feasibility study and risk assessment, developing financial projections, and obtaining a state license as an insurance carrier) to offer a Sustinet health insurance plan as an option for employers and individuals to purchase, as follows:

- Beginning as soon as possible, Sustinet should be offered to Connecticut municipalities, allowing them to purchase the same coverage that state employees and retirees receive. However, a municipality and the Sustinet governing board can agree on a different package of covered benefits.
- To the extent feasible before 2014, Sustinet should be offered to other employers, with a special focus on small firms and non-profit corporations.
- Beginning on January 1, 2014, Sustinet should be offered to all employers and individuals, both inside and outside the health insurance exchange.

In offering this coverage, every effort should be made to coordinate the design, delivery, and administration of benefits to maximize the positive impact of Sustinet on:

- Leveraging delivery system and payment reforms;
- Slowing health care cost growth;
- Simplifying administration;
- Improving health care quality; and
- Reducing racial and ethnic disparities.

BENEFITS

The Board examined benefits currently provided to groups intended for inclusion in Sustinet. We also examined the extent to which current programs incorporate prevention and reflect the cutting-edge of value-based insurance design, thereby providing a solid foundation for future efforts at cost containment and quality improvement. In addition, we reviewed the Sustinet law, which requires:

- Sustinet coverage of 15 service categories;⁷
- Sustinet compliance with all applicable state coverage and utilization review mandates;
- No copayments for preventive care;
- Behavioral health parity;
- Dental coverage comparable to that offered by large employers; and
- Compliance with collective bargaining agreements for state employee and retiree coverage.

Lastly, we reviewed benefit requirements under the federal Affordable Care Act, which include:

- An “essential benefits” requirement, including various service categories,⁸ with specific standards to be set by the U.S. Department of Health and Human Services based on “typical employer coverage;”
- A prohibition on lifetime and (beginning in 2014) annual coverage limits;
- A requirement that plans be offered in each state’s exchange at 60, 70, and 80 percent of the actuarial value of the essential benefits standard;⁹
- Limits on out-of-pocket expenditures; and
- Required coverage of preventive services with no out-of-pocket cost-sharing.

We found that current covered benefits for Medicaid and state employees are comprehensive in scope. Both include services like those required under the Sustinet law and the federal ACA, and both limit or bar cost-sharing for preventive services.

We found, however, that neither the SEHP nor Medicaid covers tobacco cessation, nutritional counseling, or wellness programs, all of which were recommended by our Preventive Care Advisory Committee and the Obesity and Tobacco Cessation Task Forces.¹⁰

Table 2 compares benefits currently offered to potential Sustinet groups.



Table 2.

Covered benefits and cost-sharing for selected coverage categories

	SustiNet Act	Husky A and Medicaid	Husky B	Charter Oak	SEHP (in- network)	Municipal Employee HIP
Preventive Care	✓	✓	✓	✓	✓\$	✓\$
Outpatient Physician Visits	✓	✓	✓\$	✓\$	✓\$	✓\$
Lab and Diagnostic X-Ray	✓	✓	✓	✓#	✓	✓\$
Inpatient Hospital	✓	✓	✓	✓#	✓	✓
Emergency Department without Inpatient Admission	✓	✓	✓\$	✓\$	✓	✓\$
Rehabilitation	✓	✓	✓	✓\$	✓	✓\$
Home Health	✓	✓	✓	○	✓	✓\$
Prescription Drugs	✓	✓	✓\$	✓\$	✓\$	✓\$
Behavioral Health Inpatient	✓	✓	✓	✓\$	✓	✓\$
Behavioral Health Outpatient	✓	✓	✓\$	✓\$	✓\$	✓\$
Substance Abuse Inpatient	✓	✓	✓	✓\$	✓	✓\$
Substance Abuse Outpatient	✓	✓	✓\$	✓\$	✓\$	✓\$
Dental Services	✓	✓	✓#	○	✓#	○
Eye Exams	✓	✓	✓\$	○	✓\$	✓\$
Tobacco Cessation	✓	○	○	○	○	○
Nutritional Counseling for Obesity	✓	○	○	○	○	○
Wellness Programs	✓	○	○	○	○	○

Notes: The SustiNet Act does not fully define applicable copays. SEHP refers to state employee/retiree coverage.

Key:

- ✓ Covered Service
- ✓\$ Covered Service with a copay
- ✓# Covered Service with co-insurance (and sometimes deductibles)
- Not covered

BOARD RECOMMENDATION:

In general, we reaffirm the direction given to us in the SustiNet law: benefits under SustiNet should be comprehensive, emphasize prevention, and integrate physical and behavioral health.

In serving existing state-sponsored membership groups—namely, state employees and retirees as well as beneficiaries of Medicaid and HUSKY, including those who qualify for the expanded coverage described later in this report—SustiNet would not change covered benefits, premiums, or out-of-pocket costs. Current consumer safeguards should likewise continue to apply, including such things as Medicaid appeals and

the role of the Cost Containment Committee in overseeing collectively bargained benefits for state employees and retirees.

We recommend that insurance plans for the commercial marketplace should be approached quite differently. In that context, the eventual SustiNet governing board should ensure that plan designs:

a Offer a variety of benefits and out-of-pocket costs, with each package providing comprehensive, commercial-style benefits, including dental care and parity of coverage for physical and mental health conditions;

b Include, to the maximum feasible extent consistent with commercial viability, patient-centered medical homes, integration of medical and behavioral health care, an emphasis on prevention, encouraging and supporting individual responsibility for controllable health risks, and other design features that make Sustinet stand out as a high-quality option that is attractive in the marketplace; and

C Include cost-effective preventive services that address physiological, emotional, mental, and developmental conditions for members throughout their life span from birth to the end of life. Sustinet should review and periodically revise its coverage of preventive care based on the most current and reliable evidence available, including results of Sustinet prevention initiatives.

In offering commercial coverage that is financed entirely by premium payments and federal tax credits, without any state General Fund dollars, we believe the Sustinet governing board should have the flexibility to change benefits and cost-sharing arrangements over time, within the constraints of applicable state and federal laws, including state benefit mandates, and based on evidence about the most effective benefit designs, categories of covered services, and cost-sharing arrangements.

We further recommend that the design of Sustinet benefits:

- Encourages personal responsibility for controllable health risks, while providing the support that consumers need to exercise that responsibility effectively; and
- Promotes reductions in health disparities.

“

If we can make Connecticut a healthier place we are all saving money and having a better quality of life.

Sustinet Board Member

”

DELIVERY SYSTEM AND PAYMENT REFORM

The Sustinet law emphasized three central components of delivery system reform:

- Patient-centered medical homes (PCMH) that combine a designated source of primary care with patient education, coordination of services, and enhanced access to medical consultation when the patient is outside the clinician’s office;
- Health information technology (HIT) that supports cost and quality management; and
- Incentives for providers to practice evidence-based medicine.

The Board reviewed the evidence that each of these initiatives would improve quality and control cost growth. We also reviewed the recommendations of our Patient-Centered Medical Home Advisory Committee, our Provider and Quality Advisory Committee, our Workforce Task Force, and our Health Information Technology Advisory Committee. Lastly, we examined federal efforts to encourage and finance these reforms.

Our Advisory Committees and Task Forces supported implementation of the PCMH model through Sustinet,

which builds on work already under way with HUSKY's Primary Care Case Management (PCCM) Program as well as a multi-payer pilot project led by the Comptroller. Our Committees and Task Forces recommended that PCMHs should eventually be required to meet nationally promulgated accreditation or certification standards. However, clinicians who serve as medical homes should not be required to provide all services directly in the office, according to our committees. In particular, small practices could share support services to meet PCMH standards. For example, the ACA authorizes funding for community health teams to perform functions that might not be undertaken within a one- or two-physician office. Our PCMH Advisory Committee further recommended that Sustinet create a "learning collaborative" through which practices could support each other in becoming medical homes—a strategy that also may be supported by the ACA. Federal legislation further permits states, beginning in 2011, to provide chronically ill Medicaid beneficiaries with PCMH services, with a 90 percent federal match rate applying to the first 8 calendar quarters. The ACA appropriated \$25 million in state planning grants for such an initiative, starting in 2011.

We also learned that efforts to develop coordinated, multi-payer reforms can be hindered by anti-trust law. To overcome those barriers, a regulatory program supervised by the State of Connecticut can be established to permit and encourage cooperative agreements between health care purchasers, hospitals, and other health care providers. Such a program is allowed when its benefits outweigh the disadvantages caused by potential adverse effects on competition.

We likewise found that a significant federal and state effort is under way to coordinate and finance implementation of electronic medical records (EMRs) and interoperable electronic health records (EHRs). Connecticut has created the Health Information Technology Exchange of Connecticut (HITECT) to oversee efforts to meet federal requirements and maximize federal support. In addition, Connecticut has received a grant to support a regional extension center that will provide support and training to practices implementing EMRs. Our HIT Advisory Committee

recommended that Sustinet leverage these efforts, rather than undertake unrelated efforts to encourage HIT diffusion. Our Committee further recommended formal representation of Sustinet on the HITECT Board. It also proposed that Sustinet seek to influence the requirements established for EMRs in Connecticut to assure that systems meet basic analytic needs and capture race and ethnicity data that will allow for ongoing measurement of health disparities.

The Provider and Quality Advisory Committee supported the use of evidence-based standards of care in practices serving Sustinet members, applying in Connecticut guidelines that have already been promulgated by national and international authorities. The committee also supported payment reform that promotes provider accountability for costs, reduces unnecessary care, and provides incentives for improving quality and safety while reducing disparities.

The Workforce Task Force highlighted a shortage of primary care providers in Connecticut, which might undermine efforts to implement delivery system reform. The Task Force made recommendations for increasing the supply of primary care clinicians through targeted efforts such as debt relief and broadening scope of practice of some non-physician primary care providers. The Task Force also recommended specific efforts to train clinicians in working within the patient-centered medical home model, including changes to nursing curricula to reflect the needs of the PCMH. The Task Force recommended that the state develop its capacity to assess the demand for and supply of primary care providers through an overall state strategic plan for its health care workforce.

We found that our recommended interventions (PCMH, HIT, evidence-based care guidelines, and payment reform) have limited use in Connecticut at present, and Sustinet could play a key role helping to expand these efforts. The State Employees Health Benefits Plan's (SEHP) large-scale pilot program for PCMH, noted above, exemplifies the leadership that Sustinet could provide on a much wider scale.

BOARD RECOMMENDATION:

We recommend that Sustinet:

- Strongly encourage and provide incentives and technical and other assistance for Sustinet providers to implement patient-centered medical homes.
- In appropriate areas, implement alternatives to fee-for-service provider payment that encourage the provision of care that improves health and safety. Such payment mechanisms could include pay-for-performance, bundled payments, global payments, or other innovations that are supported by emerging research.
- Provide incentives for evidence-based care that encourage providers to follow evidence-based clinical guidelines. Such encouragement should be carefully structured to preserve clinicians' ability to provide patients with care that meets their individual needs, even when such personalized care goes outside approved clinical guidelines.
- Establish a Pay-for-Performance system to reward providers for improving health care quality and safety and reducing racial and ethnic disparities in health access, utilization, quality of care, and health outcomes.
- Encourage, support, and eventually require Sustinet providers to use interoperable EHRs to document and manage care.
- Integrate into every component of the Sustinet plan strategies for reducing and eliminating racial and ethnic disparities.
- Take all steps necessary to collect and publish provider price information that will help consumers make informed choices.

In addition, we recommend that the Legislature establish convener authority, consistent with state and federal anti-trust law, that will allow collaboration among multiple payers and providers in developing and applying payment and delivery system innovations. The legislature also should examine the method recommended by the Workforce Task Force

for assessing and enhancing both the overall supply of primary care clinicians in the state and available training in the PCMH model.

GOVERNANCE AND ADMINISTRATION

The Board considered questions related to Sustinet's governance and administration, including the following:

- How should Sustinet relate to existing state agencies?
- What governance structure is most appropriate for Sustinet?
- What powers and duties should the Sustinet governing body have?
- What administrative structures and capacities are necessary to implement Sustinet?

We considered three basic options for governance, as follows:

1 Sustinet as quasi-governmental agency administering a health plan. Under this option, a Sustinet governing board would oversee a quasi-governmental agency that administers the Sustinet health plan. Sustinet would contract with the Comptroller's Office and the Department of Social Services (DSS) to provide health insurance coverage to state employees and enrollees in Medicaid and HUSKY.

2 Sustinet as overseer and health plan. Under this option, the Sustinet governing body would, in addition to administering the Sustinet health plan, oversee the Comptroller's Office and DSS with respect to all rules, regulations, and procedures related to SEHP, Medicaid, and HUSKY.

3 Sustinet as superagency and health plan. Under this option, Sustinet would be a new state agency going beyond health plan administration to oversee SEHP, Medicaid, and HUSKY.

Each option assumes that Sustinet would develop the capacity by 2014 to offer coverage to groups and individuals both within and outside the state's Health Insurance Exchange.

The Board was provided with examples of each governance model and considered their advantages and disadvantages. The Board was particularly concerned with minimizing disruption to current coverage arrangements, maximizing coordination across programs and plans, and minimizing (in the short term, while Connecticut is faced with serious budget shortfalls) the need for new, state-funded staff and administrative infrastructure.

We also examined the administrative capacities that would be necessary in Sustinet, regardless of its governance model. These include enrollment; premium billing and collection; marketing; provider contracting, management, and payment; customer relations; and data collection and analysis. In addition, a system for determining eligibility and calculating subsidies will be needed for Sustinet to accomplish its coverage goals. We observed that existing state agencies possess many of these capacities, which could be leveraged for Sustinet.

Lastly, the Board reviewed the recommendations of our Advisory Committees and Task Forces related to governance and administration. These included the following:

- Sustinet should have strong links with all state-run health agencies, including DSS, the Department of Public Health, the Department of Mental Health and Addiction Services, and the Department of Children and Families;
- Sustinet should have a strong link to HITECT, as discussed above;
- The Sustinet governing board should include representation of Sustinet enrollees and individuals with experience in reducing health disparities; and
- The Sustinet governing board should establish standing advisory committees on the Patient-Centered Medical Home, obesity prevention

and reduction, health care quality and payment, health care safety, preventive health care, and health disparities and equity.

BOARD RECOMMENDATION:

The Board recommends the establishment of the Sustinet Authority as a quasi-governmental agency (option #1 described above), as soon as possible. We recommend that the authority be governed by a board of directors, which could include members of the current Board, and that the Sustinet governing board should have overall responsibility for Sustinet. We further recommend including as board members both consumer representatives and individuals with specific expertise needed to oversee the operation of the Sustinet health plan. We believe that the Sustinet governing board will be more effective if it is as small as possible.

We recommend that staffing and other administrative support for Sustinet should be provided initially by the Office of the Comptroller and that such staff should help the Sustinet governing board obtain resources (including federal and philanthropic funds) to support meeting its administrative needs, in both the short and long term. We believe that a strong and adequately funded administrative infrastructure will be essential to Sustinet's success.

Table 3 summarizes our concept of how Sustinet governance and administration could evolve from 2011 through 2014.

Table 3.**Possible timeline for evolution of Sustinet governance and administration, Calendar Years 2011-2014**

	2011	2012	2013	2014
SUSTINET BOARD	Appointed and take office by 9/1/2011. Housed within the Office of the Comptroller.	Transition to independence from the Comptroller's Office.	Independent from Comptroller no later than 1/1/2013.	
SUSTINET AUTHORITY		Authority begins no later than 3/1/2012.		
SUSTINET STAFF	Existing state agencies provide staff.	After sufficient resources are identified outside the General Fund, Executive Director begins work no later than 3/1/2012. Transition to independent staff.	Staff fully independent no later than 1/1/2013.	
RESPONSIBILITIES	Begin advising Comptroller and DSS about delivery system and payment reforms for SEHP and Medicaid/HUSKY. ASAP, give municipalities the option to buy Sustinet. Analyze feasibility of offering Sustinet to small firms and non-profit corporations.	Move forward, as feasible, with offering Sustinet to small firms and non-profit corporations. Begin preparing to meet 1/1/14 deadline for offering Sustinet to firms and individuals.	Assume direct responsibility for administering Sustinet plan no later than 1/1/2013. Contract with Comptroller and DSS to serve SEHP and Medicaid/HUSKY.	Beginning 1/1/2014, offer Sustinet to all employers and individuals, inside and outside the exchange.



COVERAGE AND ACCESS

One of Sustinet's central goals is to ensure that as many Connecticut residents as possible obtain affordable, high-quality, comprehensive health coverage. After devoting significant time to understanding the impact of federal legislation, we learned that the ACA provides significantly increased federal support for subsidized coverage along with a mandate for individuals to obtain coverage and incentives for employers to offer it; the latter incentives include tax credits for small firms that provide insurance and penalties for larger companies that do not.

However, we were troubled by the limits on ACA subsidies for adults with incomes above 138 percent FPL, who fall outside the legislation's increase in required Medicaid eligibility. Subsidies for coverage in the exchange will leave these adults facing significant costs, as illustrated by Table 4.

Considerable evidence suggests that cost-sharing imposed on low-income households can deter enrollment into coverage and prevent utilization of essential services, with potentially significant adverse effects on patient health.¹¹ We were thus concerned about the impact of cost-sharing on two groups: 16,000 HUSKY parents with incomes between 138 and 185 percent FPL, who today receive comprehensive benefits and are not charged premiums or copayments; and 41,000 other low-income adults with incomes between 138 and 200 FPL, many of whom will be unable to afford what they will be charged in the exchange.¹²

To prevent today's HUSKY parents from encountering new barriers to accessing care as well as to improve coverage and access for other low-income adults, we believe that, beginning on January 1, 2014, Connecticut should implement the Basic Health Program (BH) option provided under federal law. With BH, Medicaid-ineligible adults with incomes at or below 200 percent of FPL are covered through state contracts with

Table 4. Premium and out-of-pocket costs for a single, uninsured adult receiving subsidies in the exchange under the ACA, at various income levels

FPL	MONTHLY PRE-TAX INCOME	MONTHLY PREMIUM	AVERAGE OUT-OF-POCKET COST-SHARING
150	\$1,354	\$54.15	6%
175	\$1,579	\$81.34	13%
200	\$1,805	\$113.72	13%
225	\$2,031	\$145.70	27%
250	\$2,256	\$181.63	27%

Source: Urban Institute, 2010. *Notes:* Dollar amounts assume 2010 FPL levels and enrollment into the second-lowest cost "silver" plan under the ACA, which is the plan on which ACA subsidies are based. Out-of-pocket cost-sharing represents the average percentage of covered services paid by the consumer, taking into account deductibles, copayments, and co-insurance. These costs would apply under the ACA anywhere in the country, so they are not limited to Connecticut.

health plans or providers. Such adults either (a) have incomes too high to qualify for federally-matched Medicaid or (b) are lawfully resident immigrants whose immigration status makes them ineligible for federally-matched Medicaid (most often because their status was granted within the last 5 years). To fund the state's BH contracts, the federal government provides 95 percent of what it would have spent on subsidies if BH members had received coverage through the exchange. State contracts must have "attributes of managed care," which can involve primary care case management systems, such as patient-centered medical homes, rather than risk-bearing, fully capitated, private insurance. Federal BH dollars must be placed in a trust fund and spent only to benefit BH members. Covered benefits and cost-sharing protections may not fall below federally-specified minimums. However, states may provide more comprehensive benefits with lower cost-sharing (such as the benefits and cost-sharing protections that states furnish through federally-reimbursed Medicaid).

To be clear, we would not recommend implementing the Basic Health option if the state provided no more than the minimum level of coverage required by federal law. Rather, the purpose of our proposed BH implementation is two-fold: to preserve, for populations covered by current law, HUSKY's existing affordability and comprehensiveness of coverage, so that, from the member's perspective, benefits would be exactly what Medicaid now provides; and to extend that same level of assistance to other low-income, uninsured adults.

One disadvantage of providing HUSKY rather than subsidies in the exchange is that provider payment rates are now much lower in HUSKY than in the kind of commercial coverage likely to be offered in the exchange. While we believe that, for this particular population, access to care is typically impaired more by cost-sharing than by HUSKY's provider participation limits, the BH option allows a modest improvement of provider payment rates at no cost to the General Fund. According to Dr. Gruber's modeling, federal BH payments will exceed HUSKY costs for low-income adults by at least 7 to 13 percent. Accordingly,

as the state uses BH to extend HUSKY, in its current configuration of covered benefits, cost-sharing rules, and consumer safeguards, to adults with incomes up to 200 percent FPL, the excess of federal BH payments over baseline HUSKY costs should be used to raise payment rates for adults with incomes above 138 percent FPL.

Not only would this approach make coverage and care more affordable for low-income adults, it would also save money for the state General Fund. By moving HUSKY parents above 138 percent FPL from Medicaid, for which the state pays 50 percent of all costs, into BH, where the federal government will pay all expenses, Connecticut taxpayers will save approximately \$50 million a year in net General Fund costs, according to Dr. Gruber's modeling.

Under the approach we recommend, a single, integrated HUSKY program will provide subsidized coverage to all otherwise uninsured adults with incomes up to 200 percent FPL and children up to 300 percent FPL. Not only will this make coverage more affordable, our recommended strategy will also improve continuity of care. Income levels fluctuate greatly for many low-income households. Under the recommended policy, income fluctuations that move families above or below 138 percent of FPL will not force a change between HUSKY and the very different systems of coverage and care that will be available in the exchange. Rather, coverage and care will be continuous, so long as household income does not exceed 200 percent of FPL.

We also considered two other policy options that, unlike BH, would increase state General Fund costs. First, HUSKY eligibility could expand before enhanced federal funding is first available in 2014. If HUSKY served all adults up to 185 percent FPL, rather than just parents, approximately 60,000 uninsured residents would gain coverage, according to Dr. Gruber's estimates. However, because federal matching funds would pay only 50 percent of Medicaid costs before 2014, the resulting net expense to the state General Fund would be approximately \$100 million to \$150 million a year.



Second, as noted above, HUSKY reimbursement, as a general matter, now falls far below private levels. As a result, many providers are unwilling to see HUSKY patients. Access to care could improve considerably if HUSKY payment rates increased.

To address this longstanding problem, we considered a policy option that would have increased HUSKY payment rates to the point that per capita costs would equal those paid by large employers—in effect, raising HUSKY payment to private levels. According to Dr. Gruber’s estimates, this would cost the state General Fund approximately \$180 million to \$190 million a year.

We also considered the less expensive approach of using Medicare rather than private levels as the goal for increased Medicaid payment. We learned that, with some populations (children and pregnant women, for example), Medicare levels are problematic, so a different benchmark would be needed in such cases. We further learned that, with some services, current Medicaid reimbursement is sufficient or even excessive, suggesting the need for a broader analysis and realignment of payment practices.

One final issue involves maximizing the number of eligible uninsured who sign up for coverage. According to Dr. Gruber’s estimates, nearly half (47 percent) of Connecticut residents who would remain without coverage under our recommendations will qualify for subsidies, either through HUSKY or the exchange. To reach this group of uninsured, the state will need to go beyond the minimum requirements of federal law.

BOARD RECOMMENDATION:

As part of SustiNet, we recommend that, beginning on January 1, 2014, HUSKY eligibility for adults should increase to 200 percent of FPL, continuing the same benefits, cost-sharing limits, and consumer protections that apply under current law. Federal funding for this coverage should be maximized by implementing the Basic Health Program (BH) option for individuals who are ineligible for federally-matched Medicaid. To the extent federal BH dollars exceed baseline HUSKY costs, payment rates should increase for the BH-eligible population with incomes above 138 percent of FPL.

We further recommend that the state begin down a path of increasing Medicaid and HUSKY provider payments to at least Medicare levels (except for discrete populations and services where a different benchmark than Medicare is needed). The first step down this path would occur in fiscal year 2012, when the Department of Social Services would undertake a comprehensive analysis of current reimbursement practices. Based on that review, a budget-neutral realignment of provider payments would take place in fiscal year 2013. After that point, further payment increases would require a net increase in state General Fund spending. We believe that such higher payments will be essential for HUSKY to provide adequate access to essential care, particularly with the expanded population the program will serve in the future. We also believe that, as this increase goes into effect, SustiNet should embrace the goal that Medicaid and HUSKY coverage should not impair members’ access to SustiNet providers; and that Medicaid and HUSKY members should receive the same access to care that is enjoyed by the privately insured, based on specific standards adopted by the SustiNet Authority.

We urge the General Assembly and state agencies to work together to find the resources necessary both for this increase in HUSKY payment and, before 2014, to expand HUSKY eligibility for childless adults to the highest possible income level—if possible, to the same 185 percent FPL threshold that now applies to parents.

We also urge the Legislature to examine ways in which Connecticut can increase its supply of primary care clinicians through methods other than increasing payment levels, consistent with the recommendations of the Workforce Task Force.

Finally, we recommend that SustiNet, the Department of Social Services, other state agencies, and Connecticut’s health insurance exchange should work together to maximize identification of the uninsured, determine their eligibility for assistance, and enroll them into coverage.

PREVENTION AND PUBLIC HEALTH INVESTMENTS

The Sustinet law placed a strong emphasis on health insurance coverage for preventive care and increased investment in public health. The Board considered several issues related to preventive care and public health investments. These included:

- The extent to which current coverage for potential Sustinet populations includes appropriate preventive care;
- The extent to which coverage offered in the future to privately-insured groups and individuals should include preventive care;
- The appropriate role of the Sustinet plan in promoting public health; and
- The highest priorities for state investments in public health outside Sustinet's membership, with coordination between the Department of Public Health and the Sustinet plan to maximize opportunities for success.

We also considered the recommendations of our Preventive Health Care Advisory Committee. That committee broadly defined its charge to improve health for Sustinet members, addressing the needs of the whole person, including physical health, mental health, addictive behaviors, and oral health. The Committee recommended that Sustinet cover a comprehensive package of preventive services, without requiring cost sharing. These services included:

- A basic set of preventive services (including items receiving an "A" or "B" rating on the U.S. Preventive Services Task Force list) addressing physiological, emotional, mental, and developmental conditions for members from birth to the end of life;
- All Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for Medicaid children¹³
- Regularly scheduled screenings and other preventive services, such as mammograms,

immunizations, assessments of behavioral health needs, and other evidence-based care;

- Dental services;
- An annual Individual Preventive Care Plan;
- Chronic care planning and support, including promoting healthy nutrition, sleep, exercise, and tobacco and substance abuse cessation; and
- Counseling and education about sexually-transmitted disease, infectious disease control, domestic violence, and environmental toxins.

The Obesity Task Force and the Tobacco Use and Cessation Task Force also offered guidance about preventive benefits and public health investments. On benefits, they recommended coverage for nutrition counseling and smoking cessation treatment.

Those task forces also recommended statewide efforts to:

- Enhance surveillance related to key health indicators;
- Provide more tobacco cessation services;
- Include in K-12 education tobacco, drug, and alcohol use prevention, as well as nutrition, stress management, and exercise; and
- Improve the nutrition environment in schools while reducing unhealthy marketing to children.

In addition, the PCMH Advisory Committee recognized that public education would be necessary to maximize the use of preventive services through the medical home model, and the Workforce Task Force recommended investment in the public health workforce to support broader public health efforts.

BOARD RECOMMENDATION:

The Board recommends that Sustinet continue to emphasize preventive health and public health promotion by:

- Incorporating the best available knowledge about the return on investment from preventive care in benefit designs for both current state-sponsored



groups and populations that might purchase the Sustinet plan as a competitive option in the marketplace; and

- Appropriately investing in the health of its covered population through education and support services that might go beyond traditional health insurance but could have a clear, positive impact on health.

In addition, the Board recommends that the General Assembly, in collaboration with state agencies, the Sustinet Board, and other appropriate stakeholders, identify necessary resources and enact legislation to invest in statewide primary prevention efforts that promote healthy nutrition, sleep, physical exercise, and the prevention and cessation of the use of tobacco and other addictive substances. The Board also supports investments in:

- Improving community infrastructure and investing in workforce training to support healthy lifestyles and furnish preventive care;
- Including public health workforce capacity in state health care workforce assessment and strategic planning;
- Reducing racial and ethnic disparities in access to resources that improve health while increasing support for healthy living by families from multiple, diverse cultures; and
- Facilitating the receipt of funds for health care workforce training and development, including efforts to promote cultural and linguistic competence in serving the state's diverse residents.

COVERAGE

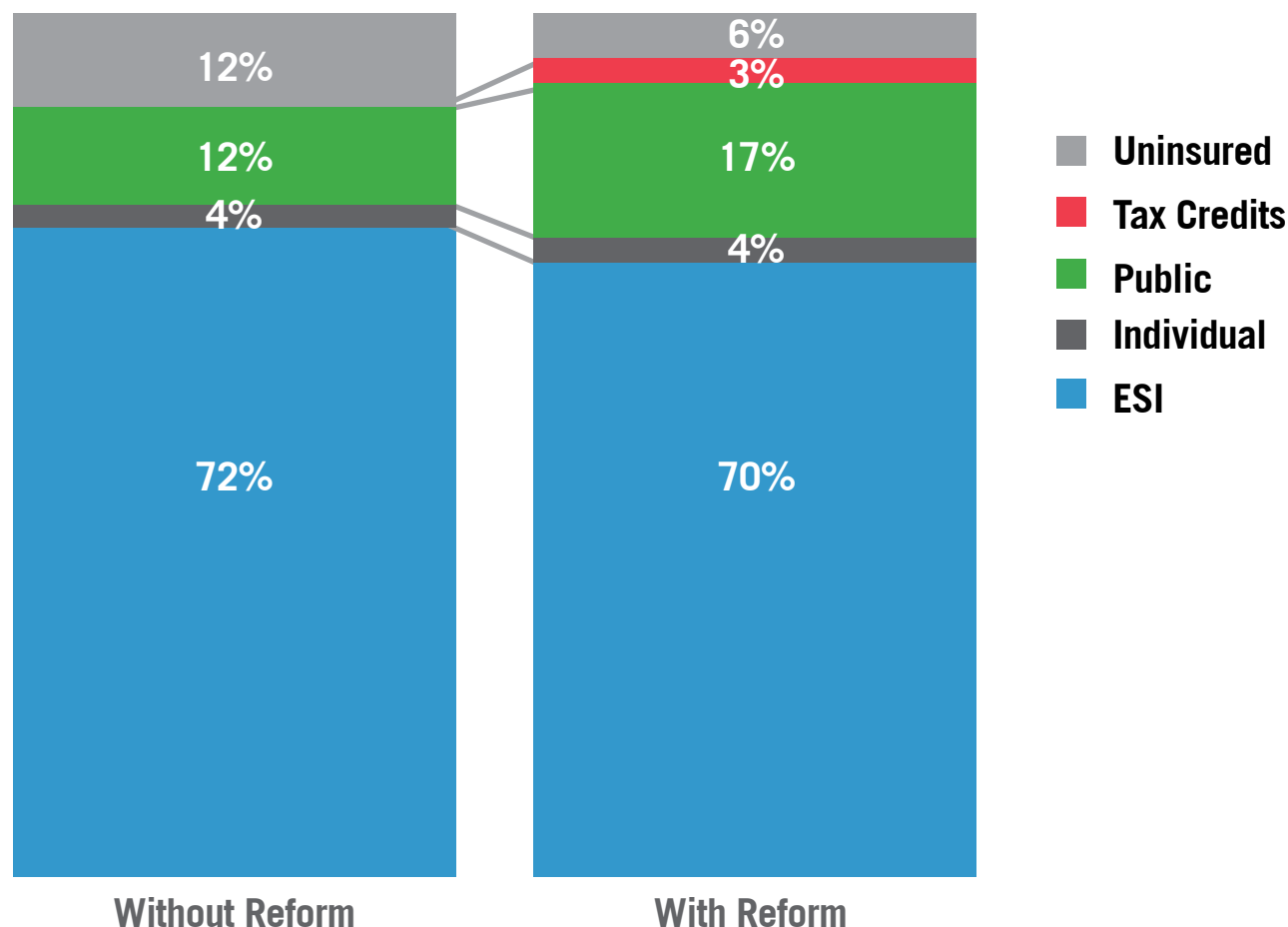
Based on Dr. Gruber's projections, our proposal, along with national legislation, would substantially increase insurance coverage in Connecticut. Taking 2017 as a representative year, the number of uninsured would fall by at least 55 percent, compared to levels in the absence of reform.¹⁴ More than 200,000 otherwise uninsured residents would gain coverage.

The availability of subsidies would cause a minority of firms with 100 or fewer employees to stop offering insurance. These are companies that, today, cover mostly low-wage workers who, beginning in 2014, would be better off if their employers stopped offering insurance so the employees could qualify for subsidies. As a result, the number of people covered by small employers would fall by 9 to 10 percent. More than 70 percent of affected workers would shift to subsidized coverage in the exchange or other individual insurance, and the overall proportion of small firm employees without coverage would decline from 45 percent to between 26 and 27 percent.

The overall impact on Connecticut coverage would include a sizable reduction in the proportion of residents without insurance, a significant increase in the percentage of Connecticut citizens receiving subsidies, and a small drop in employer-sponsored insurance (ESI) (Figure 2).

Figure 2.

Coverage of residents under age 65, with and without reform: 2017



Source: Gruber Microsimulation Model. *Notes:* “ESI” means employer-sponsored insurance. Public coverage includes Medicaid and HUSKY. With reform, “individual” coverage includes both subsidized and unsubsidized coverage in the exchange as well as nongroup insurance outside the exchange. This figure assumes that Sustinet’s delivery system and payment reforms have no effect slowing cost growth.

COST

Our discussion of cost requires several preliminary comments:

- Like the rest of Dr. Gruber’s estimates, the analysis is limited to effects involving residents under age 65.
- Costs are stated in 2010 dollars.
- The combined policies under discussion do not include either (a) an expansion of HUSKY eligibility before 2014 or (b) an increase in

HUSKY payment rates to at least Medicare levels. As explained earlier, these two initiatives will require the Legislature, Sustinet, and the Administration to collaborate in finding new resources to fund the resulting costs. The costs of these proposals, to the extent they are known,¹⁵ are set forth in the earlier discussion, rather than here.

State costs itemized below represent net charges to the State General Fund. They do not include matching federal dollars, even if those funds are subject to the state’s spending cap.

An important question involves the extent to which Sustinet slows cost growth. To address this question, Dr. Gruber produced estimates reflecting two different scenarios: a pessimistic scenario, in which Sustinet has no effect on cost growth; and an optimistic scenario, in which Sustinet slows cost growth by 1 percentage point per year. In neither case did Dr. Gruber assume any “spillover” effects, through which a reduction in uninsurance (and a consequent decrease in shifting uncompensated care costs to private insurance) or a spread of Sustinet reforms to other health plans would slow cost growth outside the four corners of the Sustinet plan.

Beginning in 2014, the proposal we recommend, combined with national reform, would improve the state’s fiscal situation, in several ways:

- Implementing the Medicaid expansion required by the ACA will greatly increase federal funding for the population formerly covered by State Administered General Assistance (SAGA). By converting SAGA into a new category of Medicaid eligibility (Medicaid for Low-Income Adults, or LIA), Governor Rell reduced the proportion of costs paid by Connecticut from 90 percent to 54 percent.¹⁶ Beginning in 2014, the state share will fall to 9 percent, yielding significant savings.
- By implementing the Basic Health Program option, the state will shift the cost of covering 16,000 HUSKY parents from Medicaid, for which the federal government pays 50 percent of all expenses, into BH, where the federal government pays all costs.
- The above-described small decline in ESI will result in a modest increase in wages, based on research showing that employers increase pay, to some degree, when they achieve health care cost savings. A slight wage increase will, in turn, raise state income tax revenues.
- If Sustinet slows health care cost growth, state Medicaid and HUSKY spending will decline, compared to projected spending without reform. The state will likewise achieve savings in providing employees and retirees with health coverage.

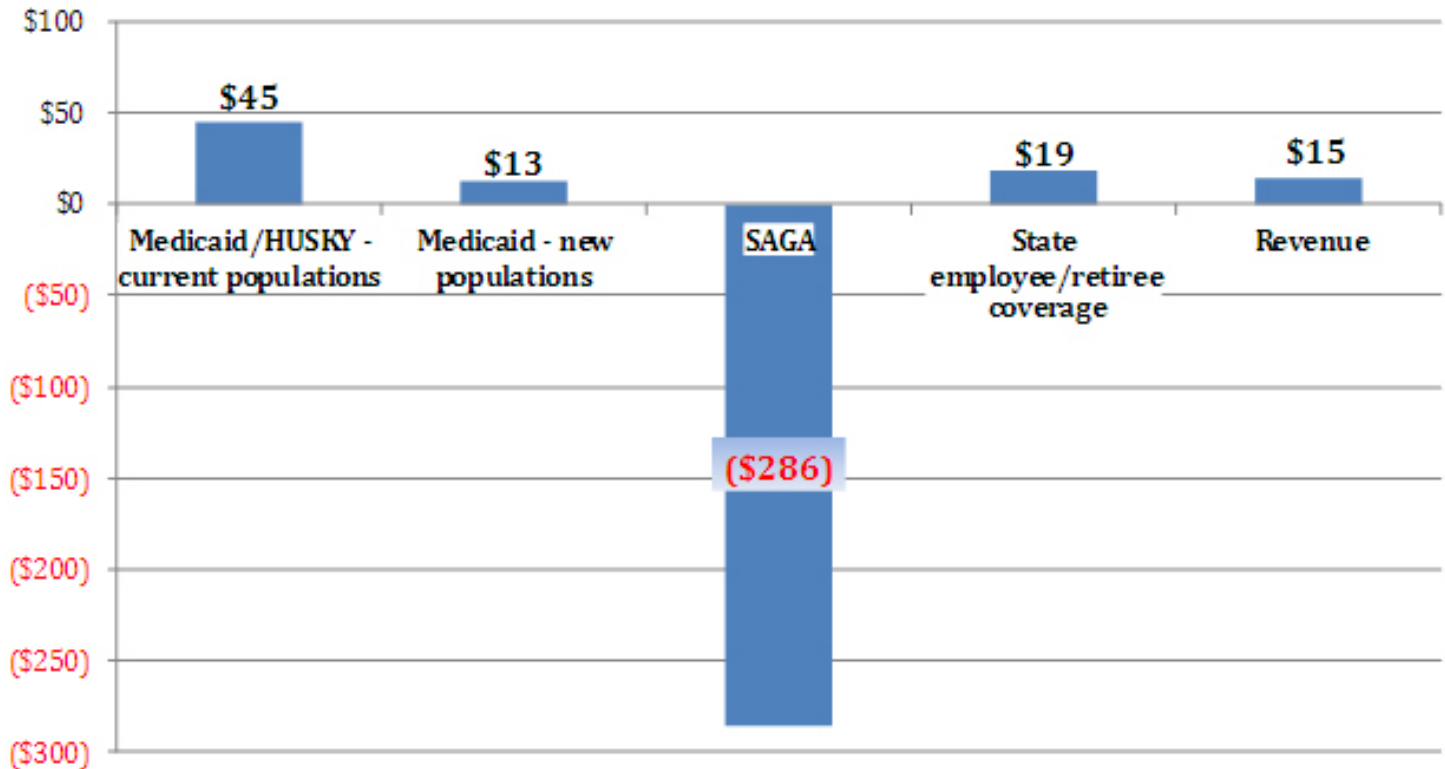
On the other hand, reform will increase state costs in several areas:

- Enrollment is likely to increase in existing categories of Medicaid and HUSKY eligibility, for which the state pays 50 percent of all costs.
- For newly eligible Medicaid adults with incomes at or below 138 percent of FPL, the federal government pays less than 100 percent of their costs after 2016. While the state’s share will be small, gradually rising to 10 percent in 2020 and remaining at that level thereafter, there will be some state costs for these adults beginning in 2017.
- Enrollment into state employee coverage is likely to increase modestly because of the individual mandate.

Altogether, state budget gains will outweigh new costs by a substantial margin. Figure 3 illustrates the magnitude of the above factors under the pessimistic scenario, through which Sustinet has no effect in moderating health care cost growth. Under this assumption, total state budget deficits would fall by \$224 million in 2017, compared to levels in the absence of reform.

Figure 3.

Effects on state spending and revenue for residents under age 65, pessimistic scenario: 2017 (millions)

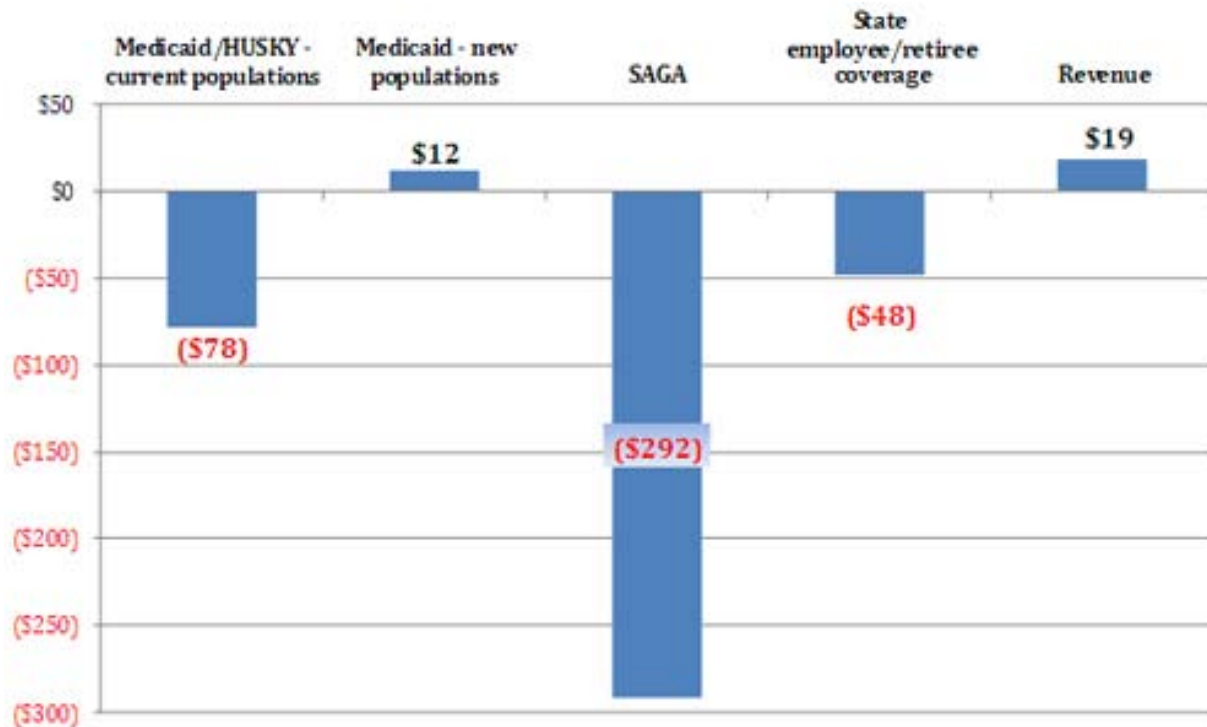


Source: Gruber Microsimulation Model. Notes: Savings from shifting HUSKY parents into BH are included in the cost estimates for existing Medicaid/HUSKY populations. Savings for the conversion of SAGA to Medicaid for low-income adults are shown against a baseline in which SAGA was not converted into Medicaid coverage of low-income adults. Cost estimates do not include any savings for state-funded immigrants with incomes at or below 138 percent of FPL, who will be shifted into federally-funded BH under our proposal.

Figure 4 shows state fiscal effects in 2017 if Sustinet succeeds in slowing cost growth by 1 percentage point per year. Under this more optimistic scenario, the state budget will improve by \$425 million.

Figure 4.

Effects on state spending and revenue for residents under age 65, optimistic scenario: 2017 (millions)

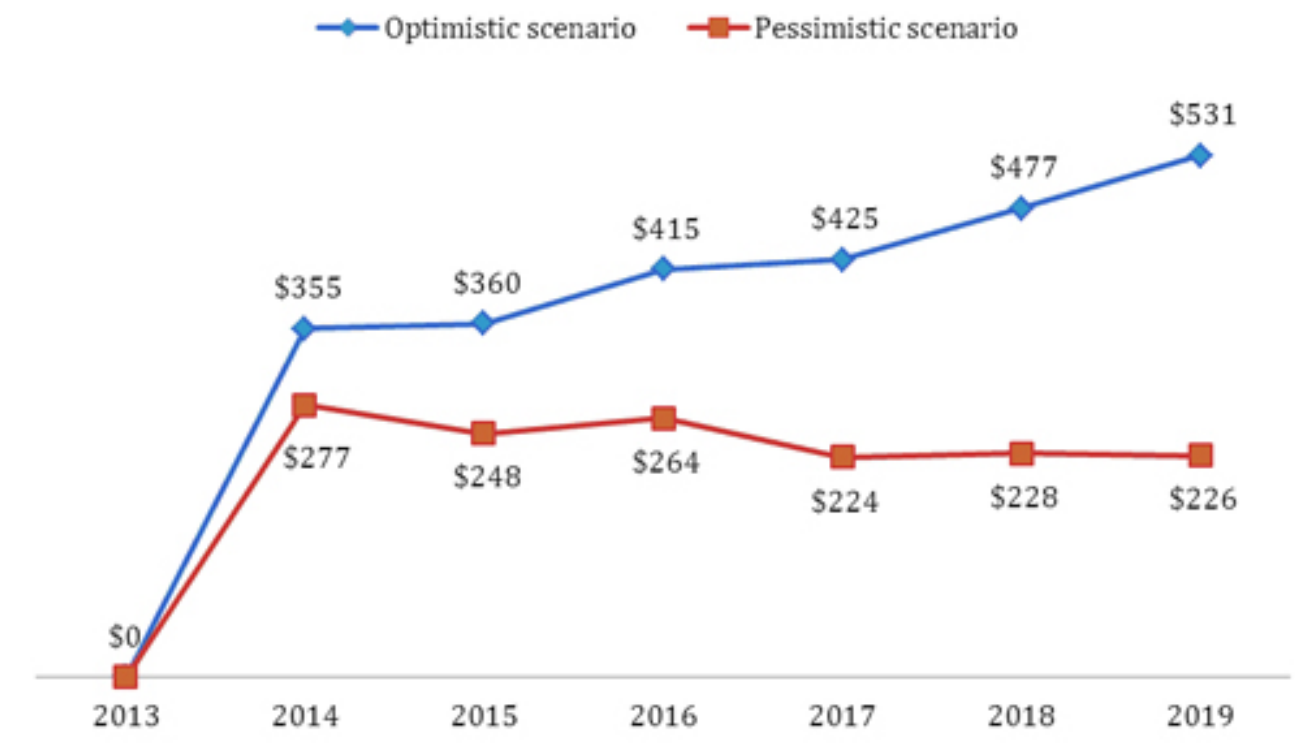


Source: Gruber Microsimulation Model. Note: This figure assumes that, in Sustinet, delivery system and payment reforms slow cost growth by 1 percentage point per year, beginning in 2012. See also notes to Figure 3.

The state's net budget gains over time are displayed in Figure 5. Under the pessimistic scenario, savings gradually decline as the federal government reduces its share of Medicaid costs for newly eligible adults. Under the optimistic scenario, the impact of Sustinet on health care spending outweighs this modest decline in federal support, so net state budget gains increase.

Figure 5.

Net state budget savings for residents under age 65, optimistic and pessimistic scenarios: 2014-2019 (millions)



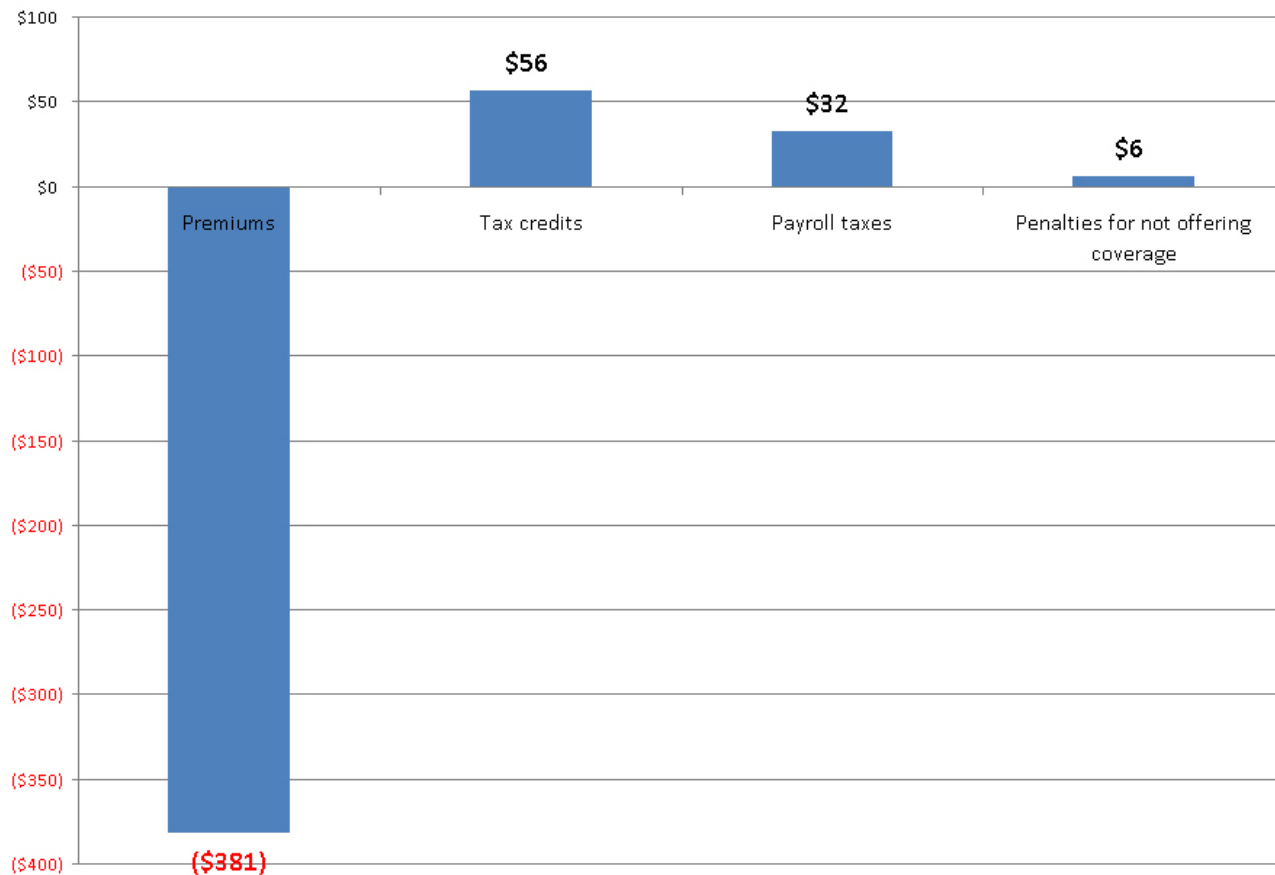
Source: Gruber Microsimulation Model. *Notes:* State budget effects include both outlays and revenues. The pessimistic scenario assumes that Sustinet does not affect cost growth. Under the optimistic scenario, Sustinet slows cost growth by 1 percentage point per year. See also notes to Figure 3.

Our proposal will also have implications for private sector costs. As noted earlier, small firm coverage will decline by 9 to 10 percent in 2017. As a result, small firms will save approximately \$380 to \$400 million in premiums. Ironically, these companies will save slightly less if Sustinet is more effective in slowing cost growth, because fewer small firms will drop coverage.

Although premium savings will be the most significant cost effect for small employers, some firms with fewer than 50 workers will also receive tax credits created by the ACA. A few companies with between 50 and 100 employees will pay penalties because they fail to offer ESI. In addition, any firms that drop coverage and increase wages will see their payroll taxes rise. The net effect of all these factors is that companies with 100 or fewer workers will realize gains of \$399 to \$415 million in 2017. Figure 6, below, shows how all these factors are projected to play out under the scenario in which small employers' costs are higher because Sustinet slows cost growth to the point that a few additional firms offer coverage.

Figure 6.

Effects on health insurance costs and taxes for firms with 100 or fewer workers, scenario in which Sustinet slows cost growth, allowing more such firms to offer coverage: 2017 (millions)



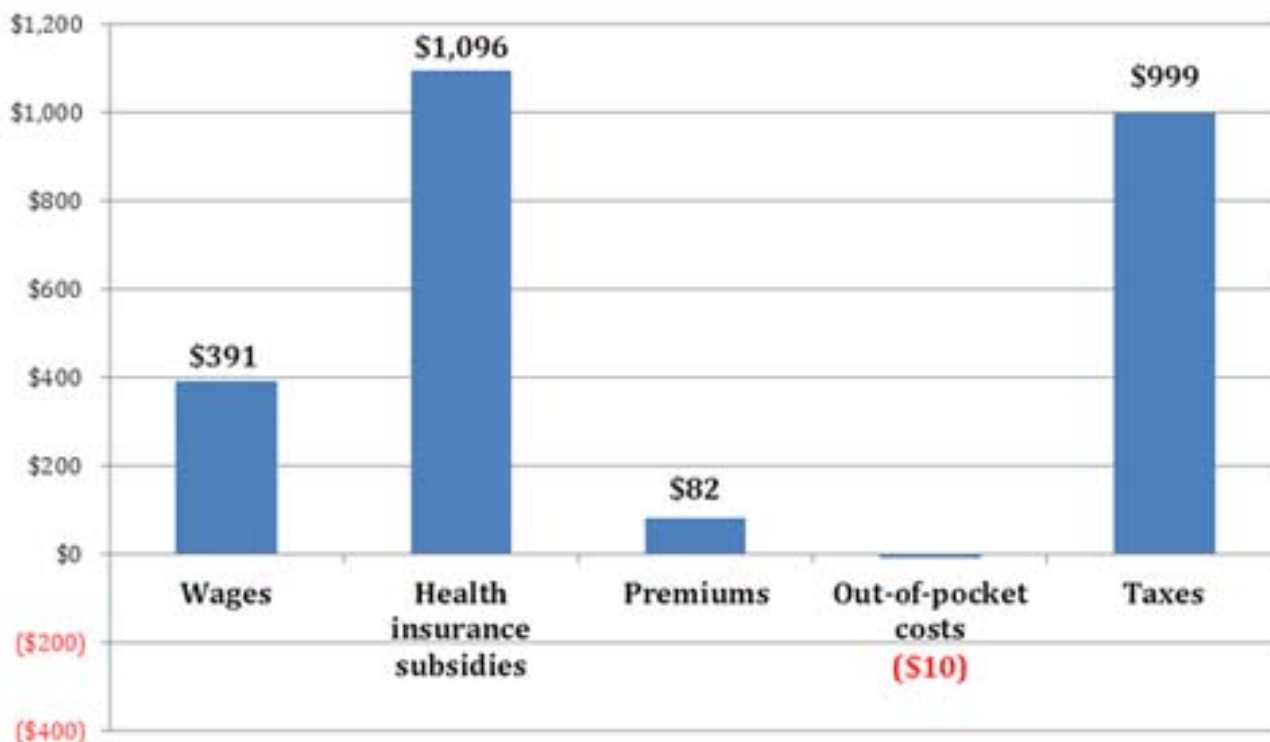
Source: Gruber Microsimulation Model. *Notes:* This figure assumes that Sustinet is effective in slowing cost growth. Under a scenario in which Sustinet has no effect slowing cost growth, premium savings will equal \$403 million, tax credit amounts will total \$52 million, payroll taxes will increase by \$34 rather than \$32 million, and penalties for not offering coverage will remain at \$6 million.

Among larger firms, the effects of reform are estimated to be negligible. In 2017, total costs for companies with more than 100 employers are projected to decline by roughly \$50 to \$70 million, or less than one-half of 1 percent

Similarly, total household post-tax purchasing power will be essentially unchanged under the combination of federal reform and our proposal, rising between \$416 and \$420 million a year, or less than one-half of 1 percent. Wages will increase modestly when some firms stop offering coverage, as explained above. Connecticut residents will receive more public-sector assistance in purchasing health coverage because of expanded Medicaid and HUSKY as well as newly created subsidies in the exchange. On the other hand, taxes will rise, mainly because the ACA increases Medicare payroll taxes for families earning more than \$250,000 a year. Premium payments will go up because more people enroll in coverage, but out-of-pocket costs will decline slightly. Figure 7 shows how these effects balance out, under the pessimistic scenario in which Sustinet fails to slow cost growth.

Figure 7.

Effects on household purchasing power for residents under age 65, scenario in which Sustinet fails to slow cost growth: 2017 (millions)



Source: Gruber Microsimulation Model. Notes: Health insurance subsidies include Medicaid and HUSKY and premium and cost-sharing subsidies in the exchange. This figure assumes that Sustinet does not slow cost growth. Under a different scenario in which Sustinet slows cost growth by 1 percentage point per year beginning in 2012, wages will increase by \$452 million, health insurance subsidies will grow by \$1.055 billion, premium payments will rise by \$72 million, out-of-pocket costs will fall by \$13 million, and taxes will increase by \$1.028 billion.

More broadly, Sustinet aims to spark broader reform of health care delivery and payment in Connecticut, using several strategies. First, Sustinet will lead by example, rather than compulsion.¹⁷ It will demonstrate the impact of nimbly implementing cutting-edge reforms that seek to improve quality, safety, and health outcomes while slowing cost growth. If Sustinet proves effective, it will be easier for others to move in similar directions.

Second, Sustinet will galvanize broader change by harnessing the power of competition. If Sustinet's initiatives slow cost growth while maintaining or

improving quality and value, then private insurers will need to implement similar reforms to preserve market share.

Third, Sustinet's continuity of coverage will strengthen the business case for savings. Today, both commercial insurers and Medicaid expect that a substantial fraction of their members will soon be gone, which reduces incentives to invest in long-term wellness. In the commercial world, an employer may change carriers, or a worker receiving ESI may move to a new job that offers different insurance. In Medicaid, small changes in income and failure to complete necessary paperwork

cause caseload “churning,” with members leaving the program. Under our proposal, by contrast, regardless of changes of income (and in some cases, even if workers move from job to job), Sustinet’s members will typically stay with the plan for the foreseeable future, thus enhancing the return on investment from efforts that increase preventive care, reduce obesity and tobacco use, or successfully intervene in the early development of other ongoing health problems.

Fourth, Sustinet will work with other payers to implement coordinated efforts to help providers make necessary changes to health care delivery. Already, the Comptroller’s office is leading such a multi-payer initiative to pilot-test patient-centered medical homes, as noted above.

Fifth and, in some ways, most important, as Sustinet enrollment increases, Sustinet’s leverage to bring about delivery system and payment reforms will likewise increase. The number of commercial enrollees who join Sustinet depends, in part, on whether Sustinet achieves cost savings. But Dr. Gruber found that, under both pessimistic and optimistic scenarios, Sustinet is likely to gain a significant share of the state’s small group and individual markets, along with a modest share of the large group market (Table 5).

Table 5. Estimated Sustinet enrollment, outside state-sponsored groups: 2017

	SMALL FIRM ENROLLMENT		LARGE FIRM ENROLLMENT		INDIVIDUAL ENROLLMENT	
	Covered lives	Share of small firm coverage	Covered lives	Share of large firm coverage	Covered lives	Share of individual market
Pessimistic scenario	136,000	24%	126,000	8%	32,000	14%
Optimistic scenario	164,000	29%	165,000	10%	33,000	15%

Source: Urban Institute, 2010. *Notes:* Dollar amounts assume 2010 FPL levels and enrollment into the second-lowest cost “silver” plan under the ACA, which is the plan on which ACA subsidies are based. Out-of-pocket cost-sharing represents the average percentage of covered services paid by the consumer, taking into account deductibles, copayments, and co-insurance. These costs would apply under the ACA anywhere in the country, so they are not limited to Connecticut.

Detailed Recommendations to the General Assembly

Our detailed recommendations address six core areas related to Sustinet:

- 1 Governance and location within state government;
- 2 Policy-making duties and responsibilities of the Authority Board;
- 3 Administrative duties and responsibilities of the Authority;
- 4 Reforming health care delivery and payment;
- 5 Expanding coverage and access to care; and
- 6 State public health investments.

As detailed above, during our sixteen months of deliberations we reviewed many of the challenges that make it difficult to simply “flip the switch” and begin Sustinet operations. These challenges include different benefits, reimbursement levels, and provider networks across state-funded groups; constraints of collective bargaining agreements and Medicaid law; and the need to obtain a state license to offer Sustinet in Connecticut’s health insurance exchange. In addition to securing licensure, Sustinet will need to undertake considerable work developing a new, publicly-administered, competitive health insurance option that can succeed in the commercial marketplace. Moreover, the lack of an adequate primary care workforce and low Medicaid payment levels must be overcome if Sustinet is to be fully successful. We have attempted, in crafting the following recommendations, to address these issues and design a solid foundation for future success. We believe strongly that the potential benefits of the Sustinet plan warrant addressing the operational, technical, and fiscal challenges inherent in start-up.

GOVERNANCE AND LOCATION WITHIN STATE GOVERNMENT

1 A quasi-governmental agency (the Sustinet Authority) should be established to oversee and operate the Sustinet plan. The Authority should generally be modeled after the Connecticut Health and Educational Facilities Authority and should be bound by the highest legal standards of ethics, transparency, and accountability. The Authority should be structured to reflect governance principles that embody the country’s best thinking about effective and accountable administration (such as those recommended by the Pew Center for the States), including providing the public with regular performance information.

2 The Authority should be established as soon as possible and in no event later than March 1, 2012.

3 The Authority should be governed by a reconstituted board of directors (the Authority Board), which should be appointed and begin service as soon as possible, no later than September 1, 2011. The Authority Board should be responsible for setting overall policy for the Sustinet health plan.

4 The Authority Board, which could include members of the current Board, should be appointed by a combination of elected officials in the Executive and Legislative branches of Connecticut state government and various stakeholder groups. Board members should be required to have specified areas of expertise. The Board should have the authority to increase its membership to bring in additional expertise. At the same time, the Board should be as small as possible, to facilitate effective decision-making.

5 The Authority Board should establish a Consumer Advisory Committee, with broad consumer representation, and provide it with appropriate levels of independent staffing. The Consumer Advisory Committee should elect two representatives (one of whom can be a professional consumer advocate) to sit as voting members on the Authority Board and to



report the full breadth of advice from the Committee to the Board. The Consumer Advisory Committee should be responsible for preparing Consumer Impact Statements describing the effects on consumers of the Authority Board's major policy decisions (identified as such by the Committee). These statements would be published to accompany the final version of the Authority Board's decisions when they are made available to the public.

6 Until the Sustinet Authority obtains funding and staffing, the Office of the Comptroller should provide administrative support to the Authority Board and help such Board maximize its access to resources outside the General Fund, including federal funds and philanthropic grants. This interim staffing arrangement should terminate as soon as possible and in no event later than January 1, 2013.

POLICY-MAKING DUTIES AND RESPONSIBILITIES OF THE AUTHORITY BOARD

1 The Authority Board should be responsible for overseeing the Sustinet plan. This role includes setting binding policy for delivery system and payment reform affecting coverage received by Sustinet members, except where such policy conflicts with state or federal law or with collective bargaining agreements. The Board should work with the Legislature and with other state agencies to identify funding sources needed to cover any necessary initial investments.

2 The Authority Board should be authorized to convene committees and advisory groups as it deems necessary to address such issues as implementation of the patient-centered medical home, health care quality, health care safety, incentives for evidence-based care, provider payment, prevention, health disparities and equity, and health information technology.

3 In addition to its policy-making authority described above, the Authority Board should be authorized to advise the State Comptroller and the Department of Social Services on other matters related to health insurance coverage for state employees and retirees and individuals covered through Medicaid and

HUSKY. The Board should likewise be authorized to make recommendations to the General Assembly, state agencies, and non-governmental organizations about changes in law, policy, practice, or procedure that would slow health care cost growth, improve health care quality or safety, increase access to health care, improve population health, or reduce racial and ethnic disparities.

4 The Authority Board should take all necessary actions (which may include conducting feasibility and risk assessment studies, developing financial projections, and obtaining a state insurance license) to offer a Sustinet health insurance plan as an option for employers and individuals to purchase, as follows:

a Beginning as soon as possible in calendar year 2011, Sustinet should be an option for purchase by municipalities, using the same benefits and out-of-pocket costs that apply to state employees and retirees. If requested by a particular municipality and approved by the Authority Board, Sustinet may provide the municipality's enrollees with different benefits or cost-sharing rules, including (but not limited to) commercial benefits like those described below. Coverage should be provided consistently with small group rules, for municipal employers subject to those rules. With larger municipal employers, Sustinet should take necessary steps to avoid adverse selection, including experience-rating premiums.

b To the extent feasible, taking into account other duties of the Authority, Sustinet should be available before 2014 to small firms and non-profit corporations, with Sustinet offering commercial benefits, as described below.

c Beginning on January 1, 2014, Sustinet should be offered to all Connecticut employers and individuals, both inside and outside the exchange.

5 In structuring insurance plans for the commercial marketplace, the Authority Board should ensure that plan designs:

a Offer a variety of benefits and out-of-pocket costs, with each package providing comprehensive, commercial-style benefits, including dental care and parity of coverage for physical and mental health conditions.

b Include, to the maximum feasible extent consistent with commercial viability, patient-centered medical homes, integration of medical and behavioral health care, an emphasis on prevention, encouraging and supporting individual responsibility for controllable health risks, and other design features that make Sustinet stand out as a high-quality option that is attractive in the marketplace.

C Include cost-effective preventive services that address physiological, emotional, mental, and developmental conditions for members throughout their life span from birth to the end of life. The Sustinet Authority should periodically review and, if necessary, revise its coverage of preventive care based on the most current and reliable evidence available, including results of Sustinet prevention initiatives.

6 The Comptroller, DSS, other appropriate government agencies, and Sustinet should encourage inclusion of cost-effective smoking cessation services within covered benefits for all Sustinet populations, at the earliest possible date.

7 When sold in the individual or group market, Sustinet should be subject to the same rules that apply in that market, including rules for permitted premium variation. The Authority may use channels of distribution and sale that apply to other plans in those markets, including the use of brokers and agents.

8 The Authority should prevent harmful adverse selection when commercial enrollees choose Sustinet. This may include experience-rating premiums when Sustinet is sold outside the exchange to firms large enough to self-insure.

9 To cover unexpected differences between plan expenditures and premiums, the Authority should maintain prudent reserves and should be authorized to take other appropriate steps, such as purchasing stop-loss coverage or reinsurance.

10 The Authority should implement multi-year action plans to achieve measurable objectives in such areas as the effective prevention and management of chronic illness, reducing racial

and ethnic disparities involving health care and health outcomes, and reducing the number of state residents without insurance. The Authority should monitor the accomplishment of such objectives and modify action plans as necessary.

11 The Authority should be authorized to conduct public education and outreach campaigns to inform state residents about the Sustinet Plan and to encourage enrollment. In seeking to cover the uninsured, such campaigns could partner with community-based organizations and target populations that are underserved by the health care delivery system. The Authority Board should monitor the effectiveness of such campaigns and modify strategies as necessary.

12 The Authority should, within available appropriations, develop and implement systematic policies and practices to identify, qualify for subsidies, enroll, and retain in coverage otherwise uninsured individuals. Such policies and practices may include collaboration with Connecticut's health insurance exchange, the Department of Revenue Services, the Labor Department, and other local, state, and federal agencies, as well as health care providers, including hospitals and community health centers, and other nongovernmental organizations, as appropriate.

ADMINISTRATIVE DUTIES AND RESPONSIBILITIES OF THE AUTHORITY

The Authority, with approval from the Authority Board, should be authorized and empowered to:

1 Recruit and hire an Executive Director, who will implement the administrative operations of the Sustinet Authority. The Executive Director should have the authority to hire staff and enter into contracts, consistent with the Board's overall direction and budget. After sufficient resources are identified outside the state General Fund, the Executive Director should be hired to begin work as soon as possible, not later than March 1, 2012.



2 Adopt guidelines, policies, and regulations necessary to carry out its duties.

3 Contract with one or more insurers or other entities for administrative purposes, such as claims processing, credentialing of providers, and establishing provider networks, provided that any such administrative contract should pay per enrollee or on another basis that does not provide an incentive for administrators to delay or deny coverage of necessary services.

4 Contract with the Comptroller and the Department of Social Services to provide health insurance coverage for the following populations:

a State employees and retirees; and

b Individuals who receive Medicaid, HUSKY (including with the eligibility expansions described below), and (if approved by the Authority Board) other state-arranged or state-funded health coverage.

Enrolling these populations in Sustinet should not be construed as authorization to modify premiums, covered benefits, out-of-pocket cost-sharing, or access to out-of-state providers for these membership categories.

5 Solicit bids from individual providers and provider organizations and arrange with insurers and others for access to existing or new provider networks and take such other steps as are needed to provide all Sustinet Plan members with access to timely, high-quality care throughout the state and medically necessary care outside the state's borders.

6 Commission surveys of consumers, employers, and providers on issues related to health care and health care coverage.

7 Negotiate on behalf of providers participating in the Sustinet Plan to obtain discounted prices for vaccines and other goods and services.

8 Make and enter into all contracts and agreements necessary or incidental to the performance of

its duties and the execution of its powers under its enabling legislation, including contracts and agreements for professional services, including but not limited to financial consultants, actuaries, bond counsel, underwriters, technical specialists, attorneys, accountants, medical professionals, consultants, bio-ethicists, and such other independent professionals or employees as the Authority shall deem necessary.

9 Enter into interagency agreements for performance of the Authority's duties where such duties can be implemented at lower cost or more cost-effectively by contracting with a state agency.

10 Establish policies and procedures:

a Governing the use of new and existing channels of sale to employers, including public and private purchasing pools, agents and brokers;

b Allowing the offering to employers of multi-year contracts with predictable premiums; and

c Ensuring that employers can easily and conveniently purchase Sustinet Plan coverage for their workers and dependents. Policies and procedures in this area may include, but are not limited to, participation requirements, timing of enrollment, open enrollment, enrollment length, and other matters deemed appropriate by the Authority Board.

11 Apply for and receive grant funding from private and public sources to support functions consistent with its mission.

12 Make optimum use of opportunities created by the federal government for securing new and increased federal funding.

REFORMING HEALTH CARE DELIVERY AND PAYMENT

The Authority should be authorized to:

1 Implement changes in health care delivery and payment for the populations covered in the Sustinet plan, within the constraints of collective

bargaining agreements and federal law (including Medicaid). Such changes may include provider contracting requirements and, to the extent consistent with the above constraints as well as other state statutes, benefit design modifications that do not increase net state-funded costs. In reforming health care delivery and payment, the Authority Board should prioritize strategies that offer the greatest potential for slowing cost growth.

2 Integrate strategies for reducing and eliminating racial and ethnic disparities into every component of the Sustinet plan, including outreach, enrollment, benefit design, provider networks, financial incentives, quality measurement, provider credentialing, enrollee communications, and appeals.

3 Establish payment methods for licensed health care providers that reflect evolving research and experience both within the state and elsewhere, promote access to care and patient health and safety, prevent unnecessary spending, and ensure, to the maximum extent feasible, sufficient compensation to cover the reasonable cost of an efficient provider to provide necessary care.

4 Strongly encourage and provide incentives and technical and other assistance for Sustinet providers to implement patient-centered medical homes. The Authority should establish a timeline for ensuring that all Sustinet members can receive care from a patient-centered medical home.

5 In appropriate cases, implement alternatives to fee-for-service provider payment. To encourage the provision of care that is safe and improves health, such alternatives may include pay-for-performance, bundled payments, global payments, or other innovations. To the extent warranted by available evidence, the Authority Board should establish goals for increasing the percentage of Sustinet expenditures made under alternative payment methodologies over time. Based on experience in Connecticut and elsewhere, the Board should evaluate the effect of alternative payment methodologies on quality, safety, and cost growth.

6 Provide incentives for evidence-based care that encourage providers to follow evidence-based clinical guidelines. Any system that rewards providers for meeting such guidelines should provide mechanisms for documenting reasons to depart from guidelines because of, for example, an individual patient's clinical condition.

7 Establish a Pay-for-Performance system to reward providers for improvements in health care quality and safety and reductions in racial and ethnic disparities in health access, utilization, quality of care, and health outcomes. Such Pay-for-Performance systems could reward providers for (a) making improvement as well as for meeting benchmarks; (b) having an effective plan in place for preventing illness and improving health status; and (c) caring for patients with the most complex and least well-controlled conditions.

8 Encourage, support, and eventually require Sustinet providers to use interoperable electronic health records to document and manage care. The Authority Board should work with other organizations within the state to maximize the usefulness and minimize the cost to providers of this transformation, taking advantage of available federal resources while leveraging the combined purchasing power of the state's health care providers to obtain goods and services of lower cost and higher value.

9 In all Sustinet systems for data intake and storage, include fields that record members' race, ethnicity, and language in addition to age, gender, and other demographic data, thereby creating the capacity to track disparities in health outcomes and health care services. Data systems should enable coding of multiple races and ethnicities for a single individual.

10 Report provider performance in health care quality, efficiency, safety, and racial and ethnic disparities in health access, utilization, quality of care, and health outcomes by geographic area and by provider or organization, where feasible, with outcomes risk-adjusted based on patient

characteristics, to the maximum extent possible. The SustiNet Authority would:

a provide information to each provider organization comparing its performance to benchmarks and to other providers;

b provide guidance to providers on specific actions that they can take to improve their performance; and

c give providers an opportunity to review their own data, suggest revisions, and take corrective action before results are made public.

11 As soon as possible, create and maintain a data warehouse tracking health care utilization by SustiNet members and other state-sponsored populations.

12 Whether through such data warehouse or otherwise, capture information necessary to publish provider price comparisons that will help consumers make informed choices.

13 Work with state agencies to develop a data system that efficiently captures information measuring cost and quality and that allows for eventual integration of claims data and clinical information from electronic medical records. In doing so, the Board should coordinate with state efforts to upgrade Medicaid and other information systems to implement the Affordable Care Act, and the state should maximize the use of available federal funding for such purposes. Whenever possible, the data development referenced in this provision should be included within broader procurement efforts undertaken by state government, whether to meet requirements of the Affordable Care Act or otherwise.

14 Ensure that privacy and data security are fully protected by the data systems described above, including but not limited to compliance with applicable federal requirements.

15 Work with other health plans and organizations inside Connecticut to facilitate multi-payer initiatives to reform health care delivery and payment.

16 Modify the above-described delivery and payment reforms as warranted by evolving evidence.

To maximize the effectiveness of the above-described reforms, the General Assembly should make the following statutory changes:

1 Where necessary, modify scope of practice laws involving such provider groups as physician assistants and advance practice nurses to help these providers function effectively as part of a patient-centered medical home.

2 Modify medical malpractice liability laws to (a) provide a “safe harbor” that precludes liability for patient injury caused by clinicians appropriately following approved clinical guidelines; and (b) ensure that patients, in such circumstances, receive compensation for the harm they suffer.

3 Authorize SustiNet or another state agency, with appropriate convener authority, to provide direction, supervision, and control over approved cooperative agreements and to give health care providers, health provider networks, and purchasers who participate in discussions or negotiations authorized by this program immunity from civil liability and criminal prosecution under federal and state antitrust laws. The purpose of such actions is to facilitate the exchange of information among hospitals, other health care providers, and other appropriate entities to encourage the development of cooperative agreements, delivery arrangements, and relationships intended to promote more cost-effective health care delivery.

4 To the extent that delivery system and payment reforms implemented by the SustiNet plan achieve cost savings, the SustiNet Authority should be permitted to retain most of the savings to invest in further improvements in services provided to SustiNet members.

EXPANDING MEDICAID COVERAGE AND ACCESS TO CARE

As of January 1, 2014, HUSKY should expand to cover uninsured adults with incomes at or below 200 percent FPL. Such expansion would receive federal financial support as follows:

- 1 Federal Medicaid matching funds should be claimed up to 138 percent FPL;¹⁸ and
- 2 Federal funding under the Basic Health Program should be claimed for individuals up to 200 percent of FPL for whom federal Medicaid funds are unavailable. Any excess in federal Basic Health funding over baseline HUSKY costs should be paid out in the form of increased payment rates to providers serving HUSKY members with incomes above 138 percent FPL. For all HUSKY adults, benefits, cost-sharing arrangements, and other consumer protections (such as appeals) should equal what current law provides to HUSKY parents.

The General Assembly, in collaboration with the Department of Social Services (DSS), other state agencies as appropriate, and the Authority Board, should take the following steps, and identify revenue sources or cost savings that are sufficient to pay for them:

- 1 Expand HUSKY eligibility to include childless adults up to ¹⁸⁵ percent FPL from July 1, 2012 through December 31, 2013.
- 2 Gradually increase HUSKY and Medicaid provider payment to at least Medicare levels for clinical services for which current rates are inadequate, beginning on July 1, 2012. Such plan should include payment increases to another appropriate benchmark for services as to which Medicare fee schedules are insufficient, such as services to pregnant women and children. Such rate increases should be part of a broader reform to Medicaid payment methodologies, which should be developed by DSS during FY 2012. Any Medicaid or HUSKY payment increases in

FY 2013 should be part of a cost-neutral, overall realignment of payment levels and methods. In subsequent years, payment should gradually increase to the levels described above. As that increase takes effect, Sustinet should commit to the goal that Medicaid and HUSKY beneficiaries will not, by virtue of that status, experience impaired access to providers who serve other Sustinet members.

- 3 Adopt specific standards that define access of care. Pursuant to those standards, HUSKY and Medicaid beneficiaries would have access to care no less than that received by the privately insured. For example, such standards could define access in terms of the number of providers within geographic areas that include a specified number of members, travel times required to reach participating providers (taking into account different populations' use of mass transit), etc.

STATE PUBLIC HEALTH INVESTMENTS

The General Assembly, in collaboration with state agencies, the Authority Board, and other appropriate stakeholders, should identify necessary resources and enact legislation to accomplish the following goals:

- 1 Invest in primary prevention efforts to promote healthy nutrition, sleep, physical exercise, and the prevention and cessation of the use of tobacco and other addictive substances.
- 2 Improve community infrastructure to support healthy lifestyles and furnish preventive care. Such investments could include, for example, creating safe spaces for low-income children to play. They should also include efforts to increase the availability of tests, immunizations, and other preventive services at work, at school, and in the community.
- 3 Implement and sustain a statewide, telephone quit-line for smoking cessation that provides both counseling and nicotine reduction products.



4 Increase the number and types of Tobacco Use Cessation (TUC) services available in diverse settings and develop and provide educational opportunities for training traditional and non-traditional TUC service providers.

5 Require age-appropriate life skill education in grades K-12 that addresses anti-tobacco education, prevention of drug and alcohol use, nutrition, stress management, exercise, health literacy, the rights and responsibilities of health insurance consumers, and other appropriate topics.

6 Update, adopt, implement, fund, and sustain the *Connecticut Tobacco Use Prevention and Control Plan*.

7 Implement statewide surveillance of key health indicators, using standard national surveys.

8 Improve the nutrition environment in schools and day care facilities, including providing breakfast in school and providing healthy school lunches.

9 Reduce unhealthy food marketing to children, including making schools “ad-free” zones.

10 Provide or otherwise facilitate the receipt of funds to expand the state’s public health workforce.

11 Include public health workforce capacity in state health care workforce assessment and strategic planning.

12 Develop and implement an overall strategic plan for assessing and addressing shortages in the state’s health workforce (including but not limited to those involving primary care), potentially incorporating such policies as targeted debt relief, broadening the permitted scope of practice for non-physician providers, training in new approaches to practice (such as those involving patient-centered medical homes and health information technology), and taking full advantage of available federal resources.

13 Reduce racial and ethnic disparities in access to resources that improve health and increase health literacy and support for healthy living by families from multiple, diverse cultures.

14 Provide or otherwise facilitate the receipt of funds for health care workforce training and development, including efforts to promote cultural and linguistic competence in serving the state’s diverse residents.

Timeline for Implementing Sustinet and the Affordable Care Act

	2011	2012	2013	2014
SUSTINET BOARD AND AUTHORITY	Board appointed by 9/1/2011. Housed within the Office of the Comptroller.	Authority operational no later than 3/1/2012	Independent from Comptroller no later than 1/1/2013.	
SUSTINET STAFF	Existing state agencies provide staff.	Executive Director begins work no later than 3/1/2012, as resources are identified outside General Fund.	Staff fully independent no later than 1/1/2013.	
SUSTINET COVERAGE	Includes current Medicaid and HUSKY enrollees and state employee and retiree health benefit program (SEHP). As soon as feasible, municipalities can buy Sustinet.	As soon as possible, offer Sustinet to small businesses and non-profits. Expand HUSKY to childless adults up to 185% FPL, if funding identified.	As soon as feasible, offer Sustinet to small businesses and non-profits. Expand HUSKY to childless adults up to 185% FPL, if funding identified.	Offer Sustinet to all individuals and employers through the Exchange and other channels, 1/1/2014. Expand HUSKY to adults up to 200% FPL, using Medicaid and Basic Health to maximize federal funds. Excess federal funds increase payment rates for BH.
DELIVERY SYSTEM AND PAYMENT REFORM	Begin advising Comptroller and DSS on delivery system and payment reforms for SEHP and Medicaid/HUSKY. Review Medicaid/HUSKY payment methods and rates, starting 7/1/11.	Implement budget-neutral re-alignment of Medicaid/HUSKY rates, 7/1/12.	Assume direct responsibility for administering Sustinet plan and implementing delivery system and payment reforms, no later than 1/1/2013. Begin multi-year initiative to increase Medicaid rates, 7/1/13, with goal of reaching Medicare levels over time. Contract with Comptroller and DSS to serve SEHP and Medicaid/HUSKY.	



	2011	2012	2013	2014
FEDERAL REFORM: COVERAGE & FUNDING	<p>States may provide Medicaid to childless adults (standard federal matching rate), beginning 2010.</p> <p>Federal planning grants and enhanced federal matching rates for medical home services available in Medicaid, 1/1/2011.</p> <p>Tax credits for some small businesses to purchase coverage, beginning 2010.</p>		<p>Medicaid payment rates for certain primary care services increased to Medicare levels, with full federal funding (2013 and 2014).</p>	
FEDERAL REFORM: Insurance Market	<p>Minimum medical loss ratio.</p> <p>Insurance market reforms prohibit rescissions, lifetime caps, pre-existing condition exclusions for children, beginning 2010.</p>			<p>States must establish an Exchange or the federal government will.</p> <p>Insurance market reforms establish community rating, eliminate pre-existing condition exclusions, limit waiting periods to 90 days, etc.</p>

Conclusion

The state of Connecticut faces daunting budget challenges. Those challenges make it more important than ever to address serious problems involving limited access to health coverage and care for thousands of state residents; misdirected incentives that interfere with the provision of high-quality, efficient care by doctors, nurses, hospitals, and clinics; and health care cost increases that are unsustainable for public and private sectors alike. Our goal has been to develop recommendations for the Connecticut General Assembly, the Administration, and Sustinet's future governing entity that, while cognizant of today's budget challenges, will help Connecticut assume a leadership role in addressing these pressing problems, which are national in scope. We urge Connecticut's policymakers to move towards a more rational and fair system of health care delivery and coverage, making wise choices in 2011 that yield major gains for the state's taxpayers, employers, and families for years to come.

Endnotes

¹*Implementing Sustinet Following Federal Enactment of the Patient Protection and Affordable Care Act of 2010: A Preliminary Report to the Connecticut General Assembly*, May 27, 2010. The report is posted on the Sustinet website at http://www.ct.gov/sustinet/lib/sustinet/board_of_directors_files/reports/sustinet_60_day_report_05272010.pdf.

²A more comprehensive description of Dr. Gruber's model is posted on the Sustinet website at http://www.ct.gov/sustinet/lib/sustinet/board_of_directors_files/resources/grubermodeollowerdescription.pdf.

³Medicaid will expand to individuals with incomes up to 133 percent FPL. However, in calculating income, 5 FPL percentage points will be subtracted from Modified Adjusted Gross Income. Accordingly, as a practical matter, Medicaid coverage will reach 138 percent FPL.

⁴Perhaps the most important reason to offer Sustinet outside the exchange is that adverse selection by large employers can be prevented more effectively than inside the exchange.

⁵In Federal Fiscal Year 2007, 530,000 Connecticut residents received Medicaid and CHIP, of whom 52.7 percent were children, according to Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on 2010 data from Medicaid Statistical Information System reports from CMS. From June 2007 through June 2009, total Medicaid and CHIP enrollment increased by more than 14 percent in Connecticut, according to data compiled in 2010 by the Health Management Associates from state Medicaid enrollment reports for the Kaiser Commission on Medicaid and the Uninsured.

⁶The Urban Institute and the Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer*, December 2010 (state data for 2008-2009).

⁷Section 1(2)(A) of the 2009 Sustinet law required "coverage of medical home services; inpatient and outpatient hospital care; generic and name-brand prescription drugs; laboratory and x-ray services; durable medical equipment; speech, physical and occupational therapy; home health care; vision care; family planning; emergency transportation; hospice; prosthetics; podiatry; short-term rehabilitation; the identification and treatment of developmental delays from birth through age three; and wellness programs, provided convincing scientific evidence demonstrates that such programs are effective in reducing the severity or incidence of chronic disease."

⁸These categories include ambulatory care, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, chronic disease management, and pediatric services (including oral and vision care). ACA §1302(b)(1).



⁹This means that, for the average enrollee, health insurance will pay the listed percentage of all health care costs included within the essential benefits standard.

¹⁰However, SEHP covers associated office visits, prescription drugs, lab tests, and other services.

¹¹See, e.g., Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured, March 2003; Bill J. Wright, Matthew J. Carlson, Heidi Allen, Alyssa L. Holmgren and D. Leif Rustvold, "Raising Premiums And Other Costs For Oregon Health Plan Enrollees Drove Many To Drop Out," *Health Affairs*, December 2010; 29(12): 2311-2316; Dana P. Goldman; Geoffrey F. Joyce; Yuhui Zheng, "Prescription Drug Cost Sharing: Associations With Medication and Medical Utilization and Spending and Health," *Journal of the American Medical Association*, July 4, 2007; 298(1):61-69; Becky A. Briesacher, Jerry H. Gurwitz, and Stephen B. Soumerai, "Patients At-Risk for Cost-Related Medication Nonadherence: A Review of the Literature," *Journal of General Internal Medicine*, June 2007; 22(6): 864–871; Samantha Artiga and Molly O'Malley, *Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent State Experiences*, Kaiser Commission on Medicaid and the Uninsured, May 2005. Of course, this research was done before enactment of an individual mandate, which, all else equal, will increase enrollment.

¹²These population estimates were developed by the Gruber Microsimulation Model.

¹³Under current federal law, these services are provided to all Medicaid children, without cost-sharing.

¹⁴Dr. Gruber's projections suggest that, under a pessimistic scenario in which Sustinet does not slow cost growth, the number of uninsured will fall by 38 percent in 2014, 48 percent in 2015, 53 percent in 2016, and 55 percent in 2017 and later years. If Sustinet slows cost growth by 1 percentage point per year, that will increase the number of insured, because fewer small firms will drop coverage. Under the latter, more optimistic scenario, the number of uninsured will fall by 56 percent in 2017 and later years—slightly more than the level stated in the text.

¹⁵The proposed increase in HUSKY payments cannot currently be modeled, because it requires a thorough analysis and revision of HUSKY and Medicaid payment. The precise details of changed payment rules will not be known until this analysis is complete. After that, modeling cost effects should be much more feasible.

¹⁶In estimating savings, Dr. Gruber compared the policy that will exist when federal and state reforms are fully implemented, beginning in 2014, with the policy that preceded this step by Governor Rell.

¹⁷This general formulation was articulated by Howard Kahn, the Chief Executive Officer of L.A. Care, at our meeting on October 13, 2010.

¹⁸Nominally, Medicaid will expand to individuals with Modified Adjusted Gross Incomes (MAGI) up to 133 percent FPL. However, in determining income, 5 FPL percentage points are subtracted from MAGI. Accordingly, the effective eligibility threshold is 138 percent FPL.

APPENDIX

A. Sustinet Health Plan – Compiled Final Reports

a. Advisory Committees

- i. Health Disparities & Equity
- ii. Health Information & Technology
- iii. Patient Centered Medical Home
- iv. Preventive Healthcare
- v. Healthcare Quality & Provider

b. Task Forces

- i. Healthcare Work Force
- ii. Tobacco & Smoking Cessation
- iii. Childhood & Adult Obesity

B. Jonathan Gruber, Ph.D. – Microsimulation Model Summary

C. Sustinet Legislative Cross-Walk

APPENDIX A

SustiNet Health Plan Compiled Final Reports

Advisory Committees

Health Disparities & Equity
Health Information & Technology
Patient Centered Medical Home
Preventive Healthcare
Healthcare Quality & Provider

Task Forces

Healthcare Work Force
Tobacco & Smoking Cessation
Childhood & Adult Obesity

HEALTH DISPARITIES AND EQUITY ADVISORY COMMITTEE FINAL REPORT TO THE SUSTINET BOARD

1. EXECUTIVE SUMMARY:

Research has demonstrated that vulnerable populations and groups that face social or economic disadvantages tend to experience lower quality care, reduced access, and poorer health outcomes than the general population. These problems are particularly acute among racial, ethnic, and linguistic minority groups. Health disparities can lead to higher health care costs and expensive acute care needs as people delay seeking care for preventable and treatable conditions that spiral into chronic ailments or lead to medical emergencies. Disparities persist within Connecticut's health care system, in part because disadvantaged populations face a dearth of culturally competent and coordinated medical services, as well as barriers to accessing insurance coverage.

The Health Disparities and Equity Advisory Committee asserts that an integrated and multi-disciplinary approach across all of SustiNet's proposed activities will be necessary to effectively address equity gaps and disparities within Connecticut's health care system. The Committee proposes that the SustiNet Board produce an annual action plan to reduce disparities. The plan should include strategies to change the health care system, measureable goals, and key objectives. The committee also offers specific recommendations regarding governance and membership of the SustiNet Board, creation of a Committee on Health Disparities and Equity, the collection and analysis of data on these topics and creation of measureable objectives, incentives and penalties for health care providers, strategies for communicating with people who have disabilities, and considerations about long-term care.

The Committee believes that reducing disparities under the SustiNet Plan will not only improve the quality of care for diverse populations, but may reduce costs, leading to a long lasting competitive advantage over other health insurance strategies.

2. PURPOSE AND MISSION

a. Sustinet Law, direction to the Committee:

Public Act No. 09-148: AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN, reads:

Sec. 4. (c) “The board of directors shall recommend that the public authority adopt periodic action plans to achieve measurable objectives in areas that include, but are not limited to, effective management of chronic illness, preventive care, **reducing racial and ethnic disparities as related to health care and health outcomes**, and reducing the number of state residents without insurance. The board of directors shall include in its recommendations that the public authority monitor the accomplishment of such objectives and modify action plans as necessary.”

b. Members of the Health Disparities and Equity Committee:

Dr. Rafael Perez-Escamilla - <i>Co-Chair</i> Director, Yale School of Public Health Office of Community Health	Dr. Marie M. Spivey - <i>Co-Chair</i> Allied Health & Nursing Initiatives, Capital Workforce Partners
Rev. Bonita Grubbs - <i>Board of Directors Liaison</i> Executive Director Christian Community Action	Estela Lopez - <i>Board of Directors Liaison</i> Senior Program Advisor Excelencia in Education
Yolanda Caldera-Durant Program Director, Economic Opportunity/Health and Human Services Fairfield County Comm. Foundation	Sharon Mierzwa Health Equity Alliance Project Director CT Association of Directors of Health
Leo Canty Second Vice President AFT Connecticut	Dr. J. Nwando Olayiwola Chief Medical Officer, Family Physician Community Health Center, Inc.
Grace Damio Center Director Hispanic Health Council	Stephanie Paulmeno, R.N. Executive Principal & CEO Global Health Systems Consultants, LLC
Elizabeth Krause Senior Program Officer Connecticut Health Foundation	Brad Plebani, Esq. Attorney and Deputy Director Center for Medicare Advocacy, Inc.
Dr. Yvette Martas Physician Mansfield OB/GYN Associates, PC	Arvind Shaw Executive Director Generations Family Health Center

c. Methodology

Members of this Health Disparities and Equity Advisory Committee were confirmed by the Sustinet Board of Directors. The committee's co-chairs officiated at each meeting. Board-appointed Liaisons participated in all meetings. Meetings were scheduled and held biweekly at 7:30 a.m. to complete work in a timely manner.

The Committee arranged call-in capability for members who were unable to physically attend particular meetings. Each meeting agenda included opportunities to discuss the overarching goal of eliminating health disparities and inequities. Committee members researched empirical sources of scientific evidence on barriers to access, cultural and linguistic approaches to quality care, and increasing equity of coverage and payment for health services to the uninsured. The Health Disparities and Equity Committee drafted and distributed questions to prompt each of the other committees and taskforces to set measurable objectives, track improvements, and evaluate outcomes for disparities-related measures.

All decisions were reached by consensus. Members had access to meeting minutes from the Board and all other task forces and committees.

3. SCOPE OF THE ISSUE

a. Statement of problem:

There is documented evidence that certain sub-populations in Connecticut have worse health outcomes than the population at large. These groups experience reduced access to culturally competent and coordinated services, often resulting in lower quality care and delayed medical treatment. Racial, ethnic, and linguistic minorities are particularly vulnerable, as are other groups that experience social and/or economic disadvantages, such as immigrants, people with disabilities, and homeless populations.

b. Goal:

Develop an action plan to reduce health disparities and increase equity through the Sustinet Health Plan with the goal of improving access to care and health outcomes for ethnic, racial, and linguistic minorities, as well as other disadvantaged populations in Connecticut.

c. Approach:

Design the Sustinet Health Plan to systematically reduce disparities and increase equity in access, quality, processes, and health outcomes for racial, ethnic, and linguistic minorities, as well as people with disabilities and other disadvantaged groups. Promoting culturally competent and integrated care models through Sustinet will not only improve the quality of care for diverse populations, but may reduce costs, leading to a long lasting competitive advantage over other health insurance strategies.

d. Principles:

- (1)** The public authority shall integrate strategies for reducing and eliminating racial and ethnic disparities into every component of the Sustinet plan, including but not limited to:
- i.** Outreach
 - ii.** Application Forms & Enrollment
 - iii.** Covered benefits, including preventive care services and interpreter services
 - iv.** Provider¹ networks & capacity
 - v.** Provider cultural competence standards based on national standards (established by the Joint Commission)
 - vi.** Provider payment methods and rates, and other financial incentives
 - vii.** Provider continuing education requirements
 - viii.** Enrollee communications, including education for enrollees on how to navigate the health care system
 - ix.** Enrollee appeals process
 - x.** Quality measurement and improvement
- (2)** The public authority shall describe these strategies, as well as measurable goals and objectives, in an action plan for reducing and eliminating racial and ethnic health disparities. The plan shall be updated at least annually.

e. Definitions

1) Health disparities:

Health disparities refer to the differences in disease risk, incidence, prevalence, morbidity, and mortality and other adverse conditions, such as unequal access to quality health 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.” (Stratton, Hynes and Nepaul, “Issue Brief: Defining Health Disparities.” Hartford, CT: Connecticut Department of Public Health, 2007).

2) Health care equity:

“A common definition of equity in the public health literature is that the primary determinant in the use of services should be the need for them. Other

¹ This document uses the term “provider” to refer to any individual or organization licensed to provide health care services.

factors such as income, race, location of residence and so forth should not play an important role in selecting who receives care and who does not.” (Berman P., Sisler D. G. and Habicht J.-P. “Equity in public sector primary health care: the role of service organization in Indonesia.” *Econ. Der. Cultural Change*, 31, 771, 1989.)

Or

‘A health disparity (inequality) is a particular type of [unfavorable] difference in health or in the most important influences on health that...disadvantaged social groups systematically experience...’ (Braveman, P. “Health disparities and health equity: Concepts and measurement.” *Annual Review of Public Health*, 27, 167–194, 2006).

Equity in Health: “The absence of potentially remediable, systematic differences on one or more aspects of health across socially, economically, demographically, or geographically defined population groups or subgroups.” (<http://www.equityhealthj.com/content/1/1/1>, from the International Society for Equity in Health).

3) Cultural competency:

“Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities” (Based on Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care Volume I*. Washington, DC: Georgetown
<http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>).

4) Health care access:

“Degree to which people are able to obtain appropriate care from the health care system in a timely manner” (IOM 2006, from: Perez- Escamilla, Rafael. “Health Care Access among Latinos: Implications for Social and Health Care Reforms.” *Journal of Hispanic Higher Education*, Vol. 9, No. 1, 43-60 (2010).

5) Vulnerable populations:

Groups of people "made vulnerable by their financial circumstances or place of residence; health, age, or functional or developmental status; or ability to communicate effectively...[and] personal characteristics, such as race, ethnicity, and sex," including "populations whose vulnerability is due to chronic or terminal disease or disability" [Final Report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, cited by the Agency for Healthcare Research and Quality (AHRQ), <http://www.ahrq.gov/news/press/vulnpr.htm>].

6) Socially disadvantaged population:

"Socially disadvantaged groups [are] those that have low [socio-economic status] or belong to an ethno racial minority ... [In health care] social disadvantage [is] related to patient, provider, and health system factors that can affect self-management and provider management and ultimately manifest as clinical outcomes." (Glazier RH, Bajcar J, Kennie NR, Willson K. "A systematic review of interventions to improve diabetes care in socially disadvantaged populations." Diabetes Care 2006; 29:1675-88.)

4. RECOMMENDATIONS

Socially disadvantaged people are more likely to become ill and die prematurely. They are also more likely to delay seeking needed care until a health care problem becomes dire, which is often the most expensive moment to provide medical treatment. In Connecticut, there is great pent-up need for health services among many disadvantaged sub-populations due to lack of health insurance, limited access to care, discrimination, and the need for the medical profession to adjust its methods of providing health care to accommodate a multiplicity of cultural, ethnic and linguistic differences in population groups throughout the state.

Beyond expanding insurance coverage – which will occur after 2014 as the state implements federal health reform – the state's greatest opportunity for increasing access to and quality of care is to reduce disparities and achieve greater equity across the state. The Committee notes, however, that treating everyone the same way will not create equity. In fact, treating everyone the same elides that certain populations, particularly the most vulnerable among us, have much greater health care needs than other people who are healthier or have more resources. Those with the greatest needs may require extra attention and support to improve their health access and outcomes.

The Committee believes that, in the long term, reducing disparities, increasing equity, and promoting better coordinated and culturally competent care for everyone will help to slow rising health care costs. Addressing the health needs of chronically ill patients through integrated care models will be particularly important in this regard. However, the Committee also acknowledges that treatment of widespread, unaddressed health care needs among vulnerable and disadvantaged people will require significant up-front

investment from the State and federal government. A financial and operational commitment to outreach among hard-to-reach populations will be crucial to bring as many people as possible into a more culturally competent health care system and realize the benefits of integrated and coordinated care delivery.

Given on-going state budget problems, the fiscal health of Connecticut may determine the success or failure of the Board's efforts. Ultimately, Sustinet's success will depend on substantial legislative involvement, as well as committed leadership from the Governor, state agencies, and advocates.

From prevention and health care quality, to workforce development and medical homes, health disparities remain an overarching problem within each substantive area. A multi-tiered approach will be necessary to address this problem holistically through Sustinet. The Committee's specific recommendations are as follows.

1) Governance of Sustinet

- a) The public authority governing board shall include at least two enrollees in the Sustinet plan.
- b) The public authority governing board shall reflect the diversity of Sustinet plan enrollees in terms of race, ethnicity, gender and age (>18).
- c) The public authority governing board shall include at least two individuals who have expertise in reducing health disparities.
- d) The public authority governing board shall establish a Community Advisory Committee comprised of Sustinet enrollees to provide consumer input on policy decisions.
- e) The public authority governing board shall establish a Committee on Health Disparities and Equity that is dedicated to reducing and eliminating racial and ethnic disparities in health care access, utilization, quality of care, and health outcomes under Sustinet. Member(s) of the public authority's governing board who have expertise in reducing disparities shall chair the committee.

2) Responsibilities of the Committee on Health Disparities and Equity:

- a) Assuring the integration of culturally competent, quality improvement objectives into the policies of the Sustinet Plan.
- b) Allocating funding dedicated to reducing disparities for uses including conducting studies and providing grants to provider organizations for improvement.
- c) Commissioning studies, as described in Data and Reporting (below).
- d) Identifying and approving measures of disparities for use by the Sustinet Plan in improvement efforts.
- e) Recommending specific measures to eliminate barriers to care for inclusion in a Pay for Performance incentive system.

- f) Reviewing the set of benefits covered by the Sustinet Plan and recommending changes that would assist in reducing disparities.
- g) The Committee shall undertake a study of the return on investment (ROI) of Connecticut's potential and actual spending on programs and initiatives that reduce disparities.

3) Budget

The public authority shall seek and allocate funding dedicated to reducing and eliminating health disparities.

4) Data Collection and Use

- a) All Sustinet plan data intake systems and data storage systems shall include member race, ethnicity & language (in addition to age, gender, and other demographic data) in order to be able to track disparities in health outcomes. Data systems shall enable coding of multiple races and ethnicities for a single individual.
- b) The Sustinet Plan shall provide one integrated system for all plan data in real time, to the extent feasible.
- c) The committee shall assess current data to document disparities and identifying gaps in data needed to fully assess disparities.
- d) The committee shall commission studies to document disparities by population group and by provider organization, as well as the cost-effectiveness of improvement efforts.
- e) The committee shall evaluate improvement efforts, establish a feedback loop based on rapid responses, and report its findings publicly.

5) Measurable objectives in reducing racial and ethnic disparities

- a) The public authority/committee shall establish specific, written, measurable goals for reducing and eliminating racial and ethnic disparities in health access, utilization, quality of care and health outcomes.
- b) These measures shall use life cycle approach and shall include appropriate measures for all age groups and for both genders.
- c) Improvement measures shall include, but not be limited to, standard measures for best practices in management of chronic physical and mental health conditions (e.g. diabetes, asthma, cardiovascular disease, and depression), use of preventive care services, use of preventive dental care services, and reductions in avoidable hospitalizations, re-admissions and emergency visits.
- d) The Sustinet Plan should start with some initial measures based on current data and knowledge and expand the list of measures over time. The committee should establish short-term, medium-term, and long-term objectives and recommendations.
- e) The public authority shall report racial and ethnic disparities in health access, utilization, quality of care and health outcomes by geographic area

and by provider or organization, where feasible. The Board/committee shall provide information data to each provider organization comparing its performance to benchmarks and to other providers.

- f) The public authority shall provide guidance to providers on specific actions that providers shall take to reduce disparities.
- g) Providers shall have an opportunity to review their own data and take corrective action before results are made public.

6) Incentives to providers for reducing disparities

- a) The public authority shall budget for incentives to providers for identifying and reducing disparities in their diverse patient population groups.
- b) The committee shall provide grant funding to provider and community-based healthcare organizations to provide initial funding to establish programs to reduce disparities.
- c) The Sustinet Plan shall establish a Pay for Performance (P4P) system to reward providers for reductions in racial and ethnic disparities in health access, utilization, quality of care and health outcomes.
- d) The P4P system should reward providers for improvement as well as for meeting benchmarks.
- e) The P4P system should reward providers for having an effective plan in place for preventing illness, as well as improving health status.
- f) The P4P system should specifically reward providers for caring for patients with the most complex and least well-controlled conditions.
- g) The P4P system should expect providers to receive cross-cultural training within regular professional development sessions for providers and staff.
- h) The P4P system should reward home care and other long-term care providers for providing patients and families with education on healthcare coverage and on navigating the healthcare system.

7) Penalties for providers failing to take action to reduce disparities

- a) The public authority/committee shall require participating providers to submit a corrective action plan, describing in detail the actions that the provider will take to reduce disparities.
- b) Providers that do not make progress toward reducing disparities, defined as achieving specified benchmarks within a specified timeframe, may be removed from the plan network.

8) Special considerations for people with disabilities. The Sustinet plan shall make accommodations for people with disabilities, which shall include the following:

- a) Provide computer-assisted real time translation (CART) or viable real time transcriptions (VRT) where applicable.
- b) Develop print materials in easy to read, low literacy, picture and symbol formats.

- c) Provide materials in alternative formats (e.g., audiotape, Braille, enlarged print).
- d) Take varied approaches to share information with individuals who experience cognitive disabilities.
- e) Develop materials that have been tested for specific cultural, ethnic and linguistic groups.
- f) Conduct outreach through ethnic media in languages other than English (e.g., television, radio, Internet, newspapers, periodicals).
 - i. Provide translations of legally binding documents (e.g., consent forms, confidentiality and patient rights statements, release of information, applications), signage, health education materials, and public awareness materials and campaigns.

9) Long Term Care

- a) Cultural differences can create difficulties for older adults and their caregivers in receiving needed services and care. Long term care providers must develop methods of recruiting, retaining and managing a workforce that mirrors the diverse population of older adults and those with disabilities requiring health care services both in long term care facilities and in home care.
- b) If the Board decided that the Sustinet Plan would include individuals who are dually eligible for Medicare and Medicaid (low income individuals with disabilities and elders over age 65), then
- c) Our committee would recommend strategies for reducing and eliminating disparities in long-term care, including providing education and training on cultural competence standards to caregivers.

10) Intersecting Issues (topics that overlap with other committees)

- a) Health Information Technology
 - i. All Sustinet plan forms, data intake systems and data storage systems shall include member race, ethnicity & language preference (in addition to age, gender, and other demographic data), which can then be used as a measurement tool to monitor racial/ethnic health disparities. Data systems shall enable coding of multiple races and ethnicities for a single individual.
 - ii. The Sustinet Plan shall provide one integrated system for all plan data in real time, to the extent feasible.
- b) Care Delivery and Medical Home
 - i. The Sustinet plan should include cultural competence standards for Medical Homes.
 - ii. Establish and continuously improve culturally competent coordination of healthcare services across the continuum of care.

- iii. Develop chronic disease self-management programs that are similar to those created by the Stanford Patient Education Research Center: <http://patienteducation.stanford.edu/programs/>.

c) Health Care Quality

- i. The SustiNet Plan shall establish a Pay for Performance (P4P) system to reward providers for reductions in racial and ethnic disparities in health access, utilization, quality of care and health outcomes. The P4P system should reward providers for improvement as well as for meeting benchmarks. The P4P system should reward providers for having an effective plan in place for preventing illness, as well as improving health status.
- ii. The SustiNet payment system, whether capitation or fee for service, should reward providers for treating the most complex patients.
- iii. The SustiNet payment system should include strategies for paying for interpreter services.
- iv. The SustiNet plan should include the standards for measuring systemic cultural competence used by the Joint Commission

d) Health Care Workforce

"Increasing racial and ethnic diversity among health professionals is important because evidence indicates that diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professions students, among many other benefits." [Institute of Medicine, Feb. 5, 2004].

- i. The SustiNet Plan shall require providers to receive ongoing cultural and linguistic competence training using effective training modules.
- ii. Culturally competent health care providers offer health care organizations a valuable opportunity to devote limited health care resources to the best possible use. Cultural competent means of care delivery will produce a twofold benefit: outcomes will improve, and this improvement may encourage some members to seek more preventive care and thus reduce their reliance on costly emergency care. (The Permanente Journal, Winter, 2000, Vol. 4, No. 1)

e) Preventive Care

- i. Define measurable objectives to determine progress in the elimination of health disparities/inequities relative to prevention.
- ii. Track improvements to ensure that SustiNet is making a difference in the elimination of health disparities/inequities relative to prevention.

f) Obesity

- i. Define measurable objectives to determine progress in the elimination of health disparities/inequities relative to the issue of obesity.

- ii. Track improvements to ensure that Sustinet is making a difference in the elimination of health disparities/inequities relative to the issue of obesity.

g) Tobacco Use

- i. Define measurable objectives to determine progress in the elimination of health disparities/inequities relative to the issue of tobacco and smoking cessation.
- ii. Track improvements to ensure that Sustinet is making a difference to eliminate health disparities/inequities relative to the issue of tobacco and smoking cessation.

5. UNKNOWN/UNRESOLVED ISSUES SUCH AS:

1) Federal funding opportunities: The federal Patient Protection and Affordable Care Act (PPACA) includes several funding opportunities that address disparities and equity issues, including the following. The Sustinet Board should consider which funding opportunities would be most beneficial for Connecticut.

- a) Incentives to prevent chronic diseases in Medicaid populations (Sec. 4108): Provide grants to states to implement incentive programs to help individuals quit smoking, control/reduce weight, lower cholesterol and blood pressure, avoid diabetes, and address co-morbidities. Test approaches that may be scalable. Funding: \$100m for five year period beginning on Jan 1, 2011.
- b) Community Transformation Grants (Sec. 4201): Grants for implementation, evaluation, and dissemination of evidence-based community preventive health activities to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming. Funding: appropriations for FYs 2010-2014.
- c) Wellness Demonstration (Sec. 4206): Establishes pilot programs in 10 states by July 2014 to implement, evaluate, and disseminate evidence-based community preventive health activities to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming. Expands demonstrations in 2017 if effective.
- d) Data collection about disparities (sec. 4302): Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. (Effective two years following enactment).

- e) Alternative dental health care providers demonstration project (Sec. 5304): Establishes programs that train or employ alternative dental health care providers to increase access to dental health care services in rural and other underserved communities. 15 projects begin no later than 2 years after enactment. Funding: Each grant will be at least \$4m over five years.
- f) Grants for cultural competency, prevention, public health and working with individuals with disabilities (Sec. 5307): Grants for development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs. Funding: necessary appropriations authorized for FYs 2010-2015.
- g) Grants to promote the community health workforce (Sec. 5313): Promote positive health behaviors and outcomes for medically underserved communities and chronically ill populations through the use of community health workers. Encourage CHW programs to collaborate with academic institutions and one-stop delivery systems, as well as outcomes-based payment systems. Funding: Appropriations as necessary for FYs 2010-2014.
- h) Supporting area health education centers (Sec. 5403): Promote infrastructure development and point-of-service maintenance, particularly for medical schools. Funding: \$125m for FY 2010-2014; not less than \$250,000 per AHEC annually; limited to 12 years for a program and 6 years for a center. Grants for health professionals working in underserved communities: Improve health care, increase retention, increase representation of minority faculty members, enhance the practice environment, and provide information dissemination and educational support to reduce professional isolation through the timely dissemination of research findings using relevant resources. Funding: \$5m for each FY 2010 through 2014.
- i) Community-based collaborative care network program (Sec. 10333): Grants for community-based collaborative care networks (consortium of health care providers with a joint governance structure) to provide comprehensive coordinated and integrated health care services for low-income populations, including: outreach and enrollment, patient navigation and care coordination, case management, transportation, expanded capacity for tele-health or after-hour services. Funding: appropriations as necessary for FYs 2011-2015.
- j) Office of Minority Health (Sec. 10334): Assure improved health status of racial and ethnic minorities by developing measures to evaluate the

effectiveness of activities aimed at reducing health disparities and supporting the local community. Evaluate community outreach activities, language services, and workforce cultural competency. Funding: As necessary for FY 2011-2016.

- k) Centers of Excellence for Depression (Sec. 10410): Establish (not more than) 30 national centers of excellence for depression by September 30, 2016 to engage in activities related to the treatment of depressive disorders. Non-federal contributions must be 1 of every 5 dollars spent on the project. Funding: \$100m for each FY 2011-2015, \$150m for each FY 2016-2020. Allocation to each center may be no more than \$5m except for the coordinating center, which may receive up to \$10m.
- l) State grants to health care providers who provide services to a high percentage of medically underserved populations or other special populations (Sec. 10501): Grants for health care providers who treat a high percentage of medically underserved populations or other special populations. The program cannot be established under the state Medicaid program. Recruit students most likely to practice in medically underserved areas, particularly rural communities; provide rural-focused training and experience, and increase the number of recent allopathic and osteopathic medical school graduates. Funding: \$4m for FYs 2010-2013.
- m) Grants for community-based diabetes prevention programs (Sec. 10501): Establish a national diabetes prevention program targeted at adults at high risk for diabetes to eliminate the preventable burden of diabetes. Funding: appropriations as necessary, FYs 2010-2014.

2) Connecticut Commission on Health Equity

- a) Connecticut Commission on Health Equity (Public Act 08-171): Established and sustainable partnerships with this Commission will facilitate linkages with other state, local and federal entities to assure support of integrated approaches to maintain Connecticut's model of healthcare to eliminate health disparities and inequities within our state.

6. ADDITIONAL MATERIALS

2009 National Healthcare Quality & Disparities Reports, US Agency for Healthcare Research and Quality (AHRQ), Publication No. 10-0004 and 10-0003, March 2010.

For the seventh year in a row, the Agency for Healthcare Research and Quality (AHRQ) has produced the National Healthcare Quality Report (NHQR) and the National Healthcare Disparities Report (NHDR). These reports measure trends in effectiveness of care, patient

safety, timeliness of care, patient centeredness, and efficiency of care. The reports present, in chart form, the latest available findings on quality of and access to health care.

<http://www.ahrq.gov/qual/qdr09.htm>

The Connecticut Health Disparities Project, Connecticut Department of Public Health

The Connecticut Health Disparities Project, Connecticut Department of Public Health, Hartford, Connecticut, January 2009.

http://www.ct.gov/dph/lib/dph/hisr/pdf/2009ct_healthdisparitiesreport.pdf

Health Disparities & Health Care Access: Definitions & Recommendations

Rafael Pérez-Escamilla, PhD, Professor of Epidemiology & Public Health, Yale School of Public Health, March 1, 2010.

http://www.ct.gov/sustinet/lib/sustinet/committeinformation/healthequity/health_disparities_health_care_access.pdf

Racial and Ethnic Disparities in Access to Health Insurance and Health Care

From the Kaiser Commission on Medicaid and the Uninsured: Racial and ethnic groups in the United States continue to experience major differences in health status compared to the majority white population. Although many factors affect health status, the lack of health insurance and other barriers to obtaining health services markedly diminish minorities' use of both preventive services and medical treatments. This report, produced in collaboration with the UCLA Center for Health Policy Research, examines health insurance coverage and access to physician services among African Americans, Latinos, Asian Americans and Pacific Islanders, and American Indians and Alaska Natives. By pooling national survey data over two years, information about particular minority subgroups is also provided.

<http://www.kff.org/uninsured/1525-index.cfm>

REPORT OF THE HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE TO THE SUSTINET BOARD

Summary

The Sustinet HIT Advisory Committee is pleased to present its recommendations to the Sustinet Board. The Advisory Committee concluded that Sustinet has a remarkable opportunity to collaborate with other state agencies to advance mutual initiatives to improve health care quality and efficiency. Federal funding to advance the uptake of HIT will provide much needed support for all aspects, including equipment, training and joint planning efforts.

The HIT Advisory Committee recommends that Sustinet electronic medical record requirements align with ongoing statewide and national efforts. A key forum for this work is the new Regional Health Information Organization -- the Health Information Technology Exchange of Connecticut (HITECT) that will be formally activated on January 1, 2011. Sustinet should have a formal role on the HITECT Board of Directors to ensure that the needs of new coverage programs and delivery systems will be integrated into the emerging system designs.

I. Purpose and mission of the Advisory Committee

A. Sustinet Law

The Sustinet legislation directed the Sustinet Board of Directors to establish an information technology advisory committee with the specific responsibility to make recommendations about electronic health record adoption to ensure a coordinated and interoperable system. The legislation recognized the complexity of creating such a system and the broad range of affected entities, including hospitals, clinics, medical groups, labs, pharmacies and solo or small medical practices. The Sustinet Health Information Technology Advisory Committee was charged with examining the process of implementation, and collaboration with state health care service delivery and oversight agencies.

B. Members

The Sustinet Health Information ("HIT") Advisory Committee membership was drawn from diverse clinical and information technology experts. Members of the Advisory Committee include:

[Alex Hutchinson](#)

Managing Partner
RPM Health
Advisory Committee Co-Chair

[Marie Smith](#)

Department Head of Pharmacy
Practice
University of Connecticut School of Pharmacy
Advisory Committee Co-Chair

[Jeffrey Kramer](#)

Associate Professor-in-Residence and Director
Programs in Healthcare and Insurance Studies
University of Connecticut School of Business
Board of Directors Committee Liaison

[Jamie Mooney](#)

Vice President and CIO Norwalk
Hospital
Board of Directors Committee Liaison

[Robert Aseltine](#)

Director
CT Health Information Network
Center for Public Health and Health Policy

[Jeffrey Asher](#)

Executive Director
CHEFA

[Iody Bishop-Pullan](#)

Public Health Dental Case Manager
Department of Health and Social Services, Stamford

[John Brady](#)

Chief Financial Officer and Vice President, Business
Planning
ChimeNet

[Angelo Carraba](#)

Chair, Board
e-health Connecticut, Inc.

[Mark Boxer](#)

Senior Vice President, Global
Technology Services
ACS Inc.

[Joel Cruz](#)

Charter Oak Health Center

[Pamela Cucinelli](#)

Nurse
Community Health Center

[Judith Fifield](#)

Professor & Director
University of Connecticut Health Center, Ethel
Donaghue Center for Translating Research into
Practice and Policy (TRIPP)

[Meg Hooper](#)

Chief, Planning Branch
Department of Public Health

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VP of Information Systems
Hartford Hospital

[Robert Tessier](#)

Executive Director
The CT Coalition of Taft-Hartley Health Funds, Inc

[Victor Villagra](#)

Founder and President
Health & Technology Vector, Inc.

C. Methodology

The HIT Advisory Committee met every other week beginning in December 2009. The Committee heard presentations from state and national electronic medical, records, and HIT experts.

The Committee formed subcommittees to examine the following topic areas: ARRA, Governance, Organization, Finance, Logistics, and Marketing and Outreach. Each subcommittee developed a set of recommendations in support of the HIT Advisory Committee's overall charge.

D. Definitions

The HIT Advisory Committee compiled a set of definitions and principles as background for specific recommendations about electronic medical records adoption and health information exchange. With many federal and state acronyms coined to describe complex organizations and functions, the Committee offers this information to create a common language for further conversations in the months ahead. These definitions are adapted from US Dept. HHS Office of the National Coordinator for Health Information Technology, ONC State HIE Toolkit, and E-Health Initiative.

These terms are in alphabetical order.

Clinical Decision-Support (CDS) -Software tools that provide evidence-based treatment recommendations to a clinician when evaluating care options for a patient, for example, offering reminders to clinicians to recommend guideline-based interventions for patients with chronic disease.

Centers for Medicare and Medicaid Services (CMS) – the federal agency within Health and Human Services with oversight for publicly funded health care programs.

Disease/Patient Registry – a database containing patient-specific clinical information for a population of patients. A clinical-based registry allows providers to proactively manage patients with chronic diseases. A population-based registry contains and tracks information on people diagnosed with a specific condition/disease within a defined geographic area or defined health plan. Registries are supplemental to EHRs (rather than substitute for EHRs). A statewide registry within the HIE creates the foundation for opportunities to analyze information and make actionable policy recommendations and decisions.

Electronic Health Record (EHR) An EHR is a medical record or any other information relating to the past, present or future physical and mental health, or condition of a patient which resides in computers which capture, transmit, receive, store, retrieve, link, and manipulate multimedia data for the primary purpose of providing health care and health-related services. EHRs may link real-time patient health records to evidence-based clinical decision support tools.

The EHR may automate and streamline a clinician's workflow, ensuring that pertinent clinical information is collected and available during the patient's next encounter. Currently, the primary use of EHRs is as a clinical documentation and practice management tool rather than a platform for care coordination and collaboration among health care professionals. If data aggregation capacity is developed within the HITECT health information exchange, EHRs may become a source of data for billing, quality management, outcome reporting, public health disease surveillance and reporting, and health services/policy research.

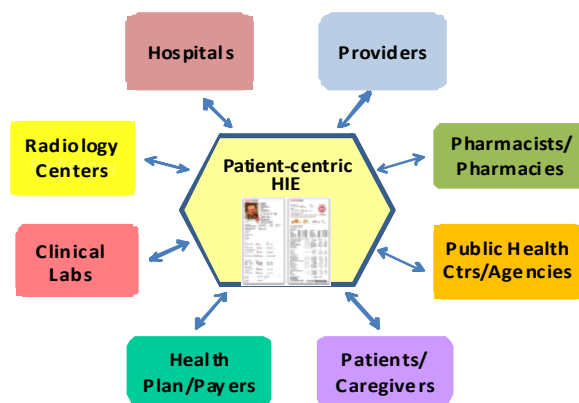
Electronic Prescribing (E-Rx) –Technology allowing prescribers to use handheld or personal computers to review drug and formulary coverage, view patient medication histories, and transmit prescriptions electronically to a pharmacy. E-prescribing software is often integrated into existing clinical information systems to screen patients for drug interactions and allergies. Some e-prescribing systems allow for two-way communication between the pharmacist and prescriber.

Health Information Exchange (HIE) - the movement of health care information electronically across organizations within a state, region, or community according to nationally recognized standards to improve the quality, safety, and efficiency of health care – with a major focus on patient-centered care coordination and interprofessional collaboration for care planning purposes. A key premise is that information should follow the patient, and artificial obstacles -- technical, bureaucratic, or business related -- should not be a barrier to the seamless exchange of information. HIE allows secure clinical information sharing among primary care medical homes and specialists, hospitals, labs, imaging centers, clinics, and pharmacies, ultimately allowing quick access to key health information at the point of care.

Successful HIE initiatives obtain input and address the needs of health care professionals, providers, government/public health agencies, payers, hospital/health systems, academic health professionals/health researchers, and the patient community. An HIE should be accessible (based on patient permission) to any licensed health care professional in CT and to out-of-state health care professionals caring for CT residents. Looking ahead, a unified HIE will allow data exchanges among state agencies such as Medicaid, public health, school, behavioral health, corrections, home health, and immunization/disease registries.

FIGURE 1

Health Information Exchange (HIE) Data Sources and Users



Health Information Technology (HIT) in this set of recommendations refers to certified electronic health records, technology and connectivity required to meaningfully use and exchange patient-level, treatment-related health information. HIT includes electronic health records (EHR), clinical decision support systems, e-prescribing, disease and patient registries, and personal health records.

Health Information Technology Exchange of CT (HITECT), a quasi-state agency, was designated as the CT statewide RHIO effective January 1, 2011 and will be governed by a Board of Directors.

Health Information Technology Exchange Advisory Committee (HITEAC): The 12 member advisory group created by Connecticut Public Act 10-117 that is responsible for advising the Department of Public Health about health information protocols, standards, and systems.

Meaningful Use –The federal Office of the National Coordinator for Health Information Technology (ONC) issued proposed regulations for “meaningful use” of certified electronic health record (EHR) technology and a second rule for initial standards, implementation specifications, and certification criteria for EHR technology.

CMS’ goal is for the definition of meaningful use to be consistent with applicable provisions of Medicare and Medicaid law while continually advancing the contributions certified EHR technology can make to improving health care quality, efficiency, and patient safety. To accomplish this, CMS’ proposed rule would phase in more robust criteria for demonstrating meaningful use in three stages.

Stage 1 begins in 2011 with 25 objectives/measures for eligible providers (EPs) and 23 objectives/measures for eligible hospitals that must be met to be deemed a meaningful EHR user. Areas of emphasis include EHR data collection, tracking clinical conditions, care coordination, and reporting clinical quality measures and public health information.

Stage 2 adds disease management, clinical decision support, medication management, support for patient access to their health information, transitions in care, quality measurement and research, and bi-directional communication with public health agencies.

Stage 3 adds achieving improvements in quality, safety and efficiency, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data, and improving population health outcomes.

Personal Health Record (PHR) – A patient-accessible application that allows individuals to maintain and manage their health information (and that of others for whom they are authorized) in a private, secure, and confidential environment.

Regional Extension Centers (also, Health Information Technology Regional Extension Centers, or HITREC) refers to federally funded regional health IT groups that will provide support to clinicians seeking to adopt EHRs. The HITREC services include training, technical assistance and resources. In Connecticut, e-Health Connecticut is the designated statewide HITREC.

Regional Health Information Organization (RHIO) - a multi-stakeholder organization that provides secure exchanges and uses of health information to improve service delivery quality, safety and efficiency. The RHIO determines the technologies, standards, laws, policies, technical services, programs and practices, business operations, and financing mechanisms that enable health information to be shared among health decision makers, including consumers and patients, to promote improvements in health and healthcare. The Health Information Technology Exchange of CT (HITECT), a quasi-state agency, was designated as the CT statewide RHIO effective January 1, 2011 and will be governed by a Board of Directors. Before then, the Department of Public Health serves as the state RHIO, which has convened an Advisory Committee (HITEAC) until the end of 2010.

II. The Sustinet HIT Advisory Committee's Approach

A. Criteria for Electronic Health Records

The Sustinet HIT Advisory Committee endorses the following functional attributes of an effective, unified EHR system.

- Collect and update patient information (in a private and timely manner) during patient-health care professional visits, at care transitions, and at home.
- Access patients' information in a timely manner to perform clinical assessments and share recommendations with other health care professionals.

- Develop and implement patient care plans (incorporating shared patient care goals among health care providers/professionals) and monitor progress toward meeting the planned goals.
- Support the medical home model by enabling chronic care coordination across care settings and collaboration among health care professionals.
- Support consumers and patients to develop and use personal health records.
- Establish and implement evidence-based quality improvement and patient safety standards, and monitor progress toward meeting goals.
- Achieve meaningful use standards and reporting requirements.
- Address health disparities.

B. Recent State Initiatives

The Sustinet Legislation framed a set of questions about the expansion and use of electronic health records. With this direction, the HIT Advisory Committee explored the opportunities and the challenges for the development, regulation and financing of a state wide electronic medical records policy.

The HIT Advisory Committee's work occurred during a period of intense focus on health information technology, both in Connecticut and at the national level. Recent initiatives and advances include:

1. Development of a statewide health information technology plan: In June 2009, the Connecticut Department of Public Health (DPH) released a report that surveyed the current state of electronic health records use and proposed a roadmap for state wide adoption. This report found that hospitals and community health centers are creating integrated records within their organizations. (CT Department of Public Health, "Connecticut State Health Information Technology Plan"). This plan is in the process of being updated.
2. Designation of the statewide Regional Health Information Organization (RHIO): The Connecticut Department of Public Health was named the lead health information exchange organization for the state and to serve as the state's RHIO (CGS Public Act 09-232). The RHIO oversees and governs the exchange of health related information among organizations according to nationally recognized standards (Office of the National Coordinator definition). An advisory committee, HITEAC, was designated to advise the DPH Commissioner about health information protocols, standards, and systems.

3. Receipt of federal grant funding for a Regional Extension Center: The federal Office of the National Coordinator awarded a \$5.7 million grant to e-Health Connecticut, a private nonprofit organization, to provide training, support and technical assistance to providers seeking to bring EHRs to their practices. The support includes compliance with national standards.
4. Robust federal activity around standardization of rules and standards for electronic health records, including privacy, release and storage, through the Office of the National Coordinator.

The CT Department of Public Health, with assistance from HITEAC and Gartner Group, is developing a strategic and operational plan for the state's health information exchange. State, private, public health care agencies will interact through a collaborative, hybrid exchange system, as shown in Figure 2.

FIGURE 2

Source: "Health Insurance Technology Exchange of Connecticut Strategic Plan, Draft, June 2010"http://www.ct.gov/dph/lib/dph/research_&_development/hite-ct_strategic_plan_draft_v2.0.pdf

Throughout its consideration of the current landscape statewide and around the country, the HIT Advisory Committee identified opportunities for Sustinet to participate in ongoing EHR development processes. Going forward, Sustinet representatives must participate in the development and implementation work now underway.

Other Sustinet Advisory Committees and Task Forces identified health information technology needs. EHRs and patient information exchanges are often a key element in designing successful patient centered medical homes. The Advisory Committee on Health Disparities and Equity recommended adding patient demographics to EHRs to permit long-term assessment of treatment outcomes and effectiveness. With the Sustinet program itself still in development, many requirements are yet to be defined, such as relationships with existing public and private programs and payers. The HIT Advisory Committee recognizes that these additional requirements will emerge as the Sustinet Board works through its design process in the next months.

III. Recommendations

A. ORGANIZATION AND GOVERNANCE

1. Align Sustinet with other statewide and national efforts

All Sustinet HIT/HIE initiatives should align with related work that is to be coordinated by HITECT, the state's Regional Health Information Organization beginning in January 2011, including electronic health records, e-prescribing, clinical decision support, and personal electronic health records.

The State's public and private healthcare providers, regulators, consumers, and payers must coordinate their efforts to advance interoperable health information technologies and a unified strategy for health information exchange. This will eliminate duplication of efforts and contradictory strategies.

Recognizing the major changes in the HIT landscape since Sustinet was enacted as well as the many different HIT/HIE planning efforts underway, the Sustinet HIT Advisory Committee recommends that Sustinet become integrated into statewide efforts. Much work is already underway to develop national standards for HIT and HIE through the US Dept. of Health and Human Services, the US Office of the National Coordinator (ONC), and the Centers for Medicaid and Medicare Services (CMS) pertaining to HIT and HIE. These include, but are not limited to the ONC framework, HITSP (privacy and security),

interoperability standards, continuity-of-care records/documents (CCR/CCD), Meaningful Use criteria, certified EHRs, and HIPAA.

The Advisory Committee believes that the HITECT agency will provide the opportunity and the required authority to convene stakeholders and develop standardized EHR rules across the range of providers and data users in the state. HITECT will provide a formal governance structure with diverse representation on its Board of Directors. Other functions that HITECT will assume in 2011 include:

- Development of a technical architecture that facilitates electronic exchange of information using common standards
- Standardization of data elements, transaction types, and standards for exchange.
- Documentation of participant roles/responsibilities to enable trust (e.g., Data Use and Reciprocal Support Agreement – DURSA).

2. Conform to national standards

SustiNet representatives who may also sit on the future HITECT Board of Directors should promote the use of the HIT/HIE national standards established by the US Dept. of Health and Human Services, the US Office of the National Coordinator (ONC), and the Centers for Medicaid and Medicare Services (CMS) pertaining to HIT and HIE. These include, but are not limited to the ONC framework, HITSP (privacy and security), interoperability standards, continuity-of-care records/documents (CCR/CCD), Meaningful Use criteria, certified EHRs, and HIPAA.

3. Formal Sustinet representation on the HITECT Board of Directors, the Regional Health Information Organization.

SustiNet should have a formal representative on the state's RHIO with a designated seat on the Health Information Technology Exchange Board of Directors. Sustinet representatives will advocate for EHR and HIE elements recommended by the Sustinet Board, including support for patient centered medical homes, inclusion of race and ethnicity fields on the EHR, monitoring EHR adoption in provider groups serving low income communities, and supporting resources for analytics and measurement capacity.

B. Financial Considerations

1. Leverage federal ARRA grants to promote EHR adoption

SustiNet should join efforts to leverage ARRA funds for health information technology and exchange in Connecticut:

- \$5 million to community health centers for capital/operating support/HIT;
- \$7 million for strategic and operational planning with implementation of selected projects by the State RHIO (DPH),
- \$5.7 million to e-Health CT, Inc for physician training in meaningful use.

Working as part of HITECT and in collaboration with other stakeholders, Sustinet should endorse rules that conform to standards developed by the Office of the National Coordinator (ONC), including meaningful use of data. ONC has developed parameters to guide the achievement of meaningful use of HIT. Eligibility for ARRA funds to offset the cost of purchasing and implementing HIT are tied to these meaningful use requirements. Furthermore, the ONC has distributed funds to Health Information Technology Regional Extension Centers (HITREC) to provide training and technical assistance to providers seeking to implement HIT capabilities. In Connecticut, eHealthConnecticut has received a grant of \$5.7 million to administer the HITREC program. Sustinet should direct interested providers to those resources (ONC, DPH, eHealthConnecticut) that have been established to provide funds and technical assistance to support the adoption of HIT.

2. Develop a long term HIT/HIE funding stream

Sustinet, in conjunction with the work now underway at the state level, should participate in the consideration of a variety of business models for funding sources beyond the ARRA, including:

- User fees: HIE access fee; could be waived or pro-rated for those who contribute data
- Cost-avoidance: streamlined administrative/clinical processes yield savings to fund HIE
- Shared cost savings with health plans
- Medical claims tax/surcharge (e.g., VT fee=2/10 of 1%/claim; PA tax=1/16 of 1%/claim).

In June 2010, the Department of Public Health and the HITEAC released a draft Strategic Plan for public review and comment. The proposed Phase One approach is to use ARRA funding and find state matching funds as needed. The Proposed Phase Two approach will include analysis of the options noted above as well as other opportunities to ensure continued operations.

(To read the draft strategic plan, click here: [HITECT Strategic Plan Draft June 2010](#))

3. Prioritize CHC EHR funding requests

Sustinet should support efforts to improve CHC access to federal and other funding sources to ensure that these providers develop their HIT capabilities and are connected to the electronic information exchange system.

CHCs are a critical part of the healthcare delivery system, meeting the needs of underserved populations. It is imperative that CHCs be a part of the Sustinet healthcare delivery system. Prior to the release of ARRA funds, CHCs were not receiving federal funding to implement HIT.

4. Maximize all available funding sources

When considering whether to assist with capital funding for EHR implementation, Sustinet and the future HITECT Board should assist providers with maximizing other funding opportunities.

Providers include physicians, nurses, hospitals, and other health care providers. The Committee recommends that Sustinet direct Connecticut providers to established sources of funding, including:

- Hospitals – should continue to collaborate with the Connecticut Hospital Association (“CHA”) and the Connecticut Health and Educational Facilities Authority (“CHEFA”) to complete the development of a pooled loan fund to acquire and implement EHR.
- Hospitals – should continue to pursue ONC grants to fund EHR projects.
- Non-profit health care providers should seek privately placed, lower cost equipment financing through CHEFA to fund EHR projects.
- Physicians and Practices – should work with eHealth Connecticut or other federally recognized regional extension centers to identify appropriate equipment and they should take advantage of the cost benefits associated with financing via a pooled loan program with regional lenders, the Connecticut Development Authority or the Department of Community and Economic Development; may also be eligible for CMS incentives on EHR/ERx use.
- Community Health Centers will receive federal funding through ARRA to purchase EHR capacity.

5. Provide short term financial support for qualifying providers during EHR transition

Sustinet should provide financial support to qualifying providers during a transition from paper to an electronic medical record system.

Given the availability of federal ARRA funds and emerging federal regulations, additional financial incentives for HIT are unlikely to accelerate EHR adoption throughout the provider community. A recent survey by Accenture indicated that 80% of physicians under the age of 55 are planning to implement an electronic medical record system within the next two years, so it is not clear that additional incentives to adopt HIT will be needed. Moreover, the incentives may not generate sufficient revenue to offset the costs of a full EHR installation. While the use of EHRs creates efficiencies and offers the potential for some cost reductions, these benefits may not be sufficient to providers to overcome the initial costs of implementing HIT.

Any direct assistance by Sustinet in this area should be clearly defined and limited to transition efforts that will not be addressed through resources such as the HITREC.

SustiNet should focus any financial incentives on transition costs faced by smaller providers. One-time grants would address potential barriers to entry, such as:

- Converting existing paper records to electronic files (if deemed necessary)
- EHR or practice management system upgrades
- Disruption of workflows during system implementation or upgrades

Hospitals currently engaged in converting to electronic health records are attempting to include affiliated physician practices as part of the development process, which increases the EHR take up rate in those geographic areas.

The expected growth of the Medical Home model, with its emphasis on using HIT to support effective care coordination, may also present opportunities above and beyond those offered through federal funding. Three primary care management pilots under HUSKY could be a natural launching platform for this line of development, to be scaled up incrementally. Other avenues include using provider contracting processes that set minimum standards for participating practices. Similarly, Sustinet's designation of approved medical home practices could specifically require EHRs and participation in the state HIE.

C. Standards

1. Set uniform standards for EHR/HIT capacities

Working collaboratively with the future HITECT Board members and state agencies, Sustinet should set minimum standards for provider based EHR/HIT systems that will enable providers to achieve the capacity, communication and practice improvements envisioned by Sustinet and under HITECT as the new agency gets underway next year.

Sustinet should not dictate specific vendors that participating providers need to use; rather, Sustinet should specify functional requirements that EHR systems must meet. Sustinet could require that providers obtain system certification by the Certification Commission for Health Information Technology (CCHIT) to ensure that products meet standards related to measuring quality, interoperability, and security among others.

At the same time, Sustinet recognizes that early CT adopters have already developed and implemented EHR/HIE capacity for at least 1 million patients. The challenge for the statewide HITECT effort will be to create systems and standards that allow integration or seamless upgrades of EHR/HIE functionality already in place.

2. Add race and ethnicity data to EHRs

Electronic medical record/electronic health record data formats should capture racial/ethnic information (consistent with individual privacy safeguards) to allow the tracking of disease prevalence as well as disease treatment by specific population groups.

Self reported race and ethnicity information is considered the "gold standard" by health and policy researchers. Many states are creating and adopting uniform coding standards, with

important advances in the hospital discharge datasets that are now compiled in virtually every state. Adding race and ethnicity fields to EHRs creates a powerful addition to the evaluation of differences in treatment, outcome and cost efficiency.

SustiNet should also begin a public information campaign about the importance of self-reported race and ethnicity data as EHRs become more widespread. Patients may be reluctant to disclose this information if it is not specifically required for treatment or claims payment. Sustinet should support a public service campaign describing how race and ethnicity data could be used to improve quality and care.

3. Create links among registries and EHRs

A robust disease registry database should interface with EHRs for updates and data exchange. Sustinet should encourage the development of these linkages to support continuity of care for new populations.

4. Promote research applications of EHRs/HIE

Decisions about the design of a statewide health information exchange should look ahead to the uses of HIT to better and more comprehensively understand the needs and health care deficits of Sustinet populations. Sustinet should support data sharing, integration and the use of HIE data stimulate development of population monitoring and research applications of EHRs/HIEs as they are implemented in CT.

D. Outreach to Providers and Monitoring Uptake

1. Provide EHR assistance to non-physician medical providers

SustiNet should recommend that future HITECT initiatives and HITREC include non-physician healthcare professionals such as dentists, pharmacists, and other health care providers in plans to engage and support the medical community in HIT/HIE adoption.

Consideration must be given to the full spectrum of providers so that these sources are linked into the HIT/HIE infrastructure. Since patients will be seeking care from multiple provider sources, care provided by these non-physician providers must be included in the patient's EHR. If these sources are not linked into the HIT/HIE infrastructure, EHRs will be incomplete.

Some of Sustinet's outreach effort should be focused and directed to patients/clients/members to create a demand-pull that sends the message to providers of expectations for standards of care under Sustinet; an analogy from the pharmaceutical industry marketing model (e.g., direct-to-consumer advertising on HIT / HIE benefits/value)

2. EHR beneficiaries include all providers

EHR innovations will create shared benefits throughout the state's provider community.

SustiNet should build on the efforts already being undertaken by the Department of Public Health, eHealth Connecticut, CHA, and CHEFA to fund EHR projects.

SustiNet should ensure that the EHR systems being purchased meet the threshold of interoperability with other systems, that they will be compatible with the operating systems of the health information exchanges and that they will meet the criteria for “meaningful use” as defined by the ONC for Health Information Technology.

All CT providers will benefit from the ability to access patient info at the point-of-care through the statewide HIE.

3. Monitor EHR adoption and use by patients

SustiNet should monitor the rate of EHR adoption across the state by provider types and populations served. If adoption rates lag, Sustinet should seek solutions to enable all members to access electronic information through secure channels.

From the patient perspective, accessing personal information and communicating electronically with providers may be limited for those who do not have access to email or for those who prefer other forms of communication. This is a particular problem for individuals with mobility issues and cognitive deficits. Young adults are often able to obtain web-based information through wi-fi sites or personal mobile devices. Sustinet should carefully monitor how personal EHRs are accessed and target outreach to underutilizing groups.

E. Emerging Sustinet Technology Needs

The Sustinet Board, its Task Forces and Advisory Committees discussed several information technology needs in addition to electronic medical records and health information exchanges. The recommendations in this section require further discussion by the Sustinet Board and related subgroups as the structure and scope of the program are developed in the next six months. The HIT Advisory Committee recommends that the Sustinet Board convene an ad hoc group to further develop these recommendations concurrent with the program design.

1. Compile and define Sustinet measurement needs

Sustinet should define the metrics and outcome measures needed to manage the cost-effective, efficient delivery of quality care as well as provide policymakers with the information needed to address issues such as ethnic and racial healthcare disparities. Data requirements also need to be defined to ensure the meaningful reporting of information to providers about quality, outcomes and performance.

Electronic medical records provide significant advancements for providers such as practice management, clinical decision support, and information sharing. Sustinet should develop a measurement plan based on the recommendations of other Sustinet Advisory Committees and Task Forces.

The plan should describe the types of measurements proposed and the data elements that should be captured in the exchange. For example, height and weight data support obesity tracking and permit analysis of interventions. The incidence of “quit smoking” counseling

would provide research information about changes in cardiovascular and pulmonary chronic disease conditions.

SustiNet should formally present this plan to HITECT early in 2011 to ensure that Sustinet program managers will be able to track the effects and outcomes of new initiatives. As HITECT begins to generate analytic data specifications, Sustinet should continue to participate in the development to ensure that specific innovations and programs will be measured, analyzed and reported.

2. Collaborate with other public payers

In addition to active participation in the development of the HIE, Sustinet should collaborate with the Department of Public Health and the Department of Social Services to address data needs of shared populations.

As a new public payer, Sustinet should build on the work of other CT state agencies to understand the information needs of providers serving low-income populations. Care may be fragmented due to changes in eligibility for publicly subsidized care, relocation, or lack of a consistent primary care clinician. For the elderly, persons with disabilities and other complex medical treatment regimens, a central medical information source will expedite service delivery.

Sustinet should actively seek shared opportunities for pilot projects, demonstrations and other emerging models that facilitate health data exchange, integration, and patient information.

3. Develop a robust administrative IT and analytic capacity.

As Sustinet develops an organizational and administrative structure, Sustinet should consider its internal analytic requirements. Sustinet will need capacity to enroll new members, including eligibility determinations, collecting premiums, transmitting information to providers, and managing disenrollments.

Moreover, Sustinet intends to pay risk-adjusted rates to providers. As explained by Milliman's actuaries in a presentation to the Patient Centered Medical Home Advisory Committee, the development of risk adjustments relies on several years of actual claims data showing a diagnosis. Claims data will also be needed to develop and adjust base payment rates for providers.

SustiNet Patient Centered Medical Home Advisory Committee Final Report

Background

Access to care is a problem for too many Connecticut residents, particularly minorities and those with low incomes. Last year twelve percent of at-risk adults in Connecticut had not visited a doctor for a routine check up in the past two years; that rate is 33% higher for state residents living under twice the poverty level. About half of Connecticut adults over age 50 do not receive recommended care; that rate is 10% higher for Latino state residents and 15% higher for black Connecticut residents than for whites. Mortality amenable to health care for black state residents is 89% higher than for whites.ⁱ One third of Connecticut emergency department visits, 1,100 per day, are for non-urgent health issues. 64% of these visits occur between 8am and 6pmⁱⁱ suggesting that access to primary care, even during working hours, is a significant challenge for many Connecticut residents. In a recent survey, almost three out of four Americans report difficulty accessing care from their doctor. Half report poor coordination of care; especially among those who see more than one doctor. One in three Americans reports getting unnecessary care or duplicate tests. Ninety one percent believe it is important to have one place or doctor responsible for their primary care and coordinating care.ⁱⁱⁱ

There is no shortage of proposals to reform the health care system and no shortage of controversy over which proposals to implement. But one option that enjoys great support across interest groups is the patient-centered medical home (PCMH) concept. PCMHs are built on coordinating care in a patient-centered model. Proponents argue that PCMHs can reduce health care spending, improve health status, support disease management and prevention, improve the quality of care, reduce medical errors, and reduce racial and ethnic health disparities.^{iv} A recent multi-database search of the research literature found 12,044 articles with the keyword patient-centered medical home.^v

PCMHs are not buildings or hospitals, but a different way of practicing medicine.

Upon entering a model PCMH in Flushing, New York, visitors are struck by the quiet – no scrambling, no rushing around. Patients spend little time in the waiting room but are moved quickly into an exam room. Then, as a practice manager described it, everything “swirls around the patient.” He doesn’t move; services and personnel come to him. The day before the visit, his team of providers, including a doctor, nurse and medical assistant, “huddled” to discuss his case, ensure that all his test results were ready and that all the services he needed would be available, and he got a reminder call. Most tests he needs are available on-site so his team can review the results and adjust his treatment while he waits. No getting back to him days later and trading phone messages. Each member of his PCMH team works at the top of their training; no control freaks allowed. You are as likely to see a medical assistant explaining how to do something to a doctor as the reverse. Not surprisingly, patients are very happy with the care they receive and providers find it a more organized and satisfying place to work. Staff turnover is not a problem and the practice is saving money.^{vi}

PCMHs offer coordinated, comprehensive primary health care that is accessible, continuous, compassionate, culturally appropriate, and patient-centered. Coordination of care can reduce duplicate tests and prevent errors in conflicting treatment when patients have several providers. Care is personalized for each patient and delivered by a team of professionals who put the patient and their needs at the center of care. The team may include a doctor, nurse, medical assistant, health educator and other professionals. PCMHs can make primary care practice more appealing to graduating physicians who are predicted to be in short supply as Connecticut's population ages.^{vii} There is ample evidence on the health benefits of access to a usual source of continuous care^{viii}, and initial evaluations of PCMH pilots are very encouraging.^{ix}

PCMH patients have to take responsibility for educating themselves and managing their care, with help from the PCMH team. They must learn about the best ways to maintain their health, communicate openly with their team of providers, and actively participate in decision making about their care. They must participate honestly in assessing their health risks and actively participate in the development of and commit to follow an individualized, feasible care plan designed to address their health issues. Treatment in PCMHs focuses on prevention and management of disease. Patients are not responsible for keeping track of the details of their care across all their providers such as test results or medication dosages; their PCMH coordinates those records. Patients don't have to wonder who they should call with a problem – they call their PCMH for help. The PCMH staff knows them and their family, their preferences, which treatments are most likely to help, and understands their cultural and language needs.

States and the federal government are recognizing the potential of the PCMH model. Eight states have defined the PCMH concept in law or regulation and seven states are developing processes and criteria to recognize PCMHs.^x In 2005 Ontario implemented the first wave of Family Health Teams, very similar to PCMHs, to reduce ER use and expand access to preventive care. There are now 150 Family Health Teams across the province in areas of need, with 50 more in planning.^{xi} Medicare recently released a solicitation for states to participate in multi-payer PCMH pilots.^{xii} The new federal health reform act includes significant incentives for PCMH implementation including grants for community resources, 90% Medicaid matching funds for care coordination services to patients with chronic conditions, and primary care workforce training incentives.^{xiii}

Despite the momentum, PCMH implementation faces some significant barriers. Coordinating care among providers, a cornerstone of the concept, is very difficult without electronic health records and structures to share health information among providers. Only 13% of US physicians have even a basic electronic medical record system^{xiv} but the recent federal stimulus package includes significant resources for providers to purchase health information systems. Care coordination also requires the cooperation of providers outside the PCMH team, who are not compensated for those activities. Patients have different responsibilities and rights within a PCMH including directing all care through their provider team; some may associate this with gatekeeping which was not popular in the

1990's and has largely been abandoned. Proposals to increase resources for primary care and PCMHs at the expense of other providers have met strong lobbying resistance.

A special concern for Connecticut is that between 50 and 62% of state physicians are in solo practices and between 70 and 88% work in groups of four or fewer providers.^{xv} Small practices face special challenges in implementing the PCMH model including weak infrastructure, inadequate capital investment, and less sophisticated management structure^{xvi}. Recommended supports for small practices transforming to the PCMH model include training and development for clinical and nonclinical staff on patient engagement skills, cultural competence, teamwork, and language needs. Tools and resources needed include patient education materials, clinical practice guidelines, quality improvement tools and shared services or staff to provide interpretation, patient education or care management, data analysis and health information technology.^{xvii}

Preliminary research on the PCMH model is promising, but also offers caution and guidance for success including patience, flexibility and support.^{xviii} Researchers have found that implementing the PCMH model requires a fundamental transformation of practice, which can be difficult for even willing practices, and is an on-going developmental process rather than a destination. New ways of practicing medicine, through teamwork, may pose the greatest challenge to PCMH adoption.^{xix} Recommendations for policymakers include assuring adequate financial resources, flexibility that respects the wide diversity of successful PCMHs, support for providers in transforming the way they practice, including training, new tools and other learning, and patience – successful practice transformation takes time. Recommendations for practices include establishing realistic timelines and gathering the resources needed, developing a technology plan, monitoring change fatigue, and developing a learning organization.

Current status of patient-centered medical homes in Connecticut

The National Committee for Quality Assurance (NCQA) has the only standardized, nationally recognized PCMH recognition program. Other national organizations are reportedly developing PCMH recognition programs. NCQA recognizes three levels of PCMHs.^{xx} There are no NCQA recognized PCMH practices in Connecticut, at any level; surrounding states have 31 (RI), 87 (MA) or 225 (NY).^{xxi} However, Connecticut does have two PCMH initiatives important to SustiNet populations – Primary Care Case Management in HUSKY and the state employee plan ProHealth pilot.

Primary Care Case Management (PCCM) was implemented as a pilot program beginning in February 2009 offering a PCMH alternative to HUSKY families living in the Waterbury and Willimantic areas. The program has since been expanded to the New Haven and Hartford areas.^{xxii} PCCM, named HUSKY Primary Care in Connecticut, has enrolled only 403 members as of June 1, 2010^{xxiii} and has suffered from inadequate resources for administration and marketing. However the program enjoys strong legislative support; a 2010 law expanding the program to two new communities passed both houses unanimously.^{xxiv} Providers participating in PCCM are paid on a fee-for-service basis for the medical services they provide (at the low Medicaid rates) but they are also compensated

\$7.50 per member per month for care coordination and other PCMH functions. HMOs are not involved in PCCM.

In the December 2009 reprocurement for the state employee health plan, the Office of the State Comptroller (OSC) included a strong PCMH component. OSC, along with Anthem and United Healthcare the winning bidders, plan to partner with ProHealth, a large primary care practice in the state. ProHealth serves about 10% of Connecticut's population including at least 35,000 state employees. By early 2011, ProHealth intends to have completed transforming all their 74 sites with 225 primary care providers to Level II or III NCQA recognized PCMHs. Several other funding partners have agreed to support ProHealth's transformation through a wide variety of payment mechanisms including enhanced fee-for-service rates for some patients, per member per month fees for others, performance-based incentives for others, and some upfront investments.^{xxv}

A regional PCMH collaborative of at least nine states is developing; the collaborative includes all the New England states but Connecticut. The collaborative is working to share resources in developing state-specific multi-payer PCMH cooperatives. The collaborative also plans to cooperate on evaluation and data collection, a learning collaborative and share best practices.^{xxvi}

What we have learned

Through readings, presentations, webinars, discussions with PCMH innovators in other states, and our discussions, the committee has explored each aspect of the PCMH model and how it could work in Connecticut.

There is some confusion about the PCMH model in Connecticut, even among providers. Information about the model is expanding through the efforts of nonprofits and provider organizations, but much more needs to be done.

Practices will not undergo the hard work of PCMH transformation for only some patients. Providers are clear that they provide the best level of care to every patient.

As in other states, many primary care practices in Connecticut are financially fragile, working on very thin margins. Most are not in a position to invest in PCMH transformation without help with upfront costs.

Primary care providers and staff in Connecticut, especially in small practices, are very busy. Training must be as easy to access as possible and they should be compensated for their time.

PCMH development is intimately tied to payment reform. Connecticut providers are used to fee-for-service, pay-for-performance and flat care management fees. Bundled payments are common in some areas such as surgery and obstetrics, but not in primary care. Capitation is not popular. Most primary care practices are not financially able to accept risk, even

performance risk, and are reluctant to accept risk for services over which they have no control, i.e. consumer behaviors and services provided by other providers or institutions.

There is strong support for including consumer incentives to follow care planning and separate funding for supports to care plans.

It is critical to ensure integration of behavioral health, oral health, nutritional, pharmacy medication management, and alternative medicine services into PCMHs.

One size does not fit all. Connecticut practices are fiercely independent and diverse. PCMH development in Connecticut must be flexible. Our diversity will be an advantage for Connecticut's health care system allowing natural experiments comparing various PCMH structures.

The work of the Committee

The Sustinet Patient Centered Medical Home Advisory Committee was convened in late 2009 and held its first meeting November 18th. The charge to the committee, created by PA 09-148, An Act Concerning the Establishment of the Sustinet Plan, is to "develop recommended internal procedures and proposed regulations governing the administration of patient-centered medical homes that provide health care services to Sustinet Plan members."

Throughout the rest of 2009 and into 2010, the task force held six in-person meetings and five meetings by webinar. A recommended reading list was provided to committee members and was publicly available. The committee heard presentations on patient centered medical homes by

- Queens long Island Medical Group Level III patient-centered medical home practice, Flushing office, slide show
- *American College of Physicians Medical Home Builder*, online video
- *Recognition of patient-centered medical homes* by Mina Harkins of NCQA
- *Integrating Pharmacists in the Patient-centered Medical Home* by Marghie Giuliano of the CT Pharmacists Association, Marie Smith and Tom Buckley of the UConn School of Pharmacy
- *Development of a Vermont Pilot Community Health System* by Jim Hester, VT Health Care Reform Commission
- *Pennsylvania's Efforts to Transform Primary Care* by Ann Torregrossa, PA Governor's Office of Health Care Reform
- *A national review of state patient-centered medical home initiatives* by Lee Partridge of the National Partnership for Women & Families
- *CT state employee plan patient-centered medical home initiative* by Cheryl Lescarbeau, ProHealth Physicians
- *CT's Primary Care Case Management program: HUSKY's patient-centered medical home initiative* by Ellen Andrews, CT Health Policy Project
- Ron Preston, New England regional PCMH collaborative

- *Risk Adjustment Basics* by David Williams and Diane Laurent, Milliman

An analysis of PCMH provisions in the 2010 federal Patient Protection and Affordable Care Act was provided for the committee and is attached. All committee meetings, minutes, agendas, reports, documents, webinars and videos were publicly available; all activities were transparent.

Contributing issues and trends impacting development of patient-centered medical homes in Connecticut

It is important to recognize important trends that are not part of the committee's charge but have profound impact on our work. These include health care workforce shortages, racial and ethnic health disparities, and payment reform trends.

Health care workforce

There is growing evidence of health professional shortages in Connecticut across fields. Between 1995 and 2015, Connecticut's total population is expected to grow by 464,000 people.^{xxvii} Between 2010 and 2030, the percentage of Connecticut residents over age 65 is expected to grow by 40% and the ratio of Connecticut seniors to 100 workers (ages 20 to 64) is expected to grow from 23 to 40.^{xxviii} An aging population will place greater demands on the health care system at the same time that many health professionals will be retiring.^{xxix} Shortages of primary care providers are particularly acute; PCMHs rely on primary care providers as clinical leaders. The Medicaid program faces particular challenges in engaging providers. Barely half of Connecticut physicians participate in the program.^{xxx} As plans for Sustinet involve merging the Medicaid and state employee plan pools, provider reluctance to participate in Medicaid is an important challenge to solve.

There is evidence that implementation of the PCMH model may ease the primary care shortage by improving primary care provider efficiency, easing time constraints on providers, easing responsibilities by reliance on team members and improving primary care provider satisfaction and retention in active practice.

Health disparities

Connecticut, like most states, is becoming more diverse. Unfortunately, our state is not exempt from the gap in health care access and outcomes between genders, races and ethnic groups. These disparities have complex causes^{xxxi}. There is evidence that the impact of fragmented care falls more heavily on minority patients. It is hoped that expansion of the PCMH model will work to reduce health disparities.

Payment reform and quality-based purchasing

There is a growing recognition that the current, fee-for-service system of paying for health care is fueling rising costs of care. Most payers are moving to a system of linking payment rates to the quality of care and realigning provider incentives away from promoting utilization and toward efficiency. This is a significant transformation in the way providers and health systems are paid and the PCMH is directly aligned with this trend. In fact, new

payment methodologies that compensate practices for care coordination, expanded access to care, and patient self-management of care are critical to the success of PCMHs.

Committee recommendations

Principles and goals

- *PCMHs are organized around each individual patient and their needs.* As one PCMH nurse manager explained it “everything swirls around the patient.” Care is individually appropriate to each patient’s circumstances. What works for one will not necessarily work for another. Patients must be engaged in improving and maintaining their own health through shared decision-making. PCMHs provide the resources and treatment necessary to support patients in managing their own health. All policies and treatment decisions are based on the needs of the patient first, before the needs of providers, staff, or finances. Patient questions are expected, embraced, welcomed and solicited at every stage of care in a PCMH. Questions can provide important clues to how the individual practice and the overall PCMH model are working and should be a treasured resource for providers and evaluators.
- *PCMHs are for everyone.* All of us could be at risk. Everyone benefits, as does the greater health care system, from coordination, self-management, emphasis on prevention and maintenance.
- *Care in a PCMH is delivered by a well-organized, interdisciplinary team of professionals,* working in a trusting environment. Each team member feels comfortable asserting their opinion, offering guidance or even challenging any other team member when necessary. Everyone works at the “top of their license.”
- *PCMH teams are embedded in their communities,* with strong linkages to community medical and non-medical supports and services. Seamless integration as appropriate with behavioral health, oral health, medical nutrition therapy, specialty, alternative medicine, and other care is essential. Strong referral networks are critical to effective care management.
- *PCMHs track not only the health of individual patients, but the larger population of patients they serve.* Health problems identified in population tracking drive practice decisions about care and services offered.
- The committee was clear that “*one size does not fit all*” in PCMHs. There is wide disparity in opinions about how PCMHs should be structured and operated. Without clear and specific guidance from a strong evaluation literature, which does not appear to be imminent, the Committee recommends supporting different models, with robust evaluation of the differences to guide future policy development.
- While the goal is to provide access to a PCMH for every CT resident, *it is not necessary that every primary care practice become recognized as a PCMH.* It is critical to guide practices toward PCMH with incentives only and not invoke penalties for practices that are not interested or able to reach recognition. Practice transformation is very difficult and the decision must be voluntary to be successful. It must continue to be a viable option for primary care practices in Connecticut to

continue to provide care in the traditional model. **Connecticut cannot afford to lose any primary care capacity.**

- Sustinet needs to balance encouragement of evidence based medicine and clinical decision support with recognition that medicine is not an exact science. Overrides must be allowed, with explanation, and monitored for patterns and outliers. Some exceptions may be indicators of lower quality care, but some may be clues to innovations that improve health and efficiency. It is critical to build a learning system that identifies and evaluates departures from accepted practice. This will require thoughtful design of health information technology and data collection systems.

Standards for PCMHs in Connecticut

- While the goal is to expand the PCMH model in Connecticut to as many primary care providers as possible, it is also critical to maintain standards and not weaken the certification. The PCMH model must remain meaningful to be successful in providing better health outcomes and to attract and warrant enhanced funding from payers.
- The committee decided to endorse NCQA as the standard for PCMH recognition in Connecticut. NCQA is a nationally recognized standard, the result of a great deal of research, and is recognized currently by many payers. Connecticut and Sustinet should consider recognizing other national PCMH certification programs as they become available. The committee endorsed tying payment to NCQA levels of PCMH recognition. However, there must be recognition for practices that are making progress working toward NCQA certification; that recognition may not necessarily be financial.
- Providers in each PCMH must have authority to prescribe medications and have or have arrangements for hospital admitting privileges.
- Concerning the future of PCCM in the PCMH model, the committee was concerned that Connecticut not create two sets of quality standards for Medicaid and other Sustinet members. However the committee acknowledges that provider participation in Medicaid is low and creating new standards may serve as a disincentive. The committee recommends allowing for current PCCM agreements to remain in place with an understanding that those practices are expected to move toward NCQA recognition in the future.
- There was strong consensus that Connecticut should do all it can to remove any barriers to certification that are not related to quality, including financial and administrative barriers.
- PCMHs are encouraged to include complementary and alternative medicine providers, including Healing Arts Practitioners, as part of the PCMH team, when appropriate, for patients who are interested.
- The committee recommends allowing specialists to serve as clinical leaders for PCMHs at the request of patients, with approval from the state PCMH guiding group. It is expected that PCMH specialists will meet the same levels of certification and provide the same level and type of services as primary care providers.

PCMH functions

The committee agreed that some PCMH functions are core to the practice and should not be contracted to outside vendors. However the committee was split on which functions are core and which can be safely contracted out. The following table gives the majority opinion, but there was wide diversity of opinion on each function. Given the inability to come to a clear consensus, the committee recommends that four functions always be provided by the practice, three can be contracted out without approval, but to contract out any of six other functions, the PCMH must apply to the state guiding group for approval (see below). In its decision the state should consider the number of proposed contracted functions, adequacy of practice policies to ensure seamless integration for patients, and dedication of resources at the practice to ensure effective contract management. Approval should be provisional and be revisited regularly.

Function	Core vs. contractual option
Referral tracking	Can contract only with approval
24/7 voice-to-voice coverage	Can contract
Patient reminders, communications	Can contract only with approval
Population health tracking and management	Can contract only with approval
Care management	Can contract only with approval
Self-management support	Can contract only with approval
Lab/test tracking and follow up	Core
Disease management	Can contract
Risk assessment tool administration	Can contract only with approval
Individualized care plan development	Core
After hours care	Core
Cultural competence, translation services	Can contract
Medication management	Core

- Risk assessments for each patient should be connected to development of an individualized care plan created with the direct participation of patients, and their families when appropriate, in face-to-face interactions at the practice. Patient agreement with the care plan is critical; great care and sufficient time should be taken to ensure the plan is realistic and meaningful to the patient. The plan should

clearly identify common goals, timeframes, the responsibilities of each team member, and resources needed. The care plan should be updated regularly and provided to patients initially and after any significant revisions.

- Care management includes population management, wellness promotion, disease prevention and screening, chronic disease management, patient engagement and education. Care management must coordinate care between the PCMH and other providers including hospitals, emergency rooms, behavioral health care, oral health care, maternity care, specialists, pharmacy, medical nutrition therapy, and other providers. Particular attention must be paid to patients in transition between care settings or pediatric to adult medicine.
- Care management must be ongoing to implement the care plan, including regular reviews of goals, challenges, available tools, and revision of the plan if necessary. Care managers can be shared with other practices or, with approval, contracted out, but must be physically located at the practice at regular times. Patients must be assigned to an individual care planner they have met face-to-face and are able to reach by phone and email in a timely fashion. The care manager should always represent themselves as part of the care team and working for the practice. Consulting arrangements should be invisible to patients. Patients must have one point of entry to care management services. A phone number that connects to a service that refers them elsewhere does not qualify.
- The committee declined to identify specific qualifications for care managers in PCMHs. Clear job descriptions and duties are critical as is accountability and evaluation to ensure care is effectively coordinated.
- Expanded access to care is critical to the PCMH model. Expanded access must include extended hours of care, not just telephone coverage. PCMHs must meet standards for timeliness of appointments for both well and sick visits. Patients must have round the clock access to advice from a medical professional, to include appointment scheduling as needed. Practices must offer some after hours access to care, and same day appointments for urgent issues. Group visits, secure electronic patient communications with the PCMH team and interactive websites are important features of the model.
- Self management supports available through the PCMH should include wellness programs, chronic disease management, integration with behavioral health care, linkages to dental care services, pharmacy medication management, smoking cessation, nutrition counseling, complementary and alternative medicine, Healing Arts Practitioners, and other community wellness resources.
- It is critical that differences between pediatric and adult patients be reflected in PCMH care management and service delivery.

Patient attribution

- A crucial element to PCMH success is accurate patient attribution to practices. The administrative burden and financial concerns of inaccurate attribution is a significant disincentive to practices considering PCMH transformation. It is critical

to invest the necessary resources and time to make this a priority in program development.

Implementation and direction of PCMH support resources

- The Sustinet law directs the committee to make recommendations for early implementation of PCMHs to prioritize enrolling patients “for whom cost savings appear most likely.”
- However, the Committee learned that practices are unlikely to undergo the hard work of transformation to a PCMH for only a subset of patients. Providers made it clear that they will not treat their patients differently; everyone gets the best care possible. Practices typically change the way they practice medicine for their entire population.
- The committee was also advised by PCMH leaders from other states to pilot the program first with practices that are enthusiastic about the concept, are willing to do the hard work of practice transformation, and most eager to change. When they are successful, these practices will serve as champions for PCMHs to their colleagues. Willing practices are more likely to have components of the PCMH model already in place, are more sophisticated about practice transformation, are likely less financially stressed, and have a patient population that will benefit from the model.
- The committee recommends that the state open applications broadly to find practices willing to begin the process. If the response overwhelms resources, the state can prioritize geographic areas of need, practices that disproportionately serve people with multiple chronic conditions, or under-served populations. The state should attempt to find a balance between large and small practices in early pilots to test the differences in resource needs and barriers. The state could also consider targeting clinical training sites for PCMH development to leverage the ability to disseminate the model to new graduates.

Payment methodologies

- Coordination of standards and payment methodologies across payers is critical. Practices will be less likely to embrace the PCMH model if payments diverge significantly between payers, i.e. enhanced fee for service rates for some patients, per member per month rates for some patients, quality incentives with different metrics for others.
- Many primary care practices in Connecticut are financially fragile. They must be certain that their investment in care management and enhanced access to care will be covered up front. There was little interest in or trust of a shared savings model to reimburse providers at some point in the future for a portion of the savings resulting from their efforts. There were mixed responses to the idea of global capitation rates or bundled payments. Most small primary care practices in Connecticut are not in a position to take financial risks.

- The committee endorsed a system of traditional fee-for-service reimbursement for medical care, in addition to a per member per month fee to compensate for care management, in addition to performance bonuses such as current pay-for-performance payments.
- Any payment system must be clear and understandable.
- Rates must be risk adjusted using a methodology that tracks historical utilization for each patient, includes the continuum of health care services, and ideally includes socio-demographic metrics such as language barriers and literacy levels in addition to diagnoses. Risk adjustment methodologies that consider only diagnosis and aggregate cost projections foster negative incentives. For example, it is critical that a PCMH have more resources and no disincentive to care for a child with asthma who has not been well-managed and has had several emergency room visits in the last year compared to a child with the same diagnosis but that is already well managed and has had no visits to the emergency room.
- Risk adjustment methods that give providers information on likely future health care events and costs for each patient, such as event probability modeling, are important tools to target resources and care management, especially for new patients. It is critical to provide these tools to PCMHs after they have accepted patients into the practice to ensure they are not used to select patients.
- Many providers, especially in small groups, will need upfront financial assistance to implement a PCMH. The Sustinet law provides for low interest loans and availability of reduced price consultants to facilitate practice transformation. This gives practices the resources they need while fairly recognizing the investment already being made by others without outside support.
- Non-financial rewards for progress toward or for achieving PCMH certification could include reductions in licensure fees and/or extending licensure periods, or reduced patient cost sharing at these practices.
- The committee recommends creating resources to support individual consumer care plans. This could be a feature of Sustinet coverage through value-based insurance design or a simpler, dedicated fund that would accept individual applications from patient/provider/care manager teams. The funds are meant to provide supports not covered by typical insurance coverage such as a vacuum cleaner for a child with asthma, gym membership or weight loss program fees. These funds must be tied directly to the patient's care plan and address a specific barrier that is keeping the patient from managing their own care.

Federal and regional funding and technical assistance opportunities

- It is critical that Connecticut take advantage of momentum at the federal level to support PCMHs. Connecticut should consider taking advantage, at minimum, of 90% Medicaid matching rates on PCMH services for people with chronic conditions, as this does not require a competitive application but only a state plan amendment. Connecticut should also consider whether a more general "health home" application under the Patient Protection and Affordable Care Act is warranted and fits with the structure of developing PCMHs in Connecticut.

- Connecticut should join the other New England states in developing a Medicare waiver for a multi-payer PCMH pilot. Connecticut should also join other states in a learning and evaluation PCMH collaborative to share resources and best practices.
- A multi-payer initiative, to include Medicare, is critical to developing uniform standards, data elements, evaluation criteria, focused studies, disease management, compatible data formats, and compliance processes for practices and removing important barriers to PCMH transformation. This should include an all-payer claims database for accurate evaluation of costs, practice trends, and provider performance.
- A multi-payer PCMH initiative allows for aligned incentives reducing efficiencies due to cost shifting between payers. Standardizing data collection and incentives across payers allows seamless tracking and ensures that quality incentives will be large enough to be salient to providers.

Support services available to PCMHs

- No current state agency has the expertise or standing in the provider or consumer communities to serve as the lead agency for a multi-payer PCMH initiative in Connecticut. We recommend an independent guiding council or organization, with membership representing critical stakeholder groups, to coordinate PCMH activities including legislative and executive branch policymakers. If the state convenes the group, anti-trust concerns are minimized.^{xxxii}
- The PCMH guiding group should coordinate and identify responsible parties for PCMH support and evaluation activities including
 - Evaluation of the program and recommendations for policy revisions as needed
 - Data collection and analysis
 - Collect and address provider and consumer feedback and grievances
 - Administer the learning collaborative
 - Develop and publish PCMH patient education materials
 - Conduct public education campaign
 - Develop a list of approved vendors for PCMH functions that can be contracted out
 - Identify, list and recruit specialists and community, social resources and other resources for PCMH care coordinators
 - Offer suggested PCMH risk assessment, care management and other provider tools
 - Administer the “early warning system” to identify and assist PCMH practices in transition that are at risk of failing
- The state guiding group will convene and facilitate provider advisory groups to drive policy decisions. The groups should be both local and statewide, include representatives from all PCMH team members. The groups should solicit input across health provider and administration fields in separate forums. Participation in these advisory group activities must be compensated.

- The state guiding group will convene and facilitate one or more consumer advisory groups with subgroups to focus on pediatrics, children with special health care needs, people with multiple chronic conditions, behavioral health, oral health, nutrition, and healthier people. Consumers participating in these advisory groups will be provided child care and transportation support in addition to compensation for their time.
- The committee recommends allowing providers flexibility in choosing vendors. It has been suggested that the state select an entity, a provider organization, academic institution or a new public utility, to create local support networks such as in Vermont or North Carolina. PCMHs in each area would be required to use a set of services from that network. The networks would share in the PCMH per member per month fees with practices. The committee did not endorse this proposal. Connecticut practices are very diverse and have traditional relationships, often very strong ones, with different support organizations. Choosing any one entity could serve as a disincentive to many Connecticut practices in creating PCMHs. It is very possible that eventually single networks will develop naturally as a result of market forces. One or a few of the entities interested in providing coordinated PCMH support services may distinguish themselves through superior performance, attracting larger shares of PCMH business. It would be a mistake for the state to impose such a network on primary care providers.
- This model requires holding practices accountable for the full range of services, regardless of whether they are contracted out or not. If services are not provided it is up to the practice to resolve the problem, either by holding the vendor accountable or choosing another vendor. Placing the locus of accountability on practices requires a larger burden of contract management and oversight on PCMHs and should be considered in any application to contract out services.
- It is critical to create an “early warning system” to monitor the health and effectiveness of practices in transition to the PCMH model. Many primary care practices in Connecticut are fragile, financially and structurally. It is critical to ensure that even if eventually the PCMH model will strengthen a practice, the investment of time and money and staff disruption during the transformation does not endanger the practice. Connecticut cannot afford to lose any primary care capacity in the PCMH transformation. Any practice in transformation that signals a need for assistance should receive intensive technical assistance and resources, if necessary, to soften the transition and ensure success.
- Sustinet should develop community-specific resource referral lists for PCMH care coordinators including specialists, medication management, behavioral health, oral health, nutritional and other medical services as well as social service resources. The resource center should develop new lists in response to requests from PCMHs and patients.

Learning collaborative

To ensure best practices are shared throughout Connecticut's PCMHs we propose the development of a Connecticut PCMH Learning Collaborative.

- The Collaborative should provide ongoing training for providers, teams, care managers, contractors, and administrative staff in best practices, the latest research, and available resources in Connecticut. The Collaborative should employ practice coaches to visit PCMHs on a regular basis, to focus on under-performing practices.
- A standard level of participation in the Collaborative should be a condition of receiving PCMH funding by Sustinet and other payers. Practices that participate at a higher level, dedicating staff for advisory committee and other optional planning activities or providing training for others, should be compensated for staff time as well as further bonuses for higher levels of involvement such as opportunities to attend national conferences or representation on national/regional PCMH advisory committees.
- Areas for learning offered by the Collaborative should include, but not be limited to:
 - Care management best practices
 - Health Information Technology
 - Patient advocacy tools including legal rights
 - Community liaisons, resources, social and other programs available
 - Team building skills
 - Workflow improvement
 - Patient centered-ness – keeping the patient at the center of care, treating the whole person
- Learning opportunities in the Collaborative must be easy to access for busy providers and practice administrators. The Collaborative should employ webinars, online learning, conference calls, online networking and feedback options, and other media when appropriate. In person training sessions should be held locally whenever possible to reduce travel barriers.
- The Collaborative should provide CME certificates when possible.
- The Collaborative should give high performing Connecticut PCMHs opportunities to share their experience with others in Connecticut and nationally.

Data and evaluation of PCMHs

- It is critical that evaluation of PCMHs be constructive and not punitive. In the early stages of PCMH development in Connecticut and for individual practices in transition, emphasis should be placed on process evaluation over outcomes.
- To ensure meaningful evaluations, it is critical to involve all stakeholders in its design including consumers, providers, payers, practice administrators, employers, and policymakers.
- While evaluation should be a collaborative effort, the evaluators chosen must be strictly independent of contractors, vendors, provider groups, payers, employers, and other stakeholders actively engaged in Sustinet. Even the perception that

evaluators are not independent will compromise the integrity of the evaluation and limit its effectiveness.

- It is particularly critical to engage consumers in evaluation design, implementation, analysis and development of resulting recommendations and policy adjustments. Consumers can be effective partners with researchers in collecting data and provide an important “real world” context to understand the meaning of data and to design feasible, effective solutions to identified problems. Consumer engagement is not only the “right thing to do” it is critical to successful program evaluation.
- Before developing metrics it is critical to outline the goals of the evaluation, the questions to be answered, and design the evaluation to answer those questions. Too often, evaluation measures are chosen because they are easily available or they are standard operating procedure. What is chosen for measurement will drive the development of the program; it is critical that this process is thoughtful and deliberate.
- It is important to distinguish between evaluation of Connecticut’s PCMH system development for policymaking purposes and evaluation of performance by individual providers and practices.
- Evaluation design must consider differences between pediatric and adult patients and their needs.
- PCMH policy evaluation should emphasize replicable lessons that can be highlighted and shared with other practices and communities to improve the quality of care for every state resident.
- It is critical that any analysis be based on adequate sample sizes and appropriate control groups to ensure fairness and trust in the results. Meaningful policy decisions can only be based on valid evaluation. This may be difficult, especially early in PCMH development in Connecticut, as it is expected that early adopters may already have many PCMH components in place.
- Evaluation should standardize measures across practices and over time. Committee members encouraged use of HEDIS measures^{xxxiii} as they are already being collected by most Connecticut practices and allow comparisons between practices, populations, payers and with other states.
- The evaluation plan should include qualitative analysis of PCMHs including key stakeholder interviews with patients, providers and others to identify important outcomes not reflected in quantitative data.
- While PCMH evaluations must include cost effectiveness, it is critical to include benefits and costs across the health care system and should include avoidance of costs including impact on medical error rates, reductions in duplication of services, and administrative efficiencies. Baseline utilization measures, by individual, are important controls for cost effectiveness analysis and the impact of pent up demand for patients with historically low access, including the uninsured and Medicaid consumers, must be accounted for. Evaluations must include not only historical utilization before PCMH implementation, but likely increases in costs in the alternative traditional medical model. It is important to include estimates for long term impact on health costs such as changes in rates of smoking or obesity and overweight.

- Cost effectiveness of the PCMH model must include impact on patients' and families' costs of care.
- Eventually it will be important to evaluate the variety of PCMH payment models used in Connecticut, and assess each for conflicting incentives, incentives to encourage appropriate care, and for unintended consequences.
- It is also critical to measure the investment in PCMH by each entity compared to the benefits. Busy primary care practices are understandably reluctant to invest funds and, more importantly, staff time in practice transformation if they do not share in the benefits. An accurate assessment of the costs and benefits to Connecticut practices who have implemented the PCMH model could overcome concerns by providers considering it. The assessment must include the costs of staff time, but also include benefits in practice efficiency and time available with patients.
- Typical evaluation measures include hospital admissions, including readmissions and avoidable hospitalizations, appropriate use of medications, wellness and screening rates, and emergency room use. The committee urges caution in relying too heavily on one or a few metrics, such as emergency room use, which are ambitious goals and may require several rounds of system adjustment and time for patients to learn to trust the new system of care to see improvement. Evaluations should separate performance on processes practices control, such as completeness of wellness visits, in-office screening rates, from performance on health care processes not directly controlled by PCMH providers, such as hospital transition planning, referral compliance, and patients filling prescriptions.
- Evaluation of care coordination could include referral follow up, anticipation of patient needs, ensuring all necessary tests and services are assembled for each patient visit, accuracy of risk assessment, patient compliance and understanding of their conditions, care planning processes, review and follow up.
- Evaluation of PCMH effectiveness must consider the full continuum of care. Investments in care coordination may have positive impact outside the PCMH practice such as reducing administrative burdens for specialists and improved discharge planning for hospitals. When possible, effects outside the health care system should be included such as in employment, educational and correctional systems.
- PCMH evaluation must focus on patients' experience of care including, but not limited to, clear and effective communications, expanded access to care, effectiveness of care coordination, traditional patient satisfaction surveys, understanding of risk assessment, involvement in care planning, self-management supports, and a secret shopper survey.
- Evaluation must consider provider and other staff satisfaction, provider retention, particularly in primary care practice, team building and interaction, and whether each member of the team is performing at the top of their license. Team building and skills are an important area to evaluate, as this is a critical component of the PCMH model and a significant divergence from current medical practices.
- Data collection should seek to minimize administrative burdens on providers and patients, focusing on metrics that are already collected or available outside the practice.

- Meaningful evaluations must cross payer populations but provide context to comparisons, for example socio-economic differences and access barriers between Medicaid and state employee populations.
- PCMH evaluation should address impact on racial and ethnic health disparities.
- As much as possible, Sustinet should work with the growing PCMH collaborative of New England and other states to pool evaluation resources and share best practices.
- Sustinet should provide public recognition for PCMH high performers and innovators through media outreach, communications with colleagues, local and national provider organizations, recognition at PCMH events, and notification of public officials.
- Providers who do not meet performance standards should receive technical assistance from the state PCMH guidance group to develop a correction plan, with mutually agreed upon goals and timelines, and resources to address shortfalls.

Patient centered-ness

- Patients must have a clear understanding of all available treatment options, and be encouraged to access second opinions. PCMHs go beyond informed consent to informed decision-making and devote the time and attention to patients that is needed to ensure patients fully understand their care.
- PCMH providers and administrative staff shall receive ongoing training in effective patient engagement, communications, available tools, cultural competence, use of translation services, and population health issues relevant to the practice.
- PCMHs should provide regular in-person patient information sessions to describe the model and answer questions. These sessions can be provided at the practice or locally by the Learning Collaborative or state guiding group.
- Sustinet should develop a set of patient materials for self-management of disease, procedures for navigating the PCMH and the larger health care system, consumer rights and responsibilities, including legal rights, and advocacy tools.
- Materials must be provided in appropriate languages and a variety of media/formats, with regular monitoring to meet changing needs. Monitoring of population health issues, in the general population and specific to practices, should drive development of materials.
- All patient communications should be developed in collaboration with providers, employers, payers and consumers, followed by extensive consumer testing.
- Sustinet and PCMHs should discourage branded patient materials at practices, such as materials from drug companies and medical suppliers.
- With assistance from Sustinet, each practice should develop a guide to accessing care within that PCMH to include accessing care after hours, how to communicate with their care team, no show policies, what information to bring to each visit, risk assessment, creating and following a care plan, self-management tools available, tracking progress, the name and phone number of their designated care manager, and available patient information sessions.
- Each PCMH must have a robust process for involving patients in the design, operation and evaluation of the practice.

Health Care Workforce Implications

- Too many students across health training programs have no exposure to the PCMH model. It is critical to create clinical training slots in mature, successful Connecticut PCMHs for students in all health professions. Effective student training is labor intensive; PCMHs must be compensated for this effort. If incentives are not sufficient to ensure adequate training opportunities for students, Sustinet should consider it a requirement for PCMH certification and funding.
- Students rarely receive training in interdisciplinary teamwork or care management; those skills are critical to practice in a PCMH.
- Effective patient communication training is critical to PCMH practice.

Health Information Technology implications

- Effective health information technology (HIT) systems are essential to PCMH success. Health information exchange across the health care system is critical to care coordination and avoiding duplication of services.
- Understanding that Connecticut's HIT environment is developing, the committee outlined priority areas for PCMHs including afterhours access to charts and patient records, systems to notify providers when patients access urgent care or advice lines, preferably within hours, information on patient follow up on referrals and prescriptions, inclusion of care plans and risk assessments in patient records, and links to care coordination meetings (huddles) for follow up. Communications with retail clinics is critical and could be a requirement for operation of clinics.
- Health IT systems for PCMH should support population health tracking, performance comparisons between providers and practices, and identify "high utilizers" and "non-compliant" patients for follow up.
- As far as possible, provider and staff HIT training and PCMH training should be coordinated.

Public education campaign

- Despite strong public support for coordination of care, there is little public understanding of the PCMH model. A public education campaign to describe the model, its benefits to individuals, population health, and health care costs would support practices making this difficult transition as well as create momentum for other practices to consider the model.
- The public education campaign should emphasize information on the importance of showing up for appointments and the consequences of repeated no-shows.
- There is ample evidence that the US health care system often provides both too much and too little care to patients. While the public is acutely aware of the dangers of too little care, there is little understanding about the dangers of over-treatment. Unfortunately, public discussion about appropriate restraint in health care is often confused with emotional "rationing" arguments. One of the keys of PCMHs is

providing appropriate care, which sometimes is “watchful waiting” or increased monitoring of a problem and delaying intensive treatment options to ensure they are indicated. PCMHs are built on a trusting patient-provider relationship which fosters a climate of more appropriate care. A public education campaign that includes information on over-treatment and its impact on health would support trust in those relationships and more effective treatment.

Role of employers in supporting PCMHs

- It is critical to engage employers in educating their workers about the benefits of PCMHs, self-management of disease, prevention and screening. Employers can provide incentives to workers who choose PCMHs such as reductions in cost sharing. Employers can also be instrumental in educating workers about their responsibilities in maintaining their health, the risks of over-treatment and in interacting with the health care system effectively. Employers can provide workers with tools to improve their health including pre-populated personal health records, coverage of community-based self-management support programs (i.e. weight loss or smoking cessation programs at work), connections to patient advocacy resources, and patient safety tools (i.e. prompts for questions to ask of providers during visits or before making treatment decisions).
- It is critical that employers design and implement these initiatives in collaboration with the PCMHs and administrators that serve their workers.
- We urge SustiNet leadership to engage and support Connecticut employers, large and small, in supporting PCMHs and patient education.

ⁱ Aiming Higher: Results from a State Scorecard on Health System Performance, The Commonwealth Fund, October 2009

ⁱⁱ Emergency Department Utilization in Connecticut, CT Hospital Association, April 2009.

ⁱⁱⁱ How, SK, et. al., “Public Views on US Health System Organization: A Call for New Directions”, Commonwealth Fund Data Brief, August 2008.

^{iv} M. Friedberg, et. al., Primary Care: A Critical Review of the Evidence on Quality and Costs of Health Care, Health Affairs 29:766-772, May 2010.

^v Yale University Library multi-database article search, 6/16/2010.

^{vi} E. Andrews and S. Toubman, Patient-Centered Medical Home: Improving Health Care by Shifting the Focus to Patients, CT Medicine 73:479-480, September 2009.

^{vii} P. Grundy, et. al., The Multi-Stakeholder Movement for Primary Care Renewal and Reform, Health Affairs 29:791-797, May 2010.

^{viii} J DeVoe, et. al., Amer J Pub Hlth, 93:786, May 2003

^{ix} K. Grumbach et. al., The Outcomes of Implementing Patient-Centered Medical Home Interventions, Patient-Centered Primary Care Collaborative, August 2009, A. Milstein and E. Gilbertson, American Medical Home Runs, Health Affairs 28:1317-1326, September 2009, R. Reid, et. al., The Group Health Medical Home at Year Two, Health Affairs 29:835-843, May 2010.

^x Christopher Atchison, presentation at Building a Medical Home: Issues and Decisions for State Policy Makers, NASHP, 10/5/08, Tampa, FL

^{xi} C Hull, The Medical Home Model and Family Health Teams, Research and Education Services, Legislative Assembly of Ontario, 5/11/09.

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- ^{xii} Multi-payer Advanced Primary Care Practice Demonstration Solicitation, CMS, June 2010.
- ^{xiii} Patient Centered medical homes in the Patient Protection and Affordable Care Act, CT Health Policy Project, April 2010.
- ^{xiv} C DesRoches, et. al., New Engl J Med online, July 3, 2008
- ^{xv} Personal communication, Matt Katz, CT State Medical Society.
- ^{xvi} Primary Care Coalition of Connecticut, March 2010.
- ^{xvii} Supporting Small Practices, NCQA, June 2009.
- ^{xviii} P Nutting, et. al., Initial Lessons from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home, *Annals of Family Medicine*, 7:254-260, May/June 2009.
- ^{xix} B. Chesluck and E. Holmboe, How Teams Work – Or Don’t – in Primary Care, *Health Affairs* 29:874-879, May 2010.
- ^{xx} Physician Practice Connections – Patient Centered Medical Home, NCQA, www.ncqa.org
- ^{xxi} NCQA, September 2009.
- ^{xxii} Primary Care Case Management, CT Health Policy Project, <http://www.cthealthpolicy.org/pccm/index.htm>
- ^{xxiii} ACS HUSKY enrollment reports, June 2010.
- ^{xxiv} PA 10-166, An Act Concerning Expansion of the Primary Care Case Management Pilot Program, 2010 General Assembly session.
- ^{xxv} Patient Centered Medical Home Initiative with ProHealth, presentation to committee, April 21, 2010.
- ^{xxvi} Ron Preston, presentation to committee, May 26, 2010, personal communications with VT state health policymakers.
- ^{xxvii} CT’s population projections, US Census.
- ^{xxviii} CT State Data Center.
- ^{xxix} CT’s Health Care Workforce: Under Construction, Briefing paper for the Sustinet Health Care Workforce Task Force, Fairfield County Business Council, Tanya Court, May 2010, B. Cleary, et. al., Expanding the Capacity of Nursing Education, *Health Affairs* 28:w634-w645, June 12, 2009.
- ^{xxx} Unpublished survey, CT Health Policy Project.
- ^{xxxi} *Addressing Racial and Ethnic Disparities in Health Care Fact Sheet*. AHRQ, February 2000.
- ^{xxxii} Lessons for State Policymakers from Kaiser Permanente, Ann Torregrossa, PA GOHCR, Using Payment Reform to Improve Health System Performance, NASHP State Health Policy Conference, Oct. 5, 2009.
- ^{xxxiii} Healthcare Effectiveness Data and Information Set 2011, NCQA.

PREVENTIVE HEALTH CARE ADVISORY COMMITTEE FINAL REPORT TO THE SUSTINET BOARD

1. EXECUTIVE SUMMARY:

The Committee approached its charge to improve health for Sustinet members broadly: to improve health for the whole person, including physical health, mental health, addictive behaviors and oral health. The Committee recommends that Sustinet cover a comprehensive package of preventive services, with no cost sharing required from the patient. Moreover, the Committee recommends that Sustinet cover additional preventive care services that a primary care clinician includes in an Annual Individual Preventive Care Plan, specifically designed to meet an individual patient's needs. These recommendations are explained in more detail below.

The Committee set forth a number of over-arching principles that guided its work. In this report, it offers detailed recommendations relating to governance, criteria for evaluating a preventive services package, the process for developing a preventive services package, components of a preventive services package, an approach for including community-based preventive care services, payment and financial incentives, data collection and use, and issues that intersect with those covered by other advisory committees and task forces.

2. PURPOSE AND MISSION

- a. **Sustinet Law; direction to the Committee.** The relevant sections of the Sustinet law are as follows (emphasis added).

Public Act No. 09-148: AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN

"Sec. 8. (NEW) (*Effective July 1, 2009*) (a) The board of directors shall establish a preventive health care advisory committee that shall use evolving medical research to draft **recommendations to improve health outcomes for members in areas involving nutrition, sleep, physical exercise, and the prevention and cessation of the use of tobacco and other addictive substances.** The committee shall include providers, consumers and other individuals chosen by said board. Such recommendations may be targeted to member populations where they are most likely to have a beneficial impact on the health of such members and may include behavioral components and financial incentives for participants. Such recommendations shall take into account existing preventive care programs administered by the state, including, but not limited to, state administered educational and awareness campaigns. **Not later than July 1, 2010, and annually thereafter, the preventive health care advisory committee shall submit such recommendations to the board of directors.**

“(b) The board of directors shall recommend that the Sustinet Plan provide **coverage for community-based preventive care services** and such services be required of all health insurance sold pursuant to the plan to individuals or employers. Community-based preventive care services are those services identified by the board as capable of being safely administered in community settings. Such services shall include, but not be limited to, immunizations, simple tests and health care screenings. Such services shall be provided by individuals or entities that satisfy board of director approved standards for quality of care. The board of directors shall recommend that: (1) Prior to furnishing a community-based preventive care service, a provider obtain information from a patient's electronic health record to verify that the service has not been provided in the past and that such services are not contraindicated for the patient; and (2) a provider promptly furnish relevant information about the service and the results of any test or screening to the patient's medical home or the patient's primary care provider if the patient does not have a medical home. The board of directors shall **recommend that community-based preventive services be allowed to be provided at job sites, schools or other community locations consistent with said board's guidelines.**”

b. Members

Michael Critelli, Co-Chair

Retired Executive Chairman and Director
Pitney Bowes

Nancy Heaton, Co-Chair

Executive Director
Foundation for Community Health

Norma Gyle, Board of Directors Liaison

Deputy Commissioner
Department of Public Health
State of Connecticut

Patricia Baker

President & CEO
CT Health Foundation

Tanya Barrett

VP 211 Health & Human Services
United Way of CT

Yvette Bello

Executive Director
Latino Community Services

Thomas Buckley

Assistant Clinical Professor
UConn School of Pharmacy

Gina Carucci

Chiropractic Physician
President, Connecticut Chiropractic
Association

David K. Emmel

Physician
President, Connecticut Society of Eye
Physicians

Dennis Gottfried
Physician

Steve Huleatt
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Robert Krzys
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Sharon Langer
Senior Policy Fellow
Connecticut Voices for Children

Steve Levinson
Practical EM

Joe Pandolfo
Public Policy Advisor
CT Society of Acupuncture and
Oriental Medicine

Stephanie Paulmeno
Principal & CEO
Global Health Systems Consultants, LLC

Lynn Rapsilber
Chair
Connecticut Coalition of Advanced
Practice Nurses

Carlos Sanchez-Fuentes
Managing Partner
Axiom Actuarial Consulting, LLC

Dorothy Shearer
Vice President
Health Sciences International, Inc.

Nancy Sheehan
Pediatrician, Dept. of Human
Development & Family Studies
University of Connecticut

Randy Trowbridge
Founder
Team Rehab

Alicia Woodsby
Public Policy Director
National Alliance on Mental Illness, CT

Nancy Yedlin
Vice President
Donaghue Foundation

c. Methodology/Process

The Preventive Healthcare Advisory Committee held meetings on

December 14, 2009
January 19, 2010
February 10, 2010
March 16, 2010
April 8, 2010
May 5, 2010
June 7, 2010
June 25, 2010

The Committee established three sub-committees, which each met at least monthly and submitted recommendations and materials to the full Committee. The three sub-committees were:

Plan Design: Carlos Fuentes, Chair

Provider and Patient: Patricia Baker, Chair

Optimal State and Community Health Programs: Stephanie Paulmeno, Chair

d. Definitions

Community - for purposes of this report, the Committee defined “community” to include workplaces, schools, school-based health clinics, places of worship, and other neighborhood centers.

Cost-effectiveness analysis – An economic analysis that views effects in terms of overall health, specific to the problem, and describes the likely costs, the likely additional health gains, and the likely savings (e.g. cost per additional stroke prevented).¹

Current best evidence – “up-to-date information from relevant, valid research about the effects of different forms of health care, the potential for harm from exposure to particular agents, the accuracy of diagnostic tests, and the predictive power of prognostic factors.”²

Evidence-based health care – “the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services.”³

Health- “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”⁴

Medically Underserved – areas and populations having “too few primary care providers, high infant mortality, high poverty and/or high elderly population.”⁵

¹ Adapted by the Committee from definition provided in the Cochrane Collaborative, Glossary. www.cochrane.org/glossary

² Gray JAM. *Evidence-based healthcare: how to make health policy and management decisions*. London: Churchill Livingstone, 1997. Cited by The Cochrane Collaborative, About Us, Evidence-Based Health Care. <http://www.cochrane.org/about-us/evidence-based-health-care>

³ The Cochrane Collaborative, About Us, Evidence-Based Health Care. <http://www.cochrane.org/about-us/evidence-based-health-care>

⁴ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

⁵ U.S. Department of Health and Human Services, Health Resources and Services Administration. <http://muafind.hrsa.gov/>

Primary prevention: "Prevention of diseases or disorders in the general population by encouraging community wide measures such as good nutritional status, physical fitness, immunization, and making the environment safe. Primary prevention maintains good health and reduces the likelihood of disease occurring."⁶

Secondary prevention: "Detection of the early stages of disease before symptoms occur, and the prompt and effective intervention to prevent disease progression."⁷

Tertiary prevention: "Prevention or minimization of complications or disability associated with established disease. Preventive measures are part of the treatment or management of the target disease or condition."⁸

Vulnerable populations - those groups of people "made vulnerable by their financial circumstances or place of residence; health, age, or functional or developmental status; or ability to communicate effectively...[and] personal characteristics, such as race, ethnicity, and sex," including "populations whose vulnerability is due to chronic or terminal disease or disability."⁹

e. Acronyms

CDC – [U.S.] Centers for Disease Control and Prevention

ECC – Enhanced Care Clinic

EPSDT – Early and Periodic Screening, Diagnostic and Treatment

PPACA - Patient Protection and Affordable Care Act of 2010 (federal health reform law)

ROI – Return on Investment

SAMHSA – [U.S.] Substance Abuse and Mental Health Services Administration

3. STATEMENT OF THE PROBLEM

- a. **Goal:** To improve the health of the people of Connecticut through the coverage of comprehensive preventive health services by maximizing the delivery and use of these services and by promoting healthy behaviors at both the individual and community levels.

⁶ The Royal Australian College of General Practitioners, Guidelines for preventive activities in general practice, 7th edition.

⁷ Ibid.

⁸ Ibid.

⁹ *Final Report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry*, cited by the Agency for Healthcare Research and Quality, <http://www.ahrq.gov/news/press/vulnpr.htm>

- b. **Approach:** The Committee approached its charge broadly: to improve health for the whole person, including physical health, mental health, addictive behaviors, and oral health.
- c. **Principles:**
 - (1) The goal to improve the health of the people of the Connecticut through the coverage of preventive health services will be most effective when all key stakeholders –including consumers, providers and payers are engaged and their incentives are aligned.
 - (2) The Sustinet Plan must develop strategies and financing mechanisms that recognize the complexity of patient’s lives and both the challenges and unique assets of the communities in which they live.
 - (3) The Sustinet Plan should pay special attention and care to insure that all vulnerable and underserved populations gain access to and are able to take full advantage of all prevention services covered under the Sustinet plan, and that these services are provided in a culturally and linguistically appropriate manner.
 - (4) The Sustinet Plan must include full mental health parity, as defined in the federal Patient Protection and Affordable Care Act (PPACA).
 - (5) Patients and providers must work together as partners toward the shared goal of improving the patient’s overall health.
 - (6) The Sustinet Plan must honor patient choice regarding providers by including all credentialed, proven preventive health professions and modalities, and by enabling patient access to clinicians with applicable specialties in various care settings.
 - (7) The Sustinet Plan must focus available resources on promoting and covering the most cost-effective care and services. Decisions should be made using the strongest and most current evidence available. Resources should be deployed to promote wellness through broad-based primary, secondary and tertiary prevention and primary care capacity building, as opposed to focusing resources on a single disease or other medical condition.

4. RECOMMENDATIONS

1) Governance

- a) Authority: Sustinet’s governing body needs to have the authority, as well as flexibility to respond (i.e. adjust the plan) to new research or evidence that may

affect preventive benefits and/or community interventions.

- b) Advisory Committee: As required in the Sustinet law, Sustinet's governing structure must include a preventive health care advisory committee. This committee should include individuals with the medical and science skills needed to review and evaluate preventive clinical and community level interventions on an ongoing basis, including, but not limited to, individuals with specific expertise in: prevention (including physical health, mental health, substance abuse, tobacco use, and oral health), evidenced-based medicine, primary care, public health, epidemiology, behavioral economics, social marketing, and experience serving vulnerable and underserved populations.
- c) Relationships with State Agencies: Sustinet's governing body needs to establish formal liaison/relationships with relevant Connecticut Departments that have responsibilities for preventive health care (including, but not limited to the Departments of Public Health, Mental Health and Addiction Services, Social Services, and Children and Families.).
- d) Relationships with Federal Entities: Sustinet's governing body should include liaisons to federal councils and task forces, to (a) access funds; (b) ensure compliance with guidelines; (c) import federal program information and practices; and (d) export Sustinet program information and practices.

2) Criteria for Developing a Preventive Services Package

- a) National Guidelines: The preventive health care advisory committee should identify a set of covered preventive care services based on national guidelines, such as those established by the US Preventives Services Task Force, the American Academy of Pediatrics' Bright Futures, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute of Mental Health, the National Institute of Health Office of Disease Prevention, the American Dental Association, the American Academy of Pediatric Dentistry, the Health Evidence Network of the World Health Organization, and the Guide to Community Preventive Services from the Centers for Disease Control and Prevention. The Committee will refer to these recommended guidelines rather than repeat them verbatim.
- b) Cost-Effectiveness: The preventive health care advisory committee should incorporate cost-effectiveness assessments into its decision-making on covered benefits whenever possible.

Cost-effectiveness and cost-saving analyses provide an assessment of how much gain in "health" each preventive service will deliver for a unit of cost and should be reviewed and considered as a component of coverage decisions. These analyses can determine which services are likely to have the greatest return on investment and thus should be strongly encouraged, with reduced barriers to delivery and use.

Cost effectiveness modeling should include projections of the actual dollar reductions to overall health care spending expected from specific prevention activities so that return on investment (ROI) analyses can be performed. The time horizon for these analyses should be appropriate to each prevention activity, often 3 years or more. Cost-effectiveness modeling should incorporate evidence-based research on behavioral responses to prevention initiatives. The committee should also consider recognizing social benefits in its cost-effectiveness modeling, such as improving school performance and reducing days missed from work.

The committee should consult multiple sources of evidence, but should give the greatest weight to the recommendations of the U.S. Preventive Services Task Force, which now considers cost effectiveness assessments when making its recommendations, and the National Committee on Prevention Priorities, which has calculated cost-effectiveness ratios for preventive services. The committee should also consult the U.S. Advisory Committee on Immunization Practices for immunization guidance, as well as the Centers for Disease Control and Prevention, the Cochrane Collaborative, and the UK's National Institute for Clinical Excellence.

In evaluating the available evidence-based research, the committee should consider factors including, but not limited to: the number of clinical studies, the size of the populations participating, the level of certainty of the results, the breadth of the study's findings, and the quality of the study methodologies used.

- c) Disparities and Health Equity: SustiNet needs to focus specifically on the prevention needs of vulnerable and underserved populations, and to devise prevention and outreach strategies that are both culturally and linguistically appropriate. The committee should evaluate cost-effectiveness and cost-saving analyses specific to underserved and/or vulnerable populations to ensure it is accurately determining the relevant assessment of gains in health outcomes.

The SustiNet plan must establish specific expectations for the reduction of health disparities in order to drive continuous quality improvement.

- d) Life Events and Transitions: Prevention efforts should attempt to capitalize on life events and transitions, which bring individuals in contact with the health care system, government agencies, or other entities that provide preventive care services. These life events and transitions include, but are not limited to, accessing pre-natal services, the birth of a child, a child entering school, a hospital discharge, discharge from active duty in the military, and release from a correctional facility.
- e) Barriers to Accessing Services: The Committee should take steps to identify and eliminate barriers to providing and using preventive health services, with a particular focus on vulnerable and underserved populations. Barriers that

prevent clinicians from providing preventive health services may include factors such as a lack of provider time, staffing, and training. Barriers that prevent patients from using preventive health services may include factors such as cost, transportation, work hours, geographic access, and family responsibilities.

3) Process for Developing a Preventive Services Package

- a) Begin with the Basics: Sustinet should begin by establishing a basic set of preventive services. Every preventive service package should include the services that have been shown unequivocally to be effective. These should include services with an “A” or “B” rating by the U.S. Preventive Services Task Force, which currently rates a comprehensive list of services for both adults and children.
- b) Update Regularly: Sustinet should update the package of services regularly. Because the evidence on the effectiveness of preventive services is continually evolving and changes frequently, it is important that the package not be a static list. The Sustinet prevention/health promotion advisory committee should review and periodically revise the covered package of services, based on the most current and reliable evidence available, including the success of Sustinet’s prevention initiatives.
- c) Feedback Loop: The Committee should review data frequently to measure utilization of specific recommended preventive services by population group, with a goal of continuously improving quality of care. Where the Committee finds that services are underutilized, the Committee should take steps to identify and eliminate barriers to clinicians providing and patients using these services.

4) Preventive Services Package Components

- a) Scope: Prevention plans and strategies should be comprehensive, addressing the full range of preventable medical conditions, with the goal of promoting overall health and wellness. These strategies should address physiological, emotional, mental, and developmental conditions for members throughout their life span (from birth to the end of life). The Sustinet plan should include the full range of EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) services.

The Sustinet plan should create easy and accessible schedules of age and gender specific prevention services, for the general population and for certain high risk and vulnerable groups. All intervention modalities that can reduce risky behaviors, decrease disease and extend life should be considered. Strategies in all these areas that have been shown to be cost-effective and/or cost-saving, by reliable research, should be included as part of the preventive services package. Sustinet should provide coverage for evidence-based early intervention programs, including birth to three, healthy steps, and head start.

Preventive services need to be provided as part of both a periodic plan and as part of episodic clinical interventions. The preventive health care advisory committee should establish a standard schedule of preventive services. Sustinet should then enable clinicians to customize preventive services for individuals based on unique risk factors and circumstances, using the Annual Individual Preventive Care Plan described below.

- i) Clinical preventive services: The Sustinet plan should include the full range of clinical preventive services in the coverage package, such as screening tests, immunizations, counseling, pharmaceuticals, evidence-based early medical intervention programs, and smoking cessation services.
- ii) Behavioral Health: The basic preventive care guidelines must include behavioral health preventive services including age and risk appropriate developmental and behavioral health assessments and screenings, as well as early interventions for depression and substance use. Screening for mental health conditions and substance abuse is even more important for individuals with chronic physical health conditions, because behavioral health and physical health conditions often exacerbate each other.

Sustinet preventive care services should include diagnostic tools for mental health conditions including depression, anxiety, suicide, bipolar disorders, developmental disorders, obsessive-compulsive disorder, psychoses, prenatal and postpartum depression, and other mental health conditions.

If the Sustinet Board decides to carve out behavioral health benefits, the carve-out plan should be modeled after or be assumed under the current Behavioral Health Partnership program (<http://www.ctbhp.com>) that has been operating in Connecticut since 2006. It has proven to be cost-effective and has resulted positive system reform and health outcomes.

- iii) Oral Health: The basic preventive care guidelines must include oral health preventive services, including screening, cleaning, fluoride applications, and sealants.

If the Sustinet Board decides to carve out oral health benefits, the carve-out should be modeled on the newly formed dental carve out for children oral health services in Connecticut, run by The Dental Health Partnership (<http://www.ctdhp.com>). It has been very effective to date in recruiting dentists as well as enrolling participants and matching them with providers.

b) Annual Individual Preventive Care Plan

The Sustinet plan should include the development and authorization of an Annual Individual Preventive Care Plan. This preventive care plan identifies and documents appropriate services prospectively, including standard recommendations based on the participant's demographics and flexible

recommendations based upon personal history and circumstances. This plan serves as a single benefit authorization mechanism for all recommended plan services and providers, informing all the participant's health providers in a consistent manner.

For patients with chronic physical and/or mental health conditions, primary care clinicians/medical home providers should have the option of working with a patient to develop a more extensive preventive care plan to meet the individual patient's needs.

The plan could address an individual patient's need for services to promote healthy nutrition, sleep, physical exercise, and the cessation of the use of tobacco and other addictive substances. The plan could include non-standard services that the clinician expects would improve the patient's health and would reduce the likelihood that the patient would require emergency department visits and hospitalizations.

The clinician would submit the patient's preventive care plan to Sustinet for approval on an annual basis. The Sustinet plan would pay for the preventive care services approved under this care plan, and the patient's copayment would be reduced or eliminated. The medical home team would be responsible for ensuring that the patient and the clinician follow the plan.

This Annual Individual Preventive Care Plan is modeled on the "individualized family service plan" benefit authorization mechanism included in the birth-to-three program (Conn.Gen.Stat. §38a-516 (a)), and on the Patient Protection and Affordable Care Act (PPACA) § 4103, which provides for Medicare coverage of an "annual wellness visit providing a personalized prevention plan." This new Medicare benefit is summarized as follows:

"The personalized prevention plan would take into account the findings of the health risk assessment and include elements such as: a five-to-ten year screening schedule; a list of identified risk factors and conditions and a strategy to address them; health advice and referral to education and preventive counseling or community-based interventions to address modifiable risk factors such as physical activity, smoking, and nutrition."¹⁰

- c) Cultural Competence: The design and practice of Sustinet must be culturally and linguistically competent with a fundamental respect for both the patient and the provider to maximize the relationship. Sustinet must provide health literacy materials for enrollees, must provide cultural and linguistic training for health care providers, and must collaborate with community based health organizations to support culturally responsive practices.

5) Community-Based Preventive Care Services

¹⁰ The Patient Protection and Affordable Care Act Section-by-Section Analysis, Democrats.Senate.Gov/Reform.

a) Locations: Sustinet should promote innovation and flexibility in the methods, organization and sites of delivery for preventive services. Many opportunities exist to provide preventive services in non-clinical settings. Therefore, their development and delivery in diverse settings such as workplaces, schools and school-based health clinics, places of worship, retail establishments, community, recreation centers and other community and fraternal organizations settings should be encouraged, supported and reimbursed where appropriate. Non-clinical settings should be designated as sites of service if they can demonstrate effectiveness. Pilot programs in unique clinical and non-clinical settings, such as the worksite for state employees, should be encouraged, financed and evaluated on an ongoing basis.

b) Areas of Focus: Sustinet should cover a broad range of effective, evidence-based preventive care services provided in community settings. The Childhood and Adult Obesity Task Force and the Tobacco and Smoking Cessation Task Force reports detail prevention strategies related to obesity and smoking that may be addressed in community settings. Community-based preventive care services should also include services promoting healthy behaviors, specifically in the areas of:

i) Nutrition

ii) Sleep and stress reduction

iii) Physical Activity, including:

- Physical activity that promotes strengthening of the cardiovascular systems of individuals; and
- Structured and targeted exercise programs that improve cardiovascular functions, strength, flexibility, and resistance to injuries.

iv) Behavioral Health, including mental health, substance abuse, and tobacco use

v) Other Services, including, but not limited to infectious disease control, sexually transmitted disease (STD) control, environmental toxins, injury prevention and domestic violence prevention.

These services may, and in most cases should, be designed to address these areas/issues with a variety of strategies and services, including, but not limited to: environmental hygiene strategies, public health strategies, individual strategies, immunizations, early intervention services and safety programs. (An example of an environmental hygiene strategy that could be included in an Annual Individual Prevention Plan might be a home audit to identify asthma triggers for a patient with poorly controlled asthma.)

- c) **Program Development:** The preventive health care advisory committee should actively encourage the participation of community and non clinical settings as sites for prevention by issuing calls for model programs, promoting and listing available sites and developing criteria, standards and best practices for community based programs.

6) Payment and Financial Incentives

- a) Preventive Care Services: Sustinet plan should cover preventive care services recommended in the standard guidelines *with no patient cost sharing* (\$0 co-payment). Sustinet plan should cover additional preventive care services included in an Annual Individual Preventive Care Plan, with the patient cost sharing reduced or eliminated.

The Sustinet plan design should be consistent with Medicaid and Exchange plan requirements for preventive care; and incorporate wellness related health incentive premium discounts consistent with those provided through insurance industry plans. However, Sustinet should *not* include premium adjustments based on an enrollee's weight.

- b) Services Delivered in Community Settings: The Sustinet plan should have a mechanism to pay for preventive care services that are provided in a community setting, such as a workplace or a place of worship. The service would need to be captured in the personal health and/or electronic medical record, and reported to and/or coordinated by the medical home provider or primary care clinician.
- c) Incentives for Providers: The Sustinet plan should include financial rewards to encourage clinicians to provide recommended preventive care services to all patients, where clinically appropriate. Sustinet must include payment mechanisms that allow clinicians to take the time to consider prevention actions that could reduce the frequency of the occurrence of that condition and the reoccurrence for that patient. Positive financial incentives should be targeted to the delivery and receipt of especially cost-effective and under-delivered clinical preventive services. These financial incentives should be developed using existing models, where successful models are available.

The Sustinet Plan should also include a mechanism that a clinician could use to indicate that the clinician chose not to provide standard preventive care service(s) to an individual patient for a specified reason. Any system established to reward clinicians for providing preventive care services should *not* penalize clinicians for *not* providing a service that the clinician judged and documented to be contra-indicated, duplicative, or otherwise clinically inappropriate for an individual patient.

- d) Incentives for Enrollees: Sustinet should be designed to provide a financial incentive for individual enrollees to prefer cost-effective preventive strategies

over discretionary therapeutic services. These incentives should be positive, not punitive, and should be targeted to increase enrollee participation in preventive services and wellness programs offered through Sustinet, with a particular focus on vulnerable and underserved populations.

7) Data Collection and Use

- a) Health Data: Health data should be collected and aggregated to inform state agencies and departments that are charged with improving the public's health on the health status of Connecticut residents. Information should be collected from multiple sources including claims and service utilization data sets and be organized in ways that are helpful -- regionally, by gender, by age group, etc. Agencies and departments, in turn, need to develop structures and processes that can receive, prioritize and act on this data.
- b) Evaluation: Sustinet needs to collect individual and population level data on an ongoing basis to enable it to measure the effectiveness of its prevention strategies.
- c) Feedback: Health data must be available to provide timely feedback to health care providers and to policy makers in order to drive continuous improvement. Clinicians will require timely access to their own patients' preventive health care services utilization data in order to monitor and improve the clinician's own performance. In addition, the preventive health care advisory committee will require ongoing access to utilization data for preventive services, stratified by factors including, but not limited to: patients' clinical condition, geographic area, age, sex, race and ethnicity.

8) Intersecting Issues (topics that overlap with other committees)

- a) Care Delivery & Medical Home
 - Sustinet should promote innovation and flexibility in the personnel, methods, organizations, and sites of delivery for preventive services, in order to increase the number of patients who receive preventive services, to contain costs, and to prepare for expected shortages of primary care physicians and nurses.
 - Primary care physicians need complementary assistance from other clinical providers, as well as community health providers. The Sustinet plan design must utilize a wide range of health professionals to deliver and assist the coordination of preventive care services, including community health workers and credentialed complementary and alternative medicine professionals.
 - The Sustinet design must enable all those delivering preventive services to coordinate their actions, and to enable the patient to have a total view of what he or she needs to do and with whom he or she needs to work. Care

coordination may be performed on-site by the medical home or primary care clinician, or it may be performed off-site by a community organization.

- Preventive care services provided in a community setting, such as a workplace or a place of worship, need to be reported to and/or coordinated by the medical home provider.
- The Sustinet Board should consider whether a medical home or medical home satellite can be located at a workplace, for example, at or near large government office buildings.
- The integration of care for physical health, mental health, and substance use conditions is critical to address the needs of people with serious mental illnesses. SAMHSA's Primary Care and Behavioral Health Integration programs should be supported models, as well as mental health and substance abuse clinics designated as Enhanced Care Clinics (ECC's).

b) Health Information Technology

- Sustinet should promote the broad-based adoption of both electronic health records to enable providers to share information and patient-controlled, portable personal health records that patients can bring with them from plan to plan and provider to provider. These electronic records will provide population-level information, clinical decision support tools, and information to support wellness and health promotion.
- Preventive care services provided in a community setting, such as a workplace or a place of worship, need to be captured in the electronic medical record.
- Sustinet should promote the demonstration and adoption of health information technologies that collect assessment information directly from, and disseminate wellness and prevention information directly to plan participants.

c) Quality and Provider: Sustinet should address cost-effective tertiary prevention strategies by including quality and safety performance measures that promote improvements, such as:

- Reducing hospital readmissions within 30 days,
- Reducing preventable hospitalizations and emergency department visits,
- Reducing hospital acquired infections,
- Reducing the incidence of "serious reportable events" as defined by the National Quality Forum,
- Reducing adverse drug events, and
- Improving care transitions.

Note that in evaluating these measures, Sustinet must also evaluate the cause of reductions in service, for example, if emergency room visits decline, but there is increased use of other inappropriate and costly settings.

Health care providers require a wide range of resources and supports in order to provide preventive care services effectively. These resources and supports include, but are not limited to sufficient payment, HIT technical support, a medical home coordination team, and after-hours call support.

- d) **Workforce:** Medical home staff and primary care physicians need appropriate training in:
- Shared decision making with patients as partners,
 - Developing and implementing an effective Annual Individual Preventive Care Plan,
 - Promoting wellness, and
 - Mental health screening and referral.

5. ADDITIONAL ISSUES BEYOND THE SCOPE OF THIS COMMITTEE

The Preventive Health Care Advisory Committee noted several issues that are beyond the Committee's charge, but that the Sustinet Board may wish to consider nonetheless.

- a. **Government's Opportunities as an Employer:** As employers, state and local governmental entities have an opportunity to drive a prevention strategy for their employees, the families of their employees, and retirees. In addition to providing a value-based health plan, such as Sustinet, government entities have three broad levers for driving a prevention agenda with the objectives of improving health, improving productivity, and containing health care costs:
- (1) Creating a healthy and supportive work environment for employees that drives healthy behaviors at the workplace; private companies, such as Pitney Bowes and General Electric, have demonstrated significant return on these investments.
 - (2) Delivering preventive clinical services at or near the workplace; partnering with community clinicians to provide preventive services in or near the workplace increases the likelihood that employees will take advantage of these services.
 - (3) Giving employees, their families and retirees tools for more effective self-management of their health; for example, a patient-controlled, portable, electronic medical record.
- b. **Promoting Healthy Sleep:** The Committee is charged with drafting "recommendations to improve health outcomes for members in areas involving ... sleep." The Committee notes that sleep deprivation issues are often related to an individual's work or school schedule, or to the total number of hours worked. State government should consider reviewing whether the extent to which sleep deprivation results from these issues, as well as quantifying the potential harm.
- c. **Public Health:** To a large extent, primary prevention efforts are the responsibility of the Department of Public Health, the Department of Mental Health and Addiction

Services, and other state and local agencies. The Committee supports these efforts and notes that these efforts ultimately produce significant savings in health care costs for individuals, employers, and government.

6. **UNKNOWN/UNRESOLVED ISSUES**

Federal funding opportunities: The federal Patient Protection and Affordable Care Act (PPACA) includes a number of funding opportunities for preventive care, including the following. The Sustinet Board should consider which funding opportunities would be most beneficial for Connecticut.

- (1) Wellness Program Demonstration Project (Sec. 1201): a 10-state demonstration program to promote health and prevent disease, no later than July 1, 2014. If effective, expand demonstration to additional states beginning July 1, 2017.
- (2) Incentives to prevent chronic diseases in Medicaid populations (Sec. 4108): Provide grants to states to implement incentive programs to help individuals quit smoking, control/reduce weight, lower cholesterol and blood pressure, avoid diabetes, and address co-morbidities, beginning 2011.
- (3) Community Transformation Grants (Sec. 4201): Implement, evaluate, and disseminate evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming, FY2010-2014.
- (4) Promoting healthy aging and living well (Sec. 4202): 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age, FY2010-2014.
- (5) Demonstration to Improve Immunization Coverage (Sec. 4204): Improve the provision of recommended immunizations for children, adolescents, and adults through the use of evidence-based, population-based interventions for high-risk populations, FY2010-2014.
- (6) Wellness Demonstration (Sec. 4206): Implement, evaluate, and disseminate evidence-based community preventive health activities to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming, beginning 2014.
- (7) Community-based collaborative care network program (Sec. 10333): Support community-based collaborative care networks (consortium of health care providers with a joint governance structure) to provide comprehensive

coordinated and integrated health care services for low-income populations, FY2011-2015.

- (8) Workplace wellness grants (Sec. 10408): Grants for small employers to provide their employees with access to comprehensive workplace wellness programs, FY2011-2015.

7. RESOURCES

Websites

U.S. Preventive Services Task Force (USPSTF), Agency for Healthcare Research and Quality (AHRQ). An independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services.

<http://www.ahrq.gov/clinic/uspstfix.htm>

American Academy of Pediatric Dentistry - The American Academy of Pediatric Dentistry (AAPD) is the membership organization representing the specialty of pediatric dentistry www.aapd.org/

ADA Center for Evidence Based Dentistry - The American Dentistry Association provides this Web site to help clinicians identify systematic reviews, the preferred method for assembling the best available scientific evidence, through its database and provides appraisal of the evidence through our critical summaries.

<http://ebd.ada.org>.

Association of State and Territorial Dental Directors (ASTDD) - provides leadership to promote a governmental oral health presence in each state and territory, to formulate and promote sound oral health policy, to increase awareness of oral health issues, and to assist in the development of initiatives for prevention and control of oral diseases.

<http://www.astdd.org/index.php?template=bestpractices.html&tier1=Best%20Practices>

Bright Futures, American Academy of Pediatrics - Bright Futures is a national health promotion and disease prevention initiative that addresses children's health needs in the context of family and community. <http://brightfutures.aap.org>

Centers for Disease Control and Prevention - CDC's Mission is to collaborate to create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability, and preparedness for new health threats. www.cdc.gov

Cochrane Collaboration - The Cochrane Collaboration is an international, independent, not-for-profit organization of over 28,000 contributors from more

than 100 countries, dedicated to making up-to-date, accurate information about the effects of health care readily available worldwide. www.cochrane.org

Guide to Community Preventive Services - The Guide to Community Preventive Services is a free resource to help users choose programs and policies to improve health and prevent disease in your community. www.thecommunityguide.org/index.html

Health Evidence Network - HEN is a network of technical members and financial partners, involving United Nations agencies with a mandate related to health, and organizations or institutions promoting the use of evidence in health policy or health technology assessment. www.euro.who.int/en/what-we-do/data-and-evidence/health-evidence-network-hen

National Committee on Prevention Priorities - Represents prevention advocates in every sector committed to improving health and controlling health costs through effective prevention policies and practices. www.prevent.org/content/view/90/74/

National Institute of Health Office of Disease Prevention - Fosters, coordinates, and assesses prevention and health promotion research as part of the NIH effort to improve public health, reduce disease burden, and improve the quality of life for all Americans. <http://prevention.nih.gov/>

UK's National Institute for Clinical Excellence - The National Institute for Health and Clinical Excellence (NICE) provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. www.nice.org.uk/aboutnice/

U.S. Advisory Committee on Immunization Practices - The Advisory Committee on Immunization Practices (ACIP) consists of 15 experts in fields associated with immunization, who provide advice and guidance on the control of vaccine-preventable diseases. www.cdc.gov/vaccines/recs/acip/default.htm

U.S. Substance Abuse and Mental Services Administration (SAMHSA) - SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. www.samhsa.gov/

World Health Organization - WHO is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. www.who.int/en/

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REPORT OF THE QUALITY AND PROVIDER ADVISORY COMMITTEE TO THE SUSTINET BOARD OF DIRECTORS

I. Executive Summary

The Healthcare Quality and Provider Advisory Committee (HQPAC) was established to advise the SustiNet board of directors on matters related to health care quality, safety, cost and provider payment. The committee, through a collaborative process, has developed recommendations in each of these areas. The committee believes that SustiNet offers the opportunity to provide high-quality, safe health care to its covered population through an efficient and effective model of care delivery. The SustiNet board should take care to incorporate the following elements in the SustiNet design:

- Use of evidence-based standards of care;
- Use of recognized quality metrics for quality measurement and provider feedback;
- Effective cost control through a combination of payment design and delivery system redesign that promote provider accountability for costs and reduce unnecessary care;
- Ongoing oversight of and advisement on quality, safety and payment by standing committees;
- Support for providers through health information technology, implementation of the medical home model and payment for better, more efficient care management.

II. Purpose and mission of this Committee

Public Act No. 09-148: AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN, directed the Healthcare Quality and Provider Advisory Committee (HQPAC) to advise the SustiNet board of directors on four issues related to the design of SustiNet:

- Procedures that require or encourage providers to engage in reviews of their quality of care and to develop plans for quality improvement;
- Adoption of clinical care and safety guidelines;
- Hospital safety standards; and
- Quality and safety recommendations that will help slow the growth of per capita health care spending.

In addition, the SustiNet board asked the committee to recommend a payment approach through which SustiNet would pay health care providers.

III. Members

The members of the Healthcare Quality and Provider Advisory Committee are:

Margaret Flinter (co-chair)

Vice President and Clinical Director

Community Health Center, Inc.
C. Todd Staub (co-chair)
Chairman
ProHealth Physicians

Paul Grady (liaison to the Sustinet board
of directors)
Principal
Mercer

Clarice Begemann
Fair Haven Community Health Center

Mark Belsky

Tina Brown-Stevenson
Senior Vice President of Analysis,
Research and Innovation Group
Ingenix

Francois de Brantes
CEO
Bridges to Excellence

Jane Deane Clark
Vice President, Data Service
Connecticut Hospital Association

Teresa Dotson
CT Dietetic Association Representative
Nutrition Solutions for Life, LLC

Kevin Galvin
Owner
Connecticut Commercial Maintenance,
Inc.

Lynne Garner
President & Trustee
Donaghue Foundation

Kathy Grimaud
CEO
Community Health and Wellness Center
of Greater Torrington

Claudia Gruss
Senior Partner
Arbor Medical Group

William Handelman
Attending Physician and Associate
Director Dialysis Unit
Charlotte Hungerford Hospital

Jerry Hardison
Connecticut Association of Optometrists

Alison Hong
Director, Quality and Patient Safety
Connecticut Hospital Association

Rodney Hornbake
Internal Medicine and Geriatrics

Mike Hudson
Northeast Region Head, Healthcare
Delivery
Aetna

Bryte Johnson
American Cancer Society

Pieter Joost van Wattum
Medical Director
Clifford W. Beers Guidance Clinic

Steve Karp
Executive Director
National Association of Social Workers,
Connecticut Chapter
& Health Care for All Coalition

Willard Kasoff
Resident
Yale-New Haven Hospital Department of
Neurosurgery

William Kohlhepp
Director, PA Program Pre-Professional
Phase
Quinnipiac University

Rick Liva
Managing Director
The CT Center for Health

Sarah Long,
Family Nurse Practitioner
Community Health Center of Enfield
CHC, Inc.

Robert McLean
American College of Physicians,
Connecticut Chapter Governor

Thomas Meehan
Chief Medical Officer
Qualidigm

Matt Pagano
Connecticut Chiropractic Association

Sara Parker McKernan
Legislative Liaison
Legal Assistance Resource Center of CT,
Inc.

Marcia Petrillo
CEO
Qualidigm

Jean Rexford
Executive Director
Connecticut Center for Patient Safety

Linda Ross

Christian Science Committee on
Publication for Connecticut

Jody Rowell
Advocate and Clinical Social Worker

Robert Scalettar

Christine Shea Bianchi
Staywell Health Center

Nelson Shub, M.D.

Arthur Tedesco
CFO, Retired
Danbury Hospital

Mark Thompson
Executive Director
Fairfield County Medical Association

Richard Torres
Chief Medical Officer
Optimus Health Care, Inc.

Joseph Treadwell
Foot & Ankle Specialists of CT

Victoria Veltri
General Counsel
State of Connecticut
Office of the Healthcare Advocate

Jeff Walter
Rushford Center

IV. Methodology

The HQPAC met seven times from December 2009 through June 2010. Two meetings were devoted to each of the committee's three areas of focus: payment, quality and safety. A free and open discussion among all members was used in a consensus-building model to

articulate general principles and specific goals for Sustinet. The accumulated expertise and experiences of the committee members was used as the basis for arriving at consensus recommendations, with several relevant articles from the literature used to supplement discussion.

The outline presented June 2, 2010 and this report were drafted by a core writing group and revised after commentary periods open to the entire committee.

V. Statement of the problem as defined by this Committee

The committee sought to use current evidence, as illustrated by already-existing examples of state-level health-care reform (e.g. in Massachusetts), as a model for Sustinet's structure and goals. We also reviewed data from the Commonwealth Fund and the Dartmouth Atlas. These data show that Connecticut ranks high, relative to other states, in terms of access to care (3rd in the nation), but much lower in terms of avoidable hospital use and costs (32nd in the nation). In addition, data from the Kaiser Family Foundation showed Connecticut to have per capita health care costs in 2004 of \$6,344, relative to a national average of \$5,283. This suggests that we in Connecticut could do much to reduce waste and improve care coordination within our health care system. We believe that this can be accomplished without compromising health care quality.

VI. Goals and Principles

As a starting point for its deliberations, the committee developed statements regarding our shared goals and principles for improved quality and safety, reduced costs and payment methodologies. These are listed below.

Goal for quality and safety

- To facilitate high-quality, safe, high-value care

Principles for quality and safety

- Care should be designed and structured to achieve agreed upon evidence-based standards that meet the overall needs of the population while maintaining necessary flexibility to meet individual circumstances.
- Care should be coordinated among different providers and levels of care
- Accountability for quality and safety is a requirement for all providers at each level of care
- Quality should be measured. Measures should be:
 - Meaningful, already validated and evidence-based
 - Reflective of both process and outcome
 - Affordable, easy to implement, and easy to use for providers (facilitated by health information technology)
 - Comprehensive across levels of care
 - Include population-based as well as individual
- Measures should be transparent and public
- Measures should be actionable
- Data collection should allow for an assessment and comparison of quality across served populations, including by race/ethnicity, income and type of insurance coverage

Goals for safety in care delivery

- To provide maximum patient safety
- To build a culture of safety among all stakeholders

Principles for safety in care delivery

- Error prevention is the ideal
- Error reporting should be blame-free, protected, transparent, facilitated and linked to quality improvement
- Practices should simplify and standardize care processes as much as possible
- Communication and teamwork are critical for error prevention and recognition
- Patients and providers should be empowered to report errors or safety concerns
- The development of safety standards should focus on hospitals as a starting point, but should, to the extent possible, eventually apply to other settings, such as long-term care facilities, home care and physician practices.
- Transitions of care and other high risk areas should be specifically targeted for improvement

Goals for cost control

- Reduce and control growth in costs while maintaining quality through appropriate care

Principles for cost control

- Cost control must be achieved through a combination of price control and system redesign
- For cost control to be effective at reducing potential overtreatment and inappropriate utilization, providers must have liability protection if standards of care are met
- Cost control is the responsibility of all stakeholders, including providers, patients, payers and government
- Stewardship of plan resources through cost control is essential to optimize access, service, quality, and safety for all plan participants

Goals for payment systems and methodologies

- Use and assure reimbursement to improve quality and safety
- Use and assure reimbursement to improve access

Principles for payment systems and methodologies

- Reimbursement has limited positive incentive value and should be structured mainly to minimize negative incentives to providers
- Reimbursement must be redesigned to fund valued but currently non-reimbursed services within the medical home, including virtual visits, telephonic management, care coordination, case management and chronic disease state management
- Eliminate differentials in payment between Medicare, Medicaid and commercial payers
- Accountability by providers for the quality and safety of services, and access to of the care provided
- Accountability for financial outcomes, such as those related to avoidable hospital admissions and unnecessary specialty services
- Transparency
- Fair balance between providers and payers
- Encourage patient accountability
- Protect consumers
- Recognize that there are different levers to use in reimbursement strategies; a single method is likely to be ineffective. There are elements within health care that respond to fee for service, as there are elements of healthcare that response to global payments or pay for performance strategies.

VII. Recommendations

The committee also developed specific recommendations for each of our areas of focus, and those are listed below.

Recommendations related to quality assessment and improvement and clinical care and safety guidelines

1. Create two standing Clinical Standards Committees – one to advise Sustinet on quality and payment and one to advise on safety. The responsibilities of the committees will intersect, and there should be regular communication between the committees on common areas of responsibility and mutual concern. These committees should be representative of all participating provider groups, to conduct ongoing reviews of best practices and establishment/adjustment of disease-specific, evidence-based clinical guidelines and should promote education and sharing of best practices. The committees also should reflect the diversity in Connecticut's population, in terms of race and ethnicity.
2. Identified guidelines will become the basis for quality measures. In identifying guidelines, the committees will embrace the goals of efficient and safe care. The committees should focus first on areas of clinical care that offer the greatest potential for cost savings and for individual and population health.
3. Sustinet should use evidence-based practice standards that have already been promulgated and nationally endorsed quality measures that have been appropriately vetted.
4. Communication with all appropriate specialties and sub-specialties will be critical to identifying guidelines that are acceptable to all providers.
5. The patient-centered medical home model should be used to coordinate care. The medical home model should fully embrace the skills and resources of all participating providers as detailed in CT state statutes.
6. Quality measurement should be based on the best available data, whether claims data, electronic medical record (EMR) data, or point-of-service measurements.
7. Quality measures and clinical guidelines should be integrated with EMRs so as to be automatic.
8. These recommendations should be integrated into the design of Sustinet's health information technology early in the design process.
9. Quality measurement should capture inpatient, outpatient, long-term, home care and hospice care.
10. A central database will need to be maintained for population-, patient- and provider-level quality data.
11. Payment-for-measurement might be used as a first step with providers (as with PQRI in Medicare).
12. Quality measures should be disseminated to the public, to providers, and to Sustinet
 - a. Which measures should be available to which parties, and at what level of reporting, will need to be established

- b. Composite measures that summarize quality measures may be more useful for public reporting and to help patients evaluate care
 - c. More detailed reporting will be needed for the purpose of quality improvement by providers
- 13. Educational resources should be available to support physicians and other providers in the areas of quality and safety, particularly to support adoption and diffusion of innovations that promote patient safety.
- 14. Quality measurement for nonmedical and alternative services should be as stringent as that used for medical services but also consistent with the patient's desire to utilize a nonmedical form of treatment, and also should be based on nationally-recognized standards and measures, if available.
- 15. Evaluation and reporting of quality measures must take into account the demographics of the patient population served by each provider.
- 16. Sustinet should develop a central resource for all providers that will:
 - a. Provide access to practice management opportunities and clinical programs for practice efficiencies and HIE options
 - b. Provide patient educational resources for provider use and patient web access
 - c. Promote the proper use of HIE to ensure real-time access to patient data by providers with the goal of providing safe and efficient care

Recommendations regarding safety

The original charge to this committee was to address standards for hospital safety. However, the committee's discussion ranged well beyond hospital safety, and we agreed that Sustinet should be concerned with safety in all care settings.

1. Separate standing quality and safety committees should be established as on-going elements of Sustinet. The responsibilities of the committees will intersect, and there should be regular communication between the committees on common areas of responsibility and mutual concern. Each of these must include consumer representatives and be focused on changing the culture of care as well as the specifics of quality and safety.
2. Sustinet should use existing safety guidelines and safety measures already being reported by hospitals and other providers wherever possible to avoid duplicate efforts.
3. Safety measures should be prioritized to the areas of maximum vulnerability, such as medication errors and system failures in the transitions of care
4. Patient advocates should be represented in all care settings.
5. Institutional safety data (including adverse events) should be transparent and made public.
6. Safety data for individual providers should be collected by Sustinet and provided confidentially to providers.
7. Providers should have access to interpreters for non-English speaking patients at all times, either telephonic or in person.

Recommendations regarding cost control

1. Sustinet should engage with coalitions of employers and other payment stakeholders aligned to reduce costs. Coalitions should examine best practice standards and cost-benefit studies as a decision factor in developing recommendations regarding specific cost control measures.
2. Cost-saving measures should be introduced into Sustinet from its inception.
3. Sustinet should identify and secure Federal funding to support at least initial efforts of this work.
4. Sustinet should develop a policy to disclose and minimize financial conflicts of interest.
5. Industry detailing should be countered with academic detailing,
6. Sustinet should promote the formation of provider organizations willing and able to be accountable for quality and financial outcomes of care provided.

Recommendations regarding payment systems and methodologies

1. New models must be explored and incorporated toward the goal of creating alternatives to fee-for-service as the dominant reimbursement model. The proposed model must be fair to both payers and providers, transparent and patient-centered. This model may be a blend of global payments, episode-based payments and limited FFS.
 - a. This should include at least pay-for-reporting or partial pay-for-performance
 - b. P4P should recognize both achievements relative to specific targets and improvement relative to baseline performance
 - c. Provider organizations should be accountable not only for quality but also for organizational structures and financial outcomes strongly associated with higher quality. These include enhancing access to primary care services and reducing avoidable hospital admissions and unnecessary specialty services.
2. Reimbursement should be tied to best practices identified above to consistently recognize providers and treatments based on clinical standards.
3. Sustinet reimbursements (including those for Medicaid and other low-income groups) should be brought in line with Medicare and commercial insurance rates.
4. Sustinet should provide clear and public formulas for reimbursement, including risk-stratification.
5. Reimbursement should include prevention, counseling, care coordination and cognitive activity, especially by PCPs, as in the Patient-Centered Medical Home model.
6. Reimbursement should recognize providers who care for high numbers of at-risk, special need and/or disadvantaged populations.

VIII. What needs to happen to make this a reality?

SustiNet should become part of a larger effort among stakeholders within the state to agree on high-level principles of delivery system reform and develop an action plan for implementing agreed-upon reforms. Sustinet is far more likely to be successful if the state's entire delivery system adopts similar reforms for quality, safety and reimbursement. The value of reducing the complexity of the current environment and creating alignment around a common set of principles cannot be overstated.

SustiNet Healthcare Workforce Task Force Final Report

Background

Connecticut's Health Care Workforce Strengths

Connecticut has some of the best trained and most experienced health care workers in the world. Connecticut has two world-class schools of medicine and one of the most highly regarded dental schools in the country. Another medical school is planned to open in 2013 or 2014. Connecticut is home to nineteen schools of nursingⁱ and hundreds of programs to train other professionals.ⁱⁱ Health care services employ one in eight Connecticut workersⁱⁱⁱ.

Health care jobs are an important engine in Connecticut's economy. In the next few years, health care employment is expected to grow twice as fast as the rest of the economy.^{iv} Traditionally, health care employment has been resistant to economic downturns as people are reluctant to skip health care services even in a recession.^v In fact, the recent economic recession has provided some temporary relief in shortage areas. For example, nationally, last year some new nursing school graduates encountered difficulty finding jobs.^{vi} The CT Hospital Association reports that nursing vacancy rates were down in 2009, but there were still 373 open positions at 27 Connecticut hospitals.^{vii} Experts expect any relief from workforce shortages due to the economy to be temporary.^{viii}

Connecticut's Health Care Workforce Challenges

Between 1995 and 2015, Connecticut's total population is expected to grow by 464,000 people.^{ix} Between 2010 and 2030, the percentage of Connecticut residents over age 65 is expected to grow by 40% and the ratio of Connecticut seniors to 100 workers (ages 20 to 64) is expected to grow from 23 to 40.^x An aging population will place greater demands on the health care system at the same time that many health professionals will be retiring.^{xi} National and state health reforms to cover the uninsured will add to the demand for providers. In 2006 when Massachusetts expanded coverage to almost all uninsured residents, wait times for physician visits increased significantly, to a year in some areas, and serious healthcare workforce shortages were reported across the state.^{xii} There are concerns that expansions of insurance coverage due to national reform and Sustinet will cause similar shortages here in Connecticut.

Connecticut is already facing a shortage of many, even most, health care workforce categories. Shortages have been reported in nursing at multiple levels including nurse managers, pharmacists, respiratory therapists, physical therapists, physician assistants, and surgical technologists, among others^{xiii}. The CT Dept. of Labor tracks occupations, annual wages, and projected openings. Growth is projected in every category except insurance clerks; in all but two other categories, double-digit growth is projected (see Table 1). 25% of Connecticut family physicians and 22% of internists report considering a career change because of the state's practice environment. 26% of Connecticut family physicians and 28% of internists are not accepting new patients. On average, CT patients wait 18 days for a routine office visit.^{xiv} 80% of CT physicians report difficulty recruiting

new physicians to their practices in the state. Challenges cited by Connecticut physicians include liability issues, insurer administrative burdens, emergency room call, high-risk patients, and challenges of technology integration.^{xv} Access issues are most acute for Connecticut residents covered by public programs; barely half of Connecticut physicians accept Medicaid, HUSKY or SAGA patients.^{xvi}

Table 1- Connecticut Health Care Occupations in Demand						
Occupational Title	Employment		Change		Annual Openings	
	2006	2016	Net	Percent		
Rehabilitation Counselors	4,370	5,220	850	19.4%	172	
Child, Family, and School Social Workers	5,200	5,700	504	9.7%	160	
Mental Health/Substance Abuse Social Workers	2,640	3,280	642	24.4%	120	
Social and Community Service Managers	2,780	3,340	560	20.1%	109	
Medical and Health Services Managers	3,690	4,070	379	10.3%	107	
Pharmacists	2,760	3,280	520	18.8%	100	
Mental Health Counselors	2,010	2,600	584	29.0%	98	
Physical Therapists	3,200	3,780	585	18.3%	98	
Medical and Public Health Social Workers	2,220	2,680	461	20.8%	93	
Medical Scientists, Except Epidemiologists	1,750	2,060	312	17.9%	85	
Health Specialties Teachers, PS	2,490	2,890	403	16.2%	82	
Clinical, Counseling, and School Psychologists	2,950	3,270	326	11.1%	78	
Substance Abuse/Behavioral Disorder Counselors	1,210	1,640	430	35.5%	67	
Chemists	1,820	1,950	136	7.5%	62	
Family and General Practitioners	2,070	2,280	216	10.4%	59	
Medical and Clinical Laboratory Technologists	2,150	2,390	238	11.1%	57	
Biological Technicians	990	1,180	189	19.1%	54	
Internists, General	1,750	1,930	186	10.6%	51	
Registered Nurses	32,840	38,560	5,722	17.4%	1,114	
Nursing Aides, Orderlies, and Attendants	24,660	27,590	2,924	11.9%	513	
Licensed Practical and Licensed Vocational Nurses	8,020	9,070	1,050	13.1%	324	
Fitness Trainers and Aerobics Instructors	3,970	4,620	658	16.6%	140	
Dental Hygienists	3,160	3,790	625	19.8%	123	
Radiologic Technologists and Technicians	2,970	3,410	437	14.7%	84	
Emergency Medical Technicians and Paramedics	2,800	3,150	346	12.3%	67	
Medical Records and Health Information Technicians	1,570	1,760	192	12.3%	61	
Surgical Technologists	1,060	1,250	184	17.3%	50	
Social and Human Service Assistants	8,350	9,670	1,322	15.8%	229	
Medical Assistants	4,990	6,520	1,529	30.7%	215	
Pharmacy Technicians	2,880	3,710	826	28.7%	171	
Medical Secretaries	5,690	6,440	753	13.2%	166	
Dental Assistants	3,390	4,060	671	19.8%	126	
Insurance Claims and Policy Processing Clerks	6,150	5,820	-332	-5.4%	74	
Home Health Aides	10,590	13,280	2,694	25.4%	364	
Personal and Home Care Aides	6,340	8,450	2,109	33.2%	319	

Source: CT Dept. of Labor data reported in T. Court, Policy Brief: Connecticut's Health Care Workforce Under Construction, The Business Council of Fairfield County, May 2010.

Connecticut's shortages, like other states, are most severe in primary care. Connecticut has only 240 primary care physician training program positions.^{xvii} Nationally there has been a trend of moving hospital primary care training slots to specialty care training.^{xviii} The difference in long-term compensation in medicine between primary care and specialists is estimated at \$3.5 million.^{xix} A 2008 analysis of primary care capacity in Connecticut for the

Primary Care Authority found that shortages are concentrated in rural areas and for inner city populations that rely on safety net providers. The report did find that suburban areas of the state may be in better shape than the rest of the country to respond to increasing demand. The report found that numbers of licensed physicians likely overstate the true capacity and there is very little data on how many providers are in active practice.^{xx} Causes of the primary care capacity shortages vary. Primary care practices are extremely busy. Payment rates are below those for specialty care. Business costs are increasing, and practices rely on an antiquated payment system that requires labor intensive, inefficient face-to-face patient encounters to generate revenue.^{xxi}

Forty Connecticut communities have been designated primary care shortage areas by the US Dept. of Health and Human Services; 19 and 39 have been designated mental health and dental workforce shortage areas, respectively. Seventeen areas of the state have been designated Medically Underserved Areas and twelve populations have been designated as Medically Underserved Populations. Designation allows these areas to attract new graduates through the National Health Service Corp and providers delivering care in these regions receive 10% higher Medicare rates. Most of the state has not been assessed for shortage area designation; it is possible that these benefits could be extended to more eligible communities in Connecticut struggling with limited capacity.^{xxii}

Connecticut's enduring nursing shortage is not due to lack of interest among students but to a lack of training slots. Nurses are the largest job classification among Connecticut health care providers. In 2006 over 1,200 qualified nursing applicants were denied entrance into Connecticut nursing programs due to lack of space.^{xxiii} Connecticut ranks 49th among states in producing nurses.^{xxiv} 23% of Connecticut's nursing faculty expects to retire in the next five years; the average age of the state's nursing faculty is 52 years.^{xxv} Nursing faculty earn significantly less than their colleagues in active practice or other health care roles including administrative, pharmaceutical and health information technology sectors^{xxvi}. Even for students who are lucky enough to enroll in a nursing program, clinical training slots are scarce^{xxvii}.

Mounting debt is a serious challenge for new health care graduates in Connecticut. Students leaving nursing school this year average between \$10,000 and \$30,000 in debt, some with debt loads up to \$130,000.^{xxviii} There is good evidence that rising debt levels of graduating physicians is a significant driver of the move to specialty care over primary care.

Despite growing public health threats, Connecticut's public health workforce per capita dropped by 16% from 2001 to 2006.^{xxix} This growing shortage mirrors national trends that have caused reductions and in some instances the elimination of vital local public health programs.^{xxx}

Nonprofessional, informal caregivers constitute a large and important part of the health care workforce. Unfortunately they are largely unrecognized, their needs and capacity are not measured. Across the US it is estimated that 34 million family caregivers, mainly women, provide 75 to 80% of long term care services in the community. Estimates of the

value of that unpaid care reach \$375 billion per year, more than US total spending on Medicaid^{xxxii}. As the long-term care system grows more complex and polices focus on transitioning patients to community settings, reliance on informal caregivers will grow.^{xxxiii} Nationally caregivers are more likely to be low income and working at other jobs. Seventeen percent report that caregiving has compromised their own health and 31% are highly stressed by their responsibilities.^{xxxiii} In Connecticut, it is estimated that 380,000 informal caregivers provide 410 million hours of care valued at \$4.8 billion.^{xxxiv} Several studies have quantified significant savings to the system from the contributions of informal caregivers, including delays and reductions in expensive institutional care^{xxxv}. It is critical that Connecticut monitor this essential but invisible sector of our health care workforce, determine the system's capacity, identify needs, and design supports and programs to ensure that they can provide care to loved ones. Suggested supports include information resources, emergency response devices, transportation assistance, and respite services.^{xxxvi}

The work of the Task Force

The Sustinet Health Care Workforce was convened in August 2009 and held its first meeting October 15th. The charge to the task force, created by PA 09-148, An Act Concerning the Establishment of the Sustinet Plan, is to “develop a comprehensive plan for preventing and remedying state-wide, regional and local shortage of necessary medical personnel, including, physicians, nurses and allied health professionals.”

Throughout the rest of 2009 and into 2010, the task force held five meetings at the Legislative Office Building and four meetings by webinar. A recommended reading list was provided to task force members and was publicly available. The task force heard presentations on

Connecticut's workforce by

- Marcia Proto, CT League for Nursing
- Matthew Katz, CT State Medical Society
- Scott Selig, CT Community Health Center Association
- Jon Davis, CT State Dental Society
- Alice Pritchard, Allied Health Workforce Policy Board
- Tanya Court, The Business Council of Fairfield County
- Kristin Sullivan, DPH
- Johanna Davis, DPH
- Jennifer Fillipone, DPH
- Cindy Lord, PA, American Academy of Physician Assistants

The CT League for Nursing generously offered to field a survey drafted by the task force of 475 new graduates of Connecticut nursing programs. Responses to the survey were analyzed by the CT Health Policy Project and helped inform our recommendations. All task force meetings, minutes, agendas, reports, documents and webinars were publicly available; all activities were transparent.

The task force membership found many engaged stakeholders making progress on expanding Connecticut's health care workforce capacity. There was a great deal of informal communication and collaboration across stakeholder groups. The task force wishes to thank those stakeholders for their generosity in sharing their resources and wisdom with us. It is important that Connecticut policymakers respect and support this uniquely collaborative environment and the potential of this network to develop effective and feasible solutions to this important challenge.

Contributing issues and trends impacting Connecticut's health care workforce

It is important to recognize important trends that are not part of the task force's charge but have profound impact on our work. These include patient-centered medical homes, racial and ethnic health disparities, and payment reform trends.

Patient Centered Medical Homes

Proponents of patient-centered medical homes argue that medical homes can reduce health care spending, improve health status, support disease management and prevention, improve the quality of care, reduce medical errors, and reduce racial and ethnic health disparities. Medical homes have become an important theme of health reform discussions at both the state and federal level and there is a great deal of momentum to transform and expand primary care practices in Connecticut.

Patient centered medical homes have important differences from traditional medical practices that will impact the health care workforce. New skills will be required including working in teams, care coordination, health information technology interaction, risk assessment and care planning, medication management, patient self-management education and support, and cultural competence. Patient centered medical homes will require expanded hours for practices and new connections to community resources, both medical and non-medical. In a patient centered medical home, care is provided by teams of providers, with every team member working at the top of their license; providers will have to become comfortable delegating care to appropriate colleagues and trusting their abilities. Patient centered medical homes treat patients as whole people, understanding the entire context of their lives. This is a significant departure from traditional roles for many providers and will require training for new graduates and retraining of the existing workforce. The challenges of transformation to a patient centered medical home model should not be under-estimated, even for willing and enthusiastic providers. Research identifying those challenges and finding solutions that work is ongoing. Sustinet would be well served by closely following those developments and working to help all Connecticut's health care workforce respond.

Health care disparities

Connecticut, like most states, is becoming more diverse. Unfortunately, our state is not exempt from the gap in health care access and outcomes between genders, races and ethnic groups. These disparities have complex causes^{xxxvii}, some attributable to provider behavior that must be addressed by training and expanding the diversity of Connecticut's health care

workforce. Solutions that impact providers include cross-cultural competence training curricula both for new providers and continuing education for established practitioners, integration and financial support of translation services into care and patient education, collection and monitoring of data on disparities, and evaluation of intervention efforts^{xxxviii}. Perhaps the most important change for Connecticut's workforce is a greater attention and sensitivity to disparities and its causes among providers, recognizing any issues in their practices and institutions their patients rely on, and engaging in solving the problem.

Payment reform and quality-based purchasing

There is a growing recognition that the current, fee-for-service system of paying for health care is fueling rising costs of care. Most payers are moving to a system of linking payment rates to the quality of care and realigning provider incentives from promoting utilization and toward efficiency.

This is a significant transformation in the way providers and health systems are paid and will require new skills and tools to navigate. Efficiencies will encourage providers to substitute more efficient care such as phone, email, interactive websites, and group visits, when appropriate, for face to face encounters. Providers will be expected to share risk and savings, with payers and with each other, under various payment reform scenarios. Connecticut's provider environment may move from predominantly independent, small practices to larger, integrated systems of care such as Accountable Care Organizations, either co-located or in virtual networks. Providers will be expected to follow evidence-based guidelines and will be measured and held accountable for the quality of the care they provide in new ways. Under payment reform, providers may find that their compensation is tied not only to their own performance, but the quality of care delivered by other providers and institutions. Providers may also find that they are held responsible for patient behavior, including adherence. Rates paid to providers will become far more complex including risk adjustment for patient complexity and history of resource use.

What we learned

Faculty, clinical training slots

Through presentations and discussions among the task force members, concerns were raised about the capacity of Connecticut's educational system to meet our state's health care workforce needs, current and future. Concerns were raised that compensation for faculty members and quality of life issues are not competitive with other employment options for qualified teachers. There are concerns that students entering health care training programs are not adequately prepared; employers need to provide extensive on-site training to new employees in some cases. It takes at least nine months to get approval for a new training program – in many cases, this delay is purely administrative and does not reflect a thoughtful process to ensure that the program is meeting a demonstrated need. There is no coordinated system to identify and share clinical training slot openings. Understandably, schools tend to jealously guard their training relationships, however it is not clear that all slots are being filled efficiently or in the best interests of Connecticut's workforce capacity. Institutions and busy providers who train students are not

compensated adequately for that time and work, creating a serious disincentive to offering training.

Primary Care Shortage

The physician primary care workforce in Connecticut is limited in number as well as diversity. The physician licensure data base maintained by the Connecticut Department of Public Health (DPH), the *Physician Characteristics and Distribution in the US, 2005*, and a 2004 database from the American Medical Association's Physicians' Professional Data, were used to arrive at estimates of the supply of primary care physicians in Connecticut. The DPH physician licensure data provide little in the way of practice information other than primary specialty. Subspecialties of internal medicine and pediatrics are not listed. Only a portion of physicians listed by self-designated specialty actually provide primary care. Based on these data the primary care physician to population ratio was estimated to be 72.2 per 100,000 (based on total population of 2,536). This ratio falls in the middle of the supply of generalist physicians recommended by the federal Council on Graduate Medical Education, 60-80 per 100,000 populations. With a physician to population ratio well within the recommended range, one might suspect that the state should have a paucity of physician shortage areas. However, given the skewed distribution of physicians, Connecticut unfortunately has a wealth of physician shortage areas.

The American Medical Association's *Physician Characteristics and Distribution in the US, 2005*, provides demographic information on the supply of physicians in the U. S. Limiting the 2004 AMA database to those physicians who are licensed in Connecticut, who are age 70 years or less, and who are involved in direct patient care, indicates that only 2.2 percent of physicians are African-American and 2.4 percent are Hispanic.

Informal caregivers

There is a network of programs providing assistance to family caregivers in Connecticut, but they meet only a small part of the need. Reportedly, the most pressing need for Connecticut's informal caregivers is respite services.^{xxxix} Programs have limited resources, for example only \$500 per family every other year, and long waiting lists. Private insurance benefits for respite and home care are often inadequate. Other suggested supports include information resources, emergency response devices, and transportation assistance.^{xl} There is a well-organized network of consumers and advocates representing Connecticut caregivers and their patients. The state needs to recognize these informal workers as an important part of Connecticut's health care workforce and the value of their services, with monitoring and providing the support they need.

Scope of practice

The patient-centered medical home model is based on every team member practicing at the top of their license. It has been suggested that removing barriers to practice for a variety of provider groups would help ease Connecticut's workforce shortages, particularly in primary care. Connecticut does not have a system to monitor and impartially evaluate scope of practice laws outside the legislature. Debate over scope of practice bills are time

consuming and often contentious. The General Assembly's Program Review and Investigations Committee completed a study of the legislative process to define and modify scope of practice laws for the health care professions in December 2009. The report recognizes that as skills needed within health care professions become more sophisticated, modifications in scope of practice laws are needed. The report makes several recommendations to improve legislative processes including a timeline for requests and responses to change scope of practice laws, analysis by the Department of Public Health, and development of an independent review committee for each request.^{xli}

Proposed recommendations

Strategic plan

Connecticut needs an in-depth analysis of current and future workforce capacity, future and current needs and a plan to address the gaps with specific annual targets and numbers of graduates each year by occupation.

It is critical to consider not just licensed providers, but to count those in active practice. Capacity must be assessed by practice area such as primary care, behavioral health, oral health, care management, by geographic area and populations served such as state employees, Medicaid, Medicare, employer coverage, state exchange coverage (individual and small group), Sustinet, undocumented immigrants, and any remaining uninsured in Connecticut after national reforms are implemented. The plan needs to consider non-traditional sectors of the health care workforce such as family caregivers and must include the public health workforce. The assessment must consider the health system from prevention, to diagnosis, to treatment, and to end of life care.

The plan must consider appropriate levels of training needed to fill gaps and develop a realistic strategy to provide that training, with discrete goals and timelines. It is critical to assess economic and other incentives driving practitioners to more highly specialized levels of training and whether that correlates with better health outcomes; to assess the Return on Investment for those providers and the public's investment of limited resources compared to continuing education. The plan should consider barriers to retention, both in school and in practice, and develop a plan to address those barriers. The plan must assess continuing education needs and employer-based training capacity.

The plan should assess each recommendation individually for the following and indicate priority goals.

- Likelihood to solve the stated problem
- Where else it has been tried – in Connecticut and elsewhere
- Timeline for implementation, current benchmarks
- Who will be ultimately responsible for implementation – which entity is accountable for each step
- Return on investment, available funding sources and other resources, i.e. federal and foundation funding opportunities

- Stakeholders that must be involved for success and the role of each
- Realistic feasibility of each recommendation, compared to competing initiatives
- What is the expected outcome, how and when will progress be evaluated

The plan must develop clear career maps for each shortage profession and track not only the numbers of primary care providers, but also measures of access to care, prevention and screening targets, by population served. The plan must assess barriers to moving up the career ladder building on the important work of the Allied Health Policy Workforce Board.

The plan should emphasize regional partnerships for implementation. The plan must consider Connecticut's health care workforce context including the impact of the proposed new medical school at Quinnipiac and expansions at the UConn Health Center.

The planning entity should be an on-going permanent planning group, possibly a Healthcare Workforce Data Center, including experts, representatives from health care professional organizations and schools, practicing providers, regulators, legislative representatives, and consumers (especially those with chronic conditions, elderly, children with special health care needs and from underserved populations and areas of the state). The group will require on-going resources, and should be coordinated through the Department of Public Health. The state should work to maximize available federal and private funding to support planning.

While developing the comprehensive strategic plan, the Department of Public Health should prominently post an annual health care workforce report card using the most recent Department of Labor occupation forecasts and Department of Higher Education enrollment, certificates and degrees awarded, as well as an assessment of actively practicing professionals in each category from Department of Public Health information.

Debt relief for students

The state must provide relief for rising tuition costs and debt levels of students considering the health professions. The state should prioritize scholarships over loan forgiveness; the costs of both programs are similar but upfront scholarships, resulting in no or less debt, are more salient to potential students than future promises to assist with debt. Assistance must require active practice in Connecticut shortage areas and/or care for underserved populations. Assistance should be targeted to minority students, particularly those who represent underserved populations. The state could also consider medical malpractice assistance, limits on liability to encourage practice in shortage professions and areas.

Scope of practice

The Task Force supports the findings of the Program Review and Investigations Committee report to the legislature to foster a more thoughtful process to revise scope of practice laws. The Task Force recommends regular review of practice standards and real-world practices, i.e. are providers routinely practicing at their top skill level.

Address primary care shortages

Connecticut must address the predicted shortage of primary care providers. Training and support for providers practicing in patient-centered medical homes is critical. Sustinet must increase primary care reimbursement rates, particularly for underserved populations such as Medicaid patients, and increase primary care clinical training slots by linking state and federal assistance to institutions to training slots and providing training stipends to institutions to compensate for the time involved in clinical training. The state should encourage institutions to ease quality of life barriers to employment for primary care providers, i.e. on call, part time practice. The state should assess and minimize insurance and administrative barriers, include online data submission. To encourage students to enter primary care professions, the state should develop an educational campaign to encourage students to pursue primary care, support innovative programs, i.e. internships, rotations, students shadowing primary care providers for a day or a week. The state should consider medical malpractice assistance or limits on liability for primary care providers and expand and support current successful programs i.e. SEARCH program by community health centers.

Maximize federal resources

Recent federal legislation creates numerous opportunities to support building Connecticut's primary care capacity. The state must apply for all appropriate federal opportunities – ARRA, national reform, Graduate Medical Education, and others as they arise. The Department of Public Health should be directed to expand analysis for health shortage area designation to entire state, potentially increasing funding to many Connecticut primary care practices. Federal funding opportunities to develop the health information technology structure within the state must be fully exploited. The state should assist Connecticut provider institutions and schools in applying for all appropriate opportunities and maintain regular communications with Connecticut's Congressional delegation about health care workforce capacity and opportunities.

Nursing shortage

Anticipating future shortages, the state needs to expand nursing education opportunities and foster retention of the current nursing workforce. The state should expand opportunities and provide financial assistance for continuing education, particularly training in team skills, health information technology, and care management. Financial assistance and scheduling assistance to encourage continuing education and moving up the career ladder are important to current nurses. A system to match training and employment opportunities to employment sites, reducing travel time, would ensure slots are filled efficiently. The state needs to consider reducing paperwork and administrative burdens on nurses in every regulation and promote workplace supports for older workers to lengthen tenure. The state should support flexible scheduling, reasonable work hours and staffing levels that foster delivery of high quality care.

The state should support ongoing initiatives such as the joint application to the Robert Wood Johnson Foundation by the CT League for Nursing, Gateway Community College, Annie E. Casey Foundation, the Workforce Alliance and the New Haven Public Schools. This project will develop systems to “fast track” nurses to the next educational level, creating

seamless pathways from LPN to RN and RN to MSN to train more nursing faculty.^{xliii} The state should convene hospitals and other institutions regularly to share best practices, through a neutral convener such as Sustinet.

Nursing faculty and education

Connecticut must address a growing shortage of nursing faculty and educational capacity. Connecticut needs to expand the capacity of current programs. It is critical to equalize nursing faculty pay with active practice and other faculties. Scholarships and loan forgiveness for faculty training are critical, dependent on work in training in shortage professions in Connecticut. It is critical to expand faculty slots in diverse settings including home care, long-term care, sub-acute and acute care and to ease administrative burdens on faculty. The state should review faculty qualifications, specific to each training position, and encourage outside resources, speakers and other opportunities to enrich the educational experience. The state should widely publicize faculty openings with specific information on positions including full or part time, benefits, and salary range.

To encourage students to pursue nursing, the state should create apprenticeship programs, targeting shortage areas and populations, tied to future practice in Connecticut. The state should create a coordinated statewide outreach campaign with input from all stakeholders to encourage students to pursue shortage professions targeting minority students, with detailed information on shortage professions, resources, career counseling for parents and students, location and qualifications for shortage professions. The state should pilot a six week high school summer health career awareness camp targeting shortage professions and minority students and create a health tutorial website. Connecticut should create a nurse residency program to help train and retain new graduates and maintain and expand current state support for paid health care internships. The state should continue current incumbent worker training support through the Dept. of Labor and the Workforce Investment Boards.

Public health workforce

Facing growing public health challenges, Connecticut must expand the state's public health workforce. Public health workforce capacity must be included in state health care workforce assessment and strategic planning. The plan should clearly define and enumerate the public health workforce, and establish career ladders and a pipeline strategy. Connecticut should create a public education plan to raise the visibility of the public health workforce and functions, including educating students, teachers, and guidance counselors at middle and high school levels and providing opportunities to experience the public health workplace. The state must support continuing education, training and mentoring programs for current public health workers.

Educational supports and support for career ladder

Connecticut must address support needs that cross health care professions including new learning modes such as online learning and simulator training. Mentoring and tutoring programs, remedial education, and academic counseling services are critical for appropriate students. Lifestyle supports, such as childcare, transportation and supplements for living expenses, are important to ensuring students are successful and

finish their course of study. The state should authorize the use of state financial aid for students pursuing non-credit certificate programs. Many students need further training after graduation; the state must support employer-based training at health care institutions and practices. The state needs to access and support foreign trained, immigrant providers to become licensed and practice in Connecticut, particularly those who are from underserved racial and ethnic groups.

Expand appropriate access to clinical training slots

Clinical training is critical to ensuring Connecticut's health care workforce capacity. The state should both provide training stipends to institutions and providers that train students, but also link state and federal assistance to creation of training slots. The state can reduce administrative burdens on primary care sites that expand training slots and the providers who serve as trainers, i.e. longer period between licensure renewals; the state could consider medical malpractice assistance or limits on liability for training sites. Connecticut should create an online statewide centralized clinical placement scheduling system and require all institutions that get state or federal assistance to participate and list their capacity.

Support family caregivers

Connecticut's family caregivers provide an essential support to very fragile patients; without their assistance, many patients would be institutionalized at the state's expense. It is critical that Connecticut expand respite programs, provide administrative supports, and provide flexible financial assistance for family and patient-directed programs. Connecticut should consider tax benefits for caregivers and provide health coverage options such as reductions in cost sharing/premiums for Sustinet coverage to family caregivers. At a minimum, the state should create and support family caregiver support groups and networks to share resources and best practices.

ⁱ The Guide: Nursing Education in CT 2010-2012, CT League for Nursing, <http://www.ctleaguefornursing.org/guide/clnnursingguide.pdf>

ⁱⁱ Allied Health Workforce Policy Board, Sustinet Healthcare Workforce Task Force Briefing Paper, Dept. of Public Health, CT Community Colleges.

ⁱⁱⁱ March 2010 data, *CT Economic Digest*, CT Dept. of Labor, May 2010, <http://www.ctdol.state.ct.us/lmi/misc/cedmay10.pdf>

^{iv} Health care jobs are estimated to grow by 15% from 2006 to 2016 compared to only 8% across all employment, Connecticut Department of Labor, Connecticut Statewide Forecast by Industry, 2006-2016, http://www.ctdol.state.ct.us/lmi/misc/fc2016_industry.htm.

^v Job numbers in Health Sector Defy Recession, More Growth Expected, Kaiser Health News, Jan. 11, 2010, Earnings of Healthcare Workers by Level of Duties and Responsibilities 2008, US Bureau of Labor Statistics, April 2010.

^{vi} Nurses, Once in High Demand, Face Job Shortages, Kaiser Health News, Aug. 28, 2009.

^{vii} Annual Legislative Report, Allied Health Workforce Policy Board, January 2010.

^{viii} P. Buerhaus, et. al., The Recent Surge in Nurse Employment: Causes and Implications, *Health Affairs* 28:w657-668, June 12, 2009.

^{ix} CT's population projections, US Census.

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- ^{xiii} Averting Crisis: Ensuring Health Care for Future Generations in Connecticut, CT Hospital Association, April 2007.
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- ^{xvi} CT Health Policy Project, unpublished survey.
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- ^{xix} R. Steinbrook, Easing the Shortage in Adult Primary Care – Is it all About Money? N Engl J Med 360:2696-2699, 2009.
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- ^{xxii} Johanna Davis, DPH, presentation to task force, Feb. 25, 2010.
- ^{xxiii} *ibid*
- ^{xxiv} CT League for Nursing, presentation to CT Sustinet Health Care Workforce Task Force, 4/15/2010
- ^{xxv} 2008 CT Nursing Study, CT League for Nursing, December 2008.
- ^{xxvi} B. Cleary, 2009.
- ^{xxvii} Clinical Placement Capacity Assessment Report, CT Hospital Association, September 2007.
- ^{xxviii} Workforce Survey of 2010 CT Nursing School Graduates, CT Health Policy Project and CT League for Nursing, March 2010
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- ^{xxxv} Benefits and Cost Savings Due to Respite, National Respite Coalition Task Force.
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- ^{xlii} CT League for Nursing communication

REPORT OF THE TOBACCO AND SMOKING CESSATION TASK FORCE TO THE SUSTINET BOARD

I. Summary

The Tobacco and Smoking Cessation Task Force is pleased to present this report to the Sustinet Board and to the Joint Standing Committee of the Legislature. This report describes the work of the Task Force over the past eight months and represents the thoughtful contributions of representatives from health care, public health, retail organizations and provider groups.

The Task Force found that although Connecticut has experienced a reduction in smoking rates over the past decade, the effects of tobacco use significantly contribute to the growing total health care costs. In reviewing the available research and the initiatives of other states in this area, the Task Force firmly believes that the rate of tobacco use should and can continue to decline.

To achieve this continued decline, the Task Force has developed a series of recommendations that address the needs of individuals attempting to quit smoking; preventing young people from becoming smokers; opportunities to increase resources dedicated to this problem; and enhanced measurement strategies to improve understanding of tobacco users and how to help them. Key recommendations include expanding access to nicotine replacement items and supportive quit counseling; supporting smoking bans in homes, in and around schools, and other child-friendly areas; update and support the state's Tobacco Use Prevention and Control Plan; determine whether changes in pricing should be pursued; and allow sales of nicotine replacement gum and patches as over the counter medications.

II. Purpose and Mission of this Task Force

A. Charge to the Task Force

The Sustinet Legislation created the Tobacco and Smoking Cessation Task Force to examine evidence-based strategies for preventing and reducing tobacco use by children and adults, and to then develop a comprehensive plan that will effectuate a reduction in tobacco use by children and adults.

B. Members of the Task Force

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Task Force Co-Chair

Jeannette DeJesus
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Task Force Members wish to thank the Workgroup members who have supported the Task Force's work and who were instrumental in the writing and editing of this Final Report.

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David Gregorio, UConn School of Medicine
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Dawn Mays-Hardy, American Lung Association
Kevin O'Flaherty, Campaign for Tobacco free Kids
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C. Methodology

The Tobacco Task Force created two workgroups, which subsequently merged to focus on data collection and on program elements of tobacco cessation. The Task Force met monthly to discuss the subcommittees' findings and to hear in-depth presentations about key issues.

III. The Task Force's Approach

The Sustinet Tobacco Task Force Co-chairs convened a working group of tobacco experts to review current data and programmatic issues related to tobacco prevention and control and develop recommendation to the Task Force. This report became the basis of the Task Force report to the Sustinet Board of Directors and to the legislature regarding the status of tobacco use as well as prevention and control efforts in the state and recommendations to reduce the burden of tobacco use on the health and healthcare costs of Connecticut residents. The Workgroups were merged into a single group and met from April through June to prepare the recommendations in Section IV.

"Tobacco kills more people each year than losses from WWI, Korea and Vietnam combined, approximately equal to WWII losses."

The Workgroup relied heavily on reports and guidelines from the Centers for Disease Prevention and Control, data and reports from the Campaign for Tobacco Free Kids, Connecticut Tobacco and Health Trust Fund, and other states' tobacco prevention and control experiences.

The CDC published a document on *Best Practices for Comprehensive Tobacco Control Programs* in August of 1999, shortly after states reached a settlement agreement with the tobacco industry; an updated edition was released in October, 2007.¹ This comprehensive approach includes not only clinical interventions, but also economic, policy, and social strategies aimed at reducing the health and economic consequences of tobacco use. The CDC recommends that state and community interventions, effective health communications, smoking cessation, surveillance and evaluation as well as administration and management should be included in tobacco control programs if they are to be effective.

The *Clinical Practice Guidelines* describe the best treatment for reducing tobacco use and dependence. Originally developed and published in 1996 by the U.S. Department of Health and Human Services (USDHHS), these *Clinical Practice Guidelines* have been

updated three times. The most recent edition, published in 2008, is based upon treatment recommendations from over 8,700 research articles published between 1975 and 2007. These recommendations, addressing both clinical and systems-based interventions, were developed using the best available evidence (also known as evidence-based), and offer guidance to clinicians, as well as administrators of healthcare delivery and insurers. These guidelines view tobacco dependence as a chronic and recurring disease often requiring repeated interventions and multiple quit attempts.²

The workgroup supports the findings and recommendations of the recently released Connecticut Public Health Policy Institute Report of April 28, 2010 titled: *Examining Tobacco Use, Consequences and Policies in Connecticut*.³ The workgroup also recognizes the Massachusetts Department of Public Health and its Massachusetts Tobacco Control Program (MTCP) as a leader in the area of tobacco prevention and control. The workgroup views the MTCP as a model program for its planning approach to comprehensive tobacco control and its many success stories. The MTCP Logic Model is included as an appendix to this document⁴. Finally, the workgroup also reviewed and evaluated the proposed 2020 Healthy People objectives for tobacco use to determine concurrence with the national health objectives.⁵

Recommendations are grouped in four major areas: the burden of tobacco use; Cessation; Prevention; and Policy/Environment Issues. Each section lists the recommendations along with background information and cost/benefit information. Costs or savings related to implementation are provided as available. Also please note that the order of the recommendations does not reflect prioritization or ranking of importance.

A paradox concerning our efforts is that CT is a tobacco producing state.

A. The Burden of Tobacco Use in Connecticut

The Surgeon General reports that tobacco use is the leading preventable cause of disease in the United States. Every year, cigarette smoking is responsible for 1 in 5 of all US deaths (or 443,000); 37% cancer, 32% heart disease and stroke and 21% due to respiratory disease. Smoking accounts for at least 30% of all cancer deaths and 87% of lung cancer deaths.

Chronic diseases are exacerbated by insufficient policies and systems; certain environments in which we live, learn, and work; and limited access to healthcare. The most effective way to improve the health of Connecticut residents and reduce the burden of chronic diseases is through comprehensive statewide health promotion.

Many deaths resulting from chronic diseases are premature and preventable. In Connecticut, tobacco use continues to be a leading cause of preventable death. Between 2000 and 2004, over 4,800 adults ages 35 and older died each year as a result of tobacco use, a smoking-attributable mortality rate of 238.3/100,000.⁶ In addition, another 440 adult nonsmokers die each year from exposure to secondhand smoke.

Annual health care costs in Connecticut attributed to cigarette use are estimated at \$2 billion (in 2008 dollars), and the portion of that covered by the State's Medicaid Program is \$507 million³. In addition, another \$1.03 billion of tobacco-related "cost" is attributed to productivity losses of persons affected by tobacco-related diseases/treatments. These amounts do not include the health consequences or economic costs of exposure to secondhand smoke, smoking-related fires, or use of other forms of tobacco.

In 2009, 15.4% of Connecticut's adult population (ages 18+) — over 400,000 individuals — were current cigarette smokers⁷. The prevalence for adult men was 16.2% and for adult women it was 14.7%. The age group with the highest smoking prevalence was among 18 to 24 year-olds (24%). Smoking rates vary by socio-economic status (SES), education, age, race, and presence of psychiatric illness. Overall, smoking rates are higher in individuals with lower income and education levels, in younger adults compared to older adults, military veterans, and in individuals with psychiatric and substance use diagnoses. Nationally, the prevalence of smoking is comparable in Caucasians and African-American groups, but is lower in Hispanics. However in Connecticut smoking rates are higher among Hispanics as compared to Blacks or Whites. For adults who reported an annual income of less than \$25,000, the cigarette-smoking rate was 30%, compared to about 12% for those earning \$50,000 or more per year.⁷

Health disparity is a hallmark of the tobacco epidemic. While the last ten years have seen dramatic changes in smoking rates for whites, college graduates and persons with incomes over \$50,000 per year, these same trends are not true for groups at high risk of being smokers. This is particularly true among Medicaid recipients, persons with no insurance, racial/ethnic groups, persons suffering from mental health and substance abuse, and low socio-economic status. Expanding and developing cessation programs that target these populations and aggressive media countermarketing activities are needed to reduce tobacco use and smoking-related medical costs.

In 2009, 3.3% of middle school students (3.3% of boys and 3.2% of girls) and 15.3% of high school students (16% of boys and 14.4% of girls) in the state smoked cigarettes.⁸ Between 9th and 12th grade smoking prevalence increases from 13.9% to 30.1% of all high school students. Data also indicated that 17.3% of middle and 23.5% of high school students who never smoked were susceptible to starting smoking within the next year. This suggests that there is a need for more age-specific programs to prevent smoking initiation.

Data collected from the 2009 Connecticut School Health

"Each day in the United States -

- *The tobacco industry spends nearly \$36 million to market and promote its products*
- *Almost 4,000 adolescents start smoking*
- *Approximately 1,200 current and former smokers die prematurely from tobacco-related diseases*
- *The nation spends more than \$260 million in direct medical costs related to smoking*
- *The nation experiences nearly \$270 million in lost productivity to premature deaths from tobacco-related disease¹."*

Survey showed that high school students who smoke are significantly more likely than non-smokers to report poorer mental health. Those with poorer mental health have a higher rate of smoking compared to their peers who report better mental health. Of the high school students who report feeling sad or hopeless in the past 12 months, 27% were smokers, compared to only 13% of the group that did not report those feelings. Among high school students who actually attempted suicide in the past year, 40.9% were smokers, compared to 15.4% of those who did not attempt suicide. These differences are statistically significant.

These findings suggest that students who smoke and students who have depressive disorders could possibly benefit from effective counseling coupled with comprehensive smoking cessation programs. Students who smoke are also more likely to participate in other high-risk behaviors than those who do not smoke.⁸

Gathering data and determining effective and evidence-based interventions to decrease smoking prevalence among these populations is crucial.

IV. RECOMMENDATIONS

A. CESSATION: Provide comprehensive tobacco use cessation (TUC) services for all Connecticut Residents

Recommendation #1: Provide Medicaid coverage for tobacco use cessation (TUC) services.

- Effective October 2010, TUC benefits for pregnant women are required under the Federal health care reform.
- Comprehensive TUC benefits should be provided to all Medicaid recipients.
- Connecticut should seek out and secure matching federal funds to help fund this benefit.
- The Department of Social Services should actively promote the benefit with eligible clients.
- Remove the barrier of physician as “gatekeeper” for TUC service
- Expand access to nicotine reduction products (NRTs) to non-prescription retailers licensed to sell other OTC medications. Medicaid offers a formulary for OTCs, such as Claritin, and it should permit vendors to sell and be reimbursed for NRTs.
- Aggressively pursue funding through the \$100 million in federal grants (available beginning Jan 2011) for Tobacco Use Cessation Programs targeting Medicaid participants. Develop a plan specifically for Connecticut or in a New England regional approach to secure the needed funds.

Background: Prevalence of smoking among Connecticut adults (≥ 18 years old) is estimated at 15.9%. Medicaid recipients smoke at roughly twice (36%) that level. Medicaid clients (i.e., persons with Low SES, substance addicted persons, the mentally ill and pregnant women) are all at high risk for tobacco addiction. Two variables, in particular, are strongly associated with tobacco use: low education and low income. Smoking prevalence among persons with incomes below \$35,000 is 24.4%, whereas prevalence among persons with incomes greater than \$35,000 is only 16.5%; the prevalence of smoking among persons with less than high school educations is 29.3%, compared to a prevalence of 11.4% among persons with college degrees.

Pregnant women are an important target population to prevent tobacco use before a subsequent pregnancy, improve birth outcomes, and reduce the effects of secondhand smoke on children. According to the American College of Obstetricians and Gynecologists, smoking is the most modifiable risk factor for poor birth outcomes. Successful treatment of tobacco dependence can achieve a 20% reduction

in low birth weight babies, a 17% decrease in preterm births, and an average increase in birth weight of 28 grams. According to the American College of Obstetricians and Gynecologists, a woman is more likely to quit smoking during pregnancy than at any other time in her life.¹⁰ Pregnancy is a good time to intervene with smokers.

In Connecticut, pregnant women on Medicaid (HUSKY A and fee-for-service) were more likely to smoke than all other pregnant mothers giving birth in 2005. Among Medicaid mothers, 15.5% of HUSKYA mothers and 6.5% of fee-for-service mothers smoked, compared to 2.7% of all other mothers who smoked.¹¹

A Healthy People 2020 goal is to ensure that evidence-based treatments for smokers are available through state Medicaid programs. The USDHHS 2008 Clinical Prevention Guidelines recommend that evidenced based medication and behavioral smoking cessation treatments should be offered as covered services in public as well as private health insurance plans. That means that smoking cessation coverage should be comprehensive including behavioral counseling and both legend (i.e., drugs requiring a prescription) and over the counter (OTC) drugs.

Connecticut had been at the forefront of tobacco policy when, in the 2002 session, the legislature authorized the coverage of smoking cessation programs for Medicaid recipients. However, the program was never funded, despite a DSS fiscal study prepared at their request in 2006 and a Medicaid reimbursement waiver that would return 62 cents on every dollar spent. Today, Connecticut is one of only four states (Connecticut, Alabama, Georgia and Missouri) still not providing any coverage for tobacco use cessation services for their Medicaid recipients.

In order to expand access to nicotine reduction products (NRTs) Tobacco Task Force recommends granting permission to sell non-prescription NRTs. It is also suggested that OTC NRTs be made available in smaller pack sizes vs. the two-week supply currently available. The current restrictions on selling non-prescription NRTs and the pack size are based on FDA requirements that allow for sale only in pharmacies. Broader access to NRTs in local shopping settings will encourage use among smokers in settings where tobacco sales occur.

Economic Burden: Total health care costs associated with smoking are nearly \$2 billion in 2008 dollars. Nearly 35% of Medicaid-insured adults under the age of 65 smoke (compared to just 18.3% of privately-insured adults). The associated health care costs for Medicaid recipients who smoke is more than \$507 million in 2008 dollars, costs primarily borne by Connecticut taxpayers.³

Program Costs: The following cost estimates assume all individuals will utilize both counseling and NRT or pharmaceutical components. The actual costs may be much

less, based on the components the smoker elects to utilize. This cost estimate was developed by the MATCH Coalition as part of the initiative to obtain funding for this benefit during the 2010 legislative session.

Our estimate of tobacco use by Medicaid recipients and benefit of comprehensive cessation interventions assumes that Medicaid recipients' ages 19-64 years would be targeted. Currently there are 377,968 Medicaid recipients in this category; we estimate that 173,534 are cigarette smokers. Smoking rates are presumed to be 36%, although estimates ranging from 36-40% have been cited in the literature. Assuming cessation programs are adequately marketed, utilization by 25% of targeted smokers could be anticipated (MassHealth experienced 40% utilization). We further assume all eligible participants would receive an average of 3 counseling session at \$150 per session (note: Mass Health experienced much lower utilization of counseling services), and 50% of eligible persons opt to use NRTs and 50% opt for pharmaceuticals. Quit rates are based on use of both counseling and drug therapy (Rates are lower when only counseling is used). The annual estimated reduction in tobacco use by proportion of participants utilizing the benefit is presented in Table 1 below:

Table 1		
Estimated Cost for Comprehensive Smoking Cessation for Medicaid Recipients in Connecticut*		
	Presumed Utilization Rates	
	25%	40%
Clients 19-64 yrs old	173,534	173,534
Percent smokers	36%	36%
Total Smokers	62,472	62,472
Utilization Rate	25%	40%
Program Participants	15,618	24,989
All Receive Counseling	\$2,342,709	\$3,748,334
90% use NRT	14,056	22,490
50% use NRT & 50% use pharmaceutical	7,028	11,245
NRT cost for 12 wks = \$125	\$878,516	\$1,405,625
25% use Bupropion	3,514	5,623
Bupropion cost for 12 wks = \$264	\$927,713	\$1,484,340
25% use Varenicline	3,514	5,623
Varenicline cost for 12 wks = \$475	\$1,669,150	\$2,670,925
TOTAL COST	\$5,818,088	\$9,309,225
# Smokers Quitting = 27.6%	4,311 fewer smokers per year	6,897 fewer smokers per year
*Based on DSS Medicaid Eligible Recipients for February, 2010, by Age		

Health and Cost Benefits: Connecticut lawmakers should look to Massachusetts for a model program that is quickly becoming the standard for the nation. Most evaluation reports deal with long-term savings and health effects from smoking cessation. In 2006, the Massachusetts legislature enacted a law providing a smoking cessation benefit for all MassHealth (Medicaid) enrollees. The “barrier-free” benefit

includes: behavioral counseling, all FDA-approved medication and nicotine replacement, and very low co-pays. In the first 2.5 years of implementation 75,000 MassHealth members used the benefit to try to quit smoking (i.e., 40% of all smokers on MassHealth) and the smoking rate fell 10% a year, from 38.2% to 28.3% (a 26% reduction). Their recent report documented a 38% drop in heart attacks among the cessation benefit users, 17% fewer emergency department visits for asthma symptoms and 17% fewer claims for adverse maternal outcomes.¹² Under the Health Reform Act, all states will be required to provide smoking cessation benefits for pregnant women, effective October 2010. Beginning in January 2011, there will be \$100 million in federal grants for TUC programs targeting the Medicaid population.

The American Legacy Foundation estimated that within five years, Connecticut would see annual savings of \$91 million (2005 dollars) with a 50 percent decrease in smoking rates, and \$18 million (2005 dollars) annually in Medicaid savings with a ten percent reduction in smoking.¹³

Recommendation #2: Require all public and private health insurers to provide comprehensive tobacco usage cessation interventions, including counseling and all FDA-approved nicotine replacement therapies and pharmaceuticals.

- Recognize tobacco dependence is a chronic disease for which periodic relapses may be anticipated that requires long-term use of NRTs and multiple opportunities for quit attempts.
- Recognize relative benefit of multi-modality interventions (e.g., counseling combined with medication) for tobacco use cessation. Best results are achieved with both counseling and medication– (USDHHS Treating Tobacco Use and Dependence: Clinical Practice Guideline, 2008).
- Define and adequately fund through public sources and reimbursement mechanisms, a broad network of clinical and community-based TUC programs and services.
- Make the business case for providing TUC coverage and make workplace programs more affordable and accessible.

Background: About 16% of Connecticut adults (age ≥ 18) smoke, as well as 17% of adolescents (grades 9 through 12). USDHHS Clinical Practice Guidelines, *Treating Tobacco Use and Dependence: 2008* recommends that evidenced based medication and behavioral smoking cessation treatments should be offered as covered services in public as well as private health insurance plans. That means that smoking cessation

coverage should be comprehensive including behavioral counseling and both legend and over the counter (OTC) drugs.

Costs and Benefits There are several business case studies that demonstrate significant cost savings to businesses that went smoke-free and provided smoking cessation benefits to their employees. Total excess cost of a smoking employee to a private employer is \$4,279 per year.¹⁴ The Insurance Committee of the Connecticut General Assembly might consider a cost-benefit analysis of the effect of mandatory insurance coverage for comprehensive smoking cessation.

The following recommendations represent three different strategies to provide and integrate cessation services into diverse settings and opportunities.

Recommendation #3: Integrate tobacco use cessation (TUC) interventions into medical encounters.

- Recognize the utility of the 5A's strategy and incorporate the 5A's into all health provider settings: Ask about tobacco use; Advise to quit; Assess willingness to make a quit attempt; Assist the patient in quitting through counseling and medication; and Arrange follow-up.
- All medical questionnaires filled out by patients should include questions on tobacco use, frequency and if the patient would like information on cessation programs.
- Initiate a collaborative service network for referral of patients to aid health care providers in guiding their patients to available programs
- Age, gender, and racial ethnic models for delivering cessation services should be developed, taking into account evidence based treatments. High-risk groups should be targeted to decrease disparities through better awareness and access.
- Provide opportunities and support for individuals in traditional and non-traditional health care settings to obtain training in evidence-based TUC protocols.
- Develop and provide training for TUC for traditional and non-traditional providers and develop and fund opportunities and training programs to do so. (Refer to Massachusetts certification program).

- Use the Connecticut Information line 211 to help citizens make connections to local cessation programs.

Background: Coordinated tobacco use interventions, delivered in a timely and effective manner, can rapidly reduce the risk of suffering from smoking-related disease. At least 70% of smokers see a physician each year. In addition, 70% of smokers report wanting to quit. Smokers state that a physician's advice to quit is an important motivator for attempting that quit attempt. A brief, three minute assessment and referral process during a routine exam can increase the rate of quitting attempts. Clinicians trained in TUC interventions significantly increase the likelihood of patients' quit attempts.

When appropriate charting (e.g. regular charting of smoking status, use of electronic reminder systems) is used, rates of patients making quit attempts may increase five-fold compared to no intervention.³ In addition, treatments delivered by multiple types of clinicians are more effective than those delivered by a single type. Even clinician-delivered brief interventions can increase the likelihood of future quit attempts among those not currently looking to quit.

The goal of these strategies is to change clinical culture and practice patterns to ensure that every patient who uses tobacco is identified, advised to quit and offered scientifically sound treatments. In addition, treatments delivered by multiple types of clinicians are more effective than those delivered by a single type. In addition, pediatricians and primary health care providers should also screen patients for exposure to second and third-hand smoke.

The sooner a patient quits smoking, the more savings: tobacco dependence treatments cost savings **per life-year** saved is \$3,539. Although health care costs may rise during the year the patient is quitting, they decline progressively from that point on. A reimbursement mechanism needs to be established for these types of preventative interventions.

Recommendation #4: Implement and sustain a statewide, telephone Quitline for smoking cessation that provides both counseling and NRT.

Create and sustain funding for the Statewide Tobacco Quit Line at levels that allow it to reach the maximum audience while providing both counseling and NRT services.

Background: There is ample evidence that smoking cessation interventions are effective in reducing the number of individuals who quit smoking. Interventions can be categorized in terms of the type, venue, intensity, duration and cost. They may be behavioral, pharmacological or both. In general, greater intensity of treatment

(duration and number of contacts and more modalities of intervention) improves cessation outcomes. Abstinence rates at a minimum of six-month follow-up are related to the intensity of the intervention in a dose-response fashion. These range from:

- 5-10% for smokers quitting on their own or with self-help materials
- 10-20% for brief, moderate intensity interventions (counseling only)
- 20- 30+% for maximally intensive individual or combined pharmacological and behavioral interventions

Costs and Benefits: Telephone Quitlines have proven to be an effective smoking cessation intervention. Recognizing their value in helping individuals to stop smoking and acknowledging recommendations for a more robust, countrywide Quitline, DHHS established a national Quitline network in 2004. The network increased funding to states with existing Quitlines, offered grants for the creation of Quitlines in states that did not yet provide the service, and made available smoking cessation counselors in states without Quitlines. The Quitline is a highly useful intervention because advertising the availability of the Quitline helps to stimulate demand and accessing it provides a low-cost service for facilitating cessation. Studies have shown that Quitlines that combine behavioral counseling and medications have significantly higher abstinence rates than medication or counseling alone (28.1%).

Based on the 2006 Connecticut Adult tobacco survey there are 455,850 adults who currently smoke cigarettes in Connecticut. The Department of Public Health has supported a Quitline model in Connecticut for several years using grant funds provided through the Centers for Disease Control to states without their own Quitlines. The Quitline provides free services to callers. These CDC funds are limited and the Quitline contract had provided for telephone counseling only. (Year 1, \$166,667, Year 2 \$285,000). During those two years there were approximately 1,200 registered callers per year.¹⁰

In FY 08, Quitline was funded through the Connecticut Cancer Partnership's Comprehensive Cancer Plan's 2006 tobacco allocation and CDC funds for a total of \$1.7 million. The new Quitline contract provided for NRT (nicotine patch or gum) and enhanced counseling for persons who registered for the program. Insured enrollees received a two-week starter of NRT. Those without private insurance or on Medicaid received up to eight weeks of NRT. Counseling was provided to all enrollees. The Quitline received over 10,000 calls and enrolled more than 6,000 residents for service in three weeks in July 2007 alone. NRT available through the Quitline was depleted

by the end of July, sending nicotine patches to 3,787 callers and nicotine gum to 858 callers. Subsequently, the Quitline provided only enhanced counseling services.¹⁰

The current cost per Connecticut Quitline user is \$497 for uninsured and Medicaid participants and \$284 per insured participants. Among the 8,405 registrants who provided insurance information, 46.5% had private insurance, 16.1% had Medicaid coverage, 11.7% had Medicare coverage and 19.3% were uninsured. Although almost half of registrants reported having commercial insurance, most insurance plans do not cover smoking cessation services. From June 2008 through March 2009, the percentage of Medicaid recipients utilizing the Connecticut Quitline increased to 30%.¹⁰

Women who use tobacco were more likely to utilize the Quitline than men, 62% vs. 38%. One in four Quitline users were 31-50 years old, one-third was 51-60 years old and 14% were 60 or older. Only 12% were 18-30 years old. Eighty percent identified themselves as white, 11% as African-American and 1.5% as other race. By ethnicity 8% identified themselves as Hispanic. Over half of Quitline users (54%) reported an educational level of high school or less.¹⁰

In a user evaluation conducted among participants who utilized the Quitline between January and June 2007 (prior to the availability of enhanced counseling and NRT), the contractor reported 7- day quit rates of 34%, and 30-day quit rates of 26%. The contractor noted that in a study performed for another state, medication increased quit rates from 33% to 44%.

Using current costs for Quitline services, the Tobacco and Health Trust Fund Board determined that \$2 million could reach 11,672 callers and provide a multiple call program to all with a two week starter kit to insured and 8 weeks delivered in 2, 4 week shipments to Uninsured and Medicaid participants. This is a penetration rate of just less than 2% (1.74%) of the adult smoking population in Connecticut. Increasing this amount to \$5 million would increase the penetration rate to about 5% of smokers.¹⁰

Recommendation #5: Increase the number and types of TUC services available in diverse settings and develop and provide educational opportunities for training traditional and non-traditional TUC service providers.

- Provide adequate training, resources and feedback to ensure that tobacco use cessation providers consistently deliver effective treatments. Offer model-training programs on tobacco dependence treatments, and provide continuing education credits and/or other incentives for participation by health care providers. Provide opportunities and support for individuals in traditional

and non-traditional health care settings to obtain training in evidence-based protocols. Ensure health care providers have necessary tools to manage a referral system.

- Provide these services in diverse settings, including traditional clinical settings (hospitals, community health centers, school-based health centers, mental health and substance abuse setting) and non-clinical setting, such as local health departments/districts, and social service organizations, as well as the statewide telephone Quitline and website assisted programs.
- Increase the number and type of providers who provide comprehensive cessation services; include pediatricians, psychiatrists, mental health and other health care workers, pharmacists, social workers, health educators and prevention specialists. Initiate a collaborative service network for referral of patients to aid health care providers in guiding their patients to available programs.
- Develop and provide training for both traditional and non-traditional providers (e.g., faith based organizations, Boys/Girls Clubs, Local Health Departments, Continuing education services, etc.) with a standardized, model curriculum and fund opportunities to ensure training attendance.
- Research potential for an online training system for health care providers to break down barriers to training participation.
- Develop age, gender, and racial ethnic models for delivering cessation services that take into account evidence based treatments. Target high-risk groups to decrease disparities through better awareness and access.
- Use the Connecticut Information line 211 to help citizens make connections to local cessation programs.

Background: Evidence-based tobacco use cessation methods have been proven to be effective in a variety of populations. Currently TUC cessation services in Connecticut are sparse and under advertised. While programs exist at some Community Health Centers, local health departments/ districts, and hospitals, many are supported by specific grants from the Tobacco and Health Trust Fund, Federal Block Grants or other funding that is not sustainable. Many of these programs will cease when these special funds are gone. There needs to be a mechanism in place, including insurance reimbursement, low cost services and government or privately supported funding, to develop and sustain tobacco use cessation opportunities in diverse settings in the community where people go to seek medical care and social services.

As noted above, even brief encounters with medical providers can increase the rate of quitting. State Quitlines also provide evidence-based cessation services that have been proven effective and need to be sustained.

The Massachusetts Tobacco Control Program has several model programs to reach smokers as well as training programs for providers and tobacco cessation certification.⁴ In FY 2009, MTCP continued to provide funding and technical support to 19 community health centers (CHCs) across the state to improve their effectiveness in motivating and assisting patients to quit smoking. The initiative is based on research demonstrating that even brief advice from physicians and nurses can influence patients to make a quit attempt.

MTCP offers confidential information and telephone-based counseling services to help smokers quit through the Massachusetts Smokers' Helpline, which is free to Massachusetts residents. In FY 2009, the Helpline reported receiving 22,000 calls, including those who were referred through QuitWorks and those responding to free nicotine patch promotions. QuitWorks was developed by MTCP in 2002 in collaboration with all major health care insurers in Massachusetts. The QuitWorks fax referral service allows health care providers to connect their patients to free phone counseling services. In FY 2009, health care professionals made nearly 3,500 referrals to the Helpline through QuitWorks. More than one hundred hospitals, community health centers, and DPH programs have adopted the QuitWorks program. Training in smoking cessation counseling is available for providers and others. The University of Massachusetts Medical School provides technical assistance and training to healthcare providers on smoking cessation and systems change through a contract with MTCP.

The National Tobacco Cessation Collaborative (NTCC) aims to improve the nation's health by increasing successful cessation among tobacco users in all U.S. populations through collaborative efforts and programs. Their website provides information on numerous on-line and in-person training opportunities for smoking cessation training, as well as certification programs for tobacco treatment specialists.¹⁵ NTCC is supported by the nation's leading funders of tobacco control research and advocacy: the American Cancer Society, American Legacy Foundation, Centers for Disease Control and Prevention, National Cancer Institute, National Institute on Drug Abuse and Robert Wood Johnson Foundation.

The Connecticut Certification Board, a state body that currently certifies Alcohol and Drug counselors is having discussions related to creating a Tobacco Treatment Specialist certification.¹⁶

Cost/Benefit Analysis: The effectiveness of TUC is well documented. Increasing the places where TUC is available and the number of persons who can provide it will vastly increase the potential for smokers to quit. Combining this training with systems changes increases the rate of attempts for tobacco use cessation. Any reduction in smoking has a lifetime of savings, and tobacco dependence treatment can prevent the development of even more costly chronic diseases.

Recommendation #6: Make the business case for smoking cessation benefits for employees.

Background: Cigarette smoking is highly prevalent in the United States, and the adverse effects of cigarette smoking have a heavy impact on employers. Employers assume the costs of health care, disability, and lost work time for employees who smoke. Due to the cost-burden of smoking on employers, providing smoking cessation benefit coverage for employees can be extremely valuable.

For businesses, making an investment in tobacco cessation benefits not only improves employee health but also reduces the significant direct and indirect costs associated with tobacco use. In fact, paying for tobacco use treatment is regarded as the single most cost-effective health insurance benefit for adults and it is also considered the benefit with the most positive impact on health.¹⁷

Literature has demonstrated that smoking among employees can have a significant cost impact on employers with respect to lost productivity and increased health care costs.

- The CDC estimates that the average smoker costs an employer \$3400 per year in smoking-attributed lost productivity and direct medical costs. However, reports show that only 4% of employers provide a comprehensive program.
- A 2007 study by Halpern and colleagues analyzed the impact of smoking cessation benefits on workplace costs and employee quit rates.¹⁸
- Smoking cessation benefit coverage yielded a greater number of successful quit attempts and a decreased rate of smoking-related diseases. Cost savings (reduced health care and workplace costs) over 4 years exceeded the cost of the smoking cessation benefit

Blue Cross and Blue Shield of Minnesota and Kaiser Permanente Northwest have each developed models for calculating the Return On Investment of tobacco cessation services.

Cost-Benefit Analysis: Scotts Miracle-Gro Company is a model for smoke-free workplaces tied to smoking cessation benefits. It is the world's largest marketer of branded consumer products for lawn and garden care, with a workforce of 6,000 employees and \$2.9 billion in annual sales. The company's CEO cited the rising cost of healthcare coverage and the desire to have a healthy workforce as reasons for a tobacco-free workplace policy. The employer was willing to provide all cessation assistance necessary to provide assistance necessary for the employee to break their nicotine addiction¹⁴

B. PREVENTION: Reduce the health and economic burden of tobacco use by:

- Preventing young people from starting to smoke
- Helping current smokers to quit
- Protecting children and adults from secondhand smoke
- Identifying and eliminating tobacco-related disparities
- Shaping social norms related to tobacco use.

PREVENTION OF SMOKING INITIATION

Recommendation #7: Require age-appropriate life skill education in grades K-12 in Connecticut that address anti-tobacco education, drug and alcohol use prevention, nutrition, stress management and exercise.

- Incorporate life skill education within existing science, mathematics, social studies and language curriculum.
- Emphasize high-risk youth behavior and cultural factors that lead to addictive or unhealthy behavior.
- Initiate a health and wellness curriculum for K-12 students in Connecticut that would incorporate risk factor and behavioral training that is consistent with Sustinet priorities.
- Add no tobacco use to substance-free pledges by student athletes.

PREVENTION OF SECONDHAND SMOKE EXPOSURE: Eliminate the exposure to Secondhand Smoke where people work, live and play

Recommendation #8: Pass legislation that prohibits smoking in all workplaces including restaurants, bars and in public places and eliminate availability of smoking rooms in workplaces. Eliminate small business exemption and smoking room option.

Background: Breathing in secondhand smoke (SHS) is similar to the mainstream smoke inhaled by the smoker in that it is a complex mixture containing many chemicals (including formaldehyde, cyanide, carbon monoxide, ammonia, and nicotine). Many of these are known carcinogens. Exposure to secondhand smoke increases the risk of developing heart disease 25-30% and contributes to between 22,700 and 69,600 premature deaths from heart disease in non-smokers each year. According to the U.S. Surgeon General, eliminating indoor smoking is the only way to fully protect non-smokers from SHS. Connecticut enacted landmark legislation that prohibited smoking in workplaces and public places in 2003 and added bars in 2004. Although the Connecticut law is 100% smoke free in restaurants and bars, the smoking prohibition does not apply to workplaces with fewer than five employees.³

The U.S. Small Business Administration (SBA) maintains data for firms by workforce size. In Connecticut, there are approximately 35,000 firms with 1 to 4 employees, or slightly more than 74,000 employees subjected to smoke in the workplace up to 8 hours or more every day. 3 Every employee in Connecticut deserves the right to a smoke-free workplace. As of January 10, 2010, there are 21 states (including Washington, D.C. and Puerto Rico) that have state laws that prohibit smoking in all workplaces, including restaurants and bars, as well as public places.

Connecticut participated in an optional module to the 2008 Behavioral Risk Factor Surveillance System (BRFSS) survey on health conditions and health risk behaviors that accessed SHS exposure at work and in the home as well as home smoking rules. Among Connecticut non-smoking participants, 6.4% reported that they were exposed to SHS inside their indoor workplace. Results of indoor workplace exposure varied widely among states, ranging from 3.2% in Arizona, a state with a 100% smoke free workplace law to 10.6% in West Virginia, a state with no smoke free workplace law. The legislature needs to make Connecticut a 100% smoke free workplace state to protect all our workers from the health effects of SHS.

Health and Cost Benefits: Smoke-free policies have also been found to prompt some smokers to quit smoking. And a number of studies have documented the positive health effects of smoke-free laws. Nine studies have reported that smoke-free laws were associated with rapid, sizeable reductions in hospitalizations for acute myocardial infarct (AMI) or heart attacks. The Pueblo Heart Study examined the impact of a smoke-free ordinance in Pueblo, Colorado. During the 18 months following the implementation of the ordinance, they documented a 27% decrease in

the rate of AMI hospitalizations (Phase 1). Over the next 18 months the rate of AMI hospitalizations continued to decrease, with a demonstrated decline of 19% from the post-implementation study and a 41% decline from the pre-implementation period. These findings suggest that smoke-free policies can produce sustained reductions in AMI hospitalizations and that these policies are important in preventing morbidity and mortality associated with heart disease.³

Recommendation #9: Ban the sale of E-Cigarettes and other non-traditional nicotine delivery devices that are not sanctioned as NRT. Develop a system to review other new products prior to their introduction and acceptance for sale in Connecticut.

- Ban Hookah Bars/Parlors in Connecticut.
- Open Indoor Clean Air Act for review.

Background: Regulation of other nicotine-based products: The tobacco industry is constantly creating and marketing new tobacco-based products. These include e-cigarettes, Orbs (tobacco containing drops similar to Tic-Tacs), tobacco strips, etc. There is no mechanism in the current Clean Indoor Air Act to regulate or ban these products. There is a need to amend the Connecticut Clean Indoor Air Act to review new products prior to their introduction for sale and ban all non-traditional nicotine delivery systems that are not FDA-approved as nicotine replacement therapies. We cannot rely on the FDA to do so.

Ban Hookah Parlors/Bars in Connecticut: Hookah or water pipe smoking has been practiced for at least 400 years. Hookah is known by a number of names, including narghile, argileh, shisha, hubble-bubble, and goza. Over recent years there has been a resurgence of use, most notably among youth. Small cafes and clubs that rent the use of hookahs and sell special hookah tobacco are making their mark on the young, hip, urban scene and college students. Hookah tobacco is available in a variety of flavors, such as apple mint and cappuccino. Smoking is usually practiced in groups, with the same mouthpiece. Water pipes generally consist of four main parts: the bowl where the tobacco is heated; the base filled with water or other liquids; the pipe that connects the bowl to the base; and the hose and mouthpiece through which smoke is blown.

Even after it has passed through water, the smoke produced by hookah contains high levels of toxic compounds, including carbon monoxide, heavy metals and cancer-causing chemicals. Due to the mode of smoking, hookah smokers may absorb higher concentrations of the toxins found in cigarette smoke. A typical 1-hour smoking session involves inhaling 100-200 times the volume of smoke inhaled with a single cigarette. Hookah smokers are at risk of the same kinds of diseases caused by

cigarette smoking, including oral cancer, esophageal and gastric carcinoma, lung cancer, reduced pulmonary function, and decreased fertility. Sharing a hookah may increase the risk of transmission of certain infectious diseases, including tuberculosis, viruses such as herpes or hepatitis, and other illnesses.

The language used in state laws regulating smoking in public places determines whether hookah would be covered or not. For example, Delaware law addresses “the burning of a lighted cigarette, cigar, pipe or any other matter or substance that contains tobacco.” However, the language in some states could actually exempt hookah bars or cafes. This may be the case in Connecticut where a test case is currently before the Department of Public Health.

Recommendation #10: Encourage adoption of Healthy Home Concept of no smoking policies in homes.

Background: Second-hand smoke (SHS) has a negative impact on the health of children. Almost 60 percent of U.S. children aged 3-11 years are exposed to secondhand smoke. Children exposed to secondhand smoke are at a greatly increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Many children and non-smokers are exposed to SHS because they live with a smoker. In 2008, five percent of non-smokers in Connecticut were exposed to second-hand smoke in their homes.

The latest Surgeon General report found children are the only population group not to have seen significant progress in being protected from secondhand smoke.¹⁹ Secondhand smoke is a carcinogen, for which there is no ‘risk-free’ level of exposure. Research now indicates exposure to third hand smoke, by definition the toxins, odors, and residues that remain on clothes, furniture and hair long after the cigarette has been extinguished, is extremely dangerous as well. A home is not a healthy home unless it is a smoke free home. While the government regulates several environmental health hazards that may be found in the home, including lead, mold and asbestos, smoking behavior remains unregulated (by the government) in housing. By eliminating smoking in multiunit housing, landlords are eliminating the number one causes of preventable death in the place people; especially children and elderly spend the majority of their time. Equally important, a 2010 report published by the Department of Housing and Urban Development (HUD), notes more than 7 million people live in public housing in the United States, with 4 in 10 units occupied with families with children.²⁰

This recommendation focuses on developing voluntary approaches in partnership with owners and residents to reducing secondhand smoke in multi-housing units, condominiums, apartments, assisted living facilities, group homes, public housing and

shelters. There is no 'one-size fits all' approach to policy adoption. It is important that landlords adopt policies that meet the needs of their property and their tenants, whether that is to ban smoking in the indoor of the building, provide designated smoking areas, or ban tobacco use completely from the confines of their property.

While there may be opposition from the general public, policymakers and pushback because of the fear of violating first amendment rights of the smoker, it is important to understand smokefree policies are not designed to be punitive, or prohibit smoking, but are intended to encourage smokers to smoke in locations outside for the safety of the property and the health of all occupants. In cases where smokefree policies have been adopted throughout the country, it has been shown that “pre-policy” anxiety far outweighs the reality of those concerns as the vast majority of residents want to live in a smoke free environment.

Health and cost benefits: There are several benefits to adoption of such voluntary policies.

- Reduction in the number of families and individuals involuntarily exposed to secondhand smoke
- Reduction in the number of smokers
- Reduction in the number of tobacco smoke-related complaints in multi-housing unit or complex
- Reduction in hospital stays for asthma, bronchitis, respiratory illness in complex
- Reduction in ED visits for asthma, bronchitis, respiratory illness in complex
- Savings to landlords in turnover costs associated with smoking indoors
- Reduction in fire risks associated with smoking materials

Smokefree housing policies are a long term, high complexity issue. However, there are considerable long-term savings in reduced health care and housing costs, improved health outcomes and quality of life. Nationwide, 65-85% of tenants report a desire to live in a smoke-free environment, and landlords can save an average of \$3,000 on a turnover unit where smoking is prohibited. Policy adoption is a win-win situation for landlords and tenants; it is the way the message is conveyed that is the most intrinsic for a successful implementation of a smoke-free housing campaign.

On July 17, 2009, the U.S. Department of Housing and Urban Development (HUD) strongly encouraged Public Housing Authorities (PHAs) to implement non-smoking

policies in some or all of their public housing units. Attachment A contains a list of the evidence-based policies implemented by the federal government and other states.

Recommendation #11: Require school districts to establish and maintain no tobacco use policies on school grounds and school events (including day-care, K-12 and college /university settings).

Background: There are no uniform policies for schools in Connecticut regarding tobacco use on school grounds and at school events. While all elementary schools have no smoking policies for students within the school, smoking on the grounds varies and may not be well enforced. Many of our colleges and universities allow smoking on the grounds and in dormitories. School and college/university properties are used for many after school and non-education events (e.g., after school care, sports events, etc.). Smoking should be banned at such events.

All Connecticut schools must be committed to providing a healthy environment for their students and staff. Therefore, a minimum standard set of no tobacco use policies need to be implemented that prohibits tobacco use on school grounds at all times and at all school sponsored events on or off school grounds. Schools may also create policies that are stronger than the minimum set.

The Department of Public Health in concert with the State Department of Education will need to draft standardized policies. School employees and school boards may oppose the policy because it involves no tobacco use at all times on school grounds, even after minors have left school for the day. Some expected outcomes of adopting a uniform no tobacco use policy on school grounds include:

A majority of schools across the state will be implementing the standard policies.

C. POLICY/ENVIRONMENT: Update, adopt, implement, fund and sustain a Comprehensive Tobacco Prevention and Control Plan as recommended by the Centers for Disease Prevention and Control.

Recommendation #12: Update, adopt, implement, fund and sustain the *Connecticut Tobacco Use Prevention and Control Plan*.

- Document the return on investment for sustaining proper funding for tobacco prevention and cessation programs to educate the legislative and executive branch on this issue.
- Require appropriate funds received from MSA and Tax revenue from tobacco sales be applied to a sustainable comprehensive tobacco control program (CDC currently recommends \$43 million annually for such programs).

- Provide sustained funding for anti-tobacco media programming that incorporates evidence-based strategies and current technologies including social marketing.
- Partner with community-based organizations including the faith-based organizations to reach high-risk populations.
- Provide sustained funding for anti-tobacco media programming that incorporates evidence-based strategies and current technologies including social marketing.
- Partner with community-based organizations including the faith-based organizations to reach high-risk populations.

Background: In 1998 Connecticut was one of 46 states to settle lawsuits against the four major tobacco companies. Under this agreement states will receive annual payments in-perpetuity. In the first twenty-five years alone states will receive \$246 billion from the Tobacco Master Settlement with Connecticut's portion \$3.6 to \$5 billion (approximately \$175 million per year). At the time, public health advocates and the Attorneys General expected that a substantial portion of these funds would be used for tobacco prevention and treatment programs. Unfortunately, that has not been the case in most states.

The Centers for Disease Control and Prevention first published *Best Practices for Comprehensive Tobacco Control Programs* in August 1999, shortly after the historic settlement with the American tobacco industry. An updated edition was released in October, 2007. This comprehensive approach that optimizes synergy through a mix of educational, clinical, economic, regulatory, and social strategies has become the principal standard for eliminating the health and economic burden of tobacco use. Evidence for the effectiveness of comprehensive programs has greatly increased with the growth in state capacity and a focus on proven interventions. CDC recommends five components of a comprehensive tobacco program: State and Community Interventions, Health Communication Interventions, Smoking Cessation, Surveillance and Evaluation and Administration and Management. In their 2007 Best Practices Guidelines, CDC provides state-by-states recommendations for how much funding should be spent for each component for successful outcomes. ¹ To that end, an updated comprehensive Tobacco Use and Control Plan is necessary to direct and coordinate state efforts to prevent initiation, increase cessation and advocate for effective policies and laws. This comprehensive plan should also combine educational, clinical, regulatory, economic, and social strategies.

A comprehensive statewide tobacco control program is a coordinated effort to establish smoke-free policies and social norms, to promote and assist tobacco users to quit, and to prevent initiation of tobacco use. This comprehensive approach combines educational, clinical, regulatory, economic, and social strategies. Research has documented the effectiveness of laws and policies in a comprehensive tobacco control effort to protect the public from secondhand smoke exposure, promote cessation, and prevent initiation, including increasing the unit price of tobacco products and implementing smoking bans through policies, regulations, and laws; providing insurance coverage of tobacco use treatment; and limiting minors' access to tobacco products. Additionally, research has shown greater effectiveness with multi-component intervention efforts that integrate the implementation of programmatic and policy interventions to influence social norms, systems, and networks.¹

Community-based interventions focus on 1) prevention of initiation among youth and young adults, 2) promoting quitting among adults and youth, 3) eliminating exposure to secondhand smoke, and 4) identifying and eliminating tobacco-related disparities among population groups. Health communication interventions can be powerful tools for promoting and facilitating smoking cessation, preventing smoking initiation and shaping social norms related to tobacco. Traditional health communication and counter-marketing strategies use multifaceted efforts, including paid TV, radio, print, billboard, and web-based advertising, on-line networking, and media. Campaigns as early as 1999 demonstrated the effectiveness of anti-tobacco advertisements to affect smoking attitudes and beliefs.¹

CDC compiled "best practices" to help states organize their tobacco control program efforts into an integrated and effective structure. The 2007 guide included state by state-recommended funding levels for each program component. These recommended levels of annual investment factor in state-specific variables, such as the overall population; the prevalence of tobacco use; the proportion of the population that is uninsured, receiving publicly financed insurance, or living at or near the poverty level; infrastructure costs; the number of local health units; geographic size; the targeted reach for Quitline services; and the cost and complexity of conducting mass media to reach targeted audiences, such as youth, racial/ethnic minorities, tobacco users interested in quitting, or people of low socioeconomic status.¹

In Connecticut, CDC recommends an annual spending rate of \$12.54 per capita (\$43.9 million) for Comprehensive Tobacco Programs. Table 2 lists total funding to date from the Tobacco and Health Fund Trust.

The legislature established the Tobacco and Health Trust Fund (THTF) in 1999 and created a Board of Trustees in 2000. It directed the transfer of \$12 million annually from the Tobacco Master Settlement dollars into the THTF to create a continuing, significant source of funds to encourage the development of programs to reduce tobacco abuse, to reduce substance abuse and to meet the unmet physical and mental health needs of the state. Initially, the THTF Board was only authorized to recommend expenditure of the interest earned on the fund principal. In 2008, the legislature amended this authority to allow expenditure of half (up to \$6 million) of the previous year's transfer from the Master Settlement to the THTF. Since its inception through FY2011, the THTF will have received \$153 million and \$114 will have been transferred out.¹ The legislature transferred \$81.1 million back into the General Fund and another \$38 million to other programs and services. In fact, the THTF Board of Trustees has only been allowed to spend \$9.2 million from the fund on tobacco prevention and control programs. The majority of the Trust Board expenditures (74%) were authorized in FY09 and FY10 (Table 2).^{3,10} The constant raids on the Trust Fund have left the fund with a balance of just \$5.2 million after the FY10 allocations. The current budget calls for additional transfers from the fund and it is likely the fund will be extinguished by the end of the biennium. The THTF dollars spent on tobacco prevention and control represent nearly all of the funds supporting anti-tobacco activities in Connecticut, and collapse of the fund would be a serious blow to anti-tobacco goals. During the 2010 legislative session, the legislature swept the remaining \$5 million from the THTF principal balance for mitigation of the FY2010 budget.^{3, 10, 21}

Table 2: Tobacco and HealthTrust Fund Board Disbursements FY03 – FY09

<i>Category</i>	<i>FY03 -FY08</i>	<i>FY09</i>	<i>FY10</i>	<i>Total</i>
Counter Marketing	\$450,000	\$2,000,000	\$1,650,000	\$4,100,000
Website Development	\$50,000			\$50,000
Cessation Programs (Community-Based)	\$1,500,000	\$412,456	\$750,000	\$2,662,456
Cessation for Mentally Ill		\$1,200,000	\$800,000	\$2,000,000
Quit-line	\$287,100	\$2,000,000	\$1,650,000	\$3,937,100
School-Based		\$500,000	\$500,000	\$1,000,000
Lung Cancer Pilot		\$250,000	\$250,000	\$500,000
Evaluation		\$500,000	\$300,000	\$800,000
Innovative Programs			\$477,745	\$477,745
Total	\$2,287,100	\$6,862,456	\$6,377,745	\$15,527,301

States that have made larger investments in comprehensive tobacco control programs have seen cigarette sales drop more than twice as much as in the United States as a whole, and smoking prevalence among adults and youth has declined faster as spending for tobacco control programs increased. In Florida, between 1998 and 2002, a comprehensive prevention program anchored by an aggressive youth-oriented health communications campaign, reduced smoking rates among middle school students by 50% and among high school students by 35%. Other states, such as Maine, New York, and Washington, have seen 45% to 60% reductions in youth smoking rates with sustained comprehensive statewide programs.¹⁶⁻¹⁸ Between 2000 and 2006, the New York State Tobacco Control Program reported that the prevalence of both adult and youth smoking declined faster in New York than in the United States as a whole.¹ Adult smoking prevalence declined 16% and smoking among high school students declined by 40%, resulting in more than 600,000 fewer smokers in the state over the 7-year intervention period.

According to the American Cancer Society (ACS), even by the most conservative estimates, more than 40% of the reduction in male cancer deaths between 1991 and 2003 was due to the declines in smoking over the last half of the 20th century. Before cigarette smoking became common, lung cancer was a rare disease. Now lung cancer is the leading cancer cause of death for men and women, killing an estimated 160,000 people in this country each year.²⁰ ACS estimates that approximately 87% of these deaths are caused by smoking and exposure to secondhand smoke. Additionally, more than 100,000 deaths from lung diseases, and more than 140,000 premature

deaths from heart disease and stroke are caused each year by smoking and exposure to secondhand smoke. Research shows that the more states spend on sustained comprehensive tobacco control programs, the greater the reductions in smoking—and the longer states invest in such programs, the greater and faster the impact.¹² In California, home of the longest-running comprehensive program, smoking rates among adults declined from 22.7% in 1988 to 13.3% in 2006. As a result, compared with the rest of the country, heart disease deaths and lung cancer incidence in California have declined at accelerated rates. Among women in California, the rate of lung cancer deaths decreased while it continued to increase in other parts of the country. Overall, from 1987–1998, approximately 11,000 cases of lung cancer were avoided. Since 1998, lung cancer incidence in California has been declining four times faster than in the rest of the nation.¹

Since FY2000, Connecticut has received about \$1.3 billion from the tobacco settlement, but less than two percent of that money has been used for programs aimed at reducing smoking or targeted toward anti-tobacco advertising and other efforts. Instead, 86 percent of the Tobacco Settlement funds (\$1.1 billion) have been used for unrestricted spending in the General Fund.^{3,10,21} At \$3.00 per pack, Connecticut state taxes on cigarettes are among the highest in the nation. For FY 2010, the Campaign for Tobacco Free Kids reported estimated cigarette tax revenues of \$377.9 million and master settlement revenue of \$141.3 million, with only \$7.2 million spent on tobacco prevention and control.

From 2000 through 2009, the state received \$1.3 billion in tobacco settlement money and \$2.36 billion in cigarette tax revenues, for a total of \$3.655 billion. However, they have spent only \$18.3 million (6.75%) on tobacco prevention and control.²² Prudent use of some of these revenues to fund a comprehensive tobacco prevention plan would result a many-fold return on investment in a very short time, and save countless lives and billions of dollars in the long term.

D. POLICY/ENVIRONMENT: ENFORCEMENT

Recommendation #13: Pass tax parity on all other tobacco products and insure any future tobacco tax increases include all tobacco and tobacco-related products.

Background: There is currently no parity between cigarette and loose tobacco products in Connecticut. Taxes on loose tobacco are considerably lower and have not changed in many years. Legislation introduced in the 2010 legislative session (SB 543) would have changed the tobacco products tax on non-cigarette smoking tobacco, including pipe and roll your own tobacco, from 27.5% of the wholesale price to 15 cents (150 mills) per 0.0325 ounces.

Benefits: This would make the non-cigarette tax equal to the tax rate on cigarettes. Approximately 460,000 ounces of roll-you-own and pipe tobacco are sold each year in Connecticut. In addition to reducing the smoking of loose tobacco, this increase would generate approximately \$1.3 million per year in addition tobacco tax revenue.

Recommendation #14: Redirect revenues generated through enforcement of youth tobacco access laws under CGS §12-295a(c) and CGS §53-344. (b) for tobacco prevention services concerning merchant and community education and administrative hearings.

- Increase the number of Department of Revenue Services administrative hearing officers to ensure full enforcement of the current laws.
- Mandate merchant education for first time violators that sell tobacco to minors instead of the imposed fine.
- Make merchant education compulsory for second time violators that sell tobacco to minors in addition to the imposed fine and pay for the training.
- Suspend the licenses for tobacco dealers that fail to pay imposed fines under CGS §12-295a(c).
- Require mandatory merchant education before a suspended licenses is activated under CGS §12-295a(c).

Background: Currently, levies collected for criminal infractions and administrative fines go into the general fund. In July 1992, Congress enacted the Synar Amendment as part of the Alcohol and Drug Abuse and Mental Health Administration Reorganization Act (P.L.103-321). The Synar Amendment is aimed at decreasing access to tobacco products among individuals under the age of 18 by requiring states to enact and enforce laws prohibiting any manufacturer, retailer, or distributor from selling or distributing tobacco products to individuals under the age of 18. States are in compliance when the rate of sales to minors occurs at less than 20% of all outlets. The Synar Amendment further defined state requirements for conducting unannounced inspections of a random sample of tobacco vendors, to assess their compliance with the state's access laws and filing an annual report. Each state must submit an annual report to the Secretary of Health and Human Services describing that year's enforcement activities, the extent to which the state reduced the availability of tobacco to minors, and a strategy including a time frame for achieving and maintaining a retailer violation rate (RVR) of no greater than 20 percent. A state that does not meet its targeted reduction is penalized 1 percent of its federal Substance Abuse Prevention and Treatment (SAPT) block grant funds for each percent it is over the 20 percent minimum threshold. Applying the above referenced

recommendations will ensure that tobacco merchants who fail compliance inspections will receive training and education so the State of Connecticut can achieve and maintain a RVR in accordance with prescribed federal mandates.

Due to a lack of administrative hearing officers the Department of Revenue Services (DRS) issued 340 warning letters to first time violators under the CGS §12-295a in FY 2009, instead of imposing an administrative fine of \$300. (The Connecticut Annual Synar Report, FFY 2010, Department of Mental Health and Addiction Services.) This represents a loss of \$102,000 in possible revenue collections in 2009. In the last five years, following this current protocol, DRS has forfeited well over one half million dollars in possible revenue collections. The fines imposed do not represent the actual fines collected due to the lack of additional administrative action (i.e., license suspension/revocation) against the license holder who failed to pay the fine. The Department of Mental Health & Addiction Services' Summary Report on Underage Sale of Tobacco 2009 indicates that 160 infractions under CGS §53-344a were issued by police agencies through their Police Partnership Program. This represents additional potential revenue collection by Judicial Branch's Centralized Infractions Bureau of \$40,000.

To redirect these revenues to support tobacco enforcement activities within DMHAS, Judicial Branch Centralized Infractions Bureau and the Department of Revenue Services would be required to deposit collected criminal and administrative fines into tobacco merchant and community education fund. The Department of Mental Health & Addiction Services in collaboration with the Department of Revenue Service and the Department of Public Health would augment existing merchant and community education services for individuals who are required to pay fines and those who opt for training. Tobacco retailers might oppose this recommendation because it will require them and/or their employees to take time from their stores to attend training. Failure by the license holder to pay a fine or penalty within a reasonable time period would be grounds for immediate suspension of a license to sell tobacco products.

Fully enforcing current laws would increase resources for merchant and community education. More merchants and retail clerks trained on how to prevent tobacco sales to minors would result in reducing youth access to tobacco. Trained merchants and reduced youth access would lower the RVR, which would not jeopardize block grant funding. Enhanced prevention enforcement activities would better position Connecticut for future funding under the Family Smoking Prevention and Tobacco Control Act. This law, passed in 2009, gave the Food and Drug Administration authority over tobacco products and advertising.

Recommendation #15: Provide voluntary cessation services for youth who are fined under the §53-344. (c) for possession of tobacco.

Background: Approximately 48,600 middle and high school students in Connecticut used some form of tobacco on at least 1 of the 30 days prior according to the Department of Health's 2007 School Health Survey. In October 2008 the youth tobacco possession law came into effect, and according to the Judicial Branch 246 youth were ticketed under this law in 2009. Minors are issued a \$50.00 fine for a first time offense of possessing tobacco products and up to \$100.00 for each subsequent offense within 18 months. The statute fails to address or provide a tobacco use cessation option. Currently, there are no requirements to provide cessation services to youth who are tobacco use dependent. Youth fined under this law should receive information about cessation services so they can easily access resources to quit using tobacco products. This preventative measure will reduce the number of youth that could develop tobacco dependency as adults by increasing cessation opportunities. Providing cessation services for youth with tobacco dependencies will ultimately reduce the health care costs associated with the treatment of tobacco related illnesses.

The data received from the Judicial Branch does not indicate previous violators or the final disposition/outcome of the cases. Assuming all tickets were issued to first time violators, potentially \$12,300 went into Connecticut General Fund as a result of enforcement of this law during the 2009 calendar year.

Operationalizing this recommendation would require infractions information be shared with the Department of Public Health, who in coordination with the Department of Mental Health and Addiction Services and State Department of Education would develop a process for referring these youth violators to school or community tobacco cessation programs. Municipal Police agencies may oppose this recommendation as they may consider it a burden on current work demands. Expected outcomes include an increase in the number of: youth who access cessation services; an increase in quit attempts by youth who participate in cessation programs will increase; and an increase in community resources available to youth in preventing tobacco addiction will also increase.

Current cessation programs need to build their capacity on how to provide cessation services to meet the needs of youth tobacco users. School resource officers, community social service providers, youth services agencies, along with prevention and health care professionals will need training on youth targeted cessation services. The Department of Public Health and the Department of Mental Health and Addiction Services will be instrumental in implementation of this type of targeted training.

These services are expected to be of a long term, low complexity nature that will utilize preexisting agencies and best practices tobacco cessation programs for minors.

E. POLICY/ENVIRONMENT: RETAIL SALES

Recommendation #16: Urge the FDA to expand access to over the counter (OTC) nicotine reduction therapies (NRT) and support similar initiatives in other states.

Background: In order to expand access to nicotine reduction products (NRTs) a suggestion of the Tobacco Task Force is to allow non-prescription NRTs to be sold by retailers licensed to sell other OTC medication. It is also suggested that OTC NRTs be made available in smaller pack sizes vs. the two-week supply currently available.

In January 2008, Richard Daines, the New York State Commissioner of Health, submitted a citizen's petition to the Secretary of DHHS and the Food and Drug Administration requesting expansion of the availability of nicotine replacement therapy to consumers who use tobacco. In August 2008, the FDA responded that they had not reached a decision in regard to this issue. It is time to pursue a decision in this matter.

The current restrictions on selling non-prescription NRTs and the pack size are based on FDA requirements.

Health Benefits

Broader access to NRTs in local shopping settings.

No Economic Burden is foreseen.

Any pack size change is the cost of the manufacturer of the product

Recommendation

The Task Force recommends that state officials, such as the AGs office, send letters urging the FDA to take up this topic and expand access to OTC NRTs.

Recommendation #17: Prevent youth access to tobacco products by restricting new cigarette licenses and reducing current cigarette license renewals

- Eliminate all vending machines by April 2011
- Eliminate renewals and new licenses to all Bars and Restaurants by October 2011
- Eliminate renewals and new licenses to all Drug Stores by January 2012

- Eliminate Mass Merchants and Supermarkets / Grocery Stores over 3000 square feet by July 2012
- Determine if there are any other locations that have licenses that are deemed inappropriate.

Background: Controlling youth access to tobacco products is an important aspect of reducing youth tobacco use. DMHAS is charged with the responsibility of monitoring licensed tobacco merchants to ensure they are enforcing limitations on youth access. There are currently 3 inspectors for over 4000 licensees. On average, a licensee will have a compliance check at least every 18 months with those that have failed previous compliance checks receiving them more frequently.

The 2009 SYNAR report indicated that less than 10% of Connecticut tobacco merchants failed compliance checks. These are great numbers that need to be maintained or improved to ensure continued federal block grant funding from SAMHSA for a range of prevention and treatment programs.

To ensure that annual inspections are conducted, the number of licensees should be reduced. Family oriented merchants and food establishments would be phased out over time. For example, the City of Boston no longer allows drug stores to hold tobacco merchant licenses.

As of March 4, 2010 there were 4,239 recorded licensed tobacco merchants. This information is updated on the 25th of each month by the keeper of the records, which is the tobacco-licensing agency in the Department of Revenue Services.

The licensees are not sorted by type of establishment on the web site. As of March 4, 2010, DMHAS had identified 90 vending machine locations and 4,149 over the counter locations. Licensed tobacco merchants in the state include:

- 180 chain supermarkets
- 80 independent supermarkets over 3000 sq ft
- 300 chain drug stores
- 25 independent drug stores
- 32 large “big box” retailers
- 90 vending machine locations, many of these are in bars, cafes, deli’s pizzerias, golf courses, auto repair / cleaning sites

- 25 check cashing sites – possibly vending sites
- Several low price variety stores

Table 3 indicates current license fee revenue and estimates of changes if renewal fees are increased and if the number of licenses is reduced:

Table 3: Estimated Effects of Changes Tobacco Merchant License Volume and Renewal Fees

	<i>Jul-10</i>	<i>Jul-12</i>	<i>Oct-11</i>	<i>Jul-12</i>
Policy Change	Current	Current fee; fewer licenses	Increased fee; fewer licenses	Increased fee; fewer licenses
Total Licenses	4,239	3,132	3,749	3,132
License Renewal Fee	\$50	\$50	\$75	\$100
Total Revenue	\$211,950	\$156,600	\$281,175	\$313,200
Change +/-		(\$55,350)	\$69,225	\$101,250

Economic Impact: Neutral to slight gain in revenue. As proposed there will be a slight revenue gain of \$101,500 once fully implemented by July 2012. This does not call for any “grandfathering” under current law.

Recognizing the concerns from all retail sectors about lost income source and concerns over more regulations, the following recommendation is offered to address those issues to ensure that the retail sector remains competitive and vital in the state of Connecticut.

Recommendation #18: Support the Connecticut Fair Trade Law, which helps counteract manufacturer trade discounting and encourage an increase to keep a viable, and competitive retail economic sector to Connecticut's economy.

Background: Cigarette price increases reduce the demand for cigarettes and thereby reduce smoking prevalence, cigarette consumption and youth initiation of smoking. Fair Trade laws were established by states in the 1940's to protect tobacco retailers from predatory business practices. The laws require adding a minimum percentage markup to the manufacturer's list price at the wholesale level and again at the retail level.

Cigarettes rank as the largest category by share of sales in convenience stores, contributing on average 32.9% of inside dollars in 2008 as stated in the NACS SOI report. Cigarettes are the third contributor to gross margin dollars / profits for convenience stores. OTP (other tobacco products) contributed 11.9% to inside sales making it the sixth highest sales category.

Economic Burden: In Connecticut, both the wholesaler and retailers are struggling with profitability as the consumption of cigarettes continues to decline. The cost of doing business in Connecticut is considerable and the loss of revenue in this area is causing higher costs/retails on non-tobacco products to make up for the losses. The Task Force supports an increase to both the wholesaler and retailer minimum markups (amounts to be determined).

Massachusetts, recognizing that the retailer was the front line in preventing youth access sales, opted to increase their minimum markup over 10 years ago to help the retailer make up for lost revenue.

Health Benefits: Further reduction in demand and a higher threshold to prevent young smokers from starting.

Cost: This increase would reduce the excise tax collection on cigarettes. There would be a slight increase in sales tax collected. All depends on the percentages established. Today, the state of Connecticut has an excise sales tax of \$30.00 per carton. The retailer lags behind this making approximately \$8-\$9 per carton – this profit on reduced demand is not allowing retailers to cover increases in medical benefits, electricity, minimum wages. The wholesaler is in the same boat with limited resources and opportunities to improve themselves and their employee's situations.

Recommendation #19: Ensure a healthy retail environment with ample competition for Connecticut citizens by offering replacement products for lost tobacco revenue for retailers.

Regulations continue to prevent retailers from expanding / replacing tobacco revenue with other viable product lines. 0

Recommendation #20: Strive to optimize FDA funding for collaboration around enforcement of youth tobacco laws

Maine and Massachusetts have received FDA funding to develop preliminary enforcement mechanisms which will be used as models for other states' efforts.

June 22, 2010 marked the first anniversary of the U.S. Food and Drug Administration's (FDA) authority over tobacco under The Family Smoking Prevention Control Act, June 22 was also the date when the agency's tobacco regulations went into effect, including a ban on the words "light" and "mild" when referring to cigarettes.

During the past year, the FDA has:

- Established the Center for Tobacco Products
- Established the tobacco user fee program, which provides funding for FDA tobacco regulation support activities
- Begun to enforce the Act's prohibition on manufacturing, distributing or selling certain flavored cigarettes, such as spice-, fruit-, and candy-flavored cigarettes
- Implemented new statutory authorities, under which tobacco product manufacturers have registered their establishments and listed their products with the FDA, provided detailed information about product ingredients and their own research into the health effects of their products
- Convened a Tobacco Products Scientific Advisory Committee, which began to study the impact of the use of menthol in cigarettes on the public health

The following provisions of the Act become effective on June 22, 2010:

FDA rules that limit the sale, distribution, and marketing of cigarettes and smokeless tobacco to protect the health of children and adolescents become legally enforceable

Provisions that prohibit the advertising or labeling of tobacco products with the descriptors “light,” “mild,” or “low” or similar descriptors without an FDA order

Requirements that new, larger health warning labels for smokeless tobacco products begin to rotate on labels, labeling, and advertising and begin to be displayed on smokeless tobacco packaging²³

F. POLICY/ENFORCEMENT: Surveillance

Recommendation #21: Develop a surveillance mechanism that utilizes health information developed through statewide health information exchanges and Sustinet.

- Collect and analyze data related to smoking prevalence, cessation interventions and quit rates and other parameters necessary to evaluate the utilization, efficacy and cost-effectiveness of tobacco prevention and control strategies.
- Launch a comprehensive, time-sensitive Information Technology (IT) system linking patient, medical encounter, smoking prevalence and tobacco-related morbidity.
- Maintain ongoing surveillance of targeted groups to assess effectiveness of tobacco prevention and control strategies.
- Engage health prevention experts and public health epidemiologists in development of the variables for inclusion in the electronic record to maximize its value to provide not only appropriate individual patient care, but also to use as population based surveillance tools to measure prevalence of risk factors and behaviors that contribute to and mediate disease, utilization of prevention services, including tobacco use cessation, and evaluation of their costs (and savings) as well as their efficacy.

Background: Sustinet expects to participate in developing a system for electronic health records. This will be an extensive and expensive process, as anyone who has developed major data systems is aware. Dr. Robert Aseltine, a member of the IT Advisory Committee, is currently the principal investigator for the Connecticut Health Information Network (CHIN), which would enable research with data combined across Connecticut state agencies that was previously impossible. Researchers and public health officials share an understanding of the need for health databases that go beyond the concept of merely the standard medical record.

As part of the Health Care Reform legislation, the federal government will also be requiring information on Preventative Services and client risk factors that contribute

to and mediate chronic diseases. On June 18, 2010, Secretary Sibelius announced the Prevention and Public Health Fund created by the Affordable Care Act. Included in the latest round of \$250 million is \$122 million for Community and Clinical Prevention. These funds will support federal, state and community prevention initiatives; the integration of primary care services into publically funded community-based behavioral health settings; obesity prevention and fitness; and tobacco cessation.

This new interest in prevention and wellness, along with secondary and tertiary care of the individual as “patient”, requires a new way of organizing information on the clients we serve in the health care setting. It is interesting that although we refer to our system of care as “health care”, it has traditionally focused only on “disease care”. The cost of this downstream focus has forced those who pay for this care to move the focus upstream and begin to focus on those behavioral and environmental factors that can be modified to prevent or ameliorate the disease. This focus not only saves lives, but is also more cost effective. Whatever IT system is finally developed needs to be a merger of the two approaches to increase the health of the people; preventing disease and treating it when it does occur. Additionally, it must be developed to be useful for the individual client and for population based research and surveillance that can provide long-term trend analysis to measure outcomes and costs.

A comprehensive tobacco surveillance system will provide disease control specialists and legislators necessary information about the utilization and impact of tobacco on populations, as well as the capacity to monitor tobacco industry practices.²⁴ The World Health Organizations (WHO), in cooperation with the U.S. Centers for Disease Control and Prevention (CDC) other stakeholders have long advocated for implementation of a Global Tobacco Surveillance System (GTSS).

This comprehensive toolkit consists of four validated and effective population survey instruments to assess tobacco use and impact that can provide national and international comparative data to assess progress reaching specific tobacco control targets.

Youth Tobacco Survey (YTS): The YTS focuses on youth aged 13-15 and collects information in schools. The YTS is a 56 item questionnaire for gathering data on individual's awareness and knowledge about smoking and environmental tobacco smoking (ETS), prevalence of tobacco use, the impact of media and advertising on youth attitudes about tobacco, youth access to tobacco products, their exposure to tobacco control curriculum in schools and the awareness and experience of young smokers about cessation opportunities.

The School Personnel Survey (SPS) The SPS surveys teachers and administrators from the same schools that participate in the YTS regarding tobacco use, their knowledge and attitudes about tobacco, availability and student access to resources focused on the prevention and control of tobacco use by students and the, existence and effectiveness of tobacco control policies in schools.

The Health Professions Student Survey (HPSS) The HPSS is intended for advanced (e.g., 3rd year) students enrolled in Dental, Medical, Nursing and Pharmacy programs about their use of tobacco, knowledge and attitudes about smoking and environmental tobacco smoke, training received on counseling patients to stop smoking and willingness of smokers to stop.

Adult Tobacco Survey (ATS) The ATS is a household survey of adults to monitor prevalence of cigarettes and smokeless tobacco products, exposure to environmental tobacco smoke, knowledge, attitudes and perceptions about tobacco, impact of media on knowledge and perceptions of tobacco, economics of smoking and efforts by smokers to stop.

Surveillance of tobacco industry efforts to undermine tobacco control efforts is equally important. Recognizing new marketing strategies and roll out of new devices for delivery for tobacco use are critical in developing effective counter marketing and regulatory strategies.

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Connecticut School Health Survey 2007

CT Judicial Branch 2009 Court Statistical Data, Centralized Infractions Bureau

List of known cessation programs:

www.ct.gov/dph/lib/dph/hems/tobacco/pdf/tobacco_use_cessation_programs_in_connecticut_2010.pdf

Centers for Disease Control and Prevention

State Cigarette Minimum Price Laws – US 2009

MMWR weekly report April 9, 2010 / 59 (13); 389-392

NACS State of the Industry Report for 2008

APPENDICES

The following documents are available at the links below and are contained in a separate compressed file titled “Sustinet Tobacco Use Cessation Task Force Report Appendices.”

Appendix 1:

The Connecticut Public Health Policy Institute. Cooney, J; Cohen, J; Checko, P; et.al.
Examining Tobacco Use, Consequences and Policies in Connecticut: Smoke and Mirrors? University of Hartford: April 28, 2010
http://enhp.hartford.edu/ctphp/pdf/Tobacco_Issue_Brief_Final.pdf

Appendix 2:

Massachusetts Department of Public Health: Massachusetts Tobacco Control and Prevention Program. **Annual Report, Fiscal Year 2009.**
http://www.mass.gov/Eeohhs2/docs/dph/tobacco_control/annual_report_2009.pdf

Appendix 3:

Tobacco and Health Trust Fund Board of Trustees: **Fiscal Year 2010 Report to the Appropriations and Public Health Committees and the Connecticut General Assembly.** December 2009.

http://www.ct.gov/opm/lib/opm/secretary/tobacco/tobacco_report_fy_2010.pdf

Appendix 4:

Tragakiss, T. **Connecticut's Tobacco Windfall: A Billion Dollars Up in Smoke.** July 2009. Yankee Institute for Public Policy, Inc. Available at www.yankeeinstitute.org/wp-content/TobaccoStudy.pdf

Appendix 5:

Healthy People 2020 Proposed Objectives for Tobacco Use.

<http://healthypeople.gov/HP2020/Objectives/TopicArea.aspx?id=47&TopicArea=Tobacco+Use>

Attachment A

Smoke Free Housing Programs

United States (Nationally): Americans for Nonsmokers' Rights: In Your Home:

<http://www.no-smoke.org/goingsmokefree.php?id=101>

California: Smoke-Free Apartment House Registry: <http://www.smokefreeapartments.org>

Colorado: My Smoke-Free Housing: <http://www.mysmokefreehousing.com>

Maine: Smoke-Free Housing: <http://www.smokefreeforme.org>

Michigan: MI Smoke-Free Apartment: <http://www.mismokefreeapartment.org>

Minnesota: Live Smoke Free: <http://www.mnsmokefreehousing.org>

Minnesota: Minnesota Multi-Housing Association: <http://www.mmha.org>

Minnesota: Minnesota Chapter of the National Association for Housing and Redevelopment Officials: <http://www.mnnahro.org>

Ohio: Smoke-Free Housing: <http://www.ohiosmokefreehousing.com>

Oregon: Smoke-Free Housing Project: <http://www.smokefreeoregon.com/housing>

Utah: The TRUTH: <http://www.tobaccofreeutah.org/aptcondoguide.html>

Final Report of the SustiNet Childhood and Adult Obesity Task Force

I. Summary

The SustiNet Task Force on Obesity is pleased to present its recommendations to address obesity among Connecticut's residents. Just over 21% of state adults are considered obese, making the state the "second least obese" nationwide. On the other hand, 12.5% of Connecticut youths aged 10-17 are obese, compared to the national average of 12%.

Treatment of obesity is an expensive and extended process, requiring significant investment of health care dollars. The Task Force concluded that increased prevention efforts at the statewide policy level will benefit both those who maintain a healthy weight as well as assisting those who have encountered difficulty in doing so. Furthermore, the increasing prevalence of obesity in children has only recently begun to come to the forefront.

To address the issues particularly facing pediatric populations, the Task Force recommends a broad range of actions, including creating a state level council to focus on policy development and coordination; emphasizing best practices among providers; improving the nutritional environment in schools and child care facilities; and ending food marketing directed at children. Within these recommendations, the Task Force notes that SustiNet should include coverage for obesity-related services such as extended nutritional counseling and parent education on healthy eating.

II. Purpose and Mission of This Task Force

A. Charge to the Task Force

Section 16 of Public Act 09-148 directs the Task Force to:

1. Examine evidence-based strategies for preventing and reducing obesity in children and adults and develop a comprehensive plan that will effectuate a reduction in obesity among children and adults
2. Develop recommendations in the context of overall SustiNet goals:
 - Improve the health of state residents
 - Improve the quality of health care and access to health care
 - Slow the growth of per capita health care spending

- Promote effective management of chronic illness
 - Promote effective preventive care
 - Reduce racial and ethnic disparities as related to health care and health outcomes
3. Submit a report containing its recommendations to the Sustinet board by July 1, 2010.

B. Members of the Task Force

The Task Force is comprised of co-chairs Lucy Nolan (End Hunger, CT!, Hartford) and Marlene Schwartz, Ph.D. (Rudd Center for Food Policy and Obesity, New Haven) and four members: Christine Finck, M.D. (Connecticut Children's Medical Center, Hartford), Andrea Rynn (Danbury Hospital, Danbury), Jennifer Turner (Girl Scouts of America, Hartford), and Neil Vitale, M.D. (Pediatric Associates of Connecticut, Southbury).

C. Methodology

The Task Force first met on November 6, 2009 at which time a meeting schedule was adopted. Over the course of its schedule of meetings, the Task Force heard presentations from a wide variety of stakeholders. A complete list is in Appendix A.

III. Obesity and Nutrition in Connecticut

A. Obesity in Connecticut

1. Defining And Measuring Obesity

In the field of public health, "obesity" and "overweight" are defined using Body Mass Index (BMI), which is calculated by dividing weight (kg) by height (meters) squared. Table 1 presents the accepted BMI ranges for each weight category. For example, if a woman who is 5'6" tall weighs between 115 and 154, she is in the normal weight range. If she weighs between 155 and 185 she is considered overweight. If she weighs 186 pounds or more, she is considered obese.

Table 1. Weight categories for adults

BMI	
Underweight	Below 18.5
Normal	18.5 - 24.9
Overweight	25.0 - 29.9
Obesity	30.0 and Above

The Task Force spent considerable time discussing the positive and negative aspects of using BMI as an index in Connecticut. **The Task Force feels that BMI is not a sufficient measure to diagnose individual obesity.** For example, BMI may overestimate body fat in athletes and others who have a muscular build, and it may underestimate body fat in older persons and others who have lost muscle mass.

It is important to understand that when assessing children between ages 2 and 18, the 25 and 30 cut-off points for overweight and obese are not appropriate. Instead, it is necessary to compute the percentile for the child's BMI based on age and sex. The CDC provides tools to do this on their website:

http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

This method compares a child's BMI to the normal range of children's BMIs of the same age and sex. Therefore, if a child is at the 85th percentile, it means that he/she is larger than 85% of all children of the same age and sex. This is the standard cut off for being considered overweight among children. If a child is at or above the 95th percentile, he or she is considered obese. **The Task Force feels strongly that the diagnosis of overweight or obesity should only be provided by the child's health professional, who has access to the child's measurements over time.** For example, there is a difference between a 10-year-old child who has been in the 70th percentile every year since age 5 and a child who was in the 30th percentile between ages 5 and 9, and then at age 10 suddenly climbs to the 70% percentile. Consistent growth along the same percentile line of the chart suggests that the child is growing appropriately. Sudden jumps, either up or down, suggest that there may be a problem in the child's eating or activity level. These circumstances require the attention of a health professional who can do a thorough examination of the child and learn more about the child's historic and current eating and activity patterns. Once the professional has this information, possible interventions may be recommended.

While the Task Force acknowledges the limitations of BMI for individual diagnosis, it feels that BMI is a good measure for the purpose of tracking weight in a population to examine public health trends. BMI is reliable and nationally standardized, which will

allow for comparison between Connecticut and other states as well as within geographic regions within the state.

2. Rates Of Overweight And Obesity In Connecticut

National data from the Centers for Disease Control and Prevention indicate that Connecticut has the lowest adult obesity prevalence among the six New England states; however, that does not mean that we do not have a serious health problem.

¹ Currently **59.7% of Connecticut adults are overweight or obese**. Specifically, **21.4% are obese (BMI = 30 and above) and 38.3% are overweight (BMI = 25-29.9)**. The trend over time is extremely concerning; the rates of obesity among adults in Connecticut have **increased by 71% since 1995**.²

Connecticut residents experience a wide range of levels of socioeconomic status, which has resulted in health disparities across the state. Rates of obesity are significantly related to income nationally, and this relationship is very evident in Connecticut. Rates of obesity vary by income (19% in the top-income bracket vs. 28% in the lowest) and education (from 17% to 34%). The differences in rates of obesity and overweight among adults are particularly pronounced when comparing different levels of education; 55% of adult college graduates are overweight or obese, compared to 65% of people who only finished high school.³

In 2009, the adult obesity rate was 35.4 percent among Blacks and 26.4 percent among Latinos, compared with 20.7 percent among Whites. Washington, DC and Mississippi had lower rates than Connecticut for Black and Latino residents, respectively.⁴

In 2007, rates of childhood overweight (BMI percentile $\geq 85 - 94.9$) were 13.3% and rates of obesity (BMI ≥ 95 percentile) were 12.3%, **meaning that a total of 25.6% (or put simply, more than 1 out of 4) of our children are at risk for weight related medical complications**. As with adults, socioeconomic and racial / ethnicity status make an important difference in risk of obesity. In Connecticut, rates of childhood obesity vary substantially by race: from 9.6% among white children to 17.5% among Latino children and 21.1% among African American school children.⁵ **In other words, in our state, Latino children are almost twice as likely and African American children are more than twice as likely to be obese compared to white children**. Obesity is clearly a health disparity issue that must be addressed.

3. Health Care Costs

According to published research, obesity-related medical expenditures in Connecticut adults are \$1.08 billion *each year* (in 2009 dollars).⁶ All taxpayers are affected. Public

funds such as Medicare and Medicaid pay for more than three quarters of all adult medical expenditures in Connecticut attributable to obesity (\$530 million per year by Medicaid and \$311 million by Medicare). This is considerably above the national average of 52% for the share of Medicaid and Medicare expenses in all obesity-attributable health care costs for adults.⁷ Clearly, state efforts to prevent obesity will have substantial financial benefits for the state over time.

4. The Link Between Food Insecurity And Obesity

While overweight and obesity are the result of overconsumption of calories, there is sometimes a paradoxical relationship between being food insecure (i.e., not knowing where your next meal is coming from) and being overweight or obese. When one looks at the economics of our food environment, this relationship makes more sense. Many densely caloric foods (such as fast food, packaged snack foods, sugar sweetened beverages and candy) are significantly less expensive than less caloric but more nutritious foods (such as fresh fruit and vegetables, low-fat dairy products and lean meats). Therefore, someone who has limited money to purchase food may make the logical choice of obtaining the maximum amount of calories for the least amount of money. Further, people who live in low-income neighborhoods and are reliant on public transportation have limited access to full service supermarkets. This makes the healthier options not only less affordable, but also less available to many individuals in our state.

5. Calories in and calories out

The simple point that obesity is a matter of energy imbalance – more calories are taken in than are expended – says everything and nothing at the same time. While it is true that this explains weight gain and loss, the real question is: what is causing people to take in more calories and expend fewer calories on a regular basis?

In the field of obesity treatment and prevention, there has been an ongoing tension between those who study the food side of the equation and those who study the activity side of the equation. Some of the most vocal advocates for the importance of more physical activity have been members of the food and restaurant industries. Recent research, however, has determined that the changes in food intake that have occurred in the last three decades are more than sufficient to explain the rise in obesity in the United States.⁸ Physical activity is recommended for reasons that go far beyond weight status – being fit is associated with many major health benefits, and there is a growing body of research indicating that children who are physically fit and active do better academically.⁹ There is also a very strong literature indicating that the best way to maintain weight loss once it has occurred is frequent physical activity. In light of the research in this area, the proposed policies in this report address both

calories in and calories out, but emphasize the food side of the equation more than the activity side.

B. Food and Nutrition Programs in Connecticut

1. Supplemental Nutrition Education Program (SNAP; formerly known as food stamps)

Connecticut assists residents in purchasing food through a range of federal nutrition programs. About 7% of the population in Connecticut (or 258,165 people) participated in SNAP in 2009, with average monthly benefits of \$134.60 per participant.¹⁰ The number of participants increased 15% from 2008. In July, 2009 SNAP income guidelines for SNAP were raised to 185% of the Federal Poverty Level (FPL) from 135% FPL allowing more people to access the program. Currently, over 333,000 Connecticut residents enrolled in the program. The federal government also provides funding of \$4 million for an education component of SNAP, called SNAP-Ed. In our state, the DPH and the University of Connecticut administer the nutrition education efforts associated with SNAP. A number of programs are delivered to different target audiences, including Captain 5-a-day for preschoolers, the Hispanic Family Nutrition Program, the Senior Nutrition Awareness Project, Husky Nutrition Education and SNAP-Ed Food Security, which serves people who participate in emergency food programs.

Women, Infants and Children (WIC) Program

In 2009, about 60,155 Connecticut children, women and infants participated in the WIC program, receiving average monthly food benefits of \$49.25 per participant.¹¹ Individuals who participate in these programs also benefit from the efforts to have farmers markets in Connecticut accept WIC¹² and SNAP benefits.¹³

Farm-to-School Program

In Connecticut, there is a growing Farm-to-School Program organized by the Department of Agriculture. At this time, over 96 schools and districts participate by obtaining produce or beef from local farmers. The most popular items are apples, pears, peaches and berries. Not only does this program give children the opportunity to taste farm fresh foods it acts as an economic stimulus for farmers to keep producing healthy foods.

National School Breakfast and Lunch Programs

Connecticut ranks last in the nation for the number of schools offering breakfast and 40th for the number of eligible children receiving a breakfast at school¹⁴. Due to a grant program instituted by the legislature in 2006, more children are receiving breakfast when they eat after the school day begins (schools that participated in the grant program to feed children in the classroom, or after the school day began, saw a three-fold increase in the number of children fed).¹⁵ Eating breakfast at school increases student's attention, ability to learn and test scores.

The National School Lunch Program began during the Second World War when the government realized that the boys enlisting were not nutritionally fit. Since that time, the School Lunch Program has been instrumental in assuring children receive at least one nutritional meal during the school day. There are three categories for reimbursement to schools: free (a family's income is no more than 130% of the FPL), reduced (a family's income falls between 130% and 185% of the FPL), and regular priced (for those families with incomes above 185%). If a family receives SNAP benefits, their children are categorically eligible for free meals at school. Connecticut has strict beverage guidelines for schools and addresses the foods that can be sold alongside the meal through the voluntary Healthy Food Certification, as outlined by the State Department of Education. Healthy Food Certification sets nutrition standards for school meals; schools choosing to obtain this certification receive enhanced lunch funding. Both the School Breakfast Program and the National School Lunch Program are administered by the Connecticut State Department of Education for the United State's Department of Agriculture.

Summer Feeding Program

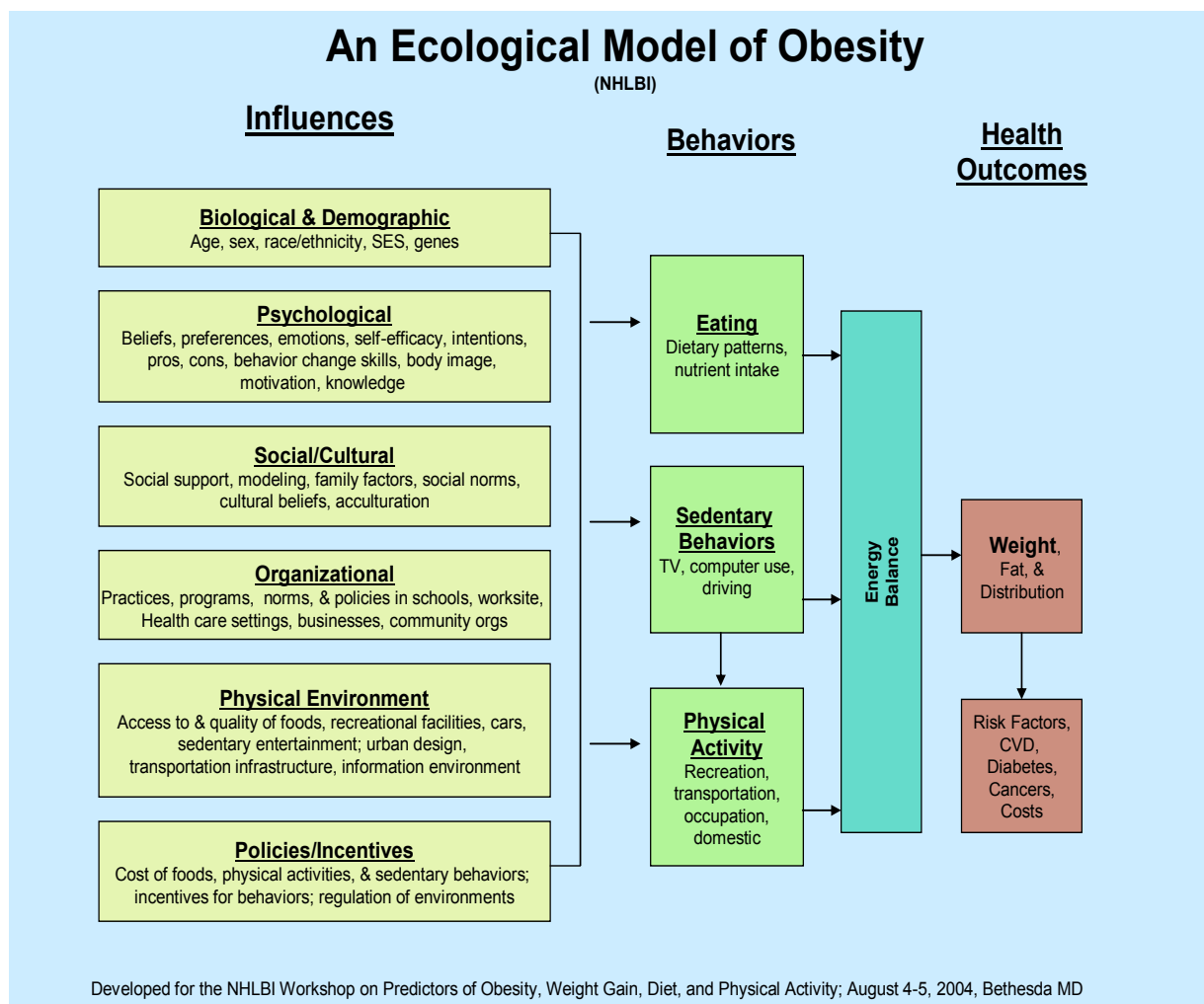
This program provides free meals (breakfast and/or lunch) to children when school is out, ensuring a healthy and happy summer for all kids 18 and under. Like the National School Lunch Program, Summer Food is funded by the USDA. In 2009 there were 468 summer feeding sites in Connecticut with an average daily attendance of over 33,000 children at which more than 1.5 million meals were served.¹⁶

Availability is either at an open site at which any child under age 18 may eat, the location of which is determined by neighborhood income, or at a closed site such as camps where applications are collected to assure a family is eligible for the federally funded meal(s). The Summer Feeding Program also allows for a safe area for children to recreate during the summer months and is often paired with summer school, camps, and Parks and Recreation activities allowing for physical activities.

IV. Guiding Principles

Figure 1 illustrates the Ecological Model of Obesity, which identifies the wide range of influences that lead to the behaviors that contribute to obesity and other health consequences. Philosophically, the Task Force believes that the role of the state is to focus on the larger influences that can be changed, with the greatest emphasis on the highest level influences: **Organizational, Physical Environment** and **Policies and Incentives**.

Figure 1



At the first meeting, members reviewed the differences between Policies and Programs and the definition of an optimal default (see Appendix B). As the task force worked to formulate recommendations, a number of guiding principles were identified to help focus these efforts. The Task Force hopes that these principles will steer future state efforts as well as those recommended this year.

1. As a state, we need to move beyond education and encouragement and actively promote policy changes that will make the healthy behavior the default behavior.

A common belief is that food decisions are made based on knowledge and conscious intention. As researchers study human eating behavior, however, we are learning that we are highly influenced by the nutrition environment – often in ways that are outside of our awareness.¹⁷ One way to address this problem is to educate people and implore them to continually fight against an environment where foods high in sugar, salt, and fat are inexpensive, highly accessible, and heavily marketed. Another strategy is to change the environment, so that the healthy foods are inexpensive, accessible, and marketed. In other words, it should require little effort to eat well and great effort to eat poorly, instead of the current situation, which is the other way around.

2. Results-Based Accountability (RBA) should be used as a tool for state government to set goals and strategies, coordinate actions, and determine impact.

The concept of RBA has already been introduced in Connecticut for some state programs (see <http://www.cga.ct.gov/2010/rpt/2010-R-0135.htm>). We recommend that RBA should be used throughout the process of state actions - for departmental planning, program implementation, and the evaluation of outcomes, including the use of the “report card” format when obesity related efforts are reported to the Appropriations committee.

3. State efforts must be coordinated, tracked, and evaluated by a central body that is supported by highest levels of state government.

Through the process of collecting data on what is already happening in the state that is relevant to obesity, the Task Force learned of many different types of initiatives, including policies, programs, advocacy efforts, and opportunities for federal and foundation funding. It became clear that no one group was given the authority or resources to make sure that all efforts were optimally synergistic. Further, in order to effectively use RBA, the state needs valid outcome measures specifically related to child and adult obesity. Different types of data are currently collected in different agencies, but these data are not all pulled together in a manner that would allow a comprehensive assessment of statewide obesity efforts.

4. Food security, good nutrition, weight stigma, and adequate physical activity need to be examined in a cohesive manner across the state.

The Task Force feels strongly that every effort must be made to ensure that new policies do not have unintended consequences. Food policies that are aimed at decreasing excess caloric consumption may concern advocates who work to ensure that people have enough to eat. These policies can also raise concerns about increasing weight stigma, discrimination and prejudice. Certainly, any policy that will impact children needs to be evaluated by individuals with a range of perspectives and the child's overall well being as the key outcome. After much discussion, the Task Force feels that conflict is avoidable, and in fact, we feel that there are many responsible policies that can promote better nutrition and more physical activity and positive self-esteem and body image for youth and adults.

5. Ensure that all new policies or programs for children in the schools are designed to promote health for everyone; do not single out overweight children for interventions.

On a related note, the Task Force feels strongly that any new policies in Connecticut must be designed in a way that do not promote negative body image and unhealthy dieting practices, especially among adolescent girls, who are at highest risk of developing clinical eating disorders. There is an emerging area of research on strategies and messaging in obesity prevention that addresses this concern directly, and future efforts in the state should consider these recommendations.¹⁸ **The key point is to keep the messaging focused on healthy behaviors for everyone – not simply weight loss for overweight individuals.** In schools in particular, it is important not to single out overweight children for interventions, but rather, focus on improving nutrition and physical activity for the entire student populations. For example, promoting calorie-restriction through activities such as a “Biggest Loser” competition for children is not recommended. Instead, the state should promote general messages, as have been used by many other states, such as “5-3-2-1-0: FIVE fruits and vegetables, THREE low-fat dairy, less than TWO hours of screen time, at least ONE hour of exercise, and ZERO sugar sweetened beverages.”

6. Efforts should be designed to reduce racial and ethnic health disparities in the state.

There are significant health disparities among racial and ethnic groups nationally, and as noted earlier in the status of obesity in Connecticut, we experience these disparities here as well. Reducing disparities will require a broad view of the causal factors leading to obesity in the first place, most prominently, the role of socio-economic status. The Task Force's recommendations to combine anti-hunger and

obesity prevention policies should move the state in the right direction by increasing access and affordability of healthy foods for all residents. Improving the nutritional quality of all of the government subsidized food programs, especially in child care facilities and in schools, will improve the diets of low-income children and thereby reduce one source of health disparities.

7. Need to focus on prevention and treatment; and support health professionals to engage in both.

There are two obesity related public health problems – the first is how to help the individuals who have already developed the condition, and the second is how to prevent more people from becoming obese. Both efforts are important and both efforts require resources. Health professionals have an important role in both efforts. From an economic standpoint, it is certainly more efficient to spend money on prevention, so that is where we recommend the majority of the state initiatives focus. However, people who have already become obese are entitled to compassionate and state-of-the-art treatment.

8. Best practices should be identified and implemented in an ongoing manner.

In the coming years, it is likely that much will be learned about the effectiveness of different public health strategies to improve the nutrition and activity environment and promote healthier behaviors. It is critical that Connecticut remain flexible and open-minded as new findings emerge, and continually challenge all relevant parties to push themselves to the highest standards of practice and policy.

V. Recommendations

Recommendation #1: Convene statewide policy making and oversight groups; move towards achieving statutory authority

1. (a). The current Childhood Obesity Council must move forward immediately.

As noted below, we recommend that the current Childhood Obesity Council should be strengthened and turned into a permanent council with statutory authority.

However, in the meantime, we strongly recommend that the existing council be reactivated so it can continue its productive line of work. Specific recommendations that can be addressed immediately include:

Tracking and Communication

- Create an information packet on all relevant state agency programs.
- Update materials and distribute them widely.
- Plan a council-led roundtable of all local childhood obesity coalitions. The purpose is to create partnerships and coordination among disparate efforts – not just among state agencies but also among the growing number of interested municipalities and nonprofit groups. There are local coalition efforts in Hartford, New Haven, Danbury, Stamford, Torrington and elsewhere that are growing stronger by the week. Everyone is chasing federal and private dollars to their own benefit, but a coordinated team would benefit all.
- Engage in a cross-agency RBA process to set goals, share agency plans and coordinate actions.
- Add the non-governmental members the group committed to add last spring. Establish the action teams announced in the spring of 2009 but which were not implemented on (1) data, (2) medical home, (3) menu labeling, (4) school/community and (5) policy development.
- Revisit the BMI proposal, re-assess other states' experiences, and reintroduce the bill.
- Incorporate emerging best practices into inter-agency projects through master contracting and memoranda of understanding.
- Conduct a regional listening tour in coordination with local obesity prevention coalitions

- Engage all 10 state agencies to analyze each of the 116 policy recommendations of the 2008 conference in a formal policy review (see http://www.cga.ct.gov/coc/obesity_forum.htm).
- Develop a public outreach campaign, starting with donated public-service announcement time as the Commission on Children and Connecticut Conference of Municipalities did in 2006.
- Conduct a leadership survey of other states' obesity coordination efforts.

Grant Coordinating

- Apply for foundation funds on behalf of the Council.
- Serve as a team to prepare cross-agency applications for federal funding through the federal stimulus and other opportunities. Our state will stand a better chance with a multi-agency application and the coordinating strength of its Childhood Obesity Council.

Cost: Minimum \$20,000 a year for council operation. Additional funding if the council assumes grant-making authority.

Leaders: Council chair with support from legislators and executive branch leaders.

Timeline: Immediate action by existing Childhood Obesity Council to achieve the 13 objectives listed above. Establishment of a statutorily authorized council would require action in the next legislative session.

Impact: Improved government response to obesity issues, establishment of a council that has statutory authority and cannot be compromised by executive branch inaction.

Measurable indicators for RBA:

1. The amount of communication that occurs throughout the state about obesity related efforts – number of people reached.
2. The amount of grant funding brought into the state for obesity related programs and policies

Recommendation #1b: Create and Support a Permanent Council on Childhood and Adult Obesity.

Why is a permanent council with statutory authority needed?

The problem of obesity cuts across all age groups and the missions of many state departments. While the Department of Public Health and the Department of Education have the most direct influence over relevant policies (including the federal food programs, licensing child care centers, regulating restaurants), other departments play important roles. Examples include the Department of Agriculture (e.g., Farm to School efforts); the Department of Transportation (e.g., “complete street” initiatives), and the Department of Social Services (e.g., Supplemental Nutrition Assistance Program [SNAP] and The Emergency Food Assistance Program [TEFAP]).

The work that has been done by the existing Childhood Obesity Council has been extensive and noteworthy, as the Task Force learned from presentations by Thomas Brooks and Mario Garcia. To be more effective, however, this council must be expanded and provided with the authority they need to promote further changes in the state. The council will need adequate funding to support its day-to-day activities as well as authority to manage additional funding provided within the state for statewide obesity related initiatives.

The Permanent Council on Child and Adult Obesity could be modeled after the Connecticut Medicaid Managed Care Council. As a collaborative body of legislators, consumers, advocates, health care providers, and state agencies, the Obesity Council can advise both state agencies and the legislature on strategies to promote environmental change and better access to health care for currently obese individuals.

Who should be members of the permanent council?

- **Legislative branch members:** It is critical that legislators, not just their designees, participate in this council. We recommend appointing members from the following committees: Select Committee on Children, Public Health, Human Services, Education, Environment, and Transportation. We also recommend that the Commission on Children continue as a council member.
- **Executive branch agencies,** including DPH, OPM, DCF, SDE, DOA, DSS, DEP, and DOT.
- **Advocacy and other non-governmental organizations:** Connecticut already has a number of active organizations that work directly on issues

relevant to obesity policy. Examples include: End Hunger, CT!, Action for Healthy Kids, the Connecticut Dietetic Association, CT Association for Health, Physical Education, Recreation and Dance, CT Food Policy Council, Connecticut Public Health Association, School Nutrition Association of Connecticut, and state chapters of the American Academy of Pediatrics, American Cancer Society, American Heart Association, and AARP.

- **School and Community Representatives** - A school superintendent, parent, young person, zoning expert, expert on parks and recreation, representative from youth-focused groups, such as the Girl Scouts.
- **Academic researchers and institutes:** Some examples include the CT Public Health Policy Institute and the Rudd Center for Food Policy and Obesity.

Core functions of the Council:

- **Track national and state efforts.** Due to the First Lady's childhood obesity initiative, this issue has gained national exposure and keen interest from the federal government. The Council will be responsible for tracking policy efforts occurring in other states and at the national level so that Connecticut can stay informed and prepared to move forward quickly as new effective strategies emerge. Further, the council will be responsible for maintaining current information on obesity related local efforts throughout the state and screening the landscape to see what resources already exist.
- **Communicate relevant information throughout the state.** The Council will use in-person meetings, webinars, newsletters, and e-mail alerts to keep all stakeholders informed and up to date on what is happening in Connecticut and outside the state to address obesity.
- **Coordinate grant applications.** There is federal money available to address obesity from a number of agencies and Connecticut has the potential to obtain significant federal funds if we can coordinate our efforts.
- **Guide state administrative and legislature policy.** As the task force learned, there are dozens of different policy strategies that have been introduced nationally. The White House Task Force Report lists over 70 recommendations. One critical role of the Council will be to sift through this information and strategically choose appropriate measures for Connecticut based on our needs and resources.

Recommendation #2: Statewide Surveillance of Key Health Indicators

One of the guiding principles of the Task Force is Results Based Accountability. In order to examine the impact of obesity related policies, we need accurate and ongoing assessments of the outcome variables, namely obesity rates. Most researchers acknowledge that while the ultimate goal is to decrease the prevalence of obesity within a population, it is highly unlikely that any one initiative will result in a statistically significant decrease in the short term. Therefore, it is critical to have not only this long-term outcome, but also several more proximal outcomes that are assessed regularly. Levels of physical activity and eating behaviors are the most relevant variables. The DPH has access to data collected by the CDC on both adults, through the Behavioral Risk Factor Surveillance System (<http://www.cdc.gov/brfss/index.htm>) and children, through the Youth Risk Behavior Surveillance System (<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>). These national surveys will provide a general index of these behaviors for our state and will allow us to compare progress with other states. It will be important that DPH obtain adequate support from schools to ensure that a representative sample is obtained for data collection.

In order to have the best data on childhood obesity rates within the state, we recommend that electronic health data reported to a statewide HIE or other statewide entity include children's BMI, and that the resultant data become a resource for researchers and health status monitors. There have been previous legislative efforts to require statewide collection of BMI data from students. The Task Force spent considerable time discussing the complicated issues regarding confidentiality, appropriate use and other concerns with this type of initiative. We recommend that the CT State Department of Education (SDE) add BMI data as a health index to the state database that is kept on all students. The SDE would be the only agency with access to the identified data, but de-identified data could be shared with other agencies, especially DPH to be added to state level tracking of chronic disease and other important health indices.

Ideally, the SDE database would include other key health indicators such as (a) food security, (b) dietary quality, and (c) physical fitness. Fortunately, fitness is already measured and reported in this database. Other possible indicators are: (a) diabetes, (b) tobacco use, and (c) an index of cardiovascular health (blood pressure). The possibility of streamlining data collection and including asthma in this database, instead of the current system of reporting asthma directly to the DPH, should be discussed.

This database could be used to create an online tracking system (similar to the SDE's school profiles) to monitor changes at the district and school level. It can be used to inform decisions about grant funding, services, and strategic economic incentives. State-level surveillance of key environmental factors that are documented as important predictors of health may be tracked as well. These include adequate nutritious food access, physical activity access, and the strength of policies that promote access to nutrition and physical activity.

Timeline: Summer 2010 – Determine whether the legislature must approve collecting these data, or whether the Commissioners of Education and Public Health can decide to implement this program. Fall 2010 – Determine the technical needs.

Cost: \$500,000 one time cost for new computers and software for any school nurses who do not currently have them. \$100,000 annually for one research position shared between SDE and DPH to analyze the data and connect it with local policies and programs.

Impact: The ability to track rates of overweight and obesity among children throughout the state in an ongoing manner. Will permit the use of RBA for all state programs and will allow tracking of racial and ethnic disparities over time.

Measurable indicators for RBA:

1. Baseline rates of overweight and obesity throughout the state
2. Findings reported on how these rates change over time and are linked to local initiatives

Recommendation #3: Promoting Best Practices Among Health Professionals

Health professionals are on the front line in the effort to decrease obesity; however, many clinicians feel that they do not have the tools and resources to do the best job possible. In reviewing some of the recent literature, certain trends have been noted. First, while there is increasing awareness of childhood obesity, there is also a persistent belief that effective treatment options are limited. The Journal of the American Board of Family Medicine¹⁹ conducted a survey of Family Physicians and found that while 71% were familiar with BMI measurements, only 41% knew the current recommendations for overweight. Further, only 45% calculate BMI at every well child visit >2 years of age. Of concern, only 45% of physicians that counseled families felt the counseling was effective and <55% knew of resources to aid in overweight management.

In Connecticut, there is a need to provide support and resources to health professionals throughout the state to help them address obesity for both adults and children. There are individual clinics around the state that provide group cognitive-behavioral therapy, nutrition education, physical activity, and family support designed to help treat obesity, but the insurance coverage for this treatment is inconsistent and availability is limited due to cost constraints. Sustinet can help overcome these barriers by forming a network of health professionals to track the available treatments and programs, communicate throughout the state through state-wide groups such as the CT chapters of the American Academy of Pediatrics and the American Academy of Family Practice, help track the outcomes from programs throughout the state and provide adequate insurance coverage for empirically validated treatments and programs.

Bariatric surgery is the only treatment for severe obesity with good long-term weight loss outcomes. The Proceedings of the Nutrition Society journal reports that non-surgical medical therapy for severely obese children produces no more than 10% weight loss and surgery for childhood obesity “remains the only effective therapy. Bariatric surgery is cost effective, and health providers should embrace the development and rapid expansion of services.”²⁰ At present, there is no mortality reported occurring from adolescent bariatric surgery. There are several options including gastric sleeve, laparoscopic banding, and roux-en Y gastric bypass. Most surgical procedures boast a 70% reduction in excess weight loss at 5 years. All procedures cause dramatic improvement in co-morbidities.²¹ Originally, the recommendations for the requirements for adolescent surgery were conservative and much stricter than the NIH guidelines for adults; recently however, a movement has been made to utilize the same criteria for adolescents as adults.²²

While the Task Force acknowledges that adolescent bariatric surgery is an extreme measure compared to other types of obesity treatment, we feel that Sustinet should carefully consider coverage for adolescent bariatric surgery. There is evidence that early surgical intervention will save money from future co-morbidities. Coverage is also necessary for concurrent supportive treatment: nutritional support, physical therapy, psychological support for the adolescent and the family, and social services. Currently Medicaid and Husky programs do not adequately cover these services. Typically Medicaid will not reimburse for ongoing nutritional support especially for children who are “only” overweight. An optimal solution would be to negotiate package rates with payers, which would cover all of the services necessary to optimally treat these adolescents. Surgical intervention needs to be covered including cost of the devices (i.e., band) and early referral to centers performing these procedures should be advocated.

Specific recommendations:

- Create and maintain a database of treatment options throughout the state for use by health professionals and consumers. This can include educational tools (e.g., videos for families, toolkits for office providers), and a “hotline” for an initial family consultation with an expert on community resources who can connect the family with local programs and providers.
- Develop model of care for children that uses empirically supported treatments.
- Ensure that physicians and patients know what treatments are already covered under all plans. Some private plans do have coverage for obesity treatment, but patients and physicians may not be aware of what coverage they have.
- Ensure that Sustinet adequately covers all empirically supported components of obesity treatment for children and adults, including nutritional counseling, parent education (especially for early childhood years), and long-term support for bariatric surgery patients and others who have achieved weight loss. Coordinate efforts to obtain insurance coverage from other companies in the state.
- Fund a peer education network for pediatricians as a two-year pilot program at \$130,000 per year. Assess impact on level of care received by patients and weight status of patients after two years.
- Expand efforts to promote and sustain breastfeeding. Connecticut’s support for breastfeeding is evident through legislation that creates workplace protections for women to express milk and to breastfeed as needed. In 2006, the percentage of children ever breastfed in CT was 75%, just above the US average of 74%. The percentage of babies breastfed through three months was 35% in CT compared to 22% across the country. Connecticut’s performance against Healthy People 2010 targets for initiating breastfeeding is encouraging, but continuing support is needed to increase rates at three and six months.
- Support hospitals’ efforts to obtain a *Baby Friendly Hospital Initiative*. The BFHI designation is the “gold standard” for hospital practices that support breastfeeding. Hospitals must demonstrate compliance with standards for staff training, written policies and procedures; and lactation initiation,

counseling and support. Three Connecticut hospitals have achieved this designation.²³

- In collaboration with state or national obstetrics and nutrition experts, create and disseminate best practices for obese pregnant women. These recommendations would provide practical recommendations for maternal health providers about strategies to address the links between obesity and poor birth outcomes, as well as long-term health implications for the mother and, according to emerging research, for the child as well. Sustinet should cover prenatal education services generally and ensure that service areas include motivational counseling about nutrition and prenatal exercise.

Recommendation #4: Improve the nutrition environment in schools and day care facilities

1. Breakfast promotion:

- a. In-school breakfast should be provided in any school that has 40% or more free/reduced lunch students. State funding is needed to support this. The proposed Institute of Medicine standards for school breakfast should be used to ensure that this meal does not add excess sugar and fat to children's diets.
- b. Social media campaign to promote breakfast in schools and at home.

2. Healthy Food Certification

40% of districts have not yet participated in this program. The State Department of Education (SDE) should contact the school board in each non-participating district; reiterate the potential funding increment, and request information on why the district chose not to participate.

3. School Wellness Policies

Hire researchers for SDE to work with school districts to re-evaluate their school wellness policies and provide "report cards" for the districts and the public.

4. Improve childcare environment

- a. Coordinate efforts between SDE and DPH to strengthen Child and Adult Care Food Program (CACFP) standards to meet New York State's new standards, and ensure implementation through licensing and state monitoring.

- b. Require limits on the use of video and computer screens in all licensed child care facilities per the American Academy of Pediatrics guidelines: under 2 years old – no screen time; over 2 years old – no more than 2 hours a day.

5. After-school programs

- a. Identify policy levers to improve access and quality of after school programs.
- b. Promote joint-use agreements between schools and community groups to increase the availability of space for physical activity for children in the afternoons and evenings.

6. Require daily PE in K-12

- a. Review the policies and procedures recommended by the National Association for Sports and Physical Education and learn from the experience of Pennsylvania, which passed legislation in 2010 requiring PE.

Recommendation #5: Reduce Unhealthy Food Marketing to Children

Many national groups are attending closely to the problem of unhealthy food marketing directed at children. The Institute of Medicine has created reports on this topic and the food industry has created initiatives to self-regulate food marketing to children. The effectiveness of this self-regulation is questionable, due to the fact that the food industry itself is defining “healthy food” and “child-directed marketing” so loosely that it allows for the status quo to continue in many cases.

One policy recommendation is to determine that schools are “ad free” zones and unhealthy food marketing is not permitted to occur on the school grounds at any time. This would entail removing scoreboards that have branded soft drink or fast food logos, removing book covers or other school supplies that have branded logos or ads, and would require any fundraising or gift certificates distributed in schools to be for only healthy products.

Another strategy that has been introduced in Santa Clara California is requiring restaurants to only market healthy foods to children through the inclusion of toys and games in meals. In practical terms, this means that in order to get the toy with a kid’s meal, the meal must meet certain nutrition standards.

VI. FUNDING OPPORTUNITIES

In the case of obesity, a penny of prevention is worth a pound of cure. The general fund should be used to promote key prevention policies in the state. There are state agencies that are already getting state funding to prevent and treat obesity. Result-

based accountability methods should be used to determine what the state is achieving with these dollars.

The proposed permanent Council on Child and Adult Obesity should track the availability of federal grants through USDA and CDC. With the recent announcement by First Lady Michelle Obama that childhood obesity is her priority, we expect increased availability of funding for community initiatives.

Centers for Disease Control and Prevention

At the present time, one source of potential funding is the CDC, which funds a number of states to implement state obesity plans. We recommend that one of the first actions of the Council is to work with the Department of Public Health to create a competitive application for this funding.

United States Department of Agriculture

In April 2010, the USDA announced the availability of \$11 million in grants through NIFA's Agriculture and Food Research Initiative Human Nutrition and Obesity program to develop effective obesity prevention strategies along with behavioral and environmental instruments for measuring progress in obesity prevention efforts. The program also promotes strategies for preventing weight gain and obesity.

Sugar sweetened beverage tax

A controversial, but innovative strategy to raise revenue for obesity related state initiatives is an excise tax on sugar-sweetened beverages. Recent data indicates that Connecticut adults drink on average 1.5 soft drinks and fruit drinks per day, summing to 255 million gallons each year – or 72.2 gallons per person, including 48.8 gallons of sugar-sweetened beverages (SSBs).²⁴ A state excise tax of one penny per ounce on SSB would decrease consumption by about 23%.²⁵ With a state excise penny-per-ounce tax on SSBs, which is approximately a 20% increase in current prices, SSB consumption in Connecticut is predicted to go down in 2010 to 134.7 million gallons, or 37.6 gallons of SSB intake per capita.²⁶ Tax revenues from a penny-per-ounce tax on these beverages in Connecticut over 2010-2012 would be \$523 million and over 2010-2015 would be \$1.06 billion.²⁷

Research on public opinion about SSB taxes indicate that when people know the revenue will be used for health promotion, the majority of individuals are in favor of the tax. There are many possibilities for the use of this revenue, but one that is particularly appealing is to use the money to provide state matched funds for federal grants. That would be an effective way to leverage this funding and ensure that it is used to promote health in the state.

Appendix A

Presentations before the Task Force on Adult and Childhood Obesity:

Shaping a Healthier Generation: Successful State Strategies to Prevent Childhood Obesity. (National Governors Association Center for Best Practices)
<http://www.nga.org/Files/pdf/0909HEALTHIERGENERATION.PDF>

Local Government Actions to Prevent Childhood Obesity (Institute of Medicine)

Lynn Parker, Annina Catherine Burns, and Eduardo Sanchez, Editors; Committee on Childhood Obesity Prevention Actions for Local Governments; Institute of Medicine; National Research Council
http://www.nap.edu/catalog.php?record_id=12674#

Connecticut Obesity Council's work on childhood obesity and state policy

Thomas Brooks, Connecticut Commission of Children

Connecticut Department of Public Health Obesity initiatives

Mario Garcia, CT DPH

Current and Future Policy Options for Connecticut

Marlene Schwartz, Rudd Center for Food Policy and Obesity

Girl Scouts initiatives re: childhood obesity and health

Jennifer Smith-Turner, President, Girl Scouts of Connecticut

Local program in Danbury re: childhood obesity

Andrea Rynn, Danbury Hospital

ConneCTing with Families initiative and the Fit for Kids pilot program

ConneCTing is a collaboration among pediatric primary care providers to adopt obesity prevention and intervention guidelines/best practices. Fit for Kids was a 2 year pilot program funded by CHDI to determine the feasibility of a pediatric obesity intervention

Cliff O'Callahan, MD, PhD, Director of Nurseries and Family Practice Residency Program at Middlesex Hospital.

http://www.ct.gov/SustiNet/lib/SustiNet/taskforces/obesitytaskforce/connecting_with_families_for_a_healthier_future_fin.pdf

Federal Nutrition Programs Overview

Lucy Nolan, End Hunger Connecticut!

http://www.ct.gov/SustiNet/lib/SustiNet/taskforces/obesitytaskforce/SustiNet_obesity_task_force.pdf

Corner Market and Healthy Food Initiative

Katie Martin, UConn School of Public Health

http://www.ct.gov/SustiNet/lib/SustiNet/taskforces/obesitytaskforce/obesity_task_force_feb_2010.pdf

Connecticut Food Policy Council

Linda Drake, UConn Expanded Food and Nutrition Assistance Program

Chair, CT Food Policy Council

http://www.ct.gov/SustiNet/lib/SustiNet/taskforces/obesitytaskforce/connecticut_2010_linda_drake.pdf

Appendix B

Comparison of a Program to a Policy

Program	Policy
One time	Permanent (as long as law isn't overturned)
Limited reach	Universal reach to everyone
Experimental, not evaluated	Evidence-based
	Can have ripple effect—local becomes state law becomes federal
Doesn't provide default change	Creates optimal default
Focus on personal responsibility	Focus on environmental change
Medical model	Public health model, prevention
Easier buy-in, feel-good	Political, controversial
Not sustainable	Sustainable? Unfunded mandate?
More immediate results	May take years to establish
Often less political	May challenge societal values of individual freedom, e.g. soda tax

Appendix C:
Recommendations from 2008 Statewide Forum.

Endnotes

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- ² Id.
- ³ Id.
- ⁴ Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF), *F as in Fat: How Obesity Threatens America's Future 2010*, Washington, DC, June 29, 2010 <http://healthyamericans.org/reports/obesity2010/release.php?stateid=CT>
- ⁵ Centers for Disease Control and Prevention (CDC). YRBSS: Youth Risk Behavior Surveillance System. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1999-2007 <http://www.cdc.gov/HealthyYouth/yrbs/index.htm>.
- ⁶ Finkelstein E, Fiebelkorn I, Wang G. 2004. State-level estimates of annual medical expenditures attributable to obesity". *Obesity Research* 12(1):18-24.
- ⁷ Finkelstein E, Fiebelkorn I, Wang G. 2004. "State-level estimates of annual medical expenditures attributable to obesity." *Obesity Research* 12(1):18-24.
- ⁸ Swinburn, B., Sacks, G., and Ravussin, E. 2009. Increased food energy supply is more than sufficient to explain the US epidemic of obesity. *American Journal of Clinical Nutrition*.
- ⁹ Centers for Disease Control and Prevention. *Physical Activity, Physical Education, and Academic Performance: A Review of the Literature*. Atlanta, GA: U.S. Department of Health and Human Services; 2010.
- ¹⁰ USDA Food and Nutrition Service. Supplemental Nutrition Assistance Program. Annual state level data. Persons participating and average monthly benefits. Available at <http://www.fns.usda.gov/pd/snapmain.htm>.
- ¹¹ USDA Food and Nutrition Service. WIC Program. Annual state level data. Total participation and food costs. Available at <http://www.fns.usda.gov/pd/wicmain.htm>.
- ¹² Food and Nutrition Service, USDA WIC Farmers' Market Nutrition Program (FMNP). <http://www.fns.usda.gov/wic/FMNP/FMNP2008.htm>
- ¹³ Connecticut Department of Social Services. A list of farmers' markets in CT accepting EBT/SNAP benefits is available at: <http://www.ct.gov/dss/cwp/view.asp?a=2345&q=315396>
- ¹⁴ Food Research and Action Center's 2009 School Breakfast Report Card, <http://www.frac.org/pdf/breakfast09.pdf>
- ¹⁵ www.endhungerct.org
- ¹⁶ http://www.sde.ct.gov/sde/LIB/sde/pdf/deps/Nutrition/SFSP/SFSP_Report.pdf
- ¹⁷ Wansink, B. *Mindless Eating*.
- ¹⁸ Austin SB, Field AE, Wiecha J, Peterson KE, Gortmaker SL. The impact of a school-based obesity prevention trial on disordered weight-control behaviors in early adolescent girls. *Arch Pediatr Adolesc Med*. 2005;159(3):225-230; Austin SB, Kim J, Wiecha J, Troped PJ, Feldman HA, Peterson KE. School-based overweight preventive intervention lowers incidence of disordered weight-control behaviors in early adolescent girls. *Arch Pediatr Adolesc Med*. 2007;161(9):865-869.; Neumark-Sztainer D. Can we simultaneously work toward the prevention of obesity and eating disorders in children and adolescents? *Int J Eat Disord*. 2005;38(3):220-227; Neumark-Sztainer D. Preventing obesity and eating disorders in adolescents: What can health care providers do? *J Adolesc Health*. 2009. 44:206-213; and Schwartz, M.B. & Henderson, K.A. (2009). Does obesity prevention cause eating disorders? *Journal of the Academy of Adolescent and Adult Psychiatry*. 48, 784-786

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²⁰ Proc Nutr Soc. 2010 May 4:1-8.

²¹ Surg Obes Relat Dis. 2005 Jul-Aug;1(4):399-405; discussion 405-7.

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²⁵ Yale Rudd Center Revenue Calculator for Soft Drink Taxes. Available at <http://www.yaleruddcenter.org/sodatax.aspx>.

²⁶ Id.

²⁷ Id.

APPENDIX B

Jonathan Gruber, Ph.D.

Microsimulation Model Summary

Short Description of Gruber Microsimulation Model

The model allows the user to input a set of policy parameters, and output the impact of that policy on public sector costs and the distribution of insurance coverage. The modeling approach used here is the type of “microsimulation” modeling used by the Treasury Department, CBO, and other government entities. This approach consists of drawing on the best evidence available in the health economics literature to model how individuals will respond to the changes in the insurance environment induced by changes in government policy.

The model takes as its base the February and March Current Population Surveys. The March survey contains information on family demographics, tax rates, and insurance coverage. The February survey contains information on insurance offering by employers. I match to these surveys information on:

- Group insurance costs and the distribution of premiums across employers and employees, imputed by firm location and firm size;
- Nongroup insurance costs, which use a base cost estimated from existing nongroup insurance pricing, adjusted by age, sex, and health status;
- Public insurance costs; and
- Underlying health care costs, which are imputed by age and health status.

This base set of data is then used to compute, for every possible policy change, the impact of that policy change on the eligibility for, and price of, various types of insurance. These price and eligibility changes are then run through a detailed and integrated set of behavioral equations that relate them to behavioral responses by individuals, families, and firms. These behavioral responses are modeled using the best available evidence from the health economics literature, and include responses such as:

- The extent to which the currently uninsured will purchase newly subsidized insurance coverage or take up newly available public coverage;
- The extent to which those with existing insurance coverage will take up subsidies to that type of insurance coverage (e.g. to what extent will the nongroup insured take up subsidies to nongroup insurance?);
- The extent to which those with one form of insurance coverage will switch to another form if it is subsidized;
- The extent to which firms will react to the subsidies to non-employer insurance by dropping their offering of insurance to their employees, or by cutting back on employer premium contributions to insurance; and
- The extent to which those employees dropped from group coverage will then take up other forms of insurance coverage.

It is very important to model potential firm responses to these policy changes. To capture firm responses, I have created “synthetic” firms in the CPS by drawing for each worker other “co-workers” in the CPS based on that worker’s wage, industry, firm size, and health insurance offering status. These synthetic co-workers are grouped together to form firms, and I then model firm responses based on the average effects of policies on their workforce.

APPENDIX C

SustiNet Legislative Cross-Walk

Substitute House Bill No. 6600

Public Act No. 09-148

AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN

Crosswalk To Report	Section	Statute
		Be it enacted by the Senate and House of Representatives in General Assembly convened:
Definitions: No action required	1	Section 1. (NEW) (Effective July 1, 2009) As used in sections 1 to 14, inclusive, of this act and section 17b-297b of the general statutes, as amended by this act: (1) "SustiNet Plan" means a self-insured health care delivery plan, that is designed to ensure that plan members receive high-quality health care coverage without unnecessary costs;
Benefits	1	(2) "Standard benefits package" means a set of covered benefits as determined by the public authority, with out-of-pocket cost-sharing limits and provider network rules, subject to the same coverage mandates described in chapter 700c of the general statutes and the utilization review requirements described in chapter 698a of the general statutes that apply to group health insurance sold in this state. The standard benefits package includes, but is not limited to, the following: (A) Coverage of medical home services; inpatient and outpatient hospital care; generic and name-brand prescription drugs; laboratory and x-ray services; durable medical equipment; speech, physical and occupational therapy; home health care; vision care family planning; emergency transportation; hospice; prosthetics; podiatry; short-term rehabilitation; the identification and treatment of developmental delays from birth through age three; and wellness programs, provided convincing scientific evidence demonstrates that such programs are effective in reducing the severity or incidence of chronic disease; (B) A per individual and per family deductible, provided preventive care or prescription drugs shall not be subject to any deductible; (C) Preventive care requiring no copayment that includes well-child visits, well-baby care, prenatal care, annual physical examinations, immunizations and screenings; (D) Office visits for matters other than preventive care for which there shall be a copayment; (E) Prescription drug coverage with copayments for generic, name-brand preferred and name-brand nonpreferred drugs; (F) Coverage of mental and behavioral health services, including tobacco

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		<p>cessation services, substance abuse treatment services, and services that prevent and treat obesity with such services being at parity with the coverage for physical health services; and</p> <p>(G) Dental care coverage that is comparable in scope to the median coverage provided to employees by large employers in the Northeast states; provided, in defining large employers, consideration shall be given to the capacity of available data to yield, without substantial expense, reliable estimates of median dental coverage offered by such employers;</p>
<p>Definitions:</p> <p>No action required</p>	1	<p>(3) "Electronic medical record" means a record of a person's medical treatment created by a licensed health care provider and stored in an interoperable and accessible digital format;</p> <p>(4) "Electronic health record" means an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed and consulted by authorized clinicians and staff across more than one health care organization;</p> <p>(5) "Northeast states" means the Northeast states as defined by the United States Census Bureau;</p> <p>(6) "Board of directors" means the Sustinet Health Partnership board of directors established pursuant to section 2 of this act;</p> <p>(7) "Public authority" means a public authority or other entity recommended by the Sustinet Health Partnership board of directors in accordance with the provisions of subsection (b) of section 3 of this act;</p> <p>(8) "Small employer" has the same meaning as provided in subparagraph (A) of subdivision (4) of section 38a-564 of the general statutes; and</p> <p>(9) "Nonstate public employer" means a municipality or other political subdivision of the state, including a board of education, quasi-public agency or public library.</p>
<p>Establishes Board of Directors:</p> <p>No action required</p>	2	<p>Sec. 2. (NEW) (Effective July 1, 2009)</p> <p>(a) There is established the Sustinet Health Partnership board of directors. The board of directors shall consist of nine members, as follows: The Comptroller; the Healthcare Advocate; one appointed by the Governor, who shall be a representative of the nursing or allied health professions; one appointed by the president pro tempore of the Senate, who shall be a primary care physician; one appointed by the speaker of the House of Representatives, who shall be a representative of organized labor; one appointed by the majority leader of the Senate, who shall have expertise in the provision of employee health benefit plans for small businesses; one appointed by the majority leader of the House of Representatives, who shall have expertise in health care economics or health care policy; one appointed by the minority leader of the Senate, who shall have</p>

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		<p>expertise in health information technology; and one appointed by the minority leader of the House of Representatives, who shall have expertise in the actuarial sciences or insurance underwriting. The Comptroller and the Healthcare Advocate shall serve as the chairpersons of the board of directors.</p> <p>(b) Initial appointments to the board of directors shall be made on or before July 15, 2009. In the event that an appointing authority fails to appoint a board member by July 31, 2009, the president pro tempore of the Senate and the speaker of the House of Representatives shall jointly appoint a board member meeting the required specifications on behalf of such appointing authority and such board member shall serve a full term. The presence of not less than five members shall constitute a quorum for the transaction of business. The initial term for the board member appointed by the Governor shall be for two years. The initial term for board members appointed by the minority leader of the House of Representatives and the minority leader of the Senate shall be for three years. The initial term for board members appointed by the majority leader of the House of Representatives and the majority leader of the Senate shall be for four years. The initial term for the board members appointed by the speaker of the House of Representatives and the president pro tempore of the Senate shall be for five years. Terms pursuant to this subdivision shall expire on June thirtieth in accordance with the provisions of this subdivision. Any vacancy shall be filled by the appointing authority for the balance of the unexpired term. Not later than thirty days prior to the expiration of a term as provided for in this subsection, the appointing authority may reappoint the current board member or shall appoint a new member to the board. Other than an initial term, a board member shall serve for a term of five years and until a successor board member is appointed. A member of the board pursuant to this subdivision shall be eligible for reappointment. Any member of the board may be removed by the appropriate appointing authority for misfeasance, malfeasance or willful neglect of duty.</p> <p>(c) The Sustinet Health Partnership board of directors shall not be construed to be a department, institution or agency of the state. The staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall provide administrative support to the board of directors.</p>
<p>Overall Design:</p> <p>Addressed in the Board's, Advisory Committees' and Task Forces' recommendations</p>	3	<p>Sec. 3. (NEW) (Effective July 1, 2009)</p> <p>(a) The Sustinet Health Partnership board of directors shall design and establish implementation procedures to implement the Sustinet Plan. The Sustinet Plan shall be designed to (1) improve the health of state residents; (2) improve the quality of health care and access to health care; (3) provide health insurance coverage to Connecticut residents who would otherwise be uninsured; (4) increase the range of health care insurance coverage options available to residents and employers; (5) slow the growth of per capita health care spending both in the short-</p>

Crosswalk To Report	Section	Statute
		term and in the long-term; and (6) implement reforms to the health care delivery system that will apply to all Sustinet Plan members, provided any such reforms to health care coverage provided to state employees, retirees and their dependents shall be subject to applicable collective bargaining agreements.
Governance and Location within State Government	3	(b) The Sustinet Health Partnership board of directors shall offer recommendations to the General Assembly on the governance structure of the entity that is best suited to provide oversight and implementation of the Sustinet Plan. Such recommendations may include, but need not be limited to, the establishment of a public authority authorized and empowered:
Administrative Duties and Responsibilities of the Authority		(1) To adopt guidelines, policies and regulations in accordance with chapter 54 of the general statutes that are necessary to implement the provisions of sections 1 to 14, inclusive, of this act;
Administrative Duties		(2) To contract with insurers or other entities for administrative purposes, such as claims processing and credentialing of providers. Such contracts shall reimburse these entities using "per capita" fees or other methods that do not create incentives to deny care. The selection of such insurers or other entities may take into account their capacity and willingness to (A) offer timely networks of participating providers both within and outside the state, and (B) help finance the administrative costs involved in the establishment and initial operation of the Sustinet Plan;
Administrative Duties		(3) To solicit bids from individual providers and provider organizations and to arrange with insurers and others for access to existing or new provider networks, and take such other steps to provide all Sustinet Plan members with access to timely, high-quality care throughout the state and, in appropriate cases, care that is outside the state's borders;
Administrative Duties		(4) To establish appropriate deductibles, standard benefit packages and out-of-pocket cost sharing levels for different providers, that may vary based on quality, cost, provider agreement to refrain from balance billing Sustinet Plan members, and other factors relevant to patient care and financial sustainability;
Administrative Duties		(5) To commission surveys of consumers, employers and providers on issues related to health care and health care coverage;
Administrative Duties		(6) To negotiate on behalf of providers participating in the Sustinet Plan to obtain discounted prices for vaccines and other health care goods and services;
Administrative Duties		(7) To make and enter into all contracts and agreements necessary or incidental to the performance of its duties and the execution of its powers under its enabling legislation, including contracts and agreements for such professional services as financial consultants, actuaries, bond

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		counsel, underwriters, technical specialists, attorneys, accountants, medical professionals, consultants, bio-ethicists and such other independent professionals or employees as the board of directors shall deem necessary;
Administrative Duties		(8) To purchase reinsurance or stop loss coverage, to set aside reserves, or to take other prudent steps that avoid excess exposure to risk in the administration of a self-insured plan;
Administrative Duties		(9) To enter into interagency agreements for performance of Sustinet Plan duties that may be implemented more efficiently or effectively by an existing state agency;
Reforming Health Care Delivery and Payment		(10) To set payment methods for licensed health care providers that reflect evolving research and experience both within the state and elsewhere, promote access to care and patient health, prevent unnecessary spending, and ensure sufficient compensation to cover the reasonable cost of furnishing necessary care;
Policy-Making Duties and Responsibilities of the Authority Board		(11) To appoint such advisory committees as may be deemed necessary for the public authority to successfully implement the Sustinet Plan, further the objectives of the public authority and secure necessary input from various experts and stakeholder groups;
Established by current board		(12) To establish and maintain an Internet web site that provides for timely posting of all public notices issued by the public authority or the board of directors and such other information as the public authority or board deems relevant in educating the public about the Sustinet Plan;
Included in federal ACA		(13) To evaluate the implementation of an individual mandate in concert with guaranteed issue, the elimination of preexisting condition exclusions, and the implementation of auto-enrollment;
Administrative Duties		(14) To raise funds from private and public sources outside of the state budget to contribute toward support of its mission and operations;
Administrative Duties		(15) To make optimum use of opportunities created by the federal government for securing new and increased federal funding, including, but not limited to, increased reimbursement revenues;
Submitted report		(16) In the event of the enactment of federal health care reform, to submit preliminary recommendations for the implementation of the Sustinet Plan to the General Assembly not later than sixty days after the date of enactment of such federal health care reform; and
Included in federal ACA		(17) To study the feasibility of funding premium subsidies for individuals with income that exceeds three hundred per cent of the federal poverty level but does not exceed four hundred per cent of the federal poverty level.

Crosswalk To Report	Section	Statute
<p>Direction to submit this report</p> <p>In process</p>	3	<p>(c) Not later than January 1, 2011, the Sustinet Health Partnership board of directors shall submit its design and implementation procedures in the form of recommended legislation to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and finance, revenue and bonding.</p> <p>(d) All state and municipal agencies, departments, boards, commissions and councils shall fully cooperate with the board of directors in carrying out the purposes enumerated in this section.</p>
<p>Overall Design:</p> <p>Addressed in the Board's, Advisory Committees' and Task Forces' recommendations</p> <p>In process</p> <p>Policy-Making Duties and Responsibilities</p>	4	<p>Sec. 4. (NEW) (Effective July 1, 2009)</p> <p>(a) The board of directors shall develop the procedures and guidelines for the Sustinet Plan. Such procedures and guidelines shall be specific and ensure that the Sustinet Plan is established in accordance with the five following principles to guide health care reform as enumerated by the Institute of Medicine: (1) Health care coverage should be universal; (2) health care coverage should be continuous; (3) health care coverage should be affordable to individuals and families; (4) the health insurance strategy should be affordable and sustainable for society; and (5) health care coverage should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered and equitable.</p> <p>(b) The board of directors shall identify all potential funding sources that may be utilized to establish and administer the Sustinet Plan.</p> <p>(c) The board of directors shall recommend that the public authority adopt periodic action plans to achieve measurable objectives in areas that include, but are not limited to, effective management of chronic illness, preventive care, reducing racial and ethnic disparities as related to health care and health outcomes, and reducing the number of state residents without insurance. The board of directors shall include in its recommendations that the public authority monitor the accomplishment of such objectives and modify action plans as necessary.</p>
<p>Information Technology Advisory Committee Recommendations</p>	5	<p>Sec. 5. (NEW) (Effective July 1, 2009)</p> <p>(a) For purposes of this section: (1) "Subscribing provider" means a licensed health care provider that: (A) Either is a participating provider in the Sustinet Plan or provides services in this state; and (B) enters into a binding agreement to pay a proportionate share of the cost of the goods and services described in this section, consistent with guidelines adopted by the board; and (2) "approved software" means electronic medical records software approved by the board, after receiving recommendations from the information technology committee, established pursuant to this section.</p> <p>(b) The board of directors shall establish an information technology advisory</p>

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	5	<p>committee that shall formulate a plan for developing, acquiring, financing, leasing or purchasing fully interoperable electronic medical records software and hardware packages for subscribing providers. Such plan shall include the development of a periodic payment system that allows subscribing providers to acquire approved software and hardware while receiving the services described in this section. The committee shall offer recommendations on matters that include, but are not limited to:</p> <p>(1) The furnishing of approved software to subscribing providers and to participating providers, as the case may be, consistent with the capital acquisition, technical support, reduced-cost digitization of records, software updating and software transition procedures described in this section; and (2) the development and implementation of procedures to ensure that physicians, nurses, hospitals and other health care providers gain access to hardware and approved software for interoperable electronic medical records and the establishment of electronic health records for Sustinet Plan members.</p> <p>(c) The committee shall consult with health information technology specialists, physicians, nurses, hospitals and other health care providers, as deemed appropriate by the committee, to identify potential software and hardware options that meet the needs of the full array of health care practices in the state. Any electronic medical record package that the committee recommends for future possible purchase shall include, to the maximum extent feasible: (1) A full set of functionalities for pertinent provider categories, including practice management, patient scheduling, claims submission, billing, issuance and tracking of laboratory orders and prescriptions; (2) automated patient reminders concerning upcoming appointments; (3) recommended preventive care services; (4) automated provision of test results to patients, when appropriate; (5) decision support, including a notice of recommended services not yet received by a patient; (6) notice of potentially duplicative tests and other services; (7) in the case of prescriptions, notice of potential interactions with other drugs and past patient adverse reactions to similar medications; (8) notice of possible violation of patient wishes for end-of-life care; (9) notice of services provided inconsistently with care guidelines adopted pursuant to section 8 of this act, along with options that permit the convenient recording of reasons why such guidelines are not being followed; and (10) such additional functions as may be approved by the information technology committee.</p> <p>(d) The committee shall offer recommendations on the procurement and development of approved software. Such recommendations may include that any approved software have the capacity to: (1) Gather information pertinent to assessing health care outcomes, including activity limitations, self-reported health status and other quality of life indicators; and (2) allow the board of directors to track the accomplishment of clinical care objectives at all levels. The board of directors shall ensure that Sustinet Plan providers who use approved software are able to electronically transmit to, and receive information from, all laboratories and pharmacies participating in the Sustinet Plan, without the need to</p>

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	5	<p>construct interfaces, other than those constructed by the public authority.</p> <p>(e) The committee shall offer recommendations on the selection of vendors to provide reduced-cost, high-quality digitization of paper medical records for use with approved software. Such vendors shall be bonded, supervised and covered entities under the provisions of the Health Insurance Portability and Accountability Act of 1996 (P. L. 104 191) (HIPAA), as amended from time to time, and in full compliance with other governing federal law.</p> <p>(f) The committee shall offer recommendations on an integration system through which electronic medical records used by subscribing providers are integrated into a single electronic health record for each Sustinet Plan member, updated in real time whenever the member seeks or obtains care, and accessible to any participating or subscribing provider serving the member. Such electronic health record shall be designed to automatically update approved software. Such updates may include incorporating newly approved clinical care guidelines, software patches or other changes.</p> <p>(g) All recommendations concerning electronic medical records and electronic health records shall be developed and administered in a manner that is consistent with guidelines approved by the board of directors for safeguarding privacy and data security and with state and federal law, including any recommendations of the United States Government Accountability Office. Such guidelines shall include the remedies and sanctions that apply in the event of a provider's failure to comply with privacy or information security requirements. Remedies shall include notice to affected members and may include, in appropriate cases, termination of network privileges and denial or reduction of Sustinet Plan reimbursement. Remedies and sanctions recommended by the board of directors shall be in addition to those otherwise available under state or federal law.</p> <p>(h) The committee shall develop recommended methods to eliminate or minimize transition costs for health care providers that, prior to January 1, 2011, have implemented comprehensive systems of electronic medical records or electronic health records. Such methods may include technical assistance in transitioning to new software and development of modules to help existing software connect to the integration system described in subsection (i) of this section.</p> <p>(i) The committee shall offer recommendations that permit subscribing providers to receive a proportionate share of systemic cost savings that are specifically attributable to the implementation of electronic medical records and electronic health records. Such subscribing providers shall include those that, throughout the period of their subscription, have been participating providers in the Sustinet Plan and that, but for the savings shared pursuant to this subsection, would incur net financial</p>

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	5	<p>losses during their first five years of using approved software. The amount of savings shared by the board with a provider shall be limited to the amount of net financial loss satisfactorily demonstrated by the provider. A provider whose losses resulted from the provider's failure to take reasonable advantage of available technical support and other services offered by the public authority shall not share in the systemic cost savings.</p> <p>(j) The committee shall offer recommendations concerning the use of electronic health records to facilitate the provision of medical home functions as described in section 6 of this act. The committee shall recommend methods for such electronic health records to generate automatic notices to medical homes that: (1) Report when an enrolled member receives services outside the medical home; (2) describe member compliance or noncompliance with provider instructions, as relate to the filling of prescriptions, referral services, and recommended tests, screenings or other services; and (3) identify the expiration of refillable prescriptions.</p> <p>(k) The committee shall offer recommendations requiring: (1) That each participating provider use either approved software or other electronic medical record software that is interoperable with approved software and the electronic health record integration system described in subsection (f) of this section; (2) the development and implementation of appropriate financial incentives for early subscriptions by participating providers, including discounted fees for providers who do not delay their subscriptions; (3) that no later than July 1, 2015, the board of directors require as a condition of participation in the Sustinet Plan that each participating provider use either approved software or other electronic medical record software that is interoperable with approved software and the electronic health record integration system described in subsection (f) of this section; (4) that after July 1, 2015, the board of directors have authority to provide additional support to a provider that demonstrates to the satisfaction of the board that such provider would experience special hardship due to the implementation of electronic medical records and electronic health records requirements within the specified time frame; and (5) that such provider be allowed to qualify for additional support and an exemption from compliance with the time frame specified in this subsection, but only if such an exemption is necessary to ensure that members in the geographic locality served by the provider continue to receive access to care.</p> <p>(l) The committee shall recommend methods to coordinate the development and implementation of electronic medical records and electronic health records in concert with the Department of Public Health and other state agencies to ensure efficiency and compatibility. The committee shall determine appropriate financing options, including, but not limited to, financing through the Connecticut Health and Educational Facilities Authority established pursuant to section 10a-179 of the general statutes.</p>

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Medical Home Advisory Committee Recommendations	6	<p>Sec. 6. (NEW) (Effective July 1, 2009)</p> <p>(a) The board of directors shall establish a medical home advisory committee that shall develop recommended internal procedures and proposed regulations governing the administration of patient-centered medical homes that provide health care services to Sustinet Plan members. The medical home advisory committee shall forward their recommended internal procedures and proposed regulations to the board of directors in accordance with such time and format requirements as may be prescribed by said board. The medical home advisory committee shall be composed of physicians, nurses, consumer representatives and other qualified individuals chosen by said board.</p> <p>(b) Committee recommendations concerning patient-centered medical homes shall include that: (1) Medical home functions be defined by the board of directors on an ongoing basis that incorporates evolving research concerning the delivery of health care services; and (2) if limitations in provider infrastructure prevent all Sustinet Plan members from being enrolled in patient-centered medical homes, enrollment in medical homes be implemented in phases with priority enrollment given to members for whom cost savings appear most likely, including, in appropriate cases, members with chronic health conditions.</p> <p>(c) Subject to revision by the board of directors, the committee shall offer recommendations that initial medical home functions include the following:</p> <p>(1) Assisting members to safeguard and improve their own health by: (A) Advising members with chronic health conditions of methods to monitor and manage their own conditions; (B) working with members to set and accomplish goals related to exercise, nutrition, use of tobacco and other addictive substances, sleep, and other behaviors that directly affect such member's health; (C) implementing best practices to ensure that members understand medical instructions and are able to follow such directions; and (D) providing translation services and using culturally competent communication strategies in appropriate cases;</p> <p>(2) Care coordination that includes: (A) Managing transitions between home and the hospital; (B) proactive monitoring to ensure that the member receives all recommended primary and preventive care services; (C) the provision of basic mental health care, including screening for depression, with referral relationships in place for those members who require additional assistance; (D) strategies to address stresses that arise in the workplace, home, school and the community, including coordination with and referrals to available employee assistance programs; (E) referrals, in appropriate cases, to nonmedical services such as housing and nutrition programs, domestic violence resources and other support groups; and (F) for a member with a complex health condition that involves care from</p>
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		<p>multiple providers, ensuring that such providers share information about the member, as appropriate, and pursue a single, integrated treatment plan; and</p> <p>(3) Providing readily accessible, twenty-four-hour consultative services by telephone, secure electronic mail or quickly scheduled office appointments for purposes that include reducing the need for hospital emergency room visits.</p> <p>(d) The committee shall offer recommendations on entities that may serve as a medical home, including that: (1) A licensed health care provider be allowed to serve as a medical home if such provider is authorized to provide all core medical home functions as prescribed by the board and operationally capable of providing such functions; and (2) a group practice or community health center serving as a medical home identify, for each member, a lead provider with primary responsibility for the member's care. In appropriate cases, as determined by the board of directors, a specialist may serve as a medical home and a patient's medical home may temporarily be with a health care provider who is overseeing the patient's care for the duration of a temporary medical condition, including pregnancy.</p> <p>(e) The committee shall offer recommendations concerning the responsibilities of a medical home provider. Such recommendations shall include that: (1) Each medical home provider be presented with a listing of all medical home functions, including patient education, care coordination and twenty-four-hour accessibility; and (2) if a provider does not wish to perform, within his or her office, certain functions outside core medical home functions, such provider shall make arrangements for other qualified entities or individuals to perform such functions, in a manner that integrates such functions into the medical home's clinical practice. Such qualified entities or individuals shall be certified by the board of directors based on factors that include the quality, safety and efficiency of the services provided. At the request of a core medical home provider, the board of directors shall make all necessary arrangements required for a qualified entity or individual to perform any medical home function not assumed by the core provider.</p> <p>(f) The medical home advisory committee may develop quality and safety standards for medical home functions that are not covered by existing professional standards, which may include care coordination and member education.</p> <p>(g) The committee shall recommend that the public authority assist in the development of community-based resources to enhance medical home functions, including, but not limited to:</p> <p>(1) The availability of loans on favorable terms that facilitate the development of necessary health care infrastructure, including community-based providers of medical home services and</p>

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		<p>community-based preventive care service providers;</p> <p>(2) The offering of reduced price consultants that shall assist physicians and other health care providers in restructuring their practices and offices so as to function more effectively and efficiently in response to changes in health care insurance coverage and the health care service delivery system that are attributable to the implementation of the Sustinet Plan; and</p> <p>(3) The offering of continuing medical education courses that assist physicians, nurses and other clinicians in order to provide better care, consistent with the objectives of the Sustinet Plan, including training in the delivery of linguistically and culturally competent health care services.</p> <p>(h) The committee shall offer recommendations concerning payment for medical home functions, including that: (1) All of the medical home functions set forth in this section be reimbursable and covered by the Sustinet Plan; (2) to the extent that such functions are generally not covered by commercial insurance, payment levels cover the full cost of performing such functions; and (3) in setting such payment levels, consideration be given to: (A) Utilizing rate-setting procedures based on those used to set physician payment levels for Medicare; (B) establishing monthly case management fees paid based on demonstrated performance of medical home functions; or (C) taking other steps, as deemed necessary by the board of directors, to make payments that cover the cost of performing each function.</p> <p>(i) The committee shall offer recommendations that specialty referrals include, under circumstances set forth in the board's guidelines, prior consultation between the specialist and the medical home to ascertain whether such referral is medically necessary. If such referral is medically necessary, the consultation shall identify any tests or other procedures that shall be conducted or arranged by the medical home, prior to the specialty visit, so as to promote economic efficiencies. The Sustinet Plan shall reimburse the medical home and the specialist for time spent in any such consultation.</p>
Quality and Provider Advisory Committee Recommendations	7	<p>Sec. 7. (NEW) (Effective July 1, 2009)</p> <p>(a) The board of directors shall establish a health care provider advisory committee that shall develop recommended clinical care and safety guidelines for use by participating health care providers. The committee shall choose from nationally and internationally recognized guidelines for the provision of care, including guidelines for hospital safety and the inpatient and outpatient treatment of particular conditions. The committee shall continually assess the quality of evidence relevant to the costs, risks and benefits of treatments described in such guidelines. The committee shall forward their recommended clinical care and safety guidelines to the board of directors in accordance with such time and</p>

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	7	<p>format requirements as may be prescribed by said board. The committee shall include both health care consumers and health care providers.</p> <p>(b) The committee shall offer recommendations that health care providers participating in the Sustinet Plan receive confidential reports comparing their practice patterns with those of their peers. Such reports shall provide information about opportunities for appropriate continuing medical education.</p> <p>(c) The committee shall offer recommendations concerning quality of care standards for the care of particular medical conditions. Such standards may reflect outcomes over the entire care cycle for each health care condition, adjusted for patient risk and general consistency of care with approved guidelines as well as other factors. The committee shall offer recommendations that providers who meet or exceed quality of care standards for a particular medical condition be publicly recognized by the board of directors in such manner as said board determines appropriate. Such recognition shall be effectively communicated to Sustinet Plan members, including those who have been diagnosed with the particular medical condition for which recognition has been extended. Such communication to members shall be in multiple forms and reflect consideration of diversity in primary language, general and health literacy levels, past health-information-seeking behaviors, and computer and Internet use among members.</p> <p>(d) The committee shall recommend procedures that require hospitals and their medical staffs, physicians, nurse practitioners, and other participating health care providers to engage in periodic reviews of their quality of care. The purpose of such reviews shall be to develop plans for quality improvement. Such reviews shall include the identification of potential problems manifesting as adverse events or events that could have resulted in negative patient outcomes. As appropriate, such reviews shall incorporate confidential consultation with peers and colleagues, opportunities for continuing medical education, and other interventions and supports to improve performance. To the maximum extent permissible, such reviews shall incorporate existing peer review mechanisms. The committee's recommendations shall include that any review conducted in accordance with the provisions of this subsection be subject to the protections afforded by section 19a-17b of the general statutes.</p> <p>(e) The board of directors, in consultation with the committee, shall develop hospital safety standards that shall be implemented in such hospitals. The board of directors shall establish monitoring procedures and sanctions that ensure compliance by each participating hospital with such safety standards and may establish performance incentives to encourage hospitals to exceed such safety standards.</p> <p>(f) The committee shall offer recommendations pertaining to information to be made available to participating providers concerning prescription drugs, medical devices, and other goods and services used in the delivery</p>

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		<p>of health care. Such information may address emerging trends that involve utilization of goods and services that, in judgment of the public authority, are less than optimally cost effective. The committee shall offer recommendations concerning the provision of free samples of generic or other prescription drugs to participating providers.</p> <p>(g) The committee shall recommend policies and procedures that encourage participating providers to furnish and SustiNet Plan members to obtain appropriate evidenced-based health care.</p>
Preventive Health Care Advisory Committee Recommendations	8	<p>Sec. 8. (NEW) (Effective July 1, 2009)</p> <p>(a) The board of directors shall establish a preventive health care advisory committee that shall use evolving medical research to draft recommendations to improve health outcomes for members in areas involving nutrition, sleep, physical exercise, and the prevention and cessation of the use of tobacco and other addictive substances. The committee shall include providers, consumers and other individuals chosen by said board. Such recommendations may be targeted to member populations where they are most likely to have a beneficial impact on the health of such members and may include behavioral components and financial incentives for participants. Such recommendations shall take into account existing preventive care programs administered by the state, including, but not limited to, state administered educational and awareness campaigns. Not later than July 1, 2010, and annually thereafter, the preventive health care advisory committee shall submit such recommendations to the board of directors.</p> <p>(b) The board of directors shall recommend that the SustiNet Plan provide coverage for community-based preventive care services and such services be required of all health insurance sold pursuant to the plan to individuals or employers. Community-based preventive care services are those services identified by the board as capable of being safely administered in community settings. Such services shall include, but not be limited to, immunizations, simple tests and health care screenings. Such services shall be provided by individuals or entities who satisfy board of director approved standards for quality of care. The board of directors shall recommend that: (1) Prior to furnishing a community-based preventive care service, a provider obtain information from a patient's electronic health record to verify that the service has not been provided in the past and that such services are not contraindicated for the patient; and (2) a provider promptly furnish relevant information about the service and the results of any test or screening to the patient's medical home or the patient's primary care provider if the patient does not have a medical home. The board of directors shall recommend that community-based preventive services be allowed to be provided at job sites, schools or other community locations consistent with said board's guidelines.</p>

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<p>Policy-Making Duties and Responsibilities</p> <p>Policy-Making Duties and Responsibilities</p> <p>Expanding Medicaid Coverage and Access to Care</p> <p>Policy-Making Duties and Responsibilities</p> <p>Policy-Making Duties and Responsibilities</p>	9	<p>Sec. 9. (NEW) (Effective July 1, 2009)</p> <p>(a) The board of directors may develop recommendations that ensure that on and after July 1, 2012, nonstate public employers are offered the benefits of the Sustinet Plan. The board of directors may develop recommendations that permit the Comptroller to offer the benefits of the Sustinet Plan to state employees, retirees and their dependents. No changes in health care benefits shall be implemented with regard to plans administered under the provisions of subsection (a) of section 5-259 of the general statutes unless such changes are negotiated and agreed to by the state and the coalition committee established pursuant to subsection (f) of section 5-278 of the general statutes, through the collective bargaining process.</p> <p>(b) The board of directors shall develop recommendations that ensure that on and after July 1, 2012, employees of nonprofit organizations and small businesses are offered the benefits of the Sustinet Plan.</p> <p>(c) The board of directors shall develop recommendations to ensure that the HUSKY Plan Part A and Part B, Medicaid, and state-administered general assistance programs participate in the Sustinet Plan. Such recommendations shall also ensure that HUSKY Plan Part A and Part B benefits are extended, to the extent permitted by federal law, to adults with income at or below three hundred per cent of the federal poverty level.</p> <p>(d) The board of directors shall make recommendations to ensure that on and after July 1, 2012, state residents who are not offered employer-sponsored insurance and who do not qualify for HUSKY Plan Part A and Part B, Medicaid, or state-administered general assistance are permitted to enroll in the Sustinet Plan. Such recommendations shall ensure that premium variation based on member characteristics does not exceed in total amount or in consideration of individual health risk, the variation permitted for a small employer carrier, as defined in subdivision (16) of section 38a-564 of the general statutes.</p> <p>(e) The board of directors shall make recommendations to provide an option for enrollment into the Sustinet Plan, rather than employer-sponsored insurance, for certain state residents who are offered employer-sponsored insurance but who have a household income at or below four hundred per cent of the federal poverty level. Said board may make recommendations for the establishment of (1) an enrollment procedure for those individuals who demonstrate eligibility to enroll in the Sustinet Plan pursuant to this subsection; and (2) a method for the collection of payments from employers, whose employees would have received employer-sponsored insurance, but instead enroll in the Sustinet Plan in accordance with the provisions of this subsection.</p>

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<p>Definition</p> <p>Administrative Duties</p> <p>Administrative Duties</p> <p>Administrative Duties</p> <p>Policy-Making Duties and Responsibilities</p> <p>Covered Populations; Policy-Making Duties and Responsibilities</p> <p>Covered Populations; Policy-Making Duties and Responsibilities</p> <p>Benefits</p>	10	<p>Sec. 10.(NEW) (Effective July 1, 2009)</p> <p>(a) As used in this section "adverse selection" means purchase of Sustinet Plan coverage by employers with unusually high-cost employees and dependents under circumstances where premium payments do not fully cover the probable claims costs of the employer's members.</p> <p>(b) The board of directors shall offer recommendations concerning:</p> <p>(1) The use of new and existing channels of sale to employers, including public and private purchasing pools, agents and brokers;</p> <p>(2) the offering of multi-year contracts to employers with predictable premiums;</p> <p>(3) policies and procedures to be established that ensure that employers can easily and conveniently purchase Sustinet Plan coverage for their workers and dependents, including, but not limited to, participation requirements, timing of enrollment, open enrollment, enrollment length and other subject matters as deemed appropriate by said board;</p> <p>(4) policies and procedures to be established that prevent adverse selection and achieve other goals specified by the board;</p> <p>(5) the availability of Sustinet Plan coverage for small employers on and after July 1, 2012, with premiums based on member characteristics as permitted for small employer carriers, as defined in subdivision (16) of section 38a-564 of the general statutes;</p> <p>(6) the availability of Sustinet Plan coverage for employers who are not small employers with premiums charged to such employers to prevent adverse selection, taking into account past claims experience, changes in the characteristics of covered employees and dependents since the most recent time period covered by claims data, and other factors approved by the board of directors; and</p> <p>(7) the availability of a standard benefits package to employers purchasing coverage under this section, provided no such benefit package provide less comprehensive coverage than that described in the model benefits packages adopted pursuant to section 12 of this act.</p>
<p>Responsibility of the Office of the Health Care Advocate</p>	11	<p>Sec. 11.(NEW) (Effective July 1, 2009)</p> <p>(a) As used in this section, "clearinghouse" means an independent information clearinghouse recommended by the board of directors that is: (1) Established and overseen by the Office of the Healthcare Advocate; (2) operated by an independent research organization that contracts with the Office of the Healthcare Advocate; and (3) responsible for providing employers, individual purchasers of health coverage, and the general public with comprehensive information about the care covered by the Sustinet Plan and by private health plans licensed in the state of Connecticut.</p>

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		<p>(b) The clearinghouse shall develop specifications for data that show for each health plan, quality of care, outcomes for particular health conditions, access to care, utilization of services, adequacy of provider networks, patient satisfaction, rates of disenrollment, grievances and complaints, and any other factors the Office of the Healthcare Advocate determines relevant to assessing health plan performance and value. In developing such specifications, the Office of the Healthcare Advocate shall consult with private insurers and with the board of directors.</p> <p>(c) The board of directors shall recommend that the following entities shall provide data to the clearinghouse in a time and manner as prescribed by the Office of the Healthcare Advocate: (1) The Sustinet Plan; (2) health insurers, as a condition of licensure; and (3) any self-insured group plan that volunteers to provide data. Dissemination of any information provided by a self-insured group plan shall be limited and in conformity with a written agreement governing such dissemination as developed and approved by the group plan and the Office of the Healthcare Advocate.</p> <p>(d) Except as provided for in subsection (c) of this section, the clearinghouse shall make public all information provided pursuant to subsection (b) of this section. The clearinghouse shall not disseminate any information that identifies individual patients or providers. The clearinghouse shall adjust outcomes based on patient risk levels, to the maximum extent possible. The clearinghouse shall make information available in multiple forms and languages, taking into account varying needs for the information and different methods of processing such information.</p> <p>(e) The clearinghouse shall collect data based on each plan's provision of services over continuous twelve-month periods. Except as provided in subsection (c) of this section, the clearinghouse shall make public all information required by this section no later than August 1, 2013, with updated information provided each August first thereafter.</p>
Responsibility of the Office of the Health Care Advocate	12	<p>Sec. 12.(NEW) (Effective July 1, 2009)</p> <p>(a) Within available appropriations, the Office of the Healthcare Advocate shall develop and update the model benefit packages, based on evolving medical evidence and scientific literature, that make the greatest possible contribution to member health for a premium cost typical of private, employer sponsored insurance in the Northeast states. Not later than December 1, 2010, and biennially thereafter, the Office of the Healthcare Advocate shall report to the board of directors on the updated model benefit packages.</p> <p>(b) After the promulgation of the model benefit packages, as provided in subsection (a) of this section, the board of directors may modify the standard benefits package if said board determines that: (1) Such modification would yield better outcomes for an equivalent expenditure of funds; or (2) providing additional coverage or reduced cost sharing for particular services as provided to particular member populations may</p>

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		<p>reduce net costs or provide sufficient improvements to health outcomes to warrant the resulting increase in net costs. Any such modification of the standard benefits package by the board shall ensure compliance with the coverage mandates described in chapter 700c of the general statutes and the utilization review requirements described in chapter 698a of the general statutes.</p> <p>(c) The Office of the Healthcare Advocate shall recommend guidelines for establishing an incentive system that recognizes employers who provide employees with health insurance benefits that are equal to or more comprehensive than the model benefit packages. Such incentives may include public recognition of employers who offer such comprehensive benefits. Not later than December 1, 2012, the Office of the Healthcare Advocate shall report, in accordance with section 11-4a of the general statutes, on such guidelines and recommendations to the board of directors, the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health, labor and public employees, and appropriations and the budgets of state agencies.</p>
Policy-Making Duties and Responsibilities	13	<p>Sec. 13.(NEW) (Effective July 1, 2011)</p> <p>(a) The board of directors shall develop recommendations for public education and outreach campaigns to ensure that state residents are informed about the Sustinet Plan and are encouraged to enroll in the plan.</p> <p>(b) The public education and outreach campaign shall utilize community-based organizations and shall include a focus on targeting populations that are underserved by the health care delivery system.</p> <p>(c) The public education and outreach campaign shall be based on evidence of the cost and effectiveness of similar efforts in this state and elsewhere. Such campaign shall incorporate an ongoing evaluation of its effectiveness, with corresponding changes in strategy, as needed.</p>
Policy-Making Duties and Responsibilities	14	<p>Sec. 14.(NEW) (Effective July 1, 2011) The board of directors, in collaboration with state and municipal agencies, shall, within available appropriations, develop and implement systematic recommendations to identify uninsured individuals in the state. Such recommendations may include that:</p> <p>(1) The Department of Revenue Services modify state income tax forms to request that a taxpayer identify existing health coverage for each member of the taxpayer's household.</p> <p>(2) The Labor Department modify application forms for initial and continuing claims for unemployment insurance to request information about health insurance status for the applicant and the applicant's dependents.</p> <p>(3) Hospitals, community health centers and other providers as determined by the board of directors shall: (A) Identify the health insurance status of</p>

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		individuals who seek health care, and (B) convey such information, via secure electronic mail transmission, to said board to facilitate the potential enrollment of such individuals into health insurance coverage.
Responsibilities of Departments of Social Services and Education	15	<p>Sec. 15. Section 17b-297b of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2011):</p> <p>(a) To the extent permitted by federal law, the Commissioners of Social Services and Education, in consultation with the board of directors, shall jointly establish procedures for the sharing of information contained in applications for free and reduced price meals under the National School Lunch Program for the purpose of determining whether children participating in said program are eligible for coverage under the Sustinet Plan or the HUSKY Plan, Part A and Part B. The Commissioner of Social Services shall take all actions necessary to ensure that children identified as eligible for [either] the Sustinet Plan, or the HUSKY Plan, Part A or Part B, are enrolled in the appropriate plan.</p> <p>(b) The Commissioner of Education shall establish procedures whereby an individual may apply for the Sustinet Plan or the HUSKY Plan, Part A or Part B, at the same time such individual applies for the National School Lunch Program.</p>
Childhood and Adult Obesity Task Force Recommendations	16	<p>Sec. 16. (Effective from passage)</p> <p>(a) There is established a task force to study childhood and adult obesity. The task force shall examine evidence-based strategies for preventing and reducing obesity in children and adults and develop a comprehensive plan that will effectuate a reduction in obesity among children and adults.</p> <p>(b) The task force shall consist of the following members:</p> <ol style="list-style-type: none"> (1) One appointed by the speaker of the House of Representatives, who shall represent a consumer group with expertise in childhood and adult obesity; (2) One appointed by the president pro tempore of the Senate, who shall be an academic expert in childhood and adult obesity; (3) One appointed by the majority leader of the House of Representatives, who shall be a representative of the business community with expertise in childhood and adult obesity; (4) One appointed by the majority leader of the Senate, who shall be a health care practitioner with expertise in childhood and adult obesity; (5) One appointed by the minority leader of the House of Representatives, who shall be a representative of the business community with expertise in childhood and adult obesity;

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		<p>(6) One appointed by the minority leader of the Senate, who shall be a health care practitioner with expertise in childhood and adult obesity;</p> <p>(7) One appointed by the Governor who shall be an academic expert in childhood and adult obesity; and</p> <p>(8) The Commissioners of Public Health, Social Services and Economic and Community Development and a representative of the Sustinet board of directors shall be ex-officio nonvoting members of the task force.</p> <p>(c) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.</p> <p>(d) All appointments to the task force shall be made no later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.</p> <p>(e) The members of the task force appointed by the speaker of the House of Representatives and the president pro tempore of the Senate shall serve as the chairpersons of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held no later than thirty days after the effective date of this section.</p> <p>(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the task force.</p> <p>(g) Not later than July 1, 2010, the task force shall submit a report on its findings and recommendations to the board of directors and the joint standing committee of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2011, whichever is later.</p>
Tobacco and Smoking Cessation Task Force Recommendations	17	<p>Sec. 17.(Effective from passage)</p> <p>(a) There is established a task force to study tobacco use by children and adults. The task force shall examine evidence-based strategies for preventing and reducing tobacco use by children and adults, and then develop a comprehensive plan that will effectuate a reduction in tobacco use by children and adults.</p> <p>(b) The task force shall consist of the following members:</p> <p>(1) One appointed by the speaker of the House of Representatives, who shall represent a consumer group with expertise in tobacco use by children and adults;</p> <p>(2) One appointed by the president pro tempore of the Senate, who</p>

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		<p>shall be an academic expert in tobacco use by children and adults;</p> <p>(3) One appointed by the majority leader of the House of Representatives, who shall be a representative of the business community with expertise in tobacco use by children and adults;</p> <p>(4) One appointed by the majority leader of the Senate, who shall be a health care practitioner with expertise in tobacco use by children and adults;</p> <p>(5) One appointed by the minority leader of the House of Representatives, who shall be representative of the business community with expertise in tobacco use by children and adults;</p> <p>(6) One appointed by the minority leader of the Senate, who shall be a health care practitioner with expertise in tobacco use by children and adults;</p> <p>(7) One appointed by the Governor who shall be an academic expert in tobacco use by children and adults; and</p> <p>(8) The Commissioners of Public Health, Social Services and Economic and Community Development and a representative of the Sustinet board of directors shall be ex-officio, nonvoting members of the task force.</p> <p>(c) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.</p> <p>(d) All appointments to the task force shall be made no later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.</p> <p>(e) The members of the task force appointed by the speaker of the House of Representatives and the president pro tempore of the Senate shall serve as the chairpersons of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held no later than thirty days after the effective date of this section.</p> <p>(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the task force.</p> <p>(g) Not later than July 1, 2010, the task force shall submit a report on its findings and recommendations to the board of directors and the joint standing committee of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2011, whichever is later.</p>
Health Care Workforce	18	<p>Sec. 18.(Effective from passage)</p> <p>(a) There is established a task force to study the state's health care</p>

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Task Force Recommendations		<p>workforce. The task force shall develop a comprehensive plan for preventing and remedying state-wide, regional and local shortage of necessary medical personnel, including, physicians, nurses and allied health professionals.</p> <p>(b) The task force shall consist of the following members:</p> <ol style="list-style-type: none"> (1) One appointed by the speaker of the House of Representatives, who shall represent a consumer group with expertise in health care; (2) One appointed by the president pro tempore of the Senate, who shall be an academic expert on the health care workforce; (3) One appointed by the majority leader of the House of Representatives, who shall be a representative of the business community with expertise in health care; (4) One appointed by the majority leader of the Senate, who shall be a health care practitioner; (5) One appointed by the minority leader of the House of Representatives, who shall be a representative of the business community with expertise in health care; (6) One appointed by the minority leader of the Senate, who shall be a primary care physician; (7) One appointed by the Governor who shall be an academic expert in health care; and (8) The Commissioners of Public Health, Social Services and Economic and Community Development, the president of The University of Connecticut, the chancellor of the Connecticut State University System, the chancellor of the Regional Community-Technical Colleges, and a representative of the Sustinet board of directors shall be ex-officio, nonvoting members of the task force. <p>(c) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.</p> <p>(d) All appointments to the task force shall be made no later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.</p> <p>(e) The members of the task force appointed by the speaker of the House of Representatives and the president pro tempore of the Senate shall serve as the chairpersons of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held no later than thirty days after the effective date of this section.</p> <p>(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the task force.</p> <p>(g) Not later than July 1, 2010, the task force shall submit a report on its</p>

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		findings and recommendations to the board of directors and the joint standing committee of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2011, whichever is later.
No reporting required	19	Sec. 19. (NEW) (Effective July 1, 2009) Any individual who serves on the Sustinet Health Partnership board of directors shall be subject to the provisions of section 1-83 of the general statutes concerning the filing of a statement of financial interests.