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 Presdient of Clinical and Regualtory 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.

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.