

January 24, 2016

Senate Finance Committee  
US Senate  
Washington D.C.

RE: Chronic Care Options Paper

Dear Committee Members and Stakeholders:

I am writing to provide input on the Chronic Care Option for Medicare service currently under consideration. I am a home health nurse with 45 years of nursing experience with 29 years in home care. I have a master's degree in nursing and use the title 'Clinical Nurse Specialist'. I have lived and worked in a rural area the vast majority of my career. I currently own and manage a home health agency so I am familiar with Medicare regulations and the day to day care of individuals with chronic conditions. I will speak to each of your goals. Some of my comments may cross goals

**Increase care coordination:**

Many hospitals now use Social Workers rather than RN's as Discharge Planners to save money. I have noticed a significant decrease in the quality of discharge planning since this has taken place. The social workers do not have the medical knowledge necessary to coordinate care. Many of them are more interested in protecting their 'power' than they are in facilitating patient care coordination. We receive referrals from urban and rural hospitals and this is a problem across the board. Social Workers would still be able to 'assist' the RN and perform some functions such as ordering Meals On Wheels, equipment, checking financial resources, etc. but an RN needs to be in charge and coordinate the actual care.

Incentivize the appropriate level of care:

Individuals with multiple Chronic Conditions need to be under the care of physicians. Mid level practitioners such as NP's and PA's do not have the knowledge or expertise to MANAGE their care. For example, we had a patient who went to the office because they were weak and falling. The PA ordered therapy rather than look for an underlying cause of the weakness. It turned out the patient had pneumonia and valuable time was lost before the proper treatment was started. We recently had a man with an exacerbation of COPD. The PA changed one of his medications but didn't follow thru with obtaining the drug which was covered under Part B of Medicare. Another patient had sleep studies ordered by a PA but they never followed thru on ordering the Oxygen indicated from the study. We don't see these problems when the appointments are with physicians.

Category- Receiving High Quality of Care in the Home:

Five levels of nursing practice have been identified- novice, advanced beginner, competent, proficient, and expert. In the home, individuals with chronic conditions need to be under the care of RN's not LPN's. The RN's should function at the proficient and expert levels of practice. When caring for individuals with chronic conditions, it is not sufficient to have a weekly case conference. We must identify and respond to changes in the patient condition and reports from team members on an on-going hourly/daily basis to keep these individuals stable and out of the hospital. The cost of their care is significantly increased. Many agencies won't take these patients because they only want 'high therapy' cases where they have minimal time investment with maximum return. There needs to be a higher level of reimbursement when caring for these individuals.

Another issue for individuals with chronic conditions is the use of inappropriate services. There is a guideline which indicates that it takes 3 days to recover for every day we are ill, hospitalized, or in exacerbation. If an individual is in the hospital 5 days it will take 15 days to recuperate. Therapy is often ordered on discharge. Ordering therapy will not hurry the recovery. The family and patient often feel that more is being done when therapy is ordered but, in fact, the individual would have been better in two weeks without therapy. Therapy may be detrimental to someone in fragile health if they aren't stable. Children hate to see a decline in their parent because it means Mom or Dad isn't doing as well. The children may be required to spend more time taking care of their parent. The children want to see the parent return to 'normal' to relieve their concern that Mom or Dad is declining and to decrease any extra demands on their time for assistance. Many years ago, we had a doctor who would send patient's with a stroke to the nursing home for 30 days to recuperate, stabilize, and adjust to their illness then readmit them for intensive therapy (rehab). This gave the patient an opportunity to make maximum progress and minimize their insurance costs. We don't allow people to recuperate anymore.

When PA's or NP's write orders for home care (which we can't take) they often order therapy instead of nursing when nursing is what the patient needs most. Nurses and aides can get people up and walk them and do basic strengthening exercises when the patient is stable. In the meantime, nurses can report changes in conditions, medication issues, etc. I support discontinuing the higher payments for therapy which should result in increased focus on nursing needs.

Medicaid and private insurance often have payment rates that make it impossible to provide care for their clients. Some discharge planners send all of their Medicare patients to an agency that pays 'referral fees' then call us to take the 'others'. We have no way to spread the cost of caring for these individuals. Their rates don't provide for any mileage or travel and cover the cost of an LPN visit not an RN visit.

#### **Streamline Medicare's current payment system to incentivize the appropriate level of care:**

Humana is not currently paying home health claims. There is not a good system in place to hold these MA plans accountable. When a state insurance plan is involved we can file a complaint with our State Department of Insurance.

We regularly have patients who are terminal but for various reasons do NOT want hospice. We provide all of the skilled service that Hospice provides and make arrangements with the physician and coroner so the patient can die at home. The patient's/families are usually people who have had a bad experience with hospice or do not want to give up their right to control their health care and make choices, or do not consider themselves to be terminal. The patient should still have a right to choose. What we consider appropriate may not be what the patient considers appropriate.

#### **Reduce the growth of Medicare Spending:**

Rural areas may be limited in their ability to provide professionals for the high levels of care discussed above. Often qualified individuals do not want to come to the rural area or the pay is too low. Home health agencies are penalized in the current system if they keep patients on service longer. We end up paying \$10-\$20 per patient survey to participate in the STAR system because our pool of eligible patients is so low (anyone with a history of alcoholism or mental illness is eliminated by our state laws). If we report a patient/family to Adult Protective Services then we will definitely receive a poor review from that home. I have heard of some agencies that direct their nurses not to report to APS. If there are only 10 surveys that month then even one negative survey will really bring us down. But, if we don't participate, then we aren't eligible to for any benefits of the STAR program and would receive even lower pay. The agencies committing fraud and abuse have made it very difficult for the legitimate agencies that are trying to meet the needs of the community. Nearly every Medicare required service (patient surveys, access to the Medicare computer billing system) has gone up in cost this year. Urban agencies can spread the cost across a large number of visits but rural agencies do not have that

option. We travel many miles because many counties do not have a home health agency. The Rural Add On does not cover the cost of mileage and travel time that we spend. Higher reimbursement would be very helpful to rural agencies.

Other policies to improve care for the chronically ill.

There are other homemaker and aide services available to help the chronically ill that may not be provided due to low reimbursement rates. The VA system has been under reorganization. We have done a lot of work for the Wichita VA. Previously, the CBOC Social Worker negotiated rates with us and paid a higher rate for out of town clients. A group of 4 people in Wichita recently decided that we would only be paid \$20 per hour regardless of location. They believed other agencies would come forward to provide the services if we dropped out. This attitude reflects the gross lack of knowledge about rural areas and the realities of receiving/providing care. This rate does not cover any travel or mileage so we have restricted our service to the city limits of our office. The Topeka VA may pay a higher rate per hour for aide service.

We have 11 Area Agencies on Aging in Kansas and each one sets their own rate for aide service. One agency might pay \$20/hr while another only pays \$14.50/hr. Every payer wants quality care and quality work, but we are at the mercy of individuals who may not understand anything about business or the rural area. At times, it feels that our efforts to meet the needs of the patients and community are abused.

In home health, we are penalized if our patients are readmitted to the hospital. Sometimes doctors will not respond to our calls or address the problems we identify. Later the patient is admitted to the hospital but this is good for the hospital's income. (Patient had orthopedic surgery in town A and is admitted in town B for a cardiac problem. Town B hospital needs patient and problem is unrelated to surgery. The hospitals are OK but we get sanctions because our patient was readmitted.) There are too many variables that we have no control over even when we are trying to provide excellent care. This is another example of an issue that affects our reputation and ratings but we have absolutely no control over it. The problem is solved if we don't take any patients who use doctors in town B. Is that the desired solution?

Thank you for taking time to read this. Finding solutions to health care is a complex complicated endeavor. During my 29 years in home care my approach to patient care has never changed. The patient has always come first. Patients receive the care they need- those who need more, receive more. We have never sat down and calculated how many visits we could make depending on the reimbursement rate and a desired 'profit margin'. I have worked without pay or received very little pay when necessary. Health care should NOT be 'big business' but should be able to survive and should meet the needs of the patient. Any groups looking at issues and solutions must consider the vast rural areas of our country.

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*HOME CARE ELITE 'TOP 100' 2008, 2010, 2012, and 2014*