General Assembly **Amendment**

January Session, 2009 LCO No. **7835**

HB0660007835HR0

Offered by:
REP. CAFERO, 142nd Dist.
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To: Subst. House Bill No. **6600** File No. 920 Cal. No. 403

"AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (*Effective from passage*) On or before July 1, 2009, the Department of Public Health shall submit, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health, the state-wide health information technology plan developed pursuant to section 19a-25d of the general statutes.

Sec. 2. (NEW) (*Effective from passage*) (a) Not later than June 1, 2009, the Governor, in consultation with the speaker of the House of Representatives, the president pro tempore of the Senate, the chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to public

health, the Lieutenant Governor and the Commissioner of Public Health, shall designate an entity to serve, on and after July 1, 2009, as the lead health information exchange organization for the state. The designated entity shall, in consultation with the Department of Public Health, seek private and federal funds, including funds made available pursuant to the federal American Recovery and Reinvestment Act of 2009, for the initial development of a state-wide health information exchange. Any private or federal funds received by such entity may be used for the purpose of establishing health information technology pilot programs. Beginning on October 1, 2009, such entity shall submit, in accordance with the provisions of section 11-4a of the general statutes, quarterly reports to the joint standing committee of the General Assembly having cognizance of matters relating to public health and to the Department of Public Health on any private or federal funds received during the preceding quarter and, if applicable, how such funds have been expended. Such reports shall minimally include the total amount of funds and the source providing such funds.

(b) The entity designated, pursuant to subsection (a) of this section, as the lead health information exchange organization for the state shall: (1) Facilitate the implementation and periodic revisions of the health information technology plan after the plan is initially submitted in accordance with the provisions of section 1 of this act, including the implementation of an integrated state-wide electronic health information infrastructure for the sharing of electronic health information among health care facilities, health care professionals, public and private payors and patients, and (2) on or before February 1, 2010, and annually thereafter, report, in accordance with the provisions of section 11-4a of the general statutes, on the implementation of such plan to the joint standing committee of the General Assembly having cognizance of matters relating to public health. Such report shall include details concerning the status of the implementation of the health information technology plan, and may include recommended revisions to such plan, statutory changes

needed to facilitate the implementation of such plan and funding needed to effectuate such plan along with the proposed sources of such funding.

Sec. 3. (NEW) (*Effective from passage*) The entity designated, pursuant to subsection (a) of section 2 of this act, as the lead health information exchange organization for the state shall develop standards and protocols for privacy in the sharing of electronic health information. Such standards and protocols shall be no less stringent than the "Standards for Privacy of Individually Identifiable Health Information" established under the Health Insurance Portability and Accountability Act of 1996, (P.L. 104-191), as amended from time to time, and contained in 45 CFR 160, 164. Such standards and protocols shall require that individually identifiable health information be secure and that access to such information be traceable by an electronic audit trail.

Sec. 4. (NEW) (*Effective from passage*) (a) Not later than June 1, 2009, the Department of Public Health shall develop, in consultation with the Attorney General and within existing budgetary resources, conflict of interest policies that shall be applicable to the board of directors, employees and agents of the entity designated, pursuant to subsection (a) of section 2 of this act, as the lead health information exchange organization for the state.

(b) In carrying out the responsibilities prescribed under sections 2 and 3 of this act, the board of directors, employees and agents of such entity shall be subject to conflict of interest policies established by the Department of Public Health, pursuant to subsection (a) of this section, to ensure that deliberations and decisions are fair and equitable.

Sec. 5. (NEW) (*Effective July 1, 2011*) (a) There is hereby created as a body politic and corporate, constituting a public instrumentality and political subdivision of the state created for the performance of an essential public and governmental function, the Connecticut Health Care Cost Containment Authority which is empowered to carry out the purposes of the authority, as defined in subsection (b) of this

section, which are hereby determined to be public purposes for which public funds may be expended. The Connecticut Health Care Cost Containment Authority shall not be construed to be a department, institution or agency of the state.

(b) "Purposes of the authority" means the purposes of the authority expressed in and pursuant to this section, including with respect to the promotion, planning and designing, developing, assisting, acquiring, constructing, reconstructing, improving, maintaining and equipping and furnishing of health care, health care information technology and the health care delivery system and assisting directly or indirectly in the financing of the costs thereof.

(c) The Connecticut Health Care Cost Authority shall develop a community-based health care utility model that shall reform the delivery of health care services in the state and finance the procurement of the technology that is required for the implementation of a comprehensive chronic disease management program and a wellness and prevention program administered through use of medical homes. Such model shall: (1) Prioritize the use of medical homes to improve outcomes for those who are chronically ill; (2) place emphasis on the use of case management services, disease management and care coordination; (3) leverage federal dollars to the maximum extent permissible to establish a viable health information exchange throughout the state; (4) reduce reliance on emergency room care as a means of accessing health care; (5) promote preventive care and wellness programs; (6) promote shared decision making between health care providers and their patients; and (7) provide incentives to health care providers who demonstrate improved health outcomes for patients through implementation of the practices set forth in this subsection.

Sec. 6. (NEW) (*Effective July 1, 2011*) (a) As used in this section and section 7 of this act:

(1) "Shared decision making" means a process whereby a physician

or other health care provider discusses with a patient, or his or her representative, the information specified in this section with the use of a patient decision aid and such patient shares personal information with the health care provider for purposes of evaluating treatment options and possible side effects associated with such treatment options; and

(2) "Patient decision aid" means a written, audio-visual, or online tool that provides a balanced presentation of the health condition and treatment options, benefits and harms associated with such treatment options, including, if appropriate, a discussion of the limits of scientific knowledge about health outcomes. Any such patient decision aid shall be certified by one or more national certifying organizations.

(b) If a patient while legally competent, or his or her duly authorized legal representative if such patient is not competent, signs: (1) A consent form, prepared in language that the patient could reasonably be expected to understand that contains: (A) The nature and character of the proposed treatment; (B) the anticipated results of the proposed treatment; (C) the recognized possible alternative forms of treatment, including nontreatment; (D) the recognized serious possible risks, side effects and complications associated with such treatment; (E) anticipated benefits of such treatment; and (F) a statement that advises the patient of the actions that he or she should take should such patient experience any side effects or complications associated with such treatment; or (2) a statement that such patient has made an informed decision not to be apprised of the elements set forth in subdivision (1) of this subsection; then such signed consent form or signed statement of the patient's informed decision not to be apprised of treatment options shall constitute prima facie evidence that such patient provided informed consent to the health care provider for the treatment administered or alternatively made an informed decision not to be apprised about treatment options. The health care provider shall ensure that the patient is immediately provided with a copy of any statement signed pursuant to the provisions of this subsection. A patient who signs such consent form or statement indicating that such

patient has made an informed decision not to be apprised of treatment options shall have the burden of rebutting by a preponderance of the evidence that such consent was not in fact informed consent or that such informed decision not to be apprised of treatment options was not in fact an informed decision.

(c) If a patient while legally competent, or his or her representative if he or she is not competent, signs an acknowledgement of shared decision making, such acknowledgement shall constitute prima facie evidence that the patient gave his or her informed consent to the treatment administered and such patient shall have the burden of rebutting by clear and convincing evidence that such consent was not in fact informed consent. An acknowledgement of shared decision making shall include: (1) A statement that the patient, or his or her representative, and the health care provider have engaged in shared decision making as an alternative means of satisfying informed consent requirements by law or professional accreditation standards; (2) a brief description of the services that the patient and provider jointly have agreed will be furnished on the patient's behalf; (3) a brief description of the patient decision aid or aids that have been used by the patient and provider to address: (A) High-quality, up-to-date information about the patient's condition, including, treatment options, benefits and harms associated with such treatment options, and, if appropriate, a discussion of the limits of scientific knowledge about health outcomes; (B) values clarification that assists the patient in selecting treatment options that conform with the patient's values and preferences; and (C) guidance in the deliberative decision process, that is designed to improve the patient's involvement in such decision process; (4) a statement that the patient, or his or her representative, understands the risk or seriousness of the disease or condition to be prevented or treated, the available treatment alternatives, including nontreatment, and the risks, benefits and uncertainties of the treatment alternatives, including nontreatment; (5) a statement that advises the patient of the actions that he or she should take should such patient experience any side effects or complications associated with such

treatment; and (6) a statement certifying that the patient, or his or her representative, has had the opportunity to ask the provider questions and to have any questions answered to the patient's satisfaction, and that indicates the patient's intent to receive the identified services. A health care provider shall ensure that a patient who signs an acknowledgement of shared decision making is immediately provided with a copy of the signed document.

(d) A health care provider's failure to use a prescribed form shall not be admissible as evidence of failure to obtain informed consent. A health care provider's failure to engage in shared decision making, with or without the use of a patient decision aid, shall not be admissible as evidence of failure to obtain informed consent. There shall be no liability, civil or otherwise, resulting from a health care provider's choice to obtain informed consent by means of the signed consent form described in subsection (b) of this section or the signed acknowledgement of shared decision making described in subsection (c) of this section.

Sec. 7. (NEW) (*Effective July 1, 2011*) (a) The Department of Public Health, in collaboration with the State Comptroller, shall develop and implement a shared decision-making demonstration project. The demonstration project shall be conducted at one or more multispecialty group practice sites providing state purchased health care.

(b) The demonstration project shall include the following elements: (1) Incorporation into clinical practice of one or more patient decision aids for one or more identified preference-sensitive care areas combined with ongoing training and support of involved health care providers and practice teams, preferably at sites with necessary supportive health information technology; and (2) an evaluation of: (A) The impact of the use of shared decision making with patient decision aids, including the use of preference-sensitive health care services selected for the demonstration project and expenditures for those services; (B) the impact on patients, including patient understanding of

the treatment options presented and the affinity between patient values and the care received; and (C) patient and provider satisfaction with the shared decision-making process.

(c) As a condition of participating in the demonstration project, a participating practice site shall bear the cost of selecting, purchasing and incorporating the chosen patient decision aids into clinical practice.

(d) Not later than July 1, 2012, the Commissioner of Public Health shall report, in accordance with the provisions of section 11-4a of the general statutes, on the status of the demonstration project to the joint standing committee of the General Assembly having cognizance of matters relating to public health."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	New section
Sec. 4	*from passage*	New section
Sec. 5	*July 1, 2011*	New section
Sec. 6	*July 1, 2011*	New section
Sec. 7	*July 1, 2011*	New section