



Testimony for the Governor's Nursing Home Task Force October 20, 2009

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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. We are the public policy and communications 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.

I appreciate the opportunity to continue to voice our concerns on the issues before you today. And yes, I said "continue" to voice our concerns. 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 be done.

Before we get into specific recommendations let me address two overarching 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 inadequacies in state's regulatory system. I would be remiss not to take this opportunity to once again put forward two overarching recommendations:

- 1.) 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
- 2.) 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.

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Terry Sullivan, will now walk you through our thoughts on the precautions that are needed to improve the system of assessment and placement of ex-offenders in licensed long term care facilities as well as background information on the complicated issue of effectively dealing with persons diagnosed with serious mental illness in Illinois.

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 an 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, is still relevant and deserves 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.

These are recommendations to improve the current assessment and treatment system for indented offenders in nursing homes. But there is no question that the Tribune series also identified some underlying systemic problems. With a continuing collaborative approach, we believe we can strive for a more effective mental health treatment system in Illinois.

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 first is the state's decision to close state mental health residential facilities in the late 70's and transition 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 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, 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.

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

Notwithstanding the seriousness of situation highlighted by the Tribune series, we would advise caution in proceeding without adequate research and deliberation taking into account potential funding and regulatory hurdles. As a first step, it is essential that a more holistic approach be taken to care and support for persons with serious mental illness. This holistic approach must include 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.

Conclusion

Resolution of the issues related to persons with serious mental illness in licensed facilities is a complicated issue. Therefore, the Health Care Council of Illinois has 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. It is our intent to provide the Governor’s Task Force on Nursing Home Safety with the results of our investigations, deliberations and additional recommendations as soon possible.

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 the Task Group 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 Task Force.



- AARP approached the nursing home profession in April of 2004, after being alerted to the problem of mixed populations in nursing homes by a long term care ombudsman, who feared for her personal safety.
- The Illinois Health Care Association, the Illinois Council on Long Term Care and Life Services Network agreed to convene a work group of all relevant parties to develop recommended solutions. The Illinois Health Care Association and the Illinois Council on Long Term Care now comprise the Health Care Council of Illinois.
- AARP agreed to chair the group.
- The work group included representatives from the Departments of State Police, Aging, Public Health, Human Services, Children and Family Services, Corrections, and Healthcare and Family Services; Long Term Care Ombudsman; Chiefs of Police Association; Attorney General's Office; Coalition on Sexual Assault; Case Coordination Units, Area Agencies on Aging; Sheriff's Association; Office of the Governor; each of the four legislative caucuses; Lifecore, Alternative Behavior Treatment Centers, Equip for Equality; County Nursing Home Association; Probation and Court Services Association; and Appellate Prosecutor's Office plus the three nursing home groups and AARP. Lifecore and Alternative Behavior Treatment Centers both work with severely mentally ill individuals in a residential setting.
- Three subcommittees were formed: identification, notification (residents and employees), and management (safeguards, assessments, etc). The notification subcommittee was chaired by the Attorney General's office, identification was co-chaired by the Case Coordination Units and DHS, and management was chaired by the Attorney General's Office.
- Only four other states were attempting to address the problem: MN, WV, WA, and OK in 2004. Only in Illinois did the nursing home profession take leadership in seeking a resolve and only in Illinois was a public/private partnership formed to seek a better understanding of the problem and identify workable solutions. Illinois was the only state of the five that attempted to put in a place a comprehensive solution. As the result of AARP's work in Illinois, national AARP commissioned a study of the issue, although a subsequent report was never issued.

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- Department of Corrections defined themselves out of the discussions early on by taking the position that they were not part of the problem. Identification is not an issue for the parolee population and when a problem occurs, the parolee is automatically returned to a correctional facility. Notification, assessments, and safeguards remain a problem for this population, however. According to DPH, problems have arisen with parolees residing in nursing homes.
- Prior to the group arriving at a formal recommendations, a Sun-Times exposé resulted in the Governor's Office calling a meeting of all relevant agencies, the nursing home associations and AARP. The Governor's representative expressed the Governor's desire for the workgroup to defer to his Office. Several subgroups were identified and the agencies, AARP and the nursing home associations were given approximately 10 days to come back with recommendations for how to proceed. The Attorney General's Office and the other private and public sector associations and providers were not included in the deliberations. The Attorney General's Office was invited to participate in the workgroup chaired by AARP.
- The Governor's Office limited the scope of the discussions to ex-offenders and did not include the issue of individuals with MI diagnosis.
- The Governor declined to move on recommendations put forward.
- The Attorney General's Office offered up an amendment to HB 2062 (PA 94-0163), specific only to felons in nursing homes in mid-May of 2005, which was negotiated with AARP and the nursing home associations. Representative Brosnahan and Senator Maloney, both of whom represented Evergreen Park, the source of the Sun-Times story, carried the bill.
- A trailer bill, HB 4785 (PA 94-0752) was moved by the Attorney General's Office in 2006 to address implementation issues that arose when HB 2062 moved to the JCAR stage.
- At the time, it was acknowledged that HB 2062/HB 4785 were first steps. The intent was to revisit the issue, including expanding the provisions to other care setting. To date this has not happened.
- Recommendations not acted upon and issues set aside for work later:
 - Identification of segregated facilities for parolees and ex-offenders.
 - Expansion of requirements to other care settings: SLF's, AL, Adult Day, CILA's and DHS group homes.
 - Rebuttable presumption of threat to others if a resident is determined after admission to be a sex offender for the purposes of expediting an involuntary discharge.
 - Individuals under age 60 with severe MI diagnosis.

- Simultaneous to these discussions, AARP entered into negotiations with DPH, DHS, The nursing home associations, and the hospital association regarding assessments of Medicare beneficiaries prior to hospital discharge. Although a provision was put in law that prohibits a discharge planner from transferring or making recommendations for a transfer of a resident to an unlicensed, uncertified, or unregistered facility, a provision specific to individuals with MI diagnosis was rejected. This provision would have required that any resident receiving either Medicare or Medicaid funded hospital care with an MI primary or secondary diagnosis to have a care plan developed prior to discharge and a prohibition against transfer to a facility not licensed to provide the required care. This language was discussed in relationship to passage of HB 2453 (PA 94-335) in 2005 and HB 809 (PA 95-80) in 2007.