Connecticut General Assembly

Neil Ayers, Director
Phone: (860) 240-0200
Fax: (860) 240-0052
http://www.cga.ct.gov/ofa

Legislative Office Building
Room 5200
Hartford, CT 06106-1591
ofa@cga.ct.gov

OFFICE OF FISCAL ANALYSIS

Request for Department of Public Health (DPH)
Information Related to the Governor's FY 24 and FY 25 Budget

DPH Work Session —— Tuesday, March 14th —— 10:00 am to 11:00 am

1. Please provide a list of all ARPA projects funded in the FY 22 and FY 23 Budget and the FY 23 Revised Budget, what was appropriated for each in FY 22 – FY 25, a summary of each projects' implementation progress, and the current timelines for project completion.

   Please see attached document

2. What funding is available, from which sources (General Fund, ARPA, CDC, or other), for the Office of Workforce Strategy in FY 24 and FY 25, and what are the Office's primary projects?

   The Office of Public Health Workforce is supported by a recent $32 million grant from the CDC. Through this grant the office will offer enhanced professional training and new wellness programs for our existing workforce, support local health departments in their efforts to build their workforces, and create a new associate's degree in public health to build an additional pipeline for people interested in beginning careers in public health.

3. How many School Based Health Center sites exist in Connecticut, how many are funded through DPH, how much funding is appropriated for them in FY 24 and FY 25 through which funding sources? What services are provided to students by these sites? How is funding distributed to sites?

   The CT Association of School Based Health Centers list 132 comprehensive sites and 152 expanded school health sites in CT for a total of 284 sites. DPH funds a total of 90 sites, 78 comprehensive sites for medical and mental health services, and 12 expanded sites for medical or mental health services.

   Funding is provided as follows:

Fund Description	Source	Amount
School Based Health Clinics	State OCE	$11,544,057
Maternal & Child Health (MCH) Block Grant	Federal	$288,090
Public Health Crisis - COVID	COVID	$12,018,594
ARPA-School Based Health Centers	ARPA	$10,000,000

Inter Community Health Center (ICHC) School Based Health Center	ARPA	$604,000
Grand Total	**All Sources**	**$34,454,741**

Funding is distributed through request for Proposal (RFP)/Request for Application (RFA), Request for Application (RFA) or at the direction of the legislature (Earmark).

School Based Health Centers are free standing medical clinics located within or on the grounds of schools and are licensed as outpatient clinics or as hospital satellites. They offer accessible medical, mental health and/or dental services to all students enrolled in the school regardless of ability to pay/insurance status. SBHC staff work collaboratively with schools, parents, and the community to ensure that students are healthy and ready to learn. SBHCS support students by providing a safe place to talk about sensitive issues such as depression, family problems, relationships, and substance abuse, support the school environment by helping children stay in school reducing absenteeism and by identifying and addressing health problems that may interfere in the learning process, and support families by allowing parents to stay at work while attending to their child's routine health care needs also resulting in fewer ED visits.
Medical:

- Physical exams and routine checkups
- Immunizations
- Diagnosis and treatment of acute injuries and illnesses
- Managing/monitoring chronic disease
- Prescribing and dispensing medications
- Reproductive health

4. Please provide information on the status of mobile dispensing unit regulation, including any preliminary policies or regulations that have been drafted.

   Policies and procedures governing Department approval of mobile narcotic treatment programs (NTPs) as facilities have been drafted pursuant to PA 22-108 Sec. 4 in close coordination with our sister agencies DMHAS, DSS and DCP, and having been submitted the week of 3/6/23 are currently pending approval of OPM. These policies and procedures mirror the federal DEA rule setting requirements for mobile NTPs, by creating an approval process for the mobile units as satellites of existing providers licensed by DPH. DPH requirements cover vehicle and program specifications, as well as contingency planning, record-keeping and diversion measures.

5. Please provide information on the diversity of licensed behavioral health professionals and the utilization of state licensure reciprocity.

   Race and ethnicity is collected on all applicants for occupational licensure through DPH including behavioral health professions. This data is collected at the time of application through the online eLicense system that was implemented in the early 2000s. It is important to note that there are many current licensees who were licensed prior to the implementation of eLicense when the Department began collecting race and ethnicity data. The Department has been able to collect race/ethnicity during renewals of some of these long-term licensees who renew electronically. However, many licensees choose

to renew via regular mail and that data is not collected. Therefore, the race/ethnicity data is incomplete, and most likely reflective of those more recently becoming licensed.

There are also applicants who do not provide race and ethnicity information when they apply for a license. Based on available data, the Department performed an analysis of race and ethnicity data for a sample of 11,515 licensed social workers.

According to this data:

Ethnicity:
Hispanic 16%
Non-Hispanic 68%
Ethnicity not available 22%

Race:
Asian < 2%
Black or African American 13%
Race not available 17%
Other 4%
White 65%

4,149 new licenses have been issued through reciprocity with 335/4,149 related to behavioral health practitioners since October of 2022.

6. When were reimbursement rates for private ambulance providers last increased? Please provide the language that is necessary for DPH to increase these rates.

Please note the following increases for private ambulance providers since 2012

Year	Rate Increase
2012	3.20%
2013	2.80%
2014	4.00%
2015	3.40%
2016	2.5% plus 10% across the board
2017	2.30%
2018	4.00%
2019	2.30%
2020	2.00%
2021	3.10%
2022	4.10%
2023	2.80%

Ambulance rate increases are predicated on the following regulatory and statutory authority.

- Section 19a-179-21 of the Regulations of the Connecticut State Agencies
- Sections 19a-177(9)(A)- 19a-177(9)(D) of the Connecticut General Statutes
- Section 19a-177b of the Connecticut General Statutes

7. Please provide detail on the Public Health Infant Mortality Review Program.

   The Infant Mortality Review (IMR) Program will examine infant deaths in the state to reduce health disparities and identify gaps in care or services for infants or pregnant persons during prepartum care or delivery. The committee will include medical professionals, doulas, and various state agencies to ensure all documents are reviewed appropriately and for the right information. This committee will operate similarly to the maternal mortality review committee.

   The Connecticut Department of Public Health has reviewed the available 2019 and 2020 reported infant death data and estimates that the IMR Program would be asked to request, review, evaluate, and summarize approximately 125 infant deaths annually. The Governor's proposed budget appropriates the creation of one position, for the which the Department plans to hire a Nurse Consultant.

   The Department will need to establish and maintain a database to collect the infant death data as well as establish a IMR Committee. The IMR committee within the department will conduct a comprehensive, multidisciplinary review of infant deaths for purposes of reducing health care disparities, identifying factors associated with infant deaths and making recommendations to reduce infant deaths. Once the IMR Committee has been established and the Co-chairs have been appointed the IMR Committee will start meeting to review the de-identified infant deaths. The CT DPH IMR Committee, in consultation with the Office of the Child Advocate, will submit a Summary Report with the recommendations and findings of the committee to the Commissioner of DPH within 90-days after each meeting.

8. Provide the budget for the Office of Injury and Violence Prevention, including staff compensation, available grant funding, what grants have been awarded to which providers to date, and how funding is distributed.
   - Staffing compensation, available funding and grants awarded to providers to-date, see attached table
   - Funding is distributed primarily through request for Proposal (RFP) and sole source agreements as applicable.
9. Please provide information on private provider contracts.

   The Department has over 500 active contracts with an average of over of 100 contracts in process at any given time. The reduction in staffing levels over the past few years has impacted the timing of both the execution of contracts and the ability to distribute funds. As of 2/21/2023 the Contract Management Section had a 76% vacancy rate (20

out of 26 positions vacant). The following steps are being taken to assist with getting this unit back on track and moving towards a more stable and efficient future:

- Priority One: Hiring of Staff
  - Hired unit supervisor in August
  - Hired Grants and Contract Director in December
  - 4 new staff members starting in March
  - 6 positions receiving offers and awaiting start dates
  - 10 positions in hiring process

- Other Priorities:
  - Change reporting schedule from monthly to quarterly (completed on all new contracts)
  - Streamline no-cost amendments and contracts (completed)
  - Prioritized contracts within each section as identified by section ensuring we are working on highest priorities (completed)
  - Working with IT to update systems to allow for efficiencies and transparency
  - Reviewing processes, procedures and policies to gain efficiencies.

10. Please provide information on the information technology being used for licensing.

    The Department uses the Connecticut eLicensing system for licensing upwards of 80 different occupational licensure categories. The eLicensing system is an enterprise system used by multiple state agencies and is a real time web-based portal where the public can check/verify licenses. Initial applications and license renewal occur through the eLicensing system. The eLicensing system has promoted efficiencies and enhancements for consumers and state agencies that utilize the system.

11. Is $1 million of the $6 million in both FY 24 and FY 25 from the Tobacco Settlement Fund for the Tobacco and Health Trust Fund being set aside by OPM and the Board for local and district health departments' tobacco prevention activities?

    No, the $1 million was in the General Fund and has been proposed to be eliminated. The $6 million proposed by the Governor in FY24 and FY25 to be invested in the Tobacco and Health Trust Fund shall be administered by the Tobacco and Health Trust Fund Board per C.G.S. Sec. 4-28f. Per this statute the purpose of these funds is to create a continuing significant source of funds to:

    a. support and encourage development of programs to reduce tobacco abuse through prevention, education, and cessation programs,
    b. support and encourage development of programs to reduce substance abuse
    c. develop and implement programs to meet the unmet physical and mental health needs in the state

12. Please provide details on the Healthcare Facility Quality Assurance and Performance Improvement Program (QAPI).

    DPH's Facility Licensing and Investigations Section (FLIS), which is part of the Healthcare Quality and Safety Branch, licenses over 40 different provider types, including the state's 205 nursing homes. Over the last few years, nursing homes have struggled to

provide quality care consistently, and these struggles were exacerbated by the pandemic. Although the worst of the pandemic may be behind us, the state's nursing homes continue to struggle with quality-of-care issues. DPH violations and citations for quality-of-care issues have increased significantly even as the pandemic has waned. Most troubling is the increase in the number of Immediate Jeopardy findings in the last few months alone.

DPH collects a variety of quality-of-care data during and after surveys and complaint inspections, including data related to infection control, abuse and neglect, incidence of depression, pressure ulcers, the utilization of psychoactive medications. resident rights, and physical plant issues. While much of this data is forwarded to the Centers for Medicare and Medicaid Services (CMS) for their own review, DPH has little capacity to analyze this data in real time to improve our own work. Under the proposed QAPI program, DPH would be able to analyze enforcement and survey data to identify trends and develop interventions to help the industry improve quality. In addition, the QAPI team would help to track the work of our survey teams, to ensure that DPH is applying quality standards consistently throughout the industry – not only the standards imposed by CMS but also the standards set forth in state law and regulation. The QAPI team would help to analyze DPH's enforcement responses to determine which enforcement tools are most effective in improving quality of care. Finally, the QAPI team would share quality data with the state's Medicaid team at the Department of Social Services (DSS) to help assess whether or to what extent various changes to the Medicaid payment structure (for example, one-time incentives or the acuity-based payment program) affect quality of care.

13. What funding is provided from which sources to address tick-borne diseases in FY 24 and FY 25?

    ELC funding (current cooperative agreement period ends 7/31/24): DPH receives funding for 25% effort of an EPI2/$60,000 and contractual funds to support CAES $284,804 for tick and mosquito testing.

    EIP funding under TickNet (current cooperative agreement period ends 12/31/23)- total is $491,670 with majority being contracted to Yale ($425,484) and WCSU ($57,350) - these are for research studies not general surveillance.

    State funding: 1 FTE (Epi 2)

14. Does the $0.75 increase to the per capita subsidies for local and district health departments that was provided in the last biennial budget adequate to address inflation costs to these departments?

    The increase was a result of CGS Sec. 19a-202, that requires that full-time health departments that serve at least 50,000 people receive $1.93 per capita per fiscal year from DPH, and district health departments that serve at least 50,000 people and/or at least three municipalities receive $2.60 per capita. Prior to this change, DPH was statutorily required to provide $1.18 per capita to eligible full-time health departments, and $1.85 per capita to eligible district health departments. The Department feels this has provided some relief to the LHD to address inflationary cost.

15. DSS incurs costs from changes to nursing home staffing ratios. Are these costs considered by DPH before these ratio changes are made? What ratios are DPH seeking to be met?

The Department of Public Health works closely with other state agencies on competing priorities and mandates and as you are aware, the Department of Social Services is the agency charged with the huge responsibility of providing fiscal supports to the nursing home industry. DPH has an integral and primary role in enhancing quality to Connecticut's healthcare beneficiaries with an emphasis on the impact to quality measures, quality of life and quality of care to the individuals served.

PA 21-185 section 10, as amended by PA 22-58 section 36 directed in part, that the Department establish minimum staffing level requirements for nursing homes of three hours of direct care per resident day. When determining the allocations for direct care, DPH identified that the certified nurse aide performs most of the direct care in facilities, including assistance with toileting, bathing, dressing, and feeding, and consideration was given to such when weighting the 3.0 ratio. Please see the following table of the old and the new requirements. Please note the increase to 3.0 represents an additional 27.6 minutes per day per resident (12 minutes of RN time and 15.6 minutes of CNA time).

	Shift	**Old Requirement**	**New Requirement**	**Increase**	**% of Increased Time**
RNs	7a-9p	.47 (28.2 minutes)	.57 (34.2 minutes)	0.1 (6 minutes)	22%
	9p-7a	.17 (10.2 minutes)	.27 (16.2 minutes)	0.1 (6 minutes)	22%
TOTAL RN TIME PER DAY PER RESIDENT		.64 (38.4 minutes)	.84 (50.4 minutes)	0.2 (12 minutes)	44%
CNAs	7a-9p	1.4 (80 minutes)	1.6 (96 minutes)	0.2 (12 minutes)	43%
	9p-7a	.5 (30 minutes)	.56 (33.6 minutes)	0.06 (3.6 minutes)	13%
TOTAL CAN TIME PER DAY PER RESIDENT		1.9 (114 minutes)	2.16 (129 minutes)	0.26 (15.6 minutes)	56%
TOTAL DIRECT CARE TIME		2.54 (152 minutes)	3.0 (180 minutes)	0.46 (27.6 minutes)	