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OUR PATIENTS. OUR UNION. OUR VOICE.

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March 24, 2022

The Honorable Akilah Weber
1021 O Street, Suite 4130
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RE: AB 2092 (Weber) OPPOSE

Dear Assemblymember Dr. Weber;

The California Nurses Association/National Nurses United (CNA), representing more than 100,000 registered nurses who provide direct patient care at the bedside, regrets to inform you of our strong opposition to AB 2092 (Weber). The bill, which would statutorily authorize general acute care hospitals (GACHs) to operate the Centers for Medicare and Medicaid Services (CMS) Acute Hospital Care at Home (AHCaH) programs, puts patients in grave danger by allowing hospitals to treat patients at home for conditions that require acute inpatient-level care.

AHCaH programs allow GACHs to treat patients with conditions that require acute inpatient-level care in the home rather than in a hospital. Kaiser has publicly stated that its "Advanced Care at Home" program is *not* about providing care for traditional home health patients. Instead, the program is for patients who would otherwise be admitted to brick and mortar medical-surgical floors.[1] The Adventist Health Hospital @Home program is described as a "virtual hospital."[2] UCI Health has proposed a "high-touch, high-quality virtual inpatient acute hospital."[3] These are but a few examples of these profit-driven programs that replace 24/7 hands-on nursing care with two visits a day by a registered nurse or a paramedic

[1] Stephen Parodi, MD, Executive Vice President External Affairs, Communications, and Brand The Permanente Federation, Associate Executive Director, The Permanente Medical Group, "Keynote Fireside Chat: Changing the Dynamics of Patient-Centered Care with the Hospital at Home Concept," available at (https://vimeo.com/637008128).

[2] Jackie Drees, "5 hospital-at-home initiatives from Adventist Health, Mayo Clinic & more," Beckers Hospital Review, June 30, 2020.

[3] Aisling Carroll, "Orange County residents benefit from UCI Health's innovative at-home monitoring program," February 28, 2022 (see question, "Can UCI Health patients receive acute-level hospital care at home today?"), https://caph.org/2022/02/28/uci-health-blog/.

These programs lower standards of acute care for patients in the program and waive numerous provider requirements and patient safety standards under Medicare, including requirements that a hospital provide 24-hour on premises nursing services, immediate availability of emergency response treatment, and ongoing in-person care by nurses or doctors. Moreover, the AHCaH program, established by the Trump Administration under a waiver and outside the normal rulemaking process, allows the hospital industry to capture windfall savings in labor costs and overhead by providing bare-bones care at inpatient-level reimbursement rates. For all these reasons and those detailed below, CNA opposes AB 2092.

- **AHCaH Programs Undermine Central Role RNs Play in Hands-On Care**

First, the AHCaH program does not and cannot provide patients with the ongoing, in-person assessment and treatment by licensed health care professionals that acute care requires. Hospitals employ a wide variety of health care professionals who are readily available 24 hours a day in hospitals, including doctors, registered nurses, respiratory therapists, and pharmacists. In contrast to the ongoing, in-person assessment by RNs around the clock in a hospital, the AHCaH program requires only two in-person visits a day by paramedics or RNs.

Nothing is more foundational to acute inpatient care than in-person, 24-hour observation and ongoing assessment by a registered nurse, but the AHCaH program is designed to eliminate 24-hour nursing services. This industry trend seeks to redefine what constitutes a hospital and what counts as nursing care. Not only do these programs endanger the imminent safety and lives of our patients, but they also completely undermine the central role registered nurses play in the hands-on care that patients need to safely heal and recover. The entire reason for being admitted into a hospital is to benefit from the 24/7 monitoring, assessment, and professional care that licensed registered nurses provide. Nurses, more than any other health care staff, spend the most time with patients.

CNA rejects the hospital industry's assertion that iPads, cameras, monitors, and the occasional visit by likely lesser-skilled and unlicensed personnel are in any way comparable to the skilled, expert nursing care and social emotional support registered nurses provide every moment of every shift.

Registered nurses are also the last line of defense in preventing medical errors. For example, prior to medication administration, nurses check to make sure the medication is administered with the right dose, right route, right drug, right time, and right patient.[4] Medication errors are more common in patients treated at home than in patients treated in a health care facility. Even when medications are administered correctly, life-threatening reactions can occur. For example, "[h]ome infusions were associated with 25% increased odds of [emergency department] or hospital admission on the same or next day after the infusion", according to a large retrospective study.[5] Another recent study that reviewed 50 patient charts in an acute hospital care at home program found 14 adverse drug events among 11 patients and 44 potential adverse drug events among 30 patients.[6] Immediate access to emergency care can be crucial to saving the life of a patient experiencing an adverse drug event.

- **AB 2092 Requires AHCaH Programs to Comply with CMS Requirements, Which Are Deficient**

Under AB 2092, GACHs may provide AHCaH services if the hospital meets specified CMS requirements. As a result, it is important to understand what those requirements actually require, and what they don't.

More specifically, the AHCaH program waives CMS "Hospital Conditions of Participation, which require nursing services to be provided on premises 24 hours a day, 7 days a week and the immediate availability of a registered nurse for care of any

[4] World Health Organization 2022. WHO Safety Curriculum. https://www.who.int/patientsafety/education/curriculum/who_mc_topic-11.pdf.
[5] Baker M et al. 2022. Comparison of Adverse Events Among Home- vs Facility-Administered Biologic Infusions, 2007-2017. *JAMA network open* 4.6:e2110268-e2110268.
[6] Mann E et al. Adverse Drug Events and Medication Problems in "Hospital at Home" Patients. *Home Health Care Serv Q*. 2018 Jul-Sep;37(3):177-186. doi: 10.1080/01621424.2018.1454372. Epub 2018 Apr 13. PMID: 29578834; PMCID: PMC6818238.

patient."[7] In an emergency, under CMS's 24-hour nursing services requirement for acute care facilities, patients in a fully operational hospital staffed 24/7 by registered nurses can be treated immediately. Under the AHCaH program, however, where patients are being treated at home, CMS only requires an emergency response within 30 minutes. In addition, after a doctor performs an initial medical history and physical exam for an AHCaH patient, CMS does not require any additional in-person registered nurse or doctor visits with patients in this program. Instead, the AHCaH program requires just two in-person patient visits a day by a nurse *or paramedic*. These lowered standards for nursing, medical, and emergency care under the AHCaH program put patients' health and safety at risk.

The Adventist Hospital at Home (HaH) program, for example, specifies that patients will receive two in-person visits each day from an NP, RN, or paramedic. Here, Adventist is clearly substituting paramedics for RNs under their HaH model which they could not do if these same patients were in the hospital.

- **Emergent Care Delayed to Patients Suffering an Emergency or Adverse Event; No Comparison with a Hospital's "Rapid Response Team"**

Further placing patients at risk, the AHCaH program does not require the immediate availability of emergency response services by licensed health care professionals. Instead, as noted above, CMS requires an emergency response only within a half hour rather than requiring emergency response be available immediately. And the response may be provided by engaging the local 911 system.

As a result, AHCaH programs can delay emergent care to patients who suffer an emergency or adverse event. In a hospital, a patient who decompensates for any reason would receive assessments and care immediately. Hospitals have developed "rapid response teams" in order to provide immediate care for a patient who becomes unstable or decompensates and to determine whether the patient needs to be transferred to the ICU. These teams most often consist of an RN and a respiratory therapist as well as

[7] U.S. Centers for Medicare & Medicaid Services. Undated. Acute Hospital Care at Home Individual Waiver Only (not a blanket waiver). https://qualitynet.cms.gov/acute-hospital-care-at-home

either a physician, advanced practice registered nurse, or a physician assistant.[8] It is the registered nurse, based on the regular monitoring and assessing of patient status, who most often initiates the rapid response emergency code. Unlike the AHCaH program which requires an emergency response within 30 minutes, a hospital's rapid response team can respond within seconds of the emergency code being activated.

This emergency care would be delayed under the AHCaH programs. For example, Adventist Health's Hospital @Home (AHH@H) program requires that the local 911 emergency system be engaged in order to provide care when an AHH@H Command Center nurse identifies:

1. certain emergent clinical indicators (e.g., chest pain, signs or symptoms of stroke, etc.);
2. an immediate or possible unstable condition or patient decompensation and the patient is unresponsive or coding; or
3. an immediate or possible unstable condition or patient decompensation and the patient is responsive and requires an urgent in-person visit. In this case, the AHH@H Command Center contacts its AHH@H RN for a nursing response. If the ETA is greater than 30 minutes or the condition warrants an immediate response, the Command Center activates the local 911 system.

Without immediate attention from a registered nurse and access to necessary treatment resources, patient morbidity and mortality rates increase.[9] Delaying emergency response by 15 minutes or more is shown to increase likelihood of intensive care unit admission or death in a variety of conditions.[10] For example, early recognition and treatment of patients with sepsis and septic shock reduce mortality rates and

[8] Mitchell O et al. 2019. Rapid Response and Cardiac Arrest Teams: a Descriptive Analysis of 103 American Hospitals. *Critical Care Explorations*, 1(8).

[9] Recio-Saucedo A et al. 2018. What Impact Does Nursing Care Left Undone Have on Patient Outcomes? Review of the literature. *J Clin Nurs, 27*(11-12), 2248-2259. doi:10.1111/jocn.14058.

[10] Chen J et al. 2015. Delayed Emergency Team Calls and Associated Hospital Mortality: A Multicenter Study. *Crit Care Med, 43*(10), 2059-2065. doi:10.1097/ccm.0000000000001192; Liu C et al. 2014. California Emergency Department Closures are Associated with Increased Inpatient Mortality at Nearby Hospitals. *Health Affairs*, 33(8), pp.1323-1329.

morbidity.[11] Severe cases of sepsis can lead to long-term cognitive impairment and physical disability.[12] Studies demonstrate that delays by emergency response teams lead to increased morbidity and mortality in cardiac arrest events while a rapid response from the team leads to improved patient outcomes.[13] Delaying cardiopulmonary resuscitation when a cardiac arrest has occurred leads to poor outcomes -- for every minute without CPR, survival from cardiac arrest decreases by 7–10%.[14]

Because the AHCaH program does not require the immediate availability of emergency response teams as is required in acute hospital settings, CNA is concerned our patients' mortality and morbidity rates will rise under the AHCaH program. Our patients' conditions can deteriorate quickly and unexpectedly. They should not be stranded at home in case of an emergency or adverse event with no way to get immediate help or medical intervention or treatment other than the local 911 system. This simply does not compare to the timely care and assessment a hospital's "rapid response team" can provide.

- **Timely Assessment by an RN is Not Assured**

AHCaH programs do not necessarily provide timely assessment by an RN of a change in a patient's condition. For example, Adventist Health's Hospital @Home (AHH@H) Program fails to require that a face-to-face RN assessment is done at no less than a 12-hour interval. Instead, the twice-daily requirement could allow for an RN through the contracted service to see a patient at the beginning of an 8-hour shift and at the end. That would mean the patient would be without a hands-on assessment by an RN for up to 16 hours. That does not happen in a hospital with either an 8-hour shift schedule or a 12-hour shift schedule. The 12-hour assessment is the lowest threshold for inpatient

[11] Seymour C et al. 2017. Time to Treatment and Mortality During Mandated Emergency Care for Sepsis. *New England Journal of Medicine*, *376*(23), 2235-2244; Iwashyna T et al. Long-term Cognitive Impairment and Functional Disability Among Survivors of Severe Sepsis. *JAMA.* 2010;304(16):1787–1794. doi:10.1001/jama.2010.1553.
[12] Iwashyna T et al. 2010. *Supra* note 11.
[13] Mitchell O et al. 2019. *Supra* note 8.
[14] Ibrahim W. 2007. Recent Advances and Controversies in Adult Cardiopulmonary Resuscitation. *Postgrad Med J, 83*(984), 649-654. doi:10.1136/pgmj.2007.057133.

assessment, and there is nothing in the program flexibility that assures timely assessment of a change in condition by an RN.

- **Acute Hospital-Level Care Requires the Appropriate Level of Services, Equipment, and Infrastructure**

In addition to the unavailability of health care professionals, patients' homes lack the full complement of resources available in a hospital setting to respond to unexpected complications or deterioration of patients' health status. Although the AHCaH program requires participating organizations to provide laboratory, radiology, pharmacy, and respiratory services, these services are not immediately available in a patient's home like they would be in a hospital. These services and medical supplies are crucial in many instances. For example, diagnosing sepsis requires blood cultures and lactate measurement, followed by administration of broad-spectrum antibiotic agents if sepsis is confirmed. All these processes are difficult to complete rapidly outside of an inpatient hospital setting.[15] Similarly, resources may be needed to evaluate patients' respiratory status through a blood gas evaluation and checking electrolytes, epinephrine may be needed for resuscitation, and dopamine may be needed to stabilize blood pressure. Finally, if a patient needs to be intubated, necessary supplies and radiological services to confirm tube placement are crucial. Ready access to all of these resources is essential to saving patients' lives.

AHCaH patients are extremely vulnerable in the event of a power, telephone, or internet outage because internet and phone service are lifelines that connect AHCaH patients to nurses and physicians for ongoing care and to emergency services when needed. In contrast to most homes, hospitals caring for Medicare patients must have emergency power and lighting in many hospital areas and battery lamps and flashlights in all other areas.[16] Additionally, even though it is not a Medicare condition of participation, many hospitals maintain an emergency power supply for the entire facility. Finally, hospitals treating Medicare patients must have an emergency gas and water supply which are lacking in patients' homes.[17]

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[15] Seymour C et al. 2017. Time to Treatment and Mortality During Mandated Emergency Care for Sepsis. *New England Journal of Medicine*, *376*(23), 2235-2244.

[16] 42 CFR § 482.41.

[17] *Id*.

- **Care Shifted – Undue Burden on Patients' Caregivers and Family**

Without 24/7 RN staffing, family members will likely need to step in, creating stress and leaving patients attended to by laypeople. This will place an undue burden on patients' unpaid caregivers and family members. And family members are an inadequate and inappropriate substitute for the provision of acute care by skilled and licensed health care professionals. Family members do not have the education and clinical experience to provide acute, inpatient-level patient care nor to perform the necessary ongoing assessment of patients.

Even the simplest RN-patient interactions involve assessment and evaluation of the patient's overall condition. Subtle changes in a patient's skin tone, respiratory rate, demeanor, and affect provide critical information to patient health and wellbeing which can be easily overlooked or misinterpreted by a family member. Clearly, care in the home by a family member plus two in-person visits by an RN or paramedic does not meet the same standards of acute in-patient care in a hospital. The lack of 24/7 RN and other health care professionals on hand is likely to lead to higher levels of missed care, medication errors, and miscommunication, leaving patients vulnerable to grave consequences. Burdening family members with care that should be provided by registered nurses and other health care professionals allows the hospital industry to increase its profits at the expense of patient safety.

Moreover, CNA is also acutely aware that AHCaH programs will ultimately shift unpaid care work onto women inside the home, while taking away paid care work from a predominantly female RN workforce at the hospital.

- **Industry's Real Agenda: Dramatically Cut Costs of Operating Traditional Hospitals and Staffing Hospital Beds; Threat to Rural Hospitals**

The AHCaH program is part of a decades long trend, intended to maximize industry profits, that has led to the steady reduction in the availability of acute inpatient services and hospital beds available across the country, and in California. AB 2092 would allow the healthcare industry to push even more patients out of the hospital and further reduce acute care capacity in California.

In its own materials, Kaiser acknowledges that the driving force behind this program to send people home and keep them out of the hospital is to dramatically cut the costs of maintaining and operating traditional hospitals and staffing hospital beds with registered nurses.

In the long term, the hospital push for AHCaH programs will result in hospitals as we know them disappearing. As more and more patients are sent home, hospitals will use the lower patient census as justification to close inpatient beds and further cut RN staffing, leading to a self-fueling death spiral of community hospitals. Brick-and-mortar rural hospitals, already an endangered species, will certainly go extinct.

In fact, the executive chairman of Medically Home, a digital health company partnering with Kaiser on its "Advanced Care at Home" program, suggested in a recent webinar that a 25-bed hospital with a five-bed census could be replaced with "super highly trained consolidated paramedics" linked to a command center to replace "the infrastructure which is no longer serving that community."[18] According to the Medically Home executive, a rural hospital with a low inpatient census is wasted money that could be put to better use so as to "liberate economic power" and provide "wholesale translation of decentralized care at the community level."[19]

CNA believes rural hospitals are a healthcare asset to communities where they are located and the disregard for this critical resource by corporate executives bent on expanding virtual care may result in the closure of rural hospitals. Ironically Acute Hospital Care at Home programs in rural settings would further reduce inpatient census and provide justification for rural closures promoted by the short-term thinking of virtual care advocates such as the Medically Home executive.

Over the last two years, the Covid-19 pandemic has shown us that the acute care provided in hospitals is essential to the health of our communities, and that we cannot afford to have it further whittled away by the profit-hungry hospital industry. Acute inpatient hospital capacity has declined dramatically in California over the last few decades, as the data below demonstrates:

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[18] Medical Alley Association, *Exploring Hospital at Home Programs with Medically Home, Kaiser Permanente, and the Mayo Clinic*, July 1, 2021, see https://medicalalley.org/2021/07/exploring-hospital-at-home-programs-with-medically-home-kaiser-permanente-and-the-mayo-clinic/?fbclid=IwAR3NnqcPg1GlWaJYTNgobW7ttVLMeJaJPK78GE-2_gQ5JB11d-FqnBoy_K0.

[19] *Id.*

- **Low level of hospital capacity**: California only has 1.85 hospital beds for every 1,000 people, one of the lowest levels of hospital beds per capita in the nation. Only 5 states have a lower number of hospital beds per capita. For comparison, New York has 2.68 hospital beds for every 1,000 people, and Florida has 2.59 hospital beds per 1,000.[20] The limited number of hospital beds in California has proven to be a major weakness in the fight against the Covid-19 pandemic, as noted by the New York Times article written in December 2020: "Surging Virus Exposes California's Weak Spot: A Lack of Hospital Beds and Staff."[21]

- **Hospital Closures**: Over the last 25 years, the number of general acute hospitals in California fell from 442 in 1995 to 337 in 2020. Over that period, California has lost 105 general acute hospitals, a reduction of 23.8%.[22]

- **Decline in beds at general acute hospitals**: Along with the decline in the number of acute hospitals, there has also been a dramatic decline in the available and staffed beds at these facilities. The number of "available beds" (i.e. existing beds) at general acute hospitals declined by 5,499 between 1995 and 2020, a 6.6% reduction. However, the number of "staffed beds" (meaning existing beds that are actually staffed), declined by 27,588, an astounding 36.1% reduction since 1995.[23]

- **Decline in Emergency Departments**: Since 1995, more than one in every four ED's at general acute hospitals has closed. In 1995, OSHPD data showed 403 general acute

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[20] Kaiser Family Foundation: State Health Facts - Total Hospital Beds, 2019. https://www.kff.org/other/state-indicator/total-hospital-beds/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[21] See https://www.nytimes.com/2020/12/01/us/california-hospital-bed-shortage.html.

[22] Department of Health Care Access and Information: Hospital Annual Financial Data - Selected Data & Pivot Tables, 1995 through 2020, see https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables.

[23] Department of Health Care Access and Information: Hospital Annual Financial Data - Selected Data & Pivot Tables, 1995 through 2020, see https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables.

hospitals receiving ED visits. By 2020, that number dropped to 301, a decline of 102 (or 25.3%) since 1995.[24]

During the Covid-19 pandemic, the loss of U.S. inpatient hospital capacity increased the overall death rate. The costs to patients stemming from the reduction in our acute care capacity were laid bare during the Covid-19 crisis. A study published by the Centers for Disease Control and Prevention (CDC) found that, between July 2020 and July 2021, intensive care unit bed use at 75% capacity was associated with an additional 12,000 excess deaths two weeks later.[25] As hospitals exceeded 100% intensive care unit bed capacity, 80,000 excess deaths would be expected two weeks later.[26] Another study published by the CDC found significant associations between availability of hospital-based resources, including beds and staff, and excess Covid-19 deaths.[27] Simply put, our anemic capacity for acute care during the Covid-19 health crisis has resulted in needless deaths.

As a state, we need to invest in the proven health care infrastructure and RN workforce we know we need – and that our current Covid-19 pandemic painfully reconfirms we must have – to care for California's patients.

- **Cherry-Picking Patients for Inclusion in Acute Hospital Care at Home Programs**

The hospital industry will claim that AHCaH programs which purport to provide acute hospital care in patients' homes have as-good-as-or-better outcomes than patients cared for in a regular hospital setting. CNA is skeptical, however, of these small, selective, limited studies and suspects that these rosy outcomes are largely the result of cherry-picking the healthiest patients with the least complications. Moreover, we question whether such outcomes could be maintained once these programs are scaled up.

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[24] Department of Health Care Access and Information: Hospital Annual Financial Data - Selected Data & Pivot Tables, 1995 through 2020, see https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables.

[25] French G et al. November 19, 2021. Impact of Hospital Strain on Excess Deaths During the COVID-19 Pandemic — United States, July 2020–July 2021. Morbidity and Mortality Weekly Report. https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7046a5-h.pdf.

[26] *Id*.

[27] Janke A et al. April 2021. Analysis of Hospital Resource Availability and COVID-19 Mortality Across the United States. https://cdn.mdedge.com/files/s3fs-public/issues/articles/janke0750_0421.pdf.

- **Exacerbating Racial Disparities Between Who is Sent Home for Care and Who Receives Care in the Hospital**

Furthermore, CNA is concerned these types of programs will exacerbate racial disparities in determining who receives hospital care and who is sent home, and—among those sent home—who fares better and who fares worse. If hospitals incentivize with lower prices the option of being sent home, it will likely be patients living in already medically underserved communities – often Black, Indigenous, Brown, and other patients of color – who are pressured to make that choice. Among those sent home, those with better housing, resources, and family and social networks will do better than those without.

- **Kaiser Operating Acute Hospital Care at Home Program without Required CDPH Approval**

Finally, even though it has not yet received regulatory approval from CDPH, Kaiser's "Advanced Care at Home" program is currently operating at two sites in California, Vacaville and Vallejo. Moreover, we understand Kaiser has plans to roll out the program system-wide. Yet, CDPH's All Facilities Letter (AFL) 20-90 specifically states, "A hospital seeking to offer acute hospital care at home services may not begin providing this service until it has received approval from CDPH." AFL 20-90 further provides:

> In addition to receiving an individual waiver for acute hospital care at home services from CMS, a GACH seeking to provide acute care services must continue to meet state licensure requirements for GACHs . . . and receive program flexibility from CDPH for any requirement that will be met using an alternative method as indicated under the Program Flex heading. (citations omitted)

We appreciate that the department is currently looking into this issue. As we understand it, Kaiser has not yet submitted a program flexibility request to obtain the required approval from CDPH detailed in AFL 20-90. We have requested that CDPH not allow Kaiser to circumvent Title 22 requirements for the care of patients who come into the hospital through the emergency department. Furthermore, we oppose Kaiser's current and long-term plans to dramatically limit opportunities for nurses to care for

patients in a hospital setting through its Acute Hospital Care at Home program and have requested that CDPH deny any such program flexibility request.

For all these reasons, CNA respectfully opposes your AB 2092. Thank you for considering our concerns.

Sincerely,

Stephanie Roberson
Director of Government Relations
California Nurses Association/National Nurses United

Cc: Assembly Health Committee Chair and Members