



Serving the Mentally Ill in Long Term Care

Testimony for the Governor's Nursing Home Task Force

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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. The Health Care Council of Illinois, or HCCI, is the public policy and communications arm of the state's two major long term care provider associations.

I appreciate your indulgence in allowing us to testify two weeks in a row, but we felt strongly that the long term care profession needed to step back and take a big picture approach to the issue of mixed populations in nursing homes. Our testimony today will focus on the issue of the mentally ill in nursing homes. I will begin by providing a historic context for our work and Terry Sullivan will walk you through the interim recommendations from our internal work group. I will close by discussing the next steps with you.

Historic Context

There are several contributing factors to fully understanding why Medicaid beneficiaries with serious mental illness are living among the general nursing home population. The first is the state's decision to close state mental health residential facilities in the late 70's and transition 15,000 residents to the community. Second, the state failed to simultaneously expand the community mental health system to absorb the influx of new clients. Third, 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

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in the community without endangering themselves or others. Finally, 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 became 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 and conflicting 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
- Federal Medicaid matching funds are only available if the seriously mentally ill are cared for in facilities where they constitute less than 50 percent of the census, discouraging the state from developing additional specialized, licensed, residential mental health treatment centers.

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

Last week, we indicated that 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. We also proposed that a more holistic approach is appropriate to the care and support for persons with serious mental illness. This holistic approach must include fully integrating community-based and facility-based care and the expansion of community resources to more adequately serve those individuals who can live independently in their communities. HCCI’s internal work group asked that we affirm their support of these statements today.

In announcing the formation of our internal work group on the mentally ill in long term care, we urged caution in proceeding without adequate research and deliberation, taking into account potential funding and regulatory hurdles. We, too, are taking this advice. As our own internal work group completes its research and deliberations, we will share our conclusions and recommendations with this Task Force.

Building upon our suggestions submitted at the last hearing, we respectfully offer the following recommendations:

Overarching Principles

- Persons with mental illness, who are non-violent, 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. As the debate about healthcare reform progresses in Washington, we all need to work together to have the federal government finally recognize that mental illness is a medical condition and not a stigmatized personal or moral failing.

Assessments and Reassessments

- Each person determined to have a mental illness shall have his or her 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

- Local community mental health agencies shall be funded to consult with nursing homes about specific psychiatric and behavioral issues.
- Each local mental health center shall enter into cooperative agreements with each long term care facility in its 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 the community and to ease the transition from the community when a short-term residential stay is needed.

Over the next few weeks as our internal task force drills down deeper on the issue, we will be challenging ourselves on many fronts. We will be reaching out to you individually and collectively to not only share our research, conclusions and recommendations, but also to seek your input and counsel. We believe that it will only be through an open and forthright interchange of ideas that a reasonable and workable solution can be achieved.

The quality of our collective work product is dependent on how clearly we define the issue and the depth of our understanding about all of its facets. We can take no fact for granted. For example, the Associated Press reported that Illinois has the highest number of young persons (age 22 to 64) in the nation residing in facilities, which is true. They failed to report that while many other states have seen huge influxes of young persons with mental illness in their long term care facilities over the last few years, Illinois' rate of growth has been steadily falling since at least 2002 with the exception of a slight blip in 2003. In fact, the increase in persons under age 64 with mental illness grew by only 1 percent between 2007 and 2008. I offer this not to argue that we need to ignore the issue and move on, but to underscore that allegations and innuendo will not get us to where we need to be in the end and to underscore why we believe that none of us truly understands the scope of the population whose needs we are attempting to address.

We also plan to identify promising practices in other states, as well as the protocols experts in the mental health field have put forward. We will be examining the definitions of mental illness, and discussing the appropriate roles for long term care facilities and IMDs in the continuum of care and the quality of the mental health services being provided. We have found numerous reports questioning the suitability of mental health care in traditional nursing homes and IMDs. So far we have not found a plethora of reports describing suitable alternative placements for those who cannot reside on their own. While many mental health experts argue strenuously that every person with serious mental illness can be successfully cared for in the community, others caution that there will always be some who cannot reside on their own. Still others liken our community mental health system to Swiss cheese.

While it may seem like baby steps to some, these are the steps that must be taken. We stand ready to share our ideas and our stories. Together we can make a difference.

The Health Care Council of Illinois is eager to continue the partnership we helped spearhead in 2005 along with the State, AARP and all other interested parties. 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.