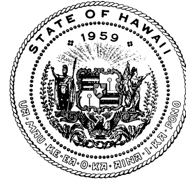
DAVID Y. IGE
GOVERNOR OF HAWAII



ELIZABETH A. CHAR, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. Box 3378
Honolulu, HI 96801-3378
doh.testimony@doh.hawaii.gov

Testimony COMMENTING on SB237
RELATING TO CARE FACILITIES

SENATOR CLARENCE K. NISHIHARA, CHAIR
SENATE COMMITTEE ON PUBLIC SAFETY,
INTERGOVERNMENTAL, AND MILITARY AFFAIRS

SENATOR JOY A. SAN BUENAVENTURA, CHAIR
SENATE COMMITTEE ON HUMAN SERVICES

Hearing Date: Thursday, February 4, 2021 Room Number:

1 **Fiscal Implications:** Less than required under SB059. At least two (2) new permanent full-time
2 equivalent (FTE) registered nurse (RN V) surveyor positions at $175,000 per surveyor per year
3 (salary and fringe), one (1) new permanent FTE administrative support position at $50,000 per
4 person per year, and start-up and operating costs for work stations, desktop and laptop
5 computers, and mileage and inter-island travel at approximately $30,000; total estimated cost of
6 $430,000 for the 1st year and $405,000 per year thereafter. Requires more staff and operating
7 resources to enforce. This work cannot be absorbed with current resources without negatively
8 affecting current survey work nor can the State's enforcement costs be shifted to the federal
9 government since these would be state requirements. And it requires current staff positions and
10 funding remain intact.
11 **Department Testimony:** The Department of Health appreciates the intent of this bill to help
12 prevent or mitigate the spread of COVID-19 and offers COMMENTS for the committee to better

1 understand the activities the Department already performs and enforces on licensed health care
2 facilities.

3 Most of the requirements of this bill are already being performed by the Department 's
4 Office of Health Care Assurance (OHCA). The Department respectfully requests the legislature
5 to clarify the terms "long term care facilities and nursing homes." The Department interprets
6 these to mean skilled nursing facilities (SNF) and intermediate care facilities for individuals with
7 intellectual disabilities (ICF-IID).

8 Please allow us to address each of the bill's 10 requirements and comment on their status.
9 These requirements are similar to requirements in SB059:

10 1. Staff Training: This is a duplication of current practice by OHCA. SNFs are required by
11 federal and state regulations to ensure that their staff are knowledgeable of and follow
12 infection control protocols while performing their duties. For example, Chapter 11-94.1
13 Hawaii Administrative Rules (HAR) on skilled nursing facilities (SNF), require SNFs to
14 have infection control and prevention policies or procedures.

15 2. At Least 2 Annual Inspections: OHCA already conducts unannounced federal and state
16 surveys and complaint investigations, and OHCA can enter facilities at any time to ensure
17 compliance. This bill increases the number of inspections and will require more staff and
18 funding resources. OHCA is unable to absorb this added workload at current staffing
19 levels, especially with restricted hiring due to the state's budget difficulties.

20 3. Administrator Requirements: DOH would enforce that the facility's governing body
21 require specific credentials as part of the administrator's job application, i.e., at least 5

1 years of experience in administrative leadership positions, references, and documentation
2 of completed training and communication skills with staff.
3 4. Continuing Training and Protocols for Contacting Emergency Response: See #1 above.
4 DOH would determine compliance that the facility established protocols to contact
5 emergency response agencies, but the bill is unclear on the thresholds that trigger the
6 contacts.
7 5. Adequate Staffing: Resident outcomes are the key to determining if staffing numbers and
8 staff training are adequate. OHCA already determines outcomes and does this to ensure
9 facility compliance with federal and state regulations. For example, Chapter 11-94.1-
10 16(b)(1) – (2), HAR requires SNFs to have "staff sufficient in number and
11 qualifications…on duty twenty-four hours a day to carry out the policies, responsibilities,
12 assessed care needs of the residents and program of the facility; and (2) The numbers and
13 categories of personnel shall be determined by the number, acuity level, and needs of
14 residents." This requirement is already in place.
15 6. Hotline for Anonymous Complaints: A hotline would be another avenue to receive
16 complaints. OHCA can do this without this bill. However, a hotline would be expected
17 to increase the number of complaints. This would require added resources.
18 7. Restrict Common Spaces: The Department has surveyed facilities on this, and facilities
19 have already implemented this as part of their COVID-19 infection control policy and
20 procedure (P&P) and protocols. This has the unfortunate consequence of eliminating or
21 reducing social interaction among residents or with their family members.

1 8. Staff Rotations and Assignments: Facilities have already assigned staff to COVID units
2 or restricted infectious illness units or have been cited by OHCA for failure to implement
3 rigorous infection control practices.
4 9. Personal Protective Equipment (PPE), Locker Rooms, and Shoes: OHCA has no
5 problem with this requirement but the activity can be part of a facility's infection control
6 or PPE inventory management protocol which can be enforced by OHCA. On locker
7 rooms and showers, this could be financially burdensome on many SNFs, especially the
8 smaller SNFs or SNFs in older buildings with limited space. And not allowing shoes
9 used during work shift to be worn outside the facility ignores the more practical use of
10 shoe covers.
11 10. Recordkeeping: Facilities already must allow OHCA access to specific patient
12 information. The requirements are at the federal and state level as facilities must prove
13 their compliance to regulations, and immediate access to such information helps to prove
14 compliance. Under federal regulations, facilities can be cited for obstructing or
15 unreasonably delaying access especially to prove compliance.
16 We trust these comments and summaries of current federal and state regulatory
17 enforcement activities are helpful to the Committee in deliberating whether this bill will help to
18 raise the standard of care at Hawaii's nursing facilities.
19 Thank you for the opportunity to testify on this measure.

February 4, 2021 at 3:00 pm
Via Videoconference

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Paige Heckathorn Choy
Director of Government Affairs
Healthcare Association of Hawaii

Re: Testimony in Opposition
SB 237, Relating to Care Facilities

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 170 member organizations who represent almost every aspect of the healthcare continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities, and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high-quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 20,000 people statewide.

Thank you for the opportunity to provide testimony in **opposition** to this bill. We understand that the COVID-19 pandemic has been particularly devastating for our older population—especially those living in congregate settings. Very early on in the pandemic, it was clear that introduction of the virus into nursing homes could yield disastrous consequences. We learned from cities like Seattle and New York City about how devastating outbreaks could be—and so we did what we could to prepare ourselves by purchasing and sourcing PPE, training staff, meticulously following best practices issued by the CDC and CMS, and convening weekly meetings to share experiences and best practices.

This preparation was essential to protecting elderly residents in skilled nursing facilities (SNFs), assisted living facilities (ALFs) and adult residential care homes (ARCHs). While any illness or death is tragic, we believe that Hawaii providers have done well considering the circumstances. We know from extensive public health research that if cases go up in the community it is inevitable that cases in nursing homes will also increase. A county-by-county analysis found

Phone: (808) 521-8961 | Fax: (808) 599-2879 | HAH.org | 707 Richards Street, PH2 - Honolulu, HI 96813

Affiliated with the American Hospital Association, American Health Care Association/National Center for Assisted Living, National Association for Home Care and Hospice, American Association for Homecare, Council of State Home Care Associations, and National Hospice and Palliative Care Organization

that, even if all protocols are followed perfectly, COVID will enter into a nursing home if the seven-day moving average of cases in a community hits an average of 3.65 cases per 100,000 population. In Hawaii, that means that if the seven-day average is at or exceeds 50 cases then there will be cases within a facility. Importantly, the outbreaks we saw this summer correlated with the surge we experienced as a state this summer. Even with these difficulties, Hawaii nursing facilities have done well. Cumulatively, Hawaii is the second lowest in the nation for COVID-19 infections per 1,000 residents and the second lowest in the nation for COVID-19 deaths per 1,000 residents.

Long-term care facilities in Hawaii have achieved this with incredible financial and labor resource difficulties. In a survey completed of our nursing home members, we found that they had additional costs and losses related to the pandemic totaling around $50 million. This would include things like increased costs for staffing, PPE, and testing—and is likely a vast undercount. Nursing facilities in the state did receive some assistance through federal provider relief fund payments, but they only covered about half of the additional costs and losses that we estimated.

Any loss of life during this pandemic is tragic—however, we believe that this bill would not achieve the aim of improving patient care. Instead, many of the requirements in this bill are duplicative and overly burdensome. We can provide federal and state laws regulating each section, but in summary:

- Training and Continuing Education. CMS regulations for SNFs require that all new and existing staff must be trained on infection prevention and control. This would include written standards, policies, and procedures. This must be done annually per Hawaii state administration rules. Similar requirements exist for ALFs and ARCHs through OSHA and state admin rules. We believe that the requirements laid out in this bill would be duplicative and unnecessary.

- Inspections. Under federal rules, a survey agency must conduct standard surveys no later than every 15 months. Under Hawaii rules, the surveys should be done annually. All inspections and complaint investigations must be unannounced and follow-up inspections can be made by DOH at any time to carry out any plans of correction. The federal government can take corrective action against deficient SNFs and can levy sanctions. If appropriate action is not taken, a SNF license can be revoked. For ALFs, they must be inspected at least once every two years, and ARCHs are subject to unannounced visits as well. We are unsure how requiring another unannounced visit would improve patient care and how this would burden the licensing agency.

- Emergency Preparedness. Under federal laws, SNFs must have a process for cooperation and collaboration with local, tribal, regional, state and federal emergency preparedness officials to maintain an integrated response. Emergency preparedness training must also be provided annually under federal regulations. State rules require SNFs, ARCHs and ALFs to have written policies and procedures to follow in an emergency, which COVID

qualifies as. We would suggest that comprehensive, flexible emergency plans are sufficient to address the requirements of the bill and would further request clarification on what type of information should be communicated to HI-EMA and at what interval.

- Staffing. The staffing requirements in this bill are particularly difficult and do not align with current federal and state requirements. CMS requires SNFs to provide services by sufficient numbers of many different types of personnel, including nurses. Numerous requirements for nurses to demonstrate proficiency are also required. State regulations also require certain nursing staff to be present for SNFs. For ARCHs and ALFs, states require staff to "meet the needs of residents" through on-site direct care 24 hours a day and to have adequate numbers of qualified staff on duty 24 hours a day, respectively. Further, there is a concern that required staff to "redirect" patients in statute for five years could cause serious funding and labor issues even when there is no longer a need for social distancing.

  Also related to staffing is the requirement not to allow rotations and assignments. According to CMS, SNFs must have an infection prevention and control program that includes systems for preventing, identifying, reporting, investigating and controlling any infections and communicable diseases. There must be written policies and procedures, along with a system of surveillance. There are also standard transmission-based precautions that must be followed in SNFs and requirements to prohibit employees who have an infection to work with residents or their food. On the state side, there are requirements to discharge staff with a knowledge of infection. We believe that following best practice guidelines and protocols, there is not a need to prevent rotation and there is a requirement to surveil and dismiss staff exhibiting signs of *any* illness.

- PPE and sanitation. While PPE was a major issue early on in the pandemic, we were able to leverage supplies from HHEM to help facilities access needed supplies. We have a good system set that SNFs, ALFs, and ARCHs may use to monitor their PPE and request more if needed from the HHEM or state supply. We would also note that there are existing federal and state regulations on sanitation on handling linens so as to prevent infection and to ensure that the storage and disposal of all hazardous and infectious waste follows best practices. There is a serious concern that having to handle all employees' clothes, storing them, and laundering them can be a large burden, especially for smaller long-term care facilities.

- Record-keeping. CMS requires SNFs to do comprehensive assessments of residents with at least 18 categories of information including special treatments and procedures, cognitive patterns, physical functioning and health conditions, psychosocial well-being, and many others. This assessment is used to develop a comprehensive plan of care. State law required similar documentation and plans of care from ARCHs and ALFs. We believe that the more extensive federal and state requirements would adequately document what this bill seeks.

- Hotline. We believe that residents, staff and family have sufficient recourse to address complaints. Under federal requirements, SNFs must post in a form and manner accessible to residents and their representatives all names, addresses, and numbers pertaining to any state agencies and advocacy groups—including DOH and the office of the ombudsman—so that a complain can be filed. The SNF must also advise residents that they may file a complaint with DOH of any suspected violation of a federal or state law or rule. State regulations also require similar notification for residents in ALFs and ARCHs.

As we continue to address this pandemic, long-term care facilities in Hawaii remain committed to working with state and federal partners to ensure that residents and staff are protected. Further, we are encouraged by national data that nursing home infections and deaths are declining as the elderly in these homes are being vaccinated. Every single Medicare-certified nursing home in the state, and most of the ALFs, participated in a federal partnership with pharmacies to vaccinate their residents and staff against COVID. We are hopeful that we are turning the corner but know that vigilance is still required and look forward to addressing any potential issues that need to be improved with the DOH or our federal regulators.

Thank you for the opportunity to testify.

SB-237
Submitted on: 2/2/2021 9:19:39 PM
Testimony for PSM on 2/4/2021 3:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Tricia M Medeiros	Testifying for The Plaza Assisted Living	Oppose	No

Comments:

The Plaza Assisted Living is a locally owned company operating all six of their communities on Oahu Hawaii. All communities are licensed and in good standing and make up a large portion of the assisted living beds in the State. Thank you for the opportunity to provide testimony in **opposition** to this bill.

The reason for our opposition to this bill is that requirements are redundant and excessive. Most of the points in the bill are already in place. For example, requesting an infection control plan. This is already a requirement from both OSHA and the Department of Health (DOH). While licensing all of our communities this was one of the first things requested prior to licensure. The DOH already has a mechanism for handling complaints and the Ombudsman program is active and contact information is posted in all long term care communities. Requirements requesting additional inspections is another example of redundancy and a waste of resources for DOH.

The requirement of notifying HI-EMA seems out of place. It just makes more sense that notification would go to DOH.

The staffing requirements in this bill are difficult to enforce, unspecific and may only make the current workforce issues worse.

Other requirements in the bill—including having sanitations stations, showers, and laundering are burdensome, costly and difficult to implement. While the main way that this virus spreads is through droplet precautions and not spread through clothing, shoes, etc.

Healthcare communities have been utilizing PPE forever and communities know how to manage PPE and calculate burn rates. This is not a problem. The real problem that occurred during that pandemic was procuring PPE and not inventorying it three times a day.

Thank you for the opportunity to testify.

February 3, 2021

<u>Senate Committee on Public Safety, Intergovernmental, and Military Affairs</u>

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

<u>Senate Committee on Human Services</u>

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Pat Duarte
President & CEO
Kāhala Senior Living Community, Inc.

Re: Testimony in Opposition
<u>SB 237, Relating to Care Facilities</u>

Thank you for the opportunity to provide testimony in **opposition** to Senate Bill 237. Kāhala Senior Living Community, Inc. is a not-for-profit organization that operates a life plan community, which does business as Kāhala Nui. In addition to our 270 independent living residences, we offer assisted living, memory care, and nursing care to approximately 120 seniors.

Infection control has always been a very high priority for all senior care facilities. Even prior to the COVID-19 pandemic, there were very stringent regulations in place to prevent and control the spread of infection. COVID-19 took infection control to another level, and even more stringent requirements were imposed by the Centers for Medicare and Medicaid Services (CMS). Although outbreaks have been impossible to prevent, Hawaii nursing facilities have done well in controlling the spread of COVID-19. Cumulatively, Hawaii is the second lowest in the nation for COVID-19 infections per 1,000 residents and the second lowest in the nation for COVID-19 deaths per 1,000 residents.

Preventing COVID-19 has come with a significant price tag. Kāhala Nui and other long-term care facilities in Hawaii have had to spend significant amounts of money on personal protective equipment, testing supplies, and additional personnel cost. While at the same time, nursing home occupancy throughout the state has declined due to more restrictive admission measures, seniors delaying medical procedures, and families not wanting their loved ones in a congregate setting with limited visitation. The combination of higher operating cost and lower

4389 Malia Street • Honolulu, Hawaii 96821 • (808) 218-7200 • Fax (808) 218-7150 • www.kahalanui.com

occupancy has put many facilities in a very precarious financial position. SB 237 will only exacerbate the situation with its additional staffing and facility requirements.

Furthermore, we find the bill to be duplicative in its training, recordkeeping, and infection control requirements. CMS already has such regulations in place. To add another layer of regulations would only make it more confusing for management and staff, not to mention the survey teams that inspect us annually. Speaking of which, the additional inspections will add a substantial financial burden to the state, and a challenge for the Office of Health Care Assurance.

Most of the long-term care facilities have completed or are nearly completed with the administration of two doses of the Moderna vaccine. We are optimistic that the vaccines will help to improve our already stellar track record of preventing the spread of COVID-19 in our facilities. For the reasons stated above, we strongly urge you not to pass SB 237.

Thank you for the opportunity to testify.

WAHIAWA NURSING AND REHABILITATION CENTER

Never Out of Touch

February 4, 2021 at 3:00 pm
Videoconference

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Rebecca Canon-Fratis
Administrator
Wahiawa Nursing and Rehabilitation Center/WGH-SNF

Re: Testimony in Opposition
SB 237, Relating to Care Facilities

Thank you for the opportunity to provide testimony in **opposition** to this bill. We understand that the COVID-19 pandemic has been particularly devastating for our older population—especially those living in congregate settings. Very early on in the pandemic, it was clear that introduction of the virus into nursing homes could yield disastrous consequences. We learned from cities like Seattle and New York City about how devastating outbreaks could be—and so we did what we could to prepare ourselves by purchasing and sourcing PPE, training staff, meticulously following best practices issued by the CDC and CMS, and convening daily meetings within our organization to further discuss best practices, develop our COVID-19 Prevention Program, and the implementation of ongoing infection control and prevention protocols.

This preparation was essential to protecting our elderly residents of nursing homes. While any illness or death is tragic, we believe that Hawaii providers have done extremely well considering the circumstances. We know from extensive public health research that if cases go up in the community it is inevitable that cases in nursing homes will also increase. A county-by-county analysis found that, even if all protocols are followed perfectly, COVID-19 will enter into a nursing home if the seven-day moving average of cases in a community hits 3.65 cases per 100,000 population. In Hawaii, that means that if the seven-day average is at or exceeds 50 cases then there will be cases within a facility. Importantly, the outbreaks we saw this summer correlated with the surge we experienced as a state this summer. Even with these difficulties, Hawaii nursing facilities

have done well. Cumulatively, Hawaii is the second lowest in the nation for COVID-19 infections per 1,000 residents and the second lowest in the nation for COVID-19 deaths per 1,000 residents.

Long-term care facilities in Hawaii have achieved this with incredible financial and labor resource difficulties. In a survey completed of our nursing home members, we found that they had additional costs and losses related to the pandemic totaling around $50 million. This would include things like increased costs for staffing, PPE, and testing—and is likely a vast undercount. There has been some federal help, but not nearly enough.

Any loss of life during this pandemic is tragic—however, we believe that this bill would not achieve the aim of improving patient care. Instead, many of the requirements in this bill are duplicative and overly burdensome. For example, there are several requirements for infection and disease control prevention (IDCP) training already in place at the federal and state level that would make the requirements in this bill duplicative. The Centers for Medicare and Medicaid Services (CMS) requires in 42 CFR §483.95 that a facility "must develop, implement, and maintain an effective training program for all new and existing staff…" including for infection control. Further, HAR §11-94.1- 20 requires all nursing homes to complete an in-service education program that includes orientation and annual in-service training on various topics including infection control. Assisted living facilities (ALFs) are also required by OHCA to have an infection control policy with annual training and had to create an action plan to respond to COVID-19. ARCH facilities also have similar requirements.

We would also note that adding a requirement to notify HI-EMA is not well defined—what has to be reported is not made clear. Further, we would suggest that if notification of certain events or information was to be mandated that DOH might be a more appropriate entity, since not all future events will be related to the pandemic.

The staffing requirements in this legislation are also difficult to enforce and may exacerbate staffing shortages that existed prior to the pandemic and worsened as COVID-19 became more prevalent in the community. By requiring staff by law to re-direct patients who cannot comply with social distancing guidelines—even after the pandemic is over—will exacerbate the staffing issues that nursing facilities have. Further, during the pandemic, staff are dedicated to the infection control plans already in place and thus will manage social distancing and other protocols appropriately. Staff do not need to be designated to do so. Restricting staff rotations and assignments will also create a critical issue with staffing—and is not required if applicable federal and state guidelines are followed.

Other requirements in the bill—including having sanitation stations, showers, and laundering may also create burdens for nursing homes, ALFs, ARCHs and smaller homes that will be costly and difficult to implement. It is unclear who is responsible for laundering clothes and how much it would cost to convert facilities or homes without these facilities already in place. It will also add cost to prevent fomite transmission, while the main way that this virus spreads is through airborne or particle spread. The review of PPE is also essential but done on a consistent basis currently—and PPE shortages are often resolved quickly using the state's supply or the supply from the Hawaii Healthcare Emergency Management Coalition.

Lastly, we would note that this bill would also create further burdens for state agencies that may cause staffing issues and increase resource needs. For example, DOH would have to complete what seems to be additional announced inspections, which would likely require more manpower—similarly, a hotline would require additional dollars and labor to man. We believe that the current inspections schedule and the ability of residents, staff, and families to call in concerns to DOH and the office of the Ombudsman are sufficient to ensure proper oversight. For the licensing piece, we would request clarification on the new requirement for a nursing home administrator license application to have five years of experience. In particular, it would be helpful to understand what experience is considered satisfactory.

As we continue to address this pandemic, long-term care facilities in Hawaii will remain committed to working with state and federal partners to ensure that residents and staff are protected. Further, we are encouraged by national data that nursing home infections and deaths are declining as the elderly in these homes are being vaccinated. Every single Medicare-certified nursing home in the state, and most of the ALFs, participated in a partnership with pharmacies to vaccinate their residents and staff against COVID-19. We are hopeful that we are turning the corner, but know that vigilance is still required and look forward to addressing any potential issues that need to be improved with the DOH or our federal regulators.

Thank you for the opportunity to submit testimony.

Kalākaua
Gardens

February 3, 2021

For Videoconference February 4, 2021 at 3:00 pm

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Colleen Kojima
Administrator
Kalakaua Gardens

Re: Testimony in Opposition
SB 237, Relating to Care Facilities

Thank you for the opportunity to provide testimony in **opposition** to this bill. We understand that the COVID-19 pandemic has been particularly devastating for our older population—especially those living in congregate settings. Very early on in the pandemic, it was clear that introduction of the virus into nursing homes could yield disastrous consequences. We learned from cities like Seattle and New York City about how devastating outbreaks could be—and so we did what we could to prepare ourselves by purchasing and sourcing PPE, training staff, meticulously following best practices issued by the CDC and CMS, and convening weekly meetings to share experiences and best practices. So far, Kalakaua Gardens has not had any COVID positive cases in our building.

This preparation was essential to protecting elderly residents in our skilled nursing facility (SNFs) and assisted living facility (ALFs). While any illness or death is tragic, we believe that we have done well considering the circumstances. We know from extensive public health research that if cases go up in the community it is inevitable that cases in nursing homes will also increase.

We have achieved this success with incredible financial and labor resource difficulties. This would include things like increased costs for staffing, PPE, and testing. We did receive some assistance through federal provider relief fund payments, but they only covered about half of the additional costs and losses that we estimated.

Any loss of life during this pandemic is tragic—however, we believe that this bill would not achieve the aim of improving patient care. Instead, many of the requirements in this bill are duplicative and overly burdensome. We can provide federal and state laws regulating each section, but in summary:

- Training and Continuing Education. CMS regulations for SNFs require that all new and existing staff must be trained on infection prevention and control. This would include written standards, policies, and procedures. This must be done annually per Hawaii state administration rules. Similar requirements exist for ALFs and ARCHs through OSHA and state admin rules. We believe that the requirements laid out in this bill would be duplicative and unnecessary.

- Inspections. Under federal rules, a survey agency must conduct standard surveys no more than every 15 months. Under Hawaii rules, the surveys should be done annually. All inspections and complaint investigations must be unannounced and follow-up inspections can be made by DOH at any time to carry out any plans of correction. The federal government can take corrective action against deficient SNFs and can levy sanctions. If appropriate action is not taken, a SNF license can be revoked. For ALFs, they must be inspected at least once every two years, and ARCHs are subject to unannounced visits as well. We are unsure how requiring another unannounced visit would improve patient care and how this would burden the licensing agency.

  Kalakaua Gardens passed their Infection Control Survey last year without any deficiencies, as well as a Complaint Survey which was unsubstantiated.

- Emergency Preparedness. Under federal laws, SNFs must have a process for cooperation and collaboration with local, tribal, regional, state and federal emergency preparedness officials to maintain an integrated response. Emergency preparedness training must also be provided annually under federal regulations. State rules require SNFs, ARCHs and ALFs to have written policies and procedures to follow in an emergency, which COVID qualifies as. We would suggest that comprehensive, flexible emergency plans are sufficient to address the requirements of the bill and would further request clarification on what type of information should be communicated to HI-EMA and at what interval.

- <u>Staffing.</u> The staffing requirements in this bill are particularly difficult and do not align with current federal and state requirements. CMS requires SNFs to provide services by sufficient numbers of many different types of personnel, including nurses. Numerous requirements for nurses to demonstrate proficiency are also required. State regulations also require certain nursing staff to be present for SNFs. For ARCHs and ALFs, states require staff to "meet the needs of residents" through on-site direct care 24 hours a day and to have adequate numbers of qualified staff on duty 24 hours a day, respectively. Further, there is a concern that required staff to "redirect" patients in statute for five years could cause serious funding and labor issues even when there is no longer a need for social distancing.

  Also related to staffing is the requirement not to allow rotations and assignments. According to CMS, SNFs must have an infection prevention and control program that includes systems for preventing, identifying, reporting, investigation and controlling any infections and communicable diseases. Kalakaua Gardens has (2) Certified Infection Prevention and Control Specialists. We have written policies and procedures, along with a system of surveillance. There are also standard transmission-based precautions that must be followed in SNFs and requirements to prohibit employees who have an infection to work with residents or their food. We believe that following best practice guidelines and protocols, there is not a need to prevent rotation and there is a requirement to surveil and dismiss staff exhibiting signs of *any* illness.

- <u>PPE and sanitation.</u> While PPE was a major issue early on in the pandemic, we have a good system set monitor our PPE and request more if needed from the HHEM or state supply. We would also note that there are existing federal and state regulations on sanitation on handling linens so as to prevent infection and to ensure that the storage and disposal of all hazardous and infectious waste follows best practices. There is a serious concern that having to handle all employees' clothes, storing them, and laundering them can be a large burden, especially for smaller long-term care facilities.

- <u>Record-keeping.</u> CMS requires SNFs to do comprehensive assessments of residents with at least 18 categories of information including special treatments and procedures, cognitive patterns, physical functioning and health conditions, psychosocial well-being, and many others. This assessment is used to develop a comprehensive plan of care. State law required similar documentation and plans of care from ARCHs and ALFs. We believe that the more extensive federal and state requirements would adequately document what this bill seeks.

- <u>Hotline.</u> We believe that residents, staff and family have sufficient recourse to address complaints. We have posted information for residents and their representatives, all names, addresses, and numbers pertaining to any state agencies and advocacy groups—including DOH and the office of the ombudsman—so that a complain can be filed. The name and contact information for the Complaint Officer is also posted on the units. The SNF must also advise residents that they may file a complaint with DOH of any suspected violation of a federal or state law or rule.

As we continue to address this pandemic, we continue to remain committed to working with state and federal partners to ensure that residents and staff are protected. Further, we are encouraged by national data that nursing home infections and deaths are declining as the elderly in these homes are being vaccinated. Kalakaua Gardens has had their first vaccine clinic in a partnership with pharmacies to vaccinate their residents and staff against COVID. Our next one is scheduled next week. We are hopeful that we are turning the corner but know that vigilance is still required and look forward to addressing any potential issues that need to be improved with the DOH or our federal regulators.

Thank you for the opportunity to testify.

Colleen Kojima

Colleen Kojima
Administrator

February 4, 2021 at 3:00 pm
Videoconference

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Paige Heckathorn Choy
Director of Government Affairs
Healthcare Association of Hawaii

Re: Testimony in Opposition
SB 237, Relating to Care Facilities

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Any loss of life during this pandemic is tragic—however, we believe that this bill would not achieve the aim of improving patient care. Instead, many of the requirements in this bill are duplicative and overly burdensome. We can provide federal and state laws regulating each section, but in summary:

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Thank you for the opportunity to testify.

Alisa Racelo, NHA, LBSW
Director of Operations – Ohana Pacific Health

February 4, 2021 at 3:00 pm
Videoconference

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Corey Crismon
Administrator
Hale Makua Wailuku

Re: Testimony in Opposition
SB 237, Relating to Care Facilities

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Corey Crismon, MBA, LNHA | Administrator

w: halemakua.org

p: 808.243.1700 | c: 808.269.5716

a: 1540 Lower Main Street Wailuku, HI 96793

3-3367 Kuhio Hwy ● Lihue, HI 96766 ● (808) 431-4211
www.ohanapacific.com

February 4, 2021 at 3:00 pm
Videoconference

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Kurt Akamine
Vice President
Ohana Pacific Health

Re: Testimony in Opposition
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Kula Hospital
MAUI HEALTH

February 3, 2021

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Paige Heckathorn Choy
Director of Government Affairs
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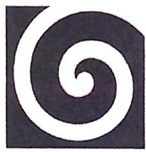

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If you should have any questions, please feel free to contact me at 808-876-4306 or by email at kerry.d.pitcher@kp.org.

Sincerely,

Kerry D. Pitcher, Senior Director of Long-Term Care and Critical Access Hospital
Hospital Administration

THE VILLAS

POST ACUTE CARE REHAB

February 4, 2021 at 3:00 p.m.
Via Videoconference

<u>Senate Committee on Public Safety, Intergovernmental, and Military Affairs</u>

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

<u>Senate Committee on Human Services</u>

To: Chair Joy A. San Buenaventura
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From: Hershel Caywood
Executive Director/Administrator
Clarence T.C. Ching Villas at St. Francis

Re: Testimony in Opposition
<u>SB 237, Relating to Care Facilities</u>

The Clarence T.C. Ching Villas at St. Francis is a 119-bed skilled nursing facility (SNF) located less than two miles northwest of downtown Honolulu, Hawaii on the island of Oahu and serves as a post-acute care rehabilitation provider to over 1,400 patients annually. In addition to providing access to appropriate, affordable, high-quality care to all of Hawaii's residents, we contribute significantly to Hawaii's economy by supporting employment for over 287 people.

Thank you for the opportunity to provide testimony in **opposition** to this bill. We understand that the COVID-19 pandemic has been particularly devastating for our older population—especially those living in congregate settings. Very early on in the pandemic, it was clear that introduction of the virus into nursing homes could yield disastrous consequences. We learned from cities like Seattle and New York City about how devastating outbreaks could be—and so we did what we could to prepare ourselves by purchasing and sourcing PPE, training staff, meticulously following best practices issued by the CDC and CMS, and convening weekly meetings to share experiences and best practices.

This preparation was essential to protecting our kupuna in SNFs, assisted living facilities (ALFs) and adult residential care homes (ARCHs). While any illness or death is tragic, we believe that Hawaii providers have done well considering the circumstances. We know from extensive public health research that if cases go up in the community it is inevitable that cases in nursing homes will also increase. A county-by-county analysis found that, even if all protocols are followed perfectly, COVID will enter a nursing home if the seven-day moving average of cases in a community hits an average of 3.65 cases per 100,000 population. In Hawaii, that means that

if the seven-day average is at or exceeds 50 cases then there will be cases within a facility. Importantly, the outbreaks we saw this summer correlated with the surge we experienced as a state this summer. Even with these difficulties, Hawaii SNFs have done well. Cumulatively, Hawaii is the second lowest in the nation for COVID-19 infections per 1,000 residents and the second lowest in the nation for COVID-19 deaths per 1,000 residents.

Long-term care facilities in Hawaii have achieved this with incredible financial and labor resource difficulties. In a survey completed of our nursing home members, found was that additional costs and losses related to the pandemic totaling around $50 million. This would include things like increased costs for staffing, PPE, and testing—and is likely a vast undercount. SNFs in the state did receive some assistance through federal provider relief fund payments, but they only covered about half of the additional costs and losses estimated.

Any loss of life during this pandemic is tragic—however, we believe that this bill would not achieve the aim of improving patient care. Instead, many of the requirements in this bill are duplicative and overly burdensome. We can provide federal and state laws regulating each section, but in summary:

- Training and Continuing Education. CMS regulations for SNFs require that all new and existing staff must be trained on infection prevention and control. This would include written standards, policies, and procedures. This must be done annually per Hawaii state administration rules. Similar requirements exist for ALFs and ARCHs through OSHA and state admin rules. We believe that the requirements laid out in this bill would be duplicative and unnecessary.

- Inspections. Under federal rules, a survey agency must conduct standard surveys no more than every 15 months. Under Hawaii rules, the surveys should be done annually. All inspections and complaint investigations must be unannounced and follow-up inspections can be made by the Department of Health (DOH) at any time to carry out any plans of correction. The federal government can take corrective action against deficient SNFs and can levy sanctions. If appropriate action is not taken, a SNF license can be revoked. For ALFs, they must be inspected at least once every two years, and ARCHs are subject to unannounced visits as well. We are unsure how requiring another unannounced visit would improve patient care and how this would burden the licensing agency.

- Emergency Preparedness. Under federal laws, SNFs must have a process for cooperation and collaboration with local, tribal, regional, state and federal emergency preparedness officials to maintain an integrated response. Emergency preparedness training must also be provided annually under federal regulations. State rules require SNFs, ARCHs, and ALFs to have written policies and procedures to follow in an emergency, which COVID qualifies as. We would suggest that comprehensive, flexible emergency plans are sufficient to address the requirements of the bill and would further

request clarification on what type of information should be communicated to HI-EMA and at what interval.

- Staffing. The staffing requirements in this bill are particularly difficult and do not align with current federal and state requirements. CMS requires SNFs to provide services by sufficient numbers of many different types of personnel, including nurses. Numerous requirements for nurses to demonstrate proficiency are also required. State regulations also require certain nursing staff to be present for SNFs. For ARCHs and ALFs, states require staff to "meet the needs of residents" through on-site direct care 24 hours a day and to have adequate numbers of qualified staff on duty 24 hours a day, respectively. Further, there is a concern that required staff to "redirect" patients in statute for five years could cause serious funding and labor issues even when there is no longer a need for social distancing.

  Also related to staffing is the requirement not to allow rotations and assignments. According to CMS, SNFs must have an infection prevention and control program that includes systems for preventing, identifying, reporting, investigation and controlling any infections and communicable diseases. There must be written policies and procedures, along with a system of surveillance. There are also standard transmission-based precautions that must be followed in SNFs and requirements to prohibit employees who have an infection to work with residents or their food. On the state side, there are requirements to discharge staff with a knowledge of infection. We believe that following best practice guidelines and protocols, there is not a need to prevent rotation and there is a requirement to surveil and dismiss staff exhibiting signs of *any* illness.

- PPE and sanitation. While PPE was a major issue early in the pandemic, we were able to leverage supplies from HHEM to help facilities access needed supplies. We have a good system set that SNFs, ALFs, and ARCHs may use to monitor their PPE and request more if needed from the HHEM or state supply. We would also note that there are existing federal and state regulations on sanitation on handling linens so as to prevent infection and to ensure that the storage and disposal of all hazardous and infectious waste follows best practices. There is a serious concern that having to handle all employees' clothes, storing them, and laundering them can be a large burden, especially for smaller long-term care facilities.

- Record-keeping. CMS requires SNFs to do comprehensive assessments of residents with at least 18 categories of information including special treatments and procedures, cognitive patterns, physical functioning and health conditions, psychosocial well-being, and many others. This assessment is used to develop a comprehensive plan of care. State law required similar documentation and plans of care from ARCHs and ALFs. We

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- Hotline. We believe that residents, staff and family have sufficient recourse to address complaints. Under federal requirements, SNFs must post in a form and manner access to residents and their representatives all names, addresses, and numbers pertaining to any state agencies and advocacy groups—including DOH and the office of the ombudsman—so that a complain can be filed. The SNF must also advise residents that they may file a complaint with DOH of any suspected violation of a federal or state law or rule. State regulations also require similar notification for residents in ALFs and ARCHs.

As we continue to address this pandemic, long-term care facilities in Hawaii remain committed to working with state and federal partners to ensure that residents and staff are protected. Further, we are encouraged by national data that nursing home infections and deaths are declining as the elderly in these homes are being vaccinated. Every single Medicare-certified SNF in the state, and most of the ALFs, participated in a partnership with pharmacies to vaccinate their residents and staff against COVID. We are hopeful that we are turning the corner but know that vigilance is still required and look forward to addressing any potential issues that need to be improved with the DOH or our federal regulators.

Thank you for the opportunity to testify.

ALOHA NURSING REHAB CENTRE
45-545 Kamehameha Hwy. • Kaneohe, HI 96744
Phone 808-247-2220 Fax 808-235-3676
www.alohanursing.com

February 4, 2021 at 3:00 pm
Videoconference

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Amy Lee
Chief Executive Officer
Aloha Nursing Rehab Centre

Re: Testimony in Opposition
SB 237, Relating to Care Facilities

Aloha Nursing Rehab Centre is a 141-bed Skilled Nursing Facility located in Kaneohe, ministering to the needs of 350 seniors and their families annually and employing 190 dedicated staff. For over thirty years, Aloha Nursing has been contributing positively to the community and to the state economy.

Thank you for the opportunity to provide testimony in **strong opposition** to this bill. We understand that the COVID-19 pandemic has been particularly devastating for our older population especially those living in congregate settings. Very early on in the pandemic, it was clear that introduction of the virus into nursing homes could yield disastrous consequences. We learned from cities like Seattle and New York City about how devastating outbreaks could be and so we did what we could to prepare ourselves by purchasing and sourcing PPE, training staff, meticulously following best practices issued by the CDC and CMS, and convening weekly meetings to share experiences and best practices.

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- Inspections. Under federal rules, a survey agency must conduct standard surveys no more than every 15 months. Under Hawaii rules, the surveys should be done annually. All inspections and complaint investigations must be unannounced and follow-up inspections can be made by DOH at any time to carry out any plans of correction. The federal government can take corrective action against deficient SNFs and can levy sanctions. If appropriate action is not taken, a SNF license can be revoked. For ALFs, they must be inspected at least once every two years, and ARCHs are subject to unannounced visits as well. We are unsure how requiring another unannounced visit would improve patient care and how this would burden the licensing agency.

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requirements for nurses to demonstrate proficiency are also required. State regulations also require certain nursing staff to be present for SNFs. Further, there is a concern that required staff to "redirect" patients in statute for five years could cause serious funding and labor issues even when there is no longer a need for social distancing.

Also related to staffing is the requirement not to allow rotations and assignments. According to CMS, SNFs must have an infection prevention and control program that includes systems for preventing, identifying, reporting, investigation and controlling any infections and communicable diseases. There must be written policies and procedures, along with a system of surveillance. There are also standard transmission-based precautions that must be followed in SNFs and requirements to prohibit employees who have an infection to work with residents or their food. On the state side, there are requirements to discharge staff with a knowledge of infection. We believe that following best practice guidelines and protocols, there is not a need to prevent rotation and there is a requirement to surveil and dismiss staff exhibiting signs of *any* illness.

- PPE and sanitation. While PPE was a major issue early on in the pandemic, we were able to leverage supplies from our GPO and HHEM to help access needed supplies. We have a good system set through HAH that we use to monitor our PPE and request more if needed from the HHEM or state supply. We would also note that there are existing federal and state regulations on sanitation on handling linens so as to prevent infection and to ensure that the storage and disposal of all hazardous and infectious waste follows best practices. There is a serious concern that having to handle all employees' clothes, storing them, and laundering them can be a large burden, especially for smaller long-term care facilities.

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Thank you for the opportunity to testify.

February 3, 2021

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Paige Heckathorn Choy
Director of Government Affairs
Healthcare Association of Hawaii

Re: Testimony in Opposition
SB 237, Relating to Care Facilities

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 170 member organizations who represent almost every aspect of the healthcare continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities, and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high-quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 20,000 people statewide.

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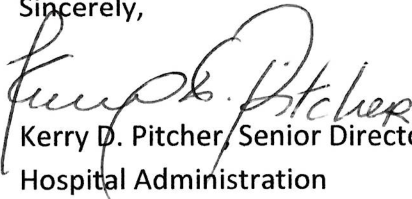
Thank you for the opportunity to testify.

If you should have any questions, please feel free to contact me at 808-876-4306 or by email at kerry.d.pitcher@kp.org.

Sincerely,



Kerry D. Pitcher, Senior Director of Long-Term Care and Critical Access Hospital
Hospital Administration

February 4, 2021 at 3:00 pm
Videoconference

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Mary Beth Santoro
Administrator
Pu'uwai 'O Makaha

Re: Testimony in Opposition
SB 237, Relating to Care Facilities

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84 390 Jade Street, Waianae, HI 96792 ♦ Telephone 808-695-9508 ♦ Fax 808-695-0225

February 4, 2021 at 3:00 pm
Videoconference

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Aja Elmore
Resident Care Manager
Ann Pearl Rehab & Nursing

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This preparation was essential to protecting elderly residents in skilled nursing facilities (SNFs), assisted living facilities (ALFs) and adult residential care homes (ARCHs). While any illness or death is tragic, we believe that Hawaii providers have done well considering the circumstances. We know from extensive public health research that if cases go up in the community it is

Affiliated with the American Hospital Association, American Health Care Association/National Center for Assisted Living, National Association for Home Care and Hospice, American Association for Homecare, Council of State Home Care Associations, and National Hospice and Palliative Care Organization

inevitable that cases in nursing homes will also increase. A county-by-county analysis found that, even if all protocols are followed perfectly, COVID will enter into a nursing home if the seven-day moving average of cases in a community hits an average of 3.65 cases per 100,000 population. In Hawaii, that means that if the seven-day average is at or exceeds 50 cases then there will be cases within a facility. Importantly, the outbreaks we saw this summer correlated with the surge we experienced as a state this summer. Even with these difficulties, Hawaii nursing facilities have done well. Cumulatively, Hawaii is the second lowest in the nation for COVID-19 infections per 1,000 residents and the second lowest in the nation for COVID-19 deaths per 1,000 residents.

Long-term care facilities in Hawaii have achieved this with incredible financial and labor resource difficulties. In a survey completed of our nursing home members, we found that they had additional costs and losses related to the pandemic totaling around $50 million. This would include things like increased costs for staffing, PPE, and testing—and is likely a vast undercount. Nursing facilities in the state did receive some assistance through federal provider relief fund payments, but they only covered about half of the additional costs and losses that we estimated.

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- Inspections. Under federal rules, a survey agency must conduct standard surveys no more than every 15 months. Under Hawaii rules, the surveys should be done annually. All inspections and complaint investigations must be unannounced and follow-up inspections can be made by DOH at any time to carry out any plans of correction. The federal government can take corrective action against deficient SNFs and can levy sanctions. If appropriate action is not taken, a SNF license can be revoked. For ALFs, they must be inspected at least once every two years, and ARCHs are subject to unannounced visits as well. We are unsure how requiring another unannounced visit would improve patient care and how this would burden the licensing agency.

- Emergency Preparedness. Under federal laws, SNFs must have a process for cooperation and collaboration with local, tribal, regional, state and federal emergency preparedness officials to maintain an integrated response. Emergency preparedness training must also be provided annually under federal regulations. State rules require SNFs, ARCHs and

ALFs to have written policies and procedures to follow in an emergency, which COVID qualifies as. We would suggest that comprehensive, flexible emergency plans are sufficient to address the requirements of the bill and would further request clarification on what type of information should be communicated to HI-EMA and at what interval.

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  Also related to staffing is the requirement not to allow rotations and assignments. According to CMS, SNFs must have an infection prevention and control program that includes systems for preventing, identifying, reporting, investigation and controlling any infections and communicable diseases. There must be written policies and procedures, along with a system of surveillance. There are also standard transmission-based precautions that must be followed in SNFs and requirements to prohibit employees who have an infection to work with residents or their food. On the state side, there are requirements to discharge staff with a knowledge of infection. We believe that following best practice guidelines and protocols, there is not a need to prevent rotation and there is a requirement to surveil and dismiss staff exhibiting signs of *any* illness.

- PPE and sanitation. While PPE was a major issue early on in the pandemic, we were able to leverage supplies from HHEM to help facilities access needed supplies. We have a good system set that SNFs, ALFs, and ARCHs may use to monitor their PPE and request more if needed from the HHEM or state supply. We would also note that there are existing federal and state regulations on sanitation on handling linens so as to prevent infection and to ensure that the storage and disposal of all hazardous and infectious waste follows best practices. There is a serious concern that having to handle all employees' clothes, storing them, and laundering them can be a large burden, especially for smaller long-term care facilities.

- Record-keeping. CMS requires SNFs to do comprehensive assessments of residents with at least 18 categories of information including special treatments and procedures, cognitive patterns, physical functioning and health conditions, psychosocial well-being, and many others. This assessment is used to develop a comprehensive plan of care. State law required similar documentation and plans of care from ARCHs and ALFs. We

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- Hotline. We believe that residents, staff and family have sufficient recourse to address complaints. Under federal requirements, SNFs must post in a form and manner access to residents and their representatives all names, addresses, and numbers pertaining to any state agencies and advocacy groups—including DOH and the office of the ombudsman—so that a complain can be filed. The SNF must also advise residents that they may file a complaint with DOH of any suspected violation of a federal or state law or rule. State regulations also require similar notification for residents in ALFs and ARCHs.

As we continue to address this pandemic, long-term care facilities in Hawaii remain committed to working with state and federal partners to ensure that residents and staff are protected. Further, we are encouraged by national data that nursing home infections and deaths are declining as the elderly in these homes are being vaccinated. Every single Medicare-certified nursing home in the state, and most of the ALFs, participated in a partnership with pharmacies to vaccinate their residents and staff against COVID. We are hopeful that we are turning the corner but know that vigilance is still required and look forward to addressing any potential issues that need to be improved with the DOH or our federal regulators.

Thank you for the opportunity to testify.

SB-237
Submitted on: 2/3/2021 2:03:35 PM
Testimony for PSM on 2/4/2021 3:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
David Fitzgerald	Testifying for HALE KUIKE	Oppose	No

Comments:

Aloha,

My name is David Fitzgerald and I’m the founder of Hale Ku’ike. We opened our first location in 2005 and operate three adult residential care homes that specialize in helping those living with dementia. We have just over one hundred employees and eighty-two licensed beds.

We are strongly opposed to SB 237.

The requirements listed in SB 237 are excessive, burdensome and in many cases vague.

Our healthcare community has worked very hard and have been quite effective in keeping our residents and staff safe during the pandemic. We have successfully collaborated with the Hawaii Department of Health and the Healthcare Association of Hawaii to navigate the challenges of the pandemic. Overall, I feel that our industry has done an excellent job. This is certainly reflected in the numbers.

Thank you very much for giving us the opportunity to submit testimony against SB 237.

With kind regards,

David Fitzgerald

President

Hale Ku’ike

February 4, 2021 at 3:00 pm
Videoconference

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Wesley Lo
Chief Executive Officer
Ohana Pacific Management Company/Hale Makua Health Services

Re: Testimony in Opposition
SB 237, Relating to Care Facilities

Thank you for the opportunity to provide testimony in **opposition** to this bill. We understand that the COVID-19 pandemic has been particularly devastating for our older population—especially those living in congregate settings. Very early on in the pandemic, it was clear that introduction of the virus into nursing homes could yield disastrous consequences. We learned from cities like Seattle and New York City about how devastating outbreaks could be—and so we did what we could to prepare ourselves by purchasing and sourcing PPE, training staff, meticulously following best practices issued by the CDC and CMS, and convening weekly meetings to share experiences and best practices.

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472 Kaulana Street | Kahului, Maui HI 96732-2099
p: 808-877-2761 | f: 808-871-9262 | www.halemakua.org

done well. Cumulatively, Hawaii is the second lowest in the nation for COVID-19 infections per 1,000 residents and the second lowest in the nation for COVID-19 deaths per 1,000 residents. Long-term care facilities in Hawaii have achieved this with incredible financial and labor resource difficulties. In a survey completed of our nursing home members, we found that they had additional costs and losses related to the pandemic totaling around $50 million. This would include things like increased costs for staffing, PPE, and testing—and is likely a vast undercount. Nursing facilities in the state did receive some assistance through federal provider relief fund payments, but they only covered about half of the additional costs and losses that we estimated.

Any loss of life during this pandemic is tragic—however, we believe that this bill would not achieve the aim of improving patient care. Instead, many of the requirements in this bill are duplicative and overly burdensome. There are currently federal and state laws regulating each section, but in summary:

- Training and Continuing Education. CMS regulations for SNFs require that all new and existing staff must be trained on infection prevention and control. This would include written standards, policies, and procedures. This must be done annually per Hawaii state administration rules. Similar requirements exist for ALFs and ARCHs through OSHA and state admin rules. We believe that the requirements laid out in this bill would be duplicative and unnecessary.

- Inspections. Under federal rules, a survey agency must conduct standard surveys no more than every 15 months. Under Hawaii rules, the surveys should be done annually. All inspections and complaint investigations must be unannounced and follow-up inspections can be made by DOH at any time to carry out any plans of correction. The federal government can take corrective action against deficient SNFs and can levy sanctions. If appropriate action is not taken, a SNF license can be revoked. For ALFs, they must be inspected at least once every two years, and ARCHs are subject to unannounced visits as well. We are unsure how requiring another unannounced visit would improve patient care and how this would burden the licensing agency.

- Emergency Preparedness. Under federal laws, SNFs must have a process for cooperation and collaboration with local, tribal, regional, state and federal emergency preparedness officials to maintain an integrated response. Emergency preparedness training must also be provided annually under federal regulations. State rules require SNFs, ARCHs and ALFs to have written policies and procedures to follow in an emergency, which COVID qualifies as. We would suggest that comprehensive, flexible emergency plans are sufficient to address the requirements of the bill and would further request clarification on what type of information should be communicated to HI-EMA and at what interval.

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- Hotline. We believe that residents, staff and family have sufficient recourse to address complaints. Under federal requirements, SNFs must post in a form and manner access to residents and their representatives all names, addresses, and numbers pertaining to any state agencies and advocacy groups—including DOH and the office of the ombudsman—so that a complain can be filed. The SNF must also advise residents that they may file a complaint with DOH of any suspected violation of a federal or state law or rule. State regulations also require similar notification for residents in ALFs and ARCHs.

As we continue to address this pandemic, all long-term care facilities in Hawaii remain committed to working with state and federal partners to ensure that residents and staff are protected. Further, we are encouraged by national data that nursing home infections and deaths are declining as the elderly in these homes are being vaccinated. Every single Medicare-certified nursing home in the state, and most of the ALFs, participated in a partnership with pharmacies to vaccinate their residents and staff against COVID. We are hopeful that we are turning the corner but know that vigilance is still required and look forward to addressing any potential issues that need to be improved with the DOH or our federal regulators.

Thank you for the opportunity to testify.

February 4, 2021 at 3:00 pm
Videoconference

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Bronson Ho
Administrator
Garden Isle Rehab & Nursing

Re: Testimony in Opposition
SB 237, Relating to Care Facilities

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 170 member organizations who represent almost every aspect of the healthcare continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities, and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high-quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 20,000 people statewide.

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Thank you for the opportunity to testify.

SB-237
Submitted on: 2/3/2021 2:24:43 PM
Testimony for PSM on 2/4/2021 3:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Bryce Sumida	Testifying for Hale Ho Aloha	Oppose	No

Comments:

February 3, 2021

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Jolene Kageyama
Executive Director & Administrator
Hale Ola Kino (a 32-bed skilled nursing community)

Re: Testimony in Opposition
SB 237, Relating to Care Facilities

Hale Ola Kino is a 32-bed skilled nursing community situated on the 2nd floor of One Kalakaua Senior Living. We are owned and operated by Life Care Services, LLC. based out of Des Moines, IA, and have been serving Hawaii's kupuna since 1997.

Thank you for the opportunity to provide testimony in **opposition** to this bill. We understand that the COVID-19 pandemic has been particularly devastating for our older population—especially those living in congregate settings. Very early on in the pandemic, it was clear that introduction of the virus into nursing homes could yield disastrous consequences. We learned from cities like Seattle and New York City about how devastating outbreaks could be—and so we did what we could to prepare ourselves by purchasing and sourcing PPE, training staff, meticulously following best practices issued by the CDC and CMS, and convening weekly meetings to share experiences and best practices both with our local team and our corporate resource team.

This preparation was essential to protecting our elderly residents in our skilled nursing community. While any illness or death is tragic, we believe that Hawaii providers have done well considering the circumstances. We know from extensive public health research that if cases go up in the community it is inevitable that cases in nursing homes will also increase. A county-by-county analysis found that, even if all protocols are followed perfectly, COVID can enter into a nursing home Even with these difficulties, Hawaii nursing facilities have done well. In fact, Hale Ola Kino has done well and continues to remain COVID free. Cumulatively, Hawaii

is the second lowest in the nation for COVID-19 infections per 1,000 residents and the second lowest in the nation for COVID-19 deaths per 1,000 residents.

Hale Ola Kino have achieved this with incredible financial and labor resource difficulties. In a survey completed of our Hawaii nursing home members, we found that they had additional costs and losses related to the pandemic totaling around $50 million. This would include things like increased costs for staffing, PPE, and testing. Nursing facilities in the state did receive some assistance through federal provider relief fund payments, but they only covered about half of the additional costs and losses that we estimated.

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As we continue to address this pandemic, long-term care facilities in Hawaii remain committed to working with state and federal partners to ensure that residents and staff are protected. Further, we are encouraged by national data that nursing home infections and deaths are declining as the elderly in these homes are being vaccinated. This community, a Medicare and Medicaid-certified nursing home, participated in partnership with Walgreens pharmacy to vaccinate our residents and staff against COVID. In fact, we successfully vaccinated 100% of our residents and 95% of our staff. We are hopeful that we are turning the corner but know that vigilance is still required and look forward to addressing any potential issues that need to be improved with the DOH or our federal regulators.

Thank you for the opportunity to testify.

Regards,

Jolene Kageyama
Executive Director/Administrator
Hale Ola Kino

SB-237
Submitted on: 2/3/2021 10:33:38 AM
Testimony for PSM on 2/4/2021 3:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Justin Morrison	Individual	Oppose	No

Comments:

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara

Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura

Vice Chair Les Ihara, Jr.

From: Paige Heckathorn Choy

Director of Government Affairs

Healthcare Association of Hawaii

Re: Testimony in Opposition

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Facility perspective in opposition to this bill is very similar We are already providing training and annual, continued education for all staff members. We have annual, complaint inspections that are unnannounced already, we have Ombudsman and call lines for residents for any complaint issues that they already use. We have resident council meetings monthly and inspectors interview residents during annual inspections. We have EMR systems that track records that are submitted to State and Federal agencies for payment review and audited quarterly. We as a community already struggle to meet staffing requirements nationally and this Pandemic has added addtional strain to labor and further restrictions would prevent care from being provided. We have fully qualified Infection Control Nurses, Policies and Procedures that have kept us as safe as possible during this Pandemic by following our current Policies and Procedures.

V/R,

Justin Morrison, Legacy Hilo SNF NHA

SB-237
Submitted on: 2/1/2021 3:58:24 PM
Testimony for PSM on 2/4/2021 3:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Alan Urasaki	Individual	Support	No

Comments:

In support of passage. My father, a Vietnam vet, was a resident of the care facility just prior to COVID. I was unsatisfied at the level of care and the administration. It seemed that they only wanted the money. Please clean up this place for future vets. Mahalo.

February 4, 2021 at 3:00 pm
Videoconference

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Lemapu Lemanua
Administrator
Ann Pearl Rehab & Nursing

Re: Testimony in Opposition
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Phone: (808) 247-8558 | Fax: (808) 247-4115 | ohanapacific.org | 45-181 Waikalua St, Kaneohe, HI 96744

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February 4, 2021 at 3:00 pm
Videoconference

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To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Ashley Wakuta
Staff Educator/Infection Preventionist
Ann Pearl Rehab & Nursing

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To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

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From: Tricia Lindell RN
Director of Nursing
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LATE

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Submitted on: 2/3/2021 11:55:53 PM
Testimony for PSM on 2/4/2021 3:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Susan Pcola_Davis	Individual	Support	No

Comments:

THE SENATE
S.B. NO. 23
RELATING TO CARE FACILITIES.
STRONGLY SUPPORT WITH RECOMMENDATIONS FOR IMPROVEMENT
First, I must say that it should not have taken a pandemic to create a bill to PROTECT OUR ELDERS!! That sad story of the State Veterans Home could have been prevented by having the correct protocols and guidance from the DOH.
Removal of the home's administration was a step in the right direction. Although "the buck stops at the top" many times shortcuts are taken due to poor staffing plans that get glossed over during an annual site Inspection due to the arrival date being known. This is why an annual unscheduled inspection is required for all facilities. Non compliance requires plans for improvement to be developed within 30 days. Some of the problems with this approach, is that the facility needs to develop corrective actions that are measurable. They need to incorporate changes based on random audits.
I do not think the Department of Health can do the inspections because inspections are standards based done by people who know the standards of care to be compliant.
If the DOH becomes responsible for a follow up inspection, the department needs to address the actions taken for anything out of compliance for appropriateness and sustainability.
Suggest amended wording :
When if a care facility is found to not be in compliance with this section, the department of health shall conduct a follow up inspection as needed to ensure compliance and that corrective action was appropriate and sustainable.
The DOH must publicize any and all findings on ALL private or other state-run long-term care facilities or nursing homes during the COVID-19 pandemic with respect to those facilities' management or response to the COVID-19 pandemic.
Training classes on infectious disease control and prevention.
Regardless of whether the training is conducted by an accredited vendor or a division of the State, it should have a pre and post test. Many types of training are conducted by watching a video(s). To ensure competency, a tool needs to be developed to measure competency.
New staff members employed by the care facility shall attend the required training and the staff member's attendance must be documented within thirty forty-five days of hire Regardless of any prior completed training. All staff need to trained in the same manner.

Leadership
The head administrator of a care facility shall:

(1) Have at least five years of experience working in an administrative position of a care facility;

(2) Provide documentation of any applicable training and certification; and

(3) Provide references from previous places of employment that demonstrate skill in communication with staff.

(4) Interviews. A team of no less than 5 members of the staff and the Acting Director, to include a charge nurse, nurse, CNA, Dietary, and a Technician will develop a list of interview questions that will be used for all candidates. A scoring mechanism will be used, along with, qualitative information will be used to rate the candidates, for assistance in decision making. If the Acting Director is applying for the position, another member of leadership will become part of this team.

Continuing training. Each care facility shall establish an ongoing training program for all staff, that teaches protocols for infectious diseases and that shall include protocols for contacting the appropriate county disaster response agency, Hawaii emergency management agency, or the Hawaii emergency response team, as applicable. As health conditions change in our society that are new and not yet clearly understood, in-services need to be developed as conditions change and new information is obtained.

Staffing. Adequate staffing during a pandemic needs to be carefully planned. Charge nurses develop the schedule with an understanding the need for staffing flexibility and ability for backups. This need is especially important because regular staffing plans may not be effective due to staff contracting the infection and the requirement to isolate, thus leaving gaps in care. Dedicating staff to redirect wandering residents/patients will deplete scarce resources from providing care. An "all hands on deck" approach will be required. This becomes everyone's duty.

Hotline. The department of health shall establish an anonymous hotline for staff, patients, and relatives of patients to call to report inadequacies of any care facility in the State. The DOH will need to document the complaint, date and time of call, place of complaint. There needs to be a mechanism for follow up.

Common Spaces. The design of these facilities are meant to be the least restrictive. Although isolation may be required, staff and patient communication must be clear and understandable. This is not like the Governor writing a proclamation for enforcement. Consideration must be given to the type of facility and its mission. These facilities are not set up to be prisons. Those developing protocols need to be mindful of the facility and its mission.

Staff rotations and assignments. Given these extenuating circumstances, business as usual with staffing is again going to need careful planning and continuous monitoring. The proper identification of needed PPE, PPE required use and supply of PPE can allow for a staffing design that includes separating staff that are assigned to work with patients or residents infected with an infectious disease and those working with patients or residents who are not infected with that infectious disease. The staff included by this section shall include kitchen, maintenance or any other staff needed in the performance of daily duties.

Personal protective equipment. Shift leaders shall document inventory of personal protective equipment at each shift change. Shift leaders shall review infectious disease

guidelines before each shift and maintain updated patient information. Personal protective equipment shall include gowns, masks, gloves, shoe booties, sanitation stations and a locker room with shower to change out of work garments and shoes to be bagged for immediate laundry. Any laundry for staff also need proper protocols for effective disinfection. For these reasons, the facility will need to consider laundering on site to include effective cleaning agents. Shoes worn at the care facility shall not be worn outside the facility.

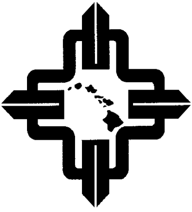
Recordkeeping. Each care facility shall keep a record of each patient that includes the patient's medical conditions, advanced directions, whether the patient can wear a mask, and whether the patient wanders due to condition or medication. An inspection of these records shall be performed by the department of health at scheduled and unscheduled inspections as described. Medical record review is a skill that is conducted by appropriate agencies. The Department of Health is not the appropriate agency for any of this. The following is the office in Hawaii that has trained staff to conduct inspections of this type. In a consult it active manner, the OHCA can provide MORE of the expected services than Department of Health can with regards to standards, and protocols.

OFFICE OF HEALTH CARE ASSURANCE (OHCA)

The Office of Health Care Assurance (OHCA) performs all state licensing activities on healthcare facilities, agencies and organizations in Hawaii. This includes conducting all on-site state licensing surveys (inspections) and Medicare certification surveys (inspections) on behalf of the U.S. Centers for Medicare and Medicaid Services (CMS).

COVID-19 Information for Licensed or Certified Health Care Facilities, Agencies, or Organizations

OHCA mails and emails facilities that are licensed or certified by the Hawaii Department of Health with information on infection control universal protocols, guidance, and tips from CMS, the U.S. Centers for Disease Control (CDC), the Hawaii Department of Health and Department of Human Services. The infection control information is applicable to almost every type of care facility, so review the information with an eye for guidance that is required of similar facilities as your own.



OAHU REGION
HAWAII HEALTH SYSTEMS CORPORATION

LATE

February 4, 2021 at 3:00 pm
Videoconference

Senate Committee on Public Safety, Intergovernmental, and Military Affairs

To: Chair Clarence K. Nishihara
Vice Chair J. Kalani English

Senate Committee on Human Services

To: Chair Joy A. San Buenaventura
Vice Chair Les Ihara, Jr.

From: Violeta Gonzales
Leahi Hospital Administrator
Hawaii Health Systems Corporation
Oahu Region

Re: Testimony in Opposition
SB 237, Relating to Care Facilities

Thank you for the opportunity to provide testimony in **opposition** to this bill. As an Administrator at Leahi Hospital, I witnessed and understand how the COVID 19 pandemic affected so much of our population, especially the elders in our community.

Leahi Hospital is one of the facilities that provides comprehensive, high –quality care to our elderly population. Our main priority at the moment is to ensure that our residents are protected from any exposure to COVID 19. From the very beginning of the pandemic, we took all reasonable measures to keep COVID 19 out of our facility. We purchased sufficient supplies of personal protective equipment – such as masks, gowns, gloves, and face shields – and required all of our staff to participate in on-going training on infection control and other safety measures.

As a matter of course, we maintain proper documentation of our residents' conditions, plan of care, medications and treatments. We also ensure that we have a sufficient number of staff working in our facility during all shifts so that our residents receive high quality care. In terms of emergency situations, all of our staff are trained (and continue to be trained) to keep our residents safe during natural disasters and other calamities. As part of this, we actively participate in training exercises with HI-EMA so that we are adequately prepared to execute all emergency responses.

With regard to family members and other loved ones of our residents, we continuously provide them with regular updates on every change implemented in our facility, including discovery of any actual or suspected cases of COVID 19 among our residents or staff.

Through the foregoing measures, which are already mandated through existing federal and state regulations, we have thus far been able to prevent any COVID-19 infections among our residents and performed well during our annual surveys with the Centers for Medicare and Medicaid Services and the State of Hawaii Office of Health Care Assurance.

It is my firm belief, therefore, that the requirements of SB 237 are unnecessary and will be duplicative of rules already in place for long-term care facilities such as Leahi Hospital. As such, we stand in **opposition** to this bill.

Thank you for the opportunity to testify regarding this important matter.