Resolution Summary

Cervical cancer has the potential to be ended in this lifetime. Medical advancements establish a range of facts in regard to cervical cancer. Nearly all cases of this cancer are caused by infection with the human papillomavirus (HPV), a virus spread by skin-to-skin contact in the genital area. HPV often causes no symptoms and clears on its own, but persistent HPV infection can lead to cervical cancer.

A Pap test may detect early cell changes in a woman’s cervix which may lead to cervical cancer. Low-cost and free Pap tests are available in every state to eligible persons. Found early, cervical cancer is potentially curable. Yet, the American Cancer Society says 11,150 American women will be diagnosed with cervical cancer in 2007, and about 3,700 will die from it.

The U.S. Food and Drug Administration approved a vaccine for use in girls to help prevent against cervical cancer infection. States and territories have taken a myriad of approaches to the HPV vaccine, and other HPV vaccines which may become available. CSG passed a resolution in 2006 with a directive to support state efforts to raise awareness of the link between HPV and cervical cancer. The resolution further encouraged states to show leadership in developing and implementing programs to educate stakeholders on HPV, cervical cancer, and available preventive technologies.

The National Lieutenant Governors Association (NLGA), a CSG affiliate, developed an original educational brochure on cervical cancer. The brochure notes the connection between HPV and cervical cancer, encourages regular Pap tests, and educates on the availability of a vaccine. The goal is to pass the information through direct constituent education and earned press coverage. The brochure won an Addy award for design, a Women in Government Leadership Award, and is recognized as one of the nation’s six best association public service efforts this year. As directed by the previous resolution, CSG recognizes and supports NLGA’s ‘Ending Cervical Cancer in our Lifetime.’

Additional Resource Information

National Lieutenant Governors Association [http://www.nlga.us/web-content/Projects/End_Cerv_Cancer_Main.htm](http://www.nlga.us/web-content/Projects/End_Cerv_Cancer_Main.htm)

Women in Government [www.womeningovernment.org](http://www.womeningovernment.org)

Management Directives

Management Directive #1: CSG will support its affiliate, NLGA, in this effort, and shall, in this campaign and other such efforts, encourage multi-branch efforts in regard to cervical cancer efforts

Management Directive #2: CSG staff will post this resolution to its Web site, and will continue to publish information about this campaign in CSG outlets
WHEREAS, cervical cancer is a nearly preventable disease, yet 11,150 American women are expected to be diagnosed with cervical cancer in 2007 and about 3,700 will die from it, according to the American Cancer Society, and

WHEREAS, cervical cancer is the second most common form of cancer found in women and it may be curable if found at an early stage, and

WHEREAS, a virus called human papillomavirus (HPV) causes 99.7 percent of all cervical cancer cases and whereas nearly all sexually active adults will be infected with HPV at some point in their life since HPV is spread by skin to skin contact in the genital area, according to the Association of Reproductive Health Professionals, and

WHEREAS, HPV causes no symptoms and usually goes away on its own, however, high-risk HPV which stays in the body a period of years can cause cervical cancer, and

WHEREAS, a Pap test, a simple, painless test done in minutes in a doctor’s office or clinic, may detect abnormal cells in the cervix caused by HPV which precede cervical cancer, and

WHEREAS, cervical cancer can be prevented or cured by removing the abnormal cells before they become cancerous and whereas, often, there are no early symptoms so women should have Pap tests done regularly, and

WHEREAS, according to the American Cancer Society, cervical cancer affects women in every demographic, with the incidence and mortality rate of cervical cancer highest among African American and Hispanic women, and with more than half the women who now develop cervical cancer having either rarely or never had a Pap test, and

WHEREAS, if a woman thinks she cannot afford a Pap test, she should call the Centers for Disease Control and Prevention (CDC) at 800-CDC-INFO (232-4636) where she will be connected with a program in her state providing free or low-cost Pap testing to low-income, uninsured, and underserved women, and

WHEREAS, The Council of State Governments 2006 Resolution on Adult Preventive Health Care Services resolved to encourage leaders to become champions in the arena of disease prevention policy and wellness, and

WHEREAS, The Council of State Governments 2006 Resolution on Cervical Cancer directed CSG to support state efforts to develop and implement educational campaigns on cervical cancer, and
WHEREAS, the nation’s “seconds-in-command” through the National Lieutenant Governors Association (NLGA) ‘Ending Cervical Cancer in our Lifetime’ campaign are now distributing information about HPV, cervical cancer, abstinence, the availability of Pap smears, and the availability of a HPV vaccine to people so they make the connection between the virus and the cancer and make informed decisions on their health, and

WHEREAS, NLGA is an affiliate of CSG, and

WHEREAS, this campaign is reaching 16 states and territories to date, and

WHEREAS, the well-designed, comprehensive and wholly educational nature of this original campaign has received recognition from the American Society of Association Executives (ASAE), Women in Government (WIG), and the Advertising Club,

NOW BE IT THEREFORE RESOLVED, The Council of State Governments supports the NLGA effort and the ‘Ending Cervical Cancer in our Lifetime’ campaign, and

BE IT FURTHER RESOLVED, that state officials support comprehensive education on the established facts regarding cervical cancer including abstinence, Pap testing and its availability, and the availability of a HPV vaccine, and that this support may be in the form of personal initiative, legislative, budgetary or executive authority, and

BE IT FURTHER RESOLVED, CSG will establish a Web link to the NLGA educational web site on the topic via this resolution, and

BE IT FURTHER RESOLVED, CSG will encourage multi-branch opportunities for education, and

BE IT FURTHER RESOLVED, we can end cervical cancer in our lifetime. Pass the information on to someone you know and help save a life.

Adopted this 14th Day of November, 2007 at the CSG Annual State Trends and Leadership Forum in Oklahoma City, Oklahoma

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Governor Brad Henry     Representative Deborah Hudson
2007 CSG President     2007 CSG Chair
Resolution Summary

Consent decrees are binding, legal decrees that specify how a particular problem will be remedied. These decrees are used to enforce agreements between state and local governments and the parties suing them. There are federal consent decrees in force in all 50 states.

Unfortunately, consent decrees can burden state and local governments, and have the potential to be a national problem as well. Consent decrees can remain in place for decades. These decisions linger long after the officials who agreed to these decisions have left office. Newly elected officials often find themselves in precarious positions because they cannot effect change as much as they would like because they are bound by the decisions of decades old consent decrees. For example, in Tennessee, hundreds of thousands of residents had their health insurance limited or cut altogether because of a series of consent decrees that prevented the state from implementing Medicaid reforms. These reforms had been approved by the governor and the legislature. In Los Angeles, consent decrees forced the Los Angeles County Metropolitan Transit Authority to spend 47 percent of its budget on buses. In New York City, special education has been governed by a consent decree since 1979, which has prevent efforts by several mayors and school chancellors to implement new reforms under the Individual with Disabilities Education Act.

The Federal Consent Decree Fairness Act (FCDA), sponsored by Senator Lamar Alexander, seeks to provide a three-pronged approach to address the issues surrounding consent decrees. The FCDA seeks to create a four year term limit for consent decrees after the state/local official who provided consent leaves office, a state or local government could ask a federal court to modify or vacate the decree. Second, the FCDA shifts the burden of proof to the plaintiff, who filed the original lawsuit, to demonstrate why continuation of the consent decree in its existing form is necessary to protect a federal right. Third, the FCDA provides guidance for future consent decrees by setting out a series of findings to guide federal courts when drafting decrees to provide that they are narrowly drafted, limited in duration and respectful of state/local policy interests and concerns.

Additional Resource Information


*Legal Times*, “Free the People’s Choice,” April 4, 2005
Management Directives

Management Directive #1: Support state efforts to raise awareness on the effect of consent decrees and to increase support for the Federal Consent Decree Act.

Management Directive #2: CSG staff will post approved resolution on CSG’s Web site and make available through its regular communication venues at the state and local level to ensure its distribution to the state government and policy community.
THE COUNCIL OF STATE GOVERNMENTS
RESOLUTION ON SUPPORTING THE FEDERAL CONSENT DECREE FAIRNESS ACT

WHEREAS, consent decrees are important instruments of federalism that place checks on the power of state and local governments; and

WHEREAS, newly elected officials inherit the effect of decades old consent decrees which limit their ability to effectively govern; and

WHEREAS, existing methods discourage state and local elected officials from modifying or terminating a consent decree, even when these decisions are no longer in the best interests of the community; and

WHEREAS, in a recent example, reforms to Tennessee’s Medicaid program were blocked in federal court because they were not in agreement with consent decrees dating back to 1979; and

WHEREAS, in another example, efforts to implement new reforms in special education in New York City were hampered by the effects of a consent decree in 1979; and

WHEREAS, consent decrees forced the Los Angeles Metropolitan Transit Authority to spend 47 percent of its budget on buses, leaving just over half the budget to pay for the county’s remaining transportation needs; and

WHEREAS, in Frew v. Hawkins, 540 U.S. 431 (2004), the Supreme Court expressed its concern about consent decrees and stated that consent decrees may “improperly deprive future officials of their designated legislative and executive powers,” which would lead to “federal court oversight of state programs for long periods of time event absent ongoing violation of federal law.”; and

WHEREAS, the Federal Consent Decree Act addresses the inherent weaknesses of the consent decree system while still preserving consent decrees as a mechanism for resolving legal disputes; and

WHEREAS, the Federal Consent Decree Act addresses these issues by (1) allowing a state or local government official to file a motion in federal court to modify or vacate a consent decree after four years or after the state or local official who provided the consent decree leaves office, whichever occurs first; (2) allowing the burden of proof to be shifted to the plaintiffs to show why after a motion to modify or vacate a consent decree has been filed; (3) setting out a series of findings based on the decision in Frew to provide guidance to federal courts to ensure that for future consent decrees are
narrowly drafted, limited in duration and maintain state and local interests; and

**BE IT THEREFORE RESOLVED,** that The Council of State Governments supports the principles espoused in the Federal Consent Decree Act; and

**BE IT FURTHER RESOLVED,** that Congress should enact the Federal Consent Decree Fairness Act.

Adopted this 14th Day of November, 2007 at the CSG Annual State Trends and Leadership Forum in Oklahoma City, Oklahoma

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Governor Brad Henry     Representative Deborah Hudson
2007 CSG President     2007 CSG Chair
THE COUNCIL OF STATE GOVERNMENTS
RESOLUTION IN SUPPORT OF THE REAUTHORIZATION OF THE
JUVENILE JUSTICE AND DELINQUENCY PREVENTION ACT

Resolution Summary

The Juvenile Justice and Delinquency Prevention Act (JJDPA) of 1974, as amended [42 U.S.C. 5601], was adopted by the U.S. Congress in order to establish a comprehensive nationwide program of juvenile delinquency prevention, offender rehabilitation and juvenile justice system improvements.

The JJDPA revolutionized how juveniles in within the justice system were managed. Juveniles were no longer to be put in jails or prisons with adult offenders, as well as recognizing the disproportionate numbers of minorities involved in the court system and asking states to monitor the occurrence. The JJDPA asked states to create governor-appointed State Advisory Groups to review current state policy and to create juvenile justice plans and prevention programs to effectively address the concerns of children involved in the justice system. The JJDPA further created federal funding to advance these goals and improve the juvenile justice system and established the Office of Juvenile Justice and Delinquency Prevention (OJJDP), which is dedicated to training, technical assistance, model programs, and research and evaluation to support state and local juvenile justice and delinquency prevention efforts.

Juvenile arrests reached an all time high in 1994, but have continued to decline since that year, with a record low in 2004. Despite this trend, over 1.4 million children under the age of 18 were arrested in 2005. Juvenile courts handle an estimated 1.6 million delinquency cases and adjudicate youth delinquent in nearly seven out of 10 cases each year. These numbers are still too high.

The JJDPA is due for reauthorization during the 110th Congress in 2007. Without reauthorization, funding for juvenile justice and delinquency prevention programs will be withdrawn- resulting in a widespread negative impact on juvenile justice and prevention programs, and the positive progress they have achieved thus far.

This resolution is meant to express The Council of State Government’s support of the reauthorization of the Juvenile Justice and Delinquency Prevention Act, and to encourage discussion with legislators pertaining to any potential changes to improve the success of the JJDPA.
**Resolution in Support of the Reauthorization of the**
**Juvenile Justice and Delinquency Prevention Act**

Management Directive #1: Support federal reauthorization of the Juvenile Justice and Delinquency Prevention Act, which has contributed to a record reduction in juvenile crime and delinquency rates nationwide.

Management Directive #2: Support and encourage the continued protection of children and youth who become involved with the juvenile and criminal justice systems, and affirm and strengthen the federal-state partnership around juvenile justice and delinquency prevention so that the federal government and the states can more effectively prevent and reduce juvenile delinquency.

Management Directive #3: CSG staff will post approved resolution on CSG’s Web site and make available through its regular communication venues at the state and local level to ensure its distribution to the state government and policy community.
THE COUNCIL OF STATE GOVERNMENTS

Resolution Supporting the Reauthorization of the
Juvenile Justice and Delinquency Prevention Act

WHEREAS, for over 30 years, the Juvenile Justice and Delinquency Prevention Act (JJDPA) has been the primary law guiding federal efforts to support effective juvenile justice and delinquency prevention activities; and

WHEREAS, the JJDPA is due for reauthorization in 2007; and

WHEREAS, according to the U.S. Department of Justice, although the juvenile violent crime arrest rate in the United States has continued to decline since its peak in 1994, over 1.4 million children under age 18 were arrested in 2005; and

WHEREAS, more than 200,000 youth are prosecuted in adult courts each year; and

WHEREAS, 49 percent of youth transferred to adult courts were rearrested, compared to 37 percent of those retained in the juvenile justice system. Nearly twice as many transferred youth were rearrested for more serious offenses; and

WHEREAS, there is a well established link between the maltreatment of children and future criminal activity and involvement with the juvenile justice system; and

WHEREAS, studies have shown that juveniles are more receptive to treatment, which results in lower re-offence rates; and

WHEREAS, the 2002 reauthorization of the JJDPA recognized that prevention initiatives, early intervention strategies, rehabilitation programs and multidisciplinary coordination are needed to reduce the juvenile crime rate; and

WHEREAS, reauthorization will strengthen the federal partnership with states to better implement the provisions of the JJDPA and keep youth out of the juvenile justice system; and

WHEREAS, if funding under this legislation is withdrawn, it will negatively impact the juvenile justice system at large and at risk youth.
BE IT THEREFORE RESOLVED that The Council of State Governments hereby endorses Congressional efforts to reauthorize the Juvenile Justice and Delinquency Prevention Act and to continue the important prevention and rehabilitation efforts it affords juveniles in the states.

Adopted this 14th Day of November, 2007 at the CSG Annual State Trends and Leadership Forum in Oklahoma City, Oklahoma

Governor Brad Henry  
2007 CSG President

Representative Deborah Hudson  
2007 CSG Chair
THE COUNCIL OF STATE GOVERNMENTS
RESOLUTION ON REAUTHORIZATION OF NO CHILD LEFT BEHIND

Resolution Summary

In 2002 President Bush signed into law the bipartisan, landmark No Child Left Behind (NCLB) Act. High academic standards and accountability for all students comprise the framework for federal education reform under the law. Achieving these objectives is important to the future of our children and our cities.

The No Child Left Behind (NCLB) Act established goals everyone supports: high standards and accountability for the learning of all children. But NCLB is falling short of its goals for many reasons. Now is the time to influence Congress as it considers changing the law.

Additional Resource Information


Council of Chief State School Officers: http://www.ccsso.org/federal_programs/NCLB/index.cfm

National Association of State Boards of Education: http://www.nasbe.org

National Education Association: http://www.nea.org/esea/index.html

Reauthorization of No Child Left Behind Management Directives

- **Management Directive #1**: Support efforts to recommend effective and efficient changes to NCLB so that all students learn at high levels and graduate with the skills necessary to be productive citizens.

- **Management Directive #2**: Create a sense of urgency for NCLB reauthorization to address the learning needs of all students and by fully funding the law so that schools can successfully implement its provisions.

- **Management Directive #3**: CSG staff will post approved resolution on CSG’s Web site and make available through its regular communication venues at the state and local level to ensure its distribution to the state government and policy community.
WHEREAS, implementing and adhering to the mandates of NCLB is proving to be a challenge and NCLB is in danger of becoming another burdensome under-funded federal mandate. Schools continue to struggle with funding, mandated annual testing, student transfers, and the requirement to provide supplemental services;

WHEREAS, schools need flexibility in implementing the standards of NCLB. A reauthorized NCLB should include a workable longitudinal or growth model as well as multiple sources of evidence to measure individual student academic achievement and school performance. There should also be greater flexibility in assessing and measuring the academic progress of students in subgroups, especially those groups facing unique learning challenges, most specifically special education students and English language learners;

WHEREAS, sufficient federal resources are needed to finance NCLB programs including full funding for Title I grants to school districts with a disproportionate number of at-risk students, the main funding source for NCLB; an increase in Title II for Teacher Quality Grants that provide funds to train, recruit, and retain highly qualified teachers; the 21st Century Community Learning Centers program that funds afterschool programs for NCLB and other programs in NCLB intended to increase the academic achievement of at-risk students;

WHEREAS, the Supplemental Education Services (SES) provision is a fundamental element of NCLB that provides disadvantaged students the extra academic help they need to meet the rigorous standards of NCLB. School districts are required to set aside 20 percent of their scarce federal Title I funds specifically for SES participation. Presently, only 17 percent of eligible students are participating in SES programs. School districts have been deficient in providing families the opportunities to participate in SES. A reauthorized NCLB should include provisions that would allow for all students who need extra help learning and achieving greater accessibility to Supplemental Education Services and provide a direct source of funding from the federal government for these services;

WHEREAS, NCLB provides for highly qualified teachers in core academic areas, but should focus on increasing flexibility for meeting the “highly qualified” teacher requirements, particularly for teachers of multiple subjects such as special education, bilingual, middle school, and rural educators, and advancing teacher quality at the highest poverty schools by providing funding to attract and retain quality teachers and improved teaching and learning conditions;

WHEREAS, NCLB should include a class size reduction program to improve student learning, with priority given to high poverty schools. Research has shown that reducing class sizes has a positive impact on maximizing student learning and closing achievement gaps, particularly in the early grades and students who need more individualized attention;
WHEREAS, NCLB should reinforce parental involvement programs and encourage community members to interact with neighborhood schools. Programs that encourage parent and community involvement in the school are vital in strengthening families and enhancing quality of life in our cities; and

WHEREAS, NCLB should support compensation systems that are designed to firmly establish teaching as a respected profession, improve student learning through improved teacher practice, and focus on factors shown to make a difference in teaching and learning - the skills, knowledge, and experience of classroom teachers.

BE IT THEREFORE RESOLVED, The Council of State Governments recognizes that to compete with their international peers, American students must graduate from high school with the academic foundation they will need to succeed in a 21st century economy. If implemented properly and funded, NCLB reforms will allow our kids to succeed and prosper; and

BE IT FURTHER RESOLVED, The Council of State Governments calls upon the federal education policymakers to work closely with state and local education officials during NCLB reauthorization to examine how NCLB is working in their communities and where improvements are needed, while maintaining a focus on accountability and standards. At the same time the federal government must live up to its commitment and provide the necessary financial resources to implement the mandates in NCLB by fully funding Title I programs to low-income school districts, Teacher Quality Grants, the 21st Century Community Learning Centers and other important programs under NCLB.

Adopted this 14th Day of November, 2007
at the CSG Annual State Trends and Leadership Forum
in Oklahoma City, Oklahoma.

Governor Brad Henry
2007 CSG President

Representative Deborah Hudson
2007 CSG Chair
THE COUNCIL OF STATE GOVERNMENTS
RESOLUTION ON THE PATIENT-CENTERED MEDICAL HOME

Resolution Summary

The Patient-Centered Medical Home (PCMH) is a health care delivery model designed to improve health, promote quality, and reduce the cost of health care that is centered primarily and explicitly on the needs of the patient. The PCMH is personalized care, access beyond the acute care episode, and integration of key medical and community resources to meet patient needs.

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for medical records of a child to be archived. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally sensitive care.

In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association—organizations dedicated to primary care representing more than 333,000 physician members—released the Joint Principles of the Patient-Centered Medical Home, with the following characteristics:

- **Relationship**: Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.

- **Team**: The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of the patients.

- **Comprehensive**: The personal physician is responsible for providing for all the patient’s health care needs at all stages of life or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute, chronic, mental health, preventative, and end of life.

- **Integration**: Care is coordinated and integrated across all domains of the health care system and the patients’ community. Care is facilitated by registries, information technology, and information exchange to assure that patients get the indicated care when and where they want it.

- **Quality and Safety**: Quality and Safety are hallmarks of the medical home. Through electronic medical records and technology providing decision-support physicians will be able to provide their patients with the most up-to-date evidence-based treatment options. This technology will facilitate physicians’ ability to participate in measurement and quality improvement activities at the practice and system level.

- **Access**: Enhanced access to care is available through systems such open scheduling, expanded hours, and new options for communication between patients, physicians, and practice staff.
• **Value:** Payment is aligned to appropriately recognize the added value provided to patients who have a PCMH.

**What does the PCMH look like?**

Primary care is a complex set of tasks managed by a multidisciplinary team. This team works together to create high quality, personalized, integrated, comprehensive, accessible care that is safe and affordable.

The PCMH takes this care to a more personal level. For example, PCMH practices will ensure multiple access points for patients. Open scheduling will allow walk-ins and same-day appointments. Interactive Web sites will allow patients to access test results, correspond with their care team, request prescription refills, schedule appointments, and access their medical record. Technology will move patient self management to exciting new levels by giving patients resources for disease management and health education.

It is understood that measurement is essential for quality improvement. Through the technology afforded in EHRs, prospective data collection becomes a reality providing the physician and payers with real-time quality measures for the purpose of benchmarking, improvement and payment. The PCMH will offer online consultations and group visits which create efficiencies that should lower the cost of care for most patients while affording physicians more time to provide the quality care their patients and payers deserve.

The North Carolina’s Medicaid program shows excellent quality and cost outcomes after adopting several components of the PCMH in their Community Care of North Carolina (CCNC) program. Through disease management payments, evidence-based clinical practice, and an emphasis on a team approach for case management they found significant improvements in cost, utilization, and quality measures. The program provides an additional per-member per-month case management fee, and an enhanced fee-for-service payment of 95 percent of the Medicare fee schedule for Medicaid covered services. Two major evaluations of this program estimated that the state saved $195 to $215 million in 2003 and between $230 million and $260 million in 2004 as compared to an alternative payment method (Wilson, C.F.). In recognition of this collaborative approach to meeting the health care needs of low-income children and families, the Ash Institute for Democratic Governance and Innovation at Harvard University’s John F. Kennedy School of Government presented the Community Care of North Carolina Program with the “Innovations in American Government Award” on Sept. 25, 2007.

The PCMH aims to deliver the high level of practice outlined by the Institute of Medicine in *Crossing the Quality Chasm*. Primary care physicians recognize that they must transform their practices to provide better value for payers and even better care for patients. Evidence-based public policy will help facilitate the transformation of their practices into PCMHs.
The Commonwealth Fund 2006 Health Care Quality Survey finds that when adults have health insurance coverage and a medical home—defined as a health care setting that provides patients with timely, well-organized care, and enhanced access to providers—racial and ethnic disparities in access and quality are reduced or even eliminated. When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially. The survey found that rates of cholesterol, breast cancer, and prostate screening are higher among adults who receive patient reminders, and that when minority patients have medical homes, they are just as likely as whites to receive these reminders. The results suggest that all providers should take steps to create medical homes for patients. Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes for all patients.

The United States health care system currently performs at a level considerably below its potential despite spending more on health care than any other nation. The United States does not have the best health care or the most effective health care system. Payers and patients alike are looking for better value in health care, desiring better quality of care for less cost. A recent study estimated that if every American had a medical home, health care costs would likely decrease by 5.6 percent, resulting in national savings of $67 billion dollars per year with improvement in the quality of the health care provided (Spann, S.J.).

With the enactment in 2006 of the Tax Relief and Health Care Act, CMS will implement a three-year medical home model demonstration project in eight states. The project recognizes the medical home provides guidance to both the patient and other health care professionals based on an integrated, coherent plan for ongoing medical care developed specific to the patient. The medical home model should result in improved coordination of care, better care management, a decrease in duplicative tests and avoidance of hospitalizations for all patients, but especially for those patients with one or more chronic conditions, thus resulting in health system savings.

Resources

American Academy of Family Physicians
http://www.futurefamilymed.org
American Academy of Pediatrics:
http://aappolicy.aappublications.org/policy_statement/index.dtl#M
American College of Physicians
http://www.acponline.org/advocacy/?hp
American Osteopathic Association
http://www.osteopathic.org


Rosser WW. Approach to diagnosis by primary care clinicians and specialists: is there a difference? *J Fam Pract.* Feb 1996;42(2):139-144.


Patient-Centered Medical Home Program Management Directives

Management Directive #1: CSG staff will prepare correspondence to Governors and legislative leadership in the states, District of Columbia and territories notifying them of the approved resolution and encouraging them to implement and fund pilot programs to demonstrate the quality, safety, value, and effectiveness of the patient-centered medical home.

Management Directive #2: CSG staff will post approved resolution on CSG’s Web site and make available through its regular communications venues CSG support of the Joint Principles of the Patient-Centered Medical Home as a guideline for states, the District of Columbia and territories to improve the health of its citizens.
WHEREAS, the patient-centered medical home provides a whole-person orientation that includes care for all stages of life, acute care, chronic care, preventive services, and end of life care; and

WHEREAS, patients in a patient-centered medical home actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met; and

WHEREAS, care in the patient-centered medical home is integrated across all elements of the health care system and the patients’ community to assure that patients received the indicated care when and where they need in a culturally and linguistically appropriate manner; and

WHEREAS, when minorities have a medical home, racial and ethnic differences in terms of medical access disappear as noted in “Closing the Divide: How Medical Homes Promote Equity in Health Care” as published by the Commonwealth Fund (June 2007); and

WHEREAS, four national physician organizations (AAP, AAFP, ACP, AOA) representing more than 333,000 physicians across the country have developed joint principles that describe the characteristics of the patient-centered medical home; and

WHEREAS, The National Committee for Quality Assurance is developing a patient-centered medical home designation program for physician practices meeting specific criteria; and

WHEREAS, a patient-centered medical home for every American has a potential national savings of $67 billion per year with improvement in the quality of health care provided; and

WHEREAS, the federal Tax Relief and Health Care Act calls for a three-year medical home demonstration project to be conducted in eight states with an estimated start in 2009;
BE IT THEREFORE RESOLVED, that the Council of State Governments support the Joint Principles of the Patient-Centered Medical Home as a guideline for states to improve the health of its citizens, and

BE IT FURTHER RESOLVED, that the Council of State Governments encourage states to implement and fund pilot programs to demonstrate the quality, safety, value, and effectiveness of the patient-centered medical home.

Adopted this 14th Day of November, 2007 at the CSG Annual State Trends and Leadership Forum in Oklahoma City, Oklahoma

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Governor Brad Henry               Representative Deborah Hudson
2007 CSG President                2007 CSG Chair
Resolution Summary

Climate change could create a variety of public health threats, according to the Centers for Disease Control and Prevention (CDC). Increasing global temperatures could lead to:

- Rising sea levels, flooding and more intense storms such as hurricanes that have the power to devastate communities, trigger public health emergencies, compromise mental health and, in the aftermath, potentially expose people to hazardous substances;
- The spread of vector-borne and infectious diseases, such as malaria and dengue; and
- More respiratory diseases, such as asthma, as air pollution worsens.

The CDC is developing an action plan to respond to the public health consequences of climate change. The CDC plan will contain recommendations for federal, state, and local actions. Components of the plan will include:

- Researching the full range of health threats posed by climate change;
- Increasing capacity to identify, monitor and model health risks, such as heat stress, vector-, food- and water-borne diseases, and other climate-related health effects;
- Implementing health promotion efforts to develop and enhance the preparedness of the public and of health care providers; and
- Working with state and local health departments and other partners as a credible resource on the public health effects of climate change.

States learned during the 9/11 crisis and after Hurricane Katrina the necessity of having emergency preparedness systems in place. Since these events, many states have undertaken strategic planning for emergency preparedness. As long as credible scientific evidence points to the possibility of health threats as a result of climate change, protecting the public requires preparing for these threats. Furthermore, there are a number of public policy strategies that could begin to address climate change that would offer co-benefits for health and the environment.

Additional Resource Information

CDC National Center for Environmental Health, upcoming action plan and other information
http://www.cdc.gov/ncceh

CDC site on environmental public health issues
http://www.atsdr.cdc.gov

U.S. Climate Change Science Program Web site information
http://www.climatescience.gov

CSG Healthy States Quarterly, Spring 2007
Public Health and Climate Change Management Directives
(Health Policy Task Force)

① Management Directive #1: Support state efforts to mitigate health impacts of climate change and to adopt strategies to address climate change that have co-benefits for health and the environment.

② Management Directive #2: CSG staff will post approved resolution on CSG’s Web site and make available through its regular communication venues at the state and local level to ensure its distribution to the state government and policy community.
WHEREAS, there is scientific evidence showing the earth’s atmospheric composition is changing, and as a result, the climate is changing;

WHEREAS, there may be climate change effects which could include heat waves, heavy precipitation events, air pollution, more variable weather, flooding, droughts and sea level rise;

WHEREAS, the effects of climate change may impact geographic regions, communities and neighborhoods differently;

WHEREAS, climate change may result in potential health impacts. These effects could be related to heat waves, injuries and death from catastrophic events, increased respiratory diseases from allergies and asthma, and increased risk of water-borne, food-borne and vector-borne disease;

WHEREAS, there are vulnerable populations which may be at greater risk for health consequences from climate change including the elderly, children, people of low socioeconomic status, racial minorities, people with some pre-existing health conditions and coastal area residents;

WHEREAS, health risks resulting from climate change can be mitigated through public health action taken at the federal, state, and local levels, and through collaboration with partners;

BE IT THEREFORE RESOLVED, that due to the potentially serious health impacts of climate change, The Council of State Governments urges state and local policymakers to consider policies and programs that support public health actions to prepare for and address health risks related to climate change.

BE IT FURTHER RESOLVED, that The Council of State Governments urges state and local policymakers to consider and adopt policies and programs that address the public health effects of climate change on vulnerable populations.

Adopted this 14th Day of November, 2007 at the CSG Annual State Trends and Leadership Forum in Oklahoma City, Oklahoma

Governor Brad Henry
2007 CSG President

Representative Deborah Hudson
2007 CSG Chair
THE COUNCIL OF STATE GOVERNMENTS  
RESOLUTION ON SMOKING CESSATION  

Resolution Summary  

Currently there are 45 million adults in the United States, representing over 20 percent of the population who smoke. Among those are more that 3.5 million who are high school students who smoke. It is alarming to note that it has been estimated that 1,000 individuals under the age of 18 begin smoking every day. Nationally, it has been estimated that smoking caused productivity losses of an estimated $97.6 billion annually.

The U.S. Centers for Disease Control and Prevention (CDC) noted that the nation’s leading cause of preventable death in tobacco use. Deaths attributable to cigarette smoking each year have included various conditions, including lung cancer (123,800 deaths), chronic lung disease (90,600 deaths), coronary heart disease (86,800 deaths), other cancers (34,700 deaths), stroke (17,400 deaths) and other diagnoses (84,600 deaths).

In 2004 it was estimated that the annual direct health care costs related to smoking reached approximately $98.6 billion. This amounted to an estimated average of $5.31 in direct medical expenses attributable to smoking for each pack of cigarettes sold in the United States. The Medicaid program covered 32 percent of these expenses or $31 billion in direct medical costs. During the same time period, it is estimated that the cost for treating smoking-related diseases were approximately $558 per Medicaid beneficiary and $3,716 per Medicaid smoker. In total, it is estimated that the annual state share of smoking-caused Medicaid payments was approximately $13.3 billion in 2004. Beyond the cost savings that may be achieved from smoking cessation, one analysis found that the benefits of quitting smoking can result in an average 7.1 years of life per quitter.

The CDC estimates that over 47 percent of smoking adults attempt to quit each year. They have further found that access to effective treatment options double the successful quit rate and has achieved reported quit rates of 25 to 33 percent.

This resolution seeks to encourage states to actively pursue efforts to promote smoking cessation, including the availability of coverage for smoking cessation treatments and programs.

Additional Resources


http://www.cdc.gov/tobacco/basic_information/00_pdfs/AAGTobacco2007.pdf

Warner KE, Mendez D, Smith DG. The financial implications of coverage of smoking cessation treatment by managed care organizations. Inquiry. 2004 (Spring);41:57-69.  
http://www.rwjf.org/pr/product.jsp?id=14760&topicid=1167
Smoking Cessation Management Directives

- **Management Directive #1**: Create a sense of urgency regarding the dangers of tobacco use and smoking.

- **Management Directive #2**: Initiate measures to educate health care practitioners and policymakers about the benefits of smoking cessation initiatives to the health of individuals, the state economy and government funded health care programs.

- **Management Directive #3**: CSG staff will post approved resolution on CSG’s Web site and make available through regular communication venues at the state and local level to ensure its distribution to the state government and policy community.
THE COUNCIL OF STATE GOVERNMENTS
Resolution on Smoking Cessation

WHEREAS, the U.S. Center for Disease Control and Prevention (CDC) has determined that tobacco use is the leading cause of preventable death in the United States with over 20 percent of the population considered to be active smokers;

WHEREAS, cigarette smoking related deaths each year have included been the result of various conditions, including lung cancer, chronic lung disease, coronary heart disease, other cancers, stroke and other conditions;

WHEREAS, an estimated 1,000 children under the age of 18 begin smoking every day;

WHEREAS, smoking has been shown to result in lost working productivity in the amount of $96.7 billion per year;

WHEREAS, related worker productivity losses account for $97.6 billion as a result of tobacco use account for

WHEREAS, in 2004 it was estimated that the annual direct health care costs related to smoking reached approximately $98.6 billion, with 32 percent of those expenses covered by the Medicaid program;

WHEREAS, beyond the cost savings that may be achieved from smoking cessation, it has been determined that the benefits of quitting smoking can result in an average 7.1 years of life per quitter;

WHEREAS, The CDC estimates that over 47 percent of smoking adults attempt to quit each year and that effective treatment options double the successful quit;

THEREFORE BE IT RESOLVED, that the Council of State Governments encourages states and the federal government to support smoking cessation initiatives and the coverage of smoking cessation therapies to assist individuals in their efforts to quit smoking while reducing the cost burden of the complications from tobacco use on the Medicaid program and the economy;
BE IT FURTHER RESOLVED, that the Council of State Governments urges state legislatures and state health officials to include the coverage of smoking cessation programs and treatments in their prevention and wellness initiatives with the goal of decreasing total health costs while improving the productivity of employees.

Adopted this 14\textsuperscript{th} Day of November, 2007 at the CSG Annual State Trends and Leadership Forum in Oklahoma City, Oklahoma

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\textit{Governor Brad Henry} \\
2007 CSG President \\
\textit{Representative Deborah Hudson} \\
2007 CSG Chair \end{flushright}