

Northern Light Home Care and Hospice

Special Committee on Aging United State Senate

“There’s No Place Like Home: Home Health Care in Rural America “

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STATEMENT FOR THE RECORD

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Chairman Collins, Ranking Member Casey and members of the United States Senate Special Committee on Aging.

Good morning, My name is Leigh Ann Howard and I thank you for the opportunity to speak before you today to share our experience as a provider of home health care in rural America. I currently serve as the Director of Home Health and Specialty Programs at Northern Light Home Care and Hospice, a Medicare certified home care and hospice agency. As a member of Northern Light Health, a Maine based statewide integrated health care system, our home care and hospice programs serve patients throughout the entire state of Maine. Maine citizens are

among the oldest in the country living in a state with a large rural geography. Over the last year Northern Light Home Care and Hospice clinicians drove over three million miles to provide care, making close to 200,000 home care and hospice home visits. At times the transportation to get to a patient's home is just as unique as the geography of the state of Maine. For example, to serve many of the island communities off the coast of Maine, we travel by lobster boat or mail boat as this is the only way to reach the patient. This time of year, our staff may have to shovel their way down a long driveway of snow to reach the front door. Traveling the winding back country roads in the unpredictable weather conditions of western Maine also brings another layer of challenge. The travel time between some patients can be more than an hour.

As the Maine's rural population continues to decline, so do the number of qualified health care professionals. Healthcare workforce shortages have reached critical levels. Maine is experiencing a current and expanding shortage of nurses expected to reach 2700 registered nurses by 2025. In the rural regions we serve, nurses are among the oldest professionals in the State of Maine. Later in my testimony I will brief you on how we utilize technology to support the care provided by our home care nurses. Unfortunately, nurses are not the only health care profession experiencing a workforce challenge, some rural areas have a shortage of physicians leaving nurse practitioners as the only primary care professionals in the area. This creates significant barriers for rural residents needing to access home health care. Federal law prohibits nurse practitioners, and physician assistants, from ordering and certifying services for Medicare home health care. This barrier has a multiplier effect as Medicare Advantage plans and MaineCare (Maine's Medicaid program) enforce the same standard. We know that Nurse Practitioners are safe and effective in ordering home care services as evidenced by commercial carrier coverage in Maine. The best example of this challenge is a patient example. We recently

received a referral for home health care from a nurse practitioner for a patient discharged from a small rural critical access hospital. The patient needed home based nursing and physical therapy services to continue recovery at home. Our home health organization and the patient's nurse practitioner worked for weeks to try and identify a physician who would agree to sign the home care orders. This delay created a significant barrier for the patient to be able to access the home health care needed to help aid in his recovery. In our experience, patients have been readmitted to the hospital before a physician could be located to sign for home health services. These patients were all receiving their primary care from nurse practitioners.

Unfortunately, these situations are repeated all too often. We know that delays in receiving home health services post discharge from the hospital significantly increase the patient's risk of being readmitted to the hospital, often due to falling at home or medication errors. Rural patients already face significant changes accessing care due to lack of providers as they live in regions with no public transportation and experience significant travel required to get to a provider's office. Removing barriers and creating access to health care for our rural residents is essential to realize improved health outcomes for everyone regardless of where they live.

With the recent changes in Medicare home health brought by PDGM (Patient Driven Groupings Model) the importance of collaboration between home care clinicians is more important than ever. We are focused on how technology can support our staff to be efficient in the delivery of clinical services that support our patients to achieve individualized clinical goals.

Supporting this focus, we have had significant success using remote patient monitoring with our rural home health patients. Remote patient monitoring is a service that places technology monitoring devices in the patient home with remote monitoring of the clinical

information by a RN working through a secure web-based portal. The technology also includes patient education modules that we can customize to align with the home health plan of care. Patients who are high risk for rehospitalization use telemonitoring equipment that checks weight, blood pressure and heart rate. The readings are then sent via cell signal or the patient's internet to our web-based portal. The telemonitoring nurses review the readings every day. The nurses reviewing the readings are certified in heart failure through a national certifying body and can take quick action depending on the readings. Based on the patient's readings the nurse may call the doctor or use a medication-based protocol to manage the patient's symptoms in the home. Every time the patient's telemonitoring readings demonstrate a need to activate the medication-based protocol qualifies as an avoided ER visit. Throughout this process we are working in collaboration with the patient's physician. If an office visit is needed the visit can be made and transportation coordinated. The telemonitoring program has realized a monthly hospitalization rate between two to four percent, compared to a national benchmark of 24.9% 30-day readmission rate. This program also allows the home care nurses to make home visits based on a demonstrated need as opposed to an anticipated need, very important given the shortage of nurses. Currently we are tele-monitoring over 300 patients state wide every day.

Knowing that the best stories are patient stories, one of our biggest successes is a patient who had over 20 ER visits and hospitalizations within six months. Once admitted to home care and telemonitoring we worked with the physician to design a medication-based protocol that would meet her unique needs. Her ER visits and hospitalizations were significantly decreased, and she has been able to stay at home for more than five years.

Telemonitoring services are not reimbursed by Medicare but it is allowable in the episodic home health plan. It is unfortunate that as we are successful keeping the patient out of

the ER and hospital, we must progress to discharge the patient from home health services. This also results in the telemonitoring equipment being removed from the home. This is unfortunate as the simple act of the patient using the telemonitoring equipment could continue to keep the patient successful at home. By continuing the use of the telemonitoring equipment the home health staff may identify symptoms early and notify the patients physician for intervention. Early identification of symptoms could help the patient avoid the ER or hospital.

We have also expanded access to telemonitoring technology to individuals at elderly housing locations and senior socialization locations. Individuals do not need to be in our formal home care program, they register to participate and receive an identification card that they use to activate the system and their clinical data is transmitted to our web-based portal. Telehealth nurses evaluate the data for risk and contact the individual to recommend follow up with a health care provider.

While we are successful in the use of technology to support home care, we also know that many of the electronic tools that help facilitate care collaboration are difficult to use due to low connectivity in our rural state. Many areas have little to no cell phone signal. Broadband is difficult to come by and the cost is above what they could afford. When we experience this challenge, patients call in the clinical data to the telemonitoring nurse and we manually enter the information into the web portal so they can benefit from the program. The telemonitoring equipment also has capability for video visits. This is not something we have been able to utilize to its full potential due to the broadband challenges.

As a certified Medicare home health agency, we know the clinical benefit our patients experience when receiving care at home, we also know the limitations of the program as it is designed today. Medications have a significant role in the health and wellness of our patients.

Many of our patients have medications in the home that were previously prescribed but are no longer needed, previously prescribed but with a new dose and medications that are new to the patient post hospital discharge. Home care nurses routinely reconcile all the medications into a clinically accurate list of medications for the patient. But, in some situations the medication regime is so complex that the patient, home care nurse, and provider would benefit from an in-home pharmacist consultation for polypharmacy management. Home pharmacist visits are not part of the skilled services in the Medicare home health benefit. We also experience the challenge that occurs when patients have completed the skilled component of their home health plan of care and are discharged in need of ongoing support for pre-filled medication boxes. Patients often rely upon family or friends to assist but in rural areas many patients are isolated without this type of support. A home health aide could be provided with training on medications to perform the med box pre-fill service for patients who are on a maintenance schedule of medications, unfortunately this is not part of the Medicare home health benefit as it exists today.

In closing I am honored to be here today sharing the important work of our home care and hospice staff and the clinical benefit provided to the patients we serve. Thank you once again for this opportunity.