

PA 14-148

HB5386

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**CONNECTICUT
GENERAL ASSEMBLY
HOUSE**

**PROCEEDINGS
2014**

**VOL.57
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2370 - 2692**

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HOUSE OF REPRESENTATIVES

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April 25, 2014

Will the Clerk please call Calendar 73.

THE CLERK:

On Page 6, House Calendar 73, Favorable Report of the Joint Standing Committee on Public Health, Substitute House Bill 5386 AN ACT CONCERNING CARE COORDINATION FOR CHRONIC DISEASE.

SPEAKER SHARKEY:

Representative Johnson.

REP. JOHNSON (49th):

Thank you, Mr. Speaker. I move the Joint Committee's Favorable Report and passage of the bill.

SPEAKER SHARKEY:

The question is acceptance of the Joint Committee's Favorable Report and passage of the bill.

Will you remark madam?

REP. JOHNSON (49th):

Yes, Mr. Speaker. This is a strike-all amendment and will call LCO Number 4383.

SPEAKER SHARKEY:

And you seek leave of the Chamber to summarize?
Is that correct?

REP. JOHNSON (49th):

Yes, I'd like to, thank you, Mr. Speaker.

SPEAKER SHARKEY:

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Will the Clerk please call LCO 4383, which will be designated House Amendment "A".

THE CLERK:

House Amendment "A", LCO 4383 introduced by Representative Johnson, Representative Srinivasan, et al.

SPEAKER SHARKEY:

The gentlewoman has sought leave of the Chamber to summarize. Is there objection? Seeing none, you may proceed with summarization, madam.

REP. JOHNSON (49th):

Thank you, Mr. Speaker. This bill is a bill that has been a work that's been ongoing to make sure that the coordination of care for persons that have chronic diseases, that the people who have the highest expense and our Medicaid and Medicare and health insurance budgets actually have a way to reduce the incidents of chronic disease, improve chronic disease care coordination in the state for each type of healthcare facility, reduce the incidents and effects of chronic disease and this must be done in consultation with the Comptroller's office, representatives of hospitals and other healthcare facilities and local regional health departments.

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The plan must address cardio-vascular disease, cancer, stroke, chronic lung disease, Lupus, diabetes, arthritis and other chronic metabolic diseases, which also means arthritis. We want to improve chronic disease care and coordination in the state and reduce the incidents and effects of the chronic disease and improve outcomes and conditions associated with chronic disease in the state.

What this will do will show that the state has an interest in reducing the cost of chronic disease and making sure that these diseases actually have a way of not actually occurring in people, so it's preventative, but it's also a way to coordinate disease, make sure people take their medications, or have the best possible access to a coordinated medical home.

So this is a bill that will really help us in the long run and I move adoption. Thank you, Mr. Speaker.

SPEAKER SHARKEY:

Thank you, madam. The question before the Chamber is adoption of House Amendment "A". Will you remark? Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Mr. Speaker. The goal of this bill is

very laudable. Care coordination for chronic disease is critical, is important, and the result will be improving outcomes and ultimately reduce the cost.

So when we have a coordinated care model for our chronic diseases, the end result is what we're hoping for, a win-win situation where we have better outcomes on the one hand and we reduce the cost as well.

So I think, I'm hoping, that the Chamber will look at this favorably and pass this bill.

Through you, Mr. Speaker, I have just one question to the proponent of the bill. Line 6 in the amended bill talks about within available resources. So the fiscal note for this particular bill, there's no fiscal note at all because it is within the available resources. For my clarification, through you, Mr. Speaker.

SPEAKER SHARKEY:

Representative Johnson.

REP. JOHNSON (49th):

Thank you, Mr. Speaker, and I thank the good Ranking Member for his question. Within available resources at this point in time, we have something called the SIM grant from the federal government.

And so our reason actually in part of having this

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new Amendment has to do with making sure that this coordination of care was within the expectations of our grant to make sure that we coordinate care and this is something that we're doing in conjunction with the federal government.

So our resources are there and we're in compliance and consistent with those requests under the SIM grant, but also showing the state has an interest in making sure that we have good coordination of care beyond the SIM grant.

Through you, Mr. Speaker.

SPEAKER SHARKEY:

Representative Srinivasan.

REP. SRINIVASAN (31st):

So through you, Mr. Speaker, as I understand it then, the funding of this will be able, the SIM grant, and also the state has a stake because it is very interested within its available resources.

Through you, Mr. Speaker.

SPEAKER SHARKEY:

Representative Johnson.

REP. JOHNSON (49th):

That's correct and a very excellent point.

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Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Mr. Speaker. And I want to thank the Chairwoman for her answers. Thank you.

SPEAKER SHARKEY:

Thank you, sir. Would you care to remark? Would you care to remark further on the House Amendment "A". Excuse me. Representative Godfrey.

REP. GODFREY (110th):

Thank you, Mr. Speaker. As many of you already know, I was diagnosed with diabetes, actually it will be three years ago next, a week from Monday and in my senior statesperson role with the Council of State Governments, I've been active with their policy academies dealing with the issue of the chronic disease of diabetes.

I learned a lot more. I'm a member of a club I never applied for membership to. I learned a lot about it and through the Council of State Government we've been putting together a collaborative process throughout the states with a diabetes action plan and there's a number of states interestingly, Kentucky, and Texas and Illinois and Louisiana, New Jersey, New Carolina, North Dakota, Oregon and Washington that

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have already done this.

So we're joining a rather interesting group of people. And of course, though, this being Connecticut, we're not doing just diabetes, we're doing chronic diseases on steroids, if I can use that phrase to cover a lot of different things, to be able to cut through a lot of the silos that we have in state government and be able to move to help a lot of people and hopefully in the long term, save a lot of money in treating chronic diseases in a better, more proactive and much less expensive way.

I've been working on some of the details of this particular Amendment the last few days. I want to thank Doctor Srinivasan who was very, very helpful because certainly he gets the chronic disease part of it, but also the Lieutenant Governor's Office who's been very active on this issue.

So I also stand and urge my colleagues to adopt this Amendment and then support the bill.

Thank you, Mr. Speaker.

SPEAKER SHARKEY:

Thank you, sir. Would you care to remark? Would you care to remark further on House Amendment "A"?

Representative Johnson.

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REP. JOHNSON (49th):

Just to summarize, quickly. Thank you, Representative Godfrey and the Ranking Member, good Ranking Member Representative Srinivasan for their work and the co-sponsors as well.

Thank you, Mr. Speaker.

SPEAKER SHARKEY:

Thank you, madam. Would you care to remark further on House Amendment "A"?

If not, let me try your minds. All those in favor of House Amendment "A" please signify by saying aye.

REPRESENTATIVES:

Aye.

SPEAKER SHARKEY:

Those opposed, nay. The ayes have it. The Amendment is adopted.

Would you care to remark further on the bill as amended? Do you care to remark further on the bill as amended?

If not, staff and guests to the Well of the House. Members take your seats. The machine will be opened.

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The House of Representatives is voting by Roll.

The House of Representatives is voting by Roll.

Members please return to the Chamber immediately.

SPEAKER SHARKEY:

Have all the members voted? Have all the members voted? Members please check the board to make sure your vote is properly cast.

If all the members have voted, the machine will be locked and the Clerk will take a tally. The Clerk please announce the tally.

THE CLERK:

House Bill 5386 as amended by House "A".

Total number voting 130

Necessary for passage 66

Those voting Yea 130

Those voting Nay 0

Those absent and not voting 20

SPEAKER SHARKEY:

The bill as amended passes.

Will the Clerk please call Calendar 192.

THE CLERK:

Yes, Mr. Speaker, on Page 11, Calendar 192, Favorable Report of the Joint Standing Committee on Education, Substitute House Bill 5561 AN ACT

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003459

And Calendar 517, House Bill 5305, move to place on the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

And Calendar 512, House Bill 5386, move to place on the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Thank you, Madam President. Moving now to Calendar Page 20, where there are two items. The first, Calendar 527, House Bill 5592, move to place on the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

And the second, Calendar 528, House Bill 5453, move to place on the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Thank you, Madam President. Moving to Calendar Page 21 where there is a single item, Calendar 531, House Bill 5299, move to place on the Consent Calendar.

THE CHAIR:

So ordered, sir.

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Calendar 500, House Bill 5547.

On Page 18, Calendar 507, House Bill 5530.

On Page 19, Calendar 512, House Bill 5386.

Calendar 514, House Bill 5521.

Calendar 516, House Bill 5500.

Calendar 517, House Bill 5305.

On Page 20, Calendar 527, House Bill 5592.

Calendar 528, House Bill 5453.

On Page 21, Calendar 531, House Bill 5299.

Calendar 533, House Bill 5290.

On Page 22, Calendar 541, House Bill 5456.

Calendar 539, House Bill 5294.

On Page 24, Calendar 551, House Bill 5588.

Calendar 552, House Bill 5269.

On Page 25, Calendar 564, House Bill 5489.

Calendar 562, House Bill 5446.

(HB5466)

On Page 26 --

THE CHAIR:

Hold on. Okay. Sorry. Please proceed.

THE CLERK:

On Page 26, Calendar 568, House Bill 5434.

Calendar 569, House Bill 5040.

Calendar 566, House Bill 5535.

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SENATOR LOONEY:

If we might pause for just a moment to verify a couple of additional items.

Madam President, to verify an additional item, I believe it was placed on the Consent Calendar and Calendar Page 30, on Calendar Page 30, Calendar 592, Substitute for House Bill 5476.

THE CHAIR:

It is, sir.

SENATOR LOONEY:

It is on? Okay. Thank you. Thank you, Madam President. If the Clerk would now, finally, Agenda Number 4, Madam President, Agenda Number 4 one additional item ask for suspension to place up on Agenda Number 4 and that is, ask for suspension to place on the Consent Calendar an item from Agenda Number 4.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR LOONEY:

Thank you, Madam President, and that item is Substitute House Bill Number 5566 from Senate Agenda Number 4.

Thank you, Madam President. If the Clerk would now, if we might call for a vote on the Consent Calendar.

THE CHAIR:

Mr. Clerk. Will you please call for a Roll Call Vote on the Consent Calendar. The machine will be opened.

THE CLERK:

An immediate Roll Call has been ordered in the Senate.

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An immediate Roll Call on Consent Calendar Number 2 has been ordered in the Senate.

THE CHAIR:

If all members have voted, all members have voted, the machine will be closed. Mr. Clerk will you please call the tally.

THE CLERK:

Consent Calendar Number 2.

Total number voting	36
Necessary for adoption	19
Those voting Yea	36
Those voting Nay	0
Those absent and not voting	0

THE CHAIR:

The Consent Calendar passes. Senator Looney.

SENATOR LOONEY:

Thank you, Madam President. Two additional items to take up before the, our final vote on the implementer. If we might stand for just, for just a moment.

The first item to mark Go is, Calendar, to remove from the Consent Calendar, Calendar Page 22, Calendar 536, House Bill 5546. If that item might be marked Go.

And one additional item, Madam President, and that was from Calendar, or rather from Agenda Number 4, ask for suspension to take it up for purposes of marking it Go, that is House Bill, Substitute for House Bill 5417. Thank you, Madam President.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR LOONEY:

**JOINT
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SENATOR GERRATANA: Senator Fasano, thank you so much for coming and testifying also. I do appreciate it and you're right, we -- you and I have had many discussions on this issue and other issues surrounding health care in the state. I thank you so much for your input and also for your very considered remarks. I -- I very much appreciate that and hearing from you today. I look forward to working with you as we go forward with this big issue, it is. And I have been working on it for many months now, so I certainly understand. Thank you, sir.

SENATOR FASANO: Thank you, Senator.

REP. JOHNSON: Any additional questions?

Thank you so much for being here today.

SENATOR FASANO: Thank you so much for having me.

REP. JOHNSON: Next on the list is Representative Godfrey. Good morning.

REP. GODFREY: Good morning.

REP. JOHNSON: Thank you for being here, Representative.

REP. GODFREY: Representative Johnson and former Representative Gerratana, always a delight to be in a room with you. And I'm delighted to be here with the Public Health Committee tackling the care coordination for chronic disease, H.B. 5386, a continuing concern not only to Connecticut, but all the states. I'm Bob Godfrey from Danbury, Connecticut. I'm the Deputy Speaker of the Connecticut House of Representatives and I'm Past Chairman of the Council of State Governments (CSG) which was founded at the height of the Great Depression in 1933 and is the only national organization

composed of and serving all three branches of state governments. It's a regional-based forum that fosters the exchange of insights and ideas to help state officials shape public policy.

And as part of our work CSG has offered a series of policy academies focusing on issues its member states have been facing. There have been three that have dealt specifically with one of the most widespread of chronic diseases, diabetes. There are over 26 million people with diabetes in the United States, I'm one of them. Seven million of the 26 million don't know they have diabetes. And more alarmingly, one in three Americans, 35 percent, is pre-diabetic. Even more alarmingly, the American Diabetes Association estimates the total cost of diagnosed diabetes in 2012 was \$245 billion, that's pretty much the amount of money that the State of Connecticut could spend on everything we do over ten years. And that's up nearly 17 percent from \$174 billion in 2007.

So how -- how do the states deal with this? What will Connecticut do? Well, we need a plan. And through the Council of State Governments we've put together a diabetes action plan that would help ensure that Legislators and other policy makers are strategically taking steps toward reducing the prevalence of diabetes in their states. Kentucky and Texas passed such plans in 2011. Seven other states, Illinois, Louisiana, New Jersey, North Carolina, North Dakota, Oregon, and Washington, passed similar legislation in 2013:

The point of it is to create a collaborative process across state agencies. You know, we've all been around for a while. The state agencies tend sometimes to be silos, but when people are looking for help from government,

they're looking for something personally specific not something bureaucratically specific. And so we need to prepare ourselves as other states are doing for a diabetes action plan and the legislation. I've given -- I transmitted to you electronically some -- this testimony and some other things including a copy of the Kentucky bill which was the first one to do it. And -- and it's typical in that the legislation includes -- usually the agency that houses the Medicaid program, kind of a DSS, Department of Public Health, usually diabetes program staff there, and the agency responsible for state employee health benefits, the Comptroller Office I guess in Connecticut

And it requires that these agencies come together and develop a collaborative plan of action. It's not really the classic diabetes folks at the table necessarily because you can add to this -- I suppose it could become like one of our task forces here in Connecticut, providers you can bring in; non-profits, believe it or not the YMCA nationally and through the United States has a program for people that -- who are pre-diabetic or to prevent diabetes from happening, Connecticut is one of the states. I only learned this last December that the YMCA here in Connecticut has been doing that for quite some time.

And it's -- it's -- with so many people that -- that are -- are dealing with this, in Connecticut alone it's almost 295,000 people. Yeah, 295,000 people, that's over eight percent of our population. That's more people than any one of our big cities that -- that are facing the -- the disease that is diabetes. So I'm hoping that you can include in your approach to chronic care this most chronic of diseases that is facing people in the State of Connecticut, and that you can include in that something very

close to the diabetes action plan that brings together all of these agencies, all of the interests, to be able to deal with a comprehensive approach.

It's clearly humane in the first instance, not only to those of us with diabetes, but our families and our friends and loved ones, it could be a way of predicting and reducing -- reducing the high cost that diabetes brings to health care in both the general population and in state and municipal employees who participate in our health insurance plan. And it could also be a means by which the health care providers and the non-profits offer an evidence-based diabetes prevention program, joining with all the lead agencies in our state in a very widely based effort.

I encourage members of the staff who are in -- interested in much more information on how this has worked and where it's happened and the statistics and the people who are involved, by going to CSG's knowledge center which deals with diabetes in general and with the diabetes action plan more specifically. And I also transmitted to you testimony -- with my testimony a letter from Stewart Perry who is a past national chair of the American Diabetes Association, and like me, a person with Type II diabetes, advocating for Connecticut's adoption of a diabetes action plan. He has in there Connecticut-specific statistics and a more detailed description of the provision of the plan. I'm hoping he can come and visit us here in Connecticut in the next few weeks as soon as we can nail down a schedule. I'll assure that any of you who are interested in following up on this and meeting with him are invited.

And I want to acknowledge two pharmaceutical companies that have been of great help to the

Council of State Governments and me in a three-year effort on diabetes, Novo Nordisk, I'm sure you've seen or heard their commercials, and Danbury-based Boehringer-Ingelheim, both which have tasked themselves in solving the challenges of diabetes and chronic diseases. You'll hear from Boehringer-Ingelheim a little later in this hearing. And I applaud their work and cooperation. So this idea is hardly a new one. I know we've discussed it here in Connecticut for a couple of years. I've been a part of those discussions. But my hope is that this year we can enact a Connecticut diabetes action plan to serve the people of our state, bring costs under control, develop a comprehensive and inclusive approach to the treatment and prevention of diabetes. Thank you for your attention. I appreciate it.

REP. JOHNSON: Thank you so much for your testimony and taking the time to be here and also looking at the chronic disease legislation that we're proposing. Because I think that certainly diabetes is one of those chronic diseases that actually has long-term impacts on people's health whether it's an impact on their vision or their ability -- their kidneys or neuropathies that occur because of the -- the deadening pain that occurs in their feet. So there are a number of things that can be really severe illnesses that -- that occur because of unintended diabetes and the lack of knowledge that somebody might have diabetes or the lack of care that they give to the diabetes once they determine that they do have it. So it's -- it's something that is of great concern.

One thing that -- in my own family a number of Type II diabetics, so and realizing that's an inherited thing, I -- I went to work when I was a little younger and to make sure that my diet was consistent with a diabetic diet. So I work

hard at that. And I think that your comments are really, really appreciated, and I think it's something that we all need to take a look at.

So are there any questions?

Representative Srinivasan followed by Representative Sayers.

REP. SRINIVASAN: Thank you, Chair. Thank you very much, sir, for coming here for your testimony this morning. I appreciate that. (Inaudible) talking about doing a chronic care and then focused extensively on diabetes. So is this legislation looking at diabetes as a first step and establishing that in a chronic care model and then moving forward or looking at all of the various chronic diseases simultaneously?

REP. GODFREY: I think the expertise in individual diseases is -- are not necessarily all the same people. So when you're reaching into various state agencies, certainly when you're reaching into (inaudible). The YMCA has a diabetes program, it doesn't have a cancer program. And diabetes is probably second only to cancer in its impact on individuals throughout our state. And the thing about diabetes, you know, I was diagnosed almost three years ago. Representative Johnson, yeah, I've been through all of that. I'm not on insulin or anything, I do diet and I should be doing more exercise, but the schedule up here makes that kind of difficult, although running from room to room could almost count.

So it's -- it's -- I think unlike some of the other chronic diseases, the prevention part is especially -- we're especially able to do more concentration there. Because -- because as I've learned kind of the hard way and diabetes

runs in my family. I have a genetic predisposition for it, both sides, both the Irish and the Italian side of my family have extensive cases of Type II diabetes including my maternal grandmother who actually lost a limb to it back -- back in the 1950s, it's been that long. So with -- understanding how bureaucracies work and understanding that diabetes in particular is more ready to be dealt with in prevention than some of the other chronic diseases, you know, I'm asking for -- for that to be a focus and for allowing that to kind of percolate up and deal with -- deal with the disease and the people with it.

REP. SRINIVASAN: Thank you very much. Thank you, Chair.

REP. JOHNSON: Thank you, Representative.

Representative Sayers. ;

REP. SAYERS: Thank you, Representative Godfrey. I think this is a very important issue that you bring forward to us today. And I think it's very important. There's so many misconceptions about diabetes out there, so many people's lack of understanding. And even their focus on the diet, they think of sweets such as candy when, in fact, it's more around carbohydrates and a number of other types of foods that we eat. So -- and so much of our cost for care for elderly people revolve around the results of the problems they've had as a result of their diabetes and lack of -- and it's not that they don't receive appropriate treatment, but lack of knowledge with how to handle it and what to do. So I thank you very much. I think it's really important. And we have a number of Legislators that have diabetes that have advocated for this. And you in particular have stood out, so thank you very much.

REP. GODFREY: You're -- you're very welcome. And you're absolutely right, it's not -- it's not candy, it's bread and potatoes, you know. I'm Irish Italian, so I have potatoes on one side and pasta on the other, they're not as good for me as I would like them to be. My comfort foods are kind of verboten. String beans are good, but they're just not the same as marinara sauce, you know.

REP. SAYERS: It's never quite the same as having a good pasta.

REP. GODFREY: Yeah, I allow myself once a month I have a macaroni and cheese or something.

REP. JOHNSON: Any additional questions?

Representative Miller.

REP. MILLER: Thank you, Chair. And thank you, Representative Godfrey. Would you -- as far as prevention of diabetes goes, would you agree with some of the assessments that say that many Americans are -- we eat too much of the macronutrients, the fats, proteins, and carbs, and not enough of the micronutrients which we only get from fresh produce and fruit, raw nuts and seeds, things like that?

REP. GODFREY: I have learned that in the last three years and forced to make adjustments in my diet. Happily outside of bagels and mom's spaghetti, I haven't had to give up too much because, of course, you don't eliminate carbs, you just have to monitor them, you have to count them in order to -- because the whole idea of the treatment is to keep your blood sugar -- your blood glucose levels as steady as possible and avoid the spikes up and down. And, in fact, lack of the correct amount of

blood sugar is sometimes even worse than too much, and I've learned that over the last few years too.

So, you know, happily I do have to have some bread and I have to have some carbs, but I have to be very careful. And I've also gotten older, so I've come to appreciate the controlling my diet in a lot of other things. And since I'm not one who likes to take medication or supplements or that kind of thing, I'm very careful. But not everybody is as you've correctly observed, Representative Miller. And there does need to be more education.

I'm happy to see our school systems are moving much, much more toward explaining to very young kids that -- about their choices in what they eat. But there is still a long ways to go. 245,000 identified cases and, you know, if we look at the 26 -- 27 -- the 27 million in the United States that have diabetes, 7 million of which don't know, do the math. So there's a lot of people in Connecticut that don't -- don't know they have it. And then there's just another huge number of pre-diabetic people with pre-diabetic conditions that should learn before it's too late, you're absolutely right.

REP. MILLER: And if I may have another question, we've heard represented that it's -- it's often the challenge in a state like Connecticut that there are some places which are occasionally food deserts where there's so much of a preponderance of heavily-processed, sugar-rich foods that are available cheaply. And we can't always have access to really good fresh produce.

And with -- we've had some real considerations right now with the failure of the weather and

the -- and the extended drought in the central valley of California where a huge amount of our produce comes from, we're looking at, you know, increased prices over the next growing season. And when we've spoken with some of our farmers, they're anticipating growing a lot more as fortunately our farmer's markets and access to them is slowly improving year by year, but anything you can add to our ability to help that along?

REP. GODFREY: Absolutely. You've hit another couple of my hot buttons. I'm an urban Legislator. I know sometimes people forget that, but, you know, I represent the seventh largest city in the State of Connecticut, Danbury, and I represent the downtown part. And it's my constituents who not -- don't necessarily have the -- the means to get to the grocery stores, the supermarkets which are in the more suburban parts of Danbury. They're not in my district, they're in David's district, they're in Jan Giegler's district. And -- and that's a problem.

So they're going to, you know, the smaller shops, the convenience stores and they're buying, you know, junk food. They're buying the potato chips and they're buying the -- the cupcakes and the processed soup in a can which is just laden with salt. And so -- so there is a nutrition problem that is not about -- that's about access and education. And the thing is we can educate to our heart's content, but if the stuff isn't there for them to purchase, that's -- that's another issue that I think we -- that nationally we're wrestling with.

REP. MILLER: Well, thank -- thank you very much for your answers. And I appreciate that you're here today because this is a huge challenge for us, and if we can't turn this progression

towards higher rates of this, it's going to be really costly for us in the future. That's not too hard to figure out I guess.

REP. GODFREY: And -- and you're absolutely right, we can stop it if we take action. If we just let it go, it's just going to get more and more and more expensive.

REP. MILLER: All right. Thank you, Representative, and thank you, Chair.

REP. JOHNSON: Thank you so much.

Any additional questions?

Thank you so much for bringing this to our attention and we'll be interested in working with you on this so that we can make the adjustments.

REP. GODFREY: I look forward to it.

REP. JOHNSON: Thank you very, very much.

Commissioner Macy.

COMMISSIONER TERRENCE MACY: Good morning.

REP. JOHNSON: Welcome.

COMMISSIONER TERRENCE MACY: Thank you. Good morning, Representative Johnson and members of the Public Health Committee. I'm Terrence Macy, Commissioner of the Department of Developmental Services. With your permission, I'd like to run through our five bills and our comments on another couple bills. Compared to the levity of some of the issues that you address on an everyday basis, our issues are relatively minor.

#B5456
SB362

contract for a house and close in a week and then you would never get the 90 days or you could never to a closing and then you have provided information to the Attorney General. It would put in question all of the information he gets until the end of the year and whether it's accurate or not.

REP. JOHNSON: Very, very good point.

Are there any questions?

Well, thank you. Thank you so much and we're looking forward to working with you to iron out some of the language so that there will be, you know, a good way -- a good procedure that we have here but also we get the transparency that we need to make sure that health care access stays the same in Connecticut. So thank you for being here.

JAMES IACOBELLIS: Thank you.

REP. MILLER: Our next speak will be Sue Nesci followed by Marghie Giuliano and this is number 5386, House Bill.

SUSAN NESCI: Good afternoon. I'm Sue Nesci, I'm Vice President for Public Policy for the Arthritis Foundation here in New England, and I'm speaking on behalf of Raised Bill 5386, AN ACT CONCERNING CARE COORDINATION FOR CHRONIC DISEASES. We support this bill, we do have some concerns that it is primarily a data collection bill and we'd like to see it be more a care coordination bill. This is from the Arthritis Foundation, but the Committee also has a letter from either other voluntary health agencies suggesting three additions to the bill.

One, that the plan not be limited to just

hospitals and health care facilities, but include other organizations that do primary care. And that it also include some of the newer entities such as patient-centered homes and accountable care organizations because this is a focus of what they do. And third that it encourage medication management. The problem with many chronic diseases is that we just don't have one, I'm an example, I have three. And I brought this from our journal, why is the Arthritis Foundation concerned? I just happened to be reading this earlier in some of the earlier testimony, because one in four arthritis patients have heart disease, 16 percent have diabetes, and half have another chronic disease.

And what happens with multiple providers particularly multiple specialists is if care isn't coordinated, you can get medication interactions, you can get one doctor not talking to another. And what we'd like to do is see the State Health Department and the State Innovation Plan, and I have talked to Dr. Mark Schaefer, both collect data and look and see how well the state is doing on this care coordination. Because as Representative Godfrey said earlier it makes a huge difference. Sixteen percent of the people with diabetes also have arthritis.

And I would note too, you know, we're the -- arthritis is the leading cause of disability, but we don't get no respect. We're not even listed in this bill as a chronic disease. So that would be something we -- we'd like to see -- we'd like to see arthritis included. And that's basically what I'd like to say. If you have any questions, I'd be happy to answer them.

REP. MILLER: Thank you for your testimony.

Are there questions from the Committee?

Yes, Representative Klarides.

REP. KLARIDES: Thank you, Mr. Chair. Welcome. Thank you for coming today. Besides having arthritis put in here, do you agree with the rest of -- of the bill the way it was written?

SUSAN NESCI: The way it's written, but we'd like to see some additions to it. It's primarily a data collection bill which would be helpful, but we'd like to see more of a care coordination component to it. And I've worked in the State Health Department, I've worked in multiple chronic diseases, I've run a diabetes center over the course of my career, and I can tell you that health care especially in specialties for some of these chronic diseases is very siloed. I've seen it in my own experience.

I had an issue with glaucoma that was -- my cardiologist and my ophthalmologist -- and I'm a health educator, I know how to do this, I teach care coordination to people, I had trouble getting the cardiologist and the ophthalmologist to talk to each other and talk to my primary care to regulate my blood pressure so I didn't lose my eyesight. So we'd like to see more -- we'd like to see this monitored, we'd like to see more emphasis on it. Because we think it will both improve the health of our state and there's substantial data to show that it will reduce health care costs.

REP. KLARIDES: Great. Thank you.

SUSAN NESCI: You're welcome.

REP.. MILLER: Are there any other questions?

Thank you for your testimony.

SUSAN NESCI: Thank you.

REP. MILLER: Next up also on 5386 is Marghie Giuliano followed by Bryte Johnson. Good morning or afternoon I should say.

MARGHERITA GIULIANO: Good afternoon, Representative Miller, and members of the Public Health Committee. My name is Marghie Giuliano and I'm the Executive Vice President of the Connecticut Pharmacists Association. And I'm here to speak on House Bill 5386 as well. This legislation requires the Commissioner of Public Health in consultation with the comptroller and other representatives to develop a plan to reduce the incidence of chronic disease in our state.

As you know, most patients who are diagnosed with a chronic disease are taking medications to manage those diseases. And medications, while being very crucial to help patients with their chronic disease, if they're not taken properly, they can cause serious issues. As you're aware hospitals are now being closely monitored on readmission rates, and unfortunately adverse drug events are one of the leading causes for patients being readmitted into hospitals. And as medications become more and more complex, it's really important, I believe, that we involve pharmacists in managing and coordinating medications for patients and with patients across the care continuum. And one of the most substantive ways to address the problems with medications is to involve the pharmacist again in managing patient's medications and coordinating those medications across their health care providers.

Pharmacists, while recognized for their expertise in medications, are often an underutilized resource because the reimbursement mechanism for them providing direct patient care services has yet to be developed. I've provided you with some statistics for your review, but I want to just focus on the last bullet. And this is from a report just from June that says medication misuse is a \$200 billion problem. So we have a lot that we can do to impact the inappropriate use of medications. So the Connecticut Pharmacists Association is recommending that this legislation be amended to include a pharmacist to work, you know, in consultation with the Public Health Department and with the comptroller in developing this plan so that we can ensure that issues concerning medication in the use of chronic -- chronic disease patients is addressed. Thank you very much.

REP. MILLER: Thank you for your testimony.

Are there questions from the Committee?

Seeing none, thank you.

MARGHERITA GIULIANO: Thank you.

REP. MILLER: Okay. Up next is Bryte Johnson and then we'll be hearing from Melodie Peters.

Is Bryte here?

No. Okay. We're going to go to House Bill 5384.

We'll first hear from Melodie Peters followed by John Brady. Good afternoon.

MELODIE PETERS: Good afternoon, Representative

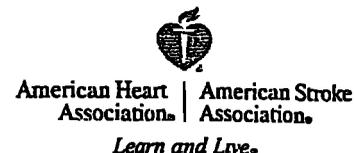
**JOINT
STANDING
COMMITTEE
HEARINGS**

**PUBLIC
HEALTH
PART 3
977 – 1267**

2014



The Honorable, Terry Gerratana
 The Honorable, Susan Johnson
 Public Health Committee
 Room 3000
 Hartford, CT



March 5, 2014

The American Heart / Stroke Association supports House Bill 5386 An Act Concerning Care Coordination for Chronic Disease.

The American Heart Association has set a goal, by 2020 to improve the cardiovascular health of all Americans by 20 percent while reducing deaths from cardiovascular diseases and stroke by 20 percent. The novel focus of the new goal will be preventing heart disease and stroke, most notably by helping people identify and adopt healthier lifestyle choices.¹

Chronic diseases – which include heart disease, stroke, cancer, and diabetes – are among the most prevalent, costly, and preventable of all health problems. Leading a healthy lifestyle (avoiding tobacco use, being physically active, and eating well) greatly reduces a person's risk for developing chronic disease. Access to high-quality and affordable prevention measures (including screening and appropriate follow-up) are essential steps in saving lives, reducing disability and lowering costs for medical care.

In Connecticut, heart disease accounted for 26% of deaths in Connecticut in 2005, while stroke caused 5% of deaths. In 2007, 26% of adults in Connecticut reported having high blood pressure (hypertension) and 38% of those screened reported having high blood cholesterol, which puts them at greater risk for developing heart disease and stroke.¹¹

Just looking at the economic burden of cardiovascular disease (CVD) to Connecticut, The department of Public Health reported that the total Connecticut CVD hospital charges in 2008 were about \$2.2 billion, with a median charge of \$23,172. About 33% of total CVD hospitalization charges were for CHD, 12% were for stroke, and 15% were for heart failure.¹⁰ Median hospital charges were \$34,792 for CHD, \$19,772 for stroke, and \$17,408 for heart failure. In contrast, the median charge for all hospital discharges in Connecticut was \$16,727.¹⁰

CVD is just one of the Chronic Diseases that are preventable through good public policy and a commitment by the state to develop a workable comprehensive plan to address the public health crisis.

The Department of Public Health and its staff are incredibly dedicated to turning the tide of the human and economic impact Chronic Diseases has on our communities. The American Heart Association feels that supporting coordinated care for chronic disease, will bring the heightened attention and the appropriate agencies together to formulate scientifically based strategies that, can assist the legislature and the executive branch in an effort to save lives and reduce the costly burden of healthcare often associate with these chronic conditions.

By supporting coordinated care for chronic disease, the state will be putting in place the framework to realize real benefits from coordinated, collaborative implementation of a chronic disease plan to ensure the achievement of positive outcomes, efficient use of resources, implementation of evidence-based interventions, and dissemination of best practices across programs that would have a direct impact on reducing the burden of chronic disease for the top five chronic disease leading causes of death.

Thank you for considering our comments and please do not hesitate to contact me if you have any questions.

John Bailey
Director of Government Relations
John.bailey@heart.org
860-833-2695

¹ http://www.heart.org/idc/groups/heart-public/@wcm/@swa/documents/downloadable/ucm_425189.pdf

² <http://www.cdc.gov/chronicdisease/states/pdf/connecticut.pdf>

³ http://www.ct.gov/dph/lib/dph/hisr/pdf/2010cvd_burdendoc_final.pdf

March 5, 2014

Public Health Committee

Connecticut Legislature

State Capitol

Hartford, CT 06106

Dear Chairpersons:

HB5386

My name is Stewart Perry. I am a Past National Chair of the Board of the American Diabetes Association, a person with Type 2 diabetes and a Diabetes Advocate and Consultant. I write today in support of legislation to create a Diabetes Action Plan for the state of Connecticut. The aim of this legislation is to establish a review and assessment of Connecticut's efforts in controlling and preventing diabetes. It accomplishes this goal by calling upon the state agencies with a vested interest in containing the reach of the diabetes epidemic to develop a systematic plan of action to confront the disease, provide a report and recommendations to the legislature, and to revisit and revise the plan every two years to assure efforts.

Legislation supporting the creation and updating of state Diabetes Action Plans enjoys broad interest from various groups, including the Council of State Governments (CSG) which recently identified the Diabetes Action Plan legislation as suggested state legislation. Women in Government (WIG) have a national effort underway to work with legislators to enact the bill and the National Association of Chronic Disease Directors (NACDD) has provided technical assistance to some states to help assemble the envisioned report. The National Conference of State Legislatures (NCSL) has featured this legislation in publications as a potential step in battling the reach and scope of diabetes. Finally, the American Diabetes Association (ADA), American Association of Diabetes Educators and a host of other organizations have supported similar Diabetes Action Plan legislation across the country.

DIABETES PREVALENCE IN CONNECTICUT: YESTERDAY, TODAY & TOMORROW

Diabetes is a serious issue for Connecticut. Unlike other chronic diseases, *diabetes prevalence trends are increasing*. It knows no boundaries. It affects men and women, all races and ethnicities, age groups, education levels and income brackets. However, research shows there are overwhelming disparities among the elderly, minority populations, and lower income and education levels.

More than 294,900 adults in Connecticut or 8.24% of adults lived with diabetes in 2010, compared with 173,000 in 2000. This represents a 60 percent increase in just the past 10 years! An additional 911,200 lived with pre-diabetes in 2010. Taken together, one in every three people in Connecticut in 2010 lived with diabetes, or its precursor – pre-diabetes.

Without significant efforts to address these trends, the burden of diabetes will only continue to grow over the years ahead. In 2025, projections suggest 477,300 Connecticut residents will live with diabetes. The population with pre-diabetes will also grow to 940,100 in 2025.

THE HUMAN TOLL OF DIABETES IN CONNECTICUT

The prevalence numbers tell only part of the story. Uncontrolled diabetes can lead to devastating complications like visual impairment that can lead to blindness, kidney failure and amputations of lower extremities. Compared with rates in 2010, projections suggest that in 2025 in Connecticut, there will be marked increases in the number of annual cases of visual impairment due to diabetes, in renal failure attributed to diabetes and in the number of lower extremity amputations directly caused by diabetes.

Uncontrolled and inappropriately managed diabetes can cost years of productivity and increase chances of premature death. Those with diabetes in Connecticut are twice as likely to report depression while also having increased rates of heart attacks and strokes, blindness, kidney failure and amputations. The heart attack risk alone for people with diabetes is four times greater than those living without the disease. Eighteen percent of all pregnancies are impacted by gestational diabetes; women with gestational diabetes are seven times more likely to develop type 2 diabetes post-pregnancy and their babies are at a higher risk for obesity and type 2 diabetes later in life.

THE COST OF DIABETES TODAY AND TOMORROW

The total financial burden of diabetes in America reached \$299 billion in 2010, and diabetes and its complications today consume one in every 10 of America's health care dollars. One in three Medicare dollars is spent on people with diabetes. People with diabetes have healthcare costs that are two times higher than people without diabetes. In Connecticut alone the total estimated medical costs for diabetes in 2010 were over \$2.0 billion, and nonmedical costs were \$0.8 billion for a total cost of \$2.8 billion. According to projections for 2025, the total cost of diabetes for the state of Connecticut will reach \$4.7 billion—representing an almost \$2.0 billion, or 60 percent increase, in costs from 2010. This trend is unsustainable.

WHAT YOU CAN DO TO COMBAT CONNECTICUT'S DIABETES CRISIS

As these startling statistics demonstrate, diabetes will be a sizable health and budgetary challenge for years to come. Passing this proposed legislation will allow Connecticut to take a concrete step in recognizing and systematically responding to the challenge.

A fundamental premise of the proposed legislation is that state officials and others charged with safeguarding the health of Connecticut's families are best equipped to assess the current state of diabetes here. Upon presentation of the Diabetes Action Plan's findings, it will be up to the legislature and the governor to take the next step and identify how best to work with as a team to fight the disease. Legislation similar has been signed into law in multiple other states -- Kentucky, Texas, New Jersey, North Carolina, Illinois, Washington, Oregon, Louisiana and North Dakota after near unanimous approval

In each legislature. The report from Kentucky recently became public and provides an excellent blueprint for other states to follow.

The legislation calls for a report every two years assessing the impact of diabetes on state programs, the benefits of existing diabetes focused programs and activities, funding needs and the development of a coordinated action plan to reduce the impact of diabetes, pre-diabetes and related complications upon the program, taxpayers and state. The plan would also include a budget blueprint identifying needs, costs and resources required to implement the biennial diabetes action plans along with other recommendations for action.

The biennial Diabetes Action Plan will offer immediate opportunities to intervene and interrupt the trends in diabetes prevalence that are having such a devastating effect on individuals and on the health care budget. It will have larger benefits in addressing chronic disease as well. By focusing on the Diabetes problem first. As Dr. Stephanie Mayfield Gibson, Kentucky's Commissioner of Health, said in support of their own Diabetes Action Plan legislation, "If we can get a handle on diabetes and its complications, we deal with a large portion of our Chronic Disease problem."

CONCLUSION

Enacting the Diabetes Action Plan legislation is an important next step in battling diabetes and associated chronic disease in Connecticut and will establish Connecticut's leadership in the effort. It will also let the citizens of the state know what their government is doing to improve coordination and eliminate duplication among state agencies and programs to improve health. The action plans and assessment tools will also greatly help legislators to prioritize resources and pursue policies to battle diabetes and its complications.

I sincerely appreciate your time and consideration of my remarks. I encourage you to approve this legislation and look forward to working with you and all the supporting entities on any and all matters related to diabetes over the months ahead.

Stewart Perry

Diabetes Advocate and Consultant

March 5, 2014

Senator Terry B. Gerranta, Co-Chair
Representative Susan M. Johnson, Co-Chair
Public Health Committee
Legislative Office Building, Room 3000
Hartford, CT 06016

RE: House Bill 5386—Chronic Disease Care Coordination

Chairman Gerranta, Chairman Johnson and members of the committee:

We are a group of voluntary health and advocacy organizations serving people with chronic conditions in Connecticut. We are writing to urge you to support House 5386, a bill to reduce the impact of chronic disease in Connecticut by improving care coordination.

Chronic diseases are the most prevalent, costly and preventable of all health problems. According to the CDC, 75% of U.S. health care dollars goes to the treatment of chronic diseases. These persistent conditions, the nation's leading causes of death and disability, leave in their wake deaths that could have been prevented, lifelong disability, compromised quality of life, and burgeoning health care costs. Reducing the impact of chronic disease, such as cardiovascular disease, stroke, heart disease, chronic obstructive pulmonary disease (COPD), diabetes, arthritis, and mental health disorders may be the single most important thing we can do to reduce health care costs.

Evidence is mounting that coordinated care may be the single best strategy to reduce the impact of chronic disease by improving patient outcomes. House 5386 would direct the state's public health commissioner to improve care coordination in Connecticut through a series of steps involving the state's hospitals and other health care facilities.

We are also writing to urge you to support three measures that we believe will strengthen House 5386:

- The commissioner's plan to develop a coordinated care plan should not be limited to just hospitals and health care facilities, but should include other organizations that provide primary care in Connecticut. The plan should also coordinate with the strategies and metrics of the State Innovation Model or SIM, which will eventually affect 80% of the state's insured.
- The plan should also involve those newly forming entities designed specifically to provide a coordinated approach to care in Connecticut—Accountable Care Organizations, Patient-Centered Medical Homes, etc.
- The plan should also include Comprehensive Medication Management (CMM) because most people suffering from chronic disease take multiple medications prescribed by different physicians. Studies have shown that coordinating medication both improves clinical outcomes and reduces health care costs. One study found that CMM saved \$614 per patient.

Coordinated care is the future of health care. With the additional measures described above and in the suggested amendment, which is attached, House 5386 will ensure that Connecticut continues to lead the way on health care, improve the lives of patients suffering from chronic disease, and reduce costs for government and employers.

Please join us in supporting this legislation with the provisions outlined above.

Thank you for your consideration.

Sincerely,



Susan M. Nesci
Vice President, Public Policy & Advocacy
Arthritis Foundation, New England Region
Rocky Hill, CT



Bryte Johnson
Government Relations Director
American Cancer Society Cancer Action
Network, Inc.
Rocky Hill, CT



Michelle Caul
Manager, Health Education, Connecticut
American Lung Association of the Northeast
East Hartford, CT

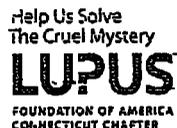


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March 5, 2013

The Honorable Terry B. Gerratana and Susan M Johnson, Co-Chairs, and Members
 Public Health Committee
 Room 3000, Legislative Office Building
 Hartford, CT 06106

TESTIMONY ON RAISED BILL 5386. An Act Concerning Care Coordination for Chronic Disease

Dear Senator Gerratana, Representative Johnson and Members of the Public Health Committee:

The Arthritis Foundation supports the goal of Raised bill 5386 to develop a plan to reduce the incidence and impact of chronic disease in the state by improving care coordination.

The bill as presently written addresses primarily data collection. We have joined with a number of other voluntary health agencies in a letter to the committee encouraging the addition of the following three measures to strengthen chronic care coordination.

- The plan should not be limited to just hospitals and health care facilities, but should include other organizations that provide primary care in Connecticut. The plan should also coordinate with the strategies and metrics of the State Innovation Model or SIM, which will eventually affect 80% of the state's insured.
- The plan should involve those newly forming entities designed specifically to provide a coordinated approach to care in Connecticut-Accountable Care Organizations, Patient-Centered Medical Homes, etc
- The plan should also include Comprehensive Medication Management (CMM) because most people suffering from chronic disease take multiple medications prescribed by different physicians. Studies have shown that coordinating medication both improves clinical outcomes and reduces costs.

Why is the Arthritis Foundation concerned about care coordination? Arthritis is the leading cause of disability affecting 23% of the state's adult population¹. The Centers for Disease Control and Prevention (CDC) reports that nearly half (47%) of adults with arthritis have at least one co-morbid condition². The two most common co-morbid conditions that contribute to disability in arthritis are heart disease (24%) and diabetes (16%)². These three conditions share common risk factor of obesity and physical inactivity. For this reason, we encourage the committee to add arthritis to the list of targeted chronic diseases.

www.arthritis.org

Thank you for your consideration

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¹CDC. Projected state-specific increases in self-reported doctor-diagnosed arthritis and arthritis-attributable activity limitations-United States, 2005-2030. *MMWR* 56: 423-425, 2006.

²cdc.gov/arthritis/data_comorbidities.htm



**TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
PUBLIC HEALTH COMMITTEE
Wednesday, March 5, 2014**

HB 5386, An Act Concerning Care Coordination For Chronic Disease

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **HB 5386, An Act Concerning Care Coordination For Chronic Disease**. CHA supports this bill.

HB 5386 would require the Commissioner of Public Health, in consultation with the Comptroller, representatives of hospital community and other healthcare providers to develop a plan to reduce the incidence of chronic disease, including, but not limited to, chronic cardiovascular disease, cancer, stroke, chronic lung disease, chronic metabolic disease and psychiatric illness. The bill also calls for the development of an improvement plan for the coordination of care of such chronic diseases.

Hospitals have long played a critical role in improving the health and quality of life of people in our communities. HB 5386 would allow healthcare providers from Connecticut hospitals to share with the commissioner, comptroller and other stakeholders their experience in identifying and addressing the variety of factors contributing to chronic disease and would allow hospital-based providers the opportunity to share their best practices in treating patients with chronic diseases. The goals of HB 5386 address the core mission of all those who work in Connecticut hospitals and for that reason, Connecticut hospitals support HB 5386.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.



COMMENTS SUBMITTED TO THE PUBLIC HEALTH COMMITTEE
March 5, 2014

HB 5386 An Act Concerning Care Coordination for Chronic Disease

Senator Gerratana, Representative Johnson, Senator Welch, Representative Srinivasan and members of the Public Health committee, Boehringer Ingelheim is pleased to submit these comments in support of Raised House Bill 5386, An Act Concerning Care Coordination for Chronic Disease.

Boehringer Ingelheim is a family owned company committed to the discovery; development, manufacture and marketing of innovative health care products that help bring more health to patients and address unmet therapeutic needs. We recognize that chronic conditions are a significant issue facing states, and we are committed to continuing to make advances in chronic disease areas that are of critical importance to patients and their families.

There is considerable evidence about how to prevent, postpone and treat chronic conditions. Implementing evidenced-based prevention strategies can reduce health care costs borne by states for its employees, state retirees and it's low-income and disabled populations enrolled in Medicaid. One estimate is that 83 cents of every Medicaid dollar is spent on preventable and highly manageable chronic diseases, including diabetes, asthma and hypertension.¹

According to the Center for Disease Control, seven in ten deaths in the United States are caused by chronic diseases, a total of 1.7 million deaths each year.² These conditions include heart disease, cancer, stroke, respiratory diseases and diabetes, and mental health disorders which are estimated to contribute more than \$1 trillion in spending across the U.S. each year.³

In Connecticut, nearly two million cases of seven common chronic diseases — cancers, diabetes, heart disease, hypertension, stroke, mental disorders, and pulmonary conditions — were reported. The cost of treating these conditions resulted in \$3.3 billion, plus the impact of lost workdays and lower employee productivity resulted in an annual economic loss of \$12.9 billion in the state.⁴

House Bill 5386 establishes a working group to develop a plan to reduce incidences of chronic disease and improve chronic care coordination. The bill further requires this work group to report to the Committee and the Governor on: the impact of chronic diseases that are most likely to

¹ Partnership To Fight Chronic Disease. (2011). "Medicaid in a New Era: Proven Solutions to Enhance Quality and Reduce Costs." <http://www.fightchronicdisease.org/events/medicaid-new-era-proven-solutions-enhance-quality-and-reduce-costs>

² Centers for Disease Control and Prevention. <http://www.cdc.gov/chronicdisease/index.htm>, accessed March 3, 2014

³ DeVol, Ross, et al. "An Unhealthy America. The economic burden of chronic disease." The Milken Institute. October 2007

⁴ Ibid



cause death or disability, the approximate number of people in the state affected by these chronic diseases, and an inventory of programs in the state that have been implemented to improve chronic care coordination. The goal of this bill is to reduce the incidence of chronic disease in Connecticut and to coordinate care for patients with multiple chronic conditions.

While BI recognizes and applauds the work that the State Department of Public Health has conducted in the past by identifying and establishing plans for a number of individual chronic conditions, we believe it is important to address the needs of patients with multiple chronic conditions, including recommendations on how best to treat this vulnerable population in a more coordinated fashion. Additionally, much of what is contemplated in this bill was originally included in Public Act 09-148. However, that Act was subsequently repealed and many of the recommendations relating to effectively managing chronic conditions were never implemented.

The passage of this bill will help provide a comprehensive and consolidated strategy to identifying best practices for addressing chronic care coordination in an effort to reduce the burden of multiple chronic conditions for vulnerable patients in the State of Connecticut.

BI offers the following recommendations to House 5386.

- We recommend the Commissioner's plan to develop a coordinated care plan should not be limited to hospitals and health care facilities only, but should include other stakeholders that provide primary care in Connecticut
- The plan should also include input from those newly forming entities designed specifically to provide a coordinated approach to care in Connecticut (i.e., Accountable Care Organizations, Patient-Centered Medical Homes, etc.)
- The plan should also include a focus on Comprehensive Medication Management (CMM), since most patients suffering from chronic disease take multiple medications prescribed by different physicians. Studies have shown that coordinating medication both improves clinical outcomes and reduces health care costs. One study found that CMM saved \$614 per patient.⁵

Finally, we have attached a recent report from the Office of Legislative Research which outlines key efforts other states have undertaken to address the Medicaid "super-utilizers" population.

Thank you for your time and consideration of our comments. If you have any questions please contact Joseph Oros, Regional Director, National Government Affairs, Boehringer Ingelheim at 860-781-2126.

⁵ "Quality Assessment of a Collaborative Approach for Decreasing Drug-Related Morbidity and Achieving Therapeutic Goals" Iseus, B., et al. *Arch Intern Med* 2003. 163, 1813-20.



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AARP Testimony on
H.B. 5386: AAC CARE COORDINATION FOR CHRONIC DISEASE
Public Health Committee
March 5, 2014

AARP is a nonpartisan social mission organization with an age 50+ membership of nearly 37 million nationwide, and over 603,000 here in Connecticut. AARP believes that one's possibilities should never be limited by their age and that, in fact, age and experience can expand your possibilities. AARP is a network of people, tools and information and an ally on issues that affect the lives of our members and the age 50+ population as a whole. A major priority for AARP is to improve health care delivery and care coordination for those with chronic conditions and health care needs.

AARP supports efforts to improve efficient delivery of optimal care for beneficiaries with chronic illness and disabling conditions that encourage:

- appropriate use of evidence-based interventions;
- interdisciplinary care teams composed of physicians, nurses, social workers, dietitians, therapists, pharmacists and others;
- appropriate use and timely monitoring of medications;
- greater affordability of medications;
- accelerated adoption of health information technology that contributes to improved care;
- rapid dissemination of information and adoption of effective, evidence-based chronic care interventions;
- support to family caregivers to help them become effective partners with professionals;
- greater emphasis on chronic care in clinical education and continuing education of health care professionals; and
- effective use of the health care workforce

H.B. 5386 provides an opportunity to bring a variety of key constituencies to the table to analyze and recommend improvements for chronic care management and reduced incidence of chronic disease. However, AARP encourages the Committee to strengthen the proposal by modifying section 1(a) to require consultation with consumer representatives and patients with chronic conditions. In order to have meaningful dialogue and actionable policy recommendations, key constituencies including consumers, must have meaningful voice in the process.

There is an urgent and compelling need to address the poor care and high costs of those with chronic conditions. In 2005, more than 70 million Americans ages 50 and older—four out of five older adults—suffered from at least one chronic condition. More than half of older adults

Robert G. Romasco, President
Addison Barry Rand, Chief Executive Officer

Page 2 of 2

have two or more chronic conditions and 11 million live with five or more chronic conditions. A 2003 study found that, on average, U.S. adults received only 56 percent of recommended services for chronic conditions. While progress has been made, there are large gaps in the quality and delivery of health care for people with chronic illness. Chronic conditions are costly for patients and payers; individuals with chronic conditions account for 83 percent of all health care spending.

H.B. 5386 addresses the critical need for research to inform optimal methods of service delivery and monitor health outcomes. AARP supports an inclusive stakeholder process that brings together health care providers, public officials, and consumers to recommend policy changes for the reduction of chronic disease in our state and improve care coordination for those with chronic diseases.

Thank you.

Find AARP Connecticut Online at: www.aarp.org/ct



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Youtube.com/AARPCT



TESTIMONY

Submitted by Barbara Katz, RN, MSN, Director, Clinical Program Development

VNA Community Healthcare, Inc., Guilford, CT

Before the Public Health Committee

Raised HB 5386 AN ACT CONCERNING CARE COORDINATION FOR CHRONIC DISEASE

Senator Gerratana, Representative Johnson and honorable members of the Public Health Committee. My name is Barbara Katz, Director of Clinical Program Development for VNA Community Healthcare (VNACHC). I am an RN with more than 40 years of experience in community health, medical practice and home health care. My agency, VNA Community Healthcare, services 36 towns and approximately 4000 patients per year.

Any state initiative to prevent and control chronic illness should maximize efficiency utilizing existing community resources. Medicare Certified home health care agencies, particularly nonprofits, are such a resource. Below is a list of specific home health care agency programs and capabilities that could be utilized by the CT Dept of Public Health in its chronic disease initiatives.

Screenings for chronic disease and injury risk factors - Certified home health care agencies conduct screenings for high blood pressure, diabetes, obesity and falls at health fairs and community sites. Using screening results, community nurses help people get medical attention and make lifestyle changes before chronic disease or complications occur. Through a grant from the Connecticut Collaboration to Prevent Falls, VNACHC has screened over 500 local residents and counseled them on fall risk reduction. Follow up screenings indicate that the vast majority have remained fall free or have had fewer falls.

Health coaching - VNA Community Healthcare, through a grant from the Anthem Blue Cross and Blue Shield Foundation screened and coached over 400 family members of people with heart disease to significantly lower their blood pressure, undertake exercise programs, stop smoking, eat healthier and lower their cholesterol and blood lipids. VNACHC, like many nonprofit home health care agencies, provides more than a dozen Well Right Now Nurse Health Coaching Clinics in senior housing sites and other community settings.

Medical consumerism education - VNACHC helps community residents become better consumers of health care through a booklet and seminar called *How to be Your Own Health Care Advocate*. Through a grant from the Connecticut Foundation for Better Health, VNACHC and a collaborative of local organizations, including a health department, are launching a health literacy campaign called *Put Yourself in Charge* that uses video models and simple written tools to help patients give and get vital health information at medical visits. VNACHC was recently selected as a partner for the *Choosing Wisely* program of the American Board of Internal Medicine and Consumer Reports. VNACHC will utilize the program's health decision support tools in community education classes, publications, web site and social media.

Chronic disease education and support – Medicare Certified home health care agencies reduce hospital readmissions by teaching patients to self manage Diabetes, Congestive Heart Failure and Chronic Obstructive Lung Disease using simple, pictorial health education materials and effective patient education methods. In addition, home health care clinicians help patients develop systems to organize medication taking, home exercise, medical transportation, diet changes, self monitoring and reporting. VNACHC also sponsors programs such as Tai Chi to Prevent Falls, Parkinson's Exercise Program, Smoking Cessation and many other wellness education classes.

Patient engagement and self-management support initiatives – VNACHC and other home health care agencies train and certify clinicians in Integrated Chronic Care, an evidence based approach to health literacy, patient goal setting, effective patient education and fostering adherence to medical treatment plans. VNACHC has built patient engagement best practices into its daily clinical work. In addition, the agency teaches all clinicians Motivational Interviewing, a communication technique that helps patients find their own motivation to change health behaviors.

Family caregiver education and support – VNA Community Healthcare provides caregiver counseling, education and support groups. Under a grant from the National Family Caregiver Alliance caregivers of patients with cardiac disease are receiving health coaching on reducing stress and maintaining their own health.

Care coordination – Home health care agency liaison nurses visit patients in hospitals and skilled nursing facilities prior to discharge. The liaison nurse helps transition patients in the smoothest and safest way possible through patient education about what to expect at home and identifying obstacles to home self management. Home health care staff assess how the patient and family function at home and coordinate with the primary care physician to develop the best possible plan of care.

Home based technology for monitoring and self management support – Home care agencies use home telemonitoring machines to help patients weigh themselves, take their blood pressure and check their blood oxygen. These readings help patients learn how their behavior affects their body. It also allows the home health care agency to closely monitor very ill chronic disease patients and take action sooner. In addition, we use tools such as automatic medication dispensers and medical alert devices to help people adhere to medical treatment and get immediate help when needed.

In summary, it may be tempting for the state health infrastructure to start a chronic disease initiative from scratch. The initiative will be both more effective and less costly if existing programs from certified home care agencies, such as the ones described, are incorporated into a new statewide program.

Please contact me with further questions or assistance (bkatz@vna-commh.org) or 203-458-4232.

Thank you.



CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

TESTIMONY

Delivered by Tracy Wodatch, R.N., V.P. Clinical and Regulatory Services
The Connecticut Association for Healthcare at Home

Before the Public Health Committee

Raised HB 5386 AN ACT CONCERNING CARE COORDINATION FOR CHRONIC DISEASE.

March 4, 2014

Senator Gerratana, Representative Johnson and honorable members of the Public Health Committee. My name is Tracy Wodatch, Vice President of Clinical and Regulatory Services for the Connecticut Association for Healthcare at Home. I am an RN with over 30 years nursing experience across the care settings including home health, hospice, long term care and acute care.

The CT Association for Healthcare at Home represents 60 Connecticut DPH licensed/Medicare certified home health and hospice agencies that foster cost-effective, person-centered coordinated healthcare in the setting people prefer most – their own home. Collectively, our agency providers deliver care to more CT residents each day than those in CT hospitals and nursing homes combined.

We fully support HB 5386 An Act Concerning Care Coordination for Chronic Disease and offer our assistance in formulating the Care Coordination plan in collaboration with the health care providers in this state and the Department of Public Health.

As outlined in the bill, the plan is to include ways to: (1) To reduce the incidence of chronic disease, including, but not limited to, chronic cardiovascular disease, cancer, stroke, chronic lung disease, chronic metabolic disease and psychiatric illness; (2) to improve chronic care coordination in the state; and (3) for each type of health care facility, to reduce the incidence and effects of chronic disease.

For decades and some for over a century, our licensed and certified home health agencies along with our hospice providers have been coordinating care for those with chronic disease. We have expert specialty programs developed within our agencies to address the primary chronic diseases within this bill including diseases such as cardiovascular, diabetes, cancer, respiratory, stroke and mental health illnesses. Many of our providers offer well-established telemonitoring programs that have been proven to reduce emergency room visits and re-hospitalizations in some instances by 50% as well as improve self-management of the chronic disease. We also have providers who have incorporated some of the best practice chronic disease management models utilizing the Coleman or Naylor teach back method along with proven behavioral modification and motivational interviewing interventions that encourage disease self-management and awareness.



CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME

Other areas of expertise provided by our home health agencies include fall prevention, medication management therapy and reconciliation (which extends well beyond "drug therapy monitoring") and effective care transition collaboration with other health care provider across the care continuum.

In addition to the expertise of our home health providers is the chronic care disease management provided at end-of-life by our hospice providers. Once the chronic disease does reach a terminal stage, our hospice providers offer cost-effective pain and symptom management along with holistic patient and family care that focuses on the physical, emotional, spiritual and psychosocial needs of end-of-life. Hospice care also reduces re-hospitalization rates and overall healthcare costs among the terminal chronically ill population.

In closing, we fully support HB 5386 and would be happy to offer our assistance in formulating the Care Coordination Plan for Chronic Disease for Connecticut as outlined in this bill.

Please contact me with further questions or assistance (wodatch@cthealthcareathome.org or 203-774-4940).

Thank you.



Testimony to the Public Health Committee

Submitted by Mag Morelli, President, LeadingAge Connecticut

March 5, 2014

Regarding

HB 5386, An Act Concerning Care Coordination for Chronic Disease

LeadingAge Connecticut is a membership organization representing over 130 mission-driven and not-for-profit provider organizations serving older adults across the continuum of long term care, services and supports and including non-profit nursing homes and senior housing.

On behalf of LeadingAge Connecticut, I would like to submit brief comments on HB 5386, An Act Concerning Care Coordination for Chronic Disease and offer the Committee our assistance as you consider this proposal.

LeadingAge Connecticut would be pleased to participate and assist in any statewide effort to improve care coordination for individuals with chronic disease. Our members are currently involved in several initiatives to improve care coordination and care transitions for their residents and clients with chronic illness. Many of these initiatives are being done on a regional basis or are specific to one chronic condition and it would be a useful endeavor to collaborate in a statewide review of the experience and outcomes of all of these initiatives.

Thank you for this opportunity to submit our comments. Please let me know if we can be of any assistance to the Committee as you review this proposal.

Mag Morelli, President



(860) 828-2903, mmorelli@leadingagect.org
1340 Worthington Ridge, Berlin, CT 06037 www.leadingagect.org



American Cancer Society
 Cancer Action Network
 825 Brook Street
 I-91 Tech Center
 Rocky Hill, CT. 06067
 (203)-379-4850
 www.acscan.org

Public Health Committee

March 5, 2014

American Cancer Society Cancer Action Network Testimony

HB 5386 (RAISED) - AN ACT CONCERNING CARE COORDINATION FOR CHRONIC DISEASE.

Achieving Patient Centered & Family Focused Care in Connecticut

It goes without question that our nation has made significant progress in the treatment of cancer. Today, we are saving 350 more lives per day than we were in 1990. However, as doctors focus on the treatment of a patient's cancer, the patients' comfort and concerns are frequently overlooked. People with cancer often suffer not only from the disease, but also from pain, nausea, shortness of breath, anxiety and other symptoms in their struggle to get well.

The American Cancer Society Cancer Action Network (ACSCAN) is pleased to support HB 5386 (Raised) An Act Concerning Care Coordination for Chronic Disease. The bill would require the Commissioner of the Department of Public Health in consultation with others to develop a chronic care plan aimed at improving chronic care coordination and reducing the incidences of chronic disease in Connecticut.

We would respectfully request that Section 1 of the bill be amended to include the Palliative Care Advisory Council among the groups to be consulted with in the development of this chronic care plan.

"Section 1. (NEW) (Effective October 1, 2014) (a) The Commissioner of Public Health, in consultation with the Comptroller, the Palliative Care Advisory Council, and representatives of hospitals and other health care facilities and local and regional health departments, shall develop a plan: (1) To reduce the incidence of chronic disease, including, but not limited to, chronic cardiovascular disease, cancer, stroke, chronic lung disease, chronic metabolic disease and psychiatric illness; (2) to improve chronic care coordination in the state; and (3) for each type of health care facility, to reduce the incidence and effects of chronic disease."

Treating the whole patient—not only the disease but also the physical and psychological consequences of treatment—is the key to both extending life and enhancing the quality of the time gained. Palliative care *is appropriate at any age and any stage of a serious or chronic illness*. Evidence building over the past decade has consistently demonstrated the benefits of palliative care in improving quality of life and addressing the harmful effects of pain, symptoms and emotional distress as well as family caregiver burden, making a clear case for the importance and value of providing palliative care at the same time

patients are provided disease-directed treatments. More recent evidence also shows that palliative care may enhance survival and reduce costs driven by unnecessary use of hospitals, diagnostic and treatment interventions, and non-beneficial intensive care.

Patients and families facing serious illness need to be educated about palliative care so they can find their way to the best choices that minimize symptoms and suffering while fighting disease. Pain, worry and other symptoms and side effects of cancer and its treatment, for example, are not an inevitable consequence of cancer. They typically can be controlled. While enhancing palliative care information and awareness, we must also enact policies to cultivate and support development of more health care professionals who are trained to provide this multidisciplinary care to meet the growing community need.

As HB 5386 comes at a time when state policy makers remain very active on issues affecting care for chronic illnesses, establishing a framework for collaboration and consensus-building at the state level is all the more important. This is particularly important for the growing population of older adults living with chronic, serious illnesses such as cancer, heart disease, lung disease, and dementia. HB 5386, will ultimately lead to patients and families having more control and choice about treatment options and will encourage more informed and shared decision making.

Submitted by
Bryte Johnson
Government Relations Director
American Cancer Society Cancer Action Network



Connecticut Department of Public Health

Testimony Presented Before the Public Health Committee

March 5, 2014

Commissioner Jewel Mullen, MD, MPH, MPA
860-509-7101

House Bill 5386: AN ACT CONCERNING CARE COORDINATION FOR CHRONIC DISEASE.

The Department of Public Health (DPH) offers the following information regarding House Bill 5386.

The Department would like to thank the Public Health Committee for acknowledging the impact of chronic disease. Seven out of the top ten causes of death in CT are due to chronic disease. It is well established that deaths and disability from chronic disease could be substantially reduced through widespread adoption of proven preventive interventions. The intent of the bill is to reduce the burden of chronic disease and improve care coordination. This bill proposes that DPH in consultation with the Comptroller, representatives of hospitals and other healthcare facilities and local and regional health departments develop a plan to reduce incidence of chronic disease and improve care coordination. The bill also requires that the Commissioner submit an annual report to the Committee concerning chronic disease and implementation of the plans described.

DPH engages in chronic disease prevention and control work, in large part through funding from the federal Centers for Disease Control and Prevention (CDC). Currently there are CDC funded programs in asthma, cancer, diabetes, cardiovascular disease, and tobacco prevention. In addition, CDC funds are supporting the development of a state-wide chronic disease plan and activities to support chronic disease prevention and control at the local level. For chronic diseases in particular, care coordination at the point of care can improve patient outcomes and reduce overall health care costs.

Although the intent of the bill is in broad alignment with DPH's chronic disease goals, DPH does note that additional staff and infrastructure would be required to meet the bill's requirements.

Thank you for your consideration of the Department's views on this bill.

Phone: (860) 509-7269, Fax: (860) 509-7100, Telephone Device for the Deaf (860) 509-7191
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From: Nesci, Sue <snesci@arthritis.org>
Sent: Tuesday, March 04, 2014 2:49 PM
To: PHC Testimony
Subject: Written testimony from voluntary health agencies on Raised Bill 5386-Public Health Committee
Attachments: CT HB5386-VHA sign on letter 3.14.docx; HB5386 Proposed Amendment.docx

Dear Public Health Committee staff:

Attached is a letter from seven voluntary health agencies as well as an attachment with suggested language to amend Raised Bill 5386 to strengthen its focus on chronic care coordination. I will be referencing this letter on behalf of my colleagues in the other agencies during oral testimony at tomorrow's hearing.

Thanks for your assistance.

Sue

Susan M. Nesci
Vice President, Public Policy & Advocacy
Arthritis Foundation
New England Region
35 Cold Spring Road, Suite 411
Rocky Hill, CT 06067
860-563-1177
800-541-8350
860-563-6018 FAX
snesci@arthritis.org

Face up to the future and win the fight against arthritis. Become an e-advocate or Ambassador at www.arthritis.org/advocacy

March 5, 2014

Senator Terry B. Gerranta, Co-Chair
Representative Susan M. Johnson, Co-Chair
Public Health Committee
Legislative Office Building, Room 3000
Hartford, CT 06016

RE: House Bill 5386-Chronic Disease Care Coordination

Chairman Gerratana, Chairman Johnson and members of the committee.

We are a group of voluntary health and advocacy organizations serving people with chronic conditions in Connecticut. We are writing to urge you to support House 5386, a bill to reduce the impact of chronic disease in Connecticut by improving care coordination.

Chronic diseases are the most prevalent, costly and preventable of all health problems. According to the CDC, 75% of U.S. health care dollars goes to the treatment of chronic diseases. These persistent conditions, the nation's leading causes of death and disability, leave in their wake deaths that could have been prevented, lifelong disability, compromised quality of life, and burgeoning health care costs. Reducing the impact of chronic disease, such as cardiovascular disease, stroke, heart disease, chronic obstructive pulmonary disease (COPD), diabetes, arthritis, and mental health disorders may be the single most important thing we can do to reduce health care costs.

Evidence is mounting that coordinated care may be the single best strategy to reduce the impact of chronic disease by improving patient outcomes. House 5386 would direct the state's public health commissioner to improve care coordination in Connecticut through a series of steps involving the state's hospitals and other health care facilities.

We are also writing to urge you to support three measures that we believe will strengthen House 5386:

- The commissioner's plan to develop a coordinated care plan should not be limited to just hospitals and health care facilities, but should include other organizations that provide primary care in Connecticut. The plan should also coordinate with the strategies and metrics of the State Innovation Model or SIM, which will eventually affect 80% of the state's insured.
- The plan should also involve those newly forming entities designed specifically to provide a coordinated approach to care in Connecticut-Accountable Care Organizations, Patient-Centered Medical Homes, etc.
- The plan should also include Comprehensive Medication Management (CMM) because most people suffering from chronic disease take multiple medications prescribed by different physicians. Studies have shown that coordinating medication both improves clinical outcomes and reduces health care costs. One study found that CMM saved \$614 per patient.

Coordinated care is the future of health care. With the additional measures described above and in the suggested amendment, which is attached, House 5386 will ensure that Connecticut continues to lead the way on health care, improve the lives of patients suffering from chronic disease, and reduce costs for government and employers.

Please join us in supporting this legislation with the provisions outlined above.

Thank you for your consideration.

Sincerely,



Susan M. Nesci
Vice President, Public Policy & Advocacy
Arthritis Foundation, New England Region
Rocky Hill, CT



Bryte Johnson
Government Relations Director
American Cancer Society Cancer Action
Network, Inc.
Rocky Hill, CT



Michelle Caul
Manager, Health Education, Connecticut
American Lung Association of the Northeast
East Hartford, CT



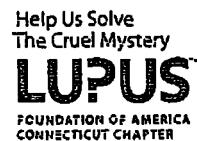
Asthma and Allergy
Foundation of America
NEW ENGLAND CHAPTER

Debra Saryan,
Executive Director
Asthma & Allergy Foundation of New
England
Needham, MA



STRONGER TOGETHER

Linda Wallace
Executive Director
Epilepsy Foundation of Connecticut
Middletown, CT



Michael Tomassi
President & CEO
Lupus Foundation of American
Connecticut Chapter
West Hartford, CT



Paul Gileno
President/Founder
U.S. Pain Foundation
Middletown, CT

Proposed Amendment to HB 5386

Section 1. (NEW) (*Effective October 1, 2014*) (a) The Commissioner of Public Health, within available appropriations, in consultation with the Commissioner of Mental Health and Addition Services[Comptroller] and representatives of hospitals, patient centered healthcare providers (including but not limited to accountable care organizations and patient centered medical homes), and other health care facilities and local and regional health departments and any other representatives deemed necessary by the Commissioner, shall develop a plan: (1) To reduce the incidence of chronic disease, including, but not limited to, chronic cardiovascular disease, cancer, stroke, chronic lung disease, chronic metabolic disease and [psychiatric illness] behavioral health; (2) to improve chronic care coordination in the state; and (3) for each type of health care facility, to reduce the incidence and effects of chronic disease.

(b) The commissioner shall, within available appropriations, on or before January fifteenth, bi-annually, submit a report 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 and the Governor concerning chronic disease and implementation of the plans described in subsection (a) of this section. The commissioner shall post such reports on the Department of Public Health's Internet web site not later than thirty days after submitting each report. Such report shall include, but need not be limited to: (1) A description of the chronic diseases that are most likely to cause a person's death or disability, the approximate number of persons affected by such chronic diseases and an assessment of the financial effect of each such disease on the state and on hospitals and health care facilities; (2) a description and assessment of programs and actions that have been implemented by the department or hospitals, patient centered healthcare providers (including but not limited to accountable care organizations and patient centered medical homes), and health care facilities to improve chronic care coordination and prevent disease; (3) the source and amounts of funding received by the department to treat persons with multiple chronic conditions and to treat or reduce the most prevalent chronic diseases in the state; (4) a description of chronic care coordination between the department and hospitals, patient centered healthcare providers (including but not limited to accountable care organizations and patient centered medical homes), and health care facilities and among health care facilities to prevent and treat chronic disease; (5) detailed recommendations concerning actions to be taken by hospitals, patient centered healthcare providers (including but not limited to accountable care organizations and patient centered medical homes), and health care facilities to reduce the effects of the most prevalent chronic diseases, including recommendations concerning: (A) Ways to reduce hospital readmission rates, (B) transitional care plans, and [(C) drug therapy monitoring]; (C) comprehensive medication management as described by the national Patient-Centered Primary Care Collaborative to help patients with multiple chronic conditions achieve clinical and patient goals of therapy and improve clinical outcomes (6) identification of anticipated results from a hospital, patient centered healthcare providers (including but not limited to accountable care organizations and patient centered medical homes), or health care facility's implementation of the recommendations described in subdivision (5) of this subsection; (7) identification of goals for coordinating care and reducing the incidence of

Coordinated care is the future of health care. With the additional measures described above and in the suggested amendment, which is attached, House 5386 will ensure that Connecticut continues to lead the way on health care, improve the lives of patients suffering from chronic disease, and reduce costs for government and employers.

Please join us in supporting this legislation with the provisions outlined above.

Thank you for your consideration.

Sincerely,



Take Control. We Can Help™

Susan M. Nesci
Vice President, Public Policy & Advocacy
Arthritis Foundation, New England Region
Rocky Hill, CT



Bryte Johnson
Government Relations Director
American Cancer Society Cancer Action
Network, Inc.
Rocky Hill, CT



Michelle Caul
Manager, Health Education, Connecticut
American Lung Association of the Northeast
East Hartford, CT



Asthma and Allergy
Foundation of America
NEW ENGLAND CHAPTER

Debra Saryan,
Executive Director
Asthma & Allergy Foundation of New
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Needham, MA



STRONGER TOGETHER

Linda Wallace
Executive Director
Epilepsy Foundation of Connecticut
Middletown, CT

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Michael Tomassi
President & CEO
Lupus Foundation of American
Connecticut Chapter
West Hartford, CT



Paul Gileno
President/Founder
U.S. Pain Foundation
Middletown, CT

persons having multiple chronic conditions; and (8) an estimate of costs and other resources necessary to implement the recommendations described in subdivision (5) of this subsection.



**Statement Before
Public Health Committee
Wednesday, March 5, 2014**

HB 5386 AAC Care Coordination for Chronic Disease

Good Afternoon Senator Gerratana, Representative Johnson and members of the Public Health Committee. My name is Margherita Giuliano and I am both a pharmacist and the Executive Vice President of the Connecticut Pharmacists Association. The Connecticut Pharmacists Association is a professional organization representing 1,000 pharmacists in the state of Connecticut. I am here today to speak to HB 5386 An Act Concerning Care Coordination for Chronic Disease.

This legislation requires the Commissioner of Public Health in consultation with the Comptroller and representatives of hospitals and other health care facilities and local and regional health departments, to develop a plan to reduce the incidence of chronic disease in our state, to improve the care coordination for patients with chronic disease and to reduce the incidence of chronic disease in each health care facility.

As you know, most patients who are diagnosed with a chronic disease take medications to help control and manage their disease. Medications, while crucial to helping patients, can be a problem when not taken appropriately. As you are aware, hospitals are now being closely monitored for their re-admission rates and unfortunately, adverse drug events account for a primary reason that patients are readmitted to a hospital.

As medications become more and more complex it is critical that we involve pharmacists in managing and coordinating medications with patients across the care continuum. One of the most substantive ways to address these problems is to involve pharmacists in medication management and coordination across the care continuum for patients with chronic disease. Pharmacists, while recognized for their expertise in medications, are often an underutilized resource because a reimbursement mechanism has yet to be developed.

I have provided you with a few statistics for your review.

- 19 % of discharged patients experienced an adverse event within 3 weeks of leaving the hospital; 66% of these adverse events were an Adverse Drug Event
- 60% of all medication errors occur at transitions of care
 - 40% of all medication errors and 20% of ADEs are due to poor communication at Transitions of Care (Gleason 2004)
 - When discharged from the hospital, approximately 50% of older adults experienced an error related to transitions of care (*Moore et al.*, 2003). These errors may result from intentional or unintentional discrepancies in medications prescribed during the hospitalization and those continued upon discharge.
- *Wong et al.* (2008) reported as many as 70% of patients discharged from the hospital have at least one unintentional medication discrepancy with almost 30% of these discrepancies potentially resulting in patient discomfort and/or clinical deterioration.
- An *IMS Institute for Healthcare Informatics* Report from June of last year shows medication misuse a \$200 billion problem

The Connecticut Pharmacists Association recommends that this legislation include a pharmacist as one of the consultants to the Commissioner of Public Health to provide input into the plan. This would assure that there is additional expertise from a pharmacist's perspective to help develop the critical piece of this plan – managing medications of patients with chronic disease.



State of Connecticut
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 STATE CAPITOL
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REPRESENTATIVE BOB GODFREY
 ONE HUNDRED TENTH DISTRICT

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Testimony before the Joint Committee on Public Health, March 5, 2014

Senator Gerratana, Representative Johnson, and members of the Public Health Committee, thank you for the opportunity to submit testimony to your committee.

I'm delighted that the Public Health Committee is tackling Care Coordination for Chronic Disease (HB 5386), a continuing concern to not only Connecticut, but all the states.

I'm Bob Godfrey, from Danbury, Connecticut, Deputy Speaker of the Connecticut House of Representatives, and Past Chairman of the Council of State Governments (CSG). Founded at the height of the Great Depression in 1933, the Council of State Governments is the ONLY national organization composed of and serving all three branches of state government. CSG is a region-based forum that fosters the exchange of insights and ideas to help state officials shape public policy.

As part of its work, CSG has offered a series of Policy Academies focusing on issues its member states have been facing. There have been three¹ that dealt specifically with one of the most widespread of chronic diseases, diabetes. There are over 26 million people with diabetes in the United States. I'm one of them. 7 million of that 26 million don't know they have diabetes. And more alarmingly, 1 in 3 Americans (35%) is pre-diabetic. Even more alarming, the American Diabetes Association estimates the total costs of diagnosed diabetes was \$245 billion in 2012, up nearly 17 percent from \$174 billion in 2007.

What will states do? What will Connecticut do?

Happily, we have a plan.

As noted in CSG's newsletter of August 29, 2013:

¹ National CSG meeting in 2012, CSG West and CSG East in 2013

"The Diabetes Action Plan is a new way to help ensure legislators and other policymakers are strategically taking steps toward reducing the prevalence of diabetes in their state. Kentucky and Texas passed Diabetes Action Plan legislation in 2011, while seven other states—Illinois, Louisiana, New Jersey, North Carolina, North Dakota, Oregon and Washington—passed legislation in 2013.

"This is legislation that aims to establish a collaborative process across state agencies," said Marti Macchi, senior consultant for diabetes for the National Association of Chronic Disease Directors. She was one of the featured speakers for a recent CSG webinar, "Preparing States for Diabetes Action Plan Legislation."

Macchi said three state agencies are typically included in the legislation—agencies that house the Medicaid program, the state Department of Health, usually the diabetes program staff, and the agency responsible for state employee health benefits.

"Really what the law requires is that these agencies come together and develop a collaborative plan of action," Macchi said. "This is a biannual report that provides a very narrowly focused look, highlighting the problems and the costs associated with diabetes. ... It does foster collaboration among state agencies to make very specific policy recommendations for people with and at risk of diabetes that are actionable for the state legislature to consider. ... Those recommendations should include a blueprint for cost and no-cost strategies."

Connie White, deputy commissioner for clinical affairs at the Kentucky Department of Health, said the legislation—KRS 211.752—was a challenge at first.

"The legislation very clearly said what partners would be at the table for this report, this plan," White said. "It was really not the classic diabetes folks at the table you would expect if you're writing a diabetes plan. We were scratching our heads a little bit, looking at all the requirements of the legislation and thinking, 'Oh wow, this is going to be a challenge.'"

Oh, wow, indeed!

I'm asking that the Public Health Committee include in HB 5386 such a Diabetes Action Plan. Knowing that diabetes needs not only to be treated, but in some senses prevented, it seems to me that we would be prudent to address comprehensively a Connecticut approach to tackling diabetes. It is, of course, humane in the first instance, not only to those of us with diabetes but also to our families and loved ones. It could be a way of predicting and reducing the high costs diabetes brings to health care in both the general population, and in state and municipal employees who participate in our health insurance plans. It could also be a means by which health care providers and non-profits (the YMCA in 39 states, including Connecticut, offer an evidence-based diabetes prevention program) join with lead agencies in a widely based effort.

I have provided the committee with language from the Kentucky law, the first in the nation, to guide you in drafting a provision for inclusion in the bill you're hearing now. I can make other state's statutes

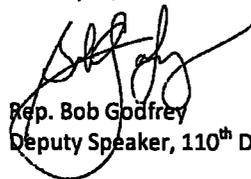
available through CSG, if that would help. I would encourage members and staff who are interested in much more information to visit CSG's Knowledge Center² on both the challenge of diabetes in general and the Diabetes Action Plan more specifically.

I'm also honored to include with my testimony a letter from Stewart Perry, a Past National Chair of the American Diabetes Association (and like me, a person with type 2 diabetes) advocating Connecticut's adoption of a Diabetes Action Plan. He has Connecticut specific statistics (there were more than 294,900 adults in Connecticut with diabetes in 2010 – 8.24% of our population, and more than the population of our biggest city – and the numbers are rising dramatically), and a more detailed description of the provisions of the Plan. He will be visiting with us here in Connecticut in the next few weeks, as soon as we can nail down the schedule; I'll ensure that you are all invited to meet him.

I want to acknowledge two pharmaceutical companies that have been of great help to the Council of State Governments and me in our three-year efforts on diabetes: Novo-Nordisk (I'm sure you've seen or heard their commercials), and Danbury-based Boehringer-Ingelheim, both of which have tasked themselves in solving the challenges of diabetes and chronic diseases. You will hear from BI later in this hearing. I applaud their cooperation.

This idea is hardly a new one. There have been discussions about this here for several years; I've been a part of them. My hope is that this year we can enact a Connecticut Diabetes Action Plan to serve the people of our state, bring costs under control, and develop a comprehensive, inclusive approach to the treatment and prevention of diabetes.

Thank you,



Rep. Bob Godfrey
Deputy Speaker, 110th District

² <http://knowledgecenter.csg.org/kc/search/site/diabetes>