Mary Myers, MS, RN
Chairman of the Board

HOMECARE & HOSPICE
NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

William A. Dombi, Esq.
President

Submission by
THE NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE (NAHC)
to the

NATIONAL COMMISSION ON SAFETY AND QUALITY IN NURSING HOMES

July 17, 2020

Since 1982, the National Association for Home Care & Hospice (NAHC) has been the leading association representing the interests of home health, hospice and home care providers across the nation, as well as home caregiving staff and the patients and families they serve. Our members are providers of all sizes and types – from small rural agencies to large national companies – and include government-based providers, nonprofit organizations, systems-based entities and public corporations. In light of our experience during the COVID-19 public health emergency (PHE), we welcome the opportunity to submit comments to the National Commission on Safety and Quality in Nursing Homes (Commission).

NAHC members have been at the forefront of delivering high-quality, community-based home and hospice care throughout the current PHE despite numerous challenges, including continuing shortages of personal protective equipment (PPE), staff limitations and other difficulties. By far the most overwhelming struggle for our providers has been – and continues to be – obtaining access to patients residing in nursing homes and other congregate living locations. This Commission has been tasked, in part, to: "Identify best practices for improved care delivery and responsiveness to the needs of all nursing home residents in preparation for, during, and following an emergency." We believe that such "best practices" should include development of clear guidance to facilities that supports a patient's right to receive patient-centered end-of-life care from certified hospice providers and that facilitates access to such care, and that address the many specific issues that we are raising as part of this submission. Each issue referenced has been reported numerous times, and by hospices across the nation. As such, we believe these concerns warrant the attention of the Commission, and urge that you address them through the recommendations that you are developing for release in September. We have grouped the concerns by category for ease of reference.

Access to Hospice Services

As part of the facility-hospice agreement related to services, the hospice and the facility are jointly responsible for ensuring that the needs of the patient are met at all times, based on the established plan of care. Any changes to the plan of care must be approved by the facility, the hospice, and the resident/representative collectively. However, with the onset of the PHE, many (if not most) facilities imposed strict rules related to patient access that dramatically curtailed access to hospice patients to meet patient care needs. Importantly, in many of these instances the access restrictions were imposed without consultation with the hospice or the hospice patients. Following are some of the practices that have been widespread:

- Imposition of no in-person hospice visits rule
- Refusal to admit hospice staff, even for death visit
- Refused hospice medical director/hospice physician access
- No in-person hospice visits unless the resident is actively dying
- Restriction of hospice visits to RN only or RN and Aide only
- Restriction of hospice visits to RN only and only once every 14 days
- Access granted to certain hospice disciplines only if these individuals are assigned exclusively to the facility and do not serve patient in other facilities
- Hospice staff not permitted to connect with patient, only permitted to speak to the facility nurse
- Chaplain/Social Work visits prohibited even when patient/family requests
- No visits; drop supplies outside facility
- Requiring that patients who test positive for COVID-19 be discharged from hospice in order to elevate the facility services to the nursing home skilled level of care (this issue will be addressed more fully later in these comments)

Technology-based Visits

Clarification by the Centers for Medicare & Medicaid Services (CMS) in late March that hospices are permitted to deliver services via telecommunications technology for patients receiving the Routine Home Care (RHC) level of care – provided use of such technologies allows the goals of care to be addressed – significantly improved hospice providers' ability to deliver needed services despite nursing facility visit limitations. However, in many instances nursing facilities refused to help facilitate the use of telecommunications technology for the provision of hospice care, citing insufficient resources or time to support such visits.

Further, despite the benefits of being permitted to use telecommunications technology to provide some hospice services, we found that nearly 24 percent of hospices participating in a nationwide survey during the first three weeks of May indicated they were able to substitute virtual visits in only limited or no cases. As part of the same survey, only 12% of hospices were able to provide most of the in-person visits that were warranted for patients in nursing facilities. Nearly 65% of hospice respondents indicated that the telehealth flexibilities addressed SOME of the challenges in addressing the care needs of facility residents, while only 4% of hospices indicated that use of telecommunications technology has addressed

all of the patient access issues in facilities. It must be concluded that many hospice patients in facilities are not receiving the full hospice benefit due to limitations on access imposed by nursing facilities.

Coordination of Care

If a nursing facility contracts with a hospice provider to deliver services to patients in the facility, the care of the resident receiving hospice services must reflect ongoing communication and collaboration between the nursing home and the hospice staff, including establishment of a communications process that can be used 24-hours a day and proper documentation of concerns and responses. Further, nursing home staff are required to immediately contact and communicate with the hospice staff regarding any significant changes in the resident's status, clinical complications or emergent situations. A member of the facility's interdisciplinary team must be designated as responsible for working with hospice representatives to coordinate care to the resident provided by the facility staff and hospice staff. However, hospices have reported, on a widespread basis, an inability to secure information about patient status, the inability to contact the facility's liaison to the hospice, and failure of the liaison to return calls regarding patient status.

Hospices have also reported that facilities have, without any communication to hospices and without a notice period, decided that only one hospice will be allowed to serve residents of the facility. While a facility can decide to restrict hospice care to only one hospice, the existing contract with other hospices must contain termination procedures. Not observing these contractual obligations negatively impacts continuity of care for existing patients.

Reduced Referrals/Discouraging Hospice Election

As part of nursing home quality requirements under the Conditions of Participation (CoPs), facilities must routinely conduct a comprehensive assessment to support development of and changes to the plan of care. The care plan must reflect person-centered care and include resident choices, preferences, goals, and concerns/needs. Further, the comprehensive assessment should provide direction for the development of the resident's care plan to address the choices and preferences of the resident who is nearing the end of life. If the nursing home has an agreement with a hospice, it is required to inform each resident before or at the time of admission, and periodically during the resident's stay, of hospice services available in the nursing home.

During the PHE, hospices have reported significantly reduced referrals from nursing facilities. When this issue has been raised with facilities, hospices have reported that the facilities have responded that they are equipped to provide end-of-life care and that hospice is not needed. We have also heard reports from family members that have indicated they wanted a family member in a facility to enter hospice care but the facility discouraged the patient from electing hospice and indicated that hospices weren't allowed to provide any visits in the facility so such care would not be beneficial to the patient. These reports run counter to the spirit of the CoPs and should be addressed going forward. We strongly recommend that the Commission and CMS examine rates of hospice enrollment for nursing facility patients prior to and during the PHE to assess the extent to which nursing facilities may be discouraging the use of hospice care and potentially failing to take patients' care preferences into account.

"Skilling" Patients/Forced Discharge from Hospice

Hospices have also reported, on a widespread basis, that nursing facilities are shifting the level of care for patients that test positive for the COVID-19 virus. While some facilities change the level of care only for those patients who are symptomatic, others are "skilling" all patients who test positive, regardless of whether they are exhibiting symptoms. In some cases the facilities expect that the hospice will continue to provide services to the patient, even though hospice services may not be provided concurrent with the Medicare skilled nursing facility benefit (except in the rare case of unrelated diagnoses), while in other cases the facilities are instructing the hospice to discharge the patient so that the facility can bill for SNF services. In these situations, the resident received SNF skilled care benefits for the 14-day COVID19 period and is then instructed by the facility to re-enroll in the Medicare Hospice Benefit. In one instance the patient had entered skilled care three weeks previous to the hospice being notified and instructed by the facility to discharge the patient. While by law it is the patient's decision whether to revoke hospice care and utilize "skilled" care, in such situations the hospice has limited options if any at all Both nursing facilities and hospice agencies need clearer guidance around how such situations should be handled going forward.

Testing

As part of the Nursing Home Reopening Guidelines, all nursing home vendors are to be tested for COVID-19. Tests are in limited supply in some areas and difficult for nursing homes and hospices to obtain. It is essential that the two work together to ensure that all hospice staff entering the facility have passed any necessary screening/testing. Some hospices are reporting that nursing homes in their area have access to tests that are free of charge and/or have results soon after testing as opposed to five days or weeks after testing. There are reports from hospices that these nursing homes are not requesting these tests for hospice staff, which prevents the staff from being able to serve residents. There are also reports of nursing homes insisting that hospices supply their own tests even in situations where the nursing homes have access to tests. Hospice staff should be considered the equivalent of nursing facility staff in terms of clinical responsibilities, not simply as an outside vendor. It is essential that hospices and nursing homes work collaboratively to observe infection control standards and reopening guidelines, and ensure that the care needs and patients' preferences are being honored.

We appreciate the opportunity to submit these comments for your consideration, and welcome your efforts to address these and other situations that have arisen in response to the PHE. If we can supply any additional information or be of assistance in any way, please contact Theresa M. Forster (tmf@nahc.org) or Katie Wehri (Katie@nahc.org).