CONNECTICUT HOSPITAL ASSOCIATION

**TESTIMONY OF**
**CONNECTICUT HOSPITAL ASSOCIATION**
**SUBMITTED TO THE**
**PUBLIC HEALTH COMMITTEE**
**Wednesday, March 17, 2021**

## SB 1, An Act Equalizing Comprehensive Access To Mental, Behavioral And Physical Health Care In Response To The Pandemic

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **SB 1, An Act Equalizing Comprehensive Access To Mental, Behavioral And Physical Health Care In Response To The Pandemic**. 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, and our opposition to certain sections as well.

Before commenting on this bill, it is important to acknowledge that, since early 2020, Connecticut's hospitals and health systems have been at the center of the global public health emergency, acting as the critical partner in the state's response to COVID-19. Hospitals expanded critical care capacity, stood up countless community COVID-19 testing locations, and are a critical component of the vaccine distribution plan. Through it all, hospitals and health systems have continued to provide high-quality care for everyone, regardless of ability to pay. This tireless commitment to the COVID-19 response confirms the value of strong hospitals in Connecticut's public health infrastructure and economy and reinforces the need for a strong partnership between the state and hospitals.

**Section 2** provides for certification and education of peer support specialists to provide mental health or co-occurring mental illness and recovery support. CHA recommends that the Committee opt instead to support the establishment of a task force to study health insurance coverage for peer support services, as provided in House Bill No. 6588, *An Act Concerning Mental Health Care And Substance Abuse Services*. HB 6588 provides for the appointment of a representative of CHA to serve on the task force. We would welcome and appreciate the opportunity to engage in this work.

**Section 4** calls for a study of the state's response to the COVID-19 pandemic by the Department of Public Health (DPH). CHA supports this section. A fundamental principle of emergency planning and response is to conduct a post-event review of an entity's preparedness for and response to a particular event. These reviews are commonly referred to as After Action Reviews (AARs). AARs are important learning tools that, when done correctly, build response capabilities and efficiencies and lead to improved processes and response

outcomes. As an organization focused on quality outcomes, we see the state's undertaking of an AAR related to the COVID-19 pandemic as an important building block in fortifying the state's response to the next public health or other emergency.

**Section 5** would establish a new position of pandemic preparedness officer within DPH. CHA opposes this section and recommends in the alternative that the state pursue an "all-hazards approach" to emergency planning. According to the United States Department of Health and Human Services, an all-hazards approach is an "integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters." The creation of a new position within DPH would result in duplication and confusion and potentially impair the department's ability to act swiftly to prepare for, respond to, and recover from any number of man-made or natural disasters or mass casualty events. Instead of creating a new position, CHA recommends that the state dedicate funding to the DPH Office of Public Health Preparedness and Response (OPHPR) to support an all-hazards approach to emergency planning.

**Section 6** and **Section 7** of the bill are a call to recognize the powerful force that racism plays as a fundamental driver of social, economic, and environmental injustice and a threat to health and well-being. The events of 2020, and especially the COVID-19 pandemic, illustrated with stunning and alarming clarity the health disparities that exist for communities of color and those affected by the disadvantages of poverty and place. The pandemic also highlighted the vulnerability associated with living and working conditions which, along with these other factors, put some communities at substantially heightened risk of morbidity and mortality from COVID-19. Even as the pandemic commanded our attention, we witnessed social unrest over police brutality, which once more highlighted the enduring and powerful role that institutional and structural racism have in threatening the health and well-being of Blacks and other communities of color, in Connecticut and throughout this nation.

Hospitals and health systems were alarmed by the magnitude of the COVID-19-related disparities, but not surprised by their appearance—hospitals have recognized the injustice of race/ethnicity as a factor in health outcomes for many years. These disparities are evident in rates of maternal mortality in the Black population that are nearly three times higher than the general population,[i] rates of cardiovascular death that are 50 percent higher,[ii] and rates of mortality from diabetes that are double that of whites.[iii] Our hospitals recognized that social determinants contribute to these outcomes and, based on this understanding, years ago began to develop solutions to screen for and address issues such as housing instability, food insecurity, and lack of transportation—barriers that are commonly encountered in communities of color.

As **Section 6** makes clear, a focus on social determinants is not enough. Racism can be manifested in a variety of ways in federal, state, and local policy, social and economic institutions, and even our everyday interpersonal encounters. CHA supports the broad-based approach set forth in this section, recognizing that, while racism is a fundamental cause of poor health, the problem requires a broad perspective that looks beyond hospitals and

healthcare providers, even while recognizing that providers are essential participants in the development of solutions. Hospitals are prepared to respond with the same vigor they have applied to medical care and social determinants, with a reliance on science and evidence-based solutions.

CHA supports **Section 7**, which establishes a Truth and Reconciliation Commission to examine racial disparities in public health. Connecticut's hospitals have decades of experience working with communities to assess health needs, identify related racial and ethnic disparities, and also to formulate and participate in the funding of solutions. As a result of this work, and their focus on improving healthcare and disparities in clinical settings, hospitals have particular insights to offer in the examination of institutional racism in the state's laws and regulations; racial disparities in access to fresh food and produce, physical activity, public safety, clean air and clean water; and disparities in access to healthcare and medical outcomes. Consequently, we believe that a representative of CHA should be included on this commission and request that the language be amended to make this explicit.

**Section 8** sets nurse staffing ratios for hospital intensive care units. CHA opposes Section 8. Connecticut hospitals are committed to providing the highest quality care to achieve optimal patient outcomes. They are intensely engaged in building and sustaining organizational cultures of safety and employing high reliability strategies and evidence-based practices to prevent patient care complications and ensure the best patient experience. Nursing professionals at Connecticut hospitals continuously assess patient care needs and consider a wide range of factors that go beyond numbers and ratios to make staffing decisions. Some examples include patient-specific factors such as the severity and urgency of a patient's condition, age, cognitive and functional ability, scheduled procedures, and stage of recovery. Staff-specific factors such as licensure, educational preparation, skill level, years of experience, tenure on the patient unit, and level of experience with a particular type of patient care are considered. These complex elements are not captured by simply counting the total number of patients and dividing by the total number of nurses.

**Section 9** creates and funds a new breast health and breast cancer awareness program within DPH. Rather than establishing a new program, CHA recommends that the Committee provide additional funding to the existing Connecticut Breast and Cervical Cancer Early Detection Program, which is a comprehensive screening program available throughout the state for medically underserved women. Through DPH funding, healthcare providers offer women free breast and cervical cancer screenings, and other diagnostic and treatment referral services. The additional funding provided by this bill could be used to create targeted outreach programs to women of color and connect them to existing free services.

CHA strongly supports efforts to address adverse maternal birth outcomes that have a disproportionate impact on Black women as mentioned in **Section 12**. We recommend the Committee consider incorporating this work into the existing DPH Maternal Mortality Review Program and the associated Maternal Mortality Review Committee. This committee was

renewed and updated under Public Act 18-150 and is charged with reviewing maternal deaths, studying the incidence of pregnancy complications, and making recommendations to improve maternal outcomes and reduce preventable risk. The committee is organized, established, and already meeting. We believe that it is well-equipped to pivot immediately in order to engage in this important work.

**Section 13** requires DPH to establish a pilot program allowing emergency medical services (EMS) personnel, in coordination with community health workers, to conduct home visits to assist individuals with managing chronic illnesses and adhering to medication plans. The authority to use EMS personnel outside the 9-1-1 system is known as mobile integrated health, and already exists under Connecticut General Statutes Sections 19a-175(32) and 19-180(b). CHA supports the implementation of mobile integrated health programs.

**Section 14** requires a physician to perform a mental health examination during a patient's annual physical examination. CHA supports periodic mental health examinations for all patients, but believes that it is critical to maintain provider judgment and discretion as to the frequency and manner of such examinations.

CHA supports **Section 15**, which requires the Office of Policy and Management (OPM) to conduct a study addressing the impacts of the COVID-19 pandemic, including the disparate impact on individuals based on race, ethnicity, language, and geography. Although SB 1 has a variety of broad provisions related to racism and racial/ethnic health disparities, we strongly support a special focus on the unique challenges presented by the pandemic, the state's response, and the resulting disparate outcomes. We believe that this study should also include an examination of income inequality, along with race, ethnicity, language, and geography.

**Section 17** imposes a requirement on every state agency, board, or commission to collect ethnic or preferred language data. CHA appreciates that the state is seeking to improve the collection of data that would allow for better assessment and analysis, and hopefully enable solutions to the many challenges that are, or may be, based on disparities in access or outcomes for different racial or ethnic groups.

CHA requests that: (1) the language be amended to clearly delineate which specific state agencies, boards, or commissions are subject to the data collection; (2) a single agency be appointed as the coordinating agency to assist providers, ensure uniformity, and to coordinate the collection of data; (3) such collection comply and align with the federal interoperability data standards set forth by the Office of the National Coordinator for Health Information Technology (ONC); and (4) prior to collecting any data, the coordinating agency detail how this sensitive data will be secured and used, and how patient privacy will be protected. Patient trust in the healthcare system is vital to delivering good patient care. Transparency with respect to how the government will use patient health data is essential to building and maintaining that trust. These protective measures must apply whether those data are aggregated or at the individual patient level when collected, reported, or shared by the state, and should specifically include reference to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protections when appropriate.

**Section 18** amends the community benefit reporting program. CHA opposes this section as written. The language of section 18 is identical to language included in *HB 6550, An Act Concerning The Office Of Health Strategy's Recommendations Regarding Various Revisions To Community Benefits Programs Administered By Hospitals.* CHA submitted detailed testimony addressing our concerns with HB 6550. In sum, Section 18 imposes substantial new reporting requirements that would be both costly and excessively burdensome to fulfill and that would potentially complicate and disrupt the administration of community benefit programs. In

addition, this section would give the Office of Health Strategy (OHS) unilateral authority to mandate community benefit spending levels, a provision that is precluded by the hospital tax settlement. These requirements fail to recognize that the greatest responsibility for the community conditions that drive poor health rest with the state, which has substantially and chronically under-funded social services and public health. As we indicated in our testimony on HB 6550, we are prepared to work with OHS to forge a mutual agreement with respect to reporting that balances administrative burden with greater transparency.

**Section 19** requires DPH and the Department of Children and Families (DCF) to study the barriers to affordable behavioral healthcare services for children. CHA recommends that any such study be conducted under the auspices and framework of the Children's Behavioral Health Plan Implementation Advisory Board, established pursuant to Connecticut General Statutes Section 17a-22ff and charged with the responsibility to redesign the children's behavioral health system. This Advisory Board includes representatives of twelve state agencies having direct impact on children's behavioral health [DPH, DCF, Connecticut Insurance Department (CID), Department of Mental Health and Addiction Services (DMHAS), Department of Social Services (DSS), Department of Developmental Services (DDS), Office of the Child Advocate (OCA), Office of Early Childhood (OEC), Office of the Healthcare Advocate (OHA), State Department of Education (SDE), Judicial Branch Court Support Services Division (JBCSSD), and the Commission on Women, Children, and Seniors (CWCS)]. The Advisory Board has been engaged in a fiscal mapping process to improve the state's fragmented system of care, with a goal of addressing multiple service gaps by maximizing available dollars and efficiency, decreasing disparities, enhancing accountability, ensuring robust data collection and quality assurance, and increasing access, quality, and improving outcomes. We recommend that the study be conducted within the Advisory Board's existing multi-agency structure, fortified by dedicated administrative support from a designated state agency such as DCF.

CHA supports **Sections 20-32** and requests a modest change. One of the most pressing challenges experienced by hospitals in responding to the COVID-19 pandemic was the availability of trained and licensed personnel. The Emergency Management Assistance Compact (EMAC) as delineated in this bill would go a long way to ease the pressure related to staffing in response to a state, regional, national, or global emergency. The state was once a party to the EMAC, but delisted due to a de-prioritization of the funding and personnel needed to be a fully active member of the compact. CHA respectfully asks that the EMAC be amended to include not only licensed personnel, but also those who hold certifications and/or are otherwise statutorily recognized.

**Section 34** appropriates state funds to expand mobile crisis intervention services. CHA supports the appropriation of state funding for this purpose and for other community-based solutions to strengthen behavioral healthcare services for children and adults. Such measures will improve access to care at the optimal level of care and reduce overreliance on emergency departments.

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

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[i] https://www.cthealth.org/wp-content/uploads/2020/08/Health-disparities-fact-sheet-infant-mortality.pdf
[ii] https://health.uconn.edu/population-health/cvd-race-ethnicity/
[iii] Connecticut Diabetes Statistics Report, 2016 Estimates of the burden of diabetes and its risk factors in Connecticut, Connecticut Department of Health, March 2016. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/hems/diabetes/CTDiabetesStats20168Apr2016final2pdf.pdf