



Good Morning. My name is Pat Comstock and I am the Executive Director of the Health Care Council of Illinois (HCCI). With me today is Terry Sullivan, Director of Regulatory Affairs for HCCI. The Health Care Council of Illinois is the public policy and communication arm of the state's two major long term care professional associations serving more than 60,000 nursing home residents in Illinois.

Thank you for the opportunity to respond to the Task Force's proposed changes. We would also like to thank Chairman Gelder and Amy Lulich for the time they took on Tuesday to address many of our questions concerning the proposals. This was the first real dialogue we have had on some of the issues. My only regret is that all of you did not have the opportunity to dig deeper into these issues with us.

For that reason, I would like to take a moment to highlight some of the points from that discussion around which there was a desire to pursue possible solutions.

1. Assessments and reassessment of residents could be accomplished using the MDS tool.
2. The importance of initiating the background checks before admission.
3. Taking into account the delay in determining Medicaid eligibility, consider payment to the facility from the day of admission.
4. The degree of precautions that could feasibly be used for provisional residents based on preliminary assessment of harm.
5. Facilities could provide a list of residents to the State Police for crosschecking against a list of those with outstanding warrants in lieu of raids by local law enforcement.
6. Using the ISP to check on "action plan" implementation to avoid duplicated oversight.
7. The impact of mandating associations to report information learned during a technical assistance phone call with a member.

We look forward to the opportunity to have more dialogue with all of you as we move to the implementation phase of these and other recommendations.

The Governor's Task Force has presented a comprehensive and thoughtful plan for establishing better screening before an individual

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enters a nursing home, better treatment while in a nursing home, and better resources for transition into the community after a nursing home. Moving these recommendations from policy to practical application will take the cooperation of regulators, providers, advocates, and residents and should be undertaken in a collaborative manner.

It will take all parties invited to a common table to discuss and debate the specifics of any changes put forward. After all, we can't lose sight of the fact that we created this situation together, so we should resolve these issues together.

For the first time, the long term care profession came together and brought forward extensive recommendations for improving the handling of identified offenders and the care of the seriously mentally ill in nursing homes. We are pleased that many of our suggestions seem to be reflected in the draft recommendations from the Task Force.

Before we get to the specifics of our comments on the Task Force proposals, we would like to put forth some overall comments. First, in some respects it was difficult to respond to these recommendations. Most of them were stated so generally that it was difficult to determine just how they would impact our current operations or what was fully anticipated by a particular recommendation. Our comments today will reflect our questions.

Second, it was difficult to determine what population of residents a particular recommendation was addressing. The work of the Task Force has focused primarily on identified offenders and residents with a severely mental illness diagnosis. However, some of the recommendations seem to apply more broadly.

Finally, we ask you to remember that we serve many types of residents very well every day. Please do not categorize all nursing homes with the same broad brush. Any time you have individuals treating other individuals, there will occasionally be issues. Please don't turn your backs on the 80,000 employees who serve our residents very professionally every day.

Section I

Pre-Admission Screening and Background Check Procedures

HCCI concurs with many of the preadmission screening and background check recommendations offered by the Task Force with some tweaks that we believe strengthen the proposal. Our own recommendations included preadmission screening and assessments as the foundation of any comprehensive overhaul of the program.

It is our belief that the following recommendations are critical to the safety of our residents and the operation of our facilities:

- background checks initiated electronically prior to admission, whether the person **enters from the community** or as the result of a hospitalization;
- preliminary risk assessments performed by highly trained pre-admission screeners **with appropriate supervision and auditing to ensure the quality of the risk determination;**
- conditional admission until a background check is complete and a security plan is developed, if applicable, with precautions taken **based on the results of the preliminary risk assessment;**
- background checks, criminal analyses and security plans as individualized and extensive as needed and completed as quickly as possible;
- full disclosure of ex-offender information to include **the annual cross check of all residents against outstanding warrants and sex offender registries** and a **consolidated** database of the criminal background check results of residents **and workers.**
- enhanced training of pass screeners to facilitate fully integrated care plans that focus on treatment of negative behavior developed **in collaboration with nursing home staff.**

In addition, HCCI urges the Task Force to give consideration to the appropriate use of MDS data in performing reassessments and the development of post-discharge care plans. The MDS is an intensive, highly sophisticated assessment tool that looks at both institutional and in-home care needs administered by clinical professionals.

Section II – Raise and Enforce Higher Standards of Care in All Settings

We support many of the concepts summarized in the second section of the Task Force reports about enforcing higher standards of care in all settings. We concur that any nursing home admitting a younger person with mental illness must have the staffing, training and programming to provide the proper treatment, supervision and protection for all its residents. We concur that the Illinois Department of Public Health needs more resources and its surveyors more training and supervision in order to do its job. And we concur that there needs to be accountability in the entire system.

In the continuing dialogue to improve the system, we do have some practical concerns and pragmatic recommendations about the initial Task Force proposals.

1. **Mental Health Certificate of Compliance:** We support the concept of a mental health certificate of compliance that ensures a nursing home is prepared to comply with the mental health standards of Subpart S. Our own recommendations

included this component for facilities specializing in persons with serious mental illness.

We do have two pragmatic concerns:

- a) We believe there needs to be a careful study of the differences between the Nursing Home Care Act and the Mental Health Code before trying to cross-breed two different animals. If there is a particular aspect of the Mental Health Code that we feel may improve aspects of the Nursing Home Care Act, consider moving that particular provision to the Nursing Home Care Act. We discuss some of the practical conflicts between the two codes later in section 4.
- b) Throughout the task force hearings, the greatest concern appears to be mixing younger psychiatric clients with an older frail geriatric population. We believe the mental health certificate of compliance program needs to be focused on psychiatric programs for younger residents. An older person over 60 with medical needs poses less of a threat to other geriatric residents than the younger, physically able psychiatric residents. We believe that a geriatric nursing home can properly care for an older resident with mental health issues and should not be prohibited from admitting that older resident.

2. Additional Surveyors: After years of having its resources cut, the Illinois Department of Public Health needs additional surveyors, supervisors and trainers. We support the concept of additional mental health training for specialized surveyors and their supervisors, since surveyors do not receive this kind of information in their regular federal surveyor training program.

3. Additional Sanctions:

- a) We believe that the Department of Public Health already has sufficient authority under the Nursing Home Care Act to revoke the licenses of facilities that continue to repeat serious violations. What has been lacking is not the authority, but the resources to carry out its mandates. Public Health already has considerable state and federal authority. Let's give the agency the resources it needs, and the job will get done.
- b) Additionally, we have never seen a study that demonstrates that increased fines and sanctions improve overall care. Care is improved through agencies working together collaboratively for the good of residents, not from a simplistic confrontational "gotcha" approach to enforcement. We don't improve care in the good facilities by nit-picking them to death; we do improve care through encouragement, collaboration and support. This year we have reintroduced legislation that would establish a separate unit with Public Health that would provide consultation with facilities that want to improve the services and care they provide. We would like the Task Force's support in this endeavor.

4. Additional Fees. Public Health needs more and better trained surveyors and supervisors. After years of the state cutting budgets to save taxpayer dollars, we believe that the responsibility of re-invigorating the enforcement process rests with the state, not with the caregivers and professionals who provide care for the residents. The funding mechanism for additional surveyors should be structured in such a way as to not divert resources away from care, as well as maximizing the possibility of federal funding opportunities.

5/6/7/8. Misconduct, Mandated Reporting of Professional Misconduct, Confidential Reporting by Department of Financial and Professional Regulation, and Whistleblower Protection.

Who doesn't agree with strengthening state laws regarding reporting abuse and neglect and protecting whistle blowers from retribution? We are, however, concerned that in our rush to find solutions that Administrators are being villianized unfairly. Be aware that federal law already requires DFPR to scrutinize every nursing home survey that includes a serious violation to determine the culpability of the Administrator; that Administrators and other employees are protected from retribution by Section 3-605 of the Nursing Home Care Act; and that health care institutions and state agencies are already mandated reporters. While we have no problem with expanding the list of mandated reporters, we urge you to allow professional organizations to continue providing technical assistance to their members.

9/10. Increased Nursing Home Staff Training/Minimum Staffing Requirements. Our original proposal instituted staff training requirements, increased staffing ratios, and mandated consultation from outside professionals for those facilities that must comply with Subpart S.

On a broader level, the issue of differing staffing levels in different nursing homes is based both on the condition of the residents served in each home and the resources available for providing that care. An inner city, all-Medicaid home must live within its resources, which may be less than a suburban home with more private pay and Medicare residents. Across-the-board, one-size-fits all staffing ratios do not improve care. Staffing should be based on the treatment needs and conditions of the residents. To provide more staff, we need to provide more resources. If the state would like more staffing in high Medicaid inner city homes, it should consider a program similar to the hospital disproportionate share program, which provides additional resources to facilities serving a high level of poor and Medicaid clients.

Section III

Expand Home and Community Housing Options for People with Serious Mental Illness

We support:

- an expanded mental health continuum of care;
- expanded transition models, more community housing/service options, greater involvement of the housing development authority, and maximized federal support for community mental health alternatives; and
- an effective case management system that follows the care of the client regardless of where the client resides or is receiving treatment.

Licensed long term care facilities have a safety net role in the mental health continuum of care in providing supervised and structured programming for individuals in need of psychiatric rehabilitation. Often a client needs more than thirty days to stabilize under an effective medication regimen. It is a system that fails the client, the nursing home, and the general public. It is a system of treatment and care we all agree needs to be changed.

The mental health system in Illinois still continues to exist in too many separate silos. No one follows the client as he or she bounces around from hospital to nursing home to residential group home to CILA to community mental health agency to jail and out again and back to the hospital. Each agency discharges to the next with little follow-up or consistency of care. The state can add some of the additional community mental health options for clients recommended by the Task Force, but the system of mental health care in Illinois will not be improved until there is a major overhaul that includes effective case management, follow-up, and a cooperative continuum of care.

Section IV

Issues Still Under Consideration

1. Applicability of Mental Health Code to Persons with Serious Mental Illness in Nursing Homes

Without an understanding of which areas of the Mental Health Code you feel should be exported to the nursing home setting, we can only ask the Task Force to bring fresh eyes

to this discussion. Often in attempting to resolve a difficult question it helps to turn the question around. In this instance, the question we pose is -- What are the benefits to residing in a nursing home enjoy that those in other setting do not?

Among the rights and protections individuals receive under the Nursing Home Care Act but not found in the Mental Health Code are the following:

- Prescreening by independent, unbiased screeners to determine eligibility for services;
- Protection from undisclosed identified offenders and sex offenders among the program's participants;
- Clear statutory guidelines for who can and cannot be involuntarily discharged;
- 30-day notice of and right to appeal an involuntary discharge;
- Informed consent in the use of restraints and psychotropic drugs; and
- Protections on the ordering and use of restraints and necessary precautions.

We can only assume that the framers of the Mental Health Code had specific rationales for providing only seven days of notice of an involuntary discharge or permitting restraints to be used without the resident's consent. Just as there are specific reasons why emergency restraints can ONLY be ordered by a physician in a nursing home and nursing homes cannot hold anyone against their will.

2. Specialized Programs for People at Risk of Harming Others

The Health Care Council of Illinois has strongly advocated for the need for specialized separate programs for individuals determined to be at risk of harming others. Placing high risk identified offenders, parolees, and sex offenders in the general nursing home population continues to place the state's frail elderly at risk of harm and the long term care facilities, mandated to care for both populations, squarely in the middle. Due to the failure of the current risk assessment process to do little more than develop cookie cutter assessments and security plans, it is impossible to estimate how many residents fall in this category. For the families, the innocent residents that have been injured, and facilities that struggle to serve and protect the frailest of our state's residents, one is too many.

3. Specialized Programs for Persons with Serious Mental Illness

Subpart S and T were specifically designed to provide for specialized programming for the seriously mentally ill. To facilitate DPH's oversight of facilities offering this programming, HCCI has recommended that certificates of compliance be issued before a facility can offer programming for the seriously mentally ill. Facilities would be able to advertise the programming and the public could be taught to inquire about the certification, much like families ask about Alzheimer's certification.

If what is really being contemplated is changing the requirements of S or T, we urge you to give serious consideration to HCCI's recommendations and that the input of providers be sought. We also urge you to consider that the seriously mentally ill are not a homogenous population. Care, safety, and housing needs of those under age 60 and those over age 60 are much different. Placing an 83-year-old woman with serious mental illness in a room with a 29-year-old would not be beneficial to either.

4. Proper Monitoring of Psychotropic Use

Currently, nursing homes are required to have a interdisciplinary team – physician, nurse, and pharmacist – in place to review medications for possible drug interactions. Expanding the scope of the team's mandate to include periodic review of psychotropic orders could be supported by the long term care profession.

5. How Can We Better Assess the Potential for Violent Behavior?

Ironically, federal and state regulations assume that propensity toward violence is easily recognized and controlled. So much so, that long term care facilities are fined and held open to civil action for their failure to predict it and stop it before it occurs, even if the facility has followed the letter of the action plan developed by the risk assessors under contract with the state. In sharp contrast, the law holds those preparing the criminal analysis and the action plan immune from any liability.

While we are not the experts to look to for answering this question, we can suggest that criminal justice and mental health professionals render similar assessments routinely. For example, the Prison Review Board reviews case files and makes determinations as to the likelihood a prisoner will re-offend, the Department of Corrections' parolee placement unit routinely places parolees in nursing homes (one assumes they make a similar assessment before doing so), and mental health professionals determine which residents can be released and those they must seek a court order to retain.

6. Informing and Empower the Public

No one condones the abuse or neglect of seniors, but the empowerment of the public is a system-wide problem that needs a system-wide response. Nursing homes are required to post the 800 number for the nursing complaint hotline, giving residents and families the opportunity to file complaints anonymously. This is sharp contrast to home and community based service program, where most clients and families have no way of finding out who to complain to when a problem exists.

Closing

We are here because of some unfortunate stories highlighting where our current system breaks down. There is no question that these situations should be corrected. We ask

that you keep in mind that most of the individuals served in our facilities function, stabilize, and improve because of the structure and programming they receive in licensed facilities. Some of these individuals can, should, and do transition to the community when there are proper support resources available. However, it has been our professional experience that some of these individuals who are able to function in a structured setting are not able to function for long in independent or semi-independent community settings.

Just as we have heard of the unfortunate stories of persons with serious mental illness in long term care settings causing harm to themselves or others, we have all heard similar stories of mental health clients causing harm to themselves or others in the community. It is also not professionally responsible that the very first step for some people out of a locked psychiatric hospital program is into a neighborhood apartment with an occasional check-in at a mental health center. That is a potential recipe for failure.

Do we need to expand the community options in the mental health system in Illinois? Yes. Do licensed long term care facilities that specialize in psychiatric rehabilitation need to be involved in collaborative transition plans with community mental health agencies? Yes. Do we need an effective mental health case management system that follows clients through all settings? Yes. Do we need better integration of licensed long term care facilities that specialize in psychiatric rehabilitation into the mental health network? Absolutely!

This Task Force has proposed some serious recommendations for better screening before entering a nursing home, better treatment while in a nursing home, and a better transition and integration of care out of the nursing home. The members of the Health Care Council of Illinois support these overall objectives and want to continue to work out the practical details with the state agencies to ensure that these recommendations are realistically and effectively implemented.

Thank you for your time and patience. We will be happy to answer any questions you may have.