

Testimony written by Amy Urban, RN, MSHS, Continuum Home Health, Inc.
Friday March 6th, 2015 for the Appropriations Subcommittee on Health Public Hearing.

Good afternoon Senator Gerratana, Representative Dillon and Members of the Appropriations Subcommittee on health,

My name is Amy Urban, a Registered Nurse and the Director of Quality and Education at Continuum Home Health, a New Haven based provider of home healthcare services to persons with severe and profound mental illness. Our current census is 520 patients, 95% of whom are covered by Medicaid.

I want to share with you that the Recovery Model using Skills Transfer training is working! Nurses are using their specialized critical thinking skills to review each plan of care, reconcile medications, and deliver care based on the State's Level of Care Guidelines, as promoted and guided by Value Options and Community Health Network. Our nurses are operating under individualized plans of care that align with the recovery principles of reducing dependency on the medication administration service, therefore promoting independence and skills transfer. Our nurses are proactively in contact with community treatment teams of MDs, APRNs, and clinicians to establish an appropriate plan of care from the start of services. They persist in moving patients towards greater independence, even though many of the community treatment providers continue to resist this movement. Our nurses have been successful in this area by providing data to the treatment providers to include results of independence testing both with medications, education retention, and task based follow through.

We service residents of supervised living programs. When appropriate, we have been able, through recovery model training and skills transfer efforts, to transition patients from twice daily medication administration to once daily or less, with non-professional staff supervising self-administration of medications without poor outcomes such as rehospitalization. In several cases, with consistent compliance to the plan of care as a result of nursing intervention, patients have been able to move from supervised living environments to independent living due to stabilization of symptoms and reduction in risk of noncompliance. We have successfully transitioned patients out of hospitals, institutions, and nursing homes/rehabilitation facilities, which have exorbitant costs. We service patients on jail and prison diversion, not only to help keep our neighborhoods safe, but also to keep the patients on a successful path to be contributing members of the community.

Our nurses are successful in partnering with MDs and APRNs to re-evaluate the medication profiles with consolidation of medications from BID administration to once daily dosing to promote reduction in utilization of medication administration services, as well as promoting skills transfer through nursing education. Our patients and treatment providers are also encouraged to explore the use of long acting injectable psychotropic medications, when appropriate, in efforts to reduce utilization of medication administration services.

Our home health nurses are providing services far beyond medication administration, which currently is the only reimbursable service provided under Medicaid Level of Care Guidelines. Our nurses are specially trained psychiatric and medical nursing case managers. In addition to managing medications, our nurses are collaborating daily with community treatment providers such as prescribers, clinicians, social workers, pharmacists, laboratories, housing program directors, waiver program clinicians, etc. Our nurses attend regular psychiatric and medical treatment and discharge planning meetings in the community to encourage and support our patients as they transition to more independent living situations.

We have successfully demonstrated the ability to reduce and discharge patients off of medication administration services. Over the past three years, we have reduced our average visits per patient by more than 20%, saving the state nearly 5 million dollars. We have scrutinized our census with the algorithm provided for the nurse delegation model and do not have the population that is appropriate for this type of skills transfer. In fact, anyone who would have been appropriate to have skilled nursing home health services delegated to home health aides, has successfully been reduced off the services all together through use of the recovery model and skills transfer training!



The patients who we continue to see have a demonstrated inability to manage their own plans of care, as evidenced by ongoing independence testing with unsuccessful results. These patients have significantly poor insight and judgment, complicated by complex medical needs and unstable psychiatric symptoms that require frequent follow up assessments. It would be detrimental to the patients' health and wellbeing, as well as to the safety of the community, for nursing services to stop or cut back for this population.

Our patients, when off their medications, are unable to abide by the required rules of their housing programs. They are at risk of becoming homeless, relapsing on abused substances, and having no chance of staying on their medications. Without nursing case management, they would not remember to go to their appointments and would lose the opportunity to obtain refills. They do not have demonstrated skills to use clean insulin syringes, order diabetic or wound care supplies, or maintain to their other durable medical equipment. They have demonstrated an ongoing inability to properly store their medications, frequently misplacing them or having them stolen as a result of their environment. For those who deny the need for medications, which otherwise would have them hospitalized or institutionalized, these patients have demonstrated that when not directly observed taking their medications with physician ordered mouth checks, they throw the medications in the garbage. For example, we have a patient on service with diagnoses of Chronic Paranoid Schizophrenia and Type II Diabetes. In part with the severity of her paranoid delusions, she denies that she is diabetic and in need of insulin, frequently throwing all of her medications and supplies in the dump, including the locked medication safe necessary to secure her medications in her home.

If any cuts occur to the medication administration reimbursement rate, we will most likely cease to exist. The public health and public safety crisis that will result will be catastrophic. I hope this helps to paint a picture of what home health care is accomplishing for our community. We will continue to do this if you allow us to stay open.

Thank you very much,
Amy Urban

The effect of Utilization Management on Visit Volume 2012-2015

Fiscal Year	Average Census	Visits	Annual Visits per Patient	Per Pt. per month
2012	332	141,311	426	35
2013	427	151,654	355	30
2014	484	161,500	334	28
6 months 2015	518	85,309	329	27

Had visits-per-patient remained at the 2012 level for the 2.5 years of 2013-2015, additional costs of \$4.9 million would have resulted.