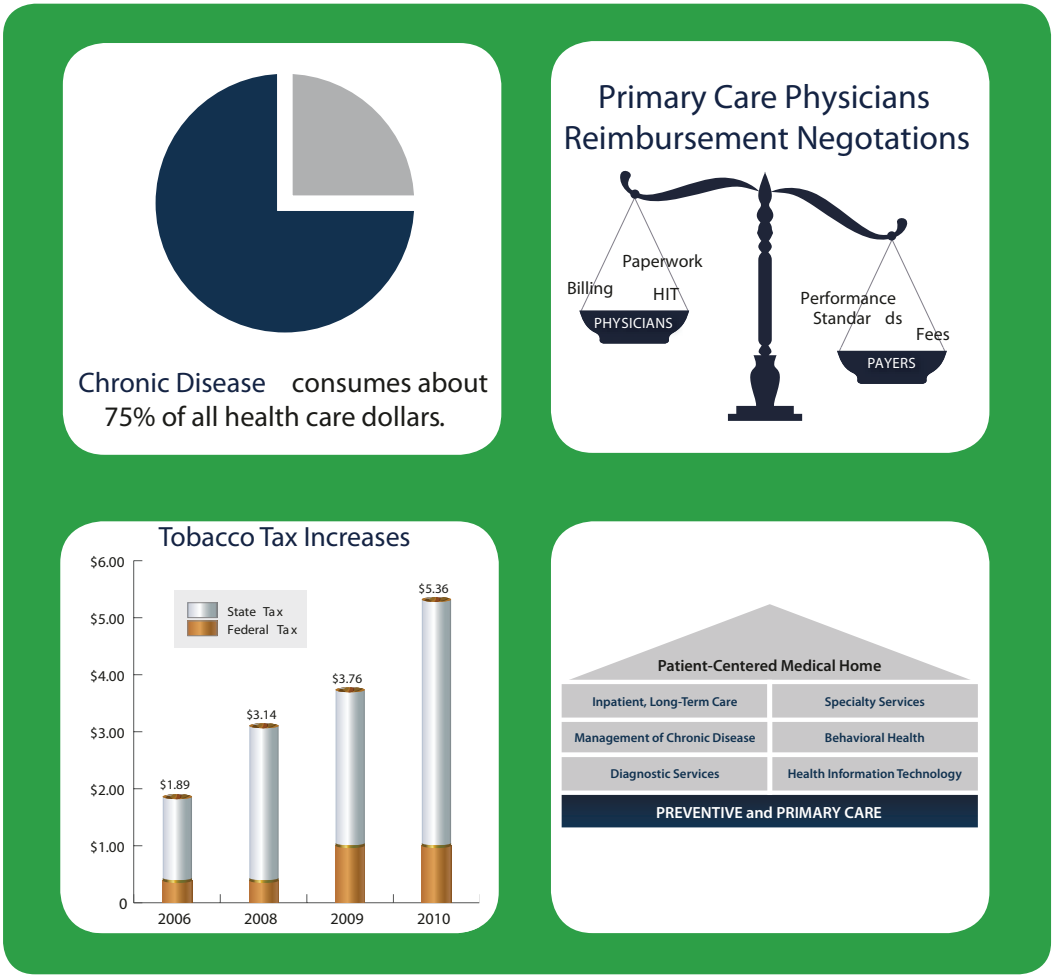
A Vision for Better Health

RECOMMENDATIONS OF THE TASK FORCE FOR IMPROVING PREVENTIVE AND PRIMARY CARE IN COLUMBIA AND GREENE COUNTIES



Project Coordinated by

The Healthcare Consortium

A *collaborative* rural health network

Improving access to quality health care

APRIL 2011

TABLE OF CONTENTS

Give us your comments, ideas, suggestions...
CLICK HERE

Give us your comments, ideas, suggestions...
CLICK HERE

RECOMMENDATIONS FOR IMPROVING PREVENTIVE AND PRIMARY CARE IN COLUMBIA AND GREENE COUNTIES

Envision the future.... five years from now. The people of Columbia and Greene Counties are experiencing better health and therefore a higher quality of life. In this vision, we see a future in which thousands fewer people suffer from cancer, cardiovascular diseases, diabetes, arthritis, asthma, mental illness, and other conditions. Fewer people are obese, fewer people use tobacco, and fewer people abuse alcohol, illegal drugs, and prescription medications. A greater number of medical conditions either are prevented or identified earlier and then treated and managed more effectively.

Achieving this vision in five years is realistic. But to do so, we must have in place a well-funded, comprehensive preventive and primary care system in both counties. We must have insurance coverage for preventive/primary care services, everyone must have access to a primary care practitioner, primary care doctors must be paid an adequate amount, and an extra concentration of services must be focused on the most costly and prevalent health conditions and diseases.

The Columbia County Community Healthcare Consortium received a 2-year grant from the New York State Department of Health to develop recommendations that will improve preventive and primary care in Columbia and Greene Counties. To guide the work of the project, the Consortium created a 13-member Task Force, which represents the wide range of interests in both Columbia and Greene Counties. See page 35 for a list of the members.

The three main purposes of this document are to:

1. Present a vision of better health.
2. Describe the current consequences of inadequately funding and developing preventive and primary care services in our two counties.
3. Provide recommendations on how we can improve our preventive/primary care system so we can achieve the aforementioned vision.

Our health status for many medical conditions falls significantly short of goals outlined by the Federal Government and the New York State Department of Health despite significant expenditures on health care. In our two counties, an estimated $800 million was spent in 2010 on personal health care services covering about 111,000 people, or nearly $7,200 per person[1]. This amount has been increasing by about 6.2% per year[2]. Health care is steadily consuming a larger percentage of New York's Gross State Product, from 12% in 1981 to 16% in 2008 to a projected level of 20% before 2019.

Our health status falls significantly short of many Federal and State goals. Yet, we expended about $800 million on health care in 2010 in our two counties or nearly $7,200 per person. Some of these funds should be shifted to build a comprehensive preventive and primary care system.

The shortcomings of our preventive and primary care system is not a criticism of the providers in our counties. They reflect standards of high quality and a deep sense of public commitment. Indeed, the Task Force does not advocate replacement of the current system of preventive/ primary care, but rather to build upon it. Our current preventive/primary care services suffer from a lack of sufficient resources and are hindered by certain State policies. With the proper amount of resources and the adoption of helpful State policies, the Task Force believes that the preventive/primary care system in our two counties could achieve the vision for better health as outlined in this document.

BENEFITS OF PREVENTIVE AND PRIMARY CARE

The main rationale for focusing on primary/preventive care is simple: extensive research demonstrates that primary and preventive health care is the most effective means for improving health status while constraining costs [3]. Moreover, many health conditions are preventable; half of all deaths, according to the U.S. Centers for Disease Control and Prevention, are linked to unhealthy behavior and unsafe environments[4].

Research also recommends that significant funds be invested in expanding preventive and primary care[5]. Such investments will prevent illness or identify them early and trigger timely treatment. The result is a reduction in the amount of medications, the use of specialists, and the number of surgeries, hospitalizations, and trips to the emergency department.[6 7 8 9]

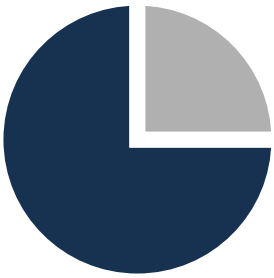
Although primary care has proven it can decrease health care expenditures, cost containment policies in New York State and the Nation have focused too narrowly on interventions such as changing the design of insurance benefits and increasing cost sharing. A longer-term, more effective strategy is to invest in preventive/primary care.

CONSEQUENCES OF INADEQUATE PREVENTIVE AND PRIMARY CARE

This section describes some of the consequences of a preventive/primary care system that suffers from inadequate resources and misdirected or outdated State policies.

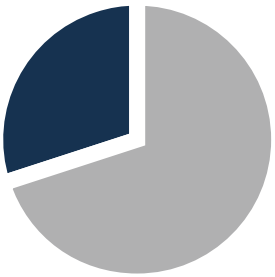
Chronic Disease

The most expensive and most damaging part of our health care system is the large presence of chronic disease, yet a large percentage of chronic diseases can be prevented or their impact mitigated and better managed through preventive/primary care services. Thousands of people in our counties suffer from conditions such as cardiovascular disease, diabetes, arthritis, cancer, and asthma, among others. In New York State, chronic disease afflicts as many as 30% of our population, causes about 75% of all deaths, and consumes about 75% of our health care dollars. Chronic disease also reduces productivity at the workplace since employees with a chronic disease or their caregivers are often forced either to miss work days or to attend work but perform poorly.



Chronic Disease consumes about 75% of all health care dollars.

Chronic Disease causes about 75% of all deaths.



Chronic Disease afflicts 30% of the population.

Inappropriate Use of Emergency Departments

In New York State, roughly 75% of ED visits are for illnesses while about 25% of visits are for injuries[10]. A large majority of ED visits do not require an inpatient admission. National studies have shown that as many as 40% of emergency department visits do not involve a true medical emergency requiring the type of service that only an emergency department typically is equipped to furnish.[11 12 13 14]

Many uninsured and under-insured people and those without geographic access to a doctor have no other place to go except to the local Emergency Department for illnesses and conditions that could have been treated in a primary care setting. Many times these people delay obtaining needed care for a relatively minor condition; thus, they wait until their condition becomes very serious, which then requires far more expensive care such as hospitalization, medications, and the use of specialists.

Many people with chronic disease use the ED for legitimate emergency situations due to a complication arising from their disease. However, if adequate resources were devoted to primary care to prevent and better manage their disease, then many of these trips could be avoided.

Inappropriately using emergency departments (ED) for primary care is costly, and many ED settings are not designed to provide continuity of care or follow-up care. Furthermore, people using the ED for primary care creates overcrowding, depriving timely access to patients who truly require emergency care.

Cost of Medications

The amount expended on medications Statewide has increased by two-and-a-half times over the past decade.[15] Extrapolating from State data, approximately 1,330,000 prescriptions are filled at pharmacies for our county residents every year.[16]

The driving force in escalating cost is the quantity of medications that are being consumed. The number of times that a prescription drug was written, renewed, or provided increased 26% in physician offices and hospital outpatient departments during the period 1995-2005 in New York State.[17] In private insurance plans, the quantity of drugs prescribed per enrollee causes 72% of the overall expenditure increases while the price of drugs causes only 28% of the increased expenditures.[18]

70% of all physician and hospital outpatient department visits result in a prescription drug being written, renewed, or provided. Although nearly everyone in the age 65+ group uses one or more medications (92%), a significant percentage of people in other age groups also use medications: 74% of adults age 45-64 and 54% of adults age 18-44.[19] A major reason for the medication use is chronic disease. People with one chronic condition fill up to 10 prescriptions per year and people with 4 chronic conditions fill up to 37 prescriptions per year.[20] Misuse and overuse of prescription drugs also leads to avoidable, potentially serious adverse drug events.

Physician and Clinic Services

Physician office and clinic visits total about 555,000 annually for residents of our two counties. These visits are provided by physicians in private offices, clinics, and hospital outpatient departments, covering primary care and all other specialty services. As with medications, the increase in spending per enrollee in private insurance plans is driven primarily by an increase in the quantity of outpatient services per enrollee (99%) rather than an increase in prices (1%). One of the reasons for the growth in the number of visits is the growing extent of chronic disease. 50% of all office visits are made by patients with one or more chronic conditions.[21]

Impact of Preventive/Primary Care

The extent of the consequences described above can be mitigated by creating and financially supporting a comprehensive primary care system. Such a system will reduce and manage the prevalence of chronic disease, provide an alternative to the emergency department for primary care needs, reduce the consumption of costly prescription drugs, lower the number of expensive visits to medical care specialists and clinics, and reduce the number of surgeries and hospitalizations.

TWO SETS OF GOALS AND RECOMMENDATIONS

The Task Force identified 14 goals for improving health status and the preventive/primary care system. The Task Force also provides 35 recommendations for achieving these goals by the end of 2015.

First Set of Recommendations

- **Tobacco Use**
- **Obesity**
- **Cardiovascular Disease**
- **Behavioral Health**

The Task Force divided the recommendations into two different but related groups. One set specifically addresses four of the most costly and unhealthy lifestyles, ones that inflict great human suffering and require significant sums of money to treat. These recommendations advocate a set of enriched and enhanced activities for the four priorities, which are: tobacco use; obesity; cardiovascular disease; and behavioral health [mental health, substance and alcohol abuse].

The Task Force selected the four top priorities after reviewing data from federal, State, and local sources on multiple medical conditions and lifestyles. To see a user-friendly summary of which medical conditions and lifestyles are the worst in each county, see "How Close...How Far, an Assessment of Health Status in Columbia and Greene Counties," which can be accessed by going to www.columbiahealthnet.org and clicking on "How Close...How Far."

Whereas the first set of recommendations focuses on the four specific conditions and lifestyles, the second set affects multiple medical conditions and harmful lifestyles because it impacts the entire preventive/primary care system. The Task Force provided recommendations for improving the cornerstones of the preventive and primary care system: expanding insurance coverage, increasing access to primary care practitioners, ensuring that everyone has a primary care medical home, and increasing reimbursement for prevention and primary care.

Second Set of Recommendations

- **Expanded Insurance Coverage**
- **Adequate Supply of Primary Care Providers**
- **Patient-Centered Medical Home**
- **Adequate Reimbursement for Primary Care**

If our recommendations are implemented, several million dollars could be saved annually in health care expenditures through reduced use of the health care system. Additional millions would be saved by reducing lost productivity.

For each recommendation, we stipulate whether its realization will require State or local action and resources.

Public Input

The recommendations were developed within the context of an extensive public process to ensure that the ones ultimately submitted to the State Department of Health reflect local concerns, creativity, and support. Our public process included multiple points of input – the Task Force; the involvement of two advisory groups; surveys of households, businesses, local officials and health care providers; focus groups; and web-based commentary. Given the thoroughness of this public process, we feel that our priorities and recommendations accurately reflect public attitudes and support, and therefore are particularly meaningful and useful to policy-makers.

Give us your comments, ideas, suggestions...
CLICK HERE

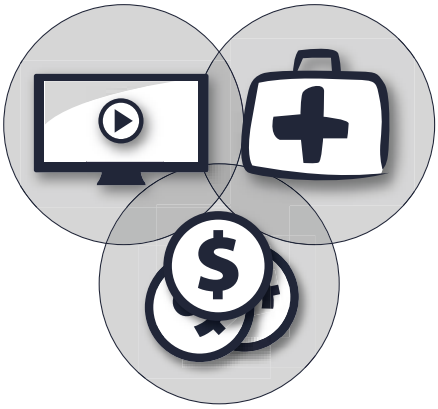
GOALS AND ACTION RECOMMENDATIONS FOR THE TOP FOUR PRIORITIES

The four top priorities are described in this section – tobacco use, obesity, cardiovascular health, and behavioral health. For each one, we present its current status and then present future goals, which are based on the Surgeon General's Healthy People 2010 and the State DOH Prevention Agenda. Although Healthy People 2010 and the Prevention Agenda list many goals, we selected only those goals for which there are data available for both Columbia and Greene Counties.

The Power of Media, Taxes, and Physician Services

A theme that runs consistently throughout our recommendations is the combination of media campaigns, taxes, and primary care physicians. Media serves to make people aware of a health problem or condition, increases their sensitivity to the problem, and motivates them to modify their behavior. Taxes create disincentives for people to continue or initiate a particular health behavior and, in conjunction with media campaigns, are powerful forces that influence behavior changes. Taxes also generate revenue to fund the recommendations. Primary care physicians are one of the most effective resources for helping patients adopt and maintain healthier lifestyles and thereby achieve a healthier status. Although these three measures – media, taxes, and physician services – are effective even when pursued as separate actions, they are an extremely potent and effective force when combined.

Media, Taxes, and Physician Services are Extremely Effective When Combined



Funding Priorities

Since many of our actions require funding, the Task Force also proposes raising money through certain taxes. Given the difficult fiscal situation facing all levels of government, the Task Force also identified its eight top priorities for the allocation of resources. These top funding priorities are denoted throughout the report by the symbol ⊕.

A. Tobacco Use

Goal: By 2015, lower the percentage of tobacco use to 12% among adults from 24% in Columbia County and 23% in Greene County. The number of adults who smoke totals about 20,700. Reaching the goal would lower this number to 10,600. [The number of adolescents who smoke in our 2 counties is unknown]

"Tobacco use and dependence is the leading preventable cause of morbidity and mortality in New York State and in the U.S.," according to the New York State Department of Health.[22] Cigarette use alone results in an estimated "25,500 deaths in New York State. Second-hand smoke kills another 2,500 New Yorkers every year. There are 389,000 children alive today who will die prematurely from smoking. More than half a million New Yorkers currently suffer from serious smoking caused diseases... including heart disease and stroke, many forms of cancer, and lung and vascular diseases." [23]

The annual health cost caused by tobacco in our two counties is over $39 million,[24] and Statewide it is $8.7 billion. For every 10% reduction in tobacco use, our counties would save nearly $4 million per year in health care costs and reduce the amount of lost productivity; if we reached the State goal of a one-third reduction, we would save about $13 million per year in health care costs alone.

Recommendations

1. Expand the State-supported Media Campaign

The State of New York has expended tens of millions of dollars over the past several years with bold, even aggressive media ads. Studies show these ads have served effectively to intensify public awareness about the consequences of tobacco and helped to motivate many smokers to quit. During a fall 2010 ad campaign, calls to the New York State Smokers' Quitline increased by more than 32 percent compared to the same time period in 2009. These ads are also needed to counteract the $430 million that is expended by tobacco companies to promote their products. The Task Force recommends that the State expand its campaign. It also recommends that some of the ads share success stories about smokers who have successfully quit.

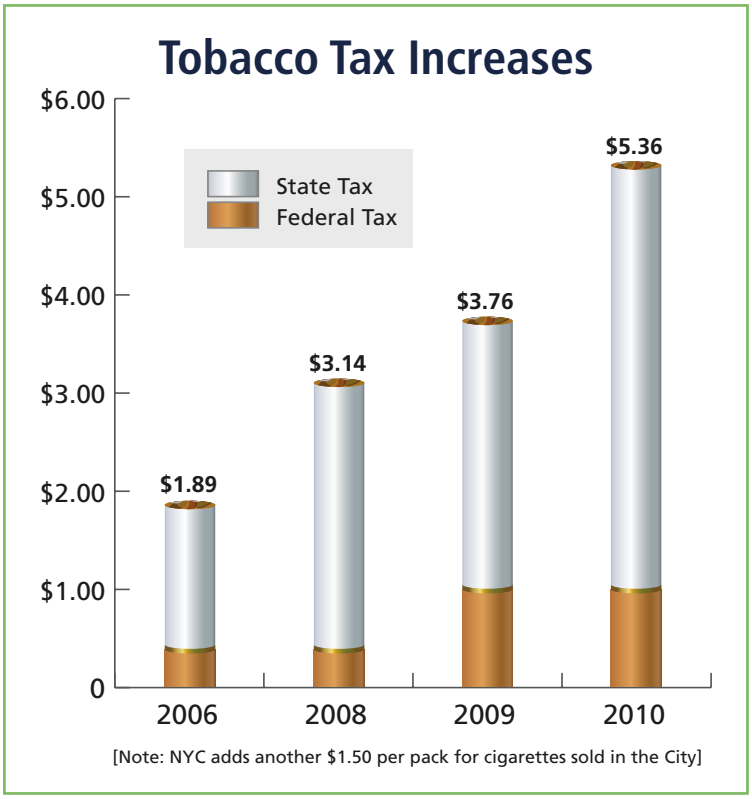
2. Maintain the High Tobacco Tax at the Current Level

The State tax is currently at $4.35 per pack. On top of that amount is a federal tax of $1.01, bringing the total tax price to $5.36 per pack. New York City adds another $1.50 per pack, which brings the total tax to $6.86 per pack in the City.

Taxes affect behavior. When the State tax was raised by a $1.60 per pack in July 2010 to the current amount of $4.35, the American Cancer Society estimated that 85,000 adults would stop smoking due to the cost of cigarettes.

Research shows unequivocally that a high tobacco tax is the single most effective step that can be taken to prevent adolescents from starting to use tobacco. When the $1.60 increase became effective, American Cancer estimated that 170,000 adolescents would be prevented from starting. Most teens have a limited amount of cash; thus, when making purchasing decisions, they find the cost of cigarettes is prohibitive and they use their cash for other purposes since they are not addicted to tobacco. A tax is certainly not the only action that helps to keep them from smoking, but it is the biggest step that, in conjunction with other actions, can create a comprehensive anti-tobacco strategy.

The Task Force certainly supports the high level of tobacco tax in the State and New York City. However, the Task Force does not recommend an increase at this time given the very large increases in recent years (the State tax has increased from $1.50 per pack to $4.35 over just a few years). But, it does recommend that the tax amount be re-visited in the next few years and possibly raised again.



Give us your comments, ideas, suggestions...
CLICK HERE

3. Increase the Use of Tobacco Cessation Counseling Reimbursement for Physicians

Physicians are the single most effective resource for helping people quit. Health insurance reimbursement codes exist to pay doctors to help smokers quit, but the codes are greatly under-utilized.

Unfortunately, most smokers try to quit without effective treatment and, as a result, the majority go back to smoking. The good news is that a 2008 New York State Department of Health report found that nearly one-third more smokers are getting help from their health care providers to quit smoking – a 31% increase since 2004. In 2008, 55% of New York's 2.6 million smokers attempted to quit. A State DoH goal is to have every clinician ensure that not one of their patients who uses tobacco leaves the office without cessation assistance.

Until recently, no reimbursement codes existed specifically to pay doctors to work with their patients on cessation. However, in 2008, two new codes were enacted and Medicare adopted them – codes 99406 and 99407. These codes were created at the behest of Medicare officials because they realized that 10% of Medicare recipients, or about 4 million people nationwide, are smokers, contributing to the high cost of care.

> **"Helping patients overcome chronic tobacco dependence is one of the best interventions clinicians can provide to improve their patients' health."**
>
> – Former State Commissioner of Health, Richard Daines

Code 99406 is for a counseling visit between 3-10 minutes. Code 99407 is used for intensive counseling that takes more than 10 minutes. Just as important, these two codes can be used for billing in addition to billing for any other services that the physician provides during the same office visit. Reimbursement in NYS varies from about $12-$15 for the briefer visit and about $25-$27 for the longer session. A patient can go for four visits per cessation attempt and can initiate two attempts per year for a total of 8 visits annually.

Despite the benefit of providing reimbursement incentives to physicians to spend time working with patients on one of society's deadliest lifestyle problems, Medicare and Medicaid are two of the few payers to recognize the codes. Many managed care plans do not offer to reimburse for services under these codes and many employers choose not to adopt the codes into the plans they offer their employees.

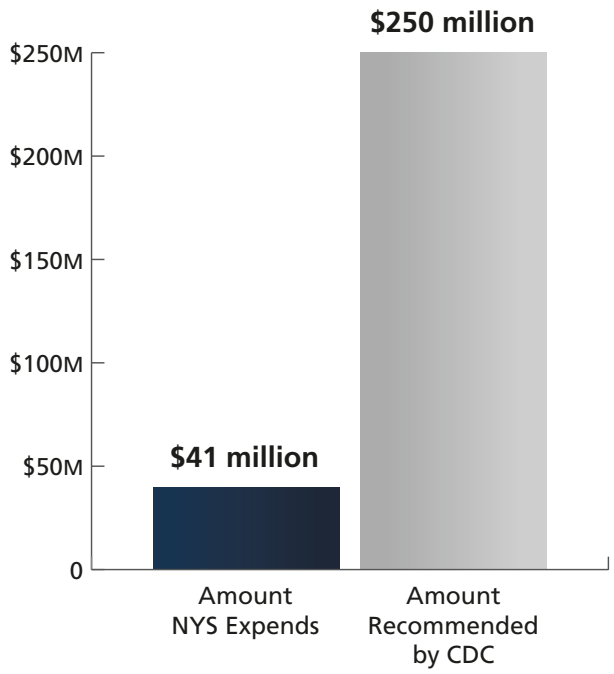
Helping patients quit tobacco use requires intense work on the part of physicians. If New York is to further reduce the number of smokers significantly, then all insurance plans should be required to reimburse for the codes, and the State Department of Health should work vigorously with employers who self-insure to convince them to include the codes in their plans. At the local level, action should be taken to convince local employers and local insurance plans to use the reimbursement codes, and educate practitioners and smokers about the existence of the codes.

If all insurers and self-employed plans adopted the codes, the cost would probably range from $300,000 - $350,000 in our two counties, assuming 10% of the nearly 21,000 smokers participated and used all eight sessions. At some point, the cost of the cessation visits would decline as more and more people quit. Meanwhile the costs of hospitalizations, visits to specialists, and medications would decrease dramatically, contributing to the 10% savings of $4 million described earlier in this section.

4. Expend Funds on Anti-Tobacco Programs at the Level Recommended by Federal CDC

Currently, the State of New York expends about $41 million a year on anti-tobacco actions such as media ads, the Quit-line, county action coalitions, and other activities. This amount is less than half of the amount expended a few years ago. However, the Federal Centers for Disease Control and Prevention recommends that about $250 million be expended in NYS to facilitate tobacco cessation and prevention. The annual

Anti-Tobacco Program Funding



Tobacco Settlement payment is about $800 million per year and the amount of revenue collected from the tobacco tax is about $1.4 billion. Obviously, NYS is expending well below the amount suggested by CDC. The Task Force recommends that the amount be raised gradually over a number of years to move toward the $250 million figure.

5. Restrict Tobacco Sales

No tobacco sales in pharmacies or stores with a pharmacy. Pharmacies are important health care partners, providing prescriptions, medical devices, and health information to heal or cure illnesses. Yet, if they sell tobacco, they are undermining their important health mission. Health-care businesses, pharmacies included, should not promote or profit from the sale of the leading cause of preventable death in the State.

San Francisco, Boston, and a few other locations in Massachusetts have banned pharmacy-based sales of tobacco, but no locality has banned it in New York State. Although legislation has been introduced in the State Legislature in the past, no known bills currently exist. County governments can pass a law to ban the sale. The Medical Society of the State of New York (a physician organization) and the Pharmacists Society of the State of New York support a ban on tobacco sales in pharmacies. In the State, 80% of independent pharmacies do not sell tobacco but all the chain pharmacies sell it. Likewise, all the chain pharmacies sell tobacco in Columbia and Greene Counties. A total of five independent pharmacies operate in both counties: Columbia has one and it sells tobacco; Greene has four independents and only one sells tobacco.

The Task Force does not recommend a legislative mandate that would ban the sale of tobacco in pharmacies, but it does recommend continued advocacy to encourage pharmacies not to sell it. The Rip Van Winkle Tobacco Free Action organization would be the logical organization to coordinate such advocacy efforts.

Stores that sell tobacco products must have aggressive warning signs posted at point of sale. Warning signs about the dangers of tobacco serve to inform and remind adults and adolescents that they should not purchase the product. Such signs also help to counteract "impulse" buying. The Task Force does not recommend a legislative mandate, but continued advocacy to encourage stores to post warning signs. Again, Tobacco Free Action would be the logical organization to coordinate such advocacy efforts.

Reduce visibility of tobacco products (cigarettes can be sold in a store, but must be kept out of sight). Research shows that repeated exposure to tobacco marketing, including store advertising and product displays, is a principal factor in adolescent smoking. 90% of tobacco marketing money, over $1 million per day in NYS, is spent on in-store advertising, product placement and discount promotions. The Task Force recommends that the State enact a law to require that tobacco products be kept out of sight. There are six nations that already have these laws. Meanwhile, Tobacco Free Action should continue its efforts on public education to raise awareness of the problem and build support for legislation.

6. Increase the Number of Outdoor "Smoke Free" Areas

Secondhand smoke has been classified by the Environmental Protection Agency (EPA) as a known cause of cancer in humans (Group A carcinogen), and the U.S. Surgeon General has concluded there is no risk-free level of exposure to secondhand smoke. The Surgeon General also has stated that inhaling secondhand smoke causes lung cancer and coronary heart disease in nonsmoking adults.[25]

Secondhand smoke is especially harmful to infants and young children because their bodies are developing, making them especially vulnerable to the poisons in secondhand smoke. The Surgeon General states that second hand smoke increases the risk of serious respiratory problems in children, such as a greater number and severity of asthma attacks and lower respiratory tract infections, and increases the risk for middle ear infections. Exposure to secondhand smoke also causes an estimated 430 newborn deaths from sudden infant death syndrome.[26]

A person sitting or standing next to a smoker outdoors can breathe in wisps of smoke that are many times more concentrated than normal background air pollution levels, and being within a few feet of a smoker outdoors may expose people to air pollution levels that are comparable, on average, to indoor levels. A child in close proximity to adult smokers in an outdoor setting also could receive substantial exposure to secondhand smoke. Children who see adults smoking in a family-friendly place like a park may believe smoking is socially acceptable and may emulate the behavior.

Discarded cigarette butts are a source of litter, they pollute streams, they start fires, their filters degrade very slowly, and they may be consumed by toddlers.

New York City has banned smoking in all parks and beaches. Many other municipalities have restricted smoking in a variety of sites, and others are considering it, urged on by the county tobacco coalitions.

The Task Force encourages local action among municipalities to ban smoking in parks and playgrounds. Prohibiting smoking at these sites will make a positive contribution to the health of children by reducing their exposure to toxic tobacco smoke and by providing them a positive model for smoke free living. It will also reduce pollution and the amount of litter.

B. Obesity

Goal: By 2015, lower the percentage of adults who are obese to 15% from about 24% in both counties. The number of obese adults is 21,000. Reaching the 2015 goal would lower this number by over one-third, reducing the number of obese adults to about 13,000.

Nearly 60% of New York's adult population, about 9 million people, is overweight or obese. The percentage of obese adults in New York State more than doubled in little over a decade, from 10% in 1997 to nearly 25% in 2008. About 25% of school children are obese and about 15% of children ages 2-5 are obese.

Obesity contributes to many chronic diseases, including diabetes, heart disease, joint problems, and some types of cancer. New York State spends more than $12 billion each year to treat obesity-related health problems—the second-highest level of spending in the nation. New Yorkers suffer another $12 billion in lost productivity. The estimated health care cost to our two counties is over $48 million.[27] A large percentage of these costs are due to unnecessary hospitalizations and

- **60% of residents are overweight or obese**
- **The percentage of obese adults has doubled over the past decade**
- **The number of people who are overweight or obese is triple the number of smokers**

Give us your comments, ideas, suggestions...
CLICK HERE

medications from cardiovascular conditions, diabetes, musculoskeletal disorders, and other afflictions.

Obesity is considered the second most harmful personal health practice and many consider it even more dangerous than tobacco use because of the sheer numbers of people who are overweight or obese in NYS – triple the number of smokers. "The rise in obesity is at the root of this increase (in health care expenditures). With younger and younger Americans suffering from overweight and obesity, the outlook is grim for finding a solution to stem rising health costs short of helping Americans transform their unhealthy behaviors." (Kenneth Thorpe, Chair of Department of Health Policy & Management at Emory University, School of Public Health).

The State DoH also has set a goal of reducing the number of obese people in NYS by about one-third by the Year 2013. Reaching this goal should be a top health priority in the allocation of resources. For every 10% reduction in obesity, we would reduce health expenditures in our counties by $5 million per year and also reduce the costs of lost productivity; if we reached the State DOH goal of a one-third reduction by 2013, we would save about $16 million per year in health care costs alone.

Recommendations

About 60% of our population is overweight or obese. We need to wage a campaign against obesity that is every bit as aggressive and successful as the one being waged against tobacco. The anti-tobacco campaign is a great model. New York State has one of the lowest tobacco user rates in the Nation – about 18% -- and a good part of that success is due to our all-out frontal assault on tobacco. We have come to realize that with tobacco no one action will significantly reduce or prevent its use. Instead, we are using multiple strategies working in unison that are discouraging many people from smoking while motivating even more to quit. We need to adopt the same strategy with obesity.

1. Create an Aggressive State-Funded Media Campaign Against Obesity, Similar to the State Media Campaign Against Tobacco

Our Household Survey indicates that only 6% of people in our counties consider themselves obese even though the real percentage is closer to 24%. Although 60% of us are overweight or obese, only 23% of respondents say they are actively trying to lose weight. An effective media campaign will help people to recognize their denial about being obese and then motivate them to modify their behavior. All four focus groups that we conducted and nearly 70% of the respondents in our Household Survey favored an aggressive campaign. However, the Focus Groups also strongly suggested that the ads attack food choices and the consequences of obesity, refraining from attacking people or appearing to be cruel. Ads should also present success stories about people losing weight and maintaining weight loss, and instill the value that healthy weight is desirable.

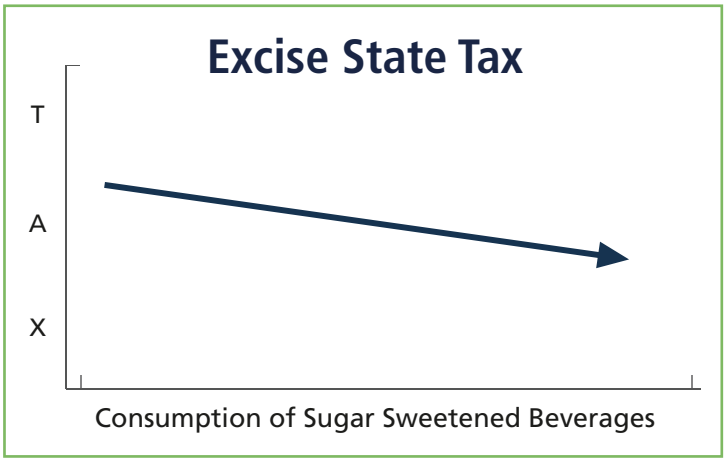
Another reason for a media campaign is to counter the billions of dollars expended to promote unhealthy foods and beverages with large caloric content. The typical child sees about 40,000 ads a year on TV and the majority of ads are for candy, soda, fast food, and cereal. Many of the advertising and marketing campaigns enlist children's favorite TV and movie characters. Research suggests that exposure to food commercials influences children's preferences and food requests, and that ads can also contribute to confusion among children about the relative health benefits of certain foods. As to be expected, research shows that adults also are influenced by advertising and it affects their food choices.

2. Enact an Excise State Tax on Sugar-Sweetened Beverages (SSB)

The Task Force recommends a small tax, perhaps 5¢ on a 12-oz can of soda and on sweetened beverages containing less than 70% fruit juice. This tax would raise approximately $400 million Statewide and about $2.3 million in Columbia and Greene Counties. The nickel tax would be levied in addition to the current sales tax. A portion of the increased tax revenue should be used to finance a major statewide anti-obesity campaign.

A strong link exists between consumption of sugar-sweetened beverages and obesity. In the past decade, US per capita intake of calories from sugar-sweetened beverages has increased by nearly 30%. These beverages now account for 10%-15% of the calories consumed by children and adolescents. Children's intake of sugared beverages has surpassed that of milk.

Just as tobacco taxes are one of the most effective strategies for influencing behavior, especially among adolescents, studies show that a soda tax will reduce consumption by approximately 1% for every 1% increase in tax.



3. Enact a State Excise Tax on Food of Limited-Nutritious Value

A 5¢ tax should be levied also on food items with limited nutritional value. Popular examples of such food include potato chips, candy bars and other candy. However, our society offers many kinds of food with limited nutritional value, and reasonable people disagree over the precise definition. A solution to the debate would be the creation of a scientific commission to determine which types of foods should be included within the definition of "limited-nutritious value." The commission would report its findings within one year to the State Legislature and Governor. Then, a tax would be enacted as quickly as possible thereafter on all foods fitting within the definition.

Although the amount of revenue that would be raised would be unknown until the Commission completed its work, we assume it would raise at least as much as the SSB tax described above, or about $400 million Statewide and $2.3 million in our two counties.

As with the sugar-sweetened beverage tax, this tax would influence purchasing decisions and it would raise revenue. Given the enormous public health toll obesity inflicts on this country every year, it is time to dedicate more resources to fighting the epidemic and a tax on SSB and certain food items would generate desperately needed money for anti-obesity programs. Some of the funds even could be used to subsidize the purchase of fruits and vegetables for low-income families.

These Taxes Are Not Regressive

Taxes on SSB and on foods of limited nutritious value are not regressive. Sugar-sweetened beverages and non-nutritious foods are discretionary. Sugared beverages are not a necessary part of the diet and generally deliver many calories with little or no nutrition. These taxes can further benefit low income families by using some of the tax revenue for obesity prevention programs or subsidies for healthier foods. The taxes would only increase food costs if families continue to buy as many non-nutritious foods and beverages as they did before the tax. If they decrease consumption by switching to water and low-fat milk and nutritious foods, they would actually save money.

Obesity-related medical expenditures were estimated in 2009 to be about $12 billion in NYS, half of which was paid with taxpayer dollars through Medicaid and Medicare. It, therefore, makes sense for consumers of sugar-sweetened beverages and "junk food" to pay a tax to help offset the State's rising medical costs. Major government interventions such as smoking restrictions, tobacco taxes, mandated seat belt usage, fluoridated water and vaccinations have been successful in improving and protecting the public's health. A tax on sugar-sweetened beverages and on food with limited nutritious value is one more critically needed intervention.

4. Create Obesity Counseling Reimbursement Codes for Physicians

Unlike the tobacco cessation reimbursement codes, no such codes exist to compensate physicians for helping patients lose weight. But as with tobacco cessation, personal physicians are a powerful resource for influencing patient behavior, including weight loss. If this recommendation cannot be implemented on a Statewide basis, then perhaps a 2-county pilot program could be established.

Working with patients to help them lose weight is time-consuming. It requires assessing readiness, identifying a weight-loss goal, developing a plan of action, setting a weight-loss start date, prescribing medications, counseling, adjusting the plan of action, and weight-loss maintenance. Given the arduous tasks involved, it is not surprising that although about 60% of our residents are overweight/obese, only about one-third of our residents reported that their doctor has ever talked to them about weight loss and only about one-fourth have had that conversation within the past year.

The Health Department requires managed care plans to assure that healthcare providers include obesity screening and counseling about nutrition and exercise in preventive health care visits for adolescents. These are useful services, but unique reimbursement codes for treating obesity, just like the unique codes for tobacco cessation, are needed to successfully address this critical health problem.

Even if a third of all obese people in both counties obtained counseling, the maximum cost would be about $3 million per year for the additional primary care visits. In return, however, the reduced costs of hospitalizations, medications, and visits to specialists would more than off-set that cost.

5. Facilitate Exercise

An important facet of maintaining weight loss is movement because it burns calories and suppresses appetite. More and more health messages are encouraging people to walk and bike. However, many rural communities are not conducive to these activities. Sidewalks and bike paths are non-existent, in disrepair, or do not connect; crosswalks have not been built; and, lighting is poor. Over half of our survey respondents stated they felt their community did not have enough sidewalks or walking paths, and only about one-third felt there are enough biking paths or dog-walking trails.

We have a potentially good market for walking and biking in Columbia and Greene Counties. A large percentage of the 111,000 people in our Counties reside in villages or hamlets where walking or biking for exercising is possible as well as for the purpose of going to work or running errands. People residing in outlying areas could still access town or county paths for exercise. But, funds are needed to create “walkable “ and “bikeable” communities.

State Program. More funding should be allocated to the NYS Consolidated Local Street and Highway Improvement Program to design, construct and repair walking/biking paths and sidewalks.

Federal Programs. Significant federal funding is available for pedestrian safety programs and projects. But, New York State spends fewer Federal dollars on pedestrian projects than almost every state in the nation, ranking 43rd in spending. Three federal funding programs specifically list improving the walking and bicycling environment as eligible activities — the Transportation Enhancements program, the Congestion Mitigation and

Air Quality Improvement Program, and the Highway Safety Improvement Program. New York State should pre-designate 10 percent of federal apportionments under those programs for pedestrian and bicycling projects.

Complete Streets. Enact the proposed "Complete Streets" State legislation requiring bicycle and pedestrian needs to be included in the planning and development of state, county, and local transportation facilities, plans, and programs. Accommodations would include bicycle lanes, paved shoulders suitable for use by bicyclists, road signage, crosswalks, pedestrian control signals, sidewalks, curb cuts, and ramps.

Increase Public Awareness About Available Resources. When survey respondents were asked to cite the reason they did not use walking or bike trails, about one-fourth said they did not know where they were located. Thus, a public information campaign should be initiated.

6. Advocate Healthier Restaurants

The Federal Food and Drug Administration estimates that people consume as many as one-third of all their calories in restaurants. Therefore, restaurants should be a focus point for helping people make wise decisions about food selections and portion sizes. The Task Force provides four key recommendations.

Smaller Portions at Smaller Prices. The portion sizes in restaurants are growing, which helps to grow our waistlines. Smaller portion sizes will help people manage their weight. Our Household Survey showed that nearly 90% of people favor smaller portions at lower prices. Restaurants should be encouraged to offer this option.

The Task Force did not recommend State or local mandates, but volunteer compliance. Local advocacy organizations would take the lead on these actions

Healthier Alternatives. Restaurants should be encouraged to offer healthy alternatives, e.g., broiled food, non-fried foods, no or reduced salt, non-fat milk, sauce/dressing on the side, and healthy side dishes, among others. The Household Survey shows that nearly 75% of people favor the option of healthier alternatives.

The "Just Ask" program was initiated in Greene County to educate patrons about the willingness of restaurants to modify recipes and portions upon request to help customers follow a healthy diet. Many restaurants have always been willing to provide this service to customers, but diners have not always been aware of this convenience. "Just Ask Us" enables customers to realize they can ask for healthy modifications. This program should be expanded in Greene County and initiated in Columbia County by local organizations.

We consume as much as 1/3 of all our calories from restaurants. Four recommendations can help us make wiser choices when eating out.

- **Smaller portions at smaller prices**
- **Healthier Alternatives**
- **Calorie Posting**
- **Banning Transfats**

Calorie Posting. Restaurants should be encouraged to post the caloric amounts of their menu items. Studies show that people will order meals with fewer calories if they are presented with calorie information at the time they order. Our Household Survey showed that 65% of people want calorie postings.

The Federal Food and Drug Administration will require chain restaurants with at least 20 sites nationally to post calories perhaps as early as 2012. However, it does not require "single site" or "limited-site" restaurants to post calories given the cost of determining calorie content in menus that change periodically. Therefore, restaurants should be offered the services of a dietician or nutritionist to assist those that want to post calories on their "lo-cal" menu options. Our Household Survey showed that 66% of people favor posting. Of course, calorie

postings are most meaningful when people know their daily calorie cap. Thus, an educational campaign should be conducted to help people determine their cap. Also, a personalized calorie counter should be distributed to people or available on-line so they can use them while patronizing a restaurant.

Transfats. Restaurants should be encouraged to ban or limit their use of trans fatty acids, also known as trans fats. They increase blood levels of low density lipoprotein (LDL), known as "bad" cholesterol, while decreasing levels of high density lipoprotein (HDL or "good" cholesterol), and are linked to coronary heart disease. According to the United States National Academy of Sciences, the consumption of trans fatty acids results in considerable potential harm but no apparent benefit. The USNAS has recommended that trans fatty acid consumption be as low as possible. New York City and several counties in the State have banned restaurants from using trans fats. According to our Household Survey, 55% of people support a ban. Local advocacy organizations should take the lead for encouraging restaurants to voluntarily cease the use of trans fats.

7. Promote Consumption of Fewer Calories

Science proves you will lose weight if you eat less food than what your body needs. Your body burns energy (calories) for breathing, digesting food, heartbeat, and for other purposes. Your body also burns calories for when you move about your home or office or when you shop and for other easy activities. If you eat fewer calories than what your body needs for these purposes, then you lose weight.

One of the obstacles to losing weight is that people are faced with the "triple challenge" of consuming less, dropping favorite foods, and exercising. Three challenges become overwhelming and thus people end up doing nothing. In our own two counties more than 50% of the people who are overweight or obese are not trying to lose weight. An alternative to assuming three challenges at once is to assume initially only one of the challenges – consuming less. Losing even 5% or 10% of one's weight is a healthy objective. Once people begin losing weight, they then may become motivated to also exercise and eat healthier.

The New York State Academy of Family Physicians, a statewide professional association of around 4,000 members, is about to embark upon a campaign in which select physicians will be working with patients to focus first on the reduced consumption of calories. This campaign aims to help people reach a healthier weight, not necessarily a "perfect" weight.

The Task Force recommends that family physicians in both counties participate in the NYS AFP program.

8. Promote Consumption of Fruits and Vegetables

Many rural communities experience limited access to fresh and affordable healthy food. In these communities, residents are forced to travel long distances for essential groceries. Residents often lack the transportation necessary to reach larger grocery stores and are thus forced to purchase food at convenience stores, which often sell poor quality produce, if at all, and highly processed food items. Furthermore, low-income families often cannot afford the higher prices of fresh fruits and vegetables. All of these factors are significant barriers for people who wish to improve their nutrition. The Task Force has two recommendations.

Farmer's Markets. Both Columbia and Greene counties currently house farmers' markets and fruit/vegetable stands. However, the markets are sparse and not always centrally located. In addition, many lower-income residents are not aware that these markets/stands exist or they harbor the misperception that the markets are expensive and even elite and therefore unapproachable. Local organizations should support the creation of more farmers' markets and stands, promote existing ones, and eliminate the current stigma associated with them.

While creating and promoting farmers' markets and stands will increase geographic accessibility to fresh produce, we also must address financial accessibility. Fortunately, the infrastructure is in place in New York

State to enhance affordability of fresh produce. The Farmers' Market Nutrition Program (FMNP) provides checks to families through the Women, Infants and Children Program (WIC) and to older people in the Commodity Supplemental Food Program for the purchase of locally grown fresh fruits and vegetables at farmers' markets. In addition, some farmers' markets in New York are equipped with a wireless Electronic Benefits Transfer (EBT) machine, an electronic debit card system for those receiving the food stamp benefit. However, only a few markets in Columbia and Greene counties have EBT machines, and even those equipped with the machines do not reach their potential in reaching the low-income population. Local organizations should expand the use of the EBT machines and the State should finance "Double Coupon Programs" and "Bonus Vouchers." These steps, combined with promotion and education, will increase sales at farmers markets and help change the eating habits of people who find it difficult to purchase fresh, healthy foods.

Buying Local and community Gardening. In 2009, the Federal Centers for Disease Control and Prevention released "Recommended Community Strategies and Measurements to Prevent Obesity in the United States." One of its recommended strategies is to "provide incentives for the production, distribution, and procurement of foods from local farms." Columbia and Greene counties are agricultural communities with the potential to affect significant change on our food systems and policies through this recommendation. Although there are current initiatives underway to implement farm-to-school programs as well as local food procurement policy, we have seen only limited success to date. The major impediments to these programs and policies are cost and awareness. Local organizations should promote buying local food by educating our residents about the cost savings associated with purchasing local as well as the increased nutritional value of locally grown food.

In recent years, there has been an increase in the number of community gardens with technical assistance from Cornell Cooperative Extension. Local organizations should further promote local gardening by increasing public awareness of the steps for growing your own fresh, healthy produce.

9. Promote Breastfeeding

Children who are breastfed are more likely to be at lower risk for obesity. But, the most recent data indicate that nearly 20% of mothers do not breastfeed, and only about 14% of children are fed breast milk exclusively up to the recommended age of six months.

State Labor Law. Reflecting the public health importance of breastfeeding, NYS Labor Law requires every employer, regardless of size, public or private, to "make reasonable efforts to provide a room or other location, in close proximity to the work area, where an employee can express milk in privacy." The Task Force recommends that local agencies inform all employers of their legal obligations.

Certified Lactation Consultants. To further the goal of increasing the number of women choosing breastfeeding, the State should provide funding for people to become certified lactation consultants (CLC), who specialize in the clinical instruction and management of breastfeeding. They work closely with prenatal and postpartum providers to help new families meet their breastfeeding goals and to help hospitals establish and support protocols for promoting breastfeeding. Although compensation varies, CLCs typically make a salary comparable to that of a Registered Nurse.

Becoming a CLC is an extensive process. General education requirements must be met in addition to lactation-specific course requirements and a clinical hours component. Finally, one must pass a certification exam. The cost of becoming a CLC varies greatly, but we estimate about $3,000 with the course-work and exam. Thus, the Task Force recommends that State funding be available for stipends to cover a percentage of the cost in order to encourage people to obtain the certification.

10. Create County Advocacy Coalitions

The State should provide funding to create county advocacy coalitions, similar to the groups they fund for anti-tobacco efforts. The anti-tobacco organization for our two counties is the Rip Van Winkle Tobacco Free Action, which is part of the Columbia County Community HealthCare Consortium. It has received funding ranging from $125,000 to $150,000 in past years. Anti-obesity coalitions would provide educational materials to individuals and organizations, conduct presentations and sponsor media campaigns to raise public awareness and support for addressing problems caused or affected by obesity, and work collaboratively with community leaders and local officials to bring about policy-based solutions and create anti-obesity programs.

11. Conduct Public Education and Information Programs

Food Labeling. The nutrition labels on pre-packaged food provide important information to help consumers make healthier choices. Labels include the number of calories, fat content, cholesterol, sugar amounts, as well as other nutritional information. The labels also include how many servings are contained in the package or can. Many items contain two and even three servings, which means the item has double or triple the number of calories of just one serving; similarly, the item also contains double or triple the fat, cholesterol, and sugar.

Nutrition Facts

Serving Size ½ cup (114g)
Servings Per Container 4

Amount Per Serving

Calories 90 — Calories from Fat 30

	% Daily Value*
Total Fat 3g	5%
Saturated Fat 0g	0%
Cholesterol 0mg	0%
Sodium 300mg	13%
Total Carbohydrate 13g	4%
Dietary Fiber 3g	12%
Sugars 3g	
Protein 3g	

Vitamin A 60% • Vitamin C 60%
Calcium 4% • Iron 4%

*Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs:

	Calories:	2,000	2,500
Total Fat	Less than	65g	80g
Sat Fat	Less than	20g	25g
Cholesterol	Less than	300mg	300mg
Sodium	Less than	2,400mg	2,400mg
Total Carbohydrate		300g	375g
Dietary Fiber		25g	30g

Calories per gram:
Fat 9 • Carbohydrate 4 • Protein 4

Although the nutrition information is easily identifiable on food containers, taking time to read and understand them is often a difficult and daunting task. According to our Household Survey, about 20% of people do not read labels and another 25% read them only "somewhat often." A State and locally-supported public awareness campaign should be initiated by local advocacy organizations to educate the public on the importance of reading labels and how to understand the labeling information. The nutrition education classes provided to Food Stamp recipients should include instruction on reading labels.

Encourage Soda Free Days and Junk Food Free Days. The rationale behind this recommendation is similar to the rationale for the annual "Great American Smoke-out." It is a mechanism that raises awareness and motivates people, strengthened by mutual involvement, to forego consumption of a product for one day. Once that barrier is broken, it then becomes more tenable for a person to consider going additional days without that product and then ultimately incorporating those days of abstinence into a permanent cycle of their life. Soda and junk food free days also create an opportunity for people to learn there are tasty and refreshing alternatives.

San Francisco was one of the first large cities to promote soda-free summers and the concept has spread throughout the Bay Area. On the East Coast, Boston also has sponsored a soda-free summer. A few other municipalities and schools have as well, but no such event has occurred as of yet in either of our two counties. Local organizations, schools, and employers should establish soda-free and junk-food free days.

Cooking Classes. Cooking classes teach people how to prepare tasty, healthy, and low-calorie meals. Often, these classes expose people to new dimensions of awareness in healthy eating, a world perhaps they did not know existed or were unable to reach. These classes also teach people to read food labels and count calories, and how to turn that knowledge into preparing healthy meals.

In most places where these classes are offered, they are free and open to the public. Classes can be one-day workshops or spread over several sessions. A longer-running program includes a Trainer (usually a Registered Dietician), food, and a location, and costs around $2,000.

Funding should be sought from private sources and grants; State funding should augment the private funding.

C. Cardiovascular Disease

Goal: By 2015, lower the coronary heart disease (CHD) death rate to 162/100,000 people from its current level of 319/100,000 people in Columbia County and 337/100,000 people in Greene County. About 365 people die each year in both counties from CHD. Achieving our goal would lower the number of deaths to about 180, and significantly reduce the cost of hospitalizations, medications, and other health care services.

Goal: By 2015, lower the stroke death rate to 24/100,000 people from its current level of 35/100,000 people in both counties. About 40 people die each year in both counties from stroke. Achieving our goal would lower the number of deaths to about 25, and significantly reduce the cost of health care services.

Cardiovascular disease (CVD) is any disease of the circulatory system. Most of the deaths from CVD relate to coronary heart disease (heart attack), stroke (cerebrovascular disease), congestive heart failure and other diseases of the circulatory system.

About 7% of adults (about 6,200 in Columbia/Greene) suffer from some form of CVD.[28] Cardiovascular disease, specifically heart disease and stroke, kills more Columbia/Greene residents than any other condition.

The health burden of CVD is matched only by its economic burden. The estimated medical care cost of CVD in the State is about $16 billion and nearly $73 million in our two counties. If we lowered the cases of CVD by 10%, then we would save nearly $7 million in our two counties (some of these savings are the same as those cited for reducing tobacco use and obesity).

A person with heart disease has substantial medical expenses for diagnostic tests, surgeries, hospitalization, specialist visits, physical therapy and drugs. A conservative estimate of the Statewide average cost of treating one person with heart disease for a 20-year period is $121,000. For those needing special procedures and on-going care, the costs can be more than $4.8 million per person over the course of a lifetime.[29]

The current death rate for coronary heart disease is nearly double the 2015 goal. About 365 people die each year in both counties from coronary heart disease. Achieving our goal would lower the number of deaths to about 180.

80% of all strokes are preventable

Stroke is a leading cause of adult disability in New York, and more than one-quarter of strokes happen to people under the age of 65 – the group least likely to suspect they are at risk. In our counties, the death rate (35 per 100,000) from stroke is 45% higher than the NYS goal (24/100,000). Stroke causes about 40 deaths, and reaching the State goal would lower the number of deaths to about 25 per year. For those who survive a stroke, there are often serious even devastating side effects the individual will have to contend with for the rest of his/her life.

Many CVD conditions are largely preventable – 80% of stokes, for example – by making healthy lifestyle choices that help reduce risk and severity. A fully-funded preventive/primary care system will help patients manage their risk factors such as controlling blood pressure, avoiding tobacco use, maintaining a proper weight, lowering cholesterol levels, striving for optimum sugar control if diabetic, and getting checked for heart rhythm disturbances, among others. Primary care will also emphasize early identification and treatment of heart attacks and strokes, and help patients avoid recurrent cardiovascular events.

Recommendations

Many of the recommendations listed above under "Tobacco" and "Obesity" will help address cardiovascular disease. Thus, the Task Force offers only two additional ones in this section.

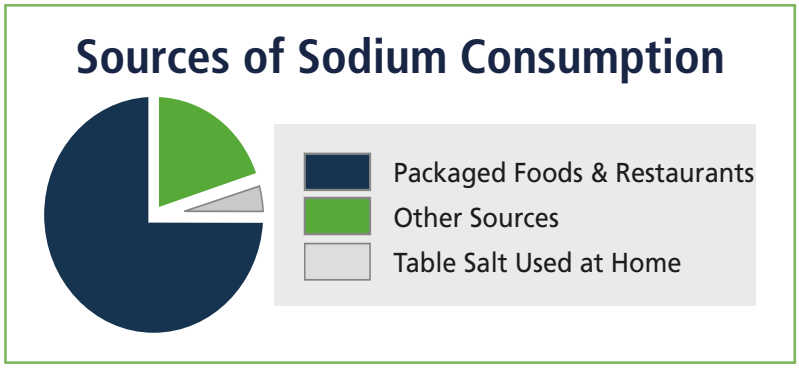
1. Promote Patient Compliance With Medications

Staying on a medication for a long period of time requires self-discipline, but proves beneficial both for health and economic reasons. However, a large number of prescription medications that need to be taken on an ongoing basis are either not completed or are never filled in the first place. According to the American Pharmacists Association, drugs for high cholesterol and high blood pressure are among those for which patients are least compliant. The leading reasons for medication noncompliance are forgetfulness, disbelief that the drug is necessary, fear of side effects or experiencing actual side effects, confusion over instructions, and a desire to save money. However, when patients clearly understand why they are being prescribed certain medications and how they can refill their prescriptions, they are more likely to be compliant.

Doctors can play a significant role in helping patients understand what they need to take and why, which can increase patient compliance and thus reduce the number of cardiovascular adverse health events. The Patient-Centered Medical Home is the mechanism to achieve this objective (see "Patient-Centered Medical Home" on page 26).

2. Conduct an Information Campaign on Consuming Less Sodium

Most of the sodium we consume is in the form of salt. Too much sodium is unhealthy. It can increase your blood pressure and your risk for a heart attack and stroke. The recommended amount of sodium intake for adults is 2,300 milligrams per day, and 1,500 milligrams for at-risk individuals with hypertension, or who are black, or middle-aged and older. However, the average daily intake among Americans is 3,400 milligrams per day, or about 50% higher than the recommended level and more than double for what is recommended for at-risk groups.



Many people mistakenly believe that our over-consumption of sodium is because we add too much while eating at the home dinner table. However, it is not the use of table salt that is harming American's health because it accounts for about 5% of salt intake. Rather, it is the salt loaded into packaged foods and restaurant meals, which account for about 75% of our intake. Another cause of over-consumption is the hidden sources of salt in foods people might not expect to be salty.

A State-supported media campaign should be conducted on the dangers of over-consumption of sodium with an added emphasis on the fact that we are consuming far too much. The campaign's key points should include:

- Making the public aware that 75% of sodium intake occurs with packaged foods and in restaurants
- Reading labels for sodium content
- Consuming foods and drinks with lower sodium content
- Encouraging people to ask stores and restaurants to offer low sodium products
- Re-assuring people that food will still taste good even with less sodium
- Encouraging physicians to ask their patients about their sodium intake since our survey shows that only about one-quarter of patients are asked

3. Screening

No recommendation is advanced at this time for screening for hypertension and cholesterol. We are quite pleased that our Household Survey indicates that 90% of people have had their blood pressure checked within

the past two years, and 87% of people have had their cholesterol checked within the past five years. Both levels exceed statewide and national averages.

D. Behavioral Health: Mental Health, Alcohol and Drug Abuse

Goal: By 2015, lower the proportion of adults reporting 14 or more poor mental health days in the past month to 8% from the level of 10% in both counties. About 8,800 people report this condition, and reaching the goal of 8% would lower the number to 7,100.

Goal: By 2015, lower the rate of suicide to 5 per 100,000 people from 11/100,000 in Greene County and 7/100,000 in Columbia; reaching this goal would lower the number of suicides from about 10 to about 6.

Goal: By 2015, lower the young adult DWI arrest rate to 44/10,000 from 87/10,000 in Columbia County and 153/10,000 in Greene County.

Goal: By 2015, lower the percentage of adults binge drinking in the past month to 13% from 19% in Columbia County and 25% in Greene County. Reaching this goal would lower the number of adults engaging in binge drinking in the past month from about 18,000 to 11,000.

Goal: By 2015, lower the alcohol-related motor vehicle crash death rate to 5/100,000 from 7/100,000 in Columbia County and 11/100,000 in Greene County. Reaching this goal would lower the number of alcohol-related deaths from about 11 to 5.

Goal: By 2015, lower the drug-related hospitalization rate below the current level of 16/10,000 in Columbia County and 23/10,000 in Greene County. These rates are already below the State goal of 26/10,000.

[Note: The goals listed above are the only ones for which data are available for Greene and Columbia Counties. Nonetheless, these goals reflect important issues in the area of behavioral health, and achieving them will reduce the number of deaths, injuries, and suffering as well as lower the cost of health care.]

Mental disorders are common – about one-fourth of American adults suffer from a diagnosable mental disorder in a given year.[30] Mental disorders are a leading cause of disability for people ages 15-44. Nearly half of all people with any mental disorder have two or more disorders.[31] An estimated 7% of adults (about 6,000) have a Major Depressive Episode in his/her lifetime (an MDE is defined as having 5 or more of 9 symptoms relating to depression). An estimated 11% of adults (about 10,000) have had an episode of Serious Psychological Distress in the past year (an SPD is defined as anxiety or mood disorders).[32] There is substantial overlap in the populations who have an MDE or an SPD. Even though mental disorders are widespread, the main burden of illness is concentrated in a much smaller proportion – about 6% -- who suffer from a serious mental illness.[33]

Alcohol abuse causes serious health problems. Long-term heavy drinking increases risk for high blood pressure, heart rhythm irregularities, heart muscle disorders, stroke, certain forms of cancer, cirrhosis and other liver disorders. Alcohol use has been linked with a substantial proportion of injuries and deaths from motor vehicle crashes, falls, fires, and drownings. It also is a factor in homicide, suicide, marital violence, child abuse, and high-risk sexual behavior. The number of adults with a dependence on alcohol is about 2,700 in both counties.

Illegal use of drugs, such as heroin, marijuana, cocaine, and methamphetamine, is associated with various health conditions and other serious consequences, including injury, vehicular crashes, disability, and death as well as crime, domestic violence, and lost workplace productivity. Drug dependence is a chronic, relapsing

disorder. An estimated 1,800 adults have a dependence on illicit drugs are. The number of youth is unknown.

Taking prescription drugs that are not prescribed to a person – or taking them in any way other than directed by a doctor — is considered non-medical use or abuse and can be as dangerous as taking an illegal drug such as cocaine or heroin. Taking prescription medication in combination with other prescription drugs, illicit drugs, or alcohol is especially dangerous.

Prescription drugs are abused more than cocaine, heroin, and methamphetamine.

The abuse of certain prescription medications is a growing problem. These medications include opioids such as codeine, oxycodone, and morphine; depressants such as barbiturates and benzodiazepines; and stimulants. The White House Office of National Drug Control Policy states that prescription drugs account for the second most commonly abused category of drugs, behind marijuana but ahead of cocaine, heroin, methamphetamine, and other drugs. According to the Federal National Institute on Drug Abuse, an estimated 20% of people age 12 and older have used prescription drugs for nonmedical reasons in their lifetimes.

Recommendations

1. Conduct a State-supported Media Campaign to Reduce the Stigma about Behavioral Health Conditions

A State-supported media campaign should be conducted to raise public awareness about the need to address mental illness, substance and alcohol abuse, and prescription drug abuse (especially pain medication) and to erase the stigma associated with seeking help for these behavioral health conditions.

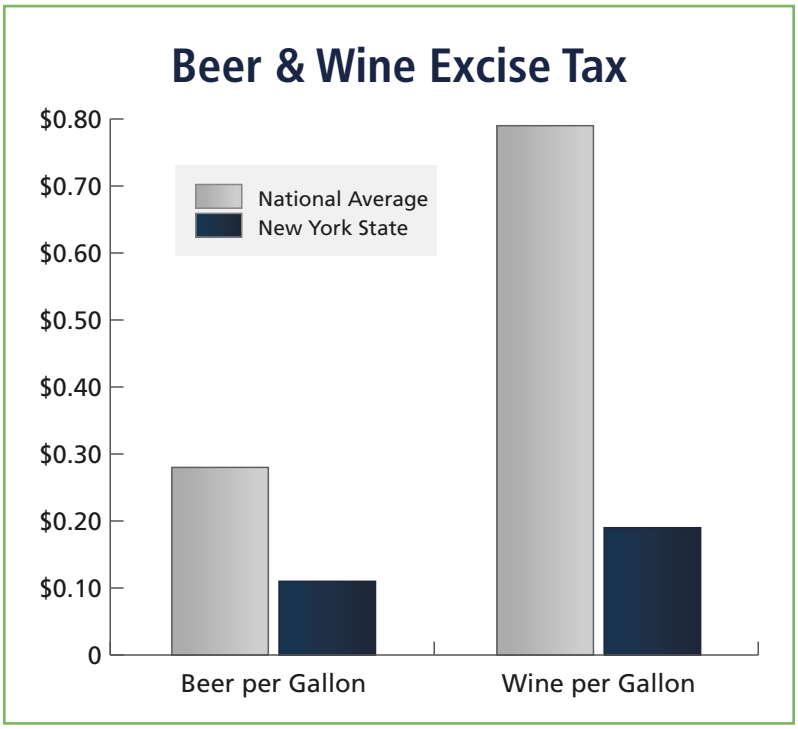
Many people with behavioral health conditions feel shame or suffer low self-esteem, and will not seek treatment services. Their friends, family and neighbors may harbor feelings of prejudice or fear and misunderstand their disease, further hindering people from seeking treatment. Although family and friends often are a great resource for helping people seek treatment, they often make it more difficult. Our Household Survey indicates that the least amount of negative opinion is directed at people with depression or anxiety; about 85% or respondents feel these conditions are a disease while only 15% feel it is more of a result of personal choice and even irresponsibility. However, the percentages decrease for other conditions. 57% believe alcoholism is a disease or condition while 40% regard it as a personal choice and even irresponsibility; 33% think abuse of prescription medication is a disease or condition while 60% see it as personal choice and even irresponsibility; and, only 30% believe illegal drug use is a condition or disease whereas 66% think it is a result of personal choice and even irresponsibility.

The objectives of a media campaign would include improving the general understanding of behavioral health conditions and diseases, making clear that recovery is possible, and helping the public to understand that people with these problems can lead productive, useful lives. Our Focus Groups feel that a campaign should avoid the issue of whether these conditions are caused by disease or by personal irresponsibility because it detracts from the larger purpose and could alienate people who feel strongly about the causes of these conditions.

2. Increase the Beer And Wine Excise Tax

Increase the excise tax on beer, which currently is 11¢/gallon whereas the national average is 28¢. The rate ranks 10th lowest in the Nation and the tax has not been changed since 1967. The wine excise tax is 19¢/gallon but the national average is 79¢, ranking it 2nd lowest in the Nation. The Task Force did not recommend an increase in the liquor excise tax, which is about double the national average and ranks 3rd highest.

Proceeds from the increased tax should be used for two purposes. One is to raise revenue for funding treatment and other alcohol-related programs. The second purpose for a tax increase is to influence behavior. According to the National Institute on Alcohol Abuse and Alcoholism, studies demonstrate that even a small increase in beer prices (about 17¢ per gallon) lead to reductions in the levels and frequency of drinking and that higher taxes on beer are associated with lower traffic crash fatality rates, especially among young drivers.

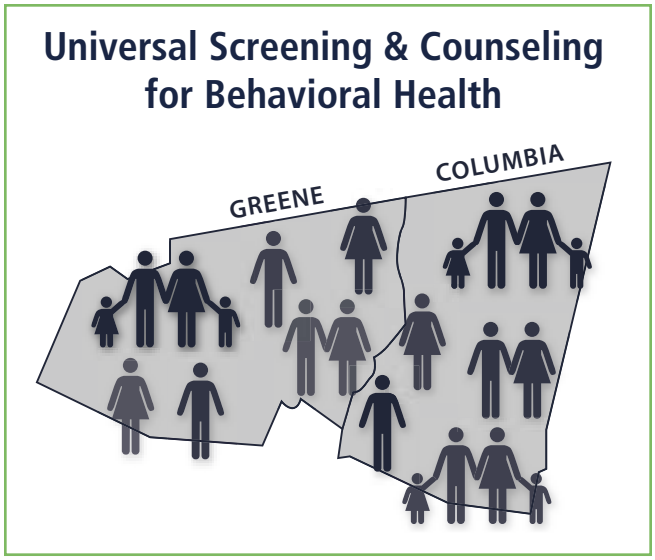


3. Implement Universal Screening and Counseling at Patient-Friendly Sites

The purpose of this recommendation is to address the fact that many people have undiagnosed behavioral health problems, and other people with a diagnosed problem cannot or do not access counseling services. Undiagnosed and untreated behavioral health problems then become critical conditions ultimately requiring far more interventions that are costly in terms of money and human suffering.

The Task Force recommends that multiple screening sites be established throughout both counties to help ensure that, over time, practically everyone is screened for a potential behavioral health problem. The Task Force also recommends that multiple "patient-friendly" sites be established to encourage people who need counseling to seek it.

Doctor offices. Primary care physician offices are an excellent resource for screening people for behavioral health problems. Our Household Survey showed that about 80% of people visited their primary care doctor within the past year and about 88% within the past two years; thus, this approach has the potential ultimately to screen almost everyone in the County.



The Task Force recommends expansion of a program started jointly by the Greene County Rural Health Network and the Greene County Mental Health Center in which people who see their primary care doctor for a routine office visit are also screened for behavioral health problems. When the patient checks in they are given a brief screening questionnaire to complete. If, based on that brief survey, the doctor or nurse believes that counseling may be needed, then it is provided to the patient at a later date at the doctor's office by a local professional counselor who is "out-stationed" in the doctor's office. Once a rapport is established between the patient and the counselor, then some patients are encouraged to go to the provider's office for additional counseling. This program is also proving to be an excellent approach to fostering cooperation in patient case management between medical doctors and

behavioral health professionals. It also recognizes the fact that many primary care doctors are not the best qualified or trained for counseling patients about behavior health problems.

The State should partner with local agencies to expand this program into every primary care office. Based on the Greene County experience, about $100,000 would be needed the first year to expand the program into other offices in both counties, and then funding could be phased out over the next few years as the program takes root. Funds are needed to help cover the cost of two Coordinators to expand the program, recruit new doctors, educate doctors and their staff about the program and its clinical benefits, train front office staff about the screening device and protocols, address problems as they arise, and collect program data. Funds would also be used to incentivize doctors to join the program such as stipends to cover start-up administrative expenses, computers for data entry, and furniture consistent with the counseling environment.

Schools. Our schools are an excellent resource for screening adolescents and pre-adolescents for behavioral health problems since nearly all of them attend school. Many children need behavioral health services. However, often they do not receive such services because of traveling distances, the family is unable to cope with the condition, lack of coverage, and the stigma of having to go to the "county mental health center." If the children are taken for a service visit, research suggests a 35%-45% no-show rate at mental health clinics after the third treatment visit. School psychologists, if a school has one, are overwhelmed with assessing and coping with learning disabilities-related issues, and do not focus on behavioral health issues.

Providing the service at the schools resolves many of the barriers described above. Thus, the Task Force recommends expansion of a program also started jointly by the Greene County Rural Health Network, the Greene County Mental Health Center, and the schools. This program maximizes the fact that teachers are in an excellent place to identify children who may need behavioral health services. If a teacher feels a student may need counseling, she informs a counselor who has been "out-stationed" in the schools by the Mental Health Center. Then, the student, with parental permission, is screened and provided on-site counseling. Families are included in the counseling if indicated.

Unfortunately, some schools have had to drop the program because of budget cuts. Thus, State funding is needed to re-start the program in some Greene County schools and to expand it into Columbia County. Approximately $100,000 is needed to expand the program into all the schools, bring in alcohol and substance abuse services, and coordinate the program. The dollar amount in subsequent years would decrease. Additional funding is needed to cover uninsured students until the Federal Affordable Care Act takes effect in 2014.

Worksites. The worksite is another excellent resource for screening people. But, the Task Force recognizes the impracticality of screening all employees and then out-stationing counselors to provide treatment. Rather, the Task Force recommends State funds to pay a Coordinator to help employers establish Employee Assistance Programs or linkages to such programs. The cost would be an estimated $30,000 per year for both counties and then funding would decrease in subsequent years.

Adequate Personnel. More counseling staff will be needed to handle the increased caseload due to the multiple-site screenings in doctors' offices, schools and worksites. State funding is needed to provide scholarships or loan forgiveness to people to attract them to the counseling profession. Also, funds should be made available to purchase video-conferencing equipment for the use of tele-psychiatry, especially for child psychiatry because of shortages in this profession.

4. Create Support Groups

Peer support groups are needed for advocacy and empowerment to encourage independence and community inclusion among people with behavioral health needs; they are an important tool that aids in recovery. Many people with behavioral health needs find daily activities and community involvement challenging. Support groups build community and help people pursue personal goals such as education and employment.

They also provide resources for personal needs such as budgeting and healthcare. A small annual stipend of about $30,000 is needed to pay someone to create the support groups, recruit members, and coordinate the group's activities

5. Facilitate One-Stop Services for the Multiply Disabled

State Mental Hygiene Law created disability silos, which is fostered by State Medicaid payment regulations. Although an individual with a Co-Occurring Mental Health and Substance Abuse diagnosis can be treated at either a mental health or substance abuse agency, both have to be very careful to only treat the diagnosis they are licensed to treat. Currently, too many individuals must be seen at multiple agencies increasing the chance of mismanaged care, missed appointments and poor outcomes. State regulations should be modified so the patient can go to only one site to obtain the different types of care they need. Co-location is an option which would enable patients with two or more problems to see two or more professionals during one visit. This arrangement increases the likelihood they will obtain the range of services required.

GOALS AND ACTION RECOMMENDATIONS FOR IMPROVING THE PREVENTIVE AND PRIMARY CARE SYSTEM

If we are to achieve better health status and adopt healthier lifestyles, several key components in our health care delivery system must be in place. The Task Force recommends a comprehensive strategy for the four cornerstones of the primary care delivery system: coverage, supply, delivery of services, and reimbursement.

A. Expand Health Insurance Coverage

Goal: By 2015, 100% of the population should have coverage or all 111,000 people living in both counties. Currently, 92% of the people in both counties have coverage.

A fundamental component for improving access to primary care is ensuring that people have insurance coverage for these services. Uninsured and underinsured persons receive less preventive care, are diagnosed at a more advanced stage of illness and, once diagnosed, tend to receive less therapeutic care and suffer higher mortality. Lack of insurance results in higher rates of emergency room use and avoidable hospitalization, especially for conditions that could have been prevented or treated in a primary care setting.

Uninsured children are five times more likely to go without needed medical care and three times more likely not to get a needed prescription medication. They are much less likely to receive preventive medical services including immunizations, dental and vision care, often leading to increases in conditions such as ear, nose and throat infections, diabetes and asthma.

Although most people in our two counties do have insurance coverage, about 8% of people do not. Employer-based and private insurances cover the largest numbers of people. Medicare covers people age 65+. Medicaid covers low-income families up to the poverty level; Family Health Plus covers parents up to 150% of the poverty level; and, Child Health Plus subsidizes coverage for children up to 400% of the Poverty Level. However, there is no public coverage for individuals whose income is over the poverty level and for parents whose income is over 150% of poverty. Although the new Federal Law – the Patient Protection and Affordable Care Act – will cover most people in this gap, that coverage will not occur until 2014.

Recommendations

1. Expand Eligibility for Public Health Insurance Programs

The State should raise the income eligibility level for Family Health Plus (individuals and parents) to 200% of poverty for the period 2011-2012 and to 250% for the period 2012-2013. After that point, the Federal law will provide coverage with subsidies for low-income people. For the few who are still not included, the State should continue subsidized coverage. We do not anticipate that expanded eligibility will create more costs over time. Funds are already being expended on care for uninsured people who cannot or do not access care until a medical crisis erupts, requiring expensive hospitalizations, emergency department visits, medications, and the use of specialists. These unnecessary health expenditures will decrease significantly once people have coverage and access to primary care.

2. Establish a Federally Qualified Health Facility in Hudson

Federally qualified health centers (FQHCs) deliver care to residents of underserved areas, including those who lack coverage. A FQHC must provide comprehensive services and have an ongoing quality assurance program. Its board must include a majority (at least 51%) of active, registered clients of the health center and who are representative of the populations served by the center.

The Centers are invaluable for helping to improve access to care for those who have limited or no insurance coverage. FQHCs must use a sliding fee scale with discounts based on patient family size and income in accordance with federal poverty guidelines. FQHCs must be open to all, regardless of their ability to pay.

FGHCs are eligible for enhanced reimbursement from Medicare and Medicaid, discounts for prescription and non-prescription medications, access to the Vaccine for Children program, and for various other federal grants and programs.

Local organizations should collaborate to seek funds for establishing a FQHC in Hudson or a nearby location.

B. Ensure an Adequate Supply of Primary Care Providers

Goal: By 2015, 100% of the population should have access to a primary care provider. Currently, 87% of the people in both counties have such access.

An insufficient supply of primary care doctors means that people cannot obtain appointments or obtain them within a useful timeframe. An insufficient supply also means some people have to travel excessive distances to seek care, which also hinders timely access, especially if transportation is not available.

More primary care doctors will be needed as our population ages out, federal law ensures more coverage, and more doctors near retirement.

Our two counties need about 34 primary care doctors based on federal guidelines, and they should be appropriately distributed throughout both counties. Certainly, both counties have made significant progress in meeting the need for primary care providers over the years. Nonetheless, a total of about 4-5 primary care doctors are still needed to meet federal guidelines, but the competition to recruit them will intensify in the coming years. More primary care doctors will be needed as our population ages out and more people assume insurance coverage under the new federal health insurance program. Also, since other areas of the Nation face these same challenges, they will also be recruiting doctors. Adding to the challenge is the fact that some of our primary care doctors are nearing retirement age and will be ending their practices within the next few years, a situation that mirrors the rest of the Nation.

Recommendations

1. Provide Incentives To Become Primary Care Doctors & Locate In Underserved Areas

Doctors Across New York. The State should continue to fund "Doctors Across New York," which is administered by the State DoH. It provides up to $150,000 over five years for loan forgiveness for primary care doctors who have just finished their residencies and locate in underserved areas. Also, it provides up to $100,000 to help underwrite the expenses for expanding a practice that includes an additional primary care doctor.

Medical Student Scholarships. The State should provide more scholarship funds to encourage medical students to declare primary care as their specialty and to locate in underserved areas. The State currently provides very little scholarship money. Scholarships reduce debt load and therefore offer two important benefits. One is that scholarships encourage medical students, who are facing large debts upon graduation, to choose the lower-paying primary care profession instead of a lucrative subspecialty that may not be needed. The other benefit of providing scholarships to medical students is it increases the likelihood they will be willing to locate in an underserved area that may not otherwise be able to produce income sufficient to re-pay their large debt load.

2. Enrich Incentives for Hospitals to Train More Primary Care Doctors

Medicare and Medicaid pay about 100 hospitals in our State to train 16,500 medical residents, a program known as Graduate Medical Education or GME. In 2007 in our State, Medicare paid about $1.8 billion and Medicaid paid about $1.4 billion for GME-related purposes. The Medicaid payment per resident was about $98,000 in 2009. Hospitals are paid a slightly higher amount for training residents in primary care as opposed to specialty residents. In order to encourage more hospitals to train residents for primary care, the Task Force recommends that the current formula be weighted even more to further favor primary care. Providing adequate reimbursement to primary care doctors will help ensure that they remain in NYS once they finish their residency (see section D on page 28).

3. Improve the Medical Schools Admission Process

New York State has 16 medical schools with 9,000 students. No medical schools are located in rural areas, which means students are not exposed to rural amenities and are less inclined to practice in a rural setting once they become doctors. One way to overcome this barrier is to admit students who are more likely to locate in rural areas once they become doctors. Medical schools, starting with the four SUNY medical schools, should expand their admission criteria to include factors that are more predictive of which medical students, upon finishing their residencies, will locate in rural and inner city areas.

Under this recommendation, medical schools will go beyond their current narrow emphasis on only medical entrance exams and grade point averages to also consider factors such as prior community service, length of time residing in an underserved community, personal values and goals, and community recommendations.

Admission to medical schools depends too heavily on entrance exams and grades.

4. Ensure an Adequate Number of Urgent-Care Centers

Urgent care is the delivery of ambulatory care in a facility outside of a hospital emergency department. Most appointments are “walk-ins”, meaning they are unscheduled. Urgent care centers primarily treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room. They provide basic medical care, imaging, laboratory services, and minor procedures such as suturing, cyst removal, incision and drainage, and splinting. Urgent care centers are open for extended hours although usually not 24/7.

The centers provide important primary care and help address health problems in a timely manner, mitigating their severity. Two such centers operate in Greene County and none operate in Columbia County. The Task Force recommends that an analysis be completed by a local organization to determine if more are needed and then coordinate efforts to establish centers where indicated.

C. Universal Participation in the Patient-Centered Medical Home

Goal: 100% of the population ultimately should have a Patient-Centered Medical Home.

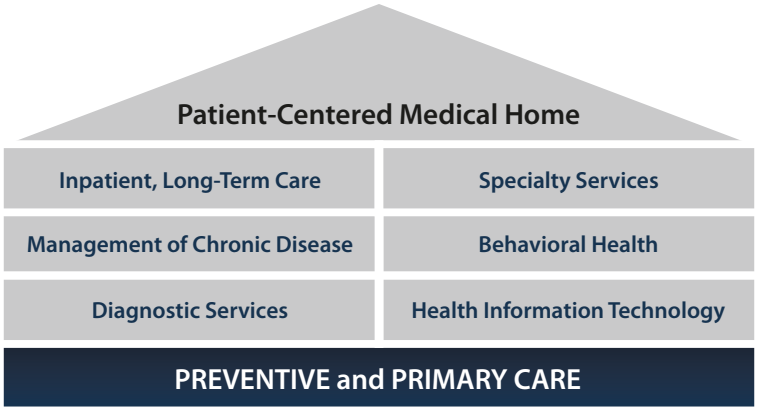
The Patient Centered Medical Home (PCMH) should be the structure for delivering primary and preventive care to all 19.5 million New Yorkers. It coordinates and manages all care for the patient, including prevention, primary care, diagnostic, specialty, inpatient, behavioral, and disease management services. The PCMH also identifies patients who potentially are in need of mental health and drug and alcohol abuse services, and helps arrange for and coordinates the appropriate treatment. People with chronic diseases will have their care managed better and the services they need will be coordinated through an integrated delivery system that provides a continuum of care. Research shows that the PCMH improves quality, reduces errors, constrains costs and increases patient satisfaction.

The PCMH is in stark contrast to the current model of delivering care, which emphasizes episodic, reactive care while de-emphasizing prevention, primary care and coordination of services with other providers.

Through the Patient-Centered Medical Home, primary care doctors and their staff:

- Send reminders to all patients about preventive care and to those patients who require routine and follow-up services
- Help patients to quit tobacco or lose weight
- Ensure that patients obtain needed immunizations and vaccinations
- Ensure that patients comply with health screening guidelines to identify and treat health care problems early, including the various chronic diseases
- Coordinate diagnostic findings from specialists and coordinate care among them and other providers
- Arrange for behavioral health services
- Manage chronic care needs by developing and following care plans, assessing progress, addressing barriers, and working with specialists
- Coordinate patient care in other settings such as hospitals and mental health/substance abuse facilities
- Teach patients how to manage their illnesses, diseases, and risk factors
- Respond to changing patient conditions
- Provide 24 hour communication access (telephone, email) to clinical support
- Ensure the availability of timely and appropriate appointments
- Use electronic health information technology
- Survey patients' care experience and use the information for service improvement
- Make referrals for patients who need assistance maintaining or obtaining public or private health insurance

Although the percentage of people who have a PCMH is unknown at this time, the proportion is presumably very low since the concept is relatively new and few insurance companies provide reimbursement for it. Transforming the current model of care into a patient-centered medical home and doing so on a timely basis will require a number of steps. The Task Force provides three recommendations for creation and implementation of the PCMH, and bases its support of PCMH on the condition that all three recommendations are implemented.



Recommendations

1. Accelerate Adoption of the Patient-Centered Medical Home Concept

A number of significant actions are taking place to implement the PCMH. The National Committee for Quality Assurance has adopted standards for the PCMH. Various physician professional associations also have adopted standards and "how-to" manuals for guiding primary care providers in creating a PCMH. Similarly, various pilot projects are underway in the State and the Nation. The purpose of these demonstration projects is to test different models of the PCMH and determine how best to design and operate the PCMH so that it improves quality, reduces cost, and most importantly, improves patient health status. The State has taken a major step

forward in approving legislation in 2009 that adopts standards for Medicaid participation in the PCMH, and in 2011 the State enacted legislation that would allow one million Medicaid recipients to join a PCMH.

The State should take the lead in accelerating adoption of the PCMH concept by working with physician professional associations, insurance companies and employer organizations to educate their respective members about the its importance, standards for becoming a PCMH, and how to establish one.

2. Provide Incentives For Voluntary Physician Participation in The PCMH

The State should provide incentives to encourage primary care doctors to provide a medical home. Doctors should have to meet reasonable standards and approval must be provided in a timely manner. Incentives would include:

Reimbursement For Re-Tooling. Doctors will have to transform their practices to become a PCMH, which requires changes in practice patterns and workflow. The State should finance technical assistance and training programs. See section D below on Reimbursement.

Capital for Health Information Technology. Health information technology (HIT) is essential to facilitating preventive care, case management, and the quality improvement necessary to build a patient-centered medical home. However, HIT remains expensive and complex. Unlike hospitals, primary care providers are many in number, small in size, and lack the capacity and necessary financial reserves to invest in and maintain information technology systems.

The State has provided grants to large health care organizations and provider networks for HIT development through the Health Care Efficiency and Affordability Law of New York (HEAL NY). Additional funding should be provided for needed capital resources for acquisition of HIT, and solo and groups practices in rural areas should be a priority for funding . Once primary care providers install or update HIT systems, they must receive reimbursement that covers the cost of maintenance and operations. See section “D” below.

3. Reimbursement of the PCMH

See section D immediately below on Reimbursement.

D. Ensure Fair and Adequate Reimbursement for Preventive and Primary Care Services

Goal: By 2015, ensure adequate reimbursement for primary care providers, including reimbursement for the primary care medical home.

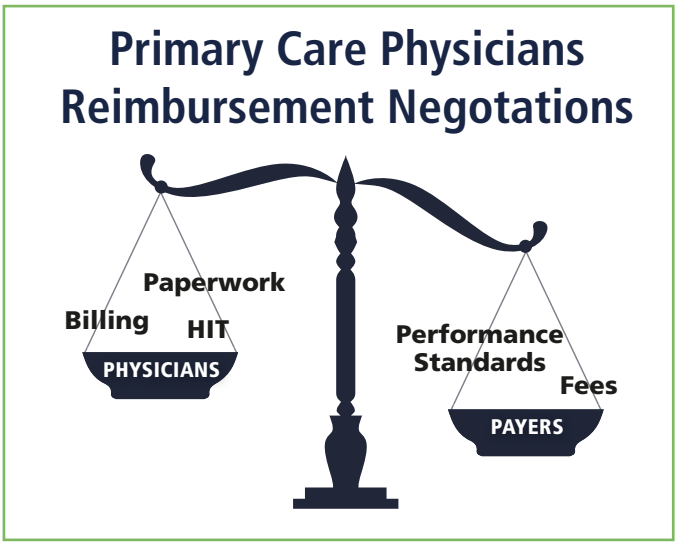
Payment reform is one the most important of all measures required to successfully address primary care problems in New York State. Despite the important work of primary care doctors and their central role in our health care system, they are paid much less than all other physician disciplines. As a consequence, too few doctors go into primary care or locate in underserved areas. Further, the primary care doctors who are practicing are not paid adequately to promote health, prevent illness, identify and treat illnesses earlier, and manage and coordinate care. Yet, they are expected to reduce the severe impact of chronic disease and other health care problems. Moreover, while primary care providers bear the costs of prevention and care management, the financial benefits of fewer emergency department visits, hospitalizations, and medications accrue to the payers. The inadequate reimbursement paid to primary care physicians jeopardizes the economic viability of the very providers who people rely upon for cost-effective care.

Recommendations

1. Enact State Legislation to Permit Reimbursement Negotiations for Primary Care Physicians

Our two primary care physician focus groups discussed how to correct the reimbursement inequities and other reimbursement-related issues facing primary care doctors. After examining a number of options, their key recommendation is to enact State legislation that permits collective negotiation between primary care providers and payers. The Task Force concurs with this recommendation. Bargaining could be used for determining the amount of reimbursement for clinical services, the amount of the coordination/management fee (see #2 below), paperwork processes required by insurers, performance standards, the impact of patient mix, and reimbursement for maintenance and operation of Health Information Technology.

Physicians who are in separate corporations are prohibited by law from joining together to negotiate contract provisions and payments because it is considered restraint of trade. As a result, managed care plans in New York State can "divide and conquer," enabling them to dominate the market to such a degree that fair and equitable negotiations are nearly impossible. Physicians currently face non-negotiable, take-it-or-leave-it contracts that allow health plans to retroactively change contract terms, with little or no notice, and to set payment rates well below the costs to physicians associated with providing the services to patients. Health plans dictate burdensome administrative procedures that add tremendous cost and detract from patient care. Health plans also dictate the terms of prior approval, second opinion, and referrals, all of which affect patient care.



Negotiation is critical to restore fairness to the contracting process between physicians and managed care plans as well as to allow physicians to advocate on behalf of their patients for the services and treatments that will best serve their health care needs.

2. Pay Primary Care Physicians a Management/Coordination Fee

An important part of reforming the model of delivery is to change payment structures. Currently, doctors are paid only for the "face time" they have with patients or for procedures they perform. They are not rewarded for the long-term management of specific conditions, coordinating care with other providers, and teaching patients how to manage their conditions.

The reimbursement structure should encourage primary care doctors to adopt the medical home model. To do this, the State should require that all payers reimburse physicians for the cost of managing and coordinating care. The fee would range, based on national models, from $7 to $15 per member per month. Some doctors would be paid more because they have a higher percentage of patients who require more coordination and management (patient mix). This fee would be paid in addition to negotiated fee-for-service and capitation payments for the delivery of clinical services. It would be linked to reasonable performance standards, one of which would consider patient willingness to comply with the physicians' clinical directives. Independent entities, rather than insurance companies, would measure physician performance.

Collective negotiation between primary care providers and payers could be used to help determine the amount of the coordination/management fee, the impact of patient mix, performance standards, and how those amounts fit in with the payment structures for all other clinical services.

GOALS FOR ADDITIONAL HEALTH CONDITIONS AND HEALTHY LIFESTYLES

Goals and related statistical information on cost and prevalence are presented for additional health conditions and lifestyles in this section. They are certainly important areas, but the Task Force needed to identify priority areas on which to focus its recommendations, which are the four described above – tobacco, obesity, cardiovascular disease, and behavioral health. However, the immediately preceding section on "Improving the Preventive and Primary Care System," will help to address the health conditions and lifestyles in this section.

A. Cancer

Goal: By 2015, lower the cancer death rate to 159/100,000 people from its current level of 191/100,000 people in Columbia County and 230/100,000 people in Greene County. About 240 people die each year in both counties from cancer. Achieving our goal would lower the number of deaths to about 180.

Although the cancer death rate in both counties is higher than the 2015 goal, it is especially high in Greene County, which has a death rate about 45% higher than the 2015 goal; in Columbia County the death rate is about 20% higher. One of the driving causes is Lung Cancer, which has a death rate in both counties that is about 40% higher than the 2015 goal. Breast cancer is another area of concern; Greene County has a death rate nearly 30% higher than the goal whereas Columbia County has a death rate that is about 20% lower. Cancer is costly, consuming an estimated $34 million each year.[34]

Research has demonstrated that many cancers could be prevented. According to the NYS Comprehensive Cancer Control Plan, developed jointly by the State DoH and the American Cancer Society, perhaps as many as one-third of cancer deaths could be prevented; some sources quote a level as high as 50%. Cancer can be prevented by eliminating the use of tobacco, improving nutrition, increasing physical activity, reducing alcohol consumption, and adopting sun-safe behaviors. A comprehensive preventive/primary care system can reduce the incidence of new cancers by helping patients adopt healthier lifestyles, and it can reduce mortality by identifying cancers earlier through patient screening tests and by coordinating the many services cancer patients need.

B. Diabetes

Goal: By 2015, lower the percentage of people who have diabetes to 3% of the population from its current level of 9% in Columbia County and 8% in Greene. Approximately 9,500 people have diabetes. Achieving our goal of 3% would lower the number of cases to about 3,400 people.

Treating diabetes is extremely expensive. Estimated diabetes medical costs in our two counties are $40 million.[35] The national annual cost of diabetes in medical expenses and lost productivity rose about 75%, during the period 1997 to 2007. The factor driving this rapid growth in cost is the rapid growth in caseload. Since 1994, New York has witnessed a near-100 percent increase in the number of people with diabetes. Equally troubling is that nearly 30% of people who have diabetes have not been diagnosed – as many as 2,900 people in our two counties – because their symptoms may be overlooked or misunderstood; therefore, they are not receiving the recommended medical care that has been proven to prevent diabetes complications. A comprehensive primary care system would perform the needed diagnoses and provide follow-up care.

An alarming recent trend is the increased number of children and adolescents, especially from minority populations, who have been diagnosed with diabetes. The Federal Centers for Disease Control and Prevention has recently predicted that one out of every three children born in the United States will develop diabetes in their lifetime. For Hispanic/Latinos, the forecast is even more alarming: one in every two.[36]

There are two main types of diabetes. Type 1, which is not preventable, most often appears during childhood and adolescence. People with Type 1 diabetes must take insulin every day to survive. Type 2 diabetes, which is linked to obesity and physical inactivity, accounts for 90%-95% of diabetes cases and most often appears in people older than 40 years of age. Type 2 diabetes can be controlled with medications and lifestyle changes, including eating healthy foods and being physically active. Conditions that exacerbate Type 2 diabetes, such as high blood sugar levels, high blood pressure, and low-density lipoprotein levels, also can be controlled with medications and lifestyle changes. Primary care can help diabetics control these conditions by working with them to alter their lifestyle and obtain the care and medications they need, and teaching them to self-manage and monitor their conditions.

C. Asthma

Goal: By 2015, lower the percentage of people who have asthma to 5% of the population from its current level of 8% in both counties. An estimated 7,100 adults and 1,750 children suffer from asthma. Reaching the 2015 goal would lower this number to 4,440 adults and 1,110 children.

Asthma affects more than 8,800 adults and children in the two counties. It is a chronic disease of the lungs and occurs at any age, but is more common in youth. Asthma is the leading chronic illness among children today; nationally, nearly 1 in 13 school-age children has asthma, and the rate in NYS is slightly higher. It has emerged as a significant chronic disease over the past 25 years and continues to be a major health problem in the U.S.

The estimated annual health care costs of asthma are about $4 million. Asthma causes lost school days for children and lost work days for adults. Although there is no cure for this health condition, asthma attacks can be prevented or controlled with proper primary and preventive care.

D. Chronic Joint Pain, Arthritis, and Osteoporosis

Goal: By 2015, lower to 33% the proportion of adults with chronic joint pain from 53% in Columbia County and 43% in Greene County. Nearly 43,000 people suffer from chronic joint pain. Achieving our goal of 33% would lower the number to about 29,000 people.

Goal: By 2015, lower to 28% the proportion of adults with arthritis and other rheumatic conditions from 32% in Columbia County and 34% in Greene County. An estimated 29,000 people have arthritis or some other rheumatic condition (this group is a subset of people with chronic joint pain). Achieving our goal of 28% would lower the number to about 25,000 people.

One of the biggest causes of chronic joint pain is arthritis, which is a leading cause of disability, affecting sufferers both at the worksite and at home. One-third of adults have a doctor-diagnosed case of arthritis. Nearly 60% of persons with arthritis are of working age, and they have a low rate of labor-force participation; arthritis trails only heart disease as a cause of work disability. Arthritis has a sizable economic impact, costing us more than $32 million per year in health care. It is the source of many visits to health care providers and causes a high number of hospitalizations per year.

Many people with arthritis do not think anything can be done to help them. They do not seek medical attention because they believe arthritis is simply part of the aging process. However, there are many strategies that can be pursued to prevent arthritis such as good nutrition and moderate physical activity to maintain a healthy body weight. For those living with arthritis, proper diagnosis by a primary care provider is a key component of effective treatment. Fundamental interventions also include good nutrition, moderate physical activity, medications that reduce pain and inflammation, heat or cold therapies, and the use of splints or braces.

Approximately 4,000 women and men age 50 and over have osteoporosis and many more are at significant risk of developing the condition.[37] Osteoporosis causes bones to become thin and weak; thus, the major health consequence of osteoporosis is an increased risk of fractures. One in three women and one in eight men aged 50 years and older will experience an osteoporotic-related fracture in their lifetime. Primary care can help prevent osteoporosis, and help patients who do have the disease to manage it.

Chronic back conditions are both common and debilitating: 70%-85% of people have back pain at some point in their lives.[38] In the United States, back pain is the most frequent cause of activity limitation in people under age 45, the second most frequent reason for physician visits, the third most common reason for surgical procedures, and the fifth-ranking reason for hospitalization.[39] A primary care system can be used to teach people how to avoid actions causing chronic back pain and help others to better manage it.

E. Dental Health

Goal: By 2015, lower the percentage of children ages 6-17 who have dental caries to 42% from its current level of 61% in Columbia County and 45% in Greene. Approximately 8,400 children in this age group have dental caries. Achieving our goal of 42% would lower the number of cases to about 6,500.

Goal: By 2015, lower the percentage of children ages 6-8 who have untreated dental caries to 21% from its current level of 44% in Columbia County and 33% in Greene. If one applies this same percentage to children ages 6-17, then approximately 6,150 children in this age group have untreated dental caries. Achieving our goal of 21% would lower the number of cases to about 3,300.

Tooth decay, gum infections, and orthodontic problems affect a large proportion of people. More than half of children experience tooth decay by third grade. Applying this percentage to children ages 6-17 could mean that as many as 8,400 have had tooth decay. More than a third of children ages 6-8 have untreated dental caries, which could mean over 6,000 children ages 6-17 have untreated tooth decay. About 70% of adults – about 61,000 people – have lost one or more teeth due to tooth decay or gum diseases.[40]

Dental caries is one of the most prevalent chronic illnesses among children. In the United States, 30% of all children's health expenditures are devoted to dental care. [41] Although most dental diseases are preventable, many children suffer the consequences of dental disease because of inadequate access to dental services.

Tooth decay and advanced gum disease lead to loss of teeth if not treated in a timely manner. Loss of one's teeth reduces daily functioning in terms of chewing and speaking and also reduces self-esteem and one's quality of life. Low-grade chronic infections in the mouth have been linked to illnesses such as cardiovascular disease, respiratory ailments, and adverse pregnancy outcomes. Persons with diabetes are also at increased risk for periodontal infections. About 5% of overall health care expenditures are for dental services.

F. Maternal And Infant Health

Goal: By 2015, increase the percentage of women who receive prenatal care in the first trimester to at least 90% from 73% in Columbia County and 75% in Greene County.

About 1,300 women give birth every year in the two counties. About 25% of pregnant women (about 335) don't receive early prenatal care, including three major components: risk assessment, education, and treatment for medical conditions or risk reduction. Each component helps reduce perinatal illness, disability, and death by identifying and mitigating potential risks and helping women to address behavioral factors such as smoking and alcohol use. Prenatal care should begin early and continue throughout pregnancy; the American College of Obstetricians and Gynecologists recommends that women receive at least 13 prenatal visits during a pregnancy.

NEXT STEPS

We will be working over the next several years to implement the recommendations contained in this report. One of the first steps is to build upon the positive, collaborative working relationship that this project created among those organizations and individuals in the community who are committed to improving access to preventive and primary care. The report provides this "Collaborative" an excellent guide for priorities for implementation, and it also describes the general actions that should be taken jointly and individually to achieve those priorities.

The Consortium will arrange for meetings of the multiple organizations and health care agencies in our two counties that have a stake in implementing the Report's priority recommendations. The purpose of the meetings will be to determine which entities should take the leadership for the various recommendations, develop specific steps for implementation, develop paths to collaboration, determine how to acquire the necessary resources, and create a schedule for completion. Periodic meetings will be held to share progress reports and institute mid-course corrections where indicated. As the top priorities are realized, this collaborative group of organizations will begin to implement additional actions to achieve the other goals in the Report.

The "Collaborative" will also periodically analyze data and determine when new priorities should be adopted. These analyses will incorporate the community health assessments conducted by the two public health agencies, the mental health centers, and Columbia Memorial Hospital. Data collection will also include a periodic Household Survey; a survey of businesses, health care providers and government officials; and, a limited number of focus groups. These data will be used not only for identifying emerging priorities and assessing success, but will also be given to local organizations for their own internal purposes, including grant applications.

We envision a future where the people of Columbia and Greene Counties experience better health and therefore a higher quality of life.

TASK FORCE MEMBERS

The Columbia County Community Healthcare Consortium created and coordinated the work of the Task Force. Its size was small enough to ensure that the workload was manageable and could be completed on time yet large enough to reflect the range of interests and perspectives in our counties. The Task Force had 13 members who were selected on the basis of the populations they serve and their relationship to preventive and primary care. The Task Force was the decision-making body for assessing preventive and primary care needs, identifying priorities and making recommendations.

Norman A. Chapin, MD, MBA
Medical Director
Columbia Memorial Hospital

Mark Evans
Vice President
State Telephone Company

Margaret M. Graham
Director
Greene County Mental Health Center

Kary Jablonka
Administrator
Columbia County Office for the Aging

Margaret S. Kennedy
Columbia County Department of Human Services

Paul Mossman
Commissioner
Columbia County Department of Social Services

Florence Ohle
Executive Director
Community Action of Greene County, Inc.

Marie Ostoyich
Director
Greene County Public Health Nursing service

Kira Pospesel
Commissioner
Greene County Department of Social Services

Robert Schneider, MD
Tannersville, NY

Nancy A. Winch
Director
Columbia County Department of Public Health

Thomas Yandeau
Director
Greene County Department for the Aging

Capital District Physicians Health Plan
(served the first half of the project)

PROCESS FOR PUBLIC INPUT

The recommendations were developed within the context of an extensive public process to ensure that the ones ultimately submitted to the State Department of Health reflected local concerns, creativity, and support. Our public process included multiple points of input – the Task Force; the involvement of two advisory groups; surveys of households, businesses, local officials and health care providers; and focus groups. Given the thoroughness of this public process, we feel that our priorities and recommendations accurately reflect public attitudes and support, and therefore are particularly meaningful and useful to policy-makers.

Community Advisory Group

Greene County Rural Health Network

20 members

Community Advisory Group

Columbia County Healthcare Consortium

34 members

Columbia/Greene Task Force on Access to Preventative and Primary Care

Columbia Co DoH	Greene Co PHNS	Primary Care Physician
Columbia Co DSS	Greene Co DSS	Business
Columbia Co MHC	Greene Co MHC	Columbia Memorial Hospital
Columbia Co OFA	Greene Co OFA	Consumer
		Payer

Six Focus Groups

Consumer Group – Columbia County
Consumer Group – Greene County
Primary Care Physicians – Columbia County
Primary Care Physicians – Greene County
Businesses – Columbia County
Businesses – Greene County

Surveys

Survey of 1,200 Households
Survey of Businesses
Survey of Local Officials
Survey of Health Care Providers

Give us your comments, ideas, suggestions...
CLICK HERE

REFERENCES

[1] Expenditure data are trended to 2010 from information published in "New York Personal Health Care Expenditures, All Payers, State of Residence, 1991-2004," Office of the Actuary, Federal Centers for Medicare and Medicaid Services. County-specific costs were extrapolated by applying the two counties' percentage of NYS population (.00569 of the State's population) to NYS costs and then adjusting for cost-of-living differences.

[2] Ibid. Annual trend factor is 6.2%, which is based on the CMS tables 1991-2004.

[3] American College of Physicians. "How Is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care? A Comprehensive Evidence Review." 2008.

[4] New York State Department of Health. Press Release. State Health Commissioner Daines Kicks Off Public Health Week. March 30, 2007.

[5] Rosenbaum S, Hin P. "Laying the Foundation: Health System Reform in New York State and the Primary Care Imperative." June 2006.

[6] Brownlee S. "Overtreated. Why Too Much Medicine is Making Us Sicker and Poorer." 2007.

[7] Franks P, Fiscella K. "Primary care physicians and specialists as personal physicians. Health care expenditures and mortality experience." Journal of Family Practice 1998;47:105–9.

[8] Mahar M. "Money-driven medicine: the real reason health care costs so much." 2006.

[9] Mark DH, Gottlieb MS, Zellner BB, Chetty VK, Midtling JE. "Medicare costs in urban areas and the supply of primary care physicians." Journal of Family Practice 1996;43:33–9

[10] New York State Department of Health. "Statewide Planning and Research Cooperative System, Table 8. 2006 Annual Report."

[11] Billings J, Parikh N, Mijanovich T.. "Emergency Department Use in New York City: A Substitute for Primary Care?" Issue Brief. The Commonwealth Fund. November 2000.

[12] Cunningham P, May J. "Insured Americans Drive Surge in Emergency Department Visits." The Center for Studying Health System Change (funded by the Robert Wood Johnson Foundation). No. 70. October 2003.

[13] National Health Statistics, Reports. "Table 5. Percent distribution of emergency department visits, by immediacy with which patient should be seen." Number 7. August 2008. [Author's note: this table shows that about 32% of ED visits are either non-urgent (should be seen within 2-24 hours) or semi-urgent (1-2 hours)].

[14] Weinick, R, Billings J, Thorpe, J. "Ambulatory Care Sensitive Emergency Department Visits: A National Perspective." Proceedings of Academy Health Meeting, Nashville, Tn, June 2003.

[15] "New York Personal Health Care Expenditures, All Payers, 1991-2004." Office of the Actuary, Federal Centers for Medicare and Medicaid Services.

[16] Kaiser State Health Facts. "New York: Total Number of Retail Prescription Drugs Filled at Pharmacies, 2008."

[17] Federal Centers for Disease Control and Prevention. Health, United States, 2008. Table 97. "Selected prescription and nonprescription drugs recorded during physician office visits and hospital outpatient department visits: United States 1995-1996 and 2004-2005."

[18] Bundorf M, Royalty A, Baker L. "Health Care Cost Growth Among the Privately Insured." Health Affairs, 28, No.5 (2009). pp.1294-1304.

[19] Federal Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey. Table 2. "Prescription Medicines-Median and Mean Expenses per Person: United States, 2006."

[20] Partnership for Solutions, Johns Hopkins University. "Chronic Conditions: Making the Case for Ongoing Care. December 2008.

[21] National Health Statistics Report. "Percent distribution of office visits by selected co-morbid conditions, United States, 2006." Number 3. August 6, 2008.

[22] New York State Department of Health. "Priority Area: Tobacco Use. The Burden of Tobacco and Secondhand Smoke." 2008.

[23] Ibid.

[24] New York State Department of Health. Press Release. "State Health Commissioner Speaks Out After Oscars to End Smoking In Youth-Related Movies." February 23, 2009. [Author's Note: this press release stated that the cost was $8.2 billion statewide; this figure was trended to 2010 or $8.7 billion. County-specific costs then were extrapolated by applying the two counties' percentage of NYS population (.00569 of the State's population) to NYS total costs and adjusting for cost-of-living differences].

[25] "The Health Consequences of Exposure to Involuntary Smoke. A Report of the US Surgeon General." US Department of Health and Human Services. 2006

[26] Ibid.

[27] Finkelstein EA,Trogdon JG, Cohen JW, Dietz W. "Annual Medical Spending Attributable To Obesity: Payer-And-Service-Specific Estimates." Health Affairs, 28, no. 5 (2009). [Author's Note: the article cited a national expense of $147 billion for 2008; since NYS accounts for about 6.4% of US population, the NYS share would be, conservatively, about $9.5 billion for 2008 and $10.7 billion trended to 2010. County-specific costs then were extrapolated by applying the two counties' percentage of NYS population (.00569 of the State's population) to NYS total costs and adjusting for cost-of-living differences].

[28] New York State Department of Health. "The Burden of Cardiovascular Disease in NYS." BRFSS, (2007). P: 4.

[29] New York State Department of Health. "Cardiovascular Health in NYS."

[30] National Institute of Mental Health. "The Numbers Count: Mental Disorders in America." 2008.

[31] Federal Substance Abuse and Mental Health Services Administration. "Prevalence of Major Depressive Episode Among Adults." 2007.

[32] Federal Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health. 2004 and 2005." Figure 6.1.

[33] National Institute of Mental Health. Op.cit.

[34] The figure of $34 million was extrapolated from different sources. The National Cancer Institute estimates that national cancer treatment costs were $72 billion in 2002. Extrapolating this figure to NYS, the cost would be conservatively about or $4.6 billion using our population percentage of 6.4%. The figure of $4.6 billion was trended to 2010. County-specific costs then were extrapolated by applying the two counties' percentage of NYS population (.00569 of the State's population) to NYS total costs and adjusting for cost-of-living differences.

[35] National direct medical costs were $116 billion in 2007 according to the Federal CDC, National Diabetes Fact Sheet, 2007. Extrapolating this figure to NYS, the cost would be conservatively about $7.4 billion since NYS has 6.4% of national population. The figure of $7.4 billion was trended to 2010 or $8.9 billion. County-specific costs then were extrapolated by applying the two counties' percentage of NYS population (.00569 of the State's population) to NYS total costs and adjusting for cost-of-living differences

[36] Ibid.

[37] New York State Department of Health. "Osteoporosis Education a Priority in New York State."

[38] US Department of Health and Human Services. "Healthy People 2010. Chronic Back Pain." 2000.

[39] Ibid.

[40] Healthy People 2010. Section on Oral Health

[41] The Commonwealth Fund. "Aiming Higher: Results from a State Scorecard on Health System Performance/" 2007.

Give us your comments, ideas, suggestions...
CLICK HERE