Mixed Populations of Residents in Nursing Homes

Testimony to a Joint Meeting of:

The Senate Public Health Committee
The Senate Human Services Committee

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By:
Pat Comstock, Executive Director
Terry Sullivan, Regulatory Director

Good morning. My name is Pat Comstock and I am the executive director of the Health Care Council of Illinois. With me today is Terry Sullivan, regulatory director for the Health Care Council of Illinois. We are the public policy and communication arm of the state's two major long term care provider associations: the Illinois Health Care Association and the Illinois Council on Long Term Care.

We appreciate the opportunity to speak out on the issue of mixed populations in nursing homes. As some of you are aware, the issue of mixed populations was first raised by the long term care profession in 2004 when it convened, along with AARP, a Mixed Population Task Force. The Task Force was charged with developing recommendations for how to best address the needs of both high risk ex-offenders and individuals with serious mental illness in need of long term care services. The group, chaired by AARP, was composed of advocates, chiefs of police, prosecutors, mental health professionals, ombudsmen, all relevant state agencies, and the Attorney General. While together we passed two pieces of legislation dealing with ex-offenders, more work needs to done.

Before we get into specific recommendations let me address two over-arching concerns. Our members do believe that appropriate levels of oversight, technical assistance, and collaboration are needed to ensure the health, safety, and care of our residents; protection of our professional nursing staff; and the continued viability of our programs. Over the last few years, HCCI has spoken to the Governor's Office, legislators, and agency personnel about the need to develop a more collaborative approach to quality care and to address the inadequacies in state's regulatory system. I would be remiss not to take this opportunity to once again put forward two overarching recommendations:

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- Establish a nursing home consultation project under the Department of Public Health's long term care bureau that provides technical assistance to nursing homes seeking to enhance the quality of care they provide; and

- Overhaul the state's regulatory oversight by increasing the number of nursing home surveyors, triaging complaints, and separating life safety code and health code violations to permit a more rapid response to plans of corrections.

The issue of mixed populations of residents in nursing homes is very complex. Often concerns about ex-offenders are linked to issues related to the mentally ill. For the purposes of our work with you, we think it is important to create two separate and distinct methods of dealing with each of these resident types. Our comments are divided accordingly.

Ex-Offenders/Parolees in Long Term Care

It was initially envisioned that the Mixed Populations Task Force would take up the care needs of both populations simultaneously. It became apparent at the first meeting that discussions about the two populations had to be decoupled. The group collectively chose to move forward first on ex-offenders, because it was believed that they posed the most immediate threat to other residents. Once recommendations concerning ex-offenders had been implemented, it was the intent of the Task Force to take up the issue of persons with serious mental illness.

This collaborative effort resulted in legislation, requested by the Attorney General, that put several key components into statute:

- Better communication from the Department of Corrections to nursing homes about the previous behavior and treatment history of parolees;

- A first-in-the-nation criminal background check program on all nursing home residents;

- An independent and impartial assessment system evaluating the level of risk posed by an individual ex-offender and identifying the security measures needed to mitigate the risk;

- Notice requirements to warn staff, residents, and resident families of the presence of a ex-offender; and

- Limited modifications to allow for the expedited transfer of high risk individuals.

The key to the success of the system rested on the validity of the independent risk assessment and the subsequent development of the security plan. Without this component, facilities would not know what security measures would be needed or evaluate if they could successfully serve the individual in the general geriatric population prior to admission. Consensus among professionals in the long term care field, state policymakers, and advocates was that not all ex-

offenders posed the same level of risk and some, based on their own health condition, may not pose a risk at all. The long term care profession and AARP argued that the Department of Corrections should perform the risk assessments and develop the security plans. The Governor's office chose instead to assign this function to the Department of Public Health, which in turned entered into contracts with private vendors to perform the functions. Because of the critical nature of this function, HCCI believes that this program should be evaluated and the contracts audited.

The nursing home associations and AARP also put forward recommendations that were not included in the initial legislation advanced by the Attorney General. Additionally, the 2005 legislation was meant to be only a first step. It was agreed that the precautions needed to be expanded to include all residential settings and the Department on Aging's Community Care Program. This concept, along with a number of other recommendations floated at that time, are still relevant and deserve your full consideration:

- Develop dedicated long term care units for high risk ex-offenders;

- Require pre-screeners to initiate criminal background checks and maintain a database of the results to eliminate the need to perform subsequent checks if an individual moves to another facility;

- Permit conditional admissions pending the results of a criminal background check and risk assessment;

- Initiate expedited discharge procedures when in the judgment of the facility, the high risk ex-offender poses a threat to him or herself or others, with the state assuming responsibility for securing an alternative placement and assisting in the transfer;

- Safety contract executed at time of admission, which waives the high risk ex-offender's right to an involuntary discharge appeal for violation of the contract;

- Failure to disclose a felony conviction at the point of admission - - a rebuttable presumption of potential endangerment of others for the purpose of discharge;

- Establish a unit within the State Police (DOC) to perform background checks currently required by law; perform reassessment at least annually or sooner at the request of the facility; and consult with the facility regarding behavioral problems and security issues; and

- Expand coverage to include assisted living, shared housing, board and care homes, supportive living, shelter care, in-home senior services, and adult day programs.

Mentally Ill in Long Term Care

There are several contributing factors to fully understand why Medicaid beneficiaries with serious mental illness are living among the general nursing home population:

The state's decision to close state mental health residential facilities in the late '70s and transition residents to the community;

The state failed to simultaneously expand the community mental health system to absorb the influx of new clients;

This massive de-institutionalization movement failed to take into account the numbers of individuals with bipolar and schizophrenic disorders who cannot live on their own in the community without endangering themselves or others; and

The federal government decided to eliminate Medicaid funding for residential settings where more than 50 percent of the residents have been diagnosed with severe mental illness. Absent other alternatives, licensed nursing facilities, by default, become the "last refuge" or "safety net" for individuals with serious mental illness.

These external events have placed nursing homes in the middle of three very difficult problems:

- If the facility turns them away, many have nowhere else to go;
- Mixing populations – the elderly and younger seriously mentally ill individuals – runs the risk of endangering the elderly residents; and
- Medicaid funds are only available if the seriously mentally ill are cared for in facilities where they constitute less than 50 percent of the census.

Considering all of these factors, it is frustrating that facilities continue to shoulder the entire responsibility for where we are today.

Because resolving the issues related to persons with serious mental illness in licensed facilities is a complicated issue, the Health Care Council of Illinois formed an internal task force made of operations professionals with long-standing experience in geriatric services; care of the severely mentally ill; federal and state regulations; and the pragmatic side of long term care service delivery. This work group has issued a preliminary set of recommendations that has been shared with the Governor's work group on the issue. Final recommendations should be available in the next few weeks and will be shared with you once they are available for distribution.

Interim recommendations include the following:

Overarching Principles

- Persons with mental illness, who are nonviolent, may be appropriately served in a skilled nursing facility, with the appropriate psychiatric rehabilitation programming and psychiatric rehabilitation staff.
- No facility should be permitted to accept a person with serious mental illness assessed as having a high-risk for harm to others unless they are certified in advance as meeting the full complement of Subpart S standards contained in the Nursing Home Care Act , including specialized psychiatric staffing.
- The Governor should work cooperatively with providers and advocates to recommend changes to the federal system for reimbursing mental health treatment, which currently encourages mixing treatment populations.

Assessments and Reassessments

- Each person determined to have a mental illness shall have their level of risk for violence assessed by a psychologist or psychiatrist as part of the existing OBRA 1 Mental Health Risk Assessment, which will give providers a clearer indication of a prospective resident's potential for violence.
- Each resident determined to have a mental illness shall be reassessed by an OBRA 1 psychologist or psychiatrist annually and at the request of the facility based on changes in behavior that indicate a potential for violence.

Intervention Strategies

- Based on the OBRA 1 assessment or re-assessment, the state, at the request of the facility, will assist residents with a potential for harm to others in transferring to a more appropriate setting.

Holistic Approach

- Fully integrating community and facility based care and expansion of community resources to more adequately serve those individuals who can live independently in their communities.
- Local community mental health agencies shall be funded to consult with nursing home about specific psychiatric and behavioral issues.
- Each local mental health center shall enter into cooperative agreements with each long term care facility in their service delivery area to provide community-based mental health services and follow-up support services to Money Follows the Person clients to permit a smoother transition to community and to ease the transition from the community when a short-term residential stay is needed.

HCCI believes that there is a way to create separate and distinct programming that has the potential for preserving Medicaid matching funds for the state. Allowing facilities to convert all or a portion of their facility to SMI segregated units would preserve jobs, allow the elderly residents to retain their home, and continue to provide a critical safety net for the mental health system in Illinois.

Conclusion

I know that our testimony has been detailed and complex, but we believe that given the seriousness of the issues before you, anything less would not be appropriate. As a coalition of more than 80,000 nursing home professionals serving 65,000 residents in 650 nursing homes in Illinois, HCCI remains firmly committed to quality care, but most importantly, to the safety, security and well being of our residents. We stand ready to work with these committees as a whole and with individual members to answer questions and vet ideas as the group determines appropriate. We are available to answer any questions from the committees.

September 8, 2009

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Speaker Michael J. Madigan
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Dear Speaker Madigan,

On behalf of HCCI and the residents we serve, I want to take this opportunity to thank you for your proven dedication to our cause.

Given your commitment to the long term care profession, we thought it prudent to alert you to a story the *Chicago Tribune* is expected to run in the near future regarding persons with mental illness, sex offenders and former felons in Illinois nursing homes. We have followed the development of this story for the past month as it has intensified in both size and scope, and we now expect it to be a multi-part series of stories, possibly running over the course of several weeks. During this time, we have informed our members of the story and helped prepare them to respond to any questions or concerns from residents, families, community members, and/or local media representatives.

We have also been in conversation with the Tribune and have submitted a formal statement detailing the profession's side of the story. While no incident of violence to an elderly person, whether in a nursing home or in the community, is acceptable in a caring society and must be addressed, a few isolated, unfortunate incidents do not reflect the overall system of protection established to provide a safe, secure and supervised environment for senior citizens cared for in nursing homes.

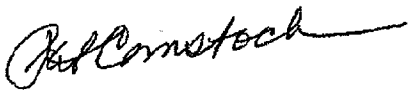
Illinois nursing home residents benefit from the strongest resident protection system in the country, a system developed in collaboration with nursing home professionals, the Attorney General's office, the State Police, the Illinois Department of Public Health, the Illinois Department on Aging, and the American Association of Retired Persons (AARP). The reason we have identified that persons with prior convictions receive care in nursing homes is because Illinois is the only state in the nation that conducts a police background check not only on everyone who works in a nursing home, but also everyone who is admitted to a nursing home. Any resident needing care and treatment in a

nursing home found to have a prior felony conviction receives an independent safety evaluation by state-contracted investigators to determine whether he or she poses any risk to other residents and to develop an individualized protection and treatment program.

Far fewer incidents of violence happen to senior citizens being cared for in nursing homes than to seniors living alone in the community. There is a greater risk to an elderly person living isolated in the community than in a structured, supervised and monitored nursing home setting. HCCI and the 65,000 nursing home professionals we represent remain committed to quality residential health care in Illinois, but most importantly, to the safety, security and well being of our residents.

I again thank you for your continued support.

Sincerely,



Pat Comstock
Executive Director

My name is Arnold Kanter and I am here on behalf of Barton Management, a service provider and management entity serving over 900 clients living with Serious Mental Illness. Barton's properties are located throughout Illinois in Chicago, Chicago Heights, and Peoria. In addition, our Chicagoland properties - Central Plaza, Clayton Home and Thornton Heights have been chosen and are a part of the Department of Healthcare and Family Services demonstration project, which means that we have enhanced staffing and programming for our clients. Recently, the Chicago Tribune featured our Expressive Arts program at Clayton Home in an article entitled "Art Therapy Produces New Healing Landscapes". The article highlighted how Clayton¹s programs help our clients with self-esteem, respect, dignity and confidence.

With me today is Randy Walker the Executive Director of The Clayton Home.

Lately, there has been negative publicity surrounding nursing facilities and the mixed populations that live within them. I want to emphasize that our properties that treat clients with serious mental illness do not have mixed populations.

At Clayton, the average age of our clients is 43 years old. We do not admit anyone over 59 or under 18 years of age. We are not a medical model; we cannot accept clients who have complex medical issues. For those of you on the committee who have visited Clayton, you probably immediately noticed that there are no wheelchairs, walkers or clients with other significant physical limitations residing in our buildings.

The Clayton Home, as well as all our other IMD properties, operates under a psychiatric rehabilitation model with a clear mission to have our clients reach their highest level of functioning and quality of life. That standard is distinct for each client since the severity of mental illness varies among individuals.

Clayton also operates as a transitional facility. This means that each client is continually evaluated to determine their ability to return to the community or other integrated setting. We recognize that we are no longer solely a "long term care facility" and that we must act as a stepping stone to less restrictive settings. This year at Clayton, we have facilitated 20 positive client discharges into the community. 5 of these clients have returned and we will continue to work with them to reach their highest individual potential whether in the community or at Clayton.

We have witnessed a sea change within the mental health community over the past decade and we have attempted to adapt our approach to reflect the best practices in the mental health arena. Again, I think Barton has emerged as a model for other facilities.

Our clients today tend to be younger and are more likely to be referred from either a state or community hospital or community-based mental health program. 95% of the client populations are likely to have Schizophrenia or schizoaffective disorder. In addition, they are likely to have a history of substance abuse or a diagnosis of substance abuse.

At Clayton, we view ourselves as part of the continuum of care for the individual with serious mental illness. In that vein, we recognize that we serve a population that cannot always be placed in other settings without the high intensity rehabilitation and structured environment we provide. In some instances that setting will not be the community because of the severity of the psychiatric symptoms of the client. For all our clients, whether long-term or transitional we provide Skills Training to address the major domains of self maintenance, social functioning, community living, occupational preparedness, symptom management and substance abuse management. These groups are led by qualified facilitators who have received intensive specialized training.

Most importantly, we strongly believe in the Foundational Principles of the Recovery model that gives every client the opportunity to live a satisfying, hopeful and contributing life, even with the limitations caused by one¹s illness.

I would like to leave you with three suggestions which would enhance our ability to provide the best care for our clients:

* Review the regulatory scheme for IMDs to permit innovative programs that may be inconsistent with the Nursing Home Care Act.

* Create more community access points so clients of IMDs can reintegrate into appropriate community settings.

* Allow the mentally disabled poor to receive services based on what they need, not where they live.