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February 28, 2023

VIA U.S. MAIL

Commissioner Manisha Juthani, MD
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134

Re: Connecticut Association of Health Care Facilities, Inc.'s Petition for Declaratory Rulings Regarding the Applicability of Conn. Gen. Stat. § 19a-563h

Dear Commissioner Juthani:

Enclosed is Connecticut Association of Health Care Facilities, Inc.'s ("CAHCF") Petition for Declaratory Rulings and supporting affidavit under General Statutes § 4-176 and RCSA § 19a-9-12 regarding the meaning and applicability of minimum staffing level requirements under Conn. Gen. Stat. § 19a-563h.

Sincerely,

Jennifer M. DelMonico

Enclosures

cc: Matthew V. Barrett, Esq. (w/o encl.)

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

PETITION OF CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC. FOR DECLARATORY RULINGS AS TO THE APPLICABILITY OF MINIMUM STAFFING REQUIREMENTS UNDER CONN. GEN. STAT. § 19a-563h	:	February 28, 2023

PETITION FOR DECLARATORY RULINGS

Pursuant to Conn. Gen. Stat. § 4-176, and the rules and regulations promulgated thereunder, including Conn. Agencies Regs. §§ 19a-9-1 *et seq.*, Connecticut Association of Health Care Facilities, Inc. ("CAHCF" or "Petitioner"),[1] a Connecticut trade association and advocacy organization which includes 151 skilled nursing facility members, hereby petitions the Commissioner of the Connecticut Department of Public Health ("DPH"), for declaratory rulings as to the meaning and applicability of minimum staffing level requirements under Conn. Gen. Stat. § 19a-563h. Specifically, CAHCF requests the following declaratory rulings:

(1) Under Conn. Gen. Stat. § 19a-563h(a), Connecticut nursing homes meet the statutory minimum staffing level requirement by providing the minimum of three (3.0) hours of direct care per resident per day with three (3.0) hours of total nursing and nurse's aide personnel time, as intended by the Connecticut General Assembly; and

[1] Petitioner CAHCF is located at 213 Court Street, Middletown, Connecticut 06457. CAHCF is an association permitted under Conn. Agencies Regs. § 19a-9-9 to file this Petition for a declaratory ruling.

(2) Regulations, policies and procedures promulgated by DPH with respect to minimum staffing level requirements that set specific minimum staffing levels for each category of nursing services (registered nurses ("RNs"), licensed practical nurses ("LPNs") and/or nurse's aide personnel ("CNAs")) for those three (3.0) hours of direct care per resident per day violate Conn. Gen. Stat. § 19a-563h(a).

I. BACKGROUND

Section 19a-563h of the General Statutes establishes minimum staffing levels for Connecticut's nursing homes. The new statute, effective May 23, 2022, requires DPH to "establish minimum staffing level requirements for nursing homes of *three hours of direct care per resident per day*." Conn. Gen. Stat. § 19a-563h(a)(1) (emphasis added). Section 19a-563h commands the Commissioner to adopt regulations to implement the new statute, and further provides the Commissioner with permissive authority to implement interim policies and procedures pending adoption of final regulations. Conn. Gen. Stat. § 19a-563h(b).

Before Section 19a-563h was enacted, the Connecticut General Assembly had refrained from adopting minimum staffing level requirements for nursing homes even though such requirements had been proposed many times over the last decade, instead maintaining the more aggressive and flexible approach under state regulations which mirror strict federal staffing requirements. These requirements are focused on ensuring sufficient staffing to meet the individual needs of nursing home residents, while state regulations also provide for minimum staffing levels.

Specifically, existing DPH regulations require that each nursing home "employ sufficient nurses and nurse's aides to provide appropriate care" to residents and that the

"number, qualifications and experience of such personnel shall be sufficient" to assure each resident receives care and treatment as prescribed in the patient care plan; be kept clean, comfortable, and well-groomed; and be protected from accident, infections, or other unusual occurrence. Conn. Agencies Regs. § 19-13-d8t(m). The regulations further require that the nursing home administrator and director of nurses meet at least once every 30 days to determine the number, experience, and qualifications of staff necessary to comply with these staffing requirements. Finally, the regulations require nursing homes to provide patients with a minimum staffing of 1.9 hours per patient per day from a combination of "total nursing and nurse's aide personnel."[2] Conn. Agencies Regs. § 19-13-D8t(m) (requiring staffing of 1.4 hours per patient from 7 a.m. to 9 p.m., and .5 hours per patient from 9 p.m. to 7 a.m.) Although a subset of the 1.9 hours of staffing per patient per day is required to be from "[l]icensed nursing personnel," *i.e.*, RNs and LPNs, *see id.* (requiring staffing of licensed nursing personnel for .47 hours per patient from 7 a.m. to 9 p.m., and .17 hours per patient from 9 p.m. to 7 a.m.), the Public Health Code has permitted nursing homes full discretion and flexibility to staff the balance of the minimum hours between licensed nursing and nurse aide personnel based on the needs of individual patients.

The existing DPH regulations are consistent with federal regulations, which similarly place focus on ensuring sufficient staffing to meet the particular needs of the facility's residents, requiring that each nursing home "have sufficient nursing staff with the

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[2] Conn. Agencies Regs. § 19-13-D8t(a)(11) defines "licensed nursing personnel" as "registered nurses or licensed practical nurses licensed in Connecticut." "CNA" is separately defined in Section 19-13-D8t(a)(3) as "a nurse's aide issued a certificate – from January 1, 1982 through January 31, 1990 – of satisfactory completion of a training program which has been approved by the department."

appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, *as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at 483.70(e)."* 42 C.F.R. 483.35 (emphasis added).

When the General Assembly in the 2021 session sought to codify minimum staffing levels in nursing homes, it initially considered a bill that would not only increase the minimum hours to 4.1 hours of direct care per resident per day, but also would impose statutory minimum staffing levels based on licensure status, *i.e.*, minimum hours for RNs, LPNs, and CNAs. The full legislative body rejected that proposal in the final version of S.B. No. 1030, however, in favor of increasing the minimum hours (from 1.9 to 3.0) while specifically eliminating mandated staffing ratios without specifying *any* minimum hours based on *any* licensure status, leaving intact the flexibility required for nursing homes to staff at different levels based on patient needs.

It is important to note that CAHCF agrees with the policy goal of increasing staffing levels to 3.0 hours per resident per day as directed by the General Assembly consistent with the state appropriations adopted for this purpose – as informed by the estimated fiscal impact – and does not seek any declaratory ruling as to the overall statutory increase of minimum staffing levels from a total of 1.9 hours to 3.0 hours of direct care per resident per day – an increase of 1.1 hours or nearly 60%. CAHCF further commends DPH for the open and transparent explanation of the limited input and factors DPH considered in its proposed agency regulations and corresponding policies and

procedures. This Petition is submitted solely to seek declaratory rulings that confirm that the statute does not reverse the policy of flexibility in determining the appropriate combination of nursing and nurse's aide staffing that has existed in Connecticut for over 30 years, and rather continues that policy of flexibility – while meeting the increased minimum total hours – as the General Assembly plainly intended.

For these reasons, as explained in more detail below: (1) under Conn. Gen. Stat. § 19a-563h(a), nursing homes should satisfy the minimum staffing level requirement of three (3.0) hours of direct care per resident per day with three (3.0) hours of total nursing and nurse's aide personnel time; and (2) regulations, policies and procedures promulgated by DPH with respect to minimum staffing level requirements that set specific minimum staffing levels for each category of nursing services (RNs, LPNs, and/or CNAs) for those three (3.0) hours of direct care per resident per day violate Conn. Gen. Stat. § 19a-563h(a).

II. DISCUSSION

A. Under The Plain Meaning Of Section 19a-563h(a), Nursing Homes Satisfy The Minimum Staffing Level Requirement Of 3.0 Hours Of Direct Care Per Resident Per Day With 3.0 Hours Of Total Nursing And Nurse's Aide Personnel Time.

As with any statutory interpretation issue, as DPH considers the meaning of Conn. Gen. Stat. § 19a-563h(a) and its applicability to staffing the minimum 3.0 hours with a combination of RNs, LPNs, and CNAs, it must first look to the plain meaning of the statute. *See* Conn. Gen. Stat. § 1-2z ("[t]he meaning of a statute shall, in the first instance, be ascertained from the text of the statute itself and its relationship to other statutes.").

In this case, the plain language in Section 19a-563h(a) mandates minimum staffing levels for nursing homes at 3.0 hours of direct care per patient per day, without mandating

minimum hours for any subset thereof and without mandating any staffing ratios among RNs, LPNs and CNAs. Accordingly, based on the plain meaning of the statute, nursing homes meet the minimum staffing level requirement 3.0 hours of direct care per resident per day, as required under Section 19a-563h, by staffing the requisite hours through a combination of total nursing and nurse's aide personnel.

B. The Legislative History And Fiscal Impact Analysis Supports The Plain Meaning Interpretation.

Although Section 19a-563h is clear, to the extent the statute could be subject to more than one interpretation, consideration of the legislative history, underlying policy issues, and existing DPH regulations further support its plain meaning interpretation.

1. The General Assembly Specifically Rejected Minimum Staffing Levels By Licensure Status, Opting Instead To Preserve Staffing Flexibility Based On Resident Needs.

Section 19a-563h began as Senate Bill 1030, introduced during the January 2021 legislative session, in which the following language regarding minimum staffing level requirements was initially proposed in the Senate:

> Sec. 13 (NEW) (Effective October 1, 2021) ... (b) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of at least four and one-tenth hours of direct care per resident, including *three and three-quarter hours of care by a registered nurse, fifty-four hundredth hours of care by a licensed practical nurse and two and eighty-one hundredth hours of care by a certified nurse's assistant*, ...

(emphasis added).[3] *See* ***Exhibit 1*** (S.B. 1030, Original Draft). The initial draft not only increased the number of direct care hours per patient from the DPH-regulated 1.9 hours per day to 4.1 hours a day, it also included particular ratios based on licensure status.

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[3] The initial version of S.B. 1030 includes a typographical error, mandating "three and three-quarter hours of care by a registered nurse," which requirement during discussions on the Senate floor and in drafts specifically included only the three-

At hearings on S.B. 1030 in March 2021, numerous interested parties, including the DPH Acting Commissioner and Commissioner of the Department of Social Services, Dr. Deidre S. Gifford, submitted testimony regarding the proposed minimum staffing level requirements. While agreeing with the desirability of creating statutory minimums at levels higher than the existing DPH regulations of 1.9 hours per patient per day, many of those presenting testimony criticized mandated staffing ratios based on licensure status and supported continuing the same degree of flexibility in staffing based on patient needs, as federal and state regulations had allowed for decades.

Notably, DPH Acting Commissioner Dr. Gifford gave testimony *supporting* the continued flexibility in determining appropriate staffing within minimum staffing level requirements rather than imposing staffing ratios on 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*.

Exhibit 2 (emphasis added) (Gifford Testimony). Dr. Gifford, as Acting Commissioner of DPH and Commissioner of the Department of Social Services, expressly recognized and supported the need to allow each facility to determine independently how to fill the minimum staffing levels to meet patient needs, consistent with the flexibility that had been

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quarter hours of direct care by registered nurses. Indeed, adding up all of the specific required hours in this initial version equals seven and one-tenth (7.1) hours rather than the four and one-tenth (4.1) hours in the bill.

fostered and permitted under DPH's existing regulation. *See* Conn. Agencies Regs. § 19-13-D8t(m).

CAHCF's President and CEO, Matthew V. Barrett, also testified, raising two significant concerns with the proposed ratios in S.B. 1030: (i) reduced flexibility in the proposed legislation in allowing nursing homes to direct the percentages of staffing resources, between RNs, LPNs and CNAs, based on specific care needs of individual nursing homes, and (ii) increased labor costs to achieve the proposed minimum staffing that would result from the mandated percentages, especially for hiring additional CNAs to meet the specific mandated ratios. ***Exhibit 3*** (Barrett Testimony).

Mag Morelli, President of LeadingAge Connecticut, also questioned the wisdom of the proposed specific ratios per licensure category. While supporting an increase in overall hours per patient per day, Morelli did not support the mandated ratios of RNs, LPNs and CNAs which would completely remove the critical flexibility nursing homes needed (and DPH regulations previously allowed) to determine how best to staff those hours based on changing patient needs. ***Exhibit 4*** (Morelli Testimony).

In addition to eliminating flexibility in staffing decisions, S.B. 1030, as originally drafted, caused concerns over the significant fiscal impact of the staffing ratios. At a Senate hearing on March 17, 2021, Dr. Gifford, as Acting Commissioner of DPH and Commissioner of the Department of Social Services, was specifically asked whether DPH and the Department of Social Services was in favor of the proposed staffing level ratios in the existing version of S.B. 1030, to which she responded:

> I think the Department would like to continue to have the conversation of minimum staffing ratios. We certainly understand the impetus behind it and ensuring that there is always adequate staff to meet the needs of the residents based on their acuity. While I think we would also want to talk

> about the implications of the minimum staffing ratios *or financial support of the facility*, so I think we probably are aligned on the intent and want to just engage you a little bit more on the specifics and how it would be implemented and *supported*.

Exhibit 5, at 20 (Connecticut Committee Transcript Excerpt, PH 3/17/2021) (emphasis added). In sum, Dr. Gifford declined to offer support for the existing version of S.B. 1030 until, among other things, the financial support for the proposed staffing ratios could be properly vetted.

The Office of Fiscal Analysis then prepared and submitted an analysis of the financial impact of the original proposed staffing ratios in the File Copy of S.B. 1030. "*Staffing ratio requirements will result in a significant cost to DSS* to the extent nursing home staffing costs are reflected in future Medicaid payments ... The cost for nursing homes to staff at the proposed levels will depend on the actual number and level of staff required and their associated wages but is anticipated to *be at least $200 million*." ***Exhibit 6*** (April 13, 2021 Fiscal Note, Office of Fiscal Analysis).

When S.B. 1030 was taken up on the floor of the State Senate prior to the end of the 2021 session, the Public Health Committee Chair offered an amended version of S.B. 1030, referred to as Senate Amendment Schedule "A" to S.B. 1030, which eliminated the staffing ratios by category of personnel, and reduced the minimum staffing level requirement from 4.1 hours to 3.0 hours of direct patient care per day. *See* ***Exhibit 7*** (Amended S.B. 1030).

The Office of Fiscal Analysis Fiscal Note on the amended version of S.B. 1030 confirmed that the amended bill (based on an evaluation of 2019 cost report data) – without mandated staffing ratios – would have a nominal financial impact:

> The amendment requires the Department of Public Health (DPH) to establish a minimum staffing level of three hours of direct care per resident per day, by January 1, 2022. Based on 2019 cost report data, there are several homes providing less than three hours of direct care per resident per day. The total cost for these homes to meet the bill's provisions is approximately $600,000 to $1 million. ***If the state supported those costs through increased rates, it would result in a state Medicaid cost of $300,000 to $500,000***. The actual cost depends on the number and type of staff required.

Exhibit 8 (May 27, 2021 Fiscal Note, Office of Fiscal Analysis) (emphasis added).

In advocating for the passage of this modified version of S.B. 1030, the Chair of the Public Health Committee, Senator Mary Daugherty Abrams summarized the new language in the provision on minimum staffing, noting that "changes have been made to address the fiscal note and feedback from various stakeholders." Senator Daugherty Abrams continued that "[s]taffing would be increased. Currently it's 1.9 hours per resident per day. This would increase that to 3.0. It would also increase the ratio of social workers from one to 120, to one to 60, and increase recreational staff as determined by the public health department." Senator Abrams emphasized the mandated staffing ratio for social workers, but specifically addressed only the overall increase in nursing and nurse's aide hours from 1.9 to 3.0 per day, making clear her committee had rejected including ratios for nursing personnel. ***Exhibit 9*** (Connecticut Senate Transcript Excerpt, 5/27/2021).

Senator Heather Somers further stated clearly that the new version of the bill "starts the beginning of the process, I believe, a process to improve the long-term care that we can provide to our citizens in the State of Connecticut. It looks at infection prevention, infection control, it looks at staffing levels *that are reasonable and are affordable*. It looks at emergency plan. It deals with visitation of loved ones. It deals with patients' rights." *Id.* (emphasis added).

Based on the data, testimony and important policy considerations, the mandated staffing ratios were eliminated. Section 19a-563h was enacted, providing:

> (a) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day ...

The statute eliminated any specific minimum hours or ratios based on licensure status, consistent with the testimony of the DPH Acting Commissioner and others. By eliminating specific staffing ratios, the statute preserved nursing homes' flexibility to determine – based on patient needs – the staffing arrangements most appropriate to meet the increased minimum staffing levels.

2. The Allocation of $500,000 To Support The Minimum Staffing Levels In Section 19a-563h Confirms The Legislative Intent To Reject Minimum Staffing Levels By Licensure Status.

The General Assembly allocated $500,000 in state funding to DSS for two fiscal years to support the minimum staffing levels imposed by Section 19a-563. This level of funding was entirely consistent with the Office of Fiscal Analysis Fiscal Note that the cost of increasing the minimum staffing level to three hours of direct care per resident per day – without mandated staffing ratios – would be nominal, an estimated $300,000 to $500,000. *See* ***Exhibit 8***. As such, the General Assembly's allocation of $500,000 to support the increased costs of Section 19a-563h further supports the legislature's intent to increase the total hours of direct care *without* imposing the mandated staffing ratios that were estimated to have a fare greater significant financial impact. ***See Exhibit 6*** (estimating the financial impact of the original S.B. 1030 – which included mandated staffing ratios – to be $200 million).

DSS interpreted the statute the same way. Indeed, in anticipation of the effective date of Public Act 21-185, now codified as Section 19a-563h, DSS included guidance for nursing homes on its website that specified the General Assembly had allocated up to $500,000 in state funding to DSS for the next two fiscal years to support the minimum nursing home staffing requirement, reflecting the figures in the May 27, 2021 Fiscal Note. This guidance reflected DSS' belief that the final statute did not require any mandatory staffing ratios – consistent with its plain language – since including mandatory staffing ratios would have substantially increased the associated costs.

It is clear that the statute was intended to *not* require mandatory staffing ratios. An interpretation that mandatory staffing ratios are permitted under Section 19a-563h would impose significant financial burdens that are not supported by the statute, that are not funded by the General Assembly, and that – as a practical matter – Connecticut's nursing homes cannot afford.

C. The DPH Policies and Procedures Violate the Statute, Do Not Comport With The Fiscal Impact Analysis and Available Appropriations, And Are Inconsistent With DSS' Interpretation And The Medicaid Increased Rate Application Process.

Section 19a-563h(b) also authorizes the Commissioner to implement interim policies and procedures "necessary to administer the provisions of this section . . . while in the process of adopting such policies and procedures as regulations, provided notice of intent to adopt regulations is published on the eRegulations System not later than twenty days after the date of implementation." Based on this, DPH has issued an Operational Policy entitled "Policies and Procedures regarding Nursing Home Staffing Levels to implement the requirements of Section 19a-563h," which amends the existing regulations in Conn. Agencies Regs. § 19-13-D8t(m) (the "Policies and Procedures").

Despite the plain language of Section 19a-563h and the opposition during the legislative process for mandatory staffing ratios – including by DPH's Acting Commissioner – DPH nevertheless has mandated in the Policies and Procedures not just an increase in the minimum staffing to 3.0 hours of direct care per resident per day, but also a specific minimum for nurse aide staffing of 2.16 hours per resident per day, requiring: (i) for licensed nursing personnel (RNs and LPNs), 0.57 hours per patient during day shifts (7 a.m. to 9 p.m.) and 0.27 hours per patient during night shifts (9 p.m. to 7 a.m.); and (ii) for CNAs, 1.6 hours per patient during day shifts (7 a.m. to 9 p.m.) and 0.56 hours per patient during night shifts (9 p.m. to 7 a.m.). In addition, the Policies and Procedures add an ambiguous definition of direct care. These interpretations are clearly contrary to the legislative intent evidenced in the final fiscal analysis dated May 27, 2021, which is uses 2019 cost report data to conclude a nominal fiscal impact resulting from the passage of Section 19a-563h.[4]

Given that the General Assembly rejected any allocation of minimum hours among different nursing staff categories, it is clear that the state legislature intended to leave specific staffing choices to the individual nursing homes, which are in the best positions to assess the specific needs of individual patients and determine specific staffing to meet those patients' needs.

The General Assembly's decision to leave specific staffing choices to individual nursing homes is evident given the significant fiscal impact that mandatory staffing ratios

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[4] Notably, in filing the Notice of Intent to Adopt Regulations concerning these minimum staffing requirements, DPH failed to include the Fiscal Note, including estimated costs or revenue impact on the State required under the regulation-making process in Connecticut. *See* Conn. Gen. Stat. § 4-168(a).

would pose for nursing homes and the State. As discussed *supra*, the initial Fiscal Note on the original draft of S.B. 1030 made clear that imposing the minimum of 4.1 hours of direct care per resident per day, plus imposing mandated staffing ratios, would cost DSS as much as an additional $200 million per year. The second Fiscal Note, addressing the amended version of S.B. 1030 that both reduced the minimum hours from 4.1 to 3.0 of direct care per resident per day and eliminated all mandatory staffing ratios, anticipated increased costs of between $300,000 and $500,000 per year. DSS then had an additional $500,000 allocated for Medicaid costs for subsequent fiscal years, reflecting the clear intent to allocate to DSS additional funding to cover only the increase in minimum staffing levels to 3.0 hours *without* accounting for additional costs of mandatory staffing ratios. The DPH Policies and Procedures do not take these financial impacts into account, and would impose an unfunded mandate that the legislature expressly chose not to impose, thus violating the statute.

Not only do the Policies and Procedures violate the plain language and legislative intent of Section 19a-563h, they represent a significant, overreaching departure from DPH's *existing* regulations regarding staffing ratios for nursing homes. *See* Conn. Agencies Regs. § 19-13-D8t(m). These regulations – which were the sole source of minimum staffing levels for nursing homes before the enactment of Section 19a-563h – permitted nursing homes to staff 1.5 hours of the total minimum 1.9 hours of direct care with any combination of "total nursing and nurse's aide personnel" based on patient needs; only 0.4 hours of the minimum time was expressly allocated for licensed nursing professionals. DPH cannot regulate beyond this without specific legislative authority, approval, and funding.

Yet, the Policies and Procedures as written have significant fiscal impact, in stark contrast with the nominal impact included in the fiscal analysis. The legislature clearly intended for the minimum staffing ratio to be established as a combined total of licensed nursing staff and nurse's aide personnel, consistent with the existing Public Health Code methods. Instead, DPH has created two separate minimum staffing levels, one for licensed nursing staff and one for nurse's aide personnel, which is a major change that will significantly increase the fiscal impact and require staffing modifications for over 100 nursing homes. In addition, in at least two presentations on the new Policies and Procedures, DPH has incorrectly claimed that the new Policies and Procedures only increase the total minimum staffing levels by 0.46 hours per day. This is clearly incorrect, as the minimum staffing levels are increased by 1.1 hours per day overall (from 1.9 to 3.0) and the Policies and Procedures establish for the first time minimum staffing levels for nurse's aide personnel, at a level of 2.16 hours per patient per day.

The Policies and Procedures undermine and contradict the plain language of Section 19a-563h and its clear legislative intent, and implement mandates that the legislature specifically sought to avoid when it modified the proposed legislation to delete staffing ratios. In addition, substantively the Policies and Procedures are not supported by proper procedure and/or substantial evidence. While the General Assembly authorized DPH to implement interim policies and procedures, DPH was not given authority to ignore the plain language of the statute or its legislative history. Accordingly, the Policies and Procedures that mandate particular minimum staffing ratios to meet the minimum staffing levels for nursing homes violate Section 19a-563h, and its purpose and intent. In addition, to the extent that DPH intends to craft regulations that incorporate any

staffing ratios, for the same reasons set forth above, those regulations also would violate Section 19a-563h.

The General Assembly intended to preserve flexibility for nursing homes to determine how best to meet the new minimum staffing level requirements based on individual patient needs, not arbitrary, fixed staffing ratios. Section 19a-563h must be read to allow nursing homes to make those staffing decisions, so long as the minimum mandate of 3.0 hours of direct patient care is achieved and staffing is sufficient to meet patient needs.

III. CONCLUSION

For the foregoing reasons, Connecticut Association of Health Care Facilities, Inc. respectfully requests that the Commissioner of the Department of Public Health issue a declaratory ruling that (i) nursing homes in Connecticut meet the minimum staffing level requirement of three (3.0) hours of direct care per resident per day under Conn. Gen. Stat. § 19a-563h with three (3.0) hours of total nursing and nurse's aide personnel time, and (ii) any regulations, policies and procedures promulgated by DPH with respect to minimum staffing level requirements which set specific minimum staffing levels for each category of nursing services (RNs, LPNs and/or CNAs) for those three (3.0) hours of

direct care per resident per day would be in violation of the purpose and intent of Conn. Gen. Stat. § 19a-563h(a).

Respectfully submitted,

CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC.

By: _____

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Exhibit 1

General Assembly

Raised Bill No. 1030

January Session, 2021

LCO No. **4720**

Referred to Committee on PUBLIC HEALTH

Introduced by:
(PH)

AN ACT CONCERNING LONG-TERM CARE FACILITIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2021*) (a) As used in this section and sections 2 to 12, inclusive, of this act, "long-term care facility" means a nursing home, as defined in section 19a-521 of the general statutes, a residential care home, as defined in section 19a-521 of the general statutes, a home health agency, as defined in section 19a-490 of the general statutes, an assisted living services agency, as defined in section 19a-490 of the general statutes, an intermediate care facility for individuals with intellectual disability, as described in 42 USC 1396d(d), except any such facility operated by a Department of Developmental Services' program subject to background checks pursuant to section 17a-227a of the general statutes, a chronic disease hospital, as defined in section 19a-550 of the general statutes, or an agency providing hospice care which is licensed to provide such care by the Department of Public Health or certified to provide such care pursuant to 42 USC 1395x.

(b) Each long-term care facility shall employ a full-time infection prevention and control specialist who shall be responsible for the

following:

(1) Ongoing training of all employees of the long-term care facility on infection prevention and control using multiple training methods, including, but not limited to, in-person training and the provision of written materials in English and Spanish;

(2) The inclusion of information regarding infection prevention and control in the documentation that the long-term care facility provides to residents regarding their rights while in the facility;

(3) Participation as a member of the long-term care facility's infection prevention and control committee; and

(4) The provision of training on infection prevention and control methods to supplemental or replacement staff of the long-term care facility in the event an infectious disease outbreak or other situation reduces the facility's staffing levels.

Sec. 2. (NEW) (*Effective October 1, 2021*) The administrative head of each long-term care facility shall participate in the development of the emergency plan of operations of the political subdivision of this state in which it is located which is required pursuant to the Intrastate Mutual Aid Compact made and entered into under section 28-22a of the general statutes.

Sec. 3. (NEW) (*Effective October 1, 2021*) (a) Not later than six months after the termination of a public health emergency declared by the Governor pursuant to section 19a-131a of the general statutes, (1) the Department of Public Health shall have and maintain at least a three-month stockpile of personal protective equipment, including, but not limited to, gowns, masks, full-face shields, goggles and disposable gloves as a barrier against infectious materials, for use by long-term care facilities, and (2) the administrative head of each long-term care facility shall ensure that the facility acquires from the department and maintains at least a three-month supply of personal protective equipment for its staff. The administrative head of each long-term care

facility shall ensure that the personal protective equipment is of various sizes based on the needs of the facility's staff. The personal protective equipment (A) shall not be shared amongst the facility's staff, and (B) may only be reused in accordance with the strategies to optimize personal protective equipment supplies in health care settings published by the National Centers for Disease Control and Prevention. The administrative head of each long-term care facility shall hold quarterly fittings of his or her staff for N95 masks or higher rated masks certified by the National Institute for Occupational Safety and Health.

(b) On or before January 1, 2022, the Department of Emergency Management and Homeland Security, in consultation with the Department of Public Health, shall establish a process to evaluate, provide feedback on, approve and distribute personal protective equipment for use by long-term care facilities in a public health emergency.

Sec. 4. (NEW) (*Effective October 1, 2021*) The administrative head of each long-term care facility shall ensure that there is at least one staff member during each shift who is licensed or certified to start an intravenous line.

Sec. 5. (NEW) (*Effective October 1, 2021*) Each long-term care facility's infection prevention and control committee shall meet (1) at least monthly, and (2) during an outbreak of an infectious disease, daily, provided daily meetings do not cause a disruption to the operations of the facility, in which case the committee shall meet at least weekly. The prevention and control committee shall be responsible for establishing infection prevention and control protocols for the long-term care facility. Not less than biannually and after every outbreak of an infectious disease in the facility, the prevention and control committee shall evaluate the implementation and analyze the outcome of such protocols.

Sec. 6. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, every administrator and supervisor of a long-term care facility shall

complete the Nursing Home Infection Preventionist Training course produced by the National Centers for Disease Control and Prevention in collaboration with the Centers for Medicare and Medicaid Services.

Sec. 7. (NEW) (*Effective October 1, 2021*) Each long-term care facility shall, during an outbreak of an infectious disease, test staff and residents of the facility for the infectious disease at a frequency determined by the Department of Public Health as appropriate based on the circumstances surrounding the outbreak and the impact of testing on controlling the outbreak.

Sec. 8. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, the administrative head of each long-term care facility shall facilitate the establishment of a family council to encourage and support open communication between the facility and each resident's family members and friends. As used in this section, "family council" means an independent, self-determining group of the family members and friends of a long-term care facility's residents that is geared to meeting the needs and interests of the residents and their family members and friends.

Sec. 9. (NEW) (*Effective October 1, 2021*) (a) On or before January 1, 2022, the administrative head of each long-term care facility shall (1) ensure that each resident's care plan addresses (A) the resident's potential for isolation, ability to interact with family members and friends and risk for depression, (B) how the resident's social and emotional needs will be met, and (C) measures to ensure that the resident has regular opportunities for in-person and virtual visitation, (2) disclose the facility's visitation protocols, any changes to such protocols and any other information relevant to visitation in a form and manner that is easily accessible to residents and their family members and friends, (3) advise residents and their family members and friends of their right to seek redress with the Office of the Long-Term Care Ombudsman under section 17a-410 of the general statutes when the resident or a family member or friend of the resident believes the facility has not complied with its visitation protocols, and (4) establish a timeline by which the facility will ensure the safe and prompt

reinstatement of visitation following the termination of the public health emergency declared by the Governor in response to the COVID-19 pandemic and a program to monitor compliance with such timeline. As used in this section "COVID-19" means the respiratory disease designated by the World Health Organization on February 11, 2020, as coronavirus 2019, and any related mutation thereof recognized by the World Health Organization as a communicable respiratory disease.

(b) On or before January 1, 2021, the administrative head of each long-term care facility shall ensure that its staff is educated regarding (1) best practices for addressing the social, emotional and mental health needs of residents, and (2) all components of person-centered care.

Sec. 10. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, the Department of Public Health shall establish an essential caregiver program for implementation by each long-term care facility. The program shall (1) set forth visitation requirements for essential caregivers of long-term care facility residents, and (2) require the same infection prevention and control training and testing standards for an essential caregiver of a resident of the facility that are required for the facility's staff. As used in this section "essential caregiver" means a person deemed critical, as determined by a long-term care facility, to the daily care and emotional well-being of a resident of the facility.

Sec. 11. (*Effective from passage*) On or before October 1, 2021, the Public Health Preparedness Advisory Committee established pursuant to section 19a-131g of the general statutes shall amend the plan for emergency responses to a public health emergency prepared pursuant to said section to include a plan for emergency responses to a public health emergency in relation to long-term care facilities and providers of community-based services to residents of such facilities.

Sec. 12. (NEW) (*Effective from passage*) (a) On and after July 1, 2021, each long-term care facility shall permit a resident to use a communication device, including a cellular phone, tablet or computer, in his or her room, in accordance with the requirements established

under subsection (b) of this section, to remain connected with their family members and friends and to facilitate the participation of a resident's family caregiver as a member of the resident's care team.

(b) On or before June 30, 2021, the Commissioner of Public Health shall (1) establish requirements regarding the use of communication devices by long-term care facility residents under subsection (a) of this section to ensure the privacy of other long-term care facility residents, and (2) communicate such requirements to each long-term care facility.

Sec. 13. (NEW) (*Effective October 1, 2021*) (a) As used in this section, "nursing home" means (1) any chronic and convalescent nursing home or any rest home with nursing supervision that provides nursing supervision under a medical director twenty-four hours per day, or (2) any chronic and convalescent nursing home that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic diseases, convalescent stages, acute diseases or injuries.

(b) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of at least four and one-tenth hours of direct care per resident, including three and three-quarter hours of care by a registered nurse, fifty-four hundredth hours of care by a licensed practical nurse and two and eighty-one hundredth hours of care by a certified nurse's assistant, (2) modify staffing level requirements for social work and recreational staff of nursing homes such that the requirements are lower than the current requirements, as deemed appropriate by the Commissioner of Public Health, and (3) eliminate the distinction between a chronic and convalescent nursing home and a rest home, as defined in section 19a-490 of the general statutes, as such distinction relates to nursing supervision, for purposes of establishing a single, minimum direct staffing level requirement for all nursing homes.

(c) On and after January 1, 2022, each nursing home shall offer its staff the option to work twelve-hour shifts.

(d) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 of the general statutes that set forth nursing home staffing level requirements to implement the provisions of this section.

Sec. 14. (NEW) (*Effective October 1, 2021*) (a) For purposes of this section: (1) "Ombudsman" means the Office of the Long-Term Care Ombudsman established pursuant to section 17a-405 of the general statutes; (2) "electronic monitoring" means the placement and use of an electronic monitoring device by a nonverbal resident or his or her resident representative in the resident's room or private living unit in accordance with this section; (3) "electronic monitoring device" means a camera or other device that captures, records or broadcasts audio, video, or both, and may offer two-way communication over the Internet that is placed in a nonverbal resident's room or private living unit and is used to monitor the nonverbal resident or activities in the room or private living unit; (4) "nursing home facility" has the same meaning as provided in section 19a-490 of the general statutes; (5) "nonverbal resident" means a resident of a nursing home facility who is unable to verbally communicate due to physical or mental conditions, including, but not limited to, Alzheimer's disease and dementia; and (6) "resident representative" means (A) a court-appointed guardian, (B) a health care representative appointed pursuant to section 19a-575a of the general statutes, or (C) a person who is not an agent of the nursing home facility and who is designated in a written document signed by the nonverbal resident and included in the resident's records on file with the nursing home facility.

(b) A nonverbal resident or his or her resident representative may install an electronic monitoring device in the resident's room or private living unit provided: (1) The purchase, installation, maintenance, operation and removal of the device is at the expense of the resident, (2) the resident and any roommate of the resident, or the respective resident representatives, sign a written consent form pursuant to subsection (c) of this section, (3) the resident or his or her resident representative places a clear and conspicuous note on the door of the room or private

living unit that the room or private living area is subject to electronic monitoring, and (4) the consent form is filed with the nursing home facility not less than seven days before installation of the electronic monitoring device except as provided in subsection (e) of this section.

(c) No electronic monitoring device shall be installed in a nonverbal resident's room or living unit unless the resident and any roommate of the resident, or a resident representative, has signed a consent form that includes, but is not limited to:

(1) (A) The signed consent of the nonverbal resident and any roommate of the resident; or (B) the signed consent of a resident representative of the nonverbal resident or roommate if the nonverbal resident or roommate lacks the physical or mental capacity to sign the form. If a resident representative signs the consent form, the form must document the following:

(i) The date the nonverbal resident or any roommate was asked if the resident or roommate wants electronic monitoring to be conducted;

(ii) Who was present when the nonverbal resident or roommate was asked if he or she consented to electronic monitoring;

(iii) An acknowledgment that the nonverbal resident or roommate did not affirmatively object to electronic monitoring; and

(iv) The source of the authority allowing the resident representative of the nonverbal resident or roommate to sign the consent form on behalf of the nonverbal roommate or resident.

(2) A waiver of liability for the nursing home facility for any breach of privacy involving the nonverbal resident's use of an electronic monitoring device, unless such breach of privacy occurred because of unauthorized use of the device or a recording made by the device by nursing home facility staff.

(3) The type of electronic monitoring device to be used.

(4) A list of conditions or restrictions that the nonverbal resident or any roommate of the resident may elect to place on the use of the electronic monitoring device, including, but not limited to: (A) Prohibiting audio recording, (B) prohibiting video recording, (C) prohibiting broadcasting of audio or video, (D) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device for the duration of an exam or procedure by a health care professional, (E) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device while the nonverbal resident or any roommate of the resident is dressing or bathing, and (F) turning off the electronic monitoring device for the duration of a visit with a spiritual advisor, ombudsman, attorney, financial planner, intimate partner or other visitor to the nonverbal resident or roommate of the resident.

(5) An acknowledgment that the nonverbal resident, roommate or the respective resident representative shall be responsible for operating the electronic monitoring device in accordance with the conditions and restrictions listed in subdivision (4) of this subsection unless the resident, roommate or the respective resident representative have signed a written agreement with the nursing home facility under which nursing home facility staff operate the electronic monitoring device for this purpose. Such agreement may contain a waiver of liability for the nursing home facility related to the operation of the device by nursing home facility staff.

(6) A statement of the circumstances under which a recording may be disseminated.

(7) A signature box for documenting that the nonverbal resident or roommate of the resident, or the respective resident representative, has consented to electronic monitoring or withdrawn consent.

(d) The ombudsman, within available appropriations, shall make available on the ombudsman's Internet web site a downloadable copy of a standard form containing all of the provisions required under

subsection (c) of this section. Nursing home facilities shall (1) make the consent form available to nonverbal residents and inform such residents and the respective resident representatives of their option to conduct electronic monitoring of their rooms or private living units, (2) maintain a copy of the consent form in the nonverbal resident's records, and (3) place a notice in a conspicuous place near the entry to the nursing home facility stating that some rooms and living areas may be subject to electronic monitoring.

(e) Notwithstanding subdivision (4) of subsection (b) of this section, a nonverbal resident or his or her resident representative may install an electronic monitoring device without submitting the consent form to a nursing home facility if: (1) The nonverbal resident or the resident representative (A) reasonably fears retaliation against the nonverbal resident by the nursing home facility for recording or reporting alleged abuse or neglect of the resident by nursing home facility staff, (B) submits a completed consent form to the ombudsman, and (C) submits a report to the ombudsman, the Commissioner of Social Services, the Commissioner of Public Health or police, with evidence from an electronic monitoring device that suspected abuse or neglect of the nonverbal resident has occurred; (2) (A) the nursing home facility has failed to respond for more than two business days to a written communication from the nonverbal resident or his or her resident representative about a concern that prompted the resident's desire for installation of an electronic monitoring device, and (B) the nonverbal resident or his or her resident representative has submitted a consent form to the ombudsman; or (3) (A) the nonverbal resident or his or her resident representative has already submitted a report to the ombudsman, Commissioner of Social Services, Commissioner of Public Health or police regarding concerns about the nonverbal resident's safety or well-being that prompted the resident's desire for electronic monitoring, and (B) the nonverbal resident or his or her resident representative has submitted a consent form to the ombudsman.

(f) If a nonverbal resident is conducting electronic monitoring and a new roommate moves into the room or living unit, the nonverbal

resident shall cease use of the electronic monitoring device unless and until the new roommate signs the consent form and the nonverbal resident or his or her resident representative files the completed form with the roommate's consent to electronic monitoring with the nursing home facility. If any roommate of a nonverbal resident wishing to use electronic monitoring refuses to sign the consent form, the nursing home facility shall reasonably accommodate the nonverbal resident's request to move into a private room or a room with a roommate who has agreed to consent to such monitoring, if available, not later than thirty days after the request. The nonverbal resident requesting the accommodation shall pay any difference in price if the new room is more costly than the resident's previous room.

(g) Subject to applicable rules of evidence and procedure, any video or audio recording created through electronic monitoring under this section may be admitted into evidence in a civil, criminal or administrative proceeding.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2021*	New section
Sec. 2	*October 1, 2021*	New section
Sec. 3	*October 1, 2021*	New section
Sec. 4	*October 1, 2021*	New section
Sec. 5	*October 1, 2021*	New section
Sec. 6	*October 1, 2021*	New section
Sec. 7	*October 1, 2021*	New section
Sec. 8	*October 1, 2021*	New section
Sec. 9	*October 1, 2021*	New section
Sec. 10	*October 1, 2021*	New section
Sec. 11	*from passage*	New section
Sec. 12	*from passage*	New section
Sec. 13	*October 1, 2021*	New section
Sec. 14	*October 1, 2021*	New section

Statement of Purpose:

To implement the recommendations of the Nursing Home and Assisted Living Oversight Working Group regarding long-term care facilities and make other revisions to the long-term care facility statutes.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Exhibit 2

Connecticut Department of Public Health

Connecticut Department of Public Health

Testimony Presented Before the Public Health Committee

March 17, 2021

Acting Commissioner Deidre S. Gifford, MD, MPH
860-509-7101

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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Exhibit 3

CAHCF/CCAL

Connecticut Association of Health Care Facilities
Connecticut Center for Assisted Living

March 17, 2021

Written testimony of Matthew V. Barrett, President/CEO of the Connecticut Association of Health Care Facilities and the Connecticut Center For Assisted Living (CAHCF/CCAL)

Good afternoon Senator Abrams, Representative Steinberg, and to the 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 (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 submit testimony concerning **S.B. No. 1030 (RAISED) AN ACT CONCERNING LONG-TERM CARE FACILITIES.**

As the committee further deliberates on the legislation, CAHCF/CCAL has the following recommendations for your consideration.

Infection Prevention and Control Specialist (Sec 1)

CAHCF/CCAL agrees in elevating that status of Infection Preventionists (IPs) in our Connecticut nursing homes. Effective infection prevention and control programs can decrease infection rates and health care acquired infections, improve attention to hand hygiene and transmission-based precautions, improve employee health, and reduce hospitalizations and adverse events among nursing home residents.

While most Connecticut nursing homes have designated full time IPs, others have one or more part-time, specially trained IPs with additional duties. Prior to COVID-19, nursing homes already experienced a nationwide shortage of registered nurses (RNs) and other challenges in recruiting qualified staff, including IPs. The pandemic has only exacerbated these workforce challenges. The increased demand for resources and dedicated, specifically trained IPs, which are most often fulfilled by an RN, remain a challenge, especially for smaller nursing homes. For these reasons, we recommend:

- The amount of time required for an IP be adjusted based on each facility's bed count, demographics of the facility's surrounding area, individual factors contributing to infection control risk levels, and flexibility for smaller facilities.
- A phased-in requirement to give nursing homes time to recruit and train the new IPs.

We also recommend that infection prevention training requirements have the flexibility to be met by training materials prepared by CAHCF/CCAL's national affiliate, the American Health Care Association (AHCA), include funds to cover any training costs, and that the intent of training language be clarified to mean the training applies to the administrator and RN supervisor.

Personal Protective Equipment Requirements (Sec 3)

CAHCF/CCAL appreciates that the proposed PPE stockpile requirements seek to establish a statewide stockpile acquired and managed by the Department of Public Health equal to a three months PPE supply level for use by nursing homes. We would like to point out that storing a three-month supply of PPE on site at the facility will present great challenge for many nursing homes with insufficient storage capabilities. Therefore, we are asking that the legislation provide the option for the PPE to be earmarked for a specific nursing home, but actually housed in a central storage site managed by the state and accessed as needed by the nursing homes. We also recommend that quarterly N-95 fit testing be available for new employees and that an annual fit testing be the standard for existing employees according to OSHA standards.

Licensed and Certified Staff to Start Intravenous Lines (Sec. 4)

CAHCF/CCAL is asking the committee to recognize that due to RN staffing shortages, most nursing homes must contract with a long-term pharmacy to secure qualified staff to start intravenous lines. Accordingly, we recommend that the language be modified to include IV starts by contracted staff, including a 24-hour remote coverage by the external contracted service provider, in addition to staff employed by the nursing homes.

Establishment of a Family Council (Section 8)

We recommend that this provision include a cross reference to federal rules concerning the establishment of family councils to assure consistency and compliance with federal requirements.

Increased Nursing Home Staffing (Sec 13)

As reported by the Staffing Levels Subcommittee of the Nursing Home and Assisted Living Oversight Work Group (NHALOWG) in January 2021: "Adequate numbers of qualified, trained, appropriately compensated, and caring staff are integral to support the needs of nursing home residents in a holistic and person-centered manner." There is no disagreement from CAHCF/CCAL on the policy goals expressed by the subcommittee. Further, the subcommittee acknowledged that achieving this result necessarily involves diverse strategies, including, but not limited to: Establishing a daily minimum staffing ratio of at least 4.1 hours of direct care per resident, composed of: ▪ .75 hours Registered Nurse ▪ .54 hours Licensed Practical Nurse ▪ 2.81 hours Certified Nurse Assistant. To help inform the implications of increasing staffing in this manner, CAHCF/CCAL obtained the support of the *Center for Health Policy Evaluation in Long Term Care* ("The Center") to provide a framework for estimating the costs of increasing minimum staffing ratios in Connecticut nursing homes. The full report is attached.

In this initial and preliminary framework, the *Center* reviewed creating minimum nurse staffing to resident thresholds in nursing homes (RN = 0.75, LPN = 0.54, and CNA = 2.81) for a Total Nursing Staffing of 4.1. In the report, the Center characterized the facilities currently below this threshold and calculated the number of additional staff and labor costs needed to achieve the proposed minimum staffing. They used staffing levels collected by the Center for

Medicare and Medicaid Census (CMS) from nursing home payroll data. To estimate total labor costs, they used average state labor costs, fringe benefits, and payroll tax rates. Further, the Center observed.

> Based on Q3 2020 staffing data, 181 (88.7%) of nursing homes in Connecticut are below the proposed minimum staffing threshold. The analysis was repeated using pre-COVID Q4 2019 staffing census data. Under pre-COVID conditions, the number of nursing homes below the minimum staffing threshold rose to 199 (97.5%). A big driver for this increase was a higher census pre-COVID. The average Connecticut nursing home census in Q4 2019 was 104 compared to 86 in Q3 2020. This is a 17% decline, which exceeds the national average decline of 14%. On average, Connecticut nursing homes below the staffing threshold are larger and have more Medicaid residents than the others. Their November 2020 Five-Star ratings were on average lower.
>
> For Connecticut to implement minimum staffing ratios, we estimate it will require between 1,793-3,364 FTEs and cost $140.9-$273.9 million dollars. The exact figure will depend on resident census.
> To get the current 181 nursing homes above the proposed minimum staffing threshold, 1,793 FTEs would be needed statewide at a total annual cost of $140.9 million, including fringe benefits and payroll taxes. CNAs make up most of the needed FTEs (1,426) and cost ($95.0 million). This assumes census stays the same as it is now, which is much lower than before the COVID pandemic.
> To estimate the costs when census increases, our simulation was repeated using pre-COVID-19 Q4 2019 PBJ staffing census data. In this analysis, the number of nursing homes below the minimum threshold rose to 199 (97.5%). Also increasing were the number of needed FTEs (3,364) and costs ($273.9 million) to meet the minimum staffing.

As census returns over the next 18 months, we can anticipate these costs to increase further, necessitating accompanying reimbursement increases.

- CAHCF/CCAL supports the effort to ensure adequate staffing at all nursing homes and to compensate all nursing home caregivers and employees at a level that recognizes their value. However, we favor a focus on elevating the status and importance of long-term care staff through recruitment and retention strategies and providing long underfunded nursing homes with the financial resources needed to address these staffing issues. A significant state and federal investment will be required to increase staffing requirements, minimum staffing ratios, or minimum wages during or after the pandemic when there are limited trained individuals to fill the positions and not enough resources to cover additional, unfunded costs.

- We do not support a recommendation to establish a minimum percentage of reimbursement to be spent on staffing without further study of the issue in the context of planned shifts in reimbursement structure to an acuity-based system and more thorough consideration of potential impacts of such a requirement. Finally, nursing homes should be given the flexibility on where to direct the percentage of staffing resources to RNs, LPNs and CNAs to address the specific care needs of the individual nursing homes.

Essential Support Caregiver or Support and Video Monitoring and Technology

CAHCF/CCAL will to continue to review and offer our recommendations on the use of technology to facility visitation and monitoring in nursing homes to both the Public and Health Committee and the Aging Committee, where legislation has now been favorably reported (HB 6552) on this matter, and is also addressed in **Section 12 and 14 of SB 1030**. Similarly, we will continue to review and offer our recommendations concerning an Essential Support Person initiative to the Public Health Committee and the Human Services Committee where legislation is under consideration (HB 6634) and is also addressed in **Section 10 of SB 1030**. At this time, because visitation in nursing homes unrestricted outside of a public health emergency, any provisions for essential caregivers or essential support persons should apply only when visitation is actually restricted by federal or state rules. Finally, additional training requirements on nursing homes, if adopted, to implement an essential caregiver or support person initiative must include additional funds for this purpose.

Thank you again for this opportunity to testify on the bill as drafted. I would be happy to answer any questions you may have.

For additional information, contact: Matthew V. Barrett, *mbarrett@cahcf.org* ***or 860-290-9424.***

Exhibit 4

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 must be addressed 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,

Mag Morelli, President of LeadingAge Connecticut
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Exhibit 5

CT Comm. Tran., PH 3/17/2021


Image 1 within document in PDF format.

Connecticut Public Health Committee Transcript, March 17, 2021

March 17, 2021
Public Health
2021

March 17, 2021

df/si PUBLIC HEALTH COMMITTEE 9:00 A.M.

CHAIRPERSONS:	Senator Mary Daugherty Abrams, Representative Jonathan Steinberg
SENATORS:	Anwar, Kushner, Haskell, Hwang, Kasser, Moore, Somers
REPRESENTATIVES:	Arnone, Berger-Girvalo, Betts, Carpino, Cook, Dauphinais, Demicco, Foster, Genga, Green, Gilchrest, Kavros DeGraw, Kennedy, Klarides-Ditria, Linehan, McCarty, Parker, Petit, Ryan, Tercyak, Young, Zupkus

REP. STEINBERG (136TH): Good morning.This is the Public Health Committee, in case you tuned into the wrong station this morning.I am State Representative Jonathan Steinberg, Co-Chair of the Public Health Committee, and I'm here today with my wonderful Co-Chair Senator Mary Daugherty Abrams, who hails from Ireland, at least going back some generations, as I imagine many of us on the call are today.

We have a number of Bills for today's Public Hearing.We have a good number of speakers, and let us get to the business at hand.I will turn it over to my Co-Chair for any opening comments.

SENATOR DAUGHERTY ABRAMS (13TH): I am Senator Mary Daugherty Abrams, and the Co-Chair of Public Health, and I'm excited today to hear the feedback on these Bills and to make them the best that they can possibly be.Thank you very much, and hope we have a great day.Jonathan, you're muted.

REP. STEINBERG (136TH): I don't remember muting myself.Happy St. Patrick's Day.Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman.A busy day in front of us with five Bills and almost 130 people signed up, so I hope we will get to the point and ask incisive questions and do the best we can to determine whether any or all of these Bills need to proceed forward.Happy St. Patrick's Day to everybody.We will probably see you tonight around 10:00 P.M.

SENATOR STEINGBERG (136TH): Well I hope you're wrong about that. Representative.Senator Hwang.

SENATOR HWANG (28TH): Thank you, Mr. Chair and Happy St. Patrick's Day to all.I am eager to hear the testimony as well, particularly a number of the Bills, but particularly on theSenate Bill 1, on the mental health, behavioral and physical health during this pandemic.And it is critical and I want to be able to offer that this is a concept that has true bipartisan support.And through the Public Hearing process and input from various shareholders that we can indeed craft a Bill meeting that goal.

So I'm eager to learn more, but I also wanted to share that there are many other Committee hearings going on via Zoom, that there may be many of our colleagues that are going in and out.Knowing that this is of very strong interest, I know they're going to be very engaged but I wanted to acknowledge that.

REP. COOK (66TH): And so what would be the difference between what was currently a Statute and what would we are proposing moving forward?Because my understanding was every facility was already supposed to have an infectious disease specialist and they were not.So why would we think, and I'm all about it, so but shy would we think that this legislation is going to change that?How are we going to look at accountability?

CHIEF ADELITA OREFICE: So the infection preventionist requirement currently is required by CMS, the Centers for Medicare and Medicaid Services, and I might ask Carbara Cass, who I think is on as well, to talk in more detail about that.But that requirement didn't compel facilities to have a fulltime infection preventionist and nor did it require the infection preventionist to sort of be, you know sort of exclusive to this, to the rule.

And so what we found through the pandemic is people in multiple hats playing that role.And clearly during the pandemic that, that part-time aspect of it didn't, didn't appear for a lot of facilities to be enough.

I know that the Bill in front of you also includes training for other senior leadership in the facilities on like the administrator on infection prevention and protocols.And that is in part to, you know have that larger foundation or stronger foundation with infection prevention throughout the leadership and management on team of a facility because even if you have, you know the full-time infection preventionist in your, your team of shift coaches, what we saw also during the pandemic is sometimes the infection preventionist was the one who got sick.

And then you needed to have a backup.You needed to have enough of a safety net of competency in the facility to cover that.

REP. COOK (65TH): Thank you for that.I think it's extremely important, obviously, from what we've learned and then you know the shortcomings of our facilities in this area, so I want to thank you for that and I do want to ensure that we figure out a way to, to look at some type of oversight in that area.Even though we are supposed to have part-time folks, we know that they didn't and so it's extremely important that we start holding these facilities accountable for their shortcomings because they are putting lives in, you know we're costing lives quite frankly.

The other thing I would like to address would be the staffing levels.I'm sure that you figured that where I would be I would be going to when we're looking at the staffing levels, I want to thank you all for your support in that regard and I know that we had suggested a variety of different opportunities for shift options and so forth and so on.

Is the Department, and I heard your testimony but I didn't hear your say one way or another, are you in complete support of what we're, where we are or are you looking at alterations from the recommendations that we have for staffing level ratios, etcetera?

COMMISSIONER GIFFORD: Representative, I think the Department would like to continue to have the conversation of minimum staffing ratios.We certainly understand the impetus behind it and ensuring that there is always adequate staff to meet the needs of the residents based on their acuity.

Well I think we would also want to talk about the implications of the minimum staffing ratios or financial support of the facility, so I think we probably are aligned on the intent and want to just engage you a little bit more on the specifics and how it would be implemented and supported.

REP. COOK (66TH): And I'm happy to continue this conversation.It's a conversation that I have been having with the Departments for many, many year's pre, you know pre-pandemic and I'm sure it will go on post-pandemic.

My, my fear is that if we do not figure out a way to invest in and hold our facilities accountable, especially the for profit facilities when their owners and operators are taking a very nice salary and we are short changing our residents.That for me is, is criminal.

We have seen a significant amount of lives lost because of the pandemic but I don't believe that all the lives that were lost during the pandemic are lives that should have been lost for a variety of reasons, and I don't think there's anybody here that would argue that point.

Exhibit 6

OFFICE OF FISCAL ANALYSIS
Legislative Office Building, Room 5200
Hartford, CT 06106 ◇ (860) 240-0200
http://www.cga.ct.gov/ofa

sSB-1030
AN ACT CONCERNING LONG-TERM CARE FACILITIES.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 22 $	FY 23 $
Public Health, Dept.	GF - Cost	5.4 million	2.4 million
State Comptroller - Fringe Benefits[1]	GF - Cost	82,130	84,600
Social Services, Dept.	GF - Cost	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill results in cost to the Department of Public Health (DPH) and the Department of Social Services (DSS) associated with requirements for long-term care facilities to build infection control capacity and new minimum staffing levels for nursing homes.

Section 1 results in a cost of approximately $96,340 in FY 22 and $96,170 to DPH (with associated fringe of $38,160 in FY 22 and $39,310 in FY 23) for infection control training. The Healthcare-Associated Infections & Antimicrobial Resistance (HAI-AR) Program provides technical assistance to healthcare facilities in infection control and prevention. HAI-AR will need an additional Nurse Consultant to support technical assistance with infection control to allow long-term care facilities to comply with the bill.

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.3% of payroll in FY 22 and FY 23.

Primary Analyst: ES 4/13/21
Contributing Analyst(s): RDP, LD, CP

Section 3 results in a cost associated with requiring DPH to maintain a 90-day stockpile of personal protective equipment (PPE) that will be used to supply long-term care facilities during a public health emergency. Funding of approximately $106,460 in FY 22 and $109,660 in FY 23 (with associated fringe of $43,970 in FY 22 and $45,290 in FY 23) will support two Material Storage staff to help manage PPE. DPH will also incur costs of approximately $3.2 million in FY 22 and $200,000 in FY 23 associated with PPE supplies, storage, and an inventory management system. In addition, the bill results in a cost of approximately $2 million in FY 22 and FY 23 to support a maintenance contract with a vendor to resupply the needed PPE prior to expiration.

Section 13 results in a cost to DSS associated with revising nursing home staffing levels and eliminating the distinction between a chronic and convalescent nursing home and a rest home with nursing supervision.

Staffing ratio requirements will result in a significant cost to DSS to the extent nursing home staffing costs are reflected in future Medicaid payments. The bill specifies that a total of 4.1 hours of direct care be provided per resident per day, including 3.75 hours by a registered nurse (RN), 0.54 hours by a licensed practical nurse (LPN), and 2.81 hours by a certified nurse's assistant (CAN).

Based on 2019 nursing home staffing data, none of the approximately 200 homes can meet the bill's requirements for RNs (with an average of 0.70 hours of direct care provided per resident per day). Approximately 10% of homes do not meet the LPN staffing requirements, while approximately 80% do not meet the requirements for CNAs. The cost for nursing homes to staff at the proposed levels will depend on the actual number and level of staff required and their associated wages but is anticipated to be at least $200 million.

The Out Years

The annualized ongoing fiscal impact identified above would

continue into the future subject to inflation.

Exhibit 7

General Assembly

Amendment

January Session, 2021

LCO No. **9433**

Offered by:
SEN. DAUGHERTY ABRAMS, 13th Dist.
REP. STEINBERG, 136th Dist.

To: Subst. Senate Bill No. **1030** File No. 457 Cal. No. 281

"AN ACT CONCERNING LONG-TERM CARE FACILITIES."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective October 1, 2021*) (a) As used in this section and sections 2 to 11, inclusive, of this act:

(1) "Nursing home" means any chronic and convalescent nursing home or any rest home with nursing supervision that provides nursing supervision under a medical director twenty-four hours per day, or any chronic and convalescent nursing home that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic diseases, convalescent stages, acute diseases or injuries; and

(2) "Dementia special care unit" means the unit of any assisted living

facility that locks, secures, segregates or provides a special program or unit for residents with a diagnosis of probable Alzheimer's disease, dementia or other similar disorder, in order to prevent or limit access by a resident outside the designated or separated area, or that advertises or markets the facility as providing specialized care or services for persons suffering from Alzheimer's disease or dementia.

(b) Each nursing home and dementia special care unit shall employ a full-time infection prevention and control specialist who shall be responsible for the following:

(1) Ongoing training of all administrators and employees of the nursing home or dementia special care unit on infection prevention and control using multiple training methods, including, but not limited to, in-person training and the provision of written materials in English and Spanish;

(2) The inclusion of information regarding infection prevention and control in the documentation that the nursing home or dementia special care unit provides to residents regarding their rights while in the home or unit and posting of such information in areas visible to residents;

(3) Participation as a member of the infection prevention and control committee of the nursing home or dementia special care unit and reporting to such committee at its regular meetings regarding the training he or she has provided pursuant to subdivision (1) of this subsection;

(4) The provision of training on infection prevention and control methods to supplemental or replacement staff of the nursing home or dementia special care unit in the event an infectious disease outbreak or other situation reduces the staffing levels of the home or unit; and

(5) Any other duties or responsibilities deemed appropriate for the infection prevention and control specialist, as determined by the nursing home or dementia special care unit.

(c) Each nursing home and dementia special care unit shall require its infection and control specialist to work on a rotating schedule that ensures the specialist covers each eight-hour shift at least once per month for purposes of ensuring compliance with relevant infection control standards.

Sec. 2. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, the administrative head of each nursing home and each dementia special care unit shall provide its emergency plan of operations to the political subdivision of this state in which it is located for purposes of the development of the emergency plan of operations for such political subdivision of this state required pursuant to the Interstate Mutual Aid Compact made and entered into under section 28-22a of the general statutes.

Sec. 3. (NEW) (*Effective October 1, 2021*) (a) The administrative head of each nursing home shall ensure that (1) the home maintains at least a two-month supply of personal protective equipment for its staff, and (2) the personal protective equipment is of various sizes based on the needs of the home's staff. The personal protective equipment shall not be shared amongst the home's staff and may only be reused in accordance with the strategies to optimize personal protective equipment supplies in health care settings published by the National Centers for Disease Control and Prevention. The administrative head of each nursing home shall hold fittings of his or her staff for N95 masks or higher rated masks certified by the National Institute for Occupational Safety and Health, at a frequency determined by the Department of Public Health.

(b) On or before January 1, 2022, the Department of Emergency Management and Homeland Security, in consultation with the Department of Public Health, shall establish a process to evaluate, provide feedback on, approve and distribute personal protective equipment for use by nursing homes in a public health emergency.

Sec. 4. (NEW) (*Effective October 1, 2021*) The administrative head of each nursing home shall ensure that there is at least one staff member

or contracted professional licensed or certified to start an intravenous line who is available on-call during each shift to start an intravenous line.

Sec. 5. (NEW) (*Effective October 1, 2021*) Each nursing home's infection prevention and control committee shall meet (1) at least monthly, and (2) during an outbreak of an infectious disease, daily, provided daily meetings do not cause a disruption to the operations of the nursing home, in which case the committee shall meet at least weekly. The prevention and control committee shall be responsible for establishing infection prevention and control protocols for the nursing home and monitoring the nursing home's infection prevention and control specialist. Not less than annually and after every outbreak of an infectious disease in the nursing home, the prevention and control committee shall evaluate (A) the implementation and analyze the outcome of such protocols, and (B) whether the infection prevention and control specialist is satisfactorily performing his or her responsibilities under subsection (b) of section 1 of this act.

Sec. 6. (NEW) (*Effective October 1, 2021*) Each nursing home shall, during an outbreak of an infectious disease, test staff and residents of the nursing home for the infectious disease at a frequency determined by the Department of Public Health as appropriate based on the circumstances surrounding the outbreak and the impact of testing on controlling the outbreak.

Sec. 7. (NEW) (*Effective October 1, 2021*) On or before January 1, 2022, the administrative head of each nursing home and dementia special care unit shall encourage the establishment of a family council and assist in any such establishment. The family council shall facilitate and support open communication between the nursing home or dementia special care unit and each resident's family members and friends. As used in this section, "family council" means an independent, self-determining group of the family members and friends of the residents of a nursing home or dementia special care unit that is geared to meeting the needs and interests of the residents and their family members and friends.

Sec. 8. (NEW) (*Effective October 1, 2021*) (a) On or before January 1, 2022, the administrative head of each nursing home shall ensure that each resident's care plan includes the following:

(1) Measures to address the resident's social, emotional and mental health needs, including, but not limited to, opportunities for social connection and strategies to minimize isolation;

(2) Visitation protocols and any other information relevant to visitation that shall be written in plain language and in a form that may be reasonably understood by the resident and the resident's family members and friends; and

(3) Information on the role of the Office of the Long-Term Care Ombudsman established under section 17a-405 of the general statutes including, but not limited to, the contact information for said office.

(b) On or before January 1, 2022, the administrative head of each nursing home shall ensure that its staff is educated regarding (1) best practices for addressing the social, emotional and mental health needs of residents, and (2) all components of person-centered care.

Sec. 9. (*Effective from passage*) On or before October 1, 2021, the Public Health Preparedness Advisory Committee established pursuant to section 19a-131g of the general statutes shall amend the plan for emergency responses to a public health emergency prepared pursuant to said section to include a plan for emergency responses to a public health emergency in relation to nursing homes and dementia special care units and providers of community-based services to residents of such homes and units.

Sec. 10. (NEW) (*Effective October 1, 2021*) (a) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day, and (2) modify staffing level requirements for social work and recreational staff of nursing homes such that the requirements (A) for social work are one full-time social worker per

sixty residents, and (B) for recreational staff are lower than the current requirements, as deemed appropriate by the Commissioner of Public Health.

(b) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 of the general statutes that set forth nursing home staffing level requirements to implement the provisions of this section.

Sec. 11. (*Effective from passage*) The Department of Public Health shall seek any federal or state funds available for improvements to the infrastructure of nursing homes in the state. Not later than January 1, 2022, the Commissioner of Public Health shall report, in accordance with the provisions of section 11-4a of the general statutes, regarding the commissioner's success in accessing such federal or state funds available for infrastructure improvement to the joint standing committee of the General Assembly having cognizance of matters relating to public health."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2021*	New section
Sec. 2	*October 1, 2021*	New section
Sec. 3	*October 1, 2021*	New section
Sec. 4	*October 1, 2021*	New section
Sec. 5	*October 1, 2021*	New section
Sec. 6	*October 1, 2021*	New section
Sec. 7	*October 1, 2021*	New section
Sec. 8	*October 1, 2021*	New section
Sec. 9	*from passage*	New section
Sec. 10	*October 1, 2021*	New section
Sec. 11	*from passage*	New section

Exhibit 8

OFFICE OF FISCAL ANALYSIS
Legislative Office Building, Room 5200
Hartford, CT 06106 ◇ (860) 240-0200
http://www.cga.ct.gov/ofa

sSB-1030
AN ACT CONCERNING LONG-TERM CARE FACILITIES.
AMENDMENT

LCO No.: 9433
File Copy No.: 457
Senate Calendar No.: 281

OFA Fiscal Note

See Fiscal Note Details

The amendment strikes the language in the underlying bill and the associated fiscal impact.

The amendment results in a cost to the Department of Social Services associated with eliminating the distinction between a chronic and convalescent nursing home and a rest home with nursing supervision and increasing minimum staffing level requirements in nursing homes.

The amendment requires the Department of Public Health (DPH) to establish a minimum staffing level of three hours of direct care per resident per day, by January 1, 2022. Based on 2019 cost report data, there are several homes providing less than three hours of direct care per resident per day. The total cost for these homes to meet the amendment's provisions is approximately $600,000 to $1 million. If the state supported those costs through increased rates, it would result in a state Medicaid cost of $300,000 to $500,000. The actual cost depends on the number and type of staff required.

The amendment also requires DPH to modify staffing requirements to (1) include one full-time social worker per sixty residents, and (2) reduce current staffing requirements for recreational staff. The net impact will depend on the adjusted staffing required for each home and the extent to which associated costs are reflected in Medicaid rates.

Primary Analyst: ES 5/27/21
Contributing Analyst(s): (FN)

The preceding Fiscal Impact statement is prepared for the benefit of the members of the General Assembly, solely for the purposes of information, summarization and explanation and does not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

Sources: 2019 Annual Cost Reports of Long Term Care Facilities per the Department of Social Services

Exhibit 9

CT S. Tran., 5/27/2021

Image 1 within document in PDF format.

Connecticut Senate Transcript, May 27, 2021

May 27, 2021
Connecticut Senate
2021

CONNECTICUT GENERAL ASSEMBLY

SENATE

Thursday, May 27, 2021

The Senate was called to order at 2:38 p.m., the President in the Chair.

THE CHAIR:

The Senate will please come to order.Give your attention to our guest Chaplain Kathy Zabel of Burlington.

ACTING CHAPLAIN KATHY ZABEL OF BURLINGTON:

Help us to live a creative life, to lose our fear of being wrong, and to let us find common ground with others.Let us know that in all things, we are not alone but are surrounded by the wisdom and kindness of our fellow man.

THE CHAIR:

Thank you very much, Madam Chaplain.We now invite Senator Winfield and Senator Berthel to come forward to lead us in the Pledge of Allegiance.

SENATOR WINFIELD (10TH) & SENATOR BERTHEL (32ND):

I pledge allegiance to the flag of the United States of America and to the republic for which it stands, one nation, under God, indivisible, with liberty and justice for all.

THE CHAIR:

Thank you very much to both Senators.Is there business on the Clerk's desk?

CLERK:

Good afternoon.The Clerk is in possession of Senate Agenda Item No. 1, dated Thursday, May 27th, 2021.

THE CHAIR:

Thank you, Mr. Clerk.Our distinguished Majority Leader, Senator Duff.

SENATOR DUFF (25TH):

Thank you, Mr. President.Good to see you this afternoon.Mr. President, I move all items on Senate agenda No. 1, dated Thursday, May 27th, 2021, be act upon as indicated and that the Agenda be incorporated by reference into Senate Journal and Senate Transcripts.

Good evening Senator.

SENATOR DAUGHERTY ABRAMS (13TH):

Good evening, Madam President.I move acceptance of the Joint Committee's favorable report and passage of the Bill.

THE CHAIR:

And the question is on passage, will you remark?

SENATOR DAUGHERTY ABRAMS (13TH):

Thank you, Madam President, the Clerk is in possession of LCO No. 9433.I ask that the Clerk please call it.I move the Amendment and ask leave to summarize.

THE CHAIR:

Mr. Clerk.

CLERK:

LCO No. 9433 Senate Schedule "A"

THE CHAIR:

And please do proceed to summarize and the question is on adoption of the Amendment.

SENATOR DAUGHERTY ABRAMS (13TH):

Thank you very much, Madam President.I cannot begin to talk about this Bill or this Amendment without remembering first the thousands of people, grandparents, mothers, fathers, sisters, brothers, residents of nursing home in assisted care living facilities who lost their lives due to COVID.Also, the staff members who put themselves and their family members at risk to take care of our most vulnerable citizens.These are the sacrifices that we must never forget.

For me, this legislation is an acknowledgment of that sacrifice.It is the most sincere hope that this Bill honors them by acting on our commitment to do better.This amended Bill is a culmination of the work of stakeholders, the Department of Public Health, the Chairs and Ranking Members of Public Health, Human Services and Appropriations Committees who held workgroups through the fall and into the winter to consider the recommendations of the Mathematica report and to evaluate current practices in nursing homes and assisted living facilities.

The Bill, as amended from the -- was amended from the original Bill because some parts of the original Bill have been taken up in other Committees.In Human Services and in the Aging Committee.In addition, changes have been made to address the fiscal note and feedback from various stakeholders.

This Bill, as amended, codifies the role of the infection preventionist.It's previously been in statute but not clearly defined.This legislation would ask that that person be full-time.They can be assigned to other duties, however.And would be asked to have a rotating schedule monthly so that they can see what is happening in the facility during all times of the day.They'd be responsible for training all administrators and staff on infection prevention and control using multiple training methods, including in-person training.They be responsible for written materials and resident documents and -- written materials that would be posted in the building that would show best practices in infection prevention.They would participate as a member of the Infection Prevention Control Committee to report on their activities.

The Infection Prevention and Control Committee would also ask to meet monthly, daily during an outbreak.They would be responsible for establishing infection prevention and control protocols, evaluate those protocols at least annually, and always after an outbreak.

We also address in this Bill PPE.Nursing homes would be asked to have a two month supply in various sizes that reflect the needs of their staff.There would be no sharing or reuse, only to -- only if it would be recommended by the CDC. It also asks that every nursing home have at least one staff member or contract professional to start an IV line available during every shift.It addresses the testing of staff and residents.It ask that nursing homes and assisted living facilities help to create family councils.It ask that the resident care plan address the social emotional needs of residents, training for staff on all components of the person centered care plan, and the social-emotional needs of the residents as well.

Staffing would be increased.Currently it's 1.9 hours per resident per day.This would increase that to 3.0.It would also increase the ratio of social workers from one to 120, to one to 60, and increase -- and increase recreational staff as determined by the public health department.

Social workers are responsible for the intake and discharge of patients for working with families and for really creating those residential care plans that address the social emotional needs of residents.We also ask in this legislation that DPH be charged to seek state and federal funds to support improvements to the infrastructure of our nursing homes.

When this pandemic began I was on weekly, sometimes daily calls regarding long-term care facilities and how we could mitigate the impact of COVID on those residents.I remember hearing that these facilities knew how to respond to infectious outbreaks.The pandemic certainly tested their ability to do that, and what we found is that we must do better.

In passing this Bill we will be doing better, so I encourage all members of the Chamber to support this Bill.Thank you.

THE CHAIR:

Thank you very much.Will you remark further?Will you remark further?Senator Somers.

SENATOR SOMERS (18TH):

Yes, good evening, Madam President.And I rise in full support of this Bill.In fact, I think it's one of the most important pieces of legislation that we will pass in this session.I should say I hope we pass this session.

One thing that the COVID pandemic has clearly shown us here in the State of Connecticut is the voids in the system that we have for caring for our elderly and long-term care in assisted living facilities.There is not one of us, I believe, in this circle that was not contacted by a family member of a loved one who was in a long-term care facility, or an assisted living facility during the COVID pandemic and during the unfortunately large loss of life that we saw here in the State of Connecticut.

I have to say that the people that work in these facilities really do God's work.It is not an easy job, and they do it with care and love and a true dedication for those who are a little more advanced in age than most of us here in the circle.

One of the things that is very clear is that this industry has -- needs some attention from our state.I think they did the best job they could under the circumstances.We all know that PPE was short in supply.We didn't realize how the virus could be transmitted at first, and unfortunately, we even had at times the National Guard going into our facility to help, but without actually being tested for COVID themselves because at that time we didn't understand the transmission.

I too received calls, sometimes on an hourly basis from some of our facilities asking for help, from family members of loved ones that felt that they were locked inside and couldn't have contact with the outside world, but most of our facilities did a great job in trying in the best of their ability to keep that contact going, whether it was through tablets that they could have, waving out the window.I know I myself, I personally visited many of these facilities obviously on the outside waiving to the individuals inside where just seeing somebody new could really brighten their day.

We saw a lot of mental health issues coming out of being isolated during the pandemic where the elderly in particular, especially those that have dementia or Alzheimer's were severely affected by this pandemic because they were moved out of their original routines.And not being able to see or have the contact with the person they were used to took its toll on so many individuals.I do believe that this industry and the long-term care that we'll see in the State of Connecticut is going through a significant change and we will see long-term care being delivered in a different way than we're seeing it now in the future.

But what this Bill does is it starts the beginning of the process, I believe, a process to improve the long-term care that we can provide to our citizens in the State of Connecticut.It looks at infection prevention, infection control, it looks at staffing levels that are reasonable and are affordable.It looks at emergency plan.It deals with visitation of loved ones.It deals with patients' rights.It deals -- also talks about testing and the necessity to make sure that our patients social and emotional needs are met the best they can.

I want to thank all of those who were engaged, including Madam President in this process of reviewing the Mathematica report of breaking out into individual workgroups, of working with the stakeholders and those who are actually working in this -- in these facilities because those truly are the people that can give us the best information so that we can adequately and strategically implement policies that can benefit the residents that live in these facilities here in the State of Connecticut.

So I ask that my colleagues in the Senate join myself and the Chair of public health, Senator Abrams, and support this very important and critical legislation that I do believe is one of the most important Bills that we could look at passing in this session.Thank you, Madam President.

THE CHAIR:

Thank you very much, Senator Somers.Will you remark further?Will you remark further?Senator Hwang.

SENATOR HWANG (28TH):

Thank you, Madam President.I rise in support of the strike-all Amendment.And I want to commend the Chair in the Senate along with the Chair of the House, Representative Steinberg, as well as the House Ranking Member Dr. Petit, and has mentioned before, I want to echo those terms because the uniqueness of the COVID challenge that we went through has raised significant awareness and sensitivity.And I hope this is a valuable lesson that we garnered from this in looking at this Bill and addressing staffing levels and reporting.It is an important and critical element that I hope we will continue as we head into the new normal, post-COVID dynamic that we're experiencing.

But that being said, I also want to commend the fact that our nursing facilities came to the table and collaborated and worked and understood the need to up their game so to speak in meeting the requirements of proper care, proper ratios, and proper reporting.So I think this is a Bill that is a great template for moving forward, as we look at public-private dynamics and us as a state looking to ensure the highest and best care for our loved ones that are at these facilities but also ensuring that we are working with our business partners to provide the highest and best care and sustainability and being in this state and doing business.

So I thank the good Chair for her efforts and collaboration and I urge supporter as well, ma'am.

THE CHAIR:

Thank you very much.Will you remark further?Will you remark further?Senator Looney.

SENATOR LOONEY (11TH):

Thank you, Madam President.Speaking in support of the Bill, rather the Amendment, want to commend the Public Health Committee for all of its works, Senator Daugherty Abrams on this Bill as so many others.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

PETITION OF CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC. FOR DECLARATORY RULINGS AS TO THE APPLICABILITY OF MINIMUM STAFFING REQUIREMENTS UNDER CONN. GEN. STAT. § 19a-563h	:

AFFIDAVIT OF JENNIFER M. DELMONICO

I, Jennifer M. DelMonico, being duly sworn, depose and say:

1. I am over eighteen years of age and believe in the obligations of an oath.

2. I am a partner at the law firm of Murtha Cullina LLP representing the Connecticut Association of Health Care Facilities, Inc. ("CAHCF") and, as such, am personally familiar with the subject matter of this petition for declaratory rulings.

3. Pursuant to Conn. Agencies Regs. § 19a-9-12, I certify that on February 28, 2003, I provided notice to the persons CAHCF knows or has reason to believe may be substantially affected by the subject matter of the petition for declaratory rulings by: (a) sending notice via email to CAHCF at mbarrett@cahcf.org, and requesting CAHCF to send notice via email to its nursing home members; and (b) providing notice via email to Leading Age of Connecticut at mmorelli@leadingagect.org, and requesting that Leading Age of Connecticut send notice to its nursing home members.

4. I further certify that CAHCF's notice contains the petition for declaratory rulings, and a detailed statement of the nursing homes' interest in the petition for declaratory rulings.

5. I certify that the petition for declaratory rulings submission conforms to the requirements of Conn. Agencies Regs. § 19a-9-6(a).

Jennifer M. DelMonico
Murtha Cullina LLP
265 Church Street, 9th Floor
New Haven, CT 06510
203.772.7700
jdelmonico@murthalaw.com

Subscribed and sworn to before me this 28th day of February, 2023.

Eleanor W. Nelson
Notary Public
My Commission Expires: 1/31/28