

**Testimony**  
**Proposed Governor's Budget**  
**February 27, 2015**

Dear Members of the Appropriations Committee, Rep. Walker and Senator Bye,

I would like to speak to and clarify what it means to be a behavioral nurse working in home care. Firstly, let me address what it IS:

- It is a profession that requires utilization of the most acute and comprehensive clinical skills, as our clients tend to have significant medical and psychiatric issues, with very little resources or assistance from family or friends.
- It is a profession that centers around gaining the trust of those whose life experience has led them to conclude "people cannot be trusted"
- It is a profession that creatively finds ways to "join" with our clients so as to motivate, inspire and encourage them to hope for a better tomorrow.
- It is a profession that celebrates the smallest change as a great success and understands that sometimes the road to success includes understanding that failures along the way do not mean, abandoning the course
- It is a profession that, with their permission and because they cannot, becomes their voice in the collaboration of their care with their psychiatrist, their clinicians and case managers, their medical doctors, their pharmacy, their entitlements specialist, their landlord and any other community resource needed in their quest to secure safety and quality in their life.
- It is a profession that must meet the Standards of Practice established by Dept. of Public Health, and whose continued service with clients, must meet the medical necessity standards set by Value Options and whose interventions and collaborations have brought about improved clinical outcomes.
- It is a profession that continues to study ourselves, our practices and our impact. – We partner with many programs within Greater Bridgeport Mental Health Center which services 3000 clients living in Bridgeport. Through the partnerships established only 22 of these clients have been identified by VO as "high utilizers" of Emergency dept. services. 22 of 3000 Bridgeport clients!!

AND yet, when our value and the definition of our role is labeled as "Med admin", does any of the above jump out at you as clarification of what we do!!! Of course the need to manage and administer medications is at the core of what brings us into the life of our client, because they cannot. Our care is comprehensive as our professional standards mandates and it is in the comprehensive management of our joint POC with our clients that change occurs.

Let me tell you about my work with Client X - growing up in foster care and surviving a great deal of trauma, she began working with our agency when she was 18 and deemed "an adult" able to now care for herself in the community. No friends, no family involvement, no job and a severe psychiatric illness made this transition very challenging. A partnership was developed with this client, a community program and our agency. Initially, there were hospitalizations for depression and suicide attempts. She had significant trust issues and had a difficult time keeping appointments or believing clinicians could be helpful. She did not drink, smoke or use substances. She has never been arrested. Instead, she, as do so many other young woman, turned to "all the wrong men" in her search for comfort and belonging. Insight and judgment were replaced with fear, anxiety, an intensely low self-image and a deep need to be "loved" at any cost. Her "cost" included giving birth to children that she desperately tried to care for, but could not. Some other own family history was repeated and she too had to "give up" her parental rights so her children could be cared for. However, with the trust developed with her nurses and team: and the support and advocacy created, she has been able to remain connected to her children through an open adoption.

Her journey has been one with many phases. As her PCN, managing her bipolar illness without a full complement of medications (as they were contraindicated with pregnancy), there were many challenges.

Her nurses provided the support and connection needed during the birth of these girls and the shoulder and support needed when she realized she could not care for them, in spite of her efforts. Her nurses were there for her then and have been there for her now supporting her connection to job training and compliance with all treatment appointments. She began as a BID client in need of oversight and administration of all meds and is now seen 3-5 x weekly while managing her own meds all the other times. She will always need medication as hers is an illness that like diabetes will need meds to maintain a functional baseline. She will NOT always need a nurse.

I can go on and on with case, no people examples!! In all of them, I dare you to describe the nurse's role as a technician there to "just give meds". I have been a nurse since 1974. I am a Master's prepared nurse clinician as well as a Certified Substance Abuse Counselor. I have worked in an in-patient psychiatric hospital, a local Mental Health Center in outpatient services, in a regional substance abuse agency and a residential rehab facility. My roles have included staff nurse, outpatient clinician, clinical supervisor, Regional Director and Administrator prior to my home care role. I can honestly and passionately say, I have taken from every role I have had in my long career and utilized it in my work with behavioral health home care nursing. Our clients continue to need a "voice" and deserve to have their voice supported in its fullest capacity. If not us, who?????

Thank you for your time and consideration,  
Gloria Merritt, RN

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Dear Members of the Appropriations Committee, Rep. Walker and Senator Bye,

My name is Maria Merced and I have been a registered nurse for more than 30 years. Fifteen of those years have been in home care. I currently serve the patients in the New Haven area. I mostly serve the patient's with mental illness of a moderate to severe nature with their co-existing conditions, like diabetes, hypertension, heart disease, and Asthma to name a few.

If one really knew and understood how the proposed budget cuts will affect our patients, specifically the mentally challenged, they would be ashamed to even think of this as a solution to the government's financial problems.

Mental illness is like any other disease, it needs to be treated, if not treated, and the consequences not only affect the individual but also the rest of the community. A physician/psychiatrist can prescribe a medication, but if the person is mentally or physically not able to follow through with the recommendations, then how can the person get better? As a homecare nurse, our role goes beyond administering medications. We assess effectiveness of the medication. Did it work? Will this person be safe? Does the person need to be seen immediately? Can we make a phone call and address side effects or the lack of effect of the medication. The effectiveness of the medication can mean the safety of others in the home.

Most recently I encountered a family that had a loved one in a complete psychotic state. This family was not able to identify that their loved one was experiencing severe hallucinations to the point of being disconnected from the real world. These hallucinations had the patient talking about killing others. The family told me that they were not afraid. They did not know that when a patient is psychotic, they are not seeing the loved one but an intense hallucination of something that is scaring them. This person had not taken meds in several weeks. This is the type case that gets referred to home care. Obviously, this pt had to be sent to the hospital, but they will be referred back home along with home care services, once he is back to his baseline level of functioning. It takes the skills of an experienced nurse to engage with this kind of patient and get him/her to take their meds each day. I would like you to wonder, what would happen if these people did not have the option of being referred to home care psychiatric services? The work and expertise that the home care psychiatric nurse provides is more than basic care, it is an essential service that helps keep our community safe and free of harm from a person that is under or not medicated at all. If left untreated and unstable, lives could be taken, accidents would happen, and the mentally ill would be forced to enter the criminal justice system.

As a home care nurse, specializing in the mentally ill, my role is to identify signs and symptoms of decompensation, educate about the medications, communicate with the entire mental health team, and also with the medical providers for the other medical problems that the patient may have. Hospitalization, 911 calls and urgent visits are sometimes avoided with these services.

Now please consider your position in terms of the budget cuts. Imagine the lives of the mentally ill and their families without these services. I implore you to consider these issues when deciding on whether to cut these services in the budget.

Thank you for your time and consideration.

Maria Merced, RN, BSN

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Dear Members of the Appropriations Committee,

My name is Vanessa Arroyo, and I respectfully speak before you as proud homecare nurse for the Greater Hartford area. I currently serve as a nurse supervisor and here representing a strong team of behavioral health nurses who could not be present here today. I like these nurse's serve a population who are often misunderstood, misconceived, and lack social services if not connected with the right providers such as homecare services. We serve the chronically mentally ill, a population which range from 18 to 91 years of age. With broad ranges of diagnosis such as severe schizophrenia with psychotic disorders to manic depressive disorders. In basic terms our patients will hears voices, which will torment daily, and without assistance or medication or nursing to assist, life would be intolerable and unsafe in some circumstances. Ladies and gentlemen, these let me be frank, these souls walk amongst us. Many of you have heard of the horror stories through the news of the few who go undiagnosed, un-medicated, and untreated. However, our nurses have tiredly trekked through bitter cold, mounds of snow, darkest of alleys, the worst of neighborhoods, and managed to keep this population stable within their home's, with the assistance of their psychiatric providers, clinicians, and or group therapies, who are all serviced on an out Pt- basis saving the ST of CT <sup>1</sup>533.5 Million between 2009-2013 (CT Association for Healthcare at Home). Our Medication Administration encompasses psychological assessments, medication evaluation, monitoring for adverse reactions, assessing for decompensation to report to psychiatrist immediate need for evaluation. Our nurses specialize in this field and will develop therapeutic rapport with their patient, which is very individualized and built slowly over time. "We are not pill pushers"

I would like to share a success story. A primary care nurse on my team has a patient who prior to her care had frequented the ER 14 times in the past 4 years. Please note the patient is a primary T-19 recipient and this cost is absorbed by the state. ER visits would include issues such as colds, constipation, need for antibiotics, or itchy skin. This patient was not stable with his medications due to lack of medication compliance. In attempts to build nurse patient relationship, the nurse feverishly worked to accommodate patients time frames, and address patients fears and often attempt to make it to patients home to establish continuity before day break to ensure patient was medicated. Medication compliance and stabilization is one of primary goals, once we are able to stabilize a patient, we can work on developing healthier habits. It took education, reinforcement, and more education, which took approximately 6 months with steady consistency. The patient now call's the nurse for assistance and attends his scheduled physician appointments instead of frequenting the ER. Ladies and gentlemen we will continue providing making contributions such as these to help reduce the deficit.

Thank you kindly for your time.

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<sup>1</sup> CT Association For Healthcare at Home

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Dear Members of the Appropriations Committee, Rep. Walker and Senator Bye,

Thank you for the opportunity to state my concerns regarding the expected targeted funding reductions that will adversely impact psychiatric homecare.

My name is Yvette E. Gonzalez, I currently reside and work in the city of Bridgeport and I'm employed as a Registered Nurse, specializing in psychiatric care , having done so since graduating from nursing school in 1994. Throughout my career I have worked in - patient setting in several hospitals, as well in out-patient care, and currently in psychiatric homecare for the last 12 years.

As a bi-lingual/bi-cultural nurse, I offer my clients, which number well over 90% Spanish -only speakers, an effective level of services addressing their chronic mental and medical conditions. This service is not limited to the simple ' Administration of medications, it also includes mental status assessment , any changes in behavior, monitoring and addressing any high risk behavior, closely monitoring safety in home /community, ensuring compliance with med regime , their effectiveness , any possible side effects, compliance of all necessary appointments, case conferencing with all theaters , as well as monitoring and addressing assorted medical conditions including insulin and noninsulin diabetes, cardiac conditions , etc.

In my experience these level of services and commitment minimizes the patient's need for ER visits as well as any hospitalization, and thereby limiting costs to the taxpayers. Additionally, these services provide a continuing reduction of risk to the client as well as the community.

In conclusion, by decreasing AGAIN funding specifically to homecare psychiatric clients, the expected savings to the state will be substantially reduced by the increase in client related costs.

Again thank you for this opportunity.

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Dear Members of the Appropriations Committee, Representative Walker and Senator Bye,

My name is Sharon Sutton. I am a registered nurse who has worked in psychiatric homecare for over a decade. This is not by first experience speaking to you. Unfortunately, the population I service seems to be consistently targeted during budget cuts.

I would like to dispel the belief that there is any clinical difference between a psychiatric medication administration visit and a skilled nursing visit. In fact, a "medication administration visit" is not a clinical term. It is a fiscal term invented during prior budget cuts to save money. The term "med admin" is utilized for any individual who needs to be seen by a nurse more than once a week. Period. It has nothing to do with the level of professional care provided during the visit. Ironically, it describes the needs of gravely impaired or medically unstable patients. Those who need care the most, and can only receive this care in the home. This population has no family or friends. They are too compromised to access community resources. The psychiatric homecare nurse is the eyes and ears for the treatment team. We report the client's status to the psychiatrists, the medical doctors, the clinicians, the parole officers, and the case workers who often go weeks - or months - without seeing these patients.

As an example, I share with you this real life experience of an individual I will call MM. One. MM had a long term psychiatric hospitalization which occurred after trying to poison all family members. This individual's "command hallucinations" told MM that the entire family "was evil and they needed to die". After a long hospitalization and MM was deemed "safe" to return home and was living alone in an apartment. MM was connected with many community resources prior to discharge, including psychiatric homecare nursing. Things went well for about a year. Then MM began to disengage from the psychiatrist and clinician. I was unable to locate MM for three days - and therefore MM went unmedicated. The psychiatrist, clinician and caseworker were notified daily of the missed medication doses. The response was to "keep trying". On the fourth day I found MM at home. MM was completely delusional and had accumulated a cache of weapons. I was informed that "God was talking to her" - telling her she "needed to kill the evil people" in her community. Because I am an experienced psychiatric nurse - and not someone who "merely gives people their pills", I was able to talk her into coming outside with me (away from the weapons) and activated the 911 system. With the police there, and standing by my side while we waited for the ambulance, a look came over MM's face I will never forget, she yelled "God says you need to die". Then she jumped me. It took two police officers and a taser to get her to stop the assault. Had it not been for the persistent care of a psychiatric home care nurse I have no doubt that many innocent people would have been hurt or killed with the weapons she had collected. Her decompensation occurred over a three day period. That is one example of why it is imperative that clients are properly medicated with every dose that the psychiatrist orders. When she is discharged from the acute care mental health hospital again - and she will be - do you want someone to check on her medication adherence once a week?

In summary, no professional psychiatric homecare nurse is ethically, morally or legally permitted to "give some pills" and walk out the door - as the term "med admin" implies. We must assess and address any medical or psychiatric issues we find. To imply that we do less than a skilled nursing visit every time, just to save money, is an insult to us and a disservice to the people in your communities.

Thank you for your time.

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Dear Members of the Appropriations Committee, Rep. Walker and Senator Bye,

My name is Gwen Salerno and I am proud to say that I am a Homecare Psychiatric RN serving East Hartford, Manchester and Vernon. I find it incomprehensible that there should be any thought toward budget cuts regarding the psychiatric population seeing as the media has heightened society's awareness of mental health needs. The general public often views mental patients with distrust and apprehension, does not recognize psychological symptoms as mental illness and feels that patients with symptoms should be excluded from the mainstream of society. Deinstitutionalization in this state began in the 1960's-70's and since the closure of Fairfield Hills in 1995 and Norwich State Hospital in 1996 many of their patients were transferred to CVH, ill prepared long term care facilities and into the streets. The number of incarcerated men and women with mental illness has grown due to the fragmentation, chronically underfunded and barriers to mental health access particularly amongst those who are poor, homeless or suffering from untreated alcoholism or drug addiction. Left untreated and unstable they break the law and enter the criminal justice system.

Psychiatric Homecare nurses are not just "pill pushers" as the term "med admin" might be preserved. During our Skilled Nursing Visits we are the frontline in the assessment of our client's well being both mentally and physically. We are the first to see signs and symptoms of decomposition, the need for medication changes as well as the effectiveness of their current medical regime. We are educators, teaching them about their disease process, medications, diet and nutrition and when they may need to call their physicians or Mobile Crisis in order to eliminate costly visits to the ER and/or hospitalization. We listen and provide guidance; if further services are needed we make the connections. We are the support system for both our client's and their families. We are the liaison between our population and their physicians, coordinating their care to fit their needs. We are their advocates and at times their only friend.

Homecare Psychiatric nurses help our client's to help themselves maintain their dignity and optimal functioning so that they can live safely in the community. If the public mental health system is to survive, it must be defined as comprising all settings, services and funding for the chronically mentally ill. Activity and treatment programs geared to meet their needs takes funding but to save money, the balance of resources must shift from institutions to community based care. I implore you to not make cuts in the budget.

Thank you for your time and consideration.  
Gwen Salerno, RN

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Dear Members of the Appropriations Committee, Representative Walker and Senator Bye,

My name is Anne Fillion, and I am a psychiatric visiting nurse in Connecticut. I have been working in behavioral health for over three decades, occupying different functions as educator, therapist and now as a nurse. Through my decades of practice, I have seen the deinstitutionalization, the emergence of new psychotropic drugs and sadly what appears to be an increase in violent mass murders by young people improperly treated or not treated at all for mental illness. Though the very vast majority of people treated for mental health problems remain non-threatening and safe for themselves or the community, all it takes is one individual that falls into the crack of the system to then having a whole community waking up on a certain December 14, 2012 facing the horror of the Sandy Hook massacre.

Now I would like to illustrate how medication administration visits allow prevention of violence by presenting one of my client. My client is in his thirties diagnosed with bipolar disorder with psychotic features. This client has a long history of self medicating with drug and alcohol prior to being diagnosed, got involved in a car accident, driving under the influence of alcohol and killed a friend that was occupying the passenger seat. My client was sentenced to 5 years in jail, got out 3 years later on probation with exacerbated symptoms as the incarceration milieu provided with ample opportunities for consuming drugs. The exacerbated symptoms translated in hearing commanding voices ordering to "Die" or to "Kill". My client went to live with a family member who happens to be a hoarder. This living situation triggers high level of anxiety to the client verbalizing not feeling safe in this environment. The tension ended up with 2 events of physical violence perpetrated by my client toward this family member. The probation is soon to be lifted and then, one can wonder what is going to happen as my client became a ticking bomb. This is where the intervention of a visiting nurse comes to play.

Overtime, through the nursing visit and after gaining the client trust, I could see an improvement in medication and plan of care adherence. Is it 100%? not quite yet but improving steadily. My client is now attending his drug and addiction meeting regularly; is now able to share and verbalize on the lack of adherence to medication; is more insightful regarding the impact of his pain on mood and affect; is able to talk about the experienced auditive hallucinations reporting if they are commanding or not; is able to express safety concerns having to live in a hoarding environment and it's impacts on stress and anxiety. Assessing and monitoring my client's mood and affect during the visit allows me to take immediate action by calling the psychiatrist, the clinician or talking with a family member when a concern is brought up. In turn adjusted medication intervention allows preventing my client's exacerbation of psychotic symptoms that could lead to commanding voices telling to kill oneself or even worse to also kill other family members or members of the community. If the past behaviors are the best predictor of future behaviors, my client is at high risk for violent behavior if not properly medicated leading to decompensation and exacerbation of psychotic symptoms. By having a visiting nurse that guarantees the medication administration, my client remains safe as well as the rest of his family and the rest of the community. Medication administration visits are more than asking our clients to take their medication, they can save lives.

Thank you for your consideration. It is highly appreciated.

Anne Fillion RN, MS, BSN, CRT, CMA

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Dear Members of the Appropriations Committee, Rep. Walker and Senator Bye,

My name is Marisol Orth. I'm a psychiatric nurse working in home care covering the New Haven area. I oppose the cuts proposed to home care in the new budget by Governor Malloy, specifically targeting the home care "medication administration visits."

I belong to the unknown industry sector that has saved the State of Connecticut an unprecedented \$533.5 million over the past five years, according to a recently released report to the legislature for 2009-2013 detailing Medicaid savings from the CT Home Care Program for Elders. This sector is on track to save an additional \$100 million more in the coming year.

I service the chronically ill psychiatric population. We keep them home at a fraction of the cost it would take the State if they were in institutions. Ninety-five percent (95%) of the clients I service not only have psychiatric diagnosis, they also have medical problems. My job is not only to take care of their mental diagnosis such as schizophrenia, bipolar disorders, depression, anxiety but also Diabetes, high blood pressure, renal failure and liver failure.

During a medication administration visit, we address all their issues not just "giving medications." We also assess the effectiveness of the drugs, their side effects and we communicate with all providers. We ensure patients make their doctors appointments, therapist appointments, drug treatments, probation officers, they go for lab work. We also work with DCF with those females patients that have small children. We keep the patients safe, the State saves and most importantly individuals remain out of the hospital. We provide on call support 24/7 saving on ER visits. We use our own cell phones and cars to service this clients.

Doctors in the community use our services to assure compliance with patients that have shown non-compliance with medications by showing no improvement no matter what they are prescribed and multiple visits to the hospital. We show up at their homes and find months of medications never taken, no family, isolation, paranoia and depression. Patients are actively psychotic in most cases. When safe and with the help of the doctors, we re-start the medications and bring them to a therapeutic level saving the State weeks of hospitalizations. Hospitals are shifting the care to the community discharging patients earlier with the support of home care. This is not just a medication pass.

Every day we experience struggles trying to keep patients at home; this population has been affected already with cuts in the past. If you continue to make cuts, these patients have nowhere to turn except the hospital and long term care facilities. These facilities are not equipped to handle this type of patient population.

Nurses support delegation of medication administration where appropriate.

Thank you for your time.  
Sincerely,  
Marisol Orth RN, BSN

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Dear Members of the Appropriations Committee, Representative Walker and Senator Bye,

My name is Shahida Chaudhary and I am a RN with New England Home Care. The reduction in the budget would impact the patients I serve profoundly. As a psychiatric nurse, I am the eyes, ears, and voice of my patients. My patients are isolated, antisocial, depressed, withdrawn, and estranged from others. They have no jobs, no families, or friends. If left un-treated, they would decompensate quickly and end up in the hospital. This would cost millions more annually. When I see my patients, I am not just a "med giver" or a "pill pusher". I am performing a skilled nursing visit with a comprehensive mental health and physical assessment. I am their nurse, counselor, therapist, advocate, and case manager. I am actively communicating with a multi disciplinary team to make sure my clients are safe in the home setting. Most times, I am the only person actively involved in the team.

I would like to give you an example of what my day to day work involves. Recently, I was assigned as the primary care nurse for a patient discharged from the hospital. He was referred to us as he was off his medications for over a three month period causing exacerbation of symptoms resulting in hospitalization. This patient was highly delusional, paranoid schizophrenic, communicating in word salad, dissociative, and hearing voices daily. There were many things I needed to follow up on which included resolving issues at the pharmacy with his medications, arranging his outpatient psychiatrist appointments, and making sure that he was safe at home, and his basic living needs were being met. When I assessed this patient, he was living in a small cluttered room, filled with bugs, filth, and trash all over the floor. I got him on track with a referral to our social worker, case conference on his treatment plan with his case manager, doctors, and conservator. I picked up his medications and developed a plan of a care that would keep him safe at home.

There are many patients like the one above in the community that would be abandoned without us. These patients are very ill with severe mental health disorders, multiple hospitalizations, suicide attempts, and drug addictions. Without their nursing care, they would present as an imminent risk to themselves and others in the society. I would like to urge please don't reduce budget on psychiatric nursing. In fact, I would like to request more focus and funding to improve and better the psychiatric population in homecare.

Thank you

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Dear Members of the Appropriations Committee, Representative Walker and Senator Bye,

My name is Ryan Keenan, RN.

It has come to my attention that there will be a meeting regarding the future of home health care and its reimbursement – specifically with behavioral health. Upon hearing this, as a nurse who has been in mental health for 12 years, I'm concerned, saddened, and, quite honestly, deeply offended. There has always been (and probably always will be) a stigma around mental health. It has been a taboo topic for years. Depression, anxiety, schizophrenia – these words tend to make people put their hands up and say, "Oh no, I'm not talking about that." The root of the issue is lack of education. When I talk to people about my job title or the field I'm in, they admit that they don't even know what we do; or that they think they know, and get it wrong. There are even times my peers refer to the medical nurses as "the real nurses". In other words – as a psych nurse- you're not *really* nursing. Today I find that the governing body of funding our day to day operations, agrees with this. We have, yet again, been minimalized.

The major issue is obviously the daily medication administration. I am perfectly aware that from an outsider's point of view it looks as though all we do is give patients medications. As I'm sure you're becoming aware, this is absolutely not the case. Recently we had a patient, who is seen daily for medication, admit to having suicidal thoughts with a plan and intent on taking his own life. Should we have not been there, assessing his mental status, only "throwing" medications at him, he would have taken the opportunity to end his life. These types of situations arise daily. We are not just there to give medications to the patient, we are there to make sure they are safe – to themselves and to others. On the other side, we have patients who are released from prison. All they know of the world is institution. Some were incarcerated for violent crimes – murder, kidnapping, arson to name a few. These patients are kept under close observation by the nurse (who is brave enough) to treat them. Imagine these patients without daily medication administration – who are notorious for being non-compliant.

In summation, it would be disasterous to cut funding to something so deeply needed by the patient and the community. To take away from these programs only shows the mental health nurses that, yet again, we're not considered important. To the patient: sometimes we're the only contact with the world that they have. I'm well aware of how it looks on the outside, but I can't stress enough on how much we keep both the patient and community safe.

Thank you

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Dear Members of the Appropriations Committee, Rep. Walker and Senator Bye,

I am writing this testimony to explain the benefit of psychiatric nurse involvement in one patient's life.

When I first met this individual in 2005, this individual had been in and out of institutions for 28 out of his approximate 40 years. This individual had been mis-diagnosed with a medical problem which resulted in anger, aggression and acting out. This created a lot of tension within his family specifically between his father and himself. He was kicked out of the house and spent many years staying with friends in various towns. He was unable to keep a job and as a result of the (incorrect) meds he was on he was restless and would frequently get up in the middle of the night and roam the streets, getting into trouble. As a result, he was placed in various institutions under various different types of treatments-iced sheets, electro-therapy, etc. None worked. During this time, his father had a heart attack and died, and his mother blamed his 'mis-behavior' and didn't speak to him for years.

He is now with a local mental health authority where he has a therapist he sees every month, after being properly worked up and diagnosed. I have also gotten him a medical MD and he has since been diagnosed as a diabetic and also found that he had had a silent heart attack that was never treated. He now has a cardiologist that he sees regularly. He has the correct meds for all these co-morbidities. I was instrumental in getting him a one room apartment in the town where he mother lives. He is able to keep this small area clean and neat. When he first moved out there I saw him regularly to assist with his meds, get him the follow up appointments he needed, the correct meds, and educate him in the meds and his current conditions. He has been put on a low fat, ADA diet and he has lost 40 lbs. At first, I had to pick up and order the meds for him. Now, he is able to do so himself. After several years, we have worked on his relationship with his family, and he now goes to his mother's house for dinner 2 x week, and she picks up his meds for him after he orders them. At first, I had to prepour his meds for him. Now when I see him, he prepours his own meds with just my supervision. At this point, I see him every two weeks for an injection only. He is stable, safe, living with the community with the least amount of nursing intervention possible.

Since I have taken care of this patient, he has never gone into the hospital, IN TEN YEARS!

Yet, the name of my visit is 'Medication Administration'...

Martina M. Porcelli, RN

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Dear Members of the Appropriations Committee, Rep. Walker and Senator Bye,

I am Malaika Coleman I have been a home care nurse for nine years and when I walk into my patients home I do not just "administer medications." I have to make sure my patients physical, mental, emotional, spiritual, environmental, and financial needs are being met appropriately. I recently admitted a patient to home care services, a substance abuser who was over using the Emergency Department, showed up there at least five times a week. The first time I walked into his apartment it was in total disarray with no heat.

The patient stated, that's why I keep going to the Emergency Room because I am not comfortable here, and I don't feel safe. The patient had no contact information for the landlord, and he lacked the mental capacity to advocate for himself. As a result, I did the advocating for him, I was able to contact the landlord and the heat was restored. I communicated with his social worker and advocated for the patient to move to a more stable structured environment. He is now living in supervised housing, with decreased substance abuse and no recent trips to the Emergency Department.

There are many times when my patients do not have the \$1.50 or more copay to get their medication from the pharmacy, and because of the rapport I have with the pharmacies my patients are able to get their medications on time and pay the copay at a later time. This prevents medication non-compliance, which leads to mental status decline, lengthy and costly re-hospitalizations.

I have another patient with extreme paranoia, she is afraid to leave her apartment, and a simple task such as taking the garbage outside was impossible for her to do. Eventually, I was able to gain her trust and convince her to go with me to the dumpster.

Now she is leaving her apartment one to two times a week independently. This was possible due to consistency with medications and continuum of care.

I urge you to continue to support the behavioral health population and reconsider making any budget cuts.

Thank you

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Dear Members of the Appropriations Committee, Rep. Walker and Senator Bye,

My name is Lynn Alberto-Rivera and I am a New England Homecare Behavioral Health Nurse serving the Hartford area. I am one of the many nurses working for an outstanding homecare agency dedicated in servicing individuals in the community, now being targeted by Gov. Malloy's budget cuts. During my tenure as an RN working in homecare, I have seen the growing need and significance of homecare in our state affecting our communities, and most importantly, the documented benefits it provides our clients in aiding in the management of healthcare.

Mental Health continues to be prevalent in our society while, at the same time, support is often difficult or challenging for those individuals to seek independently. This poses the question: How can we help individuals living with chronic mental and behavioral impairments remain safe in the community? Home Healthcare professionals provide services that allow these individuals the chance to live as close to "normal" as their neighbors. Nurses are case managers for their clients, a job entailing multiple hats to be worn. We are the coordinator of appointments, liaisons to available support programs, reporters to clinicians and physicians, while at the same time, providers of individual medical care and support to our clients.

The purpose of the Medication Administration Skilled Nursing Visits, specifically targeted in the budget cuts, serve not only to safely and consistently administer prescribed medications, but also to assess and educate the client on their specific diagnosis, as well as to support and encourage the client in becoming more invested and accountable for their healthcare. Our care is not limited to medication administration, but most often, our Behavioral Health clientele present with multiple diagnosis, including medical issues such as Diabetes, Cardiac disease, Respiratory disease, and Obesity, needing appropriate attention and care to address these areas as well. The nurses provide vital information otherwise absent to clinicians, physicians, and prescribers involved in the client's care, based on the daily observations and conversations obtained during each visit. Nurses are able to assess the compliance and effectiveness of prescribed medications, the client's adherence to their plan of care (including attendance to meetings, appointments, etc.) and are able to advocate for the client if changes are needed to provide the utmost beneficial care. Homecare allows a medical professional to view a client's life from the inside, in the comfort of their living environment, in observation of the relationships they have with individuals, and the day to day activities they may take part in--- all important factors that can make or break a treatment plan. Through the Medication Administration Skilled Nursing Visits, clients are given the chance to remain in the community and out of institutions and hospitals due to the proactive and multi-faceted care Homecare agencies provide.

In my experience, I have seen clients decompensate due to many factors, and have been able to take part, hands-on, in the restoration of the client emotionally, mentally and behaviorally in collaboration with clinicians and physicians. The relationships we develop during our visits are built through time, consistency and genuine care found exclusively through home visits. Targeting Medication Administration Psychiatric homecare visits will do a great disservice not only to hospitals and institutions in short of beds, but also to the community and most importantly, the client, who so often do not have a "voice" in matters concerning their healthcare. Allow Homecare nurses to continue to advocate for our clients. Invest in improving services to all people with disadvantages rather than taking away what little support they may have.

**Testimony**  
**Proposed Governor's Budget**  
**February 27, 2015**

Dear Members of the Appropriations Committee, Rep. Walker and Senator Bye,

Let me introduce myself, my name is Elizabeth Labbe and I have been a behavioral health nurse since 2007 when I walked on the grounds of CVH and started working on one of the most difficult units in the state. In my four years there we were able to reduce the number of restraints and seclusions by 75% and worked very hard to get these clients back into the community with the support of group homes and visiting nurses. Transition was often difficult for these clients and without these vital supports in place many patients often ended up re-hospitalized.

In 2011 I decided to become a member of the Home health team, wanting to experience the success with these clients in the community. Since this time I have watched and supported and worked side by side with dedicated and caring nurses to aid these clients in their recovery to remain in their homes.

Let me take a moment to share a story of a young man diagnosed with schizophrenia catatonic type. He receives daily visits by the visiting nurse. This young man had not spoken a word in almost a year when he came to live in a group home. He was not able to make eye contact or even manage to stay in the room with the staff or nurse for more than a few minutes. He has a loving family who desperately misses the boy he once was but no longer could maintain him at home. With the support of his recovery program and his doctors and his visiting nurses, this young man is now speaking although not fully but he will respond and he will engage in activities. This young man's family never thought that they would hear his soft voice again or look into his eyes. They have been given back a piece of their loved one. It may be a small piece but for those of us who understand mental illness this is monumental. This could not have happened without the caring and dedicated support of the nurses and the staff that care for him. It is unfathomable to me that it would be perceived that all the nurse did was to put a pill in his mouth and say swallow. I watched nurses spend time with him learning things that he likes and dislikes and slowly break through that wall of silence that schizophrenia had created. This is an example of the recovery model at its best and would not be possible without all the parties involved.

I also had the experience of walking into a group home a few years ago and was approached by a young man who said, "do you remember me" and I looked closely to realize this was a young man I took care of in CVH who struggled with his illness, often having violent outbursts and aggression to the point he had to be placed on a unit of only males due to the fear he created among the female clients on a mixed unit. Never did I think I would be standing in a group home with him smiling at me as he was preparing to make breakfast with the rest of the residents. I then found out that he was a former patient of NEHC receiving daily nursing and has since been discharged from our services with group home assistance only. This again is an example of the hard work of dedicated nurses and mental health workers and clinicians to bring the recovery model to life

Thank you