March 28, 2022

Written testimony of Matt Barrett, President/CEO of the Connecticut Association of Health Care Facilities and the Connecticut Center For Assisted Living (CAHCF/CCAL) in opposition to S.B. No. 477 (RAISED) AN ACT CONCERNING THE PUBLIC HEALTH OF RESIDENTS OF THE STATE.

Senator Anwar, Representative Steinberg, and distinguished members of the Public Health Committee, my name is Matt Barrett. I am the President and CEO of the Connecticut Association of Health Care Facilities and the Connecticut Center for Assisted Living (CAHCF/CCAL), a state trade association and advocacy organization of one-hundred and sixty skilled nursing facilities and assisted living communities. Thank you for this opportunity to submit written in opposition to S.B. No. 477 (RAISED) AN ACT CONCERNING THE PUBLIC HEALTH OF RESIDENTS OF THE STATE

CAHCF appreciates the committee's efforts to improve the quality of care provided to long-term care residents with Alzheimer's, dementia, and other similar ailments. However, we are concerned that the approach recommended in the bill is not appropriate given the nature of assisted living services agencies. The bill appears to impose the requirements that exist for skilled nursing facilities upon assisted living facilities. However, these provider-types are vastly different in the way they function to provide care to residents, rendering the proposed provisions impractical and inapplicable in the assisted living context.

By way of background, the current assisted living model is comprised of two separate entities. One entity is the managed residential community ("MRC"), which is registered with the Department of Public Health, and provides private residential units or apartments that are governed by landlord tenant laws. MRCs are required to provide certain "core services", including room and board, transportation, security and recreation. The second entity is the assisted living services agency ("ALSA"), which is licensed with the Department of Public Health. The ALSA provides assisted living services to residents of the MRC who have

been deemed "chronic and stable" and do not require constant care, but may require assistance with nursing services, medication management, and /or activities of daily living including bathing, feeding, dressing, toileting, ambulating, and the like.

Each MRC is required to enter into a contract with a licensed ALSA to provide services to residents living in the MRC. However, residents may choose to contract with a different ALSA of their choice. In addition, residents who require care beyond that which is provided by ALSAs are entitled to contract with outside entities such as home care agencies, hospice agencies, private duty aides.

The assisted living model is unique to Connecticut as it allows for flexibility for seniors to receive services they need while allowing them to preserve their independence as long as possible while providing appropriate support to ensure their care and safety. In sharp contrast, skilled nursing facilities provide a clinical setting, similar to a hospital, where residents require skilled nursing care, sometimes on a 24-hour basis. Skilled nursing facility residents often have complex medical conditions with needs that require routine skilled nursing services, including wound care, feeding tube, ventilator care and respiratory therapy, and the like.

These provider-types offer vastly different levels of care, which makes apparent that the requirements of skilled nursing facilities are not appropriate to impose upon assisted living facilities.

New Assisted Living Services Agency Staffing Mandates

The bill adds to the requirements that DPH must impose on assisted living services agency providing services as a dementia special care unit or program in the area of staffing minimum. Specifically, the bill requires:

A minimum number of staff per shift that provide direct patient care to residents of or participants in the dementia special care unit or program, including, but not limited to, advanced practice registered nurses, registered nurses, licensed practical nurses and nurse's aides. It directs DPH to prescribe the minimum staffing in state regulations that will take effect upon adoption. The bill adds the requirement that when submitting staffing plans to the Department of Public Health while completing an initial or a renewal licensure application, or upon request from the department, such staffing plans must comply with the new prescribed minimum staffing requirements.

The Public Health Code presently requires the Supervisor of the ALSA ("SALSA") to ensure that sufficient numbers of assisted living aides are available to meet the needs of clients at all times based on the clients' service programs. In addition, the Public Health Code requires that a resident's needs be assessed upon admission and every 120 days, or upon a change in condition. The SALSA must staff according to the needs of the residents. The Department of Public Health holds both the ALSA license and the SALSA license and provides appropriate regulatory oversight if sufficient staffing is not being provided.

As a practical matter, staffing ratios are far too prescriptive for assisted living communities, where residents have varying levels of direct care needs. In addition, where more than one agency provides direct care to residents in one community, it is not possible for an ALSA to adhere to rigid staffing ratios.

New Posting Requirements

The bill further specifies that assisted living services agency that provides services as a dementia special care unit or program must post the following information on a daily basis at the beginning of each shift, in a legible format and in a conspicuous place readily accessible to and clearly visible to residents, employees and visitors of the dementia special care unit or location of the dementia special care program, including, but not limited to, persons in a wheelchair:

(1) Name of the assisted living services agency and location of the dementia special care unit or program;

(2) Date;

(3) Total number of (A) advanced practice registered nurses, (B) registered nurses, (C) licensed practical nurses, and (D) nurse's aides who will be responsible for direct patient care during the shift;

(4) Total number of hours such (A) advanced practice registered nurses, (B) registered nurses, (C) licensed practical nurses, and (D) nurse's aides are scheduled to work during the shift;

(5) Total number of dementia special care unit residents or dementia special care program participants;

(6) The minimum number of nursing home facility staff per shift that is required by the regulations of Connecticut state agencies to be responsible for providing direct patient care to residents of the dementia special care unit or participants in the dementia special care program; and

(7) The telephone number or Internet web site that a resident, employee or visitor of the dementia special care unit or location of the dementia special care program may use to report a suspected violation by the assisted living services agency of a regulatory requirement concerning staffing levels and direct patient or program participant care.

Current statutes already require dementia special care units to disclose staffing ratios to residents, their legal representatives, or their responsible party, and to update the disclosures if there are changes. Requiring daily posting disclosing the number of staff and their hours on each shift is overly burdensome and impractical in the assisted living setting. Direct care staffing is specific to each assisted living resident and may be provided by various agencies who provide care on their own schedules that does not fit in the shift model, which is more appropriate in the nursing home setting.

Records Requirements

The bill also requires assisted living services agency providing services as a dementia special care unit or program to maintain a daily record of the following regarding each resident of the unit or participant in the program and make such record available to the Department of Public Health upon request:

(1) Type and number of meals served and the times each meal was offered to the resident. The assisted living services agency shall ensure that the maximum time span between a resident's or participant's evening meal and breakfast does not exceed sixteen hours unless a substantial bedtime nourishment is verbally offered by the assisted living services agency, provided the assisted living services agency shall not be required to serve such nourishment to patients or participants who decline such nourishment;

(2) The time a resident or participant bathed or was offered a bath or was

bathed by a staff member of the assisted living services agency;

(3) The medications taken by the patient or participant and times such medications were taken; and

(4) A description of the overall health of the patient or participant.

Requiring daily documentation of such care is overly burdensome and again, demonstrates a misunderstanding of the assisted living setting. With respect to meal service, this is a "core service" and is the responsibility of the MRC, not the ALSA. While the ALSA aides may assist with feeding certain residents, some residents do not require such assistance and are independent with feeding, such that they would not need the level of care required to meet the documentation requirement. Similarly, some residents are independent with bathing and medication administration. Some assisted living residents with Alzheimer's or dementia diagnoses are high functioning and do not require assistance with feeding and bathing, as contemplated by the proposed documentation requirements.

Furthermore, the requirement to document a "description of the overall health" of the resident on a daily basis is impractical in the assisted living setting, which is modeled to be a non-clinical, residential setting, where residents do not require regular medical care such that a licensed professional would be able to document such daily observations. Many assisted living residents only require assistance with activities of daily living by an unlicensed aide who is unqualified to judge a resident's "overall health".

Thank you for your consideration. We would be happy to continue to work with the committee on addressing the issues raised in the bill and the concerns expressed in our written testimony.

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