

# SustiNet Health Partnership

## Preventive Health Advisory Committee

**Co-Chairs**  
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### Preventive Healthcare Advisory Committee Regular Meeting

January 19, 2010

### Meeting Minutes

Committee Attendees: *Michael Critelli, Co-chair; Carlos Sanchez-Fuentes; Norma Gyle; Tanya Barrett; Nancy Yedlin; Nancy Heaton; Pat Baker; Alicia Woodsby; Steve Levinson; Lynn Rapsilber; David Emmel; Joe Pandolfo; Dorothy Shearer*

Office of the State Comptroller: *David Krause*

Absent: *Yvette Bello; Marian Evans; Ann Ferris; Alice Forrester; Jamesina Henderson; Robert Krzyz; Sharon Langer; Tung Nguyen; Stephanie Paulmeno*

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Michael Critelli opened the meeting by welcoming members and asking them to introduce themselves. Michael told the Committee that in today's meeting, he would share ideas submitted by members and then the group will look at the draft workplan and the SustiNet statute. He said that he hopes to form subgroups and coordinate with other Task Forces and Committees to learn what they are doing. Michael said that he discussed the charter to the Committee with Norma Gyle, who agreed with him that due to the short timeframe given to complete its work, there are some areas that require further study beyond what the Committee can do.

The minutes from the December 14, 2009 meeting were approved by all.

Next Michael said that the group would use the workplan for guidance, but would be able to expand or refine it. He briefly summarized the work that needs to be done. Regarding recommendations to be made in the area of prevention, one subject mentioned was geographic or population level interventions, to include jobsites, schools and other community sites. The second subject relates to populations, targeting specific groups such as children, the elderly, or low income and underserved populations. The third subject is risk factors, examining things such as nutrition, exercise, sleep, alcohol and substance abuse, and mental health, by using preventive screenings. The fourth subject is insurance plan

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design and financial incentives; this would include economic analyses of outcomes. The fifth subject is outreach, and how to accomplish it.

Lynn Rapsilber suggested that this Committee look at programs already in place in CT for the areas mentioned, see where the gaps are and add to them as needed. Pat Baker said that the Committee should specifically look at available data on programs done throughout the state for improving health outcomes. Norma said that she felt that this Committee should be looking at prevention, where the recommendations could do the most good. She said that the Committee should take the five areas mentioned and determine who would be the best point persons for those areas, gathering baseline data first and then deciding how to proceed.

Michael said that the charter to the Committee is broad, and covers Medicaid, the public plan and state employees. He stated that he felt that this Committee would have the most freedom in making recommendations to the public plan. Medicaid has federal guidelines that must be followed, and the state employee health plan must comply with bargaining units. Michael noted that the Health Equity Alliance is doing cutting edge work in CT. One of the things that this Committee is charged with is to identify federal or private funding that could assist with developing preventive health initiatives or pilot programs.

Steve Levinson suggested forming a creative solutions group. He said many areas haven't been explored, such as positive incentives for good behavior and raising awareness of negative incentives. He said that in his own practice he found that office visits and antibiotic use were both cut down by simply creating a one page information sheet on how to manage upper respiratory infections. Steve also mentioned that doing a thorough patient history provides a guide for where to focus early intervention efforts, picking up symptoms and diagnosing patients early, which is huge for prevention and cost saving.

Michael said that the Committee is talking about two different plan design provisions in a public health plan. One design is for provisions that incentivize patient behavior. The other rewards or discourages provider behavior. One of the workgroups clearly has to tackle recommendations the Committee would make relative to health plan design.

Nancy (H or Y?) asked if it was necessary to assess the current status of people who would likely be covered by a public plan and people who are currently under the plans that are regulated by the insurance department, to determine a baseline for what those populations are like now, from a preventive lens. She said that this could be a starting point for the Committee. Michael said that he had spoken with someone from the CT Association of Directors of Health (CADH) and found that that group is doing valuable work on health equities. It understands what the non-health care related drivers are, and they are also conducting breakthrough work on health outcomes and correlations. He said that there is very good data on state employees' healthplan costs, but that data hasn't been isolated geographically or by medical condition, which is also true of Medicaid. Steve said that the CADH project studies could be narrowed down to specific communities and

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neighborhoods, which will help in developing a preventive strategy. This project is being piloted in three test areas in Hartford, New Haven and Groton. It has the power to identify health issues, but also to identify infrastructure issues within the communities and to identify health issues related to lack of transportation or the types of transportation, and the placement of parks, schools and recreational facilities. This tool allows the examination of health problems and their causes, and it might be something that this Committee can use.

Pat said that the group needs to come to a common perspective, perhaps by agreeing on some principles, in order to provide some guidance as to how to proceed. An unidentified speaker said that a key part of prevention is providing people with healthcare before they have health problems. Michael said that there is a difference between access to health insurance, so that people aren't financially ruined by medical conditions or events, and access to health care, which is related to this but distinguishable from it. An example of this is when people go to an emergency room because they don't have convenient access to providers. Money is critical to both the insurance issue and to behaviors. If screenings and other services are paid for, people will be more likely to use them. On the other hand, for people who live rurally, there often aren't providers available nearby to provide care. Michael said that the Committee should focus on both challenges, the insurance challenge and the care access challenge as it relates to prevention. An unidentified speaker said he felt that the short term goal for the Committee is to improve efficiency of the current costs of healthcare through prevention. The long term goal for the Committee is to reduce and eliminate chronic diseases, but given the current economic situation of the state, it will be several years before there is a return on this. The same speaker said that he felt there should be some relatively quick recommendations made, such as policy changes or simple system corrections. Michael said that the SustiNet statute directs the Committee to look at certain things, namely nutrition, exercise, sleep, and alcohol, tobacco and substance abuse. The areas where a quick payback could be achieved are not mentioned in the statute; some proven areas are immunizations for infectious diseases, like flu shots, anything to do with asthma, and mental health.

An unidentified speaker asked how economic return fits into the charge to the Committee, and also how the education awareness campaign fits in. Michael said that there is no question that there needs to be an educational workgroup. He said that regarding economic return, for the Committee to make some progress, there will probably need to be some efforts made in areas that aren't specified in the workplan, such as asthma and immunizations.

Michael said that in looking at the workplan, under data analysis and development of recommendations, there are three categories. The first one is to identify and assess the nature and extent of existing preventive care programs administered by the state. The second one is to identify community based care services that can be safely administered including jobsites, schools and other community sites. The third one is about coverage for community based preventive care services. Michael said that this shows that the charge for the Committee is broader than just working on an insurance plan. An unidentified speaker

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said that insurance hasn't been linked to communities or to preventive services. Michael said that he doesn't know if insurance can be targeted at the community level. An unidentified speaker said that this would be something to examine, whether insurance companies would be willing to expand to cover programs in other geographical areas. Michael said that one of the workgroups should address this to learn how much an insurance plan can be tailored.

Michael said that the Committee could zero in on this issue, starting with focusing on the services SustiNet should cover. The second focus should be on what specific provider behaviors SustiNet should reward and discourage. The third focus should be on which plan participants' behaviors should be encouraged or discouraged. Nancy (H or Y?) said that there are a lot of community services available under different auspices, and that insurance companies have spotty coverage. She said that she feels that the SustiNet plan should provide insurance companies with recommendations for services that will help in preventing diseases, setting it up so that economically it allows people to use community-based resources.

Michael asked the group how it was possible to promote good sleep habits. Steve said that in looking at prevention, awareness is a key factor. The patient can be educated, but the reasons for sleep deprivation are vast. He said that a comprehensive history is invaluable in revealing sleep problems. Joe Pandolfo said that there are proven exercise and relaxation techniques that help with sleep and are part of community-based programs. Yoga and tai chi are some of these techniques. Joe said that perhaps these could be included in the plan.

Michael asked for Committee members who are willing to be part of a workgroup to identify community and state programs currently in place. Tanya Barrett agreed to work on this workgroup. Dorothy Shearer said that the Committee needs to keep culture in mind, and to be sure that the people who the plan is designed for will be participating in it. People who are part of the community understand what the community wants. There can be efforts made to educate people about nutrition, but if there are no grocery stores nearby, those efforts won't be effective. It will be necessary to look at the separate populations; what works in one area won't necessarily work in another area. It might also be helpful for people to go to other communities for resources; under the current system, many resources are only for community residents.

Michael said that he wanted to be sure that the following items were added to the Committee's workplan: First, cataloging federal programs and guidelines in the plan design, for example, using the US Preventive Services Task Force and CDC recommendations. Secondly, determining what the mechanism is for self care and how to incorporate this into the plan. Michael said that he thought that culture, as Dorothy mentioned, has to be part of the marketing and outreach effort. An unidentified speaker said that regarding culture, she feels that this Committee should design a culturally and linguistically competent system. Lynn said that in her community, transportation is a major barrier to people receiving the healthcare they need. Another unidentified speaker said that it's much more expensive for a one-on-one discussion with a provider and a patient versus a group discussion surrounding

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topics such as nutrition, smoking cessation, or something similar. These issues present opportunities for setting up community programs.

Michael said one of the plan design ideas that the Committee should consider is a pilot for care coordinators that was done at Hartford Children's Hospital, which has an 85% Medicaid population. Some of the charter schools that have high populations of students in school lunch programs and some of the community health clinics also have care coordinators or family advocates, which are full time problem solvers. This person assists with transportation problems, eligibility enrollment, childcare, etc.

Nancy (H or Y?) suggested that the Committee design a template organized by domain to provide a way to examine and compare all the various factors being considered. He said that once coverage is addressed, the next step is to have doctors and hospitals embrace this and make money doing this. The next step is to have the participants embrace this. This poses the question of how to make the participants aware of this while being culturally sensitive. There will need to be a group working on marketing, education, awareness outreach, and cultural differences. There will also need to be a group working on coverage and the involvement of providers and participants. Michael said that he would send an outline to all members, describing the various groups so that members can decide which ones they are most interested in.

Meeting was adjourned.

**Next meeting Feb. 10, 2010 at 1:30 pm at CT Hospital Association in Wallingford.**