CITY AND BOROUGH OF SITKA

A COAST GUARD CITY

MEMORANDUM

To: Mayor Eisenbeisz and Assembly Members

From: Assembly Members Mosher and Pike

Date: April 2, 2024

Subject: Resolution urging SEARHC to consider re-establishing a Medicare Certified Home Health Care Department

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Background

SEARHC has been offering Medicare Certified Home Health Care for over 35 years. However, in September of 2023, they made the decision to close this department and introduce a Home Based Care program. Since then, there has been significant community concern regarding this change.

While we acknowledge that we are not experts in the medical care profession and respect SEARHC's independence, we respectfully request that SEARHC consider undertaking a sincere and inclusive public outreach effort in Sitka. Furthermore, we ask SEARHC to reconsider reinstating their previous program if it is both desired by the community and feasible.

Recommendation

Approve this Resolution.

Encl: Res 2024-10
Informational handout Dr. Connie Kreiss

Sponsors: Mosher / Pike

CITY AND BOROUGH OF SITKA

RESOLUTION NO. 2024-10

A RESOLUTION OF THE CITY AND BOROUGH OF SITKA URGING SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM (SEARHC) TO CONSIDER RE-ESTABLISHING A MEDICARE CERTIFIED HOME HEALTH CARE DEPARTMENT

WHEREAS, Sitka has had a Medicare Certified Home Health Care Department for over 35 years; and

WHEREAS, hundreds of Sitkans and their families have benefited from comprehensive Medicare Certified Home Health Care allowing patients to remain at home during the last years of their lives; and

WHEREAS, Medicare Certified Home Health Care is covered 100% by Medicare; and

WHEREAS, SEARHC closed their Medicare Certified Home Health Care Department on September 30, 2023; and

WHEREAS, the City and Borough of Sitka recognizes the long and beneficial relationship between SEARHC and the community of Sitka, and Southeast Alaska; and

WHEREAS, the City and Borough of Sitka Assembly recognizes the autonomy of SEARHC; and

WHEREAS, there has been strong public outreach in the community by many people requesting SEARHC restore the Medicare Certified Home Health Care services, and recognizing that health care services are about serving those who need it.

NOW, THEREFORE, BE IT RESOLVED that the Assembly of the City and Borough of Sitka, Alaska, hereby respectfully requests that SEARHC consider re-establishing a Medicare Certified Home Health Care Department, by convening and engaging with the public, and local stakeholders in Sitka's health. We recognize that SEARHC is independent, but desire that SEARHC seek out genuine public engagement.

PASSED, APPROVED AND ADOPTED by the Assembly of the City and Borough of Sitka, Alaska on this 9th day of April, 2024.

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Kevin Mosher, Deputy Mayor

ATTEST:

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Sara Peterson, MMC
Municipal Clerk

1st and final reading: 4/9/2024

Sponsors: Mosher / Pike

Why the new SEARHC Home-Based Service is NOT the same as the former SEARHC Medicare Certified Home Health Care Department:

The new system is not free to non-beneficiaries. For Medicare patients, 80% is covered by Medicare, and there is a 20% co-pay which may or may not be covered by secondary insurance. Especially if there are multiple visits, this could be quite expensive. The former Medicare Certified Home Health Department provided care which was 100% covered by Medicare, because the services were under a "Medicare-Certified" agency. This is a big difference. Some physicians now have concerns that their patients who could benefit from home services are refusing these services because of fear of the potential cost.

The new system requires a physician to direct the care very specifically. For example, the physician could write for a home visit to draw blood, do an EKG, check a wound, or give an injection. These are one-time orders. The nurse might be able to find a reason for a follow-up visit, for example the wound might need another check later in the week. But generally, the nurse is doing one specific task, as directed by the doctor. Doctors are busy with seeing patients in the office or in the hospital, and do not generally have the time to follow closely. Doctors are also, generally, not trained in home care. They don't have the time and expertise to assess a patient at home and put together a home care plan. Nurses, not physicians, are the specialists in home care. Yet the new system is doctor-driven, and usually very limited. It is not comprehensive care.

The former system was, in contrast, nurse, not physician, directed. After the physician referred a patient to the Medicare Certified Home Health Department, a nurse made a home visit and did a complete head-to-toe assessment of the patient, assessing physical, mental and emotional needs as well as home safety. The home health team, with the patient and patient's family, developed an individualized care plan to meet the needs and goals of the patient. This included nursing, physical therapy, occupational therapy and occasionally speech therapy.

As an example, an elderly patient returning from major hip surgery in Anchorage or Seattle, might have a 60-day plan involving physical therapy visits twice a week, an occupational therapy visit to help with adaptive equipment, a nurse visit twice the first week to check the wound, and then a weekly visit to check blood pressure, review medications and assess other needs as they arose. This was a nurse-driven model where a team of nurses and rehab specialists worked together to help the patient meet their rehab goals. The care plan could be renewed after 60 days if needed. Nurses providing continuity of care in the home were in a position to notice changes in their patient's condition, would notify the physician, change the care plan as needed, thereby helping prevent ER visits and hospitalizations. The home team was the eyes and ears of the physician. As one physician said "I didn't have time in my schedule to come see the patient two times a week. I relied on the nurse team to be my eyes and ears."

These services provided care for a home-bound patient after a stroke, or heart attack, or for a patient with Parkinsons, or other neurologic problem, or for a home-bound patient with cancer. Patients recovering from severe trauma could also get care in their homes. The home health team would teach catheter care, train home caregivers, monitor nutrition and intravenous therapy, teach patients and families how to give medications, and teach family what to do if the patient was receiving end-of-life care.

Families in Sitka receiving home health services in the past, talk of how broad the care plan was, how they felt supported by a team of healthcare workers visiting their home, assessing, and helping their home-bound family member.

The new system has one full-time home nurse, experienced in home health. She has a list of others she can call in if she needs help, if they are available, but that list does not necessarily mean the other nurses are skilled in home health care. The former system had 3 full time nurses and others part-time. They were all experienced in providing the specialized type of nursing for home health care. So, the nurse staffing level has changed dramatically. The former system also used CNAs occasionally for hands-on care, part of the 100% covered Medicare-Certified plan. CNAs are not part of the new system.

To summarize:
-The old system was free to home-bound Medicare patients. The new system requires a co-pay.
-The old system was comprehensive, nurse directed and was often a 60-day plan. The new system is task-oriented, brief, and directed by the physician.
-The old system sometimes used CNA's. They are no longer involved in the new plan.
-In the old system, home health nurses and home physical therapists were located in the same office where coordination and communication was easy. Now the one home health nurses is separate from the PT and other rehab staff. This makes communication less easy.
-The old system had 3 full time home health nurses and other part-time nurses, all experienced. The new system has one full time home health nurse. One nurse can't begin to do what three plus nurses did previously.

Dr. Connie Kreiss, retired from SEARHC