TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
PUBLIC HEALTH COMMITTEE
Monday, March 18, 2024

SB 1, An Act Concerning The Health And Safety Of Connecticut Residents

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **SB 1, An Act Concerning The Health And Safety Of Connecticut Residents**. While CHA is pleased to testify in support of several of these measures, we address below an array of concerns and recommendations relating to particular sections as well as our opposition to certain sections.

Connecticut hospitals are critical to their communities. They are confronting the challenges posed by a post-pandemic healthcare system with an exemplary healthcare workforce that continues to provide outstanding care. But challenges remain. Hospitals are treating sicker patients, it continues to be challenging to hire and retain staff, and the financial headwinds are grave. Through it all, hospitals are steadfast, providing high-quality 24-hour care for everyone who walks through their doors, focusing on making Connecticut's healthcare system more equitable, and driving world-class innovation right here in Connecticut.

Workplace Safety

CHA appreciates that **Sections 1-9** seek to make legislative changes to build upon the existing laws regarding workplace violence prevention in an effort to better address the workplace safety of healthcare workers, in this case specifically home care. Connecticut hospitals are and have been focused on providing a safe setting for all persons. Hospitals have established workplace safety committees including management and staff to conduct risk assessments, develop a plan, and meet regularly to implement and modify the plan as required.[1] They are identifying patients at risk for intentional harm to themselves or others and taking steps to mitigate this risk. They are recognizing environmental safety risks for patients and staff and making changes to reduce the occurrence of incidents. They are providing ongoing education and training to staff and volunteers on crisis prevention, de-escalation techniques, and approaches to ensuring personal safety.

[1] Medicare Hospital Conditions of Participation (CoPs) at Section 482.13(c) and Connecticut General Statutes Section 19a-490q.

Last fall, CHA members adopted a model *Statewide Patient and Family Code of Conduct Policy* to be used in hospitals to help address inappropriate and unacceptable behavior that interferes with the delivery of healthcare or creates an unsafe and disrespectful environment.

CHA has significant concerns about **Section 1** as it relates to the provision of psychiatric information and other protected health and personal information about patients and others who may be present in the home of the patient needing care. As Connecticut approaches the issue of better protecting home healthcare workers, we must balance the need to provide necessary information with existing state and federal laws, including HIPAA and other laws that require healthcare providers to apply very specific protections to behavioral health information.

CHA has concerns about the practical application of the requirements of **subsection (2) of Section 1** to a home healthcare setting, specifically pertaining to collecting information about other persons present or anticipated to be present at the location where the employee will provide services. This subsection requires the home healthcare agency or home health aide agency to obtain information such as psychiatric history, history of violence or domestic abuse, criminal record, and substance use history from such other persons. As drafted, there are no limitations established on which individuals might qualify as an "other person present or anticipated to be present." As drafted, these requirements would apply to any such person, including a neighbor or acquaintance. Such information will not be known to the agency, nor would the agency have ready access to such information. CHA recommends the deletion of this subsection of the bill and that the working group established in Section 8 be charged to address this issue.

Subsection 3(E) of Section 1 at lines 23-25 calls for the home care provider to assess the location for the presence of any other safety hazards, including electrical hazards. CHA has no objections to requiring an assessment of the safety requirements from a personal safety and security perspective. This assessment should be completed before the first appointment. CHA is concerned about the section requiring the evaluation of electrical hazards. Such a requirement will add significant cost to engage a qualified evaluator and create significant potential delays in completing patient intake, resulting in delays in the provision of home care. CHA also has concerns about the provision requiring the disclosure of crime rates for the municipality in which the employee provides services and whether this provision will result in access issues for home care services in some areas of the state. CHA recommends that these provisions be deleted from the bill and that the working group established in Section 8 be charged to address this issue.

Home care services are an essential part of the care continuum. Without home care, many patients would be unable to recover and heal at home and would be forced to remain in hospitals or other licensed care settings long after they need that level of care. It is essential to balance policies to protect healthcare workers with public policies that do not limit or discourage the provision of healthcare. CHA is concerned about the unintended consequences that may lead to less availability of home care services, which will create a backup of patients in hospitals who do not need hospital level care. Therefore, we suggest that these sections of the bill be rewritten, taking into account these comments, before this legislation moves forward.

SB 1 includes references to local police in several sections, including in **Section 2(B)** at line 42 and in **Section 7** at line 132. Given the limitations of current wearable device technology, which do not provide for direct communications with local police, and consistent with language used in line 130 of **Section 7**, we suggest that the Committee either (1) insert the phrase "or other staff" after the phrase "to contact local police" or (2) remove these references to local police in these two sections and insert the phrase "call for assistance" or a variation thereof.

CHA supports the collection of workplace violence incident reporting in home care settings in Section 3 and wishes to note that there is an existing state law that requires all licensed healthcare facilities, including home health agencies and home health aide agencies, to report annually to the Department of Public Health (DPH) incidents of violence that occur in the specific area or department where the incident occurred. CHA supports expanding this reporting requirement to include home healthcare settings.[2]

In addition, CHA supports the increased level of fees payable to home health agencies that recognizes the additional expense of providing safety escorts as set forth in Section 4.

Sections 7 and 9 speak to a new home care staff safety grant program that will begin to provide essential funding to secure safety technology for dedicated home health employees. CHA supports these provisions as important and necessary next steps, expanding upon action taken last session in **SA 23-29, An Act Improving The Safety Of Health Care Providers And Patients**, which required DPH to develop a marketing campaign to discourage violent behavior toward healthcare providers and promote the availability of nonprofit organization security infrastructure grants to nonprofit hospitals to enhance patient and employee safety. The program is administered by the Department of Emergency Services and Public Protection.

CHA also would like to thank the Committee for including CHA in the working group to study staff safety issues affecting home healthcare and home health aide agencies set forth in **Section 8** of the bill. Connecticut hospitals have a strong commitment to addressing workplace violence in all healthcare settings and look forward to working with the General Assembly on this important issue.

Graduate Physician Scope of Practice

While access to primary care is an issue of concern to CHA and its member hospitals, we have concerns about the measures set forth in this bill. **Sections 10-18** would create a new provider scope of practice called Graduate Physician comprising individuals who completed medical school but who did not continue their graduate medical education. That means these individuals would lack the vital and practical experience that physicians receive during medical residency and fellowship programs. Under this bill, a graduate physician would be

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2 **Sec. 19a-490r. Health care employer: Records and report re incidents of workplace violence.** A health care employer shall maintain records which detail incidents of workplace violence and include the specific area or department of the employer's premises where the incident occurred. A health care employer shall report not later than January 1, 2016, and annually thereafter, to the Department of Public Health the number of workplace violence incidents occurring on the employer's premises during the preceding calendar year and the specific area or department where such incidents occurred.

allowed to work under a collaboration agreement with a licensed physician in areas of the state where there is a perceived need for more providers.

CHA is concerned about this approach because it is not evident that graduate physicians would have sufficient training to serve in the capacity contemplated by the bill. The language in these sections does not address whether this new category of care provider would be able to see all patients or just a subset within the scope of their practice, or how consumers would be informed about their training and education, leaving several questions unanswered, such as: (1) can they prescribe medications or order treatment modalities, (2) would they be reimbursed for services rendered through government or private insurance, and (3) what medical malpractice insurance would they need to procure and is such coverage available to be purchased in our state? Creating a new category of care provider may be premature unless and until the role of a graduate physician is made clear and until these questions are answered.

Drug Supply Chain Study

CHA appreciates the attention provided in **Section 22** to the significant issue of drug shortages, which is a problem faced by hospitals and patients every day. CHA urges the Committee to include other participants and seek feedback from pharmacists and other individuals who have experience with facility drug purchasing and hands-on knowledge of drug supply chain issues, insurance experts, and wholesalers and manufacturers who deal with these issues every day.

Physician Qualifications

CHA has significant concerns with **Sections 24 and 25** because these changes allow a provider to hold themselves out as a "specialist" for an area of care without the appropriate current certifications as long as the provider does not claim to have met a *specific* board's specialty requirements. This change would reduce the quality of care provided in Connecticut while simultaneously leading to misconceptions about a physician's current qualifications.

Opioid Drug Deactivation and Disposal Kits

Although CHA supports the goal of **Sections 26 and 27** of the bill, which is to deploy available resources to make opioid drug deactivation and disposal kits more broadly available and finance the work through Opioid Settlement Funds, we oppose these sections as written because they impose an overbroad and unwieldy administrative burden on pharmacists, pharmacies, and hospitals and rely on a potentially unsustainable funding source.

CHA remains committed to collaborating with the state to combat the opioid epidemic. Hospitals and health systems support continuing education programs for prescribers; deploying recovery coaches in emergency departments (EDs); supplying naloxone kits to first responders as well as to patients and their loved ones; incorporating opioid awareness into clinical integrated-care programs; sponsoring community awareness and education programs; screening and enrolling patients in treatment programs for opioid dependence; partnering with the CHA Connecticut Perinatal Quality Collaborative to improve the health, equity, and

quality of care for mothers and infants, including those affected by opioid-use disorder; and providing to providers and other clinical staff educational services related to the causes of opioid use disorder and associated therapeutics pursuant to the Parents Recovering from Opioid Use Disorder (PROUD) grant.

CHA supports an "all of the above" approach to fighting the opioid crisis. But we caution against unnecessary burdens to the healthcare system, healthcare workforce, and patients.

The following needs to be revised in **Section 26**:

- First, hospitals and hospital pharmacies should be exempt from the obligation to provide patients with opioid drug deactivation kits. **Section 26** applies to all pharmacies, including pharmacies located in hospitals, which is untenable. The requirements set forth in this section as drafted would apply to patients receiving medications in inpatient settings. These requirements would also apply to a patient being treated in an ED who may be waiting for an inpatient admission. Patients leaving an ED with an opioid medication will have very few tablets, making the provision of the opioid drug deactivation kit of little value. For these reasons, it makes sense to exempt hospitals and hospital pharmacies from this requirement.

- Second, Section 26 contemplates that an opioid drug disposal kit will be provided to every patient who receives a prescription for an opioid medication. This section as drafted is not sufficiently targeted to achieve this goal. Such kits are not necessary in every situation involving the dispensation of an opioid medication. It would be more reasonable to have a threshold or trigger for when a disposal system should be offered or provided. There are many situations where a patient doesn't benefit from having the kit, for example: a patient who receives two tablets post-surgery for acute pain control; a nursing home patient who never self-administers; an inpatient surgery patient, resident, or home care patient who does not self-administer; or a patient who receives a formulation that does not lend itself to kit disposal (such as a drug with a large liquid component). More precision is needed to avoid wasting kits through unnecessary deployments that do not help combat the opioid crisis.

- Third, no provider, pharmacy, or pharmacist should be required to distribute the kits unless the kits are prepaid or physically supplied by the state. As drafted, the reimbursement mechanism in this section is unfair to providers and unworkable. Section 26(b)(2) at lines 644-652 states that a pharmacy is relieved of the obligation to give out the kits if there are insufficient funds in the Opioid Settlement Fund, but a provider is only paid after the fact (if at all) with no way to know (or control) whether the state fund has sufficient resources or funds. This funding mechanism is unsustainable and will create an additional financial burden on hospitals, pharmacists, and other providers. This section stands as another potential unfunded mandate that will increase the cost of healthcare.

CHA urges the Committee to revise Section 26 in line with the above comments. This section of the bill should not move forward unless these issues are addressed.

Definition of Employer

Section 28 modifies the definition of an employer in the Labor Relations Act. It appears the goal of this section is to remove the exemption of physicians and physician assistants under the state labor relations laws as applied to healthcare facilities, including laws pertaining to union organizing and strikes. CHA wishes to continue a conversation with the Committee to better understand the goal and perceived need for this change.

Cybersecurity

Sections 31 and 32 address healthcare facility readiness and response to a cybersecurity event. As those in the hospital and healthcare provider community have come to know all too well, cyberattacks are increasing in frequency and, sadly, will be a source of concern and focus for the foreseeable future. Connecticut hospitals and health systems prepare to respond to any number of natural and man-made disasters and emergencies on a regular and continuing basis. The "all hazards" approach to emergency planning, response, and recovery has bolstered institutional resiliency and strengthened public health and healthcare delivery systems. The cost and staff resources associated with preparing for emergencies and disasters are borne solely by hospitals and health systems for the benefit of the communities they serve.

Section 31 would impose a numerous requirements on hospitals and health systems without providing any resources or support in meeting those requirements. Currently, the state does not provide any support or resources for any of the emergency planning activities undertaken by hospitals and health systems. Additionally, some of the requirements mandated in **Section 31** are redundant, impractical, and interfere with patient care. Although well-intended, CHA respectfully requests that the Committee amend the bill to require the DPH's Office of Public Preparedness and Response and the state's Chief Information Security Officer to work in collaboration with CHA and CHA-member hospitals and health systems to develop cyberattack response and recovery guidance for hospitals and health systems, with a focus on the *functions* that are required for cyberattack readiness and response rather than specify the precise *type* of technology. Technology changes rapidly, and codifying into statute a mandate to use a certain type of technology will place hospitals and health systems at a disadvantage in defending against cyberattacks.

Section 32 would appropriate the sum of $25,000 to the Department of Emergency Services and Public Protection in each of the next four fiscal years to convene an annual meeting of state stakeholders for the purpose of focusing on the prevention, identification, and management of a cybersecurity event. CHA respectfully requests that **Section 32** be amended to specifically include hospitals, health systems, and CHA as participating entities in these annual meetings.

Parkinson's Disease Registry

Section 34 seeks to establish a statewide registry relating to Parkinson's disease similar to the current statewide tumor registry, which tracks certain cancers. CHA urges the Committee to specifically include hospital association representation on the data analytics committee. Hospitals will be a primary source of the data collected in the proposed registry. Hospitals have long-standing experience with the tumor registry, including for data collection issues, privacy and security expertise, and data standardization. That knowledge is important to the process. Additionally, CHA urges the Committee to recognize that this is a major undertaking that will require significant ongoing funding and support to be successful. We also urge the Committee to consider requiring DPH to post public information so that patients know their data are being collected.

Loneliness and Social Isolation Working Group

Section 36 establishes a working group to study and make recommendations concerning methods to address loneliness and isolation experienced by persons in the state and to improve social connections among such persons. CHA supports this section and urges the Committee to consider including as a member of the working group a geriatrician who treats adults aged 65 years and older. Older adults are at increased risk for loneliness and social isolation because they are more likely to face factors such as living alone, the loss of family or friends, chronic illness, and hearing loss. We believe that a geriatrician will provide a unique and important perspective on the healthcare impacts of loneliness and social isolation in older adults.[3]

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.

3 National Academies of Sciences, Engineering, and Medicine. 2020. *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25663