

**WHAT STATES ARE DOING
TO KEEP US HEALTHY**

HEARING
OF THE
**COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS**
UNITED STATES SENATE
ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

ON

EXAMINING WHAT STATES ARE DOING TO KEEP CITIZENS HEALTHY

JANUARY 22, 2009

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WHAT STATES ARE DOING TO KEEP US HEALTHY

THURSDAY, JANUARY 22, 2009

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:07 a.m. in Room SD-430, Dirksen Senate Office Building, Hon. Tom Harkin presiding.

Present: Senators Harkin, Sanders, Casey, Hagan, Merkley, and Burr.

OPENING STATEMENT OF SENATOR HARKIN

Senator HARKIN. The Senate Health, Education, Labor, and Pensions Committee will come to order. Good morning, everyone. I'd like to thank everyone for coming this morning, the panelists and my fellow Senators and the public who are here, to discuss some of the creative ways that States are taking in promoting disease prevention and a broader culture of wellness.

Of course, I want to state that I'm very glad that our committee chair, Senator Kennedy, is out of the hospital. He's doing very well and of course we wish him a speedy return to this seat.

In December, looking ahead to the task of drafting historic health care reform legislation, Chairman Kennedy asked me to chair the Prevention, Wellness, and Public Health Working Group. I've said many times that this has to be the central part of health reform legislation, because we'll never get health care costs under control unless we place a major new emphasis on wellness and prevention and strengthening America's public health system.

It's not enough to talk about how to extend insurance coverage and how to pay the bills. Indeed, I've laid down a marker for me here in the early days of our debate about national health care reform and it's just this: If we pass a bill that greatly extends health insurance coverage, but does nothing to create a dramatically stronger prevention and public health infrastructure and agenda, then we will have failed the American people.

It simply makes no sense to legislate broader access to a health care system that costs too much, delivers too little, largely because it neglects prevention and public health. A robust emphasis on wellness is about saving lives, saving trips to the hospital, and saving money. I admit it's the only way that we're going to get a grip on skyrocketing health care costs.

To that end, I look forward to hearing from our witnesses about the exciting, innovative things that States are doing in the field of public health and prevention. I have never been one to believe that all wisdom radiates from Washington. The fact is States are often more nimble and more creative when it comes to reform and public policy innovation. We look to the States as incubators and testing grounds for new ideas, and this is certainly true with respect to wellness, prevention, and public health.

As we draft health reform legislation at the Federal level, it is important that we capture the excellent ideas and practices being pioneered by the States and to coordinate our initiatives. That is the purpose of this hearing.

We have five distinguished witnesses this morning. I welcome my good friend Senator Jack Hatch, who played a leading role last year in passing Iowa's Comprehensive Health Care Reform Act. This legislation places a major emphasis on wellness. It ties preventative care to increased reimbursements. It creates new incentives to encourage primary care providers to offer preventative care and wellness treatments.

I also welcome Dr. Jonathan Fielding, Director of the Los Angeles County Public Health, a professor at UCLA, and indeed one of America's foremost experts on public health. His testimony will focus on strategies for reducing tobacco use and obesity, especially among our young people. I especially appreciate Dr. Fielding's emphasis on the role that schools and communities can and must play in combating childhood obesity and preventing youth smoking.

I welcome Bill Emmet, Director of the Campaign for Mental Health Reform. As Mr. Emmet knows very well, mental health is too often the neglected stepchild in our health reform agenda. It should be obvious that mental health is integral to physical health. In so many cases you can't have the latter without the former, and legislation drafted by this committee needs to reflect that reality.

We have Dr. Alan Dobson, Assistant Secretary for Health Policy and Medical Assistance at the North Carolina Department of Health and Human Services. Again, North Carolina doing very exciting things. Dr. Dobson will discuss another aspect of health care reform that's important for controlling costs, the importance of getting entire communities involved in promoting wellness and prevention, something that's been done in North Carolina by emphasizing primary care and the medical home concept.

Finally, we welcome Dr. JudyAnn Bigby, the Secretary of Health and Human Services for the Commonwealth of Massachusetts. Three years ago, Massachusetts enacted health care reform legislation designed to move the State to near universal health insurance coverage. But from the outset, leaders in Massachusetts insisted that health care reform is about much more than just health insurance. Their 2006 bill promotes wellness and prevention in many ways, and we have a lot to learn from the Massachusetts example.

As I have said many times, prevention and public health have been the missing pieces in the national conversation about health care reform. It's time to make them the centerpiece of that conversation, not an asterisk, not a footnote, but the centerpiece of health care reform.

With that in mind, I again welcome all of you to the committee. Your testimony will be valuable as we move forward with health care reform at the Federal level. I look forward to your ideas and your insights and all of your expertise.

With that, I will yield to my friend and my colleague from North Carolina, Senator Burr.

STATEMENT OF SENATOR BURR

Senator BURR. Thank you, Mr. Chairman. I apologize to the panel on behalf of the other colleagues, who are scattered around the Hill with activities on the Senate floor and confirmation hearings and meetings as we try to get an administration complete as quickly as we possibly can.

Mr. Chairman, I join you in welcoming all of our guests and thank them for taking the time out of their busy schedule to travel to Washington to share with us examples of what States are doing to improve our Nation's public health. As you know, I'm a strong believer in the North Carolina community care model. Why? Because it's worked, because it's actually accomplished what it set out to do, and that's to provide a higher level of care to more people and, yes, for less money.

I believe it's important to point out—and I don't think our panelists would disagree with me today, Mr. Chairman—that one of the fallacies to our inability to address prevention and wellness is the fact that inherently we don't pay for it, or we don't build it into the reimbursement schedule. If you look at Medicare and the number of years that some of us have fought to include prevention as a reimbursed item, and we've done it on only those things where there is 100 percent consensus, but not on the things that we had 99 percent agreement that might make a difference.

Second, we have an antiquated scoring system in this town, and it can't look at a health care reform package with what it saves, only what it costs. If we attempt to modernize our health care system, hamstrung by how much we save and only altered by what it costs, we will either be unsuccessful at achieving reform or in fact we will construct something that doesn't accomplish our end goal, which is cover more people with a higher level of quality for a much less expensive cost.

An important example of the trends that bring us here today to discuss prevention and wellness is the alarming increase in obesity in this country. According to the CDC, more than a third of adults, more than 72 million people, and 16 percent of America's children are obese—not just overweight, obese. In the last 20 years the obesity rates for adults have doubled and rates for children have tripled.

We're headed in the wrong direction. We all know it. Not only is this trend costly, estimated at over \$100 billion annually, it leads to numerous chronic diseases and lowers our quality of life. It is headed in an opposite direction than most of us know we need to go.

I look forward to hearing from our witnesses today. I look forward to learning what we can from the experiences they've gone through, and it's my hope, Mr. Chairman, that we will all use what we learn today to put us down that path to a reformed system.

I thank the chair.

Senator HARKIN. Thank you very much, Senator Burr.

All statements of Senators will be made a part of the record, and we will now go to our witnesses. At the time of the questioning period we'll make sure we have enough time for Senators to make statements at that point in time.

With that, again we welcome you all here. We'll just go from left to right, and we'll start with Dr. Fielding and then go to Mr. Emmet, Mr. Dobson, Senator Hatch, and Dr. Bigby. Again, we welcome you all. Your statements will be made a part of the record in their entirety. Try to sum up in 5 minutes, but we don't bang the gavel at 5 minutes. If you run a minute or so over, I don't mind. That's fine. If you could sum it up for us, we would certainly appreciate that.

Dr. Fielding, Director of the Los Angeles County Department of Public Health, also professor at UCLA School of Medicine and Public Health at the University of California in Los Angeles; a founding member of the U.S. Preventative Health Task Force in the United States and also the chair of that at the present time; certainly one of the leading figures in prevention and wellness in America.

Dr. Fielding, welcome and please proceed as you so desire.

**STATEMENT OF JONATHAN FIELDING, M.D., M.P.H., DIRECTOR
AND HEALTH OFFICER, COUNTY OF LOS ANGELES PUBLIC
HEALTH, LOS ANGELES, CA**

Dr. FIELDING. Thank you very much, Chairman Harkin, Senator Burr, and honorable members of the committee. I am here in my capacity as the Public Health Director for the Nation's largest local government, Los Angeles County, with a population exceeding 10 million.

At a time when our Nation faces daunting economic challenges, a healthy population is an essential prerequisite for economic growth. Preventable chronic diseases sap our Nation's collective economic strength, reduce our international competitiveness, and increase medical care costs to the breaking point. Taking action now to reduce tobacco use and obesity rates can put us on the road back to economic prosperity and save tens of millions of Americans from preventable illness, disability, and premature death.

It's estimated that perhaps one-third of all deaths in the United States are caused by smoking and the two primary risk factors for obesity, poor diet and lack of physical activity, and those cause a number of chronic diseases, including cancer, heart disease, chronic lung disease, and type 2 diabetes. Despite spending 16.5 percent of our GDP on health care or more, our results in terms of health are worse than almost every developing country and worse than every developed country and as bad as many developing countries. We have great opportunities.

Of course we must make sure that our health care delivery system takes advantage of evidence-based recommendations. We also have to think about what are the changes we can make in communities and population—in things that can improve the health of populations.

We know that core public health agencies are the only ones that are charged with worrying about the health of everybody, everybody, not just particular groups. We are leaders, we are science experts, we are conveners, facilitators, and advocates for evidence-based policy and practice. We have to work, not alone, but with schools, with the private sector, which has a very important role, faith-based organizations, and community advocates that share our resolve.

Most importantly, we have to work outside what we normally consider as the realm of health care. We have to think about what goes on in other sectors. The approach of looking at other sectors has been articulated by the Federal Advisory Committee for Healthy People 2020, which I chair, and will guide the process of setting health objectives and priorities for the Nation, States, and localities.

What's also important is that we all share in success. We know that we have to pay particular attention to the higher burden borne by minorities and those with low income and less formal education.

Smoking remains the largest preventable cause of death, 440,000 people a year dying in our country. Still, almost one in five American adults smoke and the average cost annually for health care costs and productivity is about \$193 billion.

Now, what do we need to do? One prong of what we need to do is prevention and that needs to be aimed at youth because 80 percent of new smokers start before they reach their 18th birthday. What we know will work is raising the price of tobacco products through excise taxes to reduce initiation of new users, restricting minors' access to tobacco products, expanding and sustaining effective mass media campaigns targeting youth, particularly the National Truth Campaign, which has demonstrated high levels of effectiveness, eliminating tobacco marketing to minors, and reducing youth exposure to tobacco use in our popular culture, where movies have particular influence.

We also know how to help current smokers quit. Again, raising the price makes a big difference. Mounting sustained mass media campaigns, like Become an EX, which is the campaign of the American Legacy Foundation, to encourage tobacco users to quit and give them information about resources to help them do that, to expand free tobacco cessation quit lines, to cover effective tobacco use treatments under all public and private insurance plans with no deductibles and no co-pays, and to ensure that all health IT systems include screening and treatment prompts, so that all tobacco users get counseling every time they touch the medical care system.

To aid by prevention and cessation, we also need to increase regulation of tobacco products and their marketing. Finally, we have to protect every nonsmoker from the deadly effects of secondhand smoke by making sure all indoor environments are smoke-free across the Nation.

Let me now turn to obesity. Senator Burr has done a wonderful job synthesizing the information on the terrible burden of obesity. It's tripled, the rate has tripled in our kids over the last 20 to 30 years. The majority of Americans are overweight, are obese, and

the toll is huge, both economically and in terms of health, with heart disease, hypertension, diabetes, fatty liver, stroke, and other, and a number of forms of cancer.

What is most disturbing is these costs will rise at an escalating rate over the next generation as the swelling ranks of obese children reach adulthood and begin developing obesity-related diseases at progressively younger ages.

Many social, economic, and environmental factors contribute to the obesity epidemic and therefore we need multiple approaches to deal with it. Health care reform can play an important part. Providers and health plans need to have evidence-based prevention techniques. They need to do body mass index monitoring as a vital sign just like blood pressure, nutrition counseling, breastfeeding promotion, advising parents to reduce the time they spend in front of screens, and physical activity promotion.

However, we will not be successful with these efforts alone unless we change the environmental factors, so that the health choice becomes the easy choice. One policy imperative is the establishment of more rigorous nutrition standards for school meals and other foods sold on school campuses, including improvements in the Federal school meal program's nutrition requirements. Minimum nutrition requirements should also be in work and recreational settings.

Removing barriers to participation in the underutilized Supplemental Nutrition Assistance Program can provide greater access to healthy foods for eligible families, as can increasing participation in the recently improved WIC program, which now offers more healthful food, including fruits and vegetables.

Providing nutrition information at points of purchase through menu labeling or other efforts to better inform consumers is an important strategy. A recent health impact assessment conducted by my Department found that if menu labeling got patrons to as few as 10 percent of their meals that have 100 calories less than they normally would, we could reduce the percentage of increase in number of pounds per individual, by about 40 percent. We have 6.75 million pounds a year increasing in Los Angeles County. We could decrease that by 40 percent.

Restricting food marketing to young children, establishing farm subsidies that support affordable healthy choices, creating other incentives for the food industry to lower the caloric content of products and have smaller serving sizes, and supporting programs and policies that eliminate food deserts need to be part of a comprehensive solution.

Marketing of products high in calories, sugar, sodium, and fat to our youth remains the major challenge. The Federal Trade Commission has reported that the largest food and beverage companies in the country spent about \$1.6 billion in the year 2006 on marketing their products to children, including preschool children, school-aged children, and adolescents, and over 90 percent of those were for food and beverages high in sugar, fat, or sodium.

Developing community, school, and workplace environments conducive to physical activity represents another vital approach to obesity prevention and control. Interventions shown to be effective in promoting physical activity include: community-wide campaigns,

point of decision prompts to encourage stair usage, school-based physical education, and social support strategies such as in exercise buddy systems. These programs should be supported at the Federal level, both with targeted funding and economic incentives.

Addressing land use and transportation practices and policies also offers significant opportunities for reversing the epidemic. For example, the upcoming authorization of the Federal transportation bill provides an excellent opportunity for prioritizing and funding projects and infrastructure that promote walking, bicycling, and other forms of physical activity.

In addition, the Federal Government should support State and local efforts to institute land use and transportation policies that promote physical activity, including mixed use development, compact development, and expanded public transportation.

For the vast majority of our preventable serious illness and injury, our success depends on knowing what works and then disseminating that and implementing it. Unfortunately, the two major bodies that are charged with this, the Preventive Services Task Force and the Community Preventive Services Task Force, are severely underfunded. In the case of the Community Preventive Services Task Force, we only are able to cover the minority of possibly effective community policies and programs and there is no funding for dissemination or evaluation of implementation. These need substantial increases and they are very small dollar amounts.

Finally, we must recognize that there are common underlying causes for most of our chronic diseases and those reside in our socioeconomic environment and our physical environment. Poverty, poor educational attainment, and social isolation are important risk factors for virtually every chronic disease. To improve our Nation's health and competitiveness, it is vital that all congressional committees consider how their decisions affect health. Policies in agriculture, transportation, housing, environment, commerce and education all affect health and the health disparities between population groups.

We possess the tools, including health impact assessment, to determine the likely health effects of these policies being considered in each of these sectors, and by routinely using these tools and considering the health implication of all Federal policies we can jumpstart a national effort not only to make us a healthier Nation, but to make us the healthiest Nation.

Thank you very much.

[The prepared statement of Dr. Fielding follows:]

PREPARED STATEMENT OF JONATHAN FIELDING, M.D., M.P.H.

Dear Chairman Kennedy, Senator Enzi, Senator Harkin, and Honorable Members of the Senate Health, Education, Labor and Pensions Committee, thank you for this opportunity to appear before you today.

At a time when our Nation faces unprecedented economic challenges, a healthy population is an essential prerequisite for economic growth. Preventable chronic diseases sap our Nation's collective economic strength, reduce our international competitiveness, and increase medical care costs. Taking action now to reduce tobacco use and the obesity rate can help put our Nation back on the road to economic prosperity and save tens of millions of Americans from preventable illness, disability and premature death. Researchers estimate that a third of all deaths in the United States in 2000 were caused by tobacco use and the two most immediate risk factors for obesity (poor diet and a lack of physical activity), primarily by causing a wide range of chronic diseases (e.g., cancer, heart disease, chronic lung disease, diabe-

tes).⁵ These diseases are the leading killers of Americans, are very costly to treat, and result in disability and death for many during what should be their most productive years. Researchers have also found that obesity and tobacco use are linked to decreased worker productivity.

Our country currently spends more than any other nation on health care, 16.5 percent of our GDP in 2007, yet we still experience poorer health than most other developed nations and some developing countries. It is evident that the status quo approach is not working. Fortunately, many of the premature deaths and costs associated with obesity and tobacco use are preventable. However, in order to take full advantage of the opportunities for prevention, we must look beyond the borders of our health care system. To effectively reduce the rates of obesity and tobacco use, we also need to enhance the public health infrastructure of State and local public health departments with stronger, sustained support. Furthermore, we need policy changes in the other sectors that have large impacts on our Nation's health and on the serious health disparities among population groups. And we must work better with other partner agencies, in both the public and private sectors, that share our concerns about how to reduce the toll of these twin scourges.

REDUCING THE TOLL OF TOBACCO USE

Despite much success in reducing tobacco use over the past several decades, nearly one in five adults (43 million adults) continues to smoke.¹ Among high school students, 20 percent report smoking, a rate that has remained unchanged since 2003.² In addition, marked disparities in smoking rates exist, with the highest rates observed in lower income populations, African-Americans, American Indians, and those with mental health and substance abuse disorders.³

Smoking is the leading cause of preventable death in the United States, with an estimated 440,000 people dying prematurely from smoking or exposure to second-hand smoke each year.⁴ Tobacco use causes eight different forms of cancer, chronic lung disease, cardiovascular disease, osteoporosis and a host of other serious diseases. Second-hand smoke causes cardiovascular disease and lung cancer in adults, lower birth weight and SIDS in infants, and chronic ear infections and respiratory problems in children. In total, more deaths are caused by tobacco use than by HIV, alcohol use, motor vehicle injuries, illegal drug use, suicides, and homicide combined.⁵ Additionally, an estimated 8.6 million people in the United States are living with one or more serious illnesses attributable to smoking, primarily heart disease and chronic obstructive lung disease.⁶ Perhaps most disturbing is the toll that smoking takes on our Nation's children. Approximately 80 percent of smokers begin before the age of 18.⁷ Research indicates that people who start smoking in their teens and continue throughout their lifetime will die 12–21 years earlier than people who never smoked. One in three youth smokers will eventually die of a smoking related disease.⁸

In addition to the human toll, tobacco use also places an enormous economic burden on our society. During 2001–2004, average annual health care costs for smoking-related illness were an estimated \$96 billion, with an additional \$97 billion in productivity losses—making the total annual economic toll a staggering \$193 billion.⁴

Reducing tobacco use and exposure to secondhand smoke requires a four-pronged approach. First, we must prevent the initiation of new users by raising the price of tobacco products, effectively restricting minors' access to tobacco products, expanding and sustaining effective mass media campaigns, eliminating tobacco marketing to minors, and reducing the depiction of tobacco use in our popular culture, such as in movies. Second, we need to expand proven interventions that help tobacco users quit: increasing the price of tobacco products, sustained mass media campaigns to encourage tobacco users to quit and providing information about resources available to help them to do so, expanding tobacco cessation quitlines that can provide free help to tobacco users interested in quitting, covering effective tobacco-use treatments under all public and private insurance with no deductibles or co-pays, and ensuring that all health IT systems include screening and treatment prompts to ensure that all tobacco users receive treatment every time they are seen in the health care system. Third, we need to increase regulation of tobacco products and their marketing. Finally, we must protect all non-smokers from the deadly effects of secondhand smoke by ensuring that all indoor environments are smoke-free in every community in the country. The good news is that there is a strong evidence base demonstrating the effectiveness of these interventions.

Community Prevention Measures

Based on the research evidence, the Task Force on Community Preventive Services has concluded that increasing the price of tobacco is effective in preventing the

initiation of smoking and increasing the percentage of teen and adult smokers who successfully quit or reduce the amount they smoke.⁹ Price elasticity studies indicate that every 10 percent increase in the price of a pack of cigarettes results in a 4 percent decline in consumption (studies also show about 50 percent of this consumption decline is due to fewer smokers and 50 percent to fewer cigarettes consumed by continuing smokers).¹⁰ A cigarette tax resulting in a 50 percent increase in the price of cigarettes would decrease smoking prevalence by 10 percent, a net reduction of 4.3 million adult smokers in the United States. Congress is currently considering raising Federal tobacco taxes, which include increasing the tax on cigarettes from 39 cents to \$1 per pack to help pay for the State Children's Health Insurance Program (SCHIP).¹¹ This important piece of legislation is a good start towards achieving the Centers for Disease Control and Prevention Healthy People's 2010 target of a \$2 per pack tax increase. Increasing the Federal excise tax on cigarettes to the Healthy People 2010 goal offers an important opportunity to simultaneously reduce smoking rates and raise revenue that can be used to fund comprehensive tobacco prevention and control campaigns.

Another effective community prevention strategy is the use of mass media in multi-faceted anti-smoking campaigns, similar to those in California, Massachusetts, and Florida, and the national American Legacy Foundation campaign. Media campaigns can be effective in both reducing youth smoking initiation and in increasing cessation rates. For example, the American Legacy's truth[®] campaign, the only national youth peer-to-peer smoking prevention intervention, was responsible for 22 percent of the overall decline in youth smoking in its first 2 years, resulting in 300,000 fewer youth smokers.¹² Increasing support to expand these types of campaigns and assuring that the campaigns have national reach will help to counter the effects of the tobacco industry's substantial marketing efforts.

Exposure to smoking in popular culture is another powerful pro-tobacco influence on children that must be addressed. For example, studies indicate that Hollywood movies deliver billions of tobacco images to young audiences every year, and are responsible for recruiting one-third to one-half of young smokers in the United States.¹³ Additionally, the CDC has repeatedly linked smoking in films to the recent stall in the decline of youth smoking, and the National Cancer Institute has concluded that exposure to onscreen smoking causes adolescents to start smoking.^{2 14} Given these findings, it is crucial for the public health community to work with the entertainment industry to develop meaningful strategies to reduce the depiction of smoking in movies, and for the entertainment industry to implement a ratings policy for smoking that will reduce youth exposures and allow parents to make informed movie choices for their children.

Other efforts to reduce youth initiation include reducing minors' access to tobacco products. These efforts require strong community support at the local level. Smoke-free policies have also been shown to reduce youth initiation and offer protection from the harms of secondhand smoke.

Recommendations:

- Increase the Federal excise tax on cigarettes.
- Increase support to expand multi-faceted anti-smoking mass media campaigns.
- Work with the film industry to reduce the depiction of smoking in movies and implement a movie ratings policy for smoking that will reduce youth exposures.
- Reduce minors' access to tobacco products.

Smoking Cessation Interventions

A nationwide survey in 2000 found that 70 percent of smokers said they wanted to quit¹⁵ and a 2007 survey showed that nearly 40 percent of current every day smokers had made a quit attempt in the past year.¹ However, these rates are lower than in years past, and survey data show a long-term decline in the percentage of smokers who make quit attempts.¹ In addition, the majority of smokers who attempt to quit do not use recommended cessation methods and most of these untreated smokers relapse within days of making a quit attempt.¹⁵ Moreover, only about 35 percent of smokers enrolled in commercial and Medicaid health plans received cessation services recommended by the U.S. Preventive Services Task Force.¹⁶

It is clear that as part of health and health care reform we need to increase the number of smokers who try to quit as well as the percentage of smokers who are successful in their quit attempts. To achieve this we must implement community interventions that increase cessation attempts and cessation success, as well as expand access to cessation services that have proven to be effective—doubling, and in some cases, tripling the likelihood of successful quitting.¹⁷ One method for getting more smokers to make quit attempts, to contact quit lines, and avail themselves of smoking cessation aids, is to increase smokers' motivation to quit and knowledge of

cessation resources via the mass media. The American Legacy Foundation partnership with States on the “Become an EX” campaign is an excellent example of how this type of community intervention can work.

The Task Force on Community Preventive Services’ recommendations include reducing out-of-pocket costs for treatment services and utilizing telephone cessation quitlines to increase both the number of tobacco users who use treatment and the number who successfully quit.⁹ Therefore, providing barrier-free coverage for counseling and FDA-approved medications should be part of the basic benefits package offered under all public and private insurance. In addition, telephone cessation quitlines or helplines are effective ways of providing intensive counseling services in ways that are easy for tobacco-users to access. Every State now has a cessation quitline, available through a single portal number that works nationwide: 1-800-QUIT NOW. However, these quitlines are under-funded, so the extent of services available varies by State and is largely insufficient to meet the demand for such treatments.

Clinical recommendations for enhancing smoking cessation services include systems-level changes to encourage clinician screening and brief intervention every time a tobacco user is seen within the healthcare system, and increasing referrals to telephone quitlines.¹⁷ By employing evidence-based smoking cessation interventions, we will enable a greater number of Americans to live healthier, longer lives. For example, a study by the National Commission on Prevention Priorities found that increasing the delivery of tobacco-use screening and brief intervention is the single most cost-effective health insurance benefit for adults. In fact, it is more cost-effective than other commonly provided clinical preventive services, including mammography, colon cancer screening, PAP tests, treatment of mild to moderate hypertension, and treatment of high cholesterol.¹⁶

Recommendations:

- Expand access to cessation services that have proven to be effective.
- Implement systems-level changes to encourage clinicians to screen their clients for tobacco use and offer brief interventions.
- Provide barrier-free coverage for counseling and pharmacotherapy as part of a basic health care benefits package.
- Provide funding for mass media efforts to get smokers to quit, and to seek help through telephone quitlines and the medical care system.

Regulation Efforts

The tobacco industry’s marketing expenditures have risen at unprecedented rates in the 10 years since the 1998 Master Settlement Agreement. According to the Federal Trade Commission’s most recent report, tobacco marketing expenditures nearly doubled from 1998–2005, from \$6.9 billion to \$13.4 billion.¹⁸ Furthermore, the tobacco industry is using new marketing avenues, such as the internet, to pitch their products.

To counteract these efforts, we have to consider stronger regulation of tobacco products, including their sales and marketing. Considering the toll of tobacco use on the Nation’s health, legislators should consider measures that can halt tobacco marketing and sales to our youth, require tobacco companies to disclose the contents of tobacco products and remove harmful ingredients, and require more effective health warnings on tobacco products.

Recommendations:

- Consider stronger regulation of tobacco products, including their sales and marketing.
- Halt tobacco marketing and sales to youth.
- Require tobacco companies to disclose the contents of tobacco products and remove harmful ingredients.
- Require more effective health warnings on tobacco products.

Reducing Secondhand Smoke Exposure

At present, only 18 States have passed stringent indoor smoke-free ordinances that protect non-smokers from the deadly effects of secondhand smoke.¹⁹ Even fewer States have ordinances that restrict outdoor secondhand smoke exposure. This leaves most of the Nation without adequate protection against secondhand smoke. Federal legislation to make indoor and outdoor environments smoke-free, including restaurants, bars, workplaces, parks and public building entrances should be considered as a means to accelerate national progress in reducing non-smokers’ exposure to secondhand smoke.

Recommendation:

- Consider Federal legislation to make indoor environments smoke-free, including restaurants, bars, workplaces, and public buildings.

Roles of State and Local Health Departments

State and local public health agencies have been on the forefront of the fight against tobacco for decades. They have been facilitators and conveners, advocates and educators. They have taken the lead in implementing many of the evidence-based community recommendations that have greatly contributed to our progress to date in reducing tobacco use. However, many of these agencies have no sustained funding, and almost none have sufficient funding to implement the recommendations of the Centers for Disease Control and Prevention. If we are going to have a consistent nationwide effort that further reduces the overall toll tobacco places on our society, as well as the disproportionate burden it places on minorities and low-income populations, then it is essential that we increase sustained core funding for public health agencies at the State and local levels.

Recommendation:

- Enact legislation that identifies a specific source and a specific annual amount for the sustained funding of core public health activities at the State and local levels.

REDUCING THE TOLL OF OBESITY

The obesity epidemic constitutes one of the most significant public health threats facing the Nation, with health and social consequences that reverberate across all sectors of our society and economy: to individuals, families, communities, employers, schools, and government at all levels.²⁰ The obesity epidemic has resulted from the convergence of many changes in individual lifestyle behaviors, societal norms, community design, and economic trends.²¹ Eating outside of the home more often and the growth of super-sized meal portions;²² less time spent cooking at home;²⁴ more time spent in front of televisions, computers, and playing video games;²¹ pressure to spend more time on academics rather than physical education in schools;²⁵ easy access to unhealthy foods in elementary as well as secondary schools;²¹ urban design and transportation infrastructures that are automobile-centric;²⁷ and work environments that are highly conducive to sedentary lifestyles²¹ are all factors that have contributed to the rapid escalation of this epidemic during the past three decades. Given the many social, environmental, and economic factors contributing to the obesity epidemic, multiple approaches will be required to stabilize and then reverse the obesity epidemic.

Since the late 1970s, the prevalence of obesity among children—the segment of our population that is most vulnerable to this epidemic—has more than doubled among preschool (5.0 percent to 12.4 percent) and school aged (6.5 percent to 17.0 percent) children and tripled among adolescents (5.0 percent to 17.6 percent).²⁸ In addition, the child obesity epidemic is much more severe in low income and minority populations. In Los Angeles County, for example, the prevalence of childhood obesity in 2006 ranged from a low of 4 percent in the affluent community of Manhattan Beach to a high of 37 percent in the city of Maywood, one of the lowest income communities in the county.³⁴ Nationally, approximately 9,000,000 children over 6 years of age are considered obese.²⁹ If this trend is not reversed, an estimated one in three babies born today will develop diabetes in their lifetimes, and the life expectancy of our children may, for the first time in modern history, actually be shorter than the life expectancy of their parents.³⁰ ³¹ ³²

The obesity epidemic has not spared the adult population either. Among adults 20–74 years, the rate of obesity (defined as a body mass index of greater than 30) has more than doubled in the past three decades from 15.0 percent (1976–1980 NHANES) to 35.1 percent (2005–2006 NHANES).³³ In addition, another one-third of adults are overweight (defined as a body mass index of 25.0–29.9) and at risk of developing obesity and related medical complications. Significant disparities also exist in obesity rates among adults by age, gender, race-ethnicity, geography, and socio-economic status, with the highest rates seen among non-Hispanic black and Mexican-Americans. Non-Hispanic blacks and Mexican-American women aged 40–59 years, for example, continue to experience a higher rate of obesity than their non-Hispanic white counterparts (53 percent and 51 percent, respectively versus 39 percent).³³

Research studies have established that obesity is a major risk factor for numerous chronic diseases, including coronary heart disease, type 2 diabetes, hypertension, certain types of cancers, fatty liver disease, and arthritis.³⁵ Among obese middle-aged men, for example, moderate to severe obesity is associated with a 2- to 3-fold increase of developing coronary heart disease and having a heart attack.³⁶ Among children, obesity at an early age predicts a greater risk for earlier onset of type 2 diabetes and heart disease in adulthood.³⁰ ³¹ ³²

Between 1987 and 2001, the rising obesity rate and related medical conditions accounted for more than one-quarter of the growth in health care spending in the United States.³⁷ Additionally, non-health care costs such as lost productivity attributable to obesity have been estimated to be even greater than health care spending, placing many of our businesses at a disadvantage in an increasingly competitive global marketplace.²⁷ In 1995, lost productivity from obesity-related morbidity and mortality was approximately \$47.6 billion nationwide.³⁸ States are also hit hard by the productivity losses associated with obesity. In California, for example, lost productivity from obesity-related morbidity and mortality was reported to be approximately \$3.4 billion in 2000.³⁹ Together, these health care and non-health care costs are likely to grow at an escalating rate over the next generation, as the swelling ranks of obese children reach adulthood and begin developing obesity-related diseases at progressively younger ages.

As a nation, we are faced with the daunting task of stabilizing and reversing this costly epidemic. Because there are many contributors to obesity, leaders at all levels of government and in the community must work together and take a multi-pronged approach to combating the obesity epidemic, implementing effective and sustainable interventions where Americans learn, work, and play. Many national leaders, including U.S. Senator Tom Harkin and Dr. Joseph Thompson,²⁰ Surgeon General for the State of Arkansas, have echoed similar calls for action.

Roles of State and Local Health Departments

We currently have the capability to successfully implement prevention measures which will yield results in both the short-term and long-term. Progress requires leveraging resources across multiple sectors of our society. We need to thoughtfully coordinate various community efforts designed to prevent obesity, create stronger linkages between our healthcare system and public health infrastructure, establish robust public-private partnerships with our business community, and demonstrate strong leadership from our Federal, State, and local government agencies. Local health departments, in particular, working with their State counterparts, can play a crucial role in spearheading efforts to address obesity and other chronic disease threats given their close working relationships with communities, schools, health care providers, and employers. Similar to their roles in tobacco control, local health departments are often the facilitators, advocates, and implementers of evidence-based prevention policies to combat the obesity epidemic, such as improved nutrition standards, school and worksite wellness policies, and land use policies that promote physical activity. However, as with tobacco control, their ability to do this vital work is compromised in the absence of a sustained source of funding that is not subject to the yearly appropriation process.

Recommendation:

- Enact legislation that identifies a specific source and a specific annual amount for the sustained funding of core public health activities at the State and local levels.

Prevention Opportunities in the Healthcare System

Health care reform can, and must, play an important role in obesity prevention. Today's health care environment presents many missed opportunities for reducing adverse lifestyle behaviors at the individual level. Incentives must be created for health care providers and health plans to incorporate evidence-based prevention techniques, including body mass index monitoring as a vital sign, nutrition counseling, breastfeeding promotion, providing advice to parents regarding reducing their child's screen watching, and physical activity promotion (including wider use of pedometers). When providers incorporate these techniques in their clinical practice or as part of an overall health benefits package, the patient experience is enhanced with a more equitable focus on both prevention and treatment.^{21 26}

Recommendations:

- Create incentives for health care providers and health plans to incorporate evidence-based prevention techniques in their clinical practice.
- Increase the utilization of proven clinical prevention techniques such as: body mass index monitoring as a vital sign, nutrition counseling, breastfeeding promotion, providing advice to parents regarding reducing their child's screen watching, and physical activity promotion (including wider use of pedometers).

Community Prevention Measures: Changing Our Environment

Health care reform and efforts to appeal to individual responsibility have limited impact without broader community interventions and policy changes that create environments where the healthy choice becomes the easy choice. These types of efforts require investment and buy-in from different sectors of our society: schools, employ-

ers, cities, residential communities, local governments, community-based and faith-based organizations, etc.

There are numerous opportunities to improve our food environments by increasing access to more nutritious foods and by providing consumers with nutritional information to help them make informed decisions regarding how they feed their families. One type of promising policy intervention designed to address child obesity is the establishment of more rigorous nutrition standards for school meal programs and other foods sold on school campuses.²¹ For example, California's passage and implementation of Senate Bills 677, 12 and 965,^{40 41 42} which set and strengthen minimum school nutrition standards, is a step in the right direction. Minimum nutrition standards can also be instituted in other settings, including work and recreational settings.

Federal programs can also play an important role in addressing child obesity by increasing opportunities for nutrition improvement, especially among low-income families—the segment of our population hit the hardest by the obesity epidemic. Updating and improving the nutrition standards and meal requirements for the National School Lunch Program and the School Breakfast Programs, for example, can make a great impact in promoting health and combating obesity. Together, these two programs provide a significant proportion of a participating student's daily nutrient and caloric intake on school days. The programs also serve as a safety net for children in need by providing meals at no or reduced cost.⁴³ Likewise, removing barriers to participation for families eligible for the underutilized Supplemental Nutrition Assistance Program (SNAP) can provide greater access to healthful foods for these families. Another resource that low-income families can access to improve their nutrition is the recently improved Women, Infants, and Children (WIC) program food package, which now includes more healthful foods such as fruits and vegetables. WIC also promotes and supports breastfeeding, another important strategy for preventing child obesity.²⁰

Providing nutrition information at points of purchase (e.g., menu labeling) and other efforts to better inform consumers may also prove to be effective in combating the obesity epidemic. According to a recent health impact assessment (HIA) conducted by our public health department in Los Angeles County,⁴⁴ if 10 percent of large chain restaurant patrons were to order an average of 100 calories less per meal as a result of menu labeling, then 38.9 percent of the 6.75 million pound average annual weight gain in the county population aged 5 years and older would be averted. Our county was also instrumental in gaining passage of a California law (SB 1420) that will require menu labeling (including calories on the order board) at all large chain fast food and full service restaurants.

Restricting food marketing to young children, establishing farm subsidies that support affordable healthy food choices, creating other incentives for the food industry to produce lower calorie products and smaller serving sizes, and supporting programs and policies that eliminate “food deserts” are other food policy and environmental approaches that are required to stabilize and reverse the obesity epidemic.^{20 21} Oversight of food marketing of products high in calories, sugar, sodium and fat to our youth, for example, remains an important challenge. Youth (ages 8 to 18) spend an average of 6 hours per day using media, often using more than one medium at a time. In 2006, an analysis by the Federal Trade Commission (FTC) indicates that the Nation's largest food and beverage companies spent \$1.6 billion to market their products to children, including pre-school aged children, and adolescents. Of the advertisements viewed, nearly 98 percent of them by our children and 89 percent by our adolescents were for products that were high in fat, sugar or sodium.⁴⁵

The importance of engineering opportunities for physical activity in our communities, schools, and work places cannot be overstated. Developing environments which are conducive to physical activity represents a key, viable approach to obesity prevention.²⁶ Various evidence-based physical activity interventions (e.g., communitywide campaigns promoting physical activity, point-of-decision prompts to encourage stair usage, school-based physical education, social support strategies such as setting up an exercise buddy system, and individually adapted health behavior change strategies) are available, and are potentially cost-effective for promoting physical activity in different settings, including at schools and in the workplace.^{26 46} Federal incentives to help States and local school districts improve physical education programs may promote wider adoptions of these effective, and potentially sustainable, physical activity interventions.

Finally, addressing land use and transportation practices and policies offers important opportunities for reversing the obesity epidemic in America. For example, the upcoming reauthorization of the Federal transportation bill provides an excellent opportunity for prioritizing and funding projects and infrastructure that pro-

mote walking, bicycling, and other forms of physical activity. In addition, street- and community-scale urban design and land use policies, including zoning regulations, mixed-use and compact development, building codes, street lighting, roadway design standards, traffic calming approaches, and improvements to the continuity and connectivity of sidewalks and streets, are all promising built environment strategies for increasing physical activity.^{25 27} Increasing the utilization of emerging research tools such as health impact assessment can help us quantify the potential health benefits of these measures.

Recommendations:

- Establish more rigorous nutrition standards for school meal programs and other foods sold on school campuses.
- Remove barriers to participation of families eligible for the Supplemental Nutrition Assistance Program (SNAP) and Women, Infants, and Children (WIC) program.
- Provide nutrition information at points of purchase (e.g., menu labeling).
- Examine food policy and environmental approaches that may prove effective for combating the obesity epidemic such as: restricting food marketing to young children, establishing farm subsidies that support affordable healthy food choices, creating other incentives for the food industry to produce lower calorie products and smaller serving sizes, and supporting programs and policies that eliminate “food deserts.”
- Expand the implementation of evidence-based programs that increase physical activity such as: communitywide campaigns promoting physical activity, point-of-decision prompts to encourage stair usage, school-based physical education, social support strategies such as setting up an exercise buddy system, and individually adapted health behavior change strategies. Provide Federal funding for a major national education campaign that uses a multi-media approach to encourage physical activity throughout the life course.
- Expand adoption of urban planning, land use, and transportation practices and policies that promote walking, bicycling, and other forms of physical activity.
- Increase the utilization of research tools such as health impact assessment (HIA) to quantify the potential health effects of policies and practices in sectors where health is not the primary interest but decisions have significant health effects.

Knowing and Using the Best Evidence to Improve Health and Prevent Disease

For the vast majority of our serious illnesses and injuries that are preventable, our success depends on knowing what works, both for individual patients and communities, and implementing these policies and practices. Unfortunately, the two national efforts to systematically review the research, make recommendations based on these findings, and assure that these best practices are disseminated to key user groups and then implemented, are severely underfunded. The U.S. (Clinical) Preventive Services Task Force has been more comprehensive because it has a clearly delineated domain (clinical medicine) and has had a sustained, although inadequate, funding base. In contrast, the Task Force on Community Preventive Services, supported by CDC staff, has had erratic and consistently insufficient funding. It has only been able to cover a minority of the possibly effective community policies and programs, and it has had virtually no funding to disseminate its findings. A much-needed increase in funding for both of these expert panels should be coupled with increased support to fill the priority research gaps they have identified.

Recommendation:

- Increase and stabilize the funding for the U.S. (Clinical) Preventive Services Task Force and the Task Force on Community Preventive Services.

In conclusion, we have many opportunities to reduce chronic diseases, which together constitute over 80 percent of the burden of disease in the United States. Health care reform can play a vital role in these efforts. Changes in financing, health benefit structure, provider incentives, and practices can be very helpful in reducing the toll of these diseases. However, if we are to reach our health potential as a nation, we must devote equal energy to prevention at the community level. There are policy and programmatic changes at the community level that have been clearly shown to be effective in reducing tobacco use and the rate of obesity. Too often they are ignored.

Finally, we must recognize that there are common underlying causes for most of our chronic diseases, and these causes reside in our social environment and our physical environment. Poverty, poor educational attainment, and social isolation are important risk factors for virtually all chronic diseases. To improve our Nation's health and competitiveness, it is vital that all congressional committees consider how their decisions affect health. Policies in agriculture, transportation, housing, en-

vironment, commerce, and education all affect health and disparities in health among groups. We possess the tools, including health impact assessment, to determine likely health effects of policies being considered in each of these, and other, sectors. By routinely using these tools and considering the health implications of all Federal policies, we can jump-start a national effort to be not just a healthy nation, but the healthiest Nation.

Thank you again for this opportunity to address this important committee and discuss how we can bring a full dose of prevention to the diseases caused by these problems.

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Senator HARKIN. Thank you very much, Dr. Fielding.

Now we go to Mr. William Emmet, the Director of the Campaign for Mental Health Reform. In this role he coordinates the efforts of over 18 national organizations to make mental health services a national priority. He previously worked for the National Association of State Mental Health Program Directors and the National Alliance on Mental Illness.

Again, as I said, all your statements will be made a part of the record. Please proceed.

STATEMENT OF WILLIAM EMMET, DIRECTOR, CAMPAIGN FOR MENTAL HEALTH REFORM, WASHINGTON, DC

Mr. EMMET. Well, thank you very much, Mr. Chairman and Senator Burr and members of the committee. It's a wonderful opportunity to be here, and I will do my best in the brief time available to demonstrate that it is impossible in fact to consider a comprehensive approach to health reform in this country without understanding the many ways in which addiction, substance use, and a range of mental health disorders contribute to the overall picture of chronic disease.

Mental health and substance abuse have been overlooked too frequently, as you mentioned, Senator, and I appreciate your commitment to seeing that that doesn't happen in health reform efforts under way now.

The costs associated with the failure to appropriately treat mental health and substance use disorders are high. According to the National Institute on Drug Abuse, the economic cost of drug, alcohol, and tobacco use in the United States is more than \$500 billion. In 2002 mental illnesses and substance use disorders led to \$193 billion in lost productivity, which happens to be more than the revenue of 499 of the Fortune 500 companies. By 2013 this figure is estimated to rise to more than \$300 billion.

The World Health Organization has found that depression alone was the fourth leading cause of disease burden in 1990 and by 2020 predicts that it will be the single leading cause. Indeed, right now mental illness is the leading cause of disability for people between the ages of 15 and 44 in the United States and Canada. As we all know too well, suicide accounts for over 32,000 deaths annually, or at least in 2005, the last year for which we have figures, many of them preventable through timely intervention.

Mental health and substance use disorders frequently co-occur. It is in part for this reason that the mental health and addictions field, still largely separate in terms of funding and organization, now recognize the need for greater collaboration in practice and in health care policy. They are treating many of the same people with too little coordination and costly consequences.

Yet mental illness and substance abuse do not exist in a vacuum. We can now appreciate that mental health and substance use disorders are also interwoven with other chronic disorders, including obesity and tobacco consumption, heart disease, pulmonary disorders, hypertension, and the list goes on. There is a developing awareness that failure to address the co-occurrence of mental

health disorders, substance use disorders, and other chronic conditions leads to worse outcomes overall and more costs across the Nation's health care system.

Many people with mental health and substance use disorders suffer from chronic conditions simply because they are not receiving appropriate health care. People with mental illnesses are uninsured at twice the rate of the general population. Thirty-four percent of people with mental illness have no health coverage at this point. In other words, many people with mental illnesses are excluded from our Nation's porous health care system right from the start.

Mr. Chairman, people with mental illness in the public mental health system die on average 25 years earlier than the general population. This is a stunning revelation that has come to light in recent years. The vast majority die because they suffer from a host of chronic conditions that are largely preventable: respiratory ailments, complications associated with obesity and poor nutrition, diabetes, et cetera. People with mental illness may constitute in fact the most unhealthy segment of our Nation's population. As best we can tell, no other identified group of Americans lives with so many chronic medical conditions or as a consequence die so young.

The excessive morbidity and mortality they experience is certainly a public health crisis. People with schizophrenia die from diabetes at 2.7 times the rate of the general population. They die from cardiovascular disease at 2.3 times the rate of the general population, 3.2 times the rate from respiratory disease, and 3.4 times the rate from infectious diseases.

We are also learning more about the interplay of depression and other conditions. The likelihood of heart attack is four times greater for persons with depression than in the general population. The likelihood of stroke is 2.6 times greater. Depressed men are 2.3 times as likely to develop diabetes as the rest of the population.

This all adds up to more outpatient visits and hospital days for patients in whom depression accompanies a chronic condition than for those without depression. Medical-surgical costs are in fact 1.4 times higher for people who are also suffering depression.

Now, any discussion of prevention and modifiable risk factors should include a look at tobacco consumption among people with mental health diagnoses. Persons with mental illness smoke approximately half of all cigarettes produced in this country and are only half as likely to quit as smokers without mental illness. Approximately 50 percent of those with a serious mental illness are smokers, compared with 23 percent for society at large. Evidence also points to people with mental illness consuming more of each cigarette they smoke and inhaling the smoke from them more deeply.

We've seen that the mortality rates for people with mental illness are much higher than those for others in society. Roughly half of those deaths are due to smoking-related illnesses.

Looking at other ways we can look at prevention, we should give considerable thought to how the bad outcomes we are now seeing can be avoided through preventive efforts. We in the field look forward very much to the March release of an Institute of Medicine report on the prevention of mental disorders, produced in part with

support from the Substance and Mental Health Services Administration.

Prevention comes in many packages, as the members of this committee know so well. In this instance it seems evident that a baseline preventive approach has to start with public education about the fact that mental illnesses are, in fact, illnesses like any other.

I'd love to talk more about preventive efforts, but I see that the time is seeping away. I just want to say that we must develop a better understanding of many of the factors, as Dr. Fielding has mentioned, that lead to the experience of mental illness and chronic illness, including trauma, maternal depression, and many other community factors.

There is much to be done, Senator, and the effort now under way to reform our Nation's approach to health provides an unparalleled opportunity to address these issues. Thank you once again for the opportunity to discuss the ways in which substance abuse and mental health disorders contribute to the picture of chronic disease in our Nation. There is much to be learned about it. My hope is that by beginning this examination we are able to move toward a general improvement of the health status of millions of Americans and a reduction in unnecessary costs and unnecessary lives lost in this country.

Thank you, Senator.

[The prepared statement of Mr. Emmet follows:]

PREPARED STATEMENT OF WILLIAM EMMET

Mr. Chairman, members of the committee, thank you for inviting me to speak with you today about mental health and substance use disorders in the context of chronic disease. I am honored to have this opportunity and will do my best in the time available to demonstrate that it is impossible to consider a comprehensive approach to health reform in this country without understanding the many ways in which addiction, substance use, and a range of mental health disorders contribute to the overall picture of chronic disease.

I serve as Director of the Campaign for Mental Health Reform, a coalition of 18 organizations working together on Federal policy. All 18 organizations agree that "mental health is integral to health" and collaborate on development of policy informed by this verity. I also have had the privilege of working closely with colleagues in the substance abuse community through the mechanism of the Whole Health Campaign, which was formed to promote the idea that health policy cannot be addressed without incorporating an understanding of both mental health and substance abuse. I am indebted to a large number of my colleagues for the help they have provided in the preparation of this testimony.

This hearing's focus on chronic disease and prevention and the pairing of substance abuse and mental health with tobacco-use and obesity on this panel are propitious in several ways, and I applaud the decision to present these topics in this manner. It is important from the outset to understand that mental illnesses and substance use disorders are chronic conditions that are also intertwined with other chronic conditions, creating a complex web in which many lives are snared and much money is wasted.

Perhaps the first point to make about mental illnesses and substance use disorders is that they frequently travel together, wreaking havoc on individuals' lives with repeated cycles of dispiriting and destructive behavior and leaving a trail of pain and suffering that swallows whole families. In many people, it is impossible to separate one condition from the other. It is in part for this reason that the mental health and addictions fields, still largely separate in terms of funding and organization, are now recognizing the need for greater collaboration in practice and healthcare policy. They are treating many of the same people. Your invitation to discuss these issues together augurs well for the direction in which future health policy must head.

While we often use the term "co-occurring disorders" to describe concurrent mental health and substance use conditions, we are increasingly using the term to de-

scribe the overlay of mental disorders and a broader range of chronic disorders. It is important to note, also, that mental disorders themselves frequently co-occur. For example, according to the Multimodal Treatment Study of Children with Attention Deficit/Hyperactivity Disorders (MTA) conducted by the National Institute of Mental Health, 79 percent of children with AD/HD have at least one co-occurring mental disorder and according to the Centers for Disease Control and Prevention (CDC), 50 percent of children with AD/HD have a co-occurring learning disability. New data is beginning to show significant co-occurrence between AD/HD and autism.

Measures from different sources all point to the conclusion that the costs associated with the failure to appropriately treat mental health and substance use disorders are high. According to the National Institute on Drug Abuse, the economic cost of drug, alcohol and tobacco abuse in the United States is more than \$500 billion. Drug, alcohol and tobacco use currently cost schools throughout the country an extra \$41 billion per year in truancy, violence, disciplinary programs, school security and other expenses.

In 2002, mental illnesses and substance use disorders led to \$193 billion in lost productivity—more than the revenue of 499 of the Fortune 500 companies—and by 2013, this figure is estimated to rise to more than \$300 billion.

Using a measure called Disability Adjusted Life Years (DALYs) in its study of the Global Burden of Disease, the World Health Organization has found that depression was the fourth leading cause of disease-burden in 1990 and by 2020 will be the single leading cause. Indeed, mental illness is already the leading cause of disability for people between 15 and 44 in the United States and Canada.

When we examine mental health, substance use, and other chronic disorders, however, it is only by seeing how deeply interwoven they are that we truly appreciate the costs of failing to address them in an integrated approach. Mental health and substance use disorders are interwoven with other chronic disorders, including obesity, tobacco consumption, heart disease, pulmonary disorders, and hypertension. Failure to consider the co-occurrence of mental health disorders, substance use disorders, and other chronic conditions leads to worse outcomes and more costly treatment.

Many suffer from these conditions simply because they are not receiving appropriate healthcare. As Joseph Parks, M.D., director of the Missouri Department of Mental Health, points out, this is an issue for all people with limited income, which certainly includes those who utilize the public mental health system. Preventive care is all but unknown in this population. As a result, they overuse emergency rooms, get less primary care, and go for routine screens and tests at significantly lower rates. They also have very low rates of dental care, which is often not paid for by public programs. Finally, it would be a mistake to think that people receiving services in the mental health system have a direct link to general medical care; there is little integration of primary care and psychiatry.

People with mental illnesses are uninsured at twice the rate of the general population: 34 percent of people with mental illness have no health coverage at this point. In other words, many people with mental illnesses are excluded from our Nation's porous healthcare system right from the start. In addition, it is possible to identify "patient factors" (amotivation, fearfulness, homelessness, victimization/trauma, resources, advocacy, unemployment, incarceration, social instability, IV drug use, etc.), "provider factors" (comfort level and attitude of healthcare providers, coordination between mental health and general health care, stigma), and "system factors" (funding, fragmentation) as reasons people with mental illnesses are receiving poor overall healthcare.

The result? As documented by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of State Mental Health Program Directors (NASMHPD), people with mental illness in the public mental health system die *on average* 25 years earlier than the general population. They die because they suffer from a host of chronic conditions that are largely preventable: respiratory ailments, complications associated with obesity and poor nutrition, diabetes, etc. Indeed, as alarming as this data about premature death is, we should not let it obscure the fact that people with mental illness may constitute the most unhealthy segment of our Nation's population. As best we can tell, no other identified group of Americans live with so many chronic medical conditions or, as a consequence, dies so young. It is estimated that as much as 8 percent of adult Americans—17.5 million people—have a serious mental illness; the excessive morbidity and mortality they experience is certainly a public health crisis.

It is only relatively recently that researchers have begun to collect reliable data on this issue, but the scope of the problem has become clear. While suicide and injury account for about 30–40 percent of premature deaths in persons with schizophrenia, about 60 percent are due to "natural causes." According to a 2000 study

reported in *Schizophrenia Research*, people with schizophrenia die at 2.7 times the rate of the general population from diabetes, 2.3 times the rate from cardiovascular disease, 3.2 times the rate from respiratory disease, and 3.4 times the rate from infectious diseases.

Some very revealing work has been done using data from the Behavioral Risk Factor Surveillance System (BRFSS), the State-based surveys conducted by the CDC. It shows that persons with high health risks are highly likely to have a comorbid mental illness. It also shows that persons with mental illness constitute a significant portion of the target population of major public health programs. And the study leads to the conclusion that persons with mental illness appear to qualify as a Health Disparities Population.

A number of studies have looked at depression's link to various illnesses. Depression is a risk factor for stroke and coronary artery disease. The likelihood of developing myocardial infarction is four times greater for persons with depression than in general population; the likelihood of stroke is 2.6 times greater, according to two studies. Depressed men are 2.3 times as likely to develop diabetes, according to another. Other studies note the high impact of depression on outcomes of cardiovascular illness. This all adds up to more outpatient visits and hospital days for patients in whom depression accompanies a chronic condition than for those without depression. Medical/surgical costs for people also suffering depression were 1.4 times higher than for those who were not in one HMO. Myocardial infarction plus depression yielded 41 percent higher costs in another study.

A study of Medicaid patients in Maine had implications for policy on several levels. It revealed the importance of screening tools for depression in primary care and for health issues in mental health settings, the need for reimbursement for mental health interventions in primary care and health interventions in mental health settings, the benefits of integrated mental health/health care management for individuals with complex needs, and the need for integrated analysis of utilization and cost across both mental health and health care.

A new study of Medicaid patients in six States published in this month's issue of *Psychiatric Services* indicates that substance abuse also has an extreme impact on general medical costs. It shows that as patients with substance abuse disorders got older, their medical care costs increased at a far higher rate than behavioral health costs. For people with substance abuse disorders—on average, 29 percent of the Medicaid population—the six States paid \$104 million more for medical care than for those patients who did not have an alcohol or drug abuse diagnosis.

I earlier discussed the co-occurrence of mental health disorders and substance abuse. Given the scope of today's hearing, it may also be instructive to look more closely at the intersection of tobacco use with mental disorders. According to the Smoking Cessation Leadership Center, based at the University of California at San Francisco and funded largely by the Robert Wood Johnson Foundation, persons with mental illness smoke half of all cigarettes produced and are only half as likely to quit as smokers without mental illness. Approximately 50 percent of those with serious mental illness are smokers, compared with 23 percent for society at-large. Evidence also points to people with mental illnesses consuming more of each cigarette they smoke and inhaling the smoke from them more deeply. We have already seen that mortality rates for persons with mental illness are much higher than those for others in society; half of these deaths are due to smoking related illnesses. There is evidence, too, that smoking is also associated with increased insulin resistance, which clearly holds implications for the high rates of diabetes in people with mental illnesses.

Where does this lead us?

It should be apparent from this summary of data that mental health and addictions treatment must be fully integrated into a coordinated health reform agenda. As the Nation's health policy is reshaped, we must not overlook the interaction of mental health and addictions disorders with each other and with a range of chronic conditions. The committee's outreach to the substance abuse and mental health communities clearly indicates that you have no intention of crafting such an incomplete policy approach, so I am greatly encouraged and pledge the assistance of our communities in your ongoing work.

A number of models and approaches that have entered the health reform debate in recent months hold promise for improvement in the Nation's ability to address chronic conditions and prevention, but their implications for mental health and substance abuse have not, as yet, been fully explored. For example, most descriptions of the coordinated care models known as "medical homes" (or "clinical homes") make little reference to mental health or substance abuse. We have seen that the lack of coordination in medical care may, in fact, be most pronounced when it comes to

mental health and substance abuse disorders, so it is extremely important that the place of these disorders in the medical home receive more attention.

Similarly, much hope for the improvement of our Nation's healthcare delivery system has been placed in expansion of health information technology. While we feel it very important to achieve appropriate standards for privacy and security in HIT systems, we would not want such standards to somehow exclude or separate mental health and substance abuse treatments from the rest of the medical community. Properly implemented, in fact, HIT can be an instrument of consumer empowerment, leading to much greater awareness of one's health status and providing the opportunity for improved self-management strategies.

The emphasis on quality and effectiveness characterizing much healthcare discussion these days must also be cast in terms that accommodate mental health, substance abuse, and their interaction with other conditions. Approaches to the care and treatment of people with the chronic conditions discussed earlier—diabetes, heart disease, respiratory illnesses—should always include mental health and substance use screening. By the same token, mental health and substance abuse service providers should ensure their clients and patients are receiving primary medical attention. As in much of medicine, the trend should be towards payment for outcomes.

We also should give considerable thought to how the bad outcomes we are now seeing can be avoided through preventive efforts. As members of this committee know so well, prevention comes in a variety of packages. In this instance, it seems evident that a baseline preventive approach must be public education promoting the understanding that "mental health is essential to overall health." Widespread acceptance of this concept would begin to enable individuals and systems to overcome the barriers to effective care I have tried to identify in this testimony.

We must also approach prevention across the lifespan and work to provide the appropriate screens, starting with well-child visits, that can identify the co-occurrence of mental health, substance abuse, and chronic conditions. It has long been a popular belief that mental illnesses and addictions begin in late adolescence or early adulthood. In fact, this is a misconception. The average age of onset for mental disorders is 14. Addictions to alcohol, marijuana, and tobacco also start in adolescence or childhood, and studies are clear that when use of these substances is started at an early age, the consequences later in life are much more pronounced than they otherwise would be. For example, youth who first smoke marijuana under the age of 14 are more than five times as likely to abuse drugs in adulthood.

We must develop a better understanding of the role trauma plays in mental health conditions and substance abuse and then employ approaches that mitigate trauma's effect. We must understand and address maternal depression, the consequences it can have on a young child's physical and emotional development, and the ways it can play out over the span of that young child's life.

With respect to the contributions of mental health and substance abuse disorders to the range of chronic conditions, work can be done to address modifiable risk factors, including: smoking, alcohol consumption, nutrition, exercise, intravenous drug use, unsafe sexual activity, time spent in group care facilities (leading to TB and infectious diseases). It is in our failure to pay attention to these factors that we can begin to identify the roots of many chronic conditions afflicting people with mental health and substance use disorders.

Indeed, such prominent practitioners as members of NASMHPD's Medical Directors Council point out that established monitoring and treatment guidelines to lower risk are underutilized in the population of people with serious mental illnesses. This is true both in the case of practitioners in mental health and addictions treatment facilities and practitioners in the larger medical arena who see people with mental health or substance abuse disorders. The failure to treat metabolic syndrome in patients with schizophrenia is an unfortunate but common example of the sort of missed opportunities common today. If mental health professionals, who often spend much of their energy making sure their clients are taking their prescribed psychotropic medications, could monitor their follow-up with other medical interventions and lifestyle modifications, the lives of many people with mental illnesses would be extended.

We need to know more about the interplay of mental health, substance abuse, and chronic diseases. Surveillance tools that analyze both physical health and mental health and their interaction will be a boon to our growing understanding of their complex relationships. With that information, we can begin to develop public health programs aimed at risk reduction or chronic disease prevention that address mental health issues in program design, implementation and assessment. We need also to encourage collaboration between public behavioral health and public health authorities and remove financial disincentives to their coordination.

There is much to be done, and the effort now underway to reform our Nation's approach to health provides an unparalleled opportunity to address these issues. Thank you once again for the opportunity to discuss the ways in which substance abuse and mental health disorders contribute to the picture of chronic diseases in our Nation. My hope is that by beginning this examination, we are able to move towards a general improvement of the health status of millions of Americans and a reduction in unnecessary costs in our health system.

Senator HARKIN. Thank you very much, Mr. Emmet.

Now to introduce our next witness I will turn to my good friend from North Carolina, Senator Burr.

Senator BURR. Thank you, Mr. Chairman. Thank you for the opportunity to formally welcome and introduce Dr. Allen Dobson. Dr. Dobson was the Assistant Secretary of Health Policy and Medical Assistance in the North Carolina Department of Health and Human Services from 2005 to 2007. In addition to those duties as Assistant Secretary, he also served as North Carolina's medical director.

In 2007 Dr. Dobson stepped down from his State appointment to become the Vice President for Clinical Practice Development for North Carolina's health care system and returned to his position as President of Caberas Family Medicine.

Dr. Dobson is a native of North Carolina, received his undergraduate degree from North Carolina State University, his medical degree from Wake Forest University—who we were very proud of until they lost last night and lost the No. 1 spot in the national basketball rankings—and completed his residency in family medicine at East Carolina. He certainly has a biography that would lead him to run for statewide office. I am hopeful that's not in his plans.

Mr. Chairman, Dr. Dobson has been actively involved in health care policy on a State and national level for a long time. He was an early leader and developer of the nationally recognized community care program of North Carolina. It's primary care based on Medicaid managed care programs. The program received the Annie E. Casey Award for Innovations in Government, presented by the Harvard Kennedy School of Government in October 2007.

It's particularly an honor for me to introduce him, but more importantly I think a special treat for those of us on this panel to hear from somebody who has proven successes at reforming the health care system. I welcome Dr. Dobson.

Senator HARKIN. Thank you, Senator Burr.

This committee is now blessed to have two Senators from the great State of North Carolina on this committee. I would ask if our new Senator, Senator Hagan, would like to add anything to what Senator Burr said about Dr. Dobson.

STATEMENT OF SENATOR HAGAN

Senator HAGAN. Thank you, Mr. Chairman.

Senator Burr certainly gave an overview of Senator Dobson's great resume and record, but I personally had the opportunity to work very closely with him for a number of years when I was the chairman of the budget in North Carolina as a State senator. We were very lucky to have you working so hard on our behalf, and I think the Community Care program which we'll be hearing about is a model that I'm hoping that the rest of the country will take serious note of. It helps from a primary care physician's standpoint.

It's funded in a different way, and I think that there's a lot of good things that he'll share with us today.

It's definitely working and I think it's something that we need to be looking closely at from a Federal level and hopefully replicating in other areas.

Thank you.

Senator HARKIN. Thank you very much, Senator Hagan.

Dr. Dobson, it looks like you've got good support from your two Senators here. Welcome. Please proceed.

**STATEMENT OF ALLEN DOBSON, JR., M.D., FAAFP, CHAIRMAN,
NORTH CAROLINA COMMUNITY CARE NETWORKS, INC., AS-
SISTANT SECRETARY FOR HEALTH POLICY AND MEDICAL
ASSISTANCE, NORTH CAROLINA DEPARTMENT OF HEALTH
AND HUMAN SERVICES, RALEIGH, NC**

Dr. DOBSON. Thank you. You might think I was from North Carolina.

[Laughter.]

Thank you, Senator Harkin, Senator Burr, for your kind introductions, and Senator Hagan. Distinguished members of the committee, thanks for the invitation to come here today and share with you Community Care of North Carolina.

I'm going to talk about the delivery system. It's about how do you put this together and do what we know is right for the citizens. Community Care of North Carolina is a public-private partnership between the State of North Carolina and 14 not-for-profit networks that are comprised of the majority of local health care providers, mainly primary care physicians, hospitals, health departments, social service agencies, and the safety net organizations.

Some of our networks include mental health and schools. It is about putting together the pieces. Together this partnership delivers the key components of the medical home and a community-based management system for Medicaid, our SCHIP recipients, and other low-income adults and children in our State. It now includes over 3,500 primary care physicians, 1,200 medical homes, covers all 100 counties of North Carolina, and manages 875,000 recipients.

Community Care delivers quality and cost savings to our State through basically three critical elements. First, primary care physicians serve as a medical home, where patients are known, care is coordinated, and quality is kind of the first priority.

Second, these local networks serve as a virtual integrated health care system in the community that link the medical home and patients to the rest of the providers and support agencies in the community. Health care is like politics; it is local, and they're all different. These networks leverage existing community resources and relationships and provide the needed physician leadership locally and local collaboration to create creative solutions in improving care and quality to meet our statewide goals. These networks provide a flexible structure that has been adaptable to rural as well as urban areas of our State.

Third, the State funds these medical homes and networks differently. As we've heard, rather than fee for service, we provide a monthly fee to the medical home; but we also provide a monthly fee to the network to provide those additional resources that binds

the system together, such as case managers, care coordinators, clinical pharmacists, and part-time medical directors to work with practices, and a local quality improvement infrastructure to help support these medical homes. This assures that optimum supports are provided to patients and improvement goals are achieved.

Community Care has clearly identified and demonstrated quality improvement, cost savings, and growth, because we started as a pilot and it grew into a statewide program—not mandated, but by grassroots. Community Care physicians, both locally and statewide, meet as a medical directors group and they develop and agree upon quality measures, desired outcomes, and whether these are local or statewide initiatives. The results are monitored and reported back.

We have seen improvement in asthma care, resulting in a 35 percent decrease in hospitalizations and improvement in diabetes care. We've seen improvement in preventable dental caries in small children because we decided that we didn't have dental access, so we would train primary care physicians to do screenings and fluoride varnish, and we've seen decreased caries. Other networks have seen increased Medicaid preventive visits.

The network medical directors meet with State officials regularly to plan and implement initiatives to meet State goals.

We've also seen significant cost savings through reduction of costs. The Sheps Center at UNC as well as Mercer have done statistically reliable cost comparisons to show that we've saved in excess of \$100 million a year in the State Medicaid program from reducing costs.

In short, we've successfully managed the North Carolina Medicaid program through this clinical management strategy, rather than just payment reduction or regulatory controls. I would add, in this particular economic environment that our State and the Federal Government is faced with, Community Care was built for just such times. Medicaid is countercyclical. It's needed when the economy is bad. At the same time, when budget pressures are hard having a local network and a way to reach into the community and make changes is valuable and important. We look forward to our Community Care network stepping up and helping the State through this tough economic time.

Community Care is now the centerpiece strategy for North Carolina in health care. It is enthusiastically accepted by both patients and providers. We have been mandated to expand into SCHIP and into the aged, blind, and disabled. We now have a Medicare demonstration waiver that we hope will be approved very shortly to allow Community Care to serve those duly eligible for Medicare and Medicaid and our at-risk Medicare population, because this is a clinical program, not a payment program.

The Community Care program is also the platform for a multipayer public and private quality improvement effort, which is physician-led, around five key diseases in our State, and is also helping as the platform for addressing important health care issues such as health disparities, prevention, mental health integration, the uninsured, childhood obesity, and child development.

We believe that Community Care is an important national model for health care reform. It is local. Its local infrastructure can work both with rural and urban, as well as public and private settings.

We've built this on Medicaid, but this is a clinical program and it can work in any particular area.

The path forward for our system can clearly be informed by a lot of our important work that's done by our most and best integrated health care systems. I will tell you that the majority of our Nation's health care is still provided in communities where there's no system at all—rural, fragmented, multiple providers. The lessons learned in Community Care of how you put a health care system together in a virtual sense for a common cause can provide a road map of how we organize our local systems, regardless of size, to focus on quality, cost, improvement in the health of citizens.

In summary, while health IT, payment reform, and expansion of health care insurance are extremely important, I think it is essential that we have a sustained effort in organizing the health care delivery system to really achieve access, quality, and efficiency goals and achieve sustainable goals. Community Care thus I think provides an important example of what States can do and how it can provide leadership and new models to possibly provide an alternative for Congress to consider as we talk about health care reform for our Nation.

Thank you for the opportunity to be here, Senators.
[The prepared statement of Dr. Dobson follows:]

PREPARED STATEMENT OF L. ALLEN DOBSON, JR., M.D., FFAFP

Senator Kennedy, Senator Enzi and other distinguished members of the committee; thank you for the invitation to be here today and to share with you the work of Community Care of North Carolina. I am Dr. Allen Dobson, Chairman of the Board of Directors for North Carolina Community Care Networks, Inc., the statewide umbrella organization representing all our local Community Care networks, and former Assistant Secretary and Medicaid Director for the North Carolina Department of Health and Human Services.

Community Care of North Carolina (Community Care) is a public-private partnership between the State of North Carolina and 14 not-for-profit networks that are comprised of the majority of local healthcare providers; primary care physicians, hospitals, health departments, social service agencies and safety net organizations. Together this partnership delivers the key components of a medical home and community-based care management to Medicaid and SCHIP recipients and to other low-income adults and children of our State. Our Community Care networks now include over 3,500 primary care physicians in 1,200 medical homes covering all 100 counties of North Carolina and manage over 875,000 patients.

Community Care delivers improved quality and cost savings to our State through three critical elements. First, primary care physicians serve as "true medical homes" for patients—where the patients are known, care is coordinated and quality care is the first priority. Second, local networks serve as "virtual" integrated healthcare systems that link the medical home and patients to the rest of the local providers and support agencies. These networks, by leveraging existing community resources and relationships, provide the needed physician leadership and local collaboration to create local solutions for improving care management and quality to meet statewide goals. This network system provides a flexible structure that is adaptable to rural as well as to urban areas of our State. Third, the State funds the medical home through an additional monthly fee and also funds the network to provide additional local resources such as case managers/care coordinators, clinical pharmacists, part-time medical directors and the local quality improvement infrastructure to work with and support the local medical homes. This assures optimal supports are provided to patients and that improvement goals are achieved.

Community Care has demonstrated quality improvement, cost saving and phenomenal growth. Community Care physicians, both locally and through a statewide medical directors group, develop and agree upon quality measures and desired outcomes whether for local initiatives or statewide projects. The results are monitored and reported to networks and practices. Many networks have shown significant improvements in asthma care that have resulted in a 35 percent decrease in hospitalizations, as well as improvement in diabetes care. North Carolina has seen im-

improvement in preventable dental caries in small children by training primary care doctors to screen for dental disease and apply fluoride varnish. Other networks have seen a marked increase in preventive visits for Medicaid children. Network medical directors meet regularly with State officials to plan and pilot care improvement strategies. Significant cost savings have also been documented by both the Sheps Center at University of North Carolina at Chapel Hill and Mercer Human Resources Consulting Group. Statistically reliable cost comparisons have shown savings exceeding \$100 million per year since 2003. In short, North Carolina has successfully managed the cost of its Medicaid program through this clinical management strategy rather than just payment reduction and regulatory controls.

Community Care is now the centerpiece healthcare strategy in North Carolina. It is enthusiastically accepted by both patients and providers. The legislature has mandated the expansion into SCHIP and also the aged blind and disabled. Community Care is now seeking a Medicare demonstration waiver to serve citizens eligible for both Medicare and Medicaid as well as at risk Medicare recipients. Community care is also the platform for a major State initiative that will unite public and private payors in adopting and measuring physician-led quality care for 5 key diseases and is helping North Carolina address such important health issues as health disparities, prevention, the uninsured, childhood obesity and child development.

We believe Community Care can serve as an important national model for healthcare reform. Community Care's local infrastructure will work in both urban and rural as well as public and private settings. The path forward for the U.S. healthcare system can clearly be informed by the important work of some of our best and most integrated healthcare systems. However the majority of the Nations healthcare is still provided in communities where there is no "system" at all. Lessons learned in Community Care can provide a road map to organizing all local communities regardless of size in order to focus on quality, costs and improvement in the health of its citizens.

There are a number of lessons from Community Care I would like to re-state. These are: (1) primary care physicians and the medical home are essential to providing improved access to care and prevention; (2) public-private partnerships that develop and strengthen local healthcare systems are important; (3) providers are best motivated when the focus is on quality, population health and how care is delivered locally; (4) a shared responsibility and shared incentives are important; (5) the program must have flexibility that allows communities to organize themselves based on their unique characteristics and resources; (6) strong physician leadership is needed; (7) to create meaningful and lasting improvement you have to engage the physicians and other community providers who care for our patients; and (8) a portion of the saving must be reinvested to further develop local systems and programs.

In summary, while improving Health IT, payment reform, and expansion of health insurance coverage, are important, what is essential is a sustained effort in organizing the healthcare delivery system to achieve needed access, quality and efficiency goals. Community Care thus provides an important example of how States can provide leadership and new models that may provide a valuable alternative for Congress to consider.

APPENDIX 1.—EXAMPLES OF COMMUNITY CARE INITIATIVES

Asthma; Diabetes; Pharmacy Management (PAL, Nursing Home Polypharmacy); Dental Screening and Fluoride Varnish; Emergency Department Utilization Management; Case Management of High Cost-High Risk; Congestive Heart Failure (CHF); Assuring Better Child Development (ABCD); ADD/ADHD; NC HealthNet/Coordinated care for the uninsured; Gastroenteritis (GE); Otitis Media (OM); Projects with Public Health (Low Birth Weight, open access & diabetes self management); Diabetes Disparities; Medical Home/ED Communications; Aged, Blind and Disabled (ABD) care management; Depression Screening and Treatment; Mental Health Integration; Mental Health Provider Co-Location; E-Rx; Partner with AHEC to support Improving Performance in Practice Initiative; Medical Group Visits; and Dually Eligible Recipients.

Senator HARKIN. Thank you very much, Dr. Dobson.

Now it's my privilege to introduce my fellow Iowan, Senator Jack Hatch; who has had a long and distinguished career in the legislature as a State Representative and as a State Senator. He is now the Assistant Majority Leader of the Iowa Senate. He is chair of the Health and Human Services Budget Committee. In 2007 Senator Hatch led the legislature's comprehensive health care reform

effort, in which they committed to covering all Iowa children by 2011.

Senator Hatch created both the Community Health Center Incubator Program and the Iowa Collaborative Safety Net Provider Network. He has been recognized by a broad variety of groups for his health care initiatives in our State. The Iowa-Nebraska Primary Care Association gave him their Underserved Champion of the Year Award in 2005. The Polk County Medical Society gave him their Outstanding Medical Leadership Award. The Iowa Academy of Family Physicians recognized him also.

He has just been recognized by all of the providers throughout the State, and Nebraska too, I might add, for his great leadership.

He's here with his daughter. I remember—just a little tidbit—a long time ago there was a picture in the paper, the front page. I remember that, Jack, when you were a State Representative at that time. It was a wonderful picture of the State legislature meeting, and there was a photo of Senator, then Representative, Hatch on the floor holding this little baby, and with a little bassinet next to him, taking care of a baby because his wife was working. It was just a very wonderful picture. Of course now that daughter's grown and very pretty and she's here. She's here with him today.

Thank you again for all your great leadership in the State of Iowa. We're very proud of you, and your statement will be made a part of the record and please proceed, Jack.

**STATEMENT OF HON. JACK HATCH, STATE SENATOR OF IOWA,
DES MOINES, IA**

Mr. HATCH. Thank you, Senator Harkin, Senator Burr, and other members of the Senate. I appreciate being asked to come here. I come as a representative of the entire legislature. This was not done by a single person or a group of people. It was done by all of us. As a result, the enacting bill was passed by the legislature by a margin of 92 to 4 in the House and 44 to 4 in the Senate.

Some people would think that when you reach a consensus like that it is a bill that is not worth much. As I will hopefully demonstrate, Iowa extended itself and became a State that is committed to universal health care for its children and its adults.

I must say also that it wasn't done by us doing it by ourselves. We took people and we interviewed a number of people from other States—Massachusetts, Vermont, Pennsylvania, North Carolina, Wisconsin, Pennsylvania, Washington State. All of these States and others have created a part of what is needed for a universal care system. We created a commission, as a result of our preliminary discussions, of all stakeholders.

I have to tell you, though, that people thought it would fail, when you get the insurance industry, the labor unions, big, small businesses, consumer groups, that it would end up in a free-for-all. This commission traveled throughout Iowa, went to six cities, 10 monthly meetings, dozens and dozens of subcommittee meetings, and presented a proposal to the legislature a year ago.

The legislature embraced that proposal and, unlike most blue ribbon commissions, enacted most all of the recommendations. As a result, we passed the Comprehensive Reform Act of 2008. In it we focused on extending health insurance coverage to all children

by 2011, expanding coverage to some adults, but with a goal of all adults later on.

We created medical homes, statewide electronic health records, preventive and chronic care management, quality control. We dealt with the workforce shortage issue, discussed and developed programs for long-term care, and created wellness programs with the Governor's Council on Physical Fitness.

It was done in a bipartisan way. During the commission meetings we asked the two former governors, Governor Terry Brandsted, a Republican, and former Governor Tom Vilsack, now your U.S. Secretary of Agriculture, to conduct three public hearings. Senator, the first public hearing was in Council Bluffs. If I had closed my eyes and listened to Governor Brandsted, I would have thought that I was listening to you, because what he opened up with was that in America we have a sick care system. Those of you that know Senator Harkin, he has said that often, but it's rarely that a Republican governor would have said that. And when a Republican governor and a liberal Senator say it, we think maybe we're on the right track.

We proceeded with concerning ourselves with, here's an opportunity. Everybody understands that we have a system that is broken. What Iowa did was dig in and look at some of the main elements. All of those elements are of concern and have an element of prevention and wellness to it.

Specifically, with our proposal for creating medical homes it is understood that we have a coordination of care when you have one provider coordinating all of your care, and that provider could be assisted with counselors, social workers, nurses, then we're looking at how to keep a person healthy and not treating somebody only when they're sick.

The legislation specifically required a council that we created to look at how to reimburse providers on preventing sickness and reimbursing them at a rate that would incentivize them to be a medical home. There are some models now, hospital models, but we're very interested in the North Carolina model of Community Care and how they're integrating all of those functions together.

We also have a great opportunity in Iowa where we have developed a statewide fiber optics system. Along with a private hospital, we now have the opportunity to connect all the hospitals in Iowa, all 117 of them, into an electronic health records system. We have set up a commission to foster that, to lead that, and to identify additional dollars to finance it. Hopefully that will be completed within 2 years, where every hospital in the State will be connected to a fiber optic system.

We also are developing our public health programs. We've established an Iowa Healthy Communities Initiative—The Governors Council on Physical Fitness small business qualifying wellness program, where we'll give tax credits to small businesses. We've also passed the Healthy School Initiative so that school children will be able to have nutritious lunches at schools and systems to work with their families outside of school.

We have provided also mental health initiatives, as Mr. Emmet has so clearly established is necessary if we are going to really provide a universal system.

In summary, we're not finished yet. We have a second bill that will be coming and introduced next week that will create an insurance exchange similar to Massachusetts', that will be established as a nonprofit corporation separate, that will be directed to develop plans, affordable plans for adults and children above the 300 percent mark of poverty, so that they can buy into affordable products.

Second, we are going to follow the lead of Connecticut, where last year Connecticut passed a bill that provided small businesses, municipalities and nonprofits to buy into the State employee plan. Unfortunately, that was vetoed by the governor. We hope to have better success in Iowa.

We're going to also allow pharmacists to have greater flexibility. They're so much a part of the universal system that we forget that pharmacists have a consumer orientation and a patient-centered orientation that we want to be able to corral. We, of course, are going to expand transparency. There is nothing better in a free system than to have consumers have the ability to guide their own health care practices. We're going to put more responsibility on the patient. When the patient has responsibility, when they know what their health care is, when they can help participate in paying for it, then they will be better patients and healthier Americans.

With that, Senator, I thank you very much for this honor, for the opportunity to speak in front of you and your colleagues.

[The prepared statement of Mr. Hatch follows:]

PREPARED STATEMENT OF STATE SENATOR JACK HATCH

Chairman Harkin, members of the Senate HELP Committee and distinguished panel members, today, I am presenting Iowa's response to the health care crises our Nation is experiencing. On May 21, 2008, after 12 months of study by a bipartisan blue ribbon commission and thorough and vigorous debate by the legislature, Governor Culver signed HF 2539, the Health Care Reform Act into law. By overwhelming support (94-4 in the Iowa House and 42-4 in the Iowa Senate) this legislation placed Iowa at the forefront of the health care reform movement in America (See summary in Appendix A).

Iowa is in the first year of implementing this legislation, which is comprehensive in its scope, cooperative in its breadth and long-term in its goal-setting. Iowa is not alone in enacting plans to reform our health care system. Massachusetts, Vermont, Illinois, North Carolina, Pennsylvania, Maine, Washington State, Hawaii and Wisconsin, among others, have decided not to wait for Federal action and enacted into their State law some innovative initiatives on how to reach universal coverage. States are collaborating with each other through associations like the National Conference of State Legislatures, Milbank Memorial Fund, the Robert Wood Johnson Foundation and the Progressive States Network in order to remedy their health care problems.

Iowans are not getting healthier. The cost of coverage and the cost of care are becoming too expensive for average everyday Iowans. Each day we wait, Iowans are becoming more at risk of losing their coverage. Our health care system is heading for a catastrophic implosion.

However, there is light at the end of the tunnel and it may not be the light of an oncoming train. The work being done in our State and other States truly fulfills the "laboratories of democracy" role States have traditionally played.

If the Obama administration and the new Congress act now, and includes the successful experiments of many States in your design and implementation of a new system, Iowans and all Americans may be able to find health care security.

IOWA DID NOT WAIT

Our reform is comprehensive and provides a solid foundation for our next series of legislative initiatives but Iowa and the States can not do it without a national policy.

Now, Congress is poised to act. Senators Kennedy and Baucus have submitted legislation or announced drafts of proposals to reach universal health care. Senator

Harkin, your subcommittee is focused on prevention and wellness as one of several toe-holds on Congress' proposals.

I was asked to present on the topic of how Prevention played a role in Iowa's reform. It was the centerpiece of our efforts.

Preceding the enactment of the bill, the 2007 General Assembly created the *Commission on Affordable Health Care Plans for Small Businesses and Families*.¹ This commission was composed of 29 Iowans representing all the healthcare stakeholders. It reported the following:

Poor Health Status, Unhealthy Behaviors, and Chronic Disease

Even though Iowa ranks second in health system performance, the State has fallen in health status among the States declining from sixth in 1990 to eleventh in 2007.²

The United States Centers for Disease Control and Prevention report that the four factors influencing health are personal behavior, the environment (elements in the air, water, homes, communities, workplaces, and food that cause disease), and access to health care and genetic makeup. Of these, personal behavior is the most pertinent, while access to health care is the least. However, 88 percent of health resources are spent on treatment and only 4 percent on changing personal behavior.³ Fifty to seventy percent of all health care costs and premature deaths, illnesses, and disabilities are related to behaviors. Two specific behaviors in point, tobacco use and obesity, add increased financial and social costs. An average of 10 percent of total claims costs is directly attributable to tobacco use. Annually, smokers cost \$1,623 in excess medical expenditures and \$1,760 in lost productivity compared to nonsmokers. Smoking is the leading risk factor for asthma, cancer, diabetes, heart disease, and chronic obstructive pulmonary disease.

An average of 10 percent of total claims costs is directly attributable to obesity. Annual medical expenses for persons with a body mass index (BMI) of between 30 and 34 cost \$1,400 (or 25 percent) more than for persons with a BMI of less than 25; for those with a BMI greater than 35, the cost is \$2,267 (or 44 percent) more than persons with a BMI of 25; and sick days of those who are overweight are two to three times those of persons with normal weight, costing employers \$1,500–\$2,000 annually in excess sick pay. A person with a BMI of 25 or greater is subject to increased incidence of diabetes, heart disease, strokes, joint replacements, and back problems.⁴

As noted above, unhealthy behaviors often lead to chronic disease, and the increased incidence of chronic disease among Iowans has greatly contributed to the State's decline in health status. Chronic diseases are among the most prevalent, costly, and preventable of health problems. Chronic diseases are ongoing, generally incurable illnesses or conditions such as cardiovascular disease, asthma, cancer, and diabetes, but many are preventable through elimination of health-damaging behaviors and generally are manageable if diagnosed early and treated appropriately. More than 1 million Iowans suffer from at least one chronic disease. Chronic diseases are the leading cause of death and disability in the State. Approximately 23 percent of Iowans are affected by cardiovascular disease, 10 percent by asthma, 8 percent by depression, 5 percent by diabetes, and 5 percent by cancer. The percent of Iowans considered obese (a BMI of 30 or more) increased from 13 percent in 1990 to 25 percent in 2005. The estimated cost of chronic diseases to Iowa including direct and indirect costs, such as lost productivity, is \$7.6 billion. Additionally, Iowa spends an estimated \$783 million in obesity-related medical expenditures each year.⁵

Iowa's experience is not isolated to one State. These statistics of deteriorating health conditions ripple through every State of our country. Our approach to health

¹ Commission on Affordable Health Care Plans for Small Businesses and Families, State of Iowa-Legislative Service Agency, December, 2007.

² Americas' Health Rankings, A Call to Action for People & Their Communities, Findings, 2007 Results, Table 1—2007 Overall Rankings, <http://www.unitedhealthfoundation.org/ahr2007/results.html> as reported in Health Promotion in Health Care, presented by Dr. James A. Merchant, December 19, 2007.

³ David Osborne and Peter Hutchinson, The Public Strategies Group, Transforming Health Care So We Can Keep Our Promises, www.legis.state.ia.us/Isadocs/IntComHand/2008/IHPAF157.PDF.

⁴ Michael Parkinson, M.D., American College of Preventive Medicine, as reported in Health Promotion in Health Care, Presented to the Commission by Dr. James A. Merchant, December 19, 2007.

⁵ Partnership to Fight Chronic Disease, The Growing Crisis of Chronic Disease in Iowa, http://fightchronicdisease.net/dpfs/PFCD_IowaFacts.pdf.

care reform is comprehensive, but preventive care, how our providers deliver it and how patients use it are central to our reform.

In Iowa, as throughout America, our health care system is treating people ONLY when they get sick and NOT treating them to remain healthy. We spend most of our resources responding to illness, rather than preventing it.⁶ Preventive Care has to be elevated to a more integrated level of care in our new system.

Iowa is a leader in the quality of health care provided to its citizens. However, patient safety and the provision of high-quality care still can be improved. Ensuring that all Iowa health care providers understand and utilize evidence-based practice guidelines will improve patient outcomes and slow escalating health care costs. Special focus should center on effective interventions to treat chronic illnesses such as diabetes, pulmonary disease, and cardiovascular disease that affect many Iowans. Chronic disease management programs that provide easy access to health care providers, regular monitoring, and patient incentives to follow treatment plans can improve Iowans' quality of life and reduce health care costs.

Iowa should be a leader in wellness, prevention, early diagnosis, and management of chronic disease by ensuring all health care providers understand and utilize best practices and utilize established protocols for treating chronic diseases to provide best results and make the best use of different health care professionals.

As health care costs continue to escalate, incentives and education need to drive individual responsibility for use of health care services and lifestyle choices that improve health while containing costs.⁷

PREVENTIVE CARE IN KEY AREAS OF IOWA'S REFORM

1. *We Expanded Coverage to all Kids*

Iowa's comprehensive bill accepted a bold goal that by 2011, every eligible child (32,000) will have health care coverage with an appropriation of \$25 million over 3 years to ensure success. (We increased eligibility to 300 percent of FPL knowing that Iowa would have to fund most of these kids with State funds only. Hopefully, Congress will pass the extension of the SCHIP and share in this expansion).

The legislation also requires all parents of children eligible for Medicaid and our SCHIP program to acknowledge whether their child or children are covered by insurance on the State income tax form. Besides Medicaid and SCHIP programs, Iowa has initiated specific prevention strategies for kids. This included the continuation of a model program Iowa developed 2 years ago:

1st Five, a program to detect a child's developmental concerns in the first 5 years by preventing the need for more intensive and expensive care later. This program recruits primary providers to enhance their well-child exams to include:

- a. social and emotional development,
- b. autism, and
- c. family risk factors like depression and stress.

2. *We Created Medical Homes*

This is an evidence-based practice that provides superior and more cost-effective, patient-centered care that can be affordable and sustainable (American Academy of Family Physicians model). We required incentives to encourage providers to offer preventive care and wellness treatments through primary care providers. Coordinating medical care in a timely manner assumes that the patient will be seen regularly. We tied preventive care to increased reimbursements to allow the provider and the patient to practice preventive care. Providers apply to become medical homes with emphasis on primary care as well as hospitals like Iowa Methodist and Mercy Hospitals in Des Moines. Private medical practices are now pilots for developing and implementing medical homes. A Medical Home Advisory Council was created to develop and implement standards for the establishment and operation of medical homes in Iowa.

The Iowa legislature also created I-Smile⁸; a statewide prevention program for low-income children that requires a "Dental Home." More children, including those under age 5, are receiving preventive services, primarily through the title V child

⁶David Osborne, Reinventing Health Care—The Role of the States, Memo to the New President, 2009, p. 197.

⁷Commission on Affordable Health Care Plans for Small Businesses and Families, State of Iowa—Legislative Service Agency, December 2007.

⁸Inside I-Smile: A Look at Iowa's Dental Home Initiative for Children, Iowa Department of Public Health, December 2008.

health network. There has also been a significant increase in the number of physicians providing screenings and fluoride applications.

3. *We Developed a Statewide Electronic Health System*

When it comes to fiber optics, Iowa is unique. In 1987, Iowa created a state-owned and statewide fiber optics system. Originally, it was developed for education purposes and it was connected to every college, university, public library and middle and high school in the State. Today, Iowa has approved utilizing the state-owned and statewide fiber-optic system, in conjunction with the private Iowa Health System fiber-optic system, to connect all of Iowa's 117 hospitals to this system. This allows Iowa to have the only statewide electronic health care system in America before 2010.

The importance of electronic health records to preventive care is undeniable:

- a. prevents medical errors and duplicative testing,
- b. provides the consumer with direct access to their health history and encourages patient responsibility,
- c. encourages coordination of care between providers, and
- d. allows for medication therapy by Pharmacist.

As most experts will profess, the establishment of the infrastructure will not correct the difficulty in utilizing a competent electronic health system. We received two grants from the FCC to promote the development of electronic health systems in rural Iowa. As a result, we established the Health Information Technology Council to direct the competitive approaches into a single statewide system. To ensure purposeful and forceful implementation of this initiative, the legislature mandated the establishment of a single patient identification number and a coordination of care document. However, States will need the Federal Government to provide leadership in privacy standards and requisite financing to implement the system.

4. *We Strengthen Our Public Health and Prevention Programs*

The legislation also focused on developing partnerships with the private sector and local governments. The following initiatives continue to build a strong foundation of preventive care throughout our health care system:

a. *Healthy Communities Initiative.*—Building on the Harkin Wellness grants of the past few years, Iowa has created a Healthy Communities initiative which funds projects as diverse as walking trails and pathways to better nutritional options in cafeterias.

b. *Small Business Qualified Wellness Program Tax Credit.*—The Department of Public Health is to develop a plan, to be delivered to the legislature, on providing a State tax credit to small businesses that provide qualified wellness programs to their employees.

c. *Governor's Council on Physical Fitness and Nutrition.*—The Governor's Council on Physical Fitness will assist in developing a strategy for the implementation of the statewide initiative to increase physical activity, improve physical fitness, improve nutrition, and promote healthy behaviors.

d. *Healthy Kids Act.*—This act, SF 2425, with an effective date of July 1, 2009, establishes physical activity requirements for students in grades K–12. It sets out nutritional content standards for food and beverages sold on school grounds during the school day other than food provided under the school lunch program. The act also includes a requirement that students take first aid and CPR classes in order to graduate. In other legislation, we required dental and lead screenings prior to enrollment into kindergarten for all students.

e. *Preventive and Wellness Demonstration Programs.*—Blank Children's hospital in Des Moines is one of 27 sites for the National Children's study, which is the largest ever study conducted on children's long-term health, with a focus on obesity. Also, the Medicaid population has provided useful data in a project initiated in 2000 by former Governor Tom Vilsack that made use of pharmaceutical case management for patients with multiple drugs for chronic conditions.

f. *Improvement of Our Mental Health System.*—We improved our mental health system by initiating emergency mental health crisis units throughout the State. This is the start of a comprehensive mental health system redesign that was initiated in 2007 and continues today. Steps to improve mental health and substance abuse diagnosis are included in this effort.

5. *Prevention and Chronic Care Management*

In our reform legislation,⁹ Iowa was very specific on the role of prevention. We created the “Prevention and Chronic Care Management Advisory Council” to develop a State initiative for prevention and chronic care management and to report to the legislature by July 2009. The report is to provide the following:

1. Recommend organizational structure for integrating prevention and chronic care management into the private and public health care systems.
2. Coordinate care among health care professionals.
3. Prioritize chronic conditions that have a fiscal impact to the State’s health care programs.
4. Involve health care professionals in identifying patients that could receive preventive services.
5. Increase communication between providers and patients.
6. Develop educational, wellness and clinical management protocols to be used by providers.
7. Coordinate national standards on outcomes with best practices.
8. Develop methodologies to align reimbursements and create financial incentives and rewards for providers to utilize preventive services.
9. Involve all stakeholders including consumers, providers, insurers and other entities to sustain this initiative.
10. Coordinate with health care technology initiatives.
11. Involve public health researchers to develop and implement a sound basis for collecting data.

NEXT STEP

Iowa, like many other States, is proceeding with our separate health care reform initiatives. We know we can not do it without Congress and President Obama plowing the field ahead of us; but it is critical that both State and Federal Governments act in union with each other.

While we watch your progress we ask that you watch the State’s progress as well. During this year, legislation will be introduced to continue to build on our existing reforms:

1. Create an Insurance Exchange to develop more affordable insurance plans for children and adults ensuring greater access to health care coverage.
2. Expand the coverage for Iowa’s SCHIP program to include more children.
3. Allow small businesses, non-profits and cities and counties to join the State’s health insurance pool.
4. Allow pharmacies greater flexibility in providing information and medication to their patients.
5. Increase workforce by creating a partnership with hospitals to expand physician residencies and nurse education services throughout the State, especially in rural Iowa.
6. Expand the transparency initiatives to improve quality at hospitals and allow greater consumer choice.

We are eager to be partners in any long-term solution for health care in this country; however, we are realistic, the final push for reform must come from the Federal Government.

We are very grateful to Senator Harkin for his leadership and foresight in working to change the focus of our system from “a sick care system to a health care system.” All States will wait in anticipation of your deliberations in hopes that 2009 is the year we deliver on our promises to provide all Americans with universal health care.

APPENDIX A.—IOWA’S HISTORIC HEALTH CARE COVERAGE LEGISLATURE— HF2539–2008

After more than a year of traveling the State convening meetings with insurance executives, labor leaders, doctors, nurses, dentists, pharmacists, consumers, legislators and dozens of representatives from industry, hospitals, clinic, and interested citizens, the Iowa legislature passed a historic health care program to cover all kids. It is life changing for 53,000 kids.

That’s the number of uninsured children in Iowa. That’s the number of Iowa boys and girls who don’t automatically go to a doctor when they are sick. Now, we have

⁹HF 2539, passed and signed into law on May 21, 2008, Division IX, section 51, p. 43.

created new publicly subsidized programs for 34,000 of the poorest kids, and new “affordable” plans for the remaining 19,000 kids from families who are middle income and no insurance. By 2011, it is our plan that all kids will have access to affordable health insurance.

- We appropriated \$25 million over the next 3 years to enroll all the kids into a health coverage plan. Included with this financial commitment is the establishment of a council that includes the two former Governors. They are to design a plan to cover all kids and report back to the legislature for us to enact. The money is reserved for the kids; it is our guarantee that the money will be there and that health care coverage will be affordable.

- We built preventive care and chronic care management practices for all kids through the creation of medical homes as a way to deliver quality health care.

- We created a statewide electronic medical records system funded by hospitals, Federal assistance and State funds. This will do more than just process medical records electronically; we will be able to connect rural hospital doctors with specialist in Des Moines or the University of Iowa Hospitals and Clinics for immediate prognosis.

- We developed health care coverage for working adults with low wages; too low to participate in the company’s health care plan. This “premium assistance” program will be a pilot project with the “direct day care workers” who work in the nursing home industry.

- We allowed persons leaving group insurance to protect their coverage if they go to individual policy from being excluded due to pre-existing conditions. This is a small step forward.

- We created a new stakeholder’s workgroup to develop cost containment strategies and recommend new consumer transparency procedures to ensure greater navigating of the consumer through the maze of medical costs and procedures.

- We created a consumer advocate bureau in the Insurance Commissioner’s office to allow everyday Iowans a central point of contact to find answers on insurance company’s policies.

- Allow individuals working for small businesses to deduct their health care expenses on their Federal income tax obligations. This will require the small business to enroll in the Federal income tax section 125.

It is hard to underestimate the importance of health care reform to our economy and to the well-being of our kids and families. Our accomplishment this year is only the beginning. We have more to do; we have to insure low-income adults, create more small business initiatives, enact cost reduction strategies and develop greater consumer protection.

Senator HARKIN. Thank you very much, Senator Hatch, and thank you again for your great leadership in my home State.

Finally, we will hear from Dr. JudyAnn Bigby, currently the Secretary of Health and Human Services for the State of Massachusetts, where she oversees 17 State agencies. In addition, Dr. Bigby chairs the Health Care Quality and Cost Council, which was created in Massachusetts in the 2006 health care reform law.

Dr. Bigby received her medical degree from Harvard Medical School. Dr. Bigby, in no small part because the chairman of this full committee is from Massachusetts, we hear a lot about Massachusetts health care systems. Welcome and please proceed.

STATEMENT OF JUDYANN BIGBY, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, MASSACHUSETTS, BOSTON, MA

Dr. BIGBY. Thank you very much, Senator Harkin. I’m very pleased to be here today representing Massachusetts and Governor Deval Patrick, and I hope I have some additional information to share with you about what we’ve done in Massachusetts.

I want to thank you for your leadership on acknowledging the importance of prevention and the fact that we can save health care dollars if we focus more on that. I want to thank the other distin-

guished committee members for being here today and your commitment to this important topic.

As you've mentioned, in 2006 Massachusetts enacted a health care reform bill that was designed to get the State toward near-universal coverage. Our most recent survey, which we announced about 6 weeks ago, demonstrates that we have 97.4 percent of our Massachusetts residents covered, including 99 percent of our children. With that, what we've seen is that now more than 90 percent of people report that they have a regular health care provider, and they also report that they're receiving preventive care at a higher rate than they were before health care reform.

Health care reform in Massachusetts, though, is more than just a health insurance bill. The bill also includes several important initiatives that promote wellness and prevention and acknowledges the need to eliminate health disparities. In addition, Massachusetts has a significant history of adopting successful public health approaches to reduce costly risk factors and to promote wellness, and I'll spend some time talking about those as well.

One requirement in chapter 58 was that our Mass Health Program, which is our State Medicaid program, collaborate with the Department of Public Health to implement a wellness program for Mass Health members. In phase I of this program, Mass Health developed training programs and forums to promote culturally appropriate communication with members about the importance of regular preventive care, and we've seen an increase in the number who are participating in prevention.

In phase II we will implement an incentive program for Mass Health members, who will receive coupons for fruits and vegetables that they can redeem at participating grocery stores and farmers markets. They will also receive information on nutrition through these vendors and also through our WIC program.

We also implemented a program within our Mass Health Medicaid program to promote smoking cessation by extending a benefit that covers individual and group counseling, nicotine patches, and other nicotine replacements. Since we implemented that program in July 2006, more than 60,000 Mass Health subscribers have used the benefit. In over 2 years, 15,000 people have stopped smoking.

Within 1 year after they stopped smoking, cardiovascular incidents and asthma emergency room visits declined significantly among the former smokers. This decrease resulted in a dramatic reduction of health care costs in the first year alone, representing direct savings to the Commonwealth.

Beyond the initiatives directly related to health care reform, we restored funding for our tobacco control program and we've seen Massachusetts has now the lowest rate of smoking in its history at 16.4 percent. All the initiatives, many acknowledged by Dr. Fielding, we know are successful and we continue to implement them.

Using the success of the tobacco control program as a model, the Commonwealth last month announced a new comprehensive approach to tackling obesity. This is the Mass in Motion program, which will promote healthy eating and regular physical activity. It includes regulatory changes to require that schools measure the body mass index of students in grades 1, 4, 7, and 10 and provide parents with information about the significance of those measure-

ments; and will pass regulations that would require fast food chain restaurants to display calorie information on their menus.

The governor signed an executive order requiring agencies responsible for large food purchasing to follow strict nutritional guidelines. We've also given grants to communities to establish wellness initiatives at the local level, and we provide a workplace wellness program for public and private employers with a toolkit that was designed and tested by our Department of Public Health, and we will provide support to employers who want to initiate these programs.

I'm going to move on now to talk a little bit about what we're doing to address racial and ethnic health disparities. These are widespread nationwide. In Massachusetts, while we generally are known for our healthy indicators, we have documented disparities across the Commonwealth in health outcomes, health care quality, and in access to care.

In 2004 the legislature established a special commission to study racial and ethnic health disparities. The commission made recommendations in four areas: access to health care, health care quality and delivery, work force development and diversity, and also social determinants. The Patrick administration and the newly created Disparities Council are working together to model racial and ethnic disparity solutions that follow the recommendations put forward by the commission.

We know that addressing health disparities requires actions and initiatives both inside and outside of the health care system, because disparities result from a variety of intersecting factors that range from public policy to individual behaviors to the design of the health care system.

One of the things that we did, to try to get a better handle on what is happening within the health care system, was pass regulations that requires all hospitals to collect and uniformly report self-reported race-ethnicity of all patients. Beginning in July 2009, health plans will also be required to collect race and ethnicity data in a uniform standard. The State will monitor the quality of care delivered to racial and ethnic minorities on particular quality indicators, including serious reportable events, hospital-acquired infections, and overall hospital mortality, and expect providers to respond to any disparities that are demonstrated.

We also established the Office of Health Equity within the Executive Office of Health and Services. This office will ensure that health, economic, education, environmental, transportation, and other policies promote health equity and will examine the potential impact on disparities of any new policies.

Within our Medicaid program, we implemented a pay for performance program in acute care hospitals. This first of its kind in its country rewards positive outcomes based on established clinical measures in maternity and newborn care, respiratory care, surgical care, and health disparities. Hospitals are required to report to us how they are implementing established culturally and linguistically appropriate services, on how to operationalize practices designed to address the needs of racial and ethnic and linguistic population groups.

This year the program will continue to assess the structural standards and also expand the rewards to hospitals who have demonstrated that they have been able to decrease disparities in the clinical indicators I have mentioned.

This is just one example of a program that needs to be built into any of the quality monitoring initiatives that we are implementing at the State or Federal level.

I want to conclude by saying we have other initiatives that I could talk about. They are described in my written testimony. I just want to underscore the importance of getting toward universal coverage for everyone. We've been able to demonstrate that it has had an impact on people's access to prevention services and should be the foundation for moving forward on this topic.

Thank you.

[The prepared statement of Dr. Bigby follows:]

PREPARED STATEMENT OF JUDYANN BIGBY, M.D.

My name is Dr. JudyAnn Bigby, and I am the Secretary of Health and Human Services for the Commonwealth of Massachusetts. I am honored to be here with you today to represent Massachusetts and Governor Deval Patrick in offering testimony before the Health, Education, Labor, and Pensions Committee about Massachusetts' initiatives related to wellness and prevention and health disparities.

I particularly want to thank Chairman Kennedy of Massachusetts for inviting me to testify today and for holding a hearing on States' public health efforts. I also want to thank Senator Michael Enzi and the other distinguished committee members for their interest in and commitment to this important topic. I look forward to hearing your insights and perspectives and answering any questions you may have.

As you know, in April 2006, Massachusetts enacted a health care reform bill designed to move the State to near-universal coverage. Thanks to Governor Deval Patrick, the Legislature and the commitment of a coalition of advocates, providers, business leaders, and committed officials in Washington like Chairman Kennedy, Massachusetts recently reported that 97.4 percent of our State's residents, including, as far as we can measure, 100 percent of children, have health insurance. We also know that more than 90 percent of people report that they have a regular health care provider and more report receiving preventive care.

Health Care Reform, Chapter 58, was more than just a health insurance bill. Chapter 58 dealt with wellness and prevention, as well as health care disparities—all issues that the Patrick administration is focusing on through the design and implementation of several policies. Promoting wellness and prevention has begun with our Medicaid program, MassHealth, through a wellness incentive program and the coverage of tobacco replacement drugs. While health care disparities are addressed through a first-in-the-Nation pay-for-performance program for acute hospitals.

In addition to these relatively new policies, Massachusetts has had significant success using public health approaches to reduce high-cost risk factors. The Patrick administration believes that these approaches, combined with our efforts to expand health care access throughout the State, can form a powerful model for national efforts towards universal health care.

WELLNESS AND PREVENTION INITIATIVES—HEALTH CARE REFORM: MORE THAN JUST HEALTH INSURANCE

MASSHEALTH WELLNESS PROGRAM

Section 54 of Chapter 58 requires that MassHealth collaborate with the Massachusetts Department of Public Health (DPH) to implement a wellness program for MassHealth members. It specifies five clinical domains: diabetes and cancer screening for early detection, stroke education, smoking cessation, and teen pregnancy prevention. The law mandates co-payment and premium reduction for members who meet wellness goals. However, since members do not pay significant co-payments or premiums, we have recommended alternative incentives.

The MassHealth Wellness Program works with providers to design training programs and forums to promote culturally appropriate communication with members about the importance of regular preventive health care and health risk factors. It

also provides members with printed materials to help them learn about healthy lifestyle choices and the benefits of those choices.

The MassHealth Wellness Program, in collaboration with the Department of Public Health, is exploring the feasibility of developing an incentive program for MassHealth members participating in wellness-related activities. The reward would consist of coupons for fruits and vegetables that would be used in participating grocery stores and at farmers' markets. Distribution of reward information and nutrition education would occur through the existing provider (grocery stores and farmers' markets) and staff networks for the WIC program.

Tobacco Control

On the prevention front, the Mass Tobacco Control Program partnered with MassHealth to design, promote, and evaluate the MassHealth smoking cessation benefit implemented on July 1, 2006 as part of Health Care Reform. The benefit includes group or individual counseling by smoking cessation counselors and covers nicotine lozenges, patches and other cessation medication. Utilization data indicates that **over 60,000** MassHealth subscribers have used the benefit over the first 2 years, representing one in three smokers. Behavioral Risk Factor Social Survey (BRFSS) data indicate that between 2006 and 2007, the smoking rate in the MassHealth population decreased from 36.1 percent to 33.2 percent, an 8 percent reduction in the number of smokers. Over 15,000 MassHealth members quit smoking during this period.

Preliminary data also indicate that within 1 year after quitting smoking, cardiovascular incidents and asthma emergency room visits declined significantly for former smokers. This decrease resulted in a dramatic reduction in health care costs in the first year alone, representing direct savings to the Commonwealth.

The latest BRFSS analysis (2006) on the correlation between health insurance and smoking prevalence indicates that those with private health insurance are half as likely to smoke as those with no insurance or MassHealth. There was no significant difference between MassHealth members and the uninsured in terms of smoking prevalence, but this data predates the addition of a smoking cessation benefit to MassHealth.

It was imperative for our State to implement effective tobacco control. Tobacco use is the leading cause of preventable death and illness in Massachusetts. More than 8,000 Massachusetts residents die each year from the effects of smoking. And though they are not smokers themselves, an estimated 1,000 or more Massachusetts adults and children die each year from the effects of secondhand smoke. In our State, tobacco kills more people each year than car accidents, AIDS, homicides, suicides and poisonings combined.

In addition to the price paid in lives lost, tobacco imposes a heavy financial burden on the Commonwealth. Smoking costs Massachusetts an estimated \$4.3 billion each year due to excess direct health care costs.¹ Each pack of cigarettes sold in Massachusetts costs the State an estimated \$14.22 in direct health care costs.

Beyond the initiatives directly related to Health Care Reform, the Massachusetts Tobacco Control Program works to improve public health in the Commonwealth by reducing death and disability from tobacco use.

The program has:

- a community-based smoke-free families initiative,
- a web-based youth-targeted initiative called the84.org to spread the message that non-smoking is actually the norm among teenagers,
- community smoking cessation demonstration projects targeting high-risk groups such as veterans and people in recovery,
- increased monitoring of youth sales—we have seen a decrease in the number of violations,
- produced a video targeting youth,
- initiated public information campaigns advertising our Quit Line and the dangers of secondhand smoke, and
- implemented a statewide ban on smoking in workplaces.

I am happy to report there have only been a few violations.

Reversing the Rise in Obesity

The Commonwealth has adopted a similarly comprehensive approach to tackle obesity through the Mass in Motion program, which promotes healthy eating and regular physical activity.

¹Massachusetts Department of Public Health. *Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC): Massachusetts 2006*.

More than half of the Massachusetts Adult population is overweight as are a third of middle and high school students. The percentage of the population that is overweight has been increasing steadily over the last three decades. It disproportionately affects low-income populations and residents of color. In fact, almost two-thirds of adult African-Americans in Massachusetts are overweight. This disproportionate impact is a result of a variety of policies and practices, which have meant that for lower income residents the most affordable and accessible foods are often the least healthful ones.

Mass In Motion is a multi-faceted program that includes:

- Regulatory changes to promote healthy eating, such as **Body Mass Index testing** of Massachusetts students in public schools in grades 1, 4, 7 and 10, as well as **menu labeling for fast food chain restaurants**;
- An Executive order by Governor Patrick requiring Health and Human Services Agencies responsible for large food purchasing to follow strict nutritional guidelines in their food service operations. State purchases of food by these agencies runs into the tens of millions of dollars per year;
- Grants to communities to establish wellness initiatives at the local level;
- Workplace Wellness programs throughout the State and supported by a tool kit designed and tested by the Department of Public Health to help employees stay healthy, and businesses to be more productive;
- The launch of a State-sponsored Website that promotes healthy eating and physical activity at home, at work, and in the community. The objective of the Website is to provide simple, practical, cost-effective ways for Massachusetts' residents to:
 - Improve eating habits;
 - Increase physical activity;
 - Ask experts questions about improving their diet and physical exercise routine; and
 - Get involved in helping to build healthy communities.

MENTAL HEALTH PREVENTION EFFORTS

The State is also exploring public health and preventative interventions to promote mental health and to address disparities in health outcomes among individuals with mental illness.

People with mental illness experience significant health disparities with substantially increased risk of early death and significant disabling illness. Individuals with mental illness die 25 years earlier than the general population from potentially preventable and high-cost diseases such as diabetes, cardiovascular disease, respiratory illness, and lung cancer. Other high-cost risk factors among individuals with mental illness include homelessness, poverty, unemployment, incarceration, and co-occurring substance use issues.

The Commonwealth's Department of Mental Health is committed to developing comprehensive and integrated physical and behavioral health care. Enhanced integration of both physical and behavioral health results in improved health outcomes.

As a result, the Department has an extensive community provider network that coordinates medical care for mental health consumers. Benefits include improved communications for consumers through coordinators attending medical appointments and having portable medication lists.

The Department also has a strong partnership with MassHealth in the re-procurement and management of its managed care entities, which have clear requirements to coordinate physical and behavioral health care.

The Department has led a 2-year demonstration pilot with Community Mental Health Centers and Community Health Centers at six sites across Massachusetts to enhance this integration. This effort has resulted in:

- the co-location of behavioral health and primary care services,
- a centralized intake,
- a streamlined referral process,
- on-site clinicians, and
- care managers focused on assessment and treatment of mental health disorders.

The Department of Mental Health recognizes that trauma often plays a central role in the development of mental health and substance abuse problems. The Department has coupled this with recovery-focused models of care to ensure a more complete prevention model of treatment for behavioral health and substance use issues.

The Department is recognized as a national leader in trauma-informed care, having been the first State in the country to:

- implement trauma treatment guidelines (1998),
- develop and implement a trauma assessment to be used in all State facilities (1998),
- require trauma assessment for every consumer in psychiatric care in the Commonwealth (2006), and
- continuously develop specialized tools for youth and people with intellectual and developmental challenges (2001–2008).

Many of the prevention initiatives taken at the Department of Mental Health have been quite successful and have the potential for replication on a national level.

RACIAL AND ETHNIC HEALTH DISPARITIES

Racial and ethnic health disparities exist Nationwide. In Massachusetts, disparities exist throughout the Commonwealth, not just in urban areas. Massachusetts has disparities in health outcomes, health care quality, and in access to care:

- The black, non-Hispanic Infant Mortality Rate is twice as high as the white non-Hispanic IMR (9.4 vs. 4.3 deaths per 1,000 live births).
- The teen birth rate for Hispanic women is almost 6 times higher than for white non-Hispanics (73.2 vs. 12.9 per 1,000 women ages 15-19 years old).
- Cambodian, Central American and African mothers are less likely to receive prenatal care in their first trimester compared with mothers in other ethnic groups. (*Massachusetts Department of Public Health, Birth Outcomes 2007*)
- Blacks have a 35 percent higher age-adjusted mortality rate compared to whites and nearly twice the rate of Hispanics and Asians.
- Blacks have higher age-adjusted death rates for heart disease, cancer, stroke, diabetes, HIV/AIDS, homicide, MVAs and other injuries. (*2001 Massachusetts Department of Public Health report Massachusetts Health Status indicators by Race and Hispanic Ethnicity*)
- Blacks have higher hospital discharge rates for hypertension, stroke, and cardiovascular disease.
- Blacks and Hispanics have three to four times higher rates for asthma discharges compared to whites. (*2001 Massachusetts Department of Public Health report Massachusetts Health Status indicators by Race and Hispanic Ethnicity*) In one health care setting, insured Blacks with diabetes were less likely than whites to be prescribed cholesterol lowering drugs when indicated and were less likely to have their diabetes well controlled (*Sequist TD et al. Arch Intern Med 2006;166:675–81*)
- In 2007, 5.7 percent of all Massachusetts residents did not have health insurance. However, Hispanics and Black Non-Hispanic residents have higher rates of uninsurance when compared to other races and ethnicities.

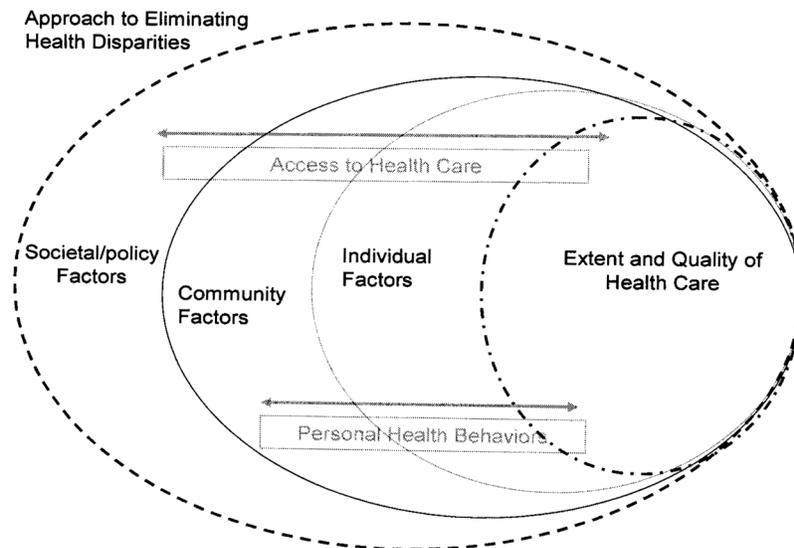
COMMONWEALTH'S APPROACH TO ELIMINATING HEALTH DISPARITIES

In 2004, the Legislature established a special commission to study racial and ethnic health disparities. The Commission issued its report in the summer of 2006 and aligned their recommendations into four categories:

1. access to health care,
2. health care quality and delivery,
3. workforce development and diversity, and
4. social determinants.

The Patrick Administration and the Disparities Council, a council created as part of Health Care Reform, are working together to model racial and ethnic disparities solutions on the recommendation put forward by the Commission. We are undertaking a number of initiatives.

We know that addressing health disparities requires actions and initiatives inside and outside of the health care system. Disparities result from a variety of intersecting factors that range from public policy to individual behaviors to design of the health care system. We must address all factors to achieve health equity.



To address these disparities, the Patrick administration has taken a number of pro-active and innovative steps, including:

- Distributing \$1 million in new funding to support a wide variety of community-based efforts to eliminate disparities. More than 30 grants were awarded to local agencies to establish culturally and linguistically appropriate health care services, training programs for health care workers, and support systems for residents of color who face challenges in navigating the health care system.
- Implementing a regulation that requires all hospitals in the State to gather and report accurate and consistent information on the race and ethnicity of all patients. This first-in-the-country regulation is producing information that will soon be published in a Department of Public Health report highlighting patterns of access to care and identifying facilities where additional efforts are needed.
- The publication of several reports that highlight disparities in particular health areas—such as HIV.
- The formation of an Office of Health Equity at both the Department of Public Health and the Executive Office of Health and Human Services to insure that multiple programs and agencies adopt policies that target disparities.

ACTIVITIES IMPLEMENTED UNDER CHAPTER 58

Pay-for Performance Program to Promote Health Care Equity

Beginning in October 2007, MassHealth implemented a pay-for-performance program in acute care hospitals. One of the first of its kind in the country, the program rewards positive outcomes based on established clinical measures in maternity and newborn care, respiratory care (including pediatric asthma control), surgical care, and health disparities.

In the first year of the program, health disparities were addressed structurally, using established Culturally and Linguistically Appropriate Services (CLAS) standards to assess how widely institutions have operationalized practices designed to address the needs of racial, ethnic and linguistic population groups that experience unequal access to health services. This year, the program will continue to assess structural CLAS standards and will expand to reward hospitals that reduce or eliminate identifiable disparities on the clinical indicators by race and ethnicity.

This promising program is only one example of how we can use quality-based purchasing strategies to address health disparities. I urge the committee to remember, as more sophisticated quality initiatives and pay-for-performance programs expand, that the elimination of health care disparities remain an essential element of quality in our health care system.

Senator HARKIN. Thank you very much, Dr. Bigby. Thank you all for just excellent testimonies.

We have a vote at 11:35. I'm just going to ask one question and we'll move on. We'll do 5-minute questions back and forth.

Dr. Fielding, you're the chair of the U.S. Preventive Services Task Force and the Community Preventive Services Task Force. As I listened to all these people, a lot of States—of course some of these I know about because you're here this morning and I've read about what you're doing. There may be other States out there and localities doing interesting things that we don't know about.

Does your Preventive Services Task Force have the ability to go out to all these different States and get input as to what they're doing, so you can kind of look at maybe some innovative things that are going on, things that are working, so we can get evidence-based programs for both workplace, but school-based and community-based kinds of programs? Do you know about all these things?

Dr. FIELDING. No, not about all these things. There are a lot of exciting things going on. What our charge is in the Community Preventive Services Task Force is to look at what's been published, primarily in peer reviewed journals, because that's then gone through a vetting process, and based on that make recommendations, what we know works or areas where there is insufficient evidence, or what we know does not work.

Unfortunately, the funding has been very, very small and we've not covered most of the areas we would like to cover. We've covered a lot of them, but it's still a minority. One of the opportunities is to really look more carefully at the evidence that comes from practice, but that is not currently part of what we're able to do with the resources that we have. We're also not able to publish or disseminate the information in ways that are essential.

Senator HARKIN. There's no central kind of a clearinghouse anywhere where States could send their information, send things in where they have done things, where they have evidence that they've actually prevented illnesses or saved costs, like North Carolina, like Massachusetts, like Iowa?

Dr. FIELDING. I'm not aware of one place. Certainly the State health officers—ASTHO has a newsletter. There are things like that in the reports that are done from time to time. I'm not aware that there is a clearinghouse, but Dr. Bigby might be able to enlighten us on that.

Senator HARKIN. Dr. Bigby, do you know of any?

Dr. BIGBY. I'm not aware of any type of clearinghouse that has this information.

Senator HARKIN. It seems to me that that's something we ought to be looking at CDCP to be doing. We'll take a look at that. I'm just curious.

Senator Burr.

Senator BURR. Allen, if you will, you did a great job of describing this integration of a network and the different providers that fit into that network. Could you clarify for the committee how much per member per month does Medicaid pay those providers to be part of that network? I think it's a shocking number and I think they need to hear it.

Dr. DOBSON. Thank you, Senator, yes. We have two different payments. Besides the Medicare-Medicaid fee schedule, which North Carolina pays pretty close to Medicare for our providers, which helps with access, we pay the primary care doctors \$2.50 per member per month for children and \$5 for the adults disabled.

The more important part is that we fund to the communities the cost of the medical home infrastructure. We send it to the network. For instance, the networks get paid \$3 for children and then up to \$8 or \$9 PMPM now for our aged, blind and disabled. It goes to discretely pay for the service, like case managers and infrastructure, clinical pharmacists, the wrap-around services that put this together.

I think the lessons we've learned, it's hard sometimes to just say we're going to pay physicians more or we're going to pay for certain services more. Having an organization who's accountable at the local level, as we add functions to and request those networks to do more, we increase those payments. It becomes a very accountable exchange. It's not a lot right now. Again, we can do more, but we've been building this gradually from the ground up. So we've been very, very conservative with the amount of money we're putting in there.

Senator BURR. The point I wanted my colleagues to hear is we're all faced with a physician network, a provider network, that increasingly does not want to handle Medicare patients. Yet when they see a successful network, when they see a structure that works for \$2.50 a month, they're willing to be part of it. I dare say if you increase their reimbursement by \$2.50 a month you wouldn't get that type of a response. In its totality the network suggests to them here's something that actually accomplishes what our mission is as providers.

Let me move to Dr. Fielding just real quick. Last Congress, Senator Coburn and I introduced a comprehensive health care bill. It was S.1019. Included in that legislation was language that instructed the USDA to develop a list of foods that were not nutritionally sound and would not be available for purchase under the food stamp program.

Now, given the extensive emphasis on obesity prevention, would you be supportive of a policy like that where USDA produced a list of items that were not nutritionally sound and we did not include those in the food stamp program?

Dr. FIELDING. Well, Senator, you're absolutely right that the food stamp program has not always helped with the solution to the problem of overweight and obesity. It may have contributed to it in some ways. I think the difficulty is that it's hard to look at any one particular purchase, because it depends on what else you're eating.

I think it works with respect to, for example, vending machines in schools to say, here are the criteria for what can be in vending machines. I think there are certain items that probably might fit on that list. In many cases it's a question of how much, it's a question of how often. What's really critical is to have much more education built into the food stamp program and to provide incentives for those recipients to eat foods that are healthful and to have access to those.

Senator BURR. Well, I heard your testimony on obesity and some or all touched on it to some degree. I think in all the testimony it was a very comprehensive approach to how we solve obesity. I think what I got out of it, we've got to quit sending a mixed signal. We've got to attack this like it's an epidemic. If we find it offensive that we would take a program that provides an individual their ability to purchase food and we include in that everything that we say for kids or whoever selectively that this is bad, then I have to ask, why would we do it that way?

That overcomes every educational piece that you could go out and try to reinforce, because you're telling them it's bad, but over here you're saying, "but we'll allow you to have the money to go purchase it." You know, if we're going to solve this problem we're going to have to make sure that we're reinforcing all of these at every aspect, and it means we're going to have to rethink the way we do certain programs that are certainly compassionate and beneficial, but let's make sure that they're compassionate and beneficial and healthy.

I thank the chair.

Senator HARKIN. Senator Burr, I look forward to working with you on it. We have to reauthorize the child nutrition bill—that's the school lunch, the school breakfast, the WIC program—this year in the Agriculture Committee. I look forward to working with you on it. I feel much akin to what you're saying on this, that we have to rethink how we're doing some of these things and what we're allowing.

We have a new ability now, as you know, under the SNAP program, as we call it now—it's not called food stamps because we don't have stamps any more. It's a credit card. With that stripe on the back, you can encode a lot of information. With those UPC codes and stuff like that, you can encode a lot of information. I'd like to work with you on that. We never talked about that.

Senator Sanders.

STATEMENT OF SENATOR SANDERS

Senator SANDERS. Thank you very much, Senator Harkin, and thank you for your continued efforts in the fight for disease prevention. Thank you all for this panel. It's been a wonderful panel.

As I think we have heard today, we spend more money by far per capita on health care than any other Nation on Earth, and yet our health care outcomes are way behind many other countries. I think one of the reasons, Mr. Chairman, is, as Tom Daschle told us, who testified here just a few weeks ago, we have an inverted pyramid. We spend huge amounts of money on specialty care and yet we underfund, grotesquely in my view, primary health care.

Right now, in my view we need a revolution in terms of primary health care in this country. Right now, among other things, we do not even produce and educate enough doctors, enough dentists, enough nurses, to get out into the rural and urban areas for primary care. We are entirely dependent upon importing people from other countries, often third world countries, and depleting their health care supply of professionals as well.

I'm going to make a few statements that I would like folks to comment on, and perhaps we could start with Dr. Dobson. One of

the things I am trying to do, and it has widespread bipartisan support—it started with Senator Kennedy, Senator Harkin's a strong supporter, President Bush a supporter—if we can quadruple the number of federally qualified community health centers, which provide good quality health care, dental care, low-cost prescription drugs, mental health counseling, we can provide community-based health care in every underserved area in America for all of \$8 billion a year, and many of the studies that we read tell us that we will save substantial sums of money by keeping people away from emergency rooms and out of the hospital. We keep people healthy rather than allow them to go to the hospital at great expense.

Also, what we know about these community health centers is you have doctors who can talk to people and educate people about obesity, about alcohol, about tobacco. We understand that one to one relationship works very, very well.

I would like, starting with Dr. Dobson, perhaps your comment on what it would mean in terms of disease prevention and keeping our people healthy if we had a community health center, if we greatly expanded the National Health Service Corps, so we educated, we provided the opportunity for people to go be doctors and nurses and dentists, serve in underserved areas? What impact would that have on the health of the Nation?

Dr. DOBSON. Thank you, Senator. Yes—well, let me just make a couple comments. No. 1, I think we should look at the community health centers and what they do right, because we have funded health centers to provide the functions that the entire health system should be providing regardless. If you look at it, we fund them such that they're made whole for providing uninsured care. We fund them such that, and they actually provide those key elements of the medical home concept that we're talking about.

It really is about investing in the primary care system. If you look at other industrialized countries, the difference is not necessarily how they pay for it. It's that they actually have a developed primary care system. I would say to you that to really get where we need to go we need to spend money on primary care and prevention, we need to train primary care physicians and providers differently than we do now and how we fund them, and we need to pay them adequately.

So where does that money come from? Part of it is an investment, but another part of it is that we have to get some efficiencies out of our system, where we're spending money that we don't need to be spending and reapply it.

Senator SANDERS. Dr. Dobson, would you feel comfortable making the argument that investing in community health centers, investing in primary care, actually saves money at the end of the day?

Dr. DOBSON. Yes, I do. But, I don't think the community health system structure is the only structure for which you could do that. My only fear of applying a single approach to solving the Nation's health care systems is that we'll end up with a two-tiered system, because unless everyone gets their care through community health systems how are we going to assure the same quality for the rest of the population?

I would assert to you those same functions that we need to put in community health centers and expanding needs to be funded throughout the health care system.

Senator SANDERS. Right, I would certainly agree.

Yes, doctor—Senator Hatch?

Mr. HATCH. Senator Sanders, thank you. I don't think we realize, when we talk about the safety net providers, that we think of our county hospitals. You've identified the community health centers as the safety net as well. Not only should they be expanded, but we have as well as the community health centers free clinics. In Iowa we have over 37 free clinics that receive and see over 150,000 patients a year. These are Iowans that can't and don't go anywhere else. Not only are there free clinics involved in our collaborative safety net provider network, but we have rural clinics too that are operating independently, most of the type with physician assistants as their major provider.

On top of that, we have visiting nurses that are the only access that Iowans have—and I'm sure in your States, too—to the people who are in their homes and can't go anywhere else.

This safety net that we're talking about is not just the community health centers. They are the most established and they are functionally the best. They provide extraordinary care to people who wouldn't or couldn't go to anybody else. Even though we should have that extended to everyone, until we have a true universal system we are going to be patchworking our health care system with these kinds of providers, and they have to be supported and we have to extend their opportunities.

Senator SANDERS. I certainly agree. I think we have to end the national, international disgrace that we are the only major country on Earth without a national health care program, and I think we have to revolutionize primary health care, keep people healthy, and save money. I think that's essentially what everyone here has been saying.

Thank you very much, Mr. Chairman.

[The prepared statement of Senator Sanders follows:]

PREPARED STATEMENT OF SENATOR SANDERS

Thank you very much, Mr. Chairman. I want to commend you for holding this hearing today. Vermont is the healthiest State in the union, but even in Vermont, this is a relative term. Obesity and tobacco are the top two causes of death in Vermont as well as the rest of the country and is responsible for many preventable chronic diseases. Substance abuse and mental illness are chronic diseases we too often sweep under the rug and are often intertwined with other chronic diseases. We are simply falling down on the job of keeping our citizens healthy and clearly can't afford to wait to tackle these problems in the United States. Individual States are making great strides, but we need to ensure that all Americans have the same basic access to prevention and care no matter what State they live in. But I am optimistic that we are entering a new age, a time to "remake America," as our new president just said.

OBESITY

Obesity does not just affect the obese, it affects everyone because of the impact it has on the health care system, health care costs, and the economy. The reality is that poor and working-class families often live in communities where healthy choices for nutrition and physical activity are limited. Vermont is one of the leanest States with among the lowest obesity rates in the Nation. Of course, that still isn't saying much when one out of eight of our Vermont high school kids is obese. Several States, including Vermont, had a small amount of Federal funding to fight obesity, but Vermont and some other States just lost those programs to Federal funding cuts. Childhood obesity is a national epidemic, tripling in the last 30 years and we need to reverse this trend. This is a big issue with many agencies from health to education to transportation to labor to commerce that have a role to play to solve it.

TOBACCO

Vermont's network of 20 coalitions has successful prevention programs that reach out to youth ages 10–18, through TV and radio media campaigns that has reduced tobacco use from one in three Vermont youth to 18 percent. Investment has been small, but results have been substantial. And yet in Vermont nearly one in five adults and more than one in six of our youth still use tobacco.

COMMUNITY HEALTH CENTERS

President Obama said the question is not whether our government is too big or too small but whether it works. Community based programs and Community Health Centers must be in the forefront of the new healthcare debate because they work. Vermont and the Nation have seen success improve health results with Community Health Centers, but those results are tenuous because funding is not strong or stable. As I've said before in previous hearings, it's been proven that people who go to Community Health Centers do better than those seen in other settings. We must change the healthcare debate from how to pay for treatment to how to prevent disease.

One quick example: we know that a key to changing behaviors is to first talk about it with a health care professional. And we know that Community Health Centers do a much better job talking to people about tobacco use than private providers. Four out of every five Medicaid patients in health care centers and nearly three quarters of all patients going to health care centers have had their tobacco use discussed with them, compared to only about half of insured adults who don't use health centers.

MENTAL HEALTH

Since the economic crisis has rapidly unfolded through the fall and winter of 2008, health facilities report a substantial spike in the number of individuals seeking mental care while there has been simultaneous funding cutbacks of mental health agencies in 32 States, including Vermont. Vermont has been a leader in this country on the issue of mental health parity; other States have

looked to Vermont as a model for where they want to go. We understand that to be successful mental health work must be at the grassroots, community level.

The health of our upcoming generation is worse than their parents. We need to make sure that the next generation has a healthy start as they head into adulthood.

I thank you all for being here this morning.

Senator HARKIN. Thank you, Senator Sanders.

Senator Casey.

STATEMENT OF SENATOR CASEY

Senator CASEY. Mr. Chairman, thank you very much. I want to say first of all that I'm honored to be part of this committee now. This is my first hearing as a member of this committee and I'm grateful for that opportunity, and grateful for your leadership on these issues over the course of many years.

This is an especially significant time in our Nation's history, not only because we're starting a new administration, but because I think on the issue of health care we've finally arrived at a point where there is a consensus. Where that consensus will take us we don't know yet, but we have a real opportunity now to confront this issue and maybe actually vote on a bill, a significant bill on health care.

So we're grateful. We're thinking today, of course, of Chairman Kennedy and his own health, but also grateful for his leadership over many years and the bipartisan way that this committee has conducted its business, Senator Kennedy and Senator Enzi being good examples of that, and we're seeing that as well today.

We're grateful for the testimony and witness provided today by those who are providing the benefit of your experience as public policymakers or analysts and what's happening in our States.

In Pennsylvania we've had good success on a number of fronts. One is on, as many of you know in the States and from the perspective you come from, children's health insurance, a tremendously successful effort that started at the State level and then made its way to become a national program. Today in Pennsylvania, for example, the Cover All Kids Initiative, a rather new initiative within—under the umbrella, I should say, of children's health insurance, has shown a dramatic improvement in health care for children.

As of 2008, only 4.6 percent of Pennsylvania children ages 0 to 18 were without health insurance. We're at the top echelon of States in terms of coverage. We now have enrollment as of January of 183,891 children. That number will go up—it's high, it's a great number, but it will go up exponentially if the Senate and the House pass the children's health insurance legislation which will be before the Senate—actually, is before the Senate after work in the House. That's a great opportunity for our State and I think for the country.

We have an adultBasic program which provides health care coverage, but the problem with that is we have a tremendously growing waiting list.

With that as background, let me just get to some basic questions for the panel and for individuals. One concern that I have—there are a number of people on this panel; you can chime in as you see fit—about this local versus the national challenge we have. Many of the proposals and experiences that have been related today have been successes at the local and State level. You have a lot to be proud of and a lot to brag about. The problem we have here is that there's a tremendous need for national legislation.

I guess I'd ask Dr. Dobson and Senator Hatch about this in particular. How do you see that conflict being resolved, where you have success at the local level—and our State is a State where we value local control, local control of education, local control of a lot of other things. We have more municipalities than any other State. We're going to be wrestling with this. How do you see that playing out when there's such a fervor and a consensus, I think, on taking action at the national level?

Dr. DOBSON. I think if you take the example that we've tried to create in North Carolina, where you establish a framework which then allows communities to innovate within the basic framework of community care and meet their needs, so it becomes more function-based versus regulatory controlled, and there becomes that shared accountability. I think the Federal Government has similar abilities to deal with States in a shared accountability, particularly in public programs, of saying, "Here is what we would like to accomplish, here is how we would like to fund it," and give some shared accountability between the States and the Federal Government to help build this delivery system and get the accountability we need to save the money and move the system forward, because again if you become—it becomes like some of our demonstration projects and some of our—within CMS.

By the time we have got them constructed to study them, they become almost unsuccessful because you're not able to adapt to the local conditions and changing environment for when you start something. I think there has to be some flexibility between the Federal Government and the States in this shared ownership.

We almost provided too much flexibility in the Medicaid program. We have programs operating so, so differently. I think that, at least for Medicare and some of the public programs, there can be this shared accountability of the Federal Government and the States to move the system forward.

Senator CASEY. Senator Hatch.

Mr. HATCH. Senator Casey, thank you. I'm going to answer this as an elected official. Like yourself and the other members here, I ran on the basis that I was going to provide universal coverage to my constituents. I've been doing that for 20 years, and I suspect that most of you have been doing that for your entire life as well.

There may be a fervor to do something nationally, but there is an absolute recognition on the States that we don't and can't wait any longer, and that States have to move on their own. It was Massachusetts that opened the door, literally allowed us to believe that we could do that. As Massachusetts so boldly entered the universal coverage politics, we then said we could do it, and you see an array of opportunities.

I've had the privilege over the last couple of months to go to three or four national conferences, talk about it with people from Hawaii, Wyoming, North Carolina, Florida, Texas, New Mexico, every State, and they all are anxious to do something.

I'm going to give you four areas of reform that my colleagues nationally have kind of put together in an informal way. The first kind of guiding principle is that we have to stabilize the financing through a payment reform. We have to reform the payment structure—not change it, not tinker it, but it's got to be a revolutionary reform in how our providers are paid, what they're paid for.

Second, we have to increase cost containment policies. States are trying to save money in containing costs, but it's difficult in the politics to ask your hospitals to save money, who are trying to get their providers to save money when they aren't getting reimbursed enough, and we're trying to force mandates on them because we know our constituents need it.

We have to have a completely new sense of cost containment initiatives. Part of that is the national medical records standards, a patient identifier number, and a document of coordination. It also needs to share data across State lines.

The third area is absolutely increase access and affordable insurance coverage. We have to commit that everybody in this country deserves health coverage and health care, and it's not for some; it's for everybody. We have to have a complete system that does it. That's why universal coverage in my State and Massachusetts and other States have focused, not on the single payer system, but on the fact that everybody deserves it. It is not a privilege any more. It is a right, just like public education.

That means we have to have flexible laws with ERISA and we have to negotiate with insurance companies on pre-existing condition exemptions and on the guarantee issues.

Then last, something your State is well known for is increasing quality. The transparency of our health care system has to be open. Hospitals, doctors, government, and patients have to have a better standard for where we operate and we have to have complete access to that transparency.

If we do those kinds of things, if we have shared decisionmaking between the provider and the patient, then the patient has more shared responsibility. They are now required to participate, and if they don't participate, if they think they can go only when they get sick, then we haven't done our job.

Those are the four kind of general areas that States and the Federal Government have to proceed with.

Senator CASEY. Thank you very much.

[The prepared statement of Senator Casey follows:]

PREPARED STATEMENT OF SENATOR CASEY

Thank you Mr. Chairman and I'd like to say at the outset what an honor it is to be here today as a new member of the HELP Committee. I have a profound commitment to the issues that fall within this committee's jurisdiction and I look forward to working together with my colleagues on issues of vital importance to the American people. So I thank Chairman Kennedy for his unparalleled leadership over these many years and you, Mr. Chairman, and Senator

Enzi for setting a standard of effective collaboration. I am proud to be a member of this team. I also thank you, Mr. Chairman, for calling this hearing and bringing together such a distinguished panel of State and national experts regarding what we can learn from ongoing State initiatives.

We all know we are in a time of change—significant and challenging change. We’ve all heard the statistics—the U.S. currently spends nearly 18 percent of its GDP on health care, more than any other nation, and yet for all that money, we still have poorer health than most developed countries and even some developing countries. As we embark on a new era of hope and change and responsibility, our health care system tops the list of priorities.

I know this committee, and the Finance Committee, have been hard at work on putting together a comprehensive health care reform initiative. But as today’s witnesses will testify, many States—rightfully—have not been able to wait for the Federal Government in order to begin moving forward on their own health care reform initiatives. The lessons we can learn from States that have pushed forward on these initiatives are invaluable. It is encouraging to hear that States like Iowa, Massachusetts, and many others, including Pennsylvania, are all coming to similar conclusions about what is truly necessary and what works for genuine health care reform.

In Pennsylvania, the Cover All Kids initiative has shown dramatic improvement in health care for children. As of 2008, only 4.6 percent of Pennsylvania children age 0 to 18 were without health insurance, which puts Pennsylvania near the best in this respect among the States.

Pennsylvania’s CHIP enrollment increased to 183,891 in January. This was more than a 10 percent increase since January 2008. Also, there were 10,774 children enrolled in CHIP in January who would not have been eligible before the Cover All Kids expansion.

The economic situation in Pennsylvania and nationwide has deteriorated in the last six months and this is reflected in the recent acceleration of monthly increases in Pennsylvania CHIP enrollment. Fortunately, no limitations have been imposed upon CHIP enrollment in Pennsylvania to date.

The increase in demand for Pennsylvania’s adultBasic program has been even more dramatic. AdultBasic provides coverage to adults who cannot obtain health insurance and is currently 100 percent State funded; adultBasic enrollment has been limited due to available funds, and efforts are being made to bring this Pennsylvania program under a Medicaid waiver to allow coverage for more adults who do not have health insurance. The adultBasic waiting list is now growing at 10 percent per month.

While there are unique aspects to many of the State initiatives, there is a clear and emerging consensus around the value of prevention for issues such as tobacco use and obesity, the importance of addressing chronic conditions including mental illness and substance use disorders, the significance of wellness programs, the importance of coordination of care through medical homes and of course, the necessity of providing health care coverage for all our citizens, especially our children.

But as I know the experts will tell us, and as we are learning in PA and elsewhere across this country, increased health care coverage must go hand in hand with prevention, wellness and cost savings measures.

One of the things I know we will hear a lot about this morning—and probably already have—is that our health care system is focused upon treating people after they are sick, not focused on preventive care that keeps people healthy. I know there has been great progress in many States to change this focus—to truly focus upon the health and wellness of our citizens—and I believe that is the only way we will truly transform our health care system into what it can and must become in the 21st century.

So thank you again Mr. Chairman, thank you to our distinguished witnesses, and I look forward to hearing more this morning.

Senator HARKIN. Senator Hagan.

Senator HAGAN. Thank you, Mr. Chairman.

Since this is a prevention meeting, talking about prevention health care, my question is relating to educational programs for children in school, whether there are any programs that are currently ongoing that have a curriculum-based nutrition education format. I know there are some piecemeal, but whether any school system actually has a K–12 curriculum-based nutritional education program.

I think if we can educate our youth on this issue, years from now we'll be a lot better off from an obesity standpoint.

Dr. Fielding, I know you commented some on that issue to start with, and I was just curious.

Dr. FIELDING. I'm not aware that there is a comprehensive integrated K–12 curriculum. In general, our findings in the Community Prevention Services Task Force in most areas is that education alone probably doesn't do it. Education can be very useful, but only as part of a more comprehensive approach.

For example, in Los Angeles County we've worked with the local school board, a very large one with 700,000 students, to change what's in the vending machines and to change the standards for what is in the school nutrition. If you do that and then at the same time try and make sure that kids are really getting good physical education, physical activity, and after-school programs and the like, I think that can work. I'm not sure that the education alone is sufficient.

The other point is that we realize that we have to think of the life course trajectory. We need to really start almost in the prenatal period. We know now that some of the things that happen prenatally affect adult diseases. We have to have it all the way through there, through breastfeeding, through what goes on in the preschools. Preschools, for example; we haven't really focused a lot on the meals that they serve and the nutrition, what they consider, "nutrition."

It requires that, and it does require, I think, looking at the incentives. What are the incentives in agriculture? What are the incentives? What kind of marketing can be done to children? As I said, \$1.6 billion is spent marketing to children from different foods,

most of which are high in things that we wouldn't like them to be high in.

I think it takes that broad approach, because there's not a magic bullet here, unfortunately. Everything is interconnected. Senator Casey made the point about SCHIP. Well, it's being funded by a 61-cent increase in tobacco excise tax. That's going to help our tobacco problem. That's going to reduce initiation among youth and that's going to increase cessation among smokers. There are ways of marrying what can be good policy in one area to what can be good policy in another.

Senator HAGAN. Mr. Chairman, I personally feel that's hitting one area a little bit too hard for this program, but that's a different day.

One of the issues that we've done in North Carolina is to take the transfat out of the school lunches. We also passed legislation having to do with what's available in vending machines during the school day in elementary, lower and middle school, and especially not having soft drinks and things like that.

Mr. Chairman, if I might ask one more question.

Dr. Dobson, the electronic medical records. I know that in some of the community health centers in North Carolina that they have very extensive electronic medical records, especially from the standpoint of disease management. I was just wondering if you had any suggestions on how that's helping from keeping people out of the emergency rooms, helping with their care. Ultimately, I know it's an expense in getting it together and putting it together, but I think long-term it will help with care and cost savings. Can you elaborate on any of that, please?

Dr. DOBSON. Yes. I think that my personal perspective on electronic records, we absolutely have to have them. It will require State and national leadership because having the records alone doesn't accomplish the goal. You have to actually share the information. It really is about saying what do we need to do, how do we get our practices at the local level to change from just dealing with the person as I see them to thinking about all my diabetics, all my asthma patients, what are our patients and our community needing, and sharing that data between the local providers.

There are some issues around when we're trying to integrate mental health services with medical services. We have significant barriers for the right kind of exchange. It's going to take Federal and State leadership to do more than just put electronic records out there. It's really dictating how we use them.

Senator HARKIN. Thank you very much, Senator Hagan.

Senator HAGAN. Thank you, Mr. Chairman.

Senator HARKIN. A vote has started, but we have 15 minutes. We have plenty of time for the distinguished Senator from Oregon, Senator Merkley.

STATEMENT OF SENATOR MERKLEY

Senator MERKLEY. I thank you very much, Mr. Chair. I really appreciate this hearing. I think that it's widely understood that the best dollar we have in health care is a dollar spent on prevention, on disease management, and therefore we need to do a whole lot more in that area.

Also, I think your testimony as a panel reflects that the States have been the laboratory in this area, and that we have a lot of ideas to share between the States and also to provide input to national health care efforts, which this is a very exciting time right now, and I look forward to working under Senator Kennedy's leadership this year that we might achieve that goal of universal coverage.

Oregon, like many States, has been experimenting. School nutrition, as in North Carolina, has been a big factor. School exercise; establishing smoke-free buildings, commercial buildings and public buildings throughout the State; having very strong tobacco prevention programs.

I thought I'd mention that we have a real choice housing program, designed to stabilize the mentally ill because if they're homeless it's very hard to address health care issues. Some of your testimony goes to that.

I wanted to ask a couple questions and I'll ask for very quick responses within the time so we can get to this vote. The first is, there's a new product being marketed in Oregon called "Snus," and it is designed largely to appeal to the young. We're very concerned about tobacco addiction through this product. It comes in different flavors, candied flavors and so forth.

Do you have any comment on this or any familiarity with it?

Dr. FIELDING. I'm not familiar with that product, but I think it raises the issue that there are a number of products that have been focused on youth and there's been a lot of marketing of those products, and that's why I and others feel that there needs to be an increased form of regulation so that we don't have these other products that try and slide in and that can unfortunately get kids hooked.

Senator MERKLEY. Yes, please?

Mr. EMMET. I think you can also extend that to alcohol use. There are any number of products that are intended to appeal to younger drinkers, and we know that starting substance use at an early age often leads to much greater problems later on in life, to alcohol abuse and substance abuse. Again, appealing to people at a young age is certainly detrimental to their health.

Senator MERKLEY. Anyone else familiar with this "Snus" issue?
[No response.]

Well, I certainly would draw it to your attention as something that merits—I'm sure what's coming to Oregon may be coming to your State soon. In part, it's a response to the success we've had in changing the culture on smoking. This is more of a chew type product.

Something I wanted to ask about is breastfeeding. In Oregon we passed what I think was really a national model bill about having hospitable workplaces for women to continue to return to work and to be able to continue breastfeeding. All the nutritional experts that we had testify said that this is really one of the best things, that we have this miracle drug for children called breast milk and shouldn't we be working a lot harder.

Is this something that you have paid attention to and are interested in?

Dr. FIELDING. Yes. In my testimony I did suggest, but went over very quickly, that promotion of breastfeeding is one of the things we know can be very effective as part of an effort not only to improve nutrition overall, but to help control over time the high rates of overweight and obesity. There are many benefits, and there are also mental health benefits of having a breastfeeding program.

We have done quite a bit in Los Angeles County and Los Angeles City to try and promote this, and also trying to reduce the impact of the give-away of formula and asking hospitals not to do that and to really promote breastfeeding. We have been pushing that with hospitals, because that's really where a lot of decisions get made.

I really applaud what's occurred in Oregon.

Dr. BIGBY. Senator Merkley, I also appreciate your raising this issue. It's a great example of how the intersection of health care policy and other outside of the health arena intersect. The biggest barrier to women breastfeeding and continuing to breastfeed for the recommended amount of time is actually their returning to work—

Senator HARKIN. That's right.

Dr. BIGBY [continuing]. And the lack of leave, paid leave, for pregnancy and postpartum. If we want to promote breastfeeding we also have to look at the types of policies that promote women being able to take a reasonable leave after birth.

Mr. HATCH. Senator, the University of Iowa's hospital and clinic has a program of a breast milk bank, which the legislature also provides financing for, to store breast milk for women and for children—for children that will need it when their mothers can't provide it.

Senator MERKLEY. I will provide to you all a copy of what we did in Oregon. We worked closely with the business community for businesses with 25 or more employees to be able to establish standards for an area and a strategy in which women would find it much easier to express milk at work and be able to continue breastfeeding.

With that, my time has expired. Thank you, Mr. Chair.

Senator HARKIN. Thank you very much, Senator Merkley. Also, I thought maybe you were going to talk a little bit about the great work that Portland has done in providing the kind of bike paths and walking paths for people to get to work and places where you put your bicycle. I have not seen it; I've just read about it, and my brother, who lives out there, says it's one of the best things he's ever seen, what Portland has done.

Senator MERKLEY. I invite you to come to Oregon. I'd love to show you that first-hand.

Senator HARKIN. I'd like to see it.

Senator Burr.

Senator BURR. Mr. Chairman, Dr. Dobson referenced in his opening statement that the State of North Carolina had filed for a 646 waiver with Medicare to begin to include dual eligibles and high-risk Medicare beneficiaries in Community Care. That program was approved last week by CMS, the waiver was approved.

I want to point out for the committee members—and it gets at the heart of what I think all our panelists have said—that when we start to get ahead, all of a sudden we get knocked back. There's

a likelihood that that approval of that waiver will get held up with the Administration's new order for all waivers that were granted in the last several weeks to stop.

I hope my colleagues, after hearing this, will work with me to distinguish for the Administration. This waiver when granted offers an opportunity for North Carolina to save \$1.4 billion over the next 5 years, and a lot of that money comes out of the Federal share of what goes into the delivery of health care to those targeted individuals.

I thank the chair.

Senator HARKIN. I'm sure our former colleague Senator Daschle, who is about to take over—he's been away because of an illness in his family, but I'm sure this is something that he would like to work with us on. Let me know and I'll be glad to work with you on it, Richard.

Well, we have a vote in progress now and we're going to have to leave. I have a lot more questions and just dialogue that I could engage with all of you on, but I think if I just might say in closing, I thank you all for your great leadership.

The record will stay open for 10 days for questions from committee members that may be submitted to you in writing. Again, just to pick up I think where Dr. Fielding started, and that is that we have to think about prevention and wellness as a lifetime type of thing. It's not one point in time that you do it. Prevention starts before birth, to make sure that every expectant mother has the proper nutrition, and cutting down on smoking and alcohol and making sure that every baby that is born has the ability to get nutritious mother's milk one way or the other, whether it's directly or through a food bank, working with workplaces to make sure that people who go back to work—my daughter lives in your county and just had her second child not too long ago, and her workplace provides breastfeeding places and places where they can pump. It's just wonderful. But not everybody does that, and we have to figure out how we do this nationally.

Then school-based programs. We haven't even talked about school-based programs really. I mentioned briefly with Senator Burr about the reauthorization of the child nutrition bill this year, getting better foods in our kids for kids in school.

One of you mentioned exercise programs. Who was it that mentioned exercise at school? Did you do that, Jack, in Iowa?

Mr. HATCH. Yes.

Senator HARKIN. The legislature passed a mandate that you have to have physical exercise programs K through 12. That's probably not been implemented yet. I don't know.

Mr. HATCH. It starts July.

Senator HARKIN. Of this year?

Mr. HATCH. Yes.

Senator HARKIN. I'll look forward to that. We've got to start thinking about that also; and fruits and vegetables in schools, which I've been pushing. School-based programs; workplace-based programs for small employers, how they can do that along with the big ones. We've got to put the incentives in. If there are tax breaks, there are tax incentives, we've got to think about how we do those things for workplaces and community-based programs.

I look around, there's a lot of communities in this country that are doing interesting things. I mentioned Portland being one that I just happen to know about because I have family members that live out there. Other cities and places are doing things. I'm familiar with some of the things we've done in Iowa, Senator Hatch, with community-based programs and things like that, simple things.

One community worked with the grocery store in their community and with the medical community and they got the grocery store to put little arrows, a heart, and it's "Heart Healthy," along every aisle, so that a shopper going through would look at it and say: "Oh, this is heart healthy." Of course, you go down the candy and the potato chip aisle and the like and you don't see any of that. I mean, it's a subtle way of letting people know that this is good for you. From my talks with people there, it has really changed some of the buying habits of the people as they go through the grocery stores.

Some of these things, you think of them and you say, "Well, that just makes sense." But not everyone's doing it, and we have to think about this comprehensively.

Community wellness programs, providing—and transportation. I tried in the last transportation bill, I offered an amendment that said that any entity that gets Federal money through transportation for streets and roads and things like that had to incorporate in their planning and architecture bike paths and walking paths. Now, I didn't say they had to do it. I just said they had to put it in their planning.

I lost that amendment. We're up in 2010 and I'm not going to lose it this time. Just things like that. You mentioned that, Dr. Fielding, about transportation and how sidewalks to schools, sidewalks in neighborhoods, lights, things like that, that encourage people.

I don't mean to go on about this, but a lot of times when I talk about prevention and wellness people say: "Well, that's a personal responsibility; people have got to take care of themselves." Well, I believe that. That is true. So much of our society is set up to inhibit you from doing the things that you know should be done, whether it's taking walks in the neighborhood or climbing stairs that are hidden and dark and you can't find them anywhere, healthy foods.

Nothing is more frustrating than to travel and you go through an airport and the only thing you can find are fatty, high sodium. Once in a while you can find salads, but most of it is junk food in the airport. Everything is against you trying to be healthy. Kids in schools now, the vending machines, soda pop, high fat, high sodium foods in our schools for kids.

No matter how hard you try—you really have to try hard to be healthy in this country. You shouldn't have to do that. It ought to be easy. It ought to be one of the easiest things you do—to eat healthy, work healthy, play healthy, be healthy. It ought to be something that we just engender. That's how I see this whole health care debate unfolding, that we just have to incentivize it, provide the incentives in there. Sometimes that's money, sometimes it's support, sometimes it's changing laws, partnerships,

State, local, Federal Government. It can be tax laws, changing tax provisions.

I sit here and I see this moment in time when we can do this. We can really make prevention and wellness the centerpiece of our health care reform, so people in America start thinking about it. If you talk about health care reform to the average American out there, they think of one thing: How am I going to pay the bills? Am I going to get insurance coverage so I can pay the bills if I get sick? We've got to start having people think anew about, how am I going to be healthy, how am I going to maintain my health, how are my kids going to be healthy, and start getting that paradigm shift—that's a well-worn word around here, "paradigm shift"—get that shift in thinking in this country, in the supportive things that we need to go along with it.

We have this moment in time to do this right now. People are ready. We know it saves money. We have good documentation from a lot of States on the money that you're saving out there, North Carolina, Massachusetts, Iowa, and we can take these examples.

Last, I just want to say one thing, Mr. Emmet. You know, so many of our physical ailments start with mental illness. We know that. It's been well-documented. The biggest single factor in young women dropping out of college are eating disorders, which start with mental health problems. A lot of these mental health problems we know start early in life. They start in grade school and in high school. And we're not paying attention to it.

Some of these kids come from tough homes, tough neighborhoods, and they don't get the kind of supportive environment that higher income kids, for example, might get at home. We have to think about the mental health of our kids. It may start with something very small when they're a child and then it eats away and it eats away and it eats away through grade school, through high school. It then relates to substance abuse, tobacco abuse, alcohol abuse, all that kind of stuff, which leads to all other kinds of chronic illnesses.

We have to focus on the mental health conditions again of our kids in schools and how by getting to that early on, and even adults, that a lot of times you can solve a lot of our physical ailments in this country. That's got to be a part of this wellness. Think of mental health as wellness and prevention as a part of this whole endeavor.

Well, that's my speech anyway. You're all leaders in this and I just encourage you to keep going and give us the benefit of your wisdom, your knowledge. I mean it sincerely. You are doing great things out there in these States, and we've got to incorporate these. We've just got to incorporate these into what we're doing, so that we have this collaboration between the Federal, the State, the local, the private, and the public sector and we can put all this together.

Well, I thank you all very much for all your great leadership in this. Like I said, we'll leave the record open for 10 days. I've got 2 minutes left. I can make it.

Thank you all.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR KENNEDY

The Nation is facing a worsening health care crisis that demands our immediate attention. As a nation, we spend \$2 trillion a year on care, yet one in two Americans suffer from chronic diseases that decrease quality of life and increase health costs. Estimates indicate that close to 200 million Americans alive today will have a chronic illness, and that \$1 in \$4 will soon be spent on health care. Without basic reform, the burden and the cost of treating these chronic conditions will not be sustainable for future generations.

In order to end this crisis, we need to deal with the factors that lead to the development of chronic disease. Poor diet, physical inactivity, smoking, and alcohol use account for 38 percent of deaths related to chronic disease among Americans. In particular, the lack of good nutrition and the lack of exercise have led to unprecedented increases in the rates of obesity. About one in three adults and a staggering one in six children and adolescents in the United States are obese, and are therefore at increased risk of diabetes, heart disease and other chronic conditions. Tobacco use leads to conditions such as lung cancer, chronic obstructive pulmonary disease and heart disease, which are estimated to cost Fortune 500 companies \$157 billion each year.

Many factors lead to chronic disease, but it is estimated that 75 percent of health care expenditures associated with these conditions are preventable. Prevention and early detection of such diseases is obviously a critical aspect of health reform. One-hundred thousand lives could be saved each year through the use of five basic services that include taking daily aspirin, putting an end to smoking, screening for colorectal disease and breast cancer, and immunization for influenza. Early detection of mental health and substance use disorders will lead to reduced symptoms and enhanced quality of life. For every dollar spent on initiatives to increase physical activity, improve nutrition and prevent smoking, a total of \$5.60 can be saved in health costs. Even though a great deal is known about the power of prevention, less than 5 percent of all health expenditures are spent on prevention.

Prevention initiatives also need to address economic, social and physical issues that often make it difficult for people to make healthy choices. Limited access to healthy food and neighborhoods that are not conducive to physical activity can prevent Americans from making healthy choices, especially in low income and minority communities that suffer a disproportionate burden of chronic disease and are less likely to have preventive services available. By providing such services, we can significantly improve the health of Americans and significantly reduce health costs.

Many States are exploring a number of innovative prevention initiatives to combat the effects of chronic illness on their residents. In Massachusetts, the combined cost of treating chronic diseases and the loss in productivity is \$34 billion a year. In response, the Massachusetts Office of Health and Human Services initiated the "Mass In Motion," a multi-faceted program that includes regulations to promote healthy eating and physical activity, grants to cities and towns to make wellness initiatives a priority, and a new

Website to give residents advice on how to make healthy eating and physical activity part of their daily lives. This is one of the many important initiatives we will hear about today that focus on reducing the burden of chronic disease on our people.

We look forward to hearing about those prevention initiatives as we work on health reform. Chronic disease can affect all Americans, and we need to focus on the steps we know will work best. The power of prevention is an essential element of health reform—the best way to address the unsustainable increase in health costs related to chronic conditions is to prevent the conditions in the first place. I commend Senator Harkin for chairing this important hearing and for emphasizing that prevention must be one of the principal pillars of overall health reform.

PREPARED STATEMENT OF DOUGLAS MCCARTHY AND KIMBERLY MUELLER*,
ISSUES RESEARCH, INC.—CASE STUDY

ABSTRACT: Community Care of North Carolina (CCNC) is a public-private partnership between the State and 14 nonprofit community care networks. The networks comprise essential local providers that deliver key components of a “medical home” for low-income adults and children enrolled in Medicaid and the State Children’s Health Insurance Program. Community-based delivery systems promote the development of locally led approaches that leverage resources and relationships to meet statewide goals. Local networks and primary care physicians receive supplemental funding for care management and quality improvement initiatives supported by statewide performance measurement and benchmarking activities. Results suggest that the program has yielded cost savings while promoting improvements in care of patients with chronic conditions. CCNC’s experience may be relevant to other States considering how to improve primary care case management programs, or how to better address the needs of low-income individuals in areas that lack effective mechanisms for coordinating care.

OVERVIEW

In August 2008, the Commonwealth Fund Commission on a High Performance Health System released a report, *Organizing the U.S. Health Care Delivery System for High Performance*, that examined problems engendered by fragmentation in the health care system and offered policy recommendations to stimulate greater organization for high performance.¹ In formulating its recommendations, the Commission identified six attributes of an ideal health care delivery system (Exhibit 1).

*The authors gratefully acknowledge Chris Collins, M.S.W., program consultant for Community Care of North Carolina, and Anne Braswell, senior analyst and HealthNet program manager, North Carolina Office of Rural Health and Community Care, both of whom kindly provided information for the case study. We also thank L. Allen Dobson, M.D., vice president for clinical practice development at Carolinas Healthcare System and formerly assistant secretary in the North Carolina Department of Health and Human Services, and other staff at the CCNC central office who provided feedback on a previous draft of the case study. The authors also thank the staff at The Commonwealth Fund for advice on and assistance with case study preparation. Editorial support was provided by Joris Stuyck.

This study was based on publicly available information and self-reported data provided by the case study institution(s). The Commonwealth Fund is not an accreditor of health care organizations or systems, and the inclusion of an institution in the Fund’s case studies series is not an endorsement by the Fund for receipt of health care from the institution.

The aim of Commonwealth Fund-sponsored case studies of this type is to identify institutions that have achieved results indicating high performance in a particular area of interest, have undertaken innovations designed to reach higher performance, or exemplify attributes that can foster high performance. The studies are intended to enable other institutions to draw lessons from the studied institutions’ experience that will be helpful in their own efforts to become high performers. It is important to note, however, that even the best-performing organizations may fall short in some areas; doing well in one dimension of quality does not necessarily mean that the same level of quality will be achieved in other dimensions. Similarly, performance may vary from one year to the next. Thus, it is critical to adopt systematic approaches for improving quality and preventing harm to patients and staff.

- Exhibit 1. Six Attributes of an Ideal Health Care Delivery System**
- **Information Continuity** Patients' clinically relevant information is available to all providers at the point of care and to patients through electronic health record systems.
 - **Care Coordination and Transitions** Patient care is coordinated among multiple providers, and transitions across care settings are actively managed.
 - **System Accountability** There is clear accountability for the total care of patients. (We have grouped this attribute with care coordination, since one supports the other.)
 - **Peer Review and Teamwork for High-Value Care** Providers (including nurses and other members of care teams) both within and across settings have accountability to each other, review each other's work, and collaborate to reliably deliver high-quality, high-value care.
 - **Continuous Innovation** The system is continuously innovating and learning in order to improve the quality value, and patient experiences of health care delivery.
 - **Easy Access to Appropriate Care** Patients have easy access to appropriate care and information at all hours, there are multiple points of entry to the system, and providers are culturally competent and responsive to patients' needs.

Community Care of North Carolina (CCNC) is 1 of 16 case study sites that the Commission examined to illustrate these six attributes in diverse organizational settings. Exhibit 2 summarizes findings for CCNC. Information was gathered from staff in the CCNC central office and from a review of supporting documents.² Although case study sites varied in the manner and degree to which they exhibited the six attributes, all offered ideas and lessons that may be helpful to other organizations seeking to improve their capabilities for achieving higher levels of performance.³

Exhibit 2. Case Study Highlights

Overview: Community Care of North Carolina (CCNC) is a public-private partnership that provides key components of a medical home and care management for more than 800,000 low-income adults and children enrolled in Medicaid and the State Children's Health Insurance Program. CCNC is a community-based system of 14 regional networks, each of which is a nonprofit organization consisting of a partnership of local providers including hospitals, primary care physicians, county health and social services departments, and other stakeholders. About 3,000 physicians in 1,200 primary care practice sites participate in CCNC networks statewide, representing about half of the primary care practices in the state. The state provides resources, information, and technical support. Physician fee-for-service reimbursement is supplemented by a per-member per-month (PMPM) fee for case management. The regional networks also receive a PMPM fee to cover the cost of care management and network administration.

Attribute	Examples from Community Care of North Carolina
Information Continuity	Partners with Blue Cross Blue Shield to promote electronic prescribing statewide with planned educational, technical, and grant support. Plans to use savings from other initiatives to promote the adoption of EHR among local essential providers. Care managers in regional networks use a common Web-based case management information system to track patients and their assessments, facilitate care planning, and engage in secure messaging.
Care Coordination and Transitions; System Accountability*	Develops and disseminates resources and tools to support population-health management for Medicaid patients Local networks hire nurse case managers who work in concert with physicians to identify high-risk patients, assist in patient education and follow-up, coordinate care, and help patients to access services. Networks collaborate with other community agencies (such as the local health department and mental health agency) to coordinate care.
Peer Review and Teamwork for High-Value Care	Network clinical directors identify best-practice models and create systemwide quality measures and initiatives; local networks implement initiatives locally. Local clinical directors work with peers in the community to support and encourage quality improvement efforts. Physicians receive comparative performance profiles (compiled by the CCNC central office) to motivate improvement on network initiatives.
Continuous Innovation	Innovative delivery model incorporates principles of public-private partnership, physician leadership, quality and population management, shared responsibility, and incentives. Chronic disease initiatives have increased adherence to clinical guidelines and improved outcomes such as reduced asthma-related emergency visits and hospitalizations. A sustainable community-based infrastructure helps launch other health initiatives.
Easy Access to Appropriate Care	Each CCNC patient selects or is assigned a primary care physician who serves as a "medical home," providing acute and preventive care and facilitating access to specialty care and after-hours coverage. Networks work with their medical homes to increase after-hours and weekend availability. Mental health integration pilot colocates behavioral health specialists in primary care and, conversely, creates access to preventive primary care services in behavioral health practices. Local networks are partnering with local safety-net providers and indigent-care programs to create integrated networks of care for uninsured adults.

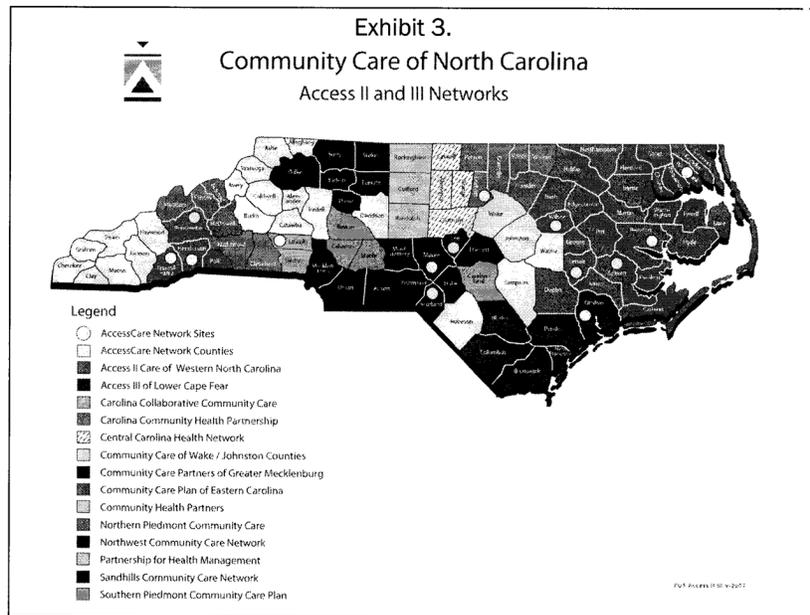
* System accountability is grouped with care coordination and transitions, since these attributes are closely related.

ORGANIZATIONAL BACKGROUND

Established in 1998, CCNC is a public-private partnership that provides key attributes of a primary care "medical home" and population-based care management

for more than 800,000 low-income adults and children enrolled in Medicaid and the State Children's Health Insurance Program (SCHIP). CCNC is a community-based delivery system that builds on and enhances the State's Medicaid primary care case-management program, known as Carolina ACCESS, which has been in operation since 1991.

CCNC has grown from a pilot project into a program encompassing the entire State through 14 local community care networks (Exhibit 3) that cover geographic areas ranging from a single county to a region comprising 27 counties (one network includes provider sites dispersed among counties throughout the State). Networks were developed by local physicians and other Medicaid providers through a request-for-proposals process initiated by the State. This State-local partnership is structured to leverage local resources and relationships to meet local needs and promote local responsibility for systemwide principles of collaboration, population health management, and accountability.



Each local network is a nonprofit organization that facilitates a partnership among essential local providers including hospitals, primary care physicians, county health and social service departments, and other key stakeholders that vary from network to network (e.g., county medical societies, which help build relationships with specialist physicians). Several networks also include State-designated Local Management Entities that oversee and coordinate the provision of local mental health, developmental disability, and substance abuse services.

About 3,000 physicians in 1,200 primary care practice sites currently participate in CCNC networks statewide, representing about half of North Carolina's primary care practices. Physicians contract with the State's Department of Medical Assistance to participate in Carolina ACCESS, then contract with a local community care network to participate in CCNC. Key participation requirements include providing primary preventive care services, assuring 24-hour coverage, coordinating the use of specialty care, and participating in care management and quality improvement activities.

The State of North Carolina partners with the program to provide resources, information, and technical support, such as analyzing Medicaid claims data and sponsoring statewide audits for performance measurement and benchmarking purposes. The North Carolina Office of Rural Health and Community Care serves as a central program office under the sponsorship of the State's Department of Health and Human Services. The North Carolina Foundation for Advanced Health Programs, a nonprofit organization, also provides staffing and grant-funding opportunities.

The State pays local networks \$3.00 per member per month (PMPM) to cover the cost of network management activities, including the salaries of a full-time program director, a part-time medical director, full- or part-time consultant pharmacists, and a team of care managers. Network management fees are intended to be competitive with those charged by commercial disease management vendors for similar services. Some networks also receive grant monies for specific initiatives relevant to their respective enrolled populations.

Physicians are paid on a fee-for-service basis (fees are set at 95 percent of Medicare rates), supplemented by an additional \$2.50 PMPM for medical home and population-management activities. This supplemental funding helps providers take a more active role in managing the health needs of their patient populations, for example by providing preventive care services and identifying patients in need of care management.

INFORMATION CONTINUITY

Many physician practices participating in CCNC have not yet implemented electronic medical records. To encourage adoption, Community Care plans to use savings from other initiatives to promote the adoption of health information technology among local essential providers. In the interim, CCNC is partnering with Blue Cross Blue Shield of North Carolina on a statewide electronic prescribing initiative. The CCNC central office will provide educational, technical, and grant support to help participating practices adopt the technology to transmit prescriptions electronically and thus improve administrative efficiency and patient safety. Some local networks are developing related information technology solutions. For example, one network provides its physicians with handheld computers that include tools for promoting cost-effective drug prescription.⁴

Care managers throughout the program use a secure, Web-based case management information system (CMIS) to help coordinate the care of enrollees. The system includes modules for patient information such as diagnoses and service use derived from claims data; reporting on guideline compliance at the individual and population levels; patient assessment and care planning to document problems, goals, and interventions provided; and secure messaging among care managers. The CCNC central office supplements the CMIS with additional data derived from Medicaid claims to help identify patients with target conditions and measure service use. Data derived from chart audits are used for measuring process and outcome quality to assess performance.

CARE COORDINATION AND TRANSITIONS: TOWARD GREATER ACCOUNTABILITY FOR TOTAL CARE OF THE PATIENT

CCNC's care management activities are designed to help mitigate the long-term medical and financial risks from poorly controlled chronic diseases. Local community care networks hire case managers who work in concert with primary care providers ("medical homes") to identify patients who will benefit most from targeted care management interventions, such as patients making repeated ER visits; patients diagnosed with asthma, diabetes, or heart failure; and patients who have two or more chronic conditions (including mental health conditions) with high service use or activity limitations indicating complex care needs. Care managers identify high-risk patients through the CMIS and from case-identification lists provided by the CCNC central office, notifications of admissions provided by hospitals, and physician referrals.

- Care managers assist in patient education and follow-up to promote treatment adherence and support lifestyle changes, help patients coordinate their care and access needed services, and collect data on process and outcome measures. During home visits, for example, care managers assess medication use for review by a consultant pharmacist and provide feedback to primary care physicians when patients are not adhering to their treatment regimen.

- Care managers also assess the psychosocial needs of patients and address barriers to care such as communication or transportation needs. For example, care managers may assist patients in scheduling follow-up appointments and by facilitating access to community-based services for behavioral health care, housing and shelter aid, or vocational and family support when needed.⁵

- A care-transitions program is currently under development as part of the chronic care initiative to help reduce hospital re-admissions among patients with complex chronic illness. In the Cumberland Network, for example, care managers based in the hospital coordinate directly with hospital staff to facilitate patient transitions to the community.

Each case manager is responsible for monitoring a population of 3,000 to 4,000 Medicaid patients (all patients are assigned to a case manager regardless of their current need for service), typically managing an active caseload of 150 to 200 patients. Because care managers may coordinate care for patients across multiple physician practices, they seek to develop personal relationships with physicians in the network so that they can effectively communicate about patient needs.⁶ To ensure consistency across the system, CCNC network leaders and program staff collaborated to develop the Standardized Case Management Plan, which offers benchmarks and guidelines for care management activities and reporting across networks. The plan includes action steps for network coordinators and case managers, as well as strategies for characterizing service intensity levels.

CCNC contracts with Area Health Education Centers (AHECs) to conduct randomized chart reviews of a representative sample of patients seen in each participating practice to assess compliance with care management guidelines. The clinic receives feedback from this audit to help improve the delivery of care. Local providers generally view the activities of the case managers as offering added value to the services provided by the practice. In a recent study of innovations in rural primary care management, physicians commented positively that care managers “add tangible benefits for the patient that the provider does not have time to offer.”⁷

PEER REVIEW AND TEAMWORK FOR HIGH-VALUE CARE

Clinical directors elected by each regional network meet regularly to select targeted diseases or care processes for improvement. The group adheres to certain guiding principles in selecting a quality improvement initiative (Exhibit 4). The group reviews and identifies relevant best-practice models, creates network-wide quality initiatives, defines outcome and process measures, and rolls them out to local practice sites. Outcome data may include utilization measures, while process data may include periodic assessments or treatment planning. Claims databases and regular chart reviews provide a source for collecting and monitoring these data. Clinical areas targeted for improvement statewide include asthma, diabetes, and heart failure, along with appropriate use of medications (specific initiatives will be described in the next section).

Exhibit 4. CCNC Guidelines for Selecting a Quality Improvement Initiative

- There are sufficient Medicaid enrollees with a particular disease to obtain a return on investment by improving its treatment.
- Evidence exists that best practices lead to predictably improved outcomes.
- Appropriate evidence-based practice guidelines are readily available.
- Physicians support the process.
- Patient education and support can lead to improved outcomes.
- Best practices and outcomes are measurable, reliable, and relevant.
- There is room for improvement: A gap exists between best practice and everyday practice.
- There is a quantifiable baseline from which to measure improvement.

Local medical management committees implement these statewide initiatives, along with their own, locally developed initiatives, using a rapid-cycle quality improvement model. Local clinical directors work with peers in the community to support and encourage quality improvement efforts. Networks covering multiple counties may also designate part-time physician “champions” to work with physician practices in each community. Some networks also employ quality improvement “coaches” to assist in practice redesign efforts, although this is not yet a systemwide undertaking.

All CCNC networks work together with the State to define, track, and report performance measures. Clinical directors choose performance measures that are evidence-based best-practice guidelines and can be measured using existing data sources, such as Medicaid claims and chart audits. CCNC physicians receive a quarterly practice profile detailing their performance on utilization and disease management measures, such as total costs per member per month and rates of asthma hospitalizations and diabetes control.

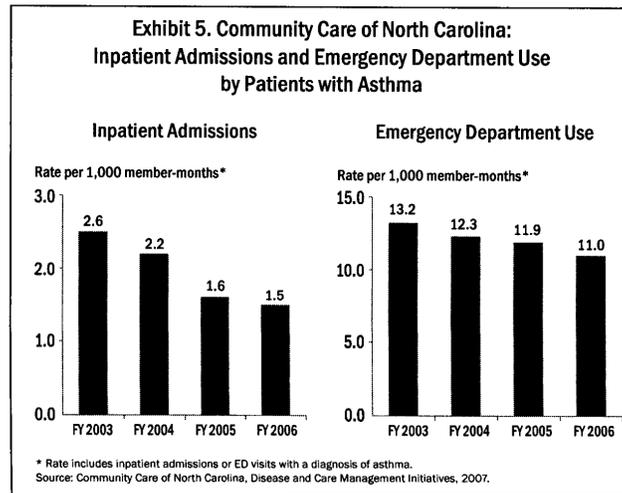
CONTINUOUS INNOVATION

The public-private partnership and community-based delivery model promotes the development of targeted initiatives that can be developed in a flexible manner to meet local, regional, or statewide needs, and the benefits of these initiatives can be shared among the networks.

Asthma Initiative. The asthma initiative supports physicians in: (1) improving routine identification, assessment, and severity staging of asthma to determine appropriate treatment; (2) reducing unintended variations in care through adherence to national practice guidelines; (3) educating patients, families, and school personnel in asthma management; and (4) reporting outcomes. Program results reported by CCNC appear promising.

- Since the program's inception in 2004, there has been a 21 percent increase in severity staging and a 112 percent increase in the administering of flu shots to asthma patients. More than 90 percent of staged patients are using appropriate medications.

- Between 2003 and 2006, asthma-related hospitalizations decreased 40 percent, from 2.6 to 1.5 admissions per 1,000 member-months, and emergency visits decreased 17 percent, from 13.2 to 11.0 visits per 1,000 member-months (Exhibit 5).

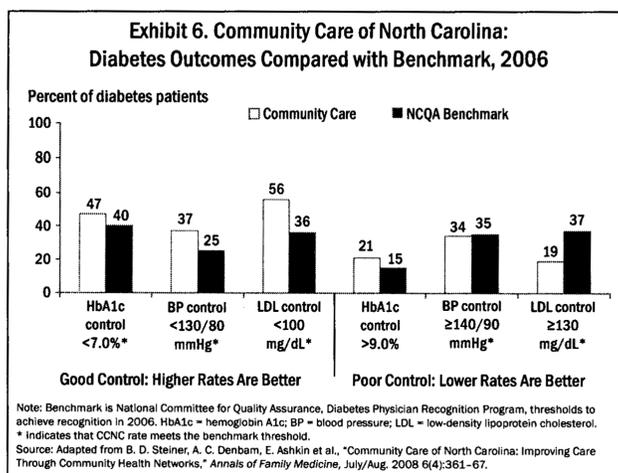


Diabetes Initiative. The diabetes initiative promotes the use of the American Diabetes Association's Clinical Practice Recommendations, along with tools to support their implementation. Case managers are trained to work with physicians to educate patients in disease self-management, targeting those at highest risk. CCNC reports increases in the provision of some chronic care services, such as blood lipid testing, which was received by 66 percent of diabetics in 2004 as compared with 77 percent in 2005.

An analysis of diabetes outcomes found that in 2006, on five of six measures, CCNC met or exceeded a benchmark set by the National Committee for Quality Assurance's Diabetes Physician Recognition Program (Exhibit 6).⁸ For example:

- Forty-seven percent of CCNC diabetes patients achieved optimal control of their blood sugar (hemoglobin A1c less than 7 percent), versus the benchmark of 40 percent.

- Fifty-six percent of CCNC diabetes patients achieved optimal control of blood cholesterol (LDL-C less than 100 mg/dL), versus the benchmark's 36 percent.



In a locally developed refinement of this statewide initiative, Cabarrus County established a disease management center and registry to sharpen their focus on diabetes. The registry tracks process and outcome measures including hemoglobin A1c, blood pressure, eye, and foot exams, regardless of patients' coverage. Practices use the data to evaluate and improve the delivery of care, as well as to compare the care received by Medicaid and uninsured patients with that provided to privately insured patients.⁹

Prescription Advantage List. The prescription advantage list (PAL) is a voluntary drug list developed by CCNC clinical directors and the North Carolina Physicians Advisory Group in cooperation with the State. The list ranks drugs within therapeutic categories (by highest frequency and opportunity to impact quality and cost) to encourage the use of less-expensive drugs, including generics and over-the-counter medications, whenever appropriate. CCNC providers receive quarterly feedback on a PAL scorecard showing the percentage of prescribed PAL drugs and the use of over-the-counter medications for their enrolled population. CCNC reports that this program has been associated with lower overall pharmacy spending and annual savings of nearly \$1 million by the State.¹⁰

Nursing Home Polypharmacy Initiative. The initiative reviewed drug regimens of 9,000 nursing home Medicaid patients and made recommendations to physicians in order to optimize overall drug management and reduce costs where appropriate. These efforts led to more than 8,000 recommendations, 74 percent of which were implemented, and an estimated \$9 million in cumulative savings since 2002, according to program figures. CCNC reports that this effort improved patient health care through reduction of drug duplications and adverse drug-drug interactions.

In addition to these statewide initiatives, local community care networks undertake their own targeted initiatives. For example, AccessCare—a statewide network with the largest registry of pediatric Medicaid patients in the State—engaged in a quality improvement intervention for gastroenteritis that reduced hospital admissions to levels substantially lower than those of a control group. Key components of the intervention included expert-led physician education on evidence-based care, peer-to-peer teaching and sharing of tools and resources, and performance feedback.¹¹

EASY ACCESS TO APPROPRIATE CARE

Medical Home. Each CCNC enrollee selects or is assigned a personal primary care provider who serves as a "medical home." This role extends to providing acute and preventive services and facilitating patient access to care through specialty referrals and after-hours coverage. Some networks work with their medical homes to increase after-hours and weekend availability. Providers in Pitt County, for example, created a community pediatric after-hours clinic staffed by a pediatrician and medical residents offering services during the evening hours every day of the year.¹²

CCNC engages patients in the medical home model through an educational campaign called “The Right Call Every Time: Your Medical Home.” The campaign touts the value of preventive services and continuity of care with the same practice. In addition to distributing patient-education materials that inform patients of the benefits of a medical home, providers and care managers work with patients on shifting triage toward the primary care setting and away from the ER when appropriate.

Mental Health Integration. In the last 2 years, four CCNC networks have worked with State mental health agencies and local management entities to pilot a model for integrating mental health care into routine medical care. This program seeks to better manage Medicaid enrollees with co-occurring behavioral and physical health needs, and to serve them in the most appropriate setting by: (1) providing education, resources, and support to primary care physicians to increase their comfort level in identifying and treating depression in their patients; (2) improving communication and coordination between primary care physicians and behavioral health care specialists; and (3) implementing a system of standardized screening and assessment tools and evaluation measures.

The Mental Health Integration pilot has led to several communitywide mental health planning efforts and to a grant program to help offset the start-up costs involved in co-locating mental health professionals in primary care sites. Another pilot innovation is “reverse co-location,” which creates access to preventive primary care in behavioral health practices. To promote this complex change in practice (a much more difficult undertaking than traditional clinical practice improvement), CCNC is participating in the statewide ICARE Partnership (www.icarenc.org), which brings stakeholders together to help break down barriers between disciplines and to address policy issues such as discrepancies in payment and regulations.

HealthNet Collaborative Networks. Under the State’s HealthNet program, CCNC networks are partnering with local safety-net providers and indigent care programs (such as free clinics and reduced-fee programs offered by community and rural health centers and public health departments) to create integrated networks of care for uninsured adults.¹³ The goal is to leverage CCNC’s case management capabilities and physician pool to increase the number of uninsured with a medical home, improve accessibility and quality of care, and promote continuity of coverage regardless of the funding source. By creating a single triage process to assess and meet the needs of low-income individuals—who often alternate between periods of eligibility and ineligibility for Medicaid coverage—an integrated program helps assure that patients receive appropriate care while also conserving free care and other resources to serve more of those in need.

The State provides technical assistance and funding to support 16 HealthNet collaborative networks that serve uninsured adults with incomes up to 200 percent of the Federal poverty level. Local networks set eligibility criteria and operating parameters based on local resources and capabilities. The HealthNet program will reach about 45,000 uninsured adults in 27 counties during its first year, with plans to expand to 10 more counties in the coming year. The CCNC case management information system is being updated with software functionalities used by indigent care networks for enrollment and referral, managing provider commitments, and tracking service utilization and value of care provided for the uninsured population.

RECOGNITION OF PERFORMANCE

In addition to the results of the specific interventions described above, Exhibit 7 discusses areas where CCNC is achieving higher levels of performance.

Exhibit 7. Externally Reported Results and Recognition	
Overall Financial Performance	An actuarial analysis by Mercer Human Resources Consulting estimated that, compared with historical fee-for-service costs, the program saved the state between \$284 million and \$314 million in fiscal year 2006. A more conservative estimate of what the State would have spent “without any concerted effort to control costs” suggests savings of \$154 million to \$170 million attributable to CCNC’s care management and quality improvement activities in 2006. ¹⁴
Ambulatory Care Quality	University of North Carolina researchers evaluated the program’s disease management programs and estimated a \$3.5 million savings resulting from the CCNC asthma management program and a \$2.1 million savings resulting from the CCNC diabetes management program during 2000–2002. ¹⁵
National Recognition	CCNC received the 2007 Annie E. Casey Innovations Award in Children and Family System Reform from the Ash Institute for Democratic Governance and Innovation at Harvard University’s John F. Kennedy School of Government. According to the institute, “Community Care’s centralized structure enables medical directors to develop improvements in care treatments and to influence the generation of larger-scale public health programs that share model practices statewide.” ¹⁶

INSIGHTS AND LESSONS LEARNED

CCNC was created to enhance and build upon North Carolina's existing primary care case management program through community-based organized delivery systems that could manage large populations. Primary care providers working alone simply did not have the tools, information, or support to manage care for the State's many Medicaid beneficiaries with complex medical and social problems. Under the CCNC program, these community health partners have come together in partnership with the State to employ a population health management approach in existing practice arrangements.

This system of care was created through an evolutionary, collaborative process involving State officials, physician leaders, and professional organizations. According to University of North Carolina professor of family medicine Beat Steiner, M.D., M.P.H., and his colleagues, some of the factors contributing to the success of this statewide system include visionary and sustained leadership, a strong State infrastructure to oversee the program, starting small to demonstrate success at a local level, and disseminating best practices through pilot programs. The perceived external threats of possible Federal funding cuts and outside interference from commercial insurers also motivated physicians to try a new approach.¹⁷

Stakeholders shaped the program around five key principles: (1) a public-private partnership that unites and strengthens local essential providers; (2) physician leadership and local control; (3) a focus on quality of care and population health management; (4) shared State/local responsibility; and (5) shared incentives. Steiner and colleagues point out that this federated organizational structure enables statewide collaborative learning while also promoting local physician participation and stronger linkages with the community than would be likely under a more centralized approach. While local control helps communities respond to local needs, it also means that quality improvement remains variable across the State.

Participation in local community care networks can empower primary care physicians, whose role in the health system is often undervalued in traditional care arrangements. "Doctors can come to the table to meet with other players and offer input [on how to improve care]," says Chris Collins, M.S.W., a program consultant to CCNC and formerly an executive director of a local network, who notes that this "gives them a voice to drive change from the bottom up." Giving physicians an opportunity for involvement increases their motivation to engage in network quality improvement initiatives, she says.

Current challenges affecting CCNC's future development, according to Steiner and colleagues, include the adequacy of the network management fee to fund effective care management for high-risk populations, the need to extend care coordination to include not just primary care physicians but subspecialists who treat patients with complex care needs, the ability to parlay focused quality improvement initiatives into larger practice re-design efforts that can lead to transformative system-level change, and the limitations of current data systems in supporting robust outcomes measurement. Comparison to other case study sites suggests that CCNC could realize further improvements through structural interventions such as the adoption of electronic health records and the "advanced access" model of patient scheduling, which can reduce patient waiting times and increase practice efficiency.

CCNC's experience may be relevant to other States considering how to improve the effectiveness of primary care case management programs, or how to better address the needs of Medicaid and SCHIP patients in areas that lack effective mechanisms for coordinating and improving care. Savings gained from an improved coordination of care could be used to help fund public program enrollment expansions. How the financial and clinical results achieved in North Carolina would compare with outcomes attained in other State Medicaid programs with alternative forms of managed care (such as those that contract with private health plans) remains a question for further evaluation.

In summary, local community care networks are a central element in the strategy to provide access to quality health care for low-income citizens of North Carolina. A community-based approach to implementing enhanced primary care case management appears to be promoting broad physician participation and making more effective and efficient use of resources to help improve population health.

NOTES

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2. Information on CCNC was synthesized from a telephone interview with Chris Collins, M.S.W., program consultant for Community Care of North Carolina; e-mail communication with L. Allen Dobson, M.D., vice president for clinical practice development at Carolinas Healthcare System and formerly assistant secretary for health policy and medical assistance in the North Carolina Department of Health and Human Services, and with Beat Steiner, M.D., M.P.H., professor of family medicine at the University of North Carolina at Chapel Hill; feedback from staff in the CCNC central office; a review of supporting documents including those on the CCNC website (www.communitycarenc.com); reports of the State Division of Medical Assistance; and the following publications or presentations: S. Wilhide and T. Henderson, *Community Care of North Carolina: A Provider-Led Strategy for Delivering Cost-Effective Primary Care to Medicaid Beneficiaries* (Washington, DC: American Academy of Family Physicians, June 2006); R. Arora, J. Boehm, L. Chimento, et al., *Designing and Implementing Medicaid Disease and Care Management Programs: A User's Guide* (Rockville, MD: Agency for Healthcare Research and Quality, Mar. 2008); D.L. Hewson, "Improving Medicaid Quality and Controlling Costs by Building Community Systems of Care," presented at the Medical Homes Summit of the National Academy for State Health Policy and the Patient-Centered Primary Care Collaborative, Washington, DC, July 2008; D.L. Hewson, "The North Carolina Experience," presented at "Communities Connect: Putting the Pieces Together," a conference held in Seattle, WA, June 2008. Other sources are noted below.

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4. S. Wegner, presentation at the workshop "Appropriate Drug Use and Prescription Drug Programs: Adding Value by Improving Quality," sponsored by the Agency for Healthcare Research and Quality, Denver, CO, Nov. 5-7, 2001, <http://www.ahrq.gov/news/ulp/pharm/pharm7.htm>.

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7. Silberman, Poley, and Slifkin, *Innovative Primary Care*, 2003.

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9. L.A. Dobson, Jr., and T.L. Wade, "Cabarrus County: A Study of Collaboration," *North Carolina Medical Journal*, May/June 2005, 66(3):234-36.

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11. A.J. Zolotor, G.D. Randolph, J.K. Johnson, et al., "Effectiveness of a Practice-Based, Multimodal Quality Improvement Intervention for Gastroenteritis Within a Medicaid Managed Care Network," *Pediatrics*, Sept. 2007 120(3):e644-e650.

12. C.F. Willson, "Community Care of North Carolina: Saving State Money and Improving Patient Care," *North Carolina Medical Journal*, May/June 2005 66(3):229-33.

13. Information on HealthNet was obtained from Anne Braswell, senior analyst and HealthNet program manager, North Carolina Office of Rural Health and Community Care.

14. K. Lurito, Mercer Government Human Services Consulting, Letter to Mr. Jeffrey Sims, State of North Carolina Division of Medical Assistance, Sept. 2007. Available at www.communitycarenc.com.

15. T.C. Ricketts, S. Greene, P. Silberman, et al., *Evaluation of Community Care of North Carolina Asthma and Diabetes Management Initiatives: January 2000-December 2002* (Chapel Hill, N.C.: University of North Carolina, Apr. 2004).

16. Ash Institute for Democratic Governance and Innovation, Community Care of North Carolina Honored as Innovations in American Government Award Winner (Cambridge, Mass.: John F. Kennedy School of Government, Sept. 2007), <http://www.innovationsaward.harvard.edu/AnnieECasey.cfm>.

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[The committee will be adjourned subject to the call of the chair.]

