CAHCF
Connecticut Association of Health Care Facilities

February 19, 2019

Written testimony of Matthew V. Barrett, President and CEO of the Connecticut Association of Health Care Facilities (CAHCF).

Good morning Senator Maroney, Representative Serra and to the distinguished members of the Aging Committee. My name is Matthew V. Barrett. I am the President and CEO of the Connecticut Association of Health Care Facilities (CAHCF), our state's trade association and advocacy organization of one-hundred and sixty skilled nursing facilities and assisted living communities. Thank you for this opportunity to testify at today's public hearing.

In opposition to:
S.B. No. 828 (RAISED) AN ACT REDEFINING EXPLOITATION OF ELDERLY PERSONS.

This legislation would amend a law adopted to define "exploitation" as the act of taking advantage of an elderly person by "another person or caregiver" for purposes of mandatory reporting of any exploitation. The bill would significantly broaden the definition to now include "nursing home facility," presumably to include all nursing home employees. Because the statute now defines exploitation to be by "any person", which would include any individual who works in a nursing home, including a nursing home administrator, it would seem redundant to add the nursing home in the definition of exploitation. If the intent is something different, CAHCF would offer the opportunity to work with the committee on addressing the issue of concern.

Support with Recommended Revisions:

H.B. No. 7099 (RAISED) AN ACT INCREASING THE MINIMUM RATIO OF DIRECT CARE STAFF IN NURSING HOMES.

CAHCF is in agreement that legislation can and should be adopted this session to increase the existing minimum staffing requirements. We agree that the Public Health Code (PHC) is outdated and overdue for an update in this regard. For example, the PHC now only requires a minimum of one and nine-tenths hours per patient for a skilled nursing facility. Similar legislation has been introduced in the Human Services Committee this session. We look forward to working with both the Aging Committee and the Human Services Committee on addressing this issue this session.

We believe more analysis is required to determine if increasing the minimum to 3.0 hours per patient is feasible. Further, CAHCF recommends that the bill include a provision that that if any nursing home facility experiences increased costs or expenditures to comply with a higher standard, the Department of Social Services must provide Medicaid reimbursement associated with these new costs. Finally, CAHCF cannot support any legislation without the statute defining "direct care" and further recommends that any reporting requirements be consistent with federal reporting requirements in the interest of efficiency.

Support with Recommended Revision:
H.B. No. 7100 (RAISED) AN ACT CONCERNING NONEMERGENCY TRANSPORTATION FOR NURSING HOME RESIDENTS.

This well-intended bill would require nursing homes, with available vehicles equipped to transport non-ambulatory residents, to provide nonemergency transportation of non-ambulatory residents to the homes of family members. The bill further provides that the transportation would only be required when the family visits are in the same municipality as the nursing home, the transportation is approved by a physician, and that the charge for such transportation to the non-ambulatory resident doesn't exceed the nursing home's cost of providing the transportation.

We are not aware of any limitation under the law or practices governing nursing homes that today would cause a nursing home to prevent family visits of residents when arranged by family members and where the costs are addressed by the family or the resident. Such family visits are routinely provided today. Payment is arranged between the transportation provider and the family or resident in the current practice. In addition, we see such visits as fully consistent with a nursing home resident's rights as a member of the nursing home community.

We believe the committee understands that transportation unrelated to a medical issue is not part of the reimbursement structures now in place for nursing homes under the various payer sources, such as Medicare, Medicaid, or private insurance. This is why families or residents who now arrange, privately pay and enjoy such visits are an important feature of the current practice. However, HB 7100 goes further by requiring, in all instances, that the nursing home actually provide the non-medical transportation with its own resources when an appropriate vehicle is available and then the nursing home invoice and collect the costs of the transportation from the family or resident. This adds unreimbursed administrative costs to the nursing home and extends liability when the nursing home is the transportation provider. Nursing homes that wish to assume these costs and liabilities may do so, and while CAHCF supports this bill in concept, we recommend this provision be permissive, not mandatory, for a nursing homes to provide transportation under these circumstances.

In opposition to:
H.B. No. 7103 (RAISED) AN ACT CONCERNING NURSING HOME FALLS.

This legislation confuses, and potentially weakens, a comprehensive body of well-established public health law and regulations holding nursing homes accountable when they fail to implement measures to mitigate the risk of resident falls.

Members of the Aging Committee should be aware that Connecticut nursing homes operate in in a highly regulated environment. The Connecticut Department of Public Health (DPH) licenses nursing homes every two years and as the agent for the Centers for Medicare and Medicaid Services (CMS) conducts certification surveys annually. During those licensure and certification activities compliance with state and federal laws and regulations is reviewed. Inspection activities include, in part, review of medical records, observations of care and interviews with facility staff, nursing home patients and family members.

The comprehensive review overseen by DPH includes evaluating processes to determine whether the clinical needs of patients are being met based on initial and ongoing assessments, including, but not limited to, the patient's risk for falls. DPH oversight is clear that when a patient be identified as at risk for falls, in accordance with laws and regulations, measures need to be implemented to mitigate such risk. Specifically, DPH provides that nursing homes must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls. DPH rules also provide that nursing homes must in all cases assure staffing to meet the needs of their residents. In addition, nursing homes are required to provide adequate supervision to mitigate the risk of falls/accidents. DPH guidance is clear that adequacy of supervision is defined by type and

frequency, based on the individual patient's assessed needs, and identified hazards in the resident environment. Adequate supervision may vary from patient to patient, and from time to time for the same patient. The rules also require that nursing homes must not only review a patient's risk of falling, but also assess the patient's surroundings for environmental hazards as well. The consequences in terms of citations and fines are harsh, and were strengthened in new federal nursing homes requirements for participation in the Medicare and Medicaid program in 2016. A nursing home could be fined tens of thousands of dollars for violations of this type.

However, as comprehensive and unforgiving the rules are for nursing homes found to fall short on required falls mitigation measures, the federal and state rules overseen by DPH importantly note that not all falls can be avoided. To be sure, the federal Centers for Medicaid and Medicare Services (CMS) rules appropriately acknowledge that accidents, such as falls, can still exist despite adequate interventions and supervision by staff. Recognizing antecedents, determine facility wide hazards in addition to person-specific risk factors are regulatory expectations, but, according to CMS, this does not mean all accidents and falls will ever or always be preventable. Additionally, falls can occur with following the recommended plan of care and in some cases the fall is with a staff member present. Even one to one care will not prevent fall. Indeed unavoidable falls may happen when two caregivers are assisting with the transfer of a resident requiring the assistance of assistive technology.

H.B. No. 7103 ignores a comprehensive state and federal regulatory system mentioned above and confusingly places duplicated liability for nursing home resident falls wrongly in the Nursing Home Resident Bill of Rights law found at 19a-550 of the Connecticut General Statutes. The bill also undermines a firmly and long established principle found in federal and state rules governing oversight of nursing homes recognizing, while nursing homes must be held accountable for falls mitigation measures, they cannot be unreasonably held accountable for falls that cannot be prevented in all situations.

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