Connecticut Department of Public Health

Testimony Presented Before the Public Health Committee

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Senate Bill 1030, An Act Concerning Long Term Care Facilities

The Department of Public Health (DPH) provides the following information regarding Senate Bill 1030, which will implement the recommendations for long-term care facilities of the Nursing Home and Assisted Living Oversight Working Group in addition to revising specific long-term care facility statutes. Thank you for the opportunity to testify on this important bill.

It was our honor to serve the Nursing Home and Assisted Living Oversight Working Group, which has been jointly led by members of the General Assembly and representatives of the Department of Public Health, the Department of Social Services, and the Office of Policy and Management. We are grateful to the leaders and members of each of the subcommittees for the significant time and attention they have devoted to the work of the group.

Section 1 defines a long-term care facility as a nursing home (NH), residential care home (RCH), home health agency (HHA), assisted living services agency (ALSA), intermediate care facility for individuals with intellectual disabilities (ICF/IID), chronic disease hospital, or hospice agency for the purposes of Sections 2-12 of the bill. Since ICF/IID facilities are licensed by the Department of Developmental Services (DDS), DPH would defer to DDS for comments regarding such facilities.

This section also requires a long-term care facility, as defined in the bill, to employ a full-time infection preventionist. Over the past year, the Department has had several findings in these healthcare settings, with the vast majority in nursing homes, that relate to infection control. We often found that the individual in charge of infection prevention was handling multiple positions or working part time and was unable to provide the support needed during the COVID-19 pandemic. The Department supports this initiative in the nursing home setting. It is important to note that ICF/IIDs, RCHs, HHAs, ALSAs, and agencies providing hospice care are not medical models and they do not have the same staffing levels as a NH or chronic disease hospital. The requirement for a full-time infection preventionist may not be appropriate in these settings. However, these facilities should have policies and procedures in place to address infection prevention and control measures. Additionally, the Department would be happy to collaborate with DDS on reviewing appropriate procedures for ICF/IID facilities.

Section 2 requires the administrative head of each long-term care facility to participate in the development of the emergency plan of operations of the Intrastate Mutual Aid Compact pursuant to C.G.S. Section 28-22a. The Department is supportive of the concept outlined in this section and requests further discussion with the proponents of the bill and the Department of Emergency Services and Public Protection to determine the best approach for long-term care facilities to be involved in emergency response planning. For your information, the Centers for Medicare & Medicaid Services (CMS) issued a Final Rule in September 2016 to establish national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with state, and local emergency preparedness systems. Guidance on these requirements was issued to impacted entities. The federal rule applies to 17 healthcare provider and supplier types, including long-term care facilities. Each provider has its own set of regulations and conditions or requirements for certification. Such healthcare providers and suppliers must be in compliance with the federal emergency preparedness regulations to participate in the Medicare and Medicaid programs.

Section 3 requires DPH to have and maintain at least a three-month stockpile of personal protective equipment (PPE) not later than six months after the termination of a public health emergency. Additionally, it requires the administrative head of each long-term care facility to acquire from the Department and maintain a three-month supply of PPE. Lastly, it requires the administrator for each long-term care facility to fit test their staff for N95 masks on a quarterly basis.

Occupational Safety and Health Administration (OSHA) standards require that persons who use N95 equipment be fit tested on a yearly basis. The Department recommends that long term care facilities adopt OSHA standards, which includes a plan to ensure these individuals are appropriately fit tested. During the pandemic, DPH was provided federal funds, which were used to provide PPE to facilities. There were some instances of PPE shortages and mitigation strategies involving multiple use of PPE had to be put in place. These strategies were recommended by the Centers for Disease Control and Prevention (CDC).

DPH recognizes the importance of PPE while caring for a patient with an infectious disease to protect the health and safety of the workers. During the pandemic, the Commissioner put forward a commissioner's order that required nursing homes to have a reserve stockpile of enough PPE and hand sanitizer to manage an outbreak of twenty percent of the facility's average daily census for a thirty-day period. Facilities were required to fill out an online attestation acknowledging they had implemented the requirements of the commissioner's order. The Department notes that PPE has expiration dates and also may be unused if an outbreak is not taking place. Additionally, PPE is stored in large boxes, which means it may be difficult for a facility to find storage. It is the facility's responsibility, however, to ensure they have enough PPE to appropriately protect their staff on a day to day basis. The Department agrees that a comprehensive strategy needs to be in place during extraordinary circumstances such as the COVID-19 pandemic. However, the Department does not think that legislation is needed; often

such a statute may diminish our ability to be flexible in responding to an emergency that is ever evolving.

Section 4 requires each long-term care facility to have at least one staff person per shift that can start an intravenous line. While well-intentioned, this requirement may be onerous for a long-term care facility as defined, with the exception of a chronic disease hospital. These settings do not use intravenous lines frequently enough to retain their skills in starting and maintaining intravenous lines. Most of these facilities enter into a contract for this service with an infusion company to care for their residents with intravenous lines. Additionally, an order would have to be given from an independent practitioner to prescribe what medication would be delivered through an intravenous line. DPH would welcome a discussion with the proponents of the bill about the requirements in Section 4 as there are many factors to consider in determining how an intravenous line should be introduced to a patient.

Section 5 requires each long-term care facility to have an infection prevention and control committee that meets monthly; and daily during an outbreak. This committee will be responsible for establishing, implementing and reviewing infection prevention and control protocols for the facility. The Department is supportive of measures that can be put in place to mitigate the impact of an infectious disease outbreak in a facility.

Section 6 requires every administrator and supervisor of a long-term care facility to complete the Nursing Home Infection Preventionist training course produced by CDC in collaboration with CMS. The Department is supportive of training in infection control and prevention core activities to reduce the spread of an infectious disease for administrators and supervisors of long-term care facilities. During the COVID-19 pandemic, the Department identified that when the infection preventionist was out sick or on leave, they needed other personnel to fill in for their duties. These individuals included the administrator and the director of nursing. However, we think the CDC course may not provide the most appropriate training. In lieu of the CDC training course, the Department recommends inserting language that would require a nursing home administrator to have a minimum of four contact hours of continuing education on "infection control and the prevention of infections associated with antimicrobial use, including antimicrobial resistant infections" within subsection (b) of C.G.S. Section 19a-515. These CEU's would allow the administrator to continually train on the best practices for infection prevention and control.

Section 7 requires DPH to provide each long-term care facility with a frequency for testing staff and residents during an outbreak of an infectious disease. Such frequency will be based on the circumstances surrounding the outbreak and the impact of testing on controlling the outbreak. During an outbreak, the Department may look to CDC for guidance on best practices in the treatment and mitigation of an infectious disease, which may include testing. Some infectious diseases do not require regular testing. As an outbreak evolves, guidance is modified to appropriately adapt to the situation. DPH already provides guidance to long-term care facilities

that reflects recommendations supported by CDC pertaining to appropriate prevention and control approaches to mitigating an infectious disease. The Department recommends not moving forward with this section of the bill.

Section 8 requires each long-term care facility to establish a "family council" to enhance communication between the facility, its residents and their families or representatives. The Department supports this effort to facilitate communication between facilities, families and residents as this communication is imperative to the well-being of the resident. We learned during the COVID-19 pandemic, when visitation was restricted, that virtual and other means of communication with representatives and family was crucial.

Section 9 requires each long-term care facility to ensure that a resident's care plan addresses provisions related to the health and well-being of the resident, to include social and emotional needs being met and that visitation by any means is provided. Additionally, the bill requires the facility to establish a timeline for the reinstatement of visitation following the termination of a public health emergency as declared by the Governor. Nursing homes are required to follow CMS guidance relating to visitation, which is revised as new information arises. While visitation is critically important to a long-term care facility resident's physical, mental and psychosocial well-being, it is also important to balance visitation with control measures to reduce the transmission of an infectious disease. The Department's goal is to ensure the safety of the residents and staff, however, balancing this at all times with resident rights.

Section 10 requires the Department to establish an essential caregiver program for implementation by each long-term care facility, which includes standards for infection prevention and control training and testing. DPH is currently working with the State Long Term Care Ombudsman and other stakeholders on developing an essential support person program.

Section 11 requires the Department's Public Health Preparedness Advisory Committee to amend the plan for emergency responses to a public health emergency to include a plan for long-term care facilities and providers of community-based services. The Department supports this recommendation and will work with our Office of Public Health Preparedness to review the Public Health Emergency Response Plan to determine the best way to incorporate long-term facility emergency planning during a disaster. The aforementioned CMS Final Rule establishes national emergency preparedness requirements through CMS to ensure adequate planning for both natural and man-made disasters as well as coordination with state and local emergency preparedness systems. Guidance on these requirements was issued to impacted entities. The federal rule applies to 17 healthcare provider and supplier types, including long-term care facilities. Each provider has its own set of regulations and conditions or requirements for certification. Such healthcare providers and suppliers must be in compliance with the federal emergency preparedness regulations to participate in the Medicare and Medicaid programs.

Section 12 requires each long-term care facility to permit a resident to use a communication device to connect with family members and friends and to facilitate the participation of a resident's family caregiver as a member of the resident's care team. This section also requires DPH to establish requirements for the use of these communication devices by July 1, 2021. The Department supports efforts that connect the resident with their family, friends and representatives. In May 2020, the Department, through the use of Civil Money Penalty Reinvestment Funds, provided each of Connecticut's nursing homes with at least two electronic devices, which will support this effort. The Department respectfully requests that the timeline to develop policies regarding the use of communication devices be extended until December 2021.

Section 13 requires DPH to establish minimum staffing level requirements for nursing homes and eliminates the distinction between a chronic and convalescent nursing home (CCNH) and a rest home with nursing services (RHNS) to ensure a minimum staffing level requirement for all nursing homes. The Department recommends all facilities have adequate staffing with the appropriate competencies and skill sets to provide nursing and related services, based on a facility assessment, to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident. The facility assessment uses individual resident assessments and plans of care to ascertain the number, type of diagnoses, and acuity of the facility's resident population. In the nursing home setting, regulations require that the administrator and director of nursing meet monthly to determine adequate staffing levels using a tool based on the acuity of their current resident census.

Thank you for your consideration of this information. DPH encourages committee members to reach out with any questions.

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