Healthcare Workforce Safety Working Group

To Study Worker Safety for Home Health and Hospice

2024 Report and Recommendations

January 31, 2025

On behalf of the Healthcare Workforce Safety Working Group, we submit the following recommendations to the Public Health Committee pursuant to Public Act 24-19. We hope that the Committee will consider these recommendations during its deliberations in the 2025 legislative session.

The report and the efforts of the working group are dedicated to the two home care workers who lost their lives while providing care to those in need---Joyce Grayson, a home health nurse, allegedly murdered by a behavioral health patient in Willimantic on October 28, 2023; and Otolegile Morulane, a caregiver from the Republic of Botswana, who died on January 16, 2024 while attempting to rescue his patient from a house fire in East Lyme.

In response to these tragedies, the Connecticut General Assembly (CGA) enacted Public Act 24-19, An Act Concerning the Health and Safety of Connecticut Residents. This bill included specific provisions aimed at addressing the safety of home healthcare workers, including convening this working group to study and understand the safety issues affecting staff of home health care, home health aide and hospice agencies.

Starting on September 23, 2024, the working group held a total of eight meetings, where it was able to hear from agency representatives and experts to understand the challenges in the current legislative framework and identify recommendations for the Public Health Committee to further improve safety conditions for staff of home health care, home health aide and hospice agencies.

A special thank you to all the members of the Healthcare Workforce Safety Working Group for their dedicated time, hard work and meaningful contributions. We look forward to working with the Public Health Committee over the coming months to continue to achieve the policy goals and objectives started in 2024.

Sincerely,

Sasa Harriott, MSN, APRN, PMHNP- BC
Co-Chair
Harriott Home Health Services

Tracy Wodatch, BSN, RN
Co-Chair
CT Association for Healthcare at Home

Healthcare Workforce Safety Working Group Members

All members appointed by the Public Health Committee

Co-Chairs

- Sasa Harriott, President (Pres)/Chief Executive Officer (CEO), Harriott Home Health Services
- Tracy Wodatch, Pres/CEO, Connecticut Association for Healthcare at Home

Members

- Eric Smullen, Senior Vice President (VP), Hartford HealthCare, Community Network
- Teri Henning, VP Government Affairs, Aveanna
- Barbara Pearce, CEO, The Connecticut Hospice
- Lauren Nadeau, Registered Nurse (RN) Clinical Manager, Yale New Haven Health Hospice
- Karen Enders, Director of Home Hospice Program, The Connecticut Hospice
- Jennifer LeDuc, Director Quality and Operations, Day Kimball Healthcare at Home
- Chris Pankratz, CEO, Masters in Home Care
- Stephen Magro, Policy and Research Director, SEIU District 1199
- Sarah Gadsby, CEO, River Valley Services
- Tyler Booth, Exec VP & Chief Operating Office (COO), InterCommunity Health Care
- Benjamin Murphy, Deputy Chief, East Windsor Police Department
- Joshua Clark, Lieutenant, Willimantic Police Department
- Karen Buckley, VP Advocacy, Connecticut Hospital Association (CHA)
- Kimberly Sandor, Executive Director, Connecticut Nurses Association (CNA)
- John Brady, VP, AFT Connecticut
- Julienne Giard, Section Chief, Community Services at Department (Dept) of Mental Health and Addiction Services (DMHAS)
- Angel Quiros, Commissioner, Dept of Corrections (DOC)
- Barbara Cass, Long Term Care Advisor to the Commissioner, Dept of Public Health (DPH)
- Anna Karabin, Social Work Supervisor, Dept of Social Services (DSS)
- David Bothwell, Legal Counsel, Connecticut Board of Pardons and Paroles
- Auden Grogins, Judge, Connecticut Superior Court
- Ron Cotta, Chief of Staff, Dept of Corrections
- Rhianna Gingras, Director, Connecticut Parole and Community Services

Administrative Staff:

- Piotr Kolakowski, Clerk, Public Health Committee
- Beverley Henry, Committee Administrator, Public Health Committee

Working Group Meetings and Presentations

September 23, 2024 | Agenda | Meeting Summary | Recording

September 30, 2024 | Agenda | Meeting Summary | Recording

October 15, 2024 | Agenda | Meeting Summary | Recording

October 29, 2024 | Agenda | Meeting Summary Recording

November 12, 2024 | Agenda | Meeting Summary | Recording

- Presentation from Department of Emergency Services and Public Protection (DESPP): Crime in Connecticut Fall 2024 Summary (Link)
- Presentation from Department of Public Health (DPH): Community/Private Home Visits Summary (Link)

November 19, 2024 | Agenda | Meeting Summary | Recording

- Meeting with a subgroup of home health and hospice provider working group members

December 3, 2024 | Agenda | Meeting Summary | Recording

January 7, 2025 | Agenda | Meeting Summary | Recording

January 16, 2025 | Meeting Summary

- Meeting with DHMAS to review risk assessment tool

January 23, 2025 | Agenda | Meeting Summary | Recording

Legislation Overview

In its 2024 legislative session, the Connecticut General Assembly (CGA) enacted Public Act 24-19, An Act Concerning The Health and Safety of Connecticut Residents.

Section 6 of this public act is the authorizing legislation for this working group. The section reads:

> *(a) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall convene a working group to study staff safety issues affecting (1) home health care and home health aide agencies, as such terms are defined in section 19a-490 of the general statutes, and (2) hospice organizations licensed by the Department of Public Health pursuant to section 19a-122b of the general statutes.*

Sections 1-4 created new requirements around home health care and home health aide agencies aimed at improving worker safety. The requirements are outlined below:

- Additional intake referral data collection to identify risk for violent behaviors, to alert staff to those risks and to implement mitigation measures to enhance protection of staff making visits in the community
- Onboarding and annual training to address risk mitigation identification and response measures based on nationally recognized CDC and OSHA guidance
- Staff safety check-ins to ensure open reporting of potential workplace violence/abuse incidents
- DPH to set up a reporting process for Home Health Care and Home Health Aide Agencies to perform mandated timely reporting of client to staff abuse as defined in the law
- DSS may offer a rate enhancement for those agencies who consistently and timely report such incidents
- DSS shall establish a home health worker safety grant program to mitigate costs of safety initiatives as outlined in the law and implemented by agencies

The safety working group convened to study and make recommendations on safety issues affecting home health care, home health aide and hospice agencies. In particular, the working group focused on the legislative requirements outlined in Sections 1-4 to understand their effectiveness and feasibility.

Several concerns/challenges with the current legislation were brought forward at the Working Group meetings—these can be found below.

Current Challenges with Public Act 24-19

Section 1 Safety Initiative Mandate

- **The working group could not reach a consensus on the effectiveness and impact of the requirements laid out in Section 1 of Public Act 24-19**
- Some home health and hospice agency working group members shared that they have struggled with accessing the information required by Section 1. These members support repealing the mandate in Section 1 in favor of a shift to best practices. A best practice framework they believe would allow each agency to develop standards in line with its own capacity and resources. These members advocated for a safety initiative framework that is in alignment with OSHA standards, along with evidence-based best practices, that places a strong emphasis on staff safety and access to care.
- Other working group members, including those representing home health care workers, home health aides, and hospice workers, felt that the mandate was needed to set a minimum standard statewide. These members expressed concern about repealing the legislature's most recent action without any substantive data on if the mandate had improved safety conditions.
- Upon final review of the requirements in Section 1 at the meeting held on January 23, 2025, several home health and hospice agency working group members expressed that they had no issues with the current framework and were seeing it implemented successfully within their own agencies.
- Several working group members and other stakeholders have submitted written feedback regarding the mandate in Section 1.

Data Sources for Risk Assessment

- Some home health and hospice agency working group members expressed concern regarding the accuracy and timeliness of the requirement to source data from three different sources. Several agency working group members also shared concern regarding the burden and impact of such requirements on smaller agencies with less capacity and resources. These members shared that the state systems required under Public Act 24-19 are not set up to provide timely, useful, and accurate information. Law enforcement agencies participating in the workgroup further explained and validated these limitations during discussions.
    - **Judicial Branch (JB) website:**
        - The website is not comprehensive as it only covers the past 10 years.
        - It does not include out-of-state offenses or juveniles.
        - It also requires a search by year of birth, not full birth date, which can lead to identifying multiple people with the same name and year of birth resulting in inaccurate information and potential for violating individuals' privacy.

    - Additional records can be accessed through record requests to the Department of Emergency Services and Public Protection (DESPP), but request processing can take days or weeks.
- **Sex Offender Registry (SOR):** The additional separate look-up adds more time to intake process.
- **Municipal Crime Rate Report:** These reports are often outdated (1-2 years old) and limited to overall municipal crime rates without any meaningful recent data on high-risk neighborhoods.
- There is inconsistent information provided by the Department of Correction (DOC), with no standard risk scores or history-sharing practices to inform care plans.
- **The working group did not reach consensus on the impact of the data collection requirements and has not put forth a recommendation on this challenge**.
    - Some home health care agency members shared that they did not have any challenges in complying with the requirements.
    - Other home health and hospice agency working group members were in favor of a centralized, state-maintained system. This system would consolidate multiple checks into a single access point and integrate more accurate data sources as recommended by law enforcement workgroup members. The members in favor of a consolidated system also felt that it would help ensure data accuracy and integrity, while also ensuring the privacy of sensitive information of patients and staff.

Intake Referral Data Collection

- **Inconsistencies in shared information:** Referral data can vary significantly among referral sources leading to an incomplete picture for providers.
- **Environmental assessment is limited:** Focus is on patient/client environments, not others in the home or neighborhood.
- There is no consistent, standard safety risk assessment scale or scoring system for risk evaluation. This is at odds with other sectors, such as DOC and DMHAS, which have standard risk assessments for individuals being reintroduced into the community.

Operational and Resource Constraints

- Concerns were voiced by home health and hospice working group members regarding delays in access to care due to new laws requiring added intake data collection. All agree that we need a balance of provider safety and access to care.
- Initial assessments
    - State and federal regulations require agencies to conduct initial assessment within 48 hours of referral, however the difficulties in obtaining information can delay this process. This requirement applies to home health care, home health aide and hospice agencies.

    - The exemptions for hospice organizations under PA 24-19 create inconsistent practices, yet many concerns were raised over potential delays in starting hospice care for those with terminal illness needing care immediately.
- Law enforcement support
    - The response or accompaniment by local/state police can be unreliable or inconsistent increasing risk for agency staff.
- Unfunded Mandates
    - The requirements set forth in Public Act 24-19 for data collection, training, and reporting do not have an adequate funding structure which further burdens home health care, home health aide and hospice agencies.
    - Home health and hospice agencies already have a requirement to comply with the OSHA General Duty Clause
    - DSS funding is restricted to Medicaid populations, which excludes other patients under other payers who may pose safety risks.
    - Smaller and rural agencies who already struggle with limited staff and resources will face increased difficulties to meet the statutory requirements.
- Burden on Agencies
    - The responsibility for intake data collection is disproportionately placed on home health care agencies.
        - Referral sources need to share this responsibility.
        - If referral sources are aware of safety challenges/history of violence, they should be required to share information.

Privacy and Discrimination Risks

- Working group members raised concerns about potential misuse of collected data, leading to discrimination against patients based on risk or denial of care if agencies feel unprepared to provide safe services.
- Concerns were raised about the importance of notifying individuals in a household about data collection and its potential implications.

Impact on Service Delivery

- There is a risk that the requirements may lead to altering care plans (e.g., sending fewer staff if information is incomplete) based on collected data, which may compromise care, quality and safety.

Safety and Training Requirements

- Despite risk mitigation efforts, agencies remain vulnerable to citations and/or fines from DPH/OSHA after adverse events.
- There is a lack of clarity on how to best train staff to create an open, safe environment for sharing concerns.
- There is currently limited access to safety devices (e.g., GPS-enabled wearables) due to cost and limited satellite/cell coverage service areas especially in rural areas.
- There is an absence of streamlined applications for accessing safety data.

Working Group Recommendations

These recommendations are intended to enhance safety and mitigate risk for the home care worker while ensuring access to timely care in the community. Of note, each Home Health Care, Home Health Aide and Hospice Agency, as such terms are defined in section 19a-490 of the general statutes, are already required to comply with the OSHA General Duty Clause.

I. Maintain Section 1 of PA 24-19 with the following additional considerations:

a. Add language to support transparency of referral information from the referral source and from other providers who are a part of the continuum of care:

i. Recommendation: Each entity referring or transferring patients to a home health care agency, home health aide agency, or hospice agency shall, at the time of referral and to the extent feasible and consistent with state and federal laws, provides any documentation or information in its possession regarding the requirements specified in Section 1(a)(1) of Public Act 24-19. This includes, but is not limited to, information concerning the client's history of violence toward health care workers, history of substance use, history of domestic abuse, psychiatric history, stability of diagnoses or symptoms, and any records or registry information related to violent acts or sex offender status, as applicable.

II. **Amend Section 2 Training to include Hospice Organizations in training requirements**

a. **Proposed Revision to Section 2(a):** *Each home health care and home health aide agency, and hospice organization, as such terms are defined in section 19a-490 of the general statutes, shall (1) (A) adopt and implement a health and safety training curriculum for home care workers that is consistent with the health and safety training curriculum for such workers that is endorsed by the Centers for Disease Control and Prevention's National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration, including, but not limited to, training to recognize hazards commonly encountered in home care workplaces and applying practical solutions to manage risks and improve safety, and (B) provide annual staff training consistent with such health and safety curriculum; and (2) conduct monthly safety assessments with direct care staff at the agency or organization's monthly meeting*.

III. **Expand and amend funding for safety initiatives** *(within available appropriations)*

a. **Consider eliminating the Subsequent Visit Rate Penalty:** Medicaid **reimbursement** policies create barriers to implementing effective safety measures by underfunding care in multi-generational homes and congregate settings.

1. Currently, Medicaid reimburses at **only 50% of the regular rate** for visits beyond the first patient in a household, even when additional family members require equal or greater levels of care.

b. **Consider evaluating a Provider Add-On Rate:** In some high-risk cases, additional staff support is necessary to ensure safe and effective home health or hospice care. The reintroduction of a provider add-on rate would allow Medicaid and other payers to fund essential staffing support when required.
    1. **Implementation:** The provider agency could determine staffing needs based on a patient's risk score, ensuring agencies can provide adequate personnel for high-risk situations.

c. **Expand Safety Initiative Funding:**
    1. The current funding framework for safety initiatives under Public Act 24-19 applies only to Medicaid patients, excluding other insured and uninsured individuals who may also pose safety risks. This limited scope creates funding gaps for agencies providing home care and hospice services.
    2. **Recommendation:** The working group urges the CGA to establish a comprehensive funding mechanism that supports safety initiatives for all patients, regardless of payer type. Expanding funding eligibility will ensure agencies have the necessary resources to protect both staff and patients across all home-based care settings.

d. **Support ongoing incentives for reporting:** To encourage prompt and accurate reporting of workplace violence incidents, the working group recommends amending the language in Section 2(c) to encourage a mandatory rate enhancement, within available appropriations, for compliant agencies and to include Hospice.
    1. **Proposed Revision to Section 2(c):** *Within available appropriations, the commissioner may provide a rate enhancement under the Connecticut medical assistance program for any home health care agency, home health aide agency, or hospice organization licensed by the Department of Public Health pursuant to section 19a-122b of the general statutes, for timely reporting of any workplace violence incident*.
    2. This change ensures **consistent financial support** for agencies adhering to reporting requirements, reinforcing workplace safety without creating undue financial burdens.
    3. **Recommendation:** Include reporting abuse by other people not just client to staff and give Hospice Agencies opportunities for rate enhancement based on timely reporting, **amend PA 24-19, Section 3 (a)**
        i. **Proposed Revision:** *Not later than January 1, 2026, and annually thereafter, each home health care agency, home health aide agency and* ***hospice organization*** *as defined in*

section 19a-490 of the general statutes, shall report, in a form and manner prescribed by the Commissioner of Public Health, each instance of verbal abuse that is perceived as a threat or danger by a staff member of such agency, physical abuse, sexual abuse or any other abuse by ***an agency client or other person*** *against a staff member of such agency (while performing work duties) and the actions taken by the agency to ensure the safety of the staff member.*

4. **Recommendation:** In order to align more comprehensive reporting requirements with rate enhancement opportunities, **DPH will need to update reporting portal to include payer, timing of report** (date of incident and date of report submission) **and differentiate between whether abuse reported was by client or other person** (such as, people in household or in community).

IV. Finally, the working group puts forth the following additional recommendations. **In the interest of transparency, we note that the group did not reach full consensus on the following recommendations**. A summary of the reasoning in favor, in opposition, and suggested changes has been included.

a. **Establish a pilot program of internal mental health services and consultation within a home care agency:** The working group recommends that the CGA consider establishing a pilot program of internal mental health services and consultation within a home health agency to address the complex needs of individuals with significant behavioral health challenges, including those at risk of harming themselves or others. The services could include a licensed clinician and a peer specialist/worker (e.g., recovery support specialist, recovery coach). The focus of this pilot program would be to create services that can immediately support high-risk patients, and improve care delivery, worker safety, and overall patient outcomes. Some home health and hospice agency members expressed concern about the pilot program. They believed additional discussion would be necessary to understand the pilot program details, including to whom it would apply and how it would be rolled out, implemented, and funded. Other members recommended increased funding to support MSWs and LCSWs, whose expertise would provide significant value to all home-based care providers in the evolving landscape of risk and patient needs.

b. **Conduct a comprehensive study** to understand the current state of home health care, home health aide, and hospice services in Connecticut

1. The meetings of this working group have revealed an urgent need for a deeper understanding of the current landscape of home health care, home health aide, and hospice services and agencies in Connecticut.
2. **Recommendation:** Members of the working group strongly urge that a comprehensive study be conducted statewide to gather and analyze data on all home health care, home health aide, and hospice agencies

and services delivered in Connecticut, including staff demographics, training standards, agency capacity, and referral loops.

3. **Support**: This recommendation received support from those working group members who represent home health care workers, home health aides, and hospice workers, as well as some home health care agency members. These members felt that a study is needed due to a lack of current data on working conditions, service delivery, and patient referrals.
4. **Opposition:** Other working group members expressed concern that such a study would be outside the scope of this working group and would require significant, additional discussion of purpose, scope, costs, and implementation details. These members opposed the study as they felt delayed action by the working group and legislature would risk the safety of workers and patients.

c. Finally, the working group urges the Public Health Committee **to continue to allow the working group to operate through 2025**.
    1. To ensure the working group's continued effectiveness, consider the addition of a behavioral health practitioner.
    2. Some home health agency working group members also recommended expanding the membership of the working group to include a more diverse range of home health and hospice providers, including additional leadership-level representation in the workgroup, to allow for more strategic input and alignment with operational realities.
    3. An additional area of exploration would be the review and evaluation of validated community safety risk assessment tools and mental health training for those providing care to the behavioral health population. DMHAS has offered their expertise to collaborate on this initiative.
    4. The working group may reconvene following the 2025 legislative session to review and re-evaluate the steps taken by the CGA to continue to improve safety conditions for home health care, home health aide and hospice agencies. An updated report should be submitted to the Public Health Committee on or before January 1, 2026, with new and revised recommendations.
    5. An alternative recommendation was proposed that the working group be dissolved in favor of a more structured safety task force or advisory group with a formal governance framework. It is believed that this structure would provide clearer roles, accountability, and direction, leading to more impactful and sustainable safety initiatives for both staff and patients.

Again, thank you to the members of the working group for their expertise and thoughtful consideration to ensure the health and safety of Connecticut residents.