



***On June 6, 2011, Karen Gomes, RN, Executive Director of Home Health of Home Health Services for Northeast Senior Health, provided the following testimony at the Health Care Payment Reform Committee meeting held at Salem State University:***

Good morning. I would like to thank Chairman Moore, Chairman Walsh, and all the members of the committee and staff for giving me the opportunity to speak with you today.

My name is Karen Gomes and I am a Registered Nurse and the Executive Director of Home Health Services for Northeast Senior Health. My Medicare-certified home health agency, Northeast HomeCare, has been in existence for five years, and we currently serve about 350 patients per day with home-based nursing, rehabilitation and social work services.

Northeast Senior Health is an affiliate of Northeast Health System, which is anchored by two community acute care hospitals here on the North Shore. I believe I have a unique perspective as the leader of home health services within a system such as Northeast, because in a way, the leaders of our system recognized the need to build a continuum of care before ideas such as Accountable Care Organizations (also called ACOs), bundled payments, and Medical Homes became common catch-phrases. That recognition of the need to provide quality care for patients in a lower cost setting, where patients prefer to be, was the driving force behind the inception of Northeast HomeCare.

If you consider Northeast Health System within the context of an Accountable Care Organization, you will see an organization that has many of the required elements: Primary Care Physicians who oversee the care of a large number of patients within a geographical area; community hospitals which care for people of all ages with all sorts of acute and chronic conditions; a robust psychiatric care continuum; and a Senior Health division which offers inpatient rehab services, Alzheimer's/memory loss care, assisted living, geriatric care management, adult day health and home care. All of these elements deliver valuable services to the citizens of the North Shore, but taken together they become so much more than themselves. I am proud to say that Northeast Health System recognizes the value of every element in this tapestry of care. Projects such as the State Action on Avoidable Re-hospitalizations have illustrated to all of us within our system that each level of care must have a seat at the table if we are to have a meaningful impact on improving healthcare quality.

Home care is a crucial piece of the equation and I urge you on the committee to consider what will happen to care coordination if you leave out the very people who can help fill in the gaps in terms of what happens to patients in between their 3- or 6-month check-ups, or between their hospital stays. Our trained home care staff interact with patients and families in their own environments. These professionals shine a light on the real reasons why patients sometimes don't manage their medications effectively or go the Emergency Department, and home care staff offer practical solutions that help patients stay home safely.

It would be nearly impossible for me to quantify for you the resources that we at Northeast HomeCare have spent over the past 5 years in order to provide our patients with professional healthcare services

based on best practice, use of state-of-the-art technology and proven chronic disease management techniques. Instead, I want to share a simple story that just recently happened over the past Memorial Day Weekend, because I think it illustrates far better than any statistics or accounting ledgers can, the value of home care to a frail and vulnerable patient trying her best to stay at home.

Our patient, Mrs. S., lives in an elderly housing complex in a North Shore town. She had recently been hospitalized for an infection, and has several chronic diseases including diabetes, congestive heart failure and low back pain. When our home care nurse, Carol, arrived for the first visit she discovered that Mrs. S. had called 911 three times in the past 24 hours, once due to a fall off of her toilet, and twice more because she could not get off of her toilet. Mrs. S. had banged her head when she fell, but she had refused to go to the Emergency Room. Carol knew that Mrs. S. was at high risk for another fall, and arranged for her to have a physical therapy evaluation later that day. Our Physical Therapist, Wendy, found Mrs. S. to be weak but functionally able to manage most of her mobility and transfers, with the exception of her toilet transfer. Her difficulty with this most basic of activities placed Mrs. S. at risk for repeated falls, and potentially a serious injury such as a hip fracture. This deficit in toileting ability, without further context, would likely be enough for some providers to come to the conclusion that Mrs. S. probably shouldn't be at home. Maybe she would be better off in a skilled nursing facility.

Wendy proactively evaluated the situation and came to some conclusions: first, Mrs. S. adamantly refused to leave her home; second, Mrs. S. would be safe at home if the toileting issue could be addressed; and third, the reason she was having so much trouble in her bathroom was that the elderly housing authority had recently replaced all of the toilets in the facility, and instead of comfort-height toilets, had installed low toilets. A raised commode seat, an item which might cost all of \$100, was basically what was needed to prevent Mrs. S. from having to move to a skilled nursing facility. But the story doesn't end there. This was a holiday weekend. Wendy, who definitely knows her way around the medical community, called three durable medical equipment providers, two senior service agencies, the patient's insurance company, two outpatient rehabilitation centers, and a hospice provider, to beg, borrow or steal a seat so that our patient could be independent and safe at home. When Wendy was fortunate enough to get someone on the phone, she would receive a sympathetic ear but no solution to the problem. Finally, Wendy asked the patient if any of her friends were in the hospital. It turns out, one of her neighbors was in the hospital. Wendy called the neighbor's daughter, and she gave her permission to get the neighbor's commode to use in an emergency. Wendy helped clean the commode and set it up, and low and behold, no more 911 calls, no more need for skilled nursing facility placement, and it only took Wendy about 3 and a half hours to coordinate all of this.

I don't know about you, but when I heard this story, I thought, Wendy is an extraordinary clinician performing the most ordinary of tasks in the context of a payment system that does not even begin to compensate for the time and effort it takes to pull all the little pieces of the puzzle together and enable patients to stay safely in their own homes for as long as possible. This is why it is crucial that home care not only is recognized for the unique role we play but also is included at the leadership level of Accountable Care Organizations that strive to provide the highest quality of care at the lowest cost in the most appropriate setting. For most of our seniors, if you ask them, that setting is their own home.