Testimony of Rhonda Boisvert
President, Connecticut Association of Residential Care Homes
In Opposition to
SB 1030- AN ACT CONCERNING LONG-TERM CARE FACILITIES
Public Health Committee Public Hearing, March 17, 2021

Senator Abrams, Representative Steinberg, Senator Somers, Representative Petit, and Esteemed Members of the Public Health Committee, **thank you for the opportunity to offer testimony in opposition to the inclusion of residential care homes in Senate Bill 1030- AN ACT CONCERNING LONG-TERM CARE FACILITIES.**

My name is Rhonda Boisvert and I am the President of the Connecticut Association of Residential Care Homes, the trade organization for the approximately 100 residential care homes in the state. Residential care homes are a non-medical model of community living. The majority of our residents have mental health diagnoses with many having other ailments. Our residents are mostly in shared rooms with communal living spaces and are provided meals, medication administration, personal care assistance, laundry and other home services. Residents in our homes are often mobile and free to come and go as they please in the home. Our residents can range from adults in their 30's to seniors in their 80's and 90's.

The pandemic was a particularly challenging time for our residents and staff as our homes are congregate settings with shared living spaces. Our employees worked on the frontlines during the pandemic for wages slightly above minimum wage. Our administrators and experienced staff often covered additional shifts and at times worked 80 plus hours due to the lack of available staff. And most of our residents spent months in lockdown with limited contact outside the home and some becoming ill with the virus.

Senate Bill 1030 tries to take a one size fits all approach to long-term care. By doing so, the requirements to residential care homes would frankly change the current residential care home model. We are also concerned that such sweeping legislation would be proposed coming from the Nursing Home and Assisted Living Workgroup without our inclusion as an Association or individual homes. We were not invited to the table and for good reason, we are a different model and the concerns of residential care homes during the pandemic were more in line with group homes.

In fact, the requirements in sections 2 through 10 of the bill run counter to other efforts being made by the administration and this legislature to ensure that residential care homes are a home and community based model. It is clear that the drafters of the proposal do not understand the clear differences of residential care homes with nursing homes, assisted living, home care and other models of long-term care.

We welcome the opportunity to discuss our model with legislators but instead have faced a barrage of proposals that either seek to make us more like a medical model, such as this bill, or that seek to ensure that our community setting is more like a landlord-tenant model including a bill passed by this committee last week. In the past,

we have proposed a bifurcated model of residential care homes for this very reason. There is not a one size fits all for residential care homes. There are some residential care homes that are located on the same site as a nursing home while others are multi-family homes located in neighborhoods across the state.

For additional specifics, please find in our written testimony a section-by-section list of our concerns.

Section by Section Concerns

Section 3 requires at least a three-month supply of personal protective equipment for its staff. This would be cost prohibitive for homes unless the Department of Public Health was supplying such PPE at no cost to the homes. During the pandemic, our homes struggled to obtain and pay for PPE. Thankfully, the Department of Public Health provided significant PPE to our homes.

Section 4 requires a "certified or licensed" staff member to start an intraveneous line. Most of our homes have no such licensed staff and hiring any staff is a problem. Our rates continue to be capped and our entry-level workers make barely more than minimum wage. It is very challenging to hire anyone when we can't compete with other long-term care providers or even frankly big-box stores or the fast food industry!

Section 5 goes on to require a full-time infection prevention and control committee. Some of our homes are 6-8 beds with few staff and certainly no infection prevention expertise. We think requiring a non-medical model with non-licensed staff to run a full-time infection prevention committee without training would be inappropriate.

Section 6 requires Nursing Home Infection Preventionist Training. The CDC describes that as a "course [which] is designed for individuals responsible for infection prevention and control (IPC) programs in nursing homes." As we have noted, residential care homes are a very different model serving different types of residents than nursing homes.

Section 7 requires mass testing available during a Public Health Emergency at each long-term care facility. While we agree mass testing is appropriate it was not always available to residential care homes during the pandemic. We did not have staff that was trained or able to administer tests. We required outside agencies to come test staff so any such requirement on homes will require outside resources to be able to effectively and appropriately test our residents and staff.

Section 8 requires the establishment of family councils inside each residential care home. This may occur in some homes but there is no one size fits all approach. Some homes have many residents with limited or no family outside the home so the residential care home becomes a family-like community home. We therefore oppose any such

blanket requirement especially as participation of our residents' families or conservators can be a challenge and vary depending on the resident and home.

Section 9 presumes that every resident in a residential care home has a "resident care plan." This is not always the case. Many of our residents have been living in their home for over a decade plus and are highly independent. Additionally, most homes do not employ social workers or other such licensed staff that would be equipped to address isolation or how the social and emotional needs of each resident may be met. As we noted earlier, finding staff is a challenge due to the low pay and challenging work that can be required. Putting additional requirements on staff that average wages between $13-$15 is problematic. We continue to advocate for a raise for our employees who worked on the front lines of the pandemic.

Section 10 requires each long-term care facility, including residential care homes, to establish an essential caregiver program for implementation. Again, the one size fits all approach is inappropriate. Our residents are often mobile individuals and are free to come and go as they please from the residential care home. Our staff is also on-site 24-7 and always focused on the daily care and well-being of all residents. The nature of living in a residential care home means there is likely no caregiver and certainly not someone "critical" to the daily care and well-being of the resident. If there is someone "critical" to the well-being of that resident, there is a good chance that individual needs a higher level of care than a residential care home.

Section 12 is less of a concern for the industry as residents in residential care homes are free to have their own cell-phones and other devices. We would, however, caution that not every residential care home has access to WiFi either due to the age of the home or other factors such as cost. Any requirements for technology should prioritize funding and installation of WiFi in residential care homes that lack Internet connectivity.

With all this in mind, we hope you better appreciate that a one-size fits all approach does not work for residential care homes. If you move forward with this bill, we urge you to remove residential care homes from the bill.

Thank you.

Rhonda Boisvert