Testimony to the Public Health Committee

Presented by Mag Morelli, President of LeadingAge Connecticut

March 17, 2021

Regarding

Senate Bill 1030, An Act Concerning Long Term Care Facilities

Good afternoon Senator Abrams, Representative Steinberg and members of the Public Health Committee. My name is Mag Morelli and I am the President of LeadingAge Connecticut, a statewide membership association representing not-for-profit provider organizations serving older adults across the continuum of aging services, including not-for-profit skilled nursing facilities, residential care homes, home health care agencies, hospice agencies, adult day centers, assisted living communities, senior housing and life plan communities. As an association, we encourage the state and federal government to value aging by investing in quality.

On behalf of LeadingAge Connecticut I am pleased to provide testimony on *Senate Bill 1030, An Act Concerning Long Term Care Facilities.*

Over the past year, the aging services field has been at the center of the global Covid-19 pandemic. Covid-19 is a virus that has targeted the very people we serve. As such, our member organizations have been uniquely impacted by the pandemic, unlike any other health care provider sector. And we are proud of our efforts. LeadingAge Connecticut members have faced this pandemic head on and continue to do so as we protect and compassionately care for the most vulnerable older adults in our state.

The bill before you today reflects many of the recommendations that came out of the Nursing Home and Assisted Living Oversight Working Group (NHALOWG). The NHALOWG was formed to make recommendations on proposed legislation for the 2021 session addressing lessons learned from COVID-19, based upon the Mathematica final report (A Study of the COVID-19 Outbreak and Response in Connecticut Long-Term Care Facilities) and other related information, concerning structural challenges in the operation and infrastructure of nursing homes and assisted living facilities; and changes needed to meet the demands of any future pandemic.

LeadingAge Connecticut was represented on NHALOWG and actively participated in the four subcommittees. While we support many of the recommendations that resulted from the valuable work done by NHALOWG, we do disagree with elements of some of them. Today's hearing provides us the opportunity to present our perspective, opinion and alternative language for

those sections of the bill and allows us to offer our assistance to the Committee as you work on this and other bills related to aging services.

Our first request is that the Committee consider adding the recommendations related to the NHALOWG's Subcommittee on Infrastructure and Capital Improvements into this bill. We have linked that subcommittee's report and recommendations to our testimony here and specifically, we would ask for the Committee's support of the following financing and funding options to enable necessary maintenance and improvements in the nursing home physical plant:

- Establishment of a state backed loan guarantee program,
- Establishment of a forgivable loan program for nursing homes,
- Establishment of a long-term bonding or direct lending program.

Our specific comments on Senate Bill 1030 are as follows:

Section 1

This bill begins by stating that Sections 1 through 12, if passed, would apply not only to nursing homes, but also to six other licensed settings including assisted living service agencies, residential care homes, intermediate care facilities for individuals with intellectual disability, chronic disease hospitals, home health care agencies, and hospice agencies. Each type of provider listed is unique in their service delivery and is regulated through separate state and/or federal laws and regulations. **We do not believe that all of the sections of this bill should apply to all of these settings and we will point this out as we go through each section of the bill.** (*Please note that we will not provide any comment on the relevance of the proposed bill to the intermediate care facility for individuals with intellectual disability setting as we do not represent that category of provider.)*

Subsection 1b would require that a full-time *infection prevention and control specialist* be employed by providers in each of the seven categories of licensed entities listed in Section 1a. An *infection preventionist* is a position defined and required by the federal Centers for Medicare and Medicaid (CMS) for all nursing homes and for which an on-line training course was established by CMS in collaboration with the Centers for Disease Control (CDC). The course is approximately 19 hours long, is made up of 23 modules and submodules, and is focused on the nursing home setting.

CMS has required the infection preventionist position in nursing homes since 2019. Currently CMS requires the infection preventionist to work at least part-time at the facility, but we understand that this requirement is under review in light of the pandemic. DPH has asked that each nursing home have an infection preventionist on staff for 32 hours per week and has advised that this function can be shared by two part-time individuals. **We have voiced our request to DPH that the infection preventionist hours be scaled to the size of the facility and that the individual be allowed to serve other functions within the building such as staff development**. We ask that the Committee consider this request.

While the specific position of infection preventionist is defined and required on the federal level for a nursing home, the other settings included in this proposal are not included in that CMS requirement. Similar to nursing homes, chronic disease hospitals as well as home health care, hospice and assisted living service agencies are all required to address infection control and prevention by state and federal regulation. **We do not think it is necessary to impose the specific infection preventionist position onto those provider entities.**

Regarding the residential care home, while licensed by the Department of Public Health, this is not a health care setting and therefore this full-time clinical position is not appropriate or practicable.

Section 2

We do not support this proposal which would require each of these licensed healthcare entities to participate in the actual *development* (line 32) of their municipal emergency operations plans. This is not their responsibility. We do agree, however, that the healthcare entities should inform the town or city emergency manager in the community where they are located of their own emergency preparedness plans and participate in ongoing emergency preparedness efforts in their community.

Section 3

Nursing homes are currently required through a DPH Commissioner's Order to stockpile a 30-day supply of personal protective equipment (PPE). The increase to a 90-day stockpiled supply raises the concern of adequate storage space in already space challenged nursing home floor plans. The nursing home would need to store this 90-day stockpile in addition to the operational supply of PPE that is being stored for daily use. This would be the same concern for the other provider entities included in this bill.

- **We request clarity** for the provision that seems to require the provider entities to purchase their PPE from the Department for Public Health. (Lines 44-47)
- **We do not understand** why the bill would require quarterly fit testing of N95 masks (line 55) when annual fit testing is what is the current federal requirement. This appears to be an unnecessary utilization of resources.
- While the early, severe shortages of PPE are now behind us, there continues to be sporadic shortages of various types and sizes of PPE in the market place. **We would hope that these types of situations would be recognized within the stockpiling requirement.**

Section 4

We oppose this section of the bill that would require that every provider listed in Section 1a be able to ensure that a licensed health care professional (in most cases that would be a registered nurse), who is certified to initiate an intravenous line, is scheduled on every shift. We cannot support this requirement because we simply do not understand why it is being proposed and what gap in long term care it is attempting to address.

While there is always a registered nurse on duty in Connecticut nursing homes, and technically the start of an intravenous line is within their licensed scope of practice, there is also a

competency standard that requires a continuous practice of this licensed function. The nursing home setting does not see the volume of intravenous therapy that would support this continuous practice. Rather, most nursing homes contract with a professional service to initiate intravenous therapy when and if it is needed. However, most nursing homes never have to provide this service, and those that do, specialize in it. Again, we do not understand why this requirement is being proposed and absent a logical reason, we cannot support it.

Regarding the other providers in this bill, assisted living service agencies are not staffed to the degree of nursing homes, and they would need to add a significant number of registered nurses to their schedule if they were to meet this requirement. Home care and hospice agencies which choose to provide IV therapy would be staffed appropriately to provide this service and this additional requirement would be unnecessary. Residential care homes are not a health care setting and therefore this requirement is not applicable or practicable.

Section 5

Regarding nursing homes, the Public Health Code requires that each facility have an infection control committee that meets quarterly. This section of the bill would require that this committee meet at least monthly and daily during an outbreak. This is more specific than the current federal requirements for nursing homes and we do not feel that it is necessary. The nursing home conducts daily infection control clinical surveillance under the guidance and direction of the director of nursing, medical director and infection preventionist. The quarterly meeting of the full committee is inclusive of this team and other medical and nursing staff, as well as consultants. **The nursing homes are of the opinion that a quarterly meeting schedule for the formal infection control committee is a sufficient minimum requirement to address the infection control needs of the facility** and that the frequency can be increased when necessary.

This specific committee is not currently a public health code requirement for the other health care providers addressed in the bill and is inappropriate for the residential care home setting.

Section 6

We have concerns regarding several aspects of this section. First, the mandated training course is specific to nursing homes, yet it would apply to all of the provider entities listed in the bill. It is not appropriate to require nursing home specific training of non-nursing home providers.

Second, we request that this section be clarified to specify exactly who is expected to take the course as the term “supervisor” is very broad and could be applied to several staff members throughout the nursing home. This specific course is currently a 19-hour, 23-module course that is designed for a clinically trained person. This would not be the appropriate training course for all levels of supervisor within the facility.

Finally, if we assume that the intent is to apply this section just to the nursing home setting, **we would suggest that instead of prescribing the specific training course within the statute, that the Committee rely upon the infection preventionist to determine the appropriate training for the nursing home staff members.** Section 1a of this bill would place the responsibility for ongoing

training of all employees of the facility on the infection preventionist. We would propose that the responsibility for selecting the appropriate training material should remain with the infection preventionist.

Section 7

The availability of testing was a pivotal milestone in the fight against the Covid-19 virus. Ensuring that the Department of Public Health has a role in determining the frequency and appropriateness of testing ensures that this statutory requirement remains timely and relevant.

Section 8

Specifically addressing the nursing home setting, these settings must adhere to federal OBRA regulations which currently allow for family councils to be established and require that nursing homes provide an advisor or liaison to the council, as well as meeting space and other assistance if requested. We believe the federal guidelines were designed to promote the independence of the council and we further believe the OBRA regulations to be sufficient for the nursing home setting. **We are also happy to work with our members to ensure that families are aware of the opportunity.**

We are concerned that if a nursing home or any other provider included in this bill is *mandated* to establish a family council (line 90: "…shall facilitate the establishment…"), that they would then have a statutory obligation to create an entity that families may not be interested in participating in; indeed, some of our members have found that to be the case. Family participation is something that the provider cannot force, and therefore we would oppose the mandated aspect of this section. While a provider may be required to assist upon request and even encourage the establishment of such a council, it should not be required to force its establishment.

Section 9

Again, it appears that this section is specifically addressing the nursing home setting. As such, we would agree that addressing a resident's psychosocial needs as outlined in lines 97 through 107 is appropriate, **but we request that the words "seek redress with" in line 108 be replaced with the word "contact."** Residents and families are encouraged to contact the Office of the Long-Term Care Ombudsman for guidance and advocacy, but there is not a mechanism to seek *redress* through that office.

We also request that the wording addressing reinstatement of visitation in lines 111 – 119 be removed as this references a federal restriction specific to the Covid-19 pandemic that was placed on nursing homes and will hopefully be outdated by the January 1, 2022 deadline in the bill.

Section 10

We have been supportive of the establishment of an essential caregiver or essential support person program that can be activated during a public health emergency when visitation to a long-term care facility is restricted. It is our understanding that this program would be most applicable to the nursing home setting.

Section 11
We support this section.

Section 12
We have been involved in discussions with the Aging Committee on another, similar legislative proposal regarding the use of communication technology specifically within the nursing home setting. **We reference that because we strongly support the need for privacy provisions for the use of communication devices for visitation as articulated in this proposal (lines 148 – 152);** the current Aging Committee bill does not contain privacy provisions related to the use of technology for virtual visitation. We would encourage the inclusion of this requirement in any bill focused on the use of communication technology in a long-term care setting.

This section of the bill may be more appropriate for the nursing home, chronic disease hospital and residential care setting where residents reside within a communal setting. For persons receiving care from an assisted living service agency or home health care agency, they would be residing in their own homes and would not need the protections afforded by this section of the bill.

Section 13
LeadingAge Connecticut understands the interest in raising the minimum nursing home staffing requirements that are currently listed in the Public Health Code for licensed and certified nursing staff. We do, however, want to reassure the Committee that both the Public Health Code and federal oversight regulations currently require nursing homes **to staff at a level that meets the needs of residents**. These same regulations authorize the Department of Public Health to assess penalties in certain cases when facilities fall short of staffing requirements and fail to employ sufficient staff to meet resident needs.

This bill proposes 4.1 hours of direct care per resident day minimum, **but it also proposes specific ratios per licensure category within that overall direct care minimum and we cannot support those specific ratios** (Lines 163 -166). To mandate specific ratios of CNA, RN and LPN within an overall minimum staffing level goes against the concept of flexing your staffing to meet the needs of the resident and flies in the face of our new acuity-based reimbursement system which is expected to be implemented later this year. These specific ratios* are based on a 20-year-old national study that does not recognize this states' 24 hour registered nurse requirement nor our strong use of the LPN in our nursing homes. More importantly, of the approximately sixty nursing homes that currently staff above a 4.1 hours per patient day, most would need to reduce the hours of licensed RN and LPN direct care staff (not administrative staff) in order to hire additional CNAs to meet those internal ratios. *(*We note that we believe there is a drafting error in the printing of these ratios and that they are intended to propose .75 hours of care by a registered nurse.)*

Nursing care is important. The direct care provided to a nursing home resident is not just personal care. Residents also receive direct nursing care such as medication administration and

treatments as well as nursing assessments. Nursing care must be provided by a registered nurse (RN) or licensed practical nurse (LPN). In fact, only a registered nurse is authorized to perform the actual nursing assessment; an LPN can examine the resident and provide information to the registered nurse, but the actual assessment must be done by the registered nurse. Nursing assessments are important, and required, components of the resident's overall care. Assessments determine the individualized care plan and must be conducted whenever there is a significant change of condition, and when required to be updated under state and federal requirements. Some nursing homes have chosen to staff nursing positions with more highly qualified registered nurses. Nursing homes that provide a strong level of direct registered nursing care are to be commended, not discounted, and we strongly object to any minimum staffing levels that disregard the importance of direct resident care that is provided by a registered nurse.

A very important issue that <u>must be addressed</u> is the Medicaid reimbursement with regard to nursing home staffing. Quality nursing home providers staff to meet the needs of their residents and many homes are staffing near or above the proposed 4.1 hours of direct care per resident day, but the Medicaid reimbursement rate does not cover the cost of this higher staffing. The vast majority of nursing homes that show high levels of staffing are also showing significant differentials between what the state Medicaid system is supposed to pay them according to their costs – and what the Medicaid system is actually paying them. **Very simply, they are not being reimbursed for their staffing costs.** As a result, we have a reimbursement system that is vastly underfunding the cost of staffing – at a time when the state is planning to transition to a staffing dependent acuity-based rate system – and without a plan to increase the funding. **We therefore urge the Committee to insist that any legislation implemented to raise the minimum staffing levels also must address the need to fully fund the reimbursement system.**

We would also be remiss if we did not raise our concern regarding the ability to recruit and retain an aging services workforce that can meet the needs and demands of our aging population. **We ask that the Committee support efforts to enhance the long-term services and supports workforce through expanded training opportunities, increased funding for reimbursement rates, and other efforts aimed at attracting and retaining workforce talent within the field of aging services**. Workforce competition has intensified with the increase in the minimum wage and recruitment efforts in the field of aging services have been dramatically impacted by the pandemic. **We need a long-term investment in aging services provider rates to assist providers with recruitment and retention of a strong and skilled workforce that is urgently needed as our state rapidly ages.**

This section of the bill also proposes a requirement for the Department of Public Health to modify staffing levels for social work and recreational staff of nursing homes (lines 167 – 169. We believe the intent may be to raise the levels, but as written would lower the required levels; we believe that this must be a drafting error. We agree that social work and recreational staff are critical to the overall resident experience within a nursing home. These positions, however, have never been categorized as direct care by the state and as such, have not received previously

legislated wage enhancements and other resources that have been directed to that category of the workforce. We are pleased to see these important services recognized.

This section of the bill also proposed to eliminate the Rest Home with Nursing Supervision (RHNS) level of care licensure (lines 170 -174). This is a licensure category defined in the Public Health Code and designed to care for a lower acuity level of resident. While most of these beds were converted many years ago to the higher licensure level of Chronic and Convalescent Nursing Home (CCNH), there are currently ten nursing homes that have beds licensed in this category. Three of the ten are non-profit, LeadingAge Connecticut members who have both levels of licensure within their buildings.

We must insist that if RHNS beds are required to be converted to the higher level Chronic and Convalescent Nursing Home (CCNH) licensure, that the Medicaid rates for those beds be increased to meet the additional staffing requirements and costs of the CCNH level. For a nursing home that currently has both levels of care, any rate adjustment must not be achieved through the "blending" of the RHNS and CCNH bed rates - which has been the state's previously proposed approach. Those homes that have sought to convert the beds in the last several years have been told that they must combine their RHNS and CCNH rates to create a blended rate for all of the beds and which would mean lowering their CCNH rate in order raise the RHNS rate. As a result, they have not converted the beds because it was not financially feasible. **Therefore, we ask that this bill specifically address this issue and require an increase in the RHNS rate without lowering the CCNH rate.**

This section of the bill also includes a definition of "nursing home" on lines 153 – 160 that we do not agree with and which seems to have been newly created. The reference should simply be: *A nursing home, as defined in section 19a-490 of the general statutes.*

Finally, this section (lines 175 – 176) would mandate nursing homes always offer a 12-hour shift option to all staff. While the option of utilizing a 12- hour shift during a workforce crisis brought on by the virus was discussed, we do not believe it was the intent of the working group to mandate that all nursing homes always offer this option to all of their work force. **Many nursing homes would find this mandate to be unworkable and we cannot support it**.

Section 14.

We support the establishment of a comprehensive statutory framework to govern and facilitate the use of technology by residents in nursing homes. It is important to establish good public policy on this important issue - and we need to do it right.

Allowing resident access to and use of technology for the purpose of visitation and socialization was an issue raised and discussed in the NHALOWG subcommittees. After years of debate here in the General Assembly, we knew there would be an interest in not only permitting access, but also enabling surveillance. As a result, we updated our comprehensive analysis of all the state statutes that had been passed over the last several years in this regard and drafted what we

considered to be a comprehensive approach to the entire issue of communication technology in a nursing home setting

We have been involved in discussions with the Aging Committee on this issue as they raised a related bill earlier in the session. We provided extensive written comments on their initial proposal with the intent of assisting in the development of a statute that addresses the many complex needs and concerns of ensuring resident rights within this highly regulated setting and in consideration of the common situations that impact many nursing home residents. Many of our comments were accepted and we plan to continue to work with the Committee to help shape the legislation. We have included this link to our comments in this testimony.

Our priority goal is to ensure the self-determination, privacy and dignity of the nursing home resident. The proposal in the bill before you would apply only to "nonverbal" residents, but we would prefer and strongly suggest a more comprehensive statute that is inclusive of all situations. We would be eager to work with this Committee as well as others to ensure that any statute that enacted creates good public policy for all those residing within the nursing home.

Thank you for this opportunity to testify on this bill. We know we have made extensive comments on several sections of the bill and we would be happy to provide suggested substitute language if that would be helpful to the Committee.

Respectfully submitted,

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