Mental Health Issues in Nursing Homes

The Illinois Experience
People Are Complex

- People with psychiatric issues also have medical issues
- People with medical issues also have mental health issues
- Not everyone easily fits into our service and reimbursement silos
- More than one-quarter of all Illinois nursing home residents have significant mental health issues.
Federal IMD Designation

- Institutions for Mental Disease
- More than 50% psychiatric clients with no other medical issues
- Certified for Medicaid but no federal match for under 65
- 24 IMD nursing homes in Illinois – nearly 100% psychiatric and under 65.
2010: CMS Concerns

* Chicago Tribune expose of mental health clients and offenders in nursing homes – focus on IMD incidents
* Results in IL Governor’s Task Force and subsequent new legislation and regulations
* At the same time, after reviewing state surveys and look-behinds, CMS 5 concerned about IMD specific citations of neglect, resident rights, lack of supervision, and inadequate specialized rehabilitation services.
* CMS convenes a meeting of all Illinois IMDs to discuss these concern
IMD Response

After listening to CMS concerns, IMDs strongly respond:

- Inadequacy of MDS and survey process – developed for geriatric nursing home population - in evaluating psychiatric treatment issues
- Lack of understanding by nursing-oriented surveyors of the mental health population
- Conflicting and contradictory interpretations and citations over resident rights, supervision and treatment.
As a result of the initial meeting, CMS established a work group with key IL IMD companies, IDPH, and HFS (Medicaid agency)

- Discussed interpretive issues and reviewed specific survey citations
- Met quarterly for two years
Issues Discussed:

* Person with paranoia who refuses to sign anything – either contracts or consents
* Should a person with a history of substance abuse, alcoholism or unprotected sex have a right to leave? What is the facility’s obligation?
* Does the facility have a right to search residents for contraband who are returning from pass
If a resident leaves over facility’s objection and gets harmed in the community, what is the facility’s liability?

Does a facility have a right – or even an obligation – to prevent someone from leaving. Is this a restraint?

If a resident smokes weed in the community, does the facility have an obligation to report illegal activity?
A resident regularly ignores curfew. Can a facility have pass restrictions as a consequence?

Facilities have behavior management/modification programs with incentives. Can there be negative incentives, like pass or smoking restrictions?

Should facilities use cigarettes to reward behavior?
CMS has an initiative to reduce the use of psychotropics. How does that apply to a psychiatric population?

Residents commonly use street vulgarity. Is this verbal abuse?

Two residents push one another arguing over a cigarette. Is this abuse, a reportable altercation or just a note in the clinical record?
Issues Discussed

* A resident with poor hygiene tells a surveyor “I choose to smell funky.” Should the facility be cited for poor ADL care?

* Resident takes pictures on his cell phone of other residents and posts on internet – over their objections. What should the facility do if resident continues to do so after counseling?

* Evidence based recovery treatment focuses primarily on resident setting own goals. What if it means not addressing other issues the surveyor thinks should be addressed?
Results of Discussion

* No formal statement or new set of policy directives
* Greater surveyor flexibility and less rigidity in discussing mental health treatment issues
* Greater understanding by IMD staff of compliance issues
* Since 2012 no serious violations, fewer IMD citations than statewide average, higher star ratings
* CMS discussions informed new public policy review in Illinois on IMDs and mental health treatment in nursing homes
IMDs transitioning out of the nursing home system and into the mental health system, with new services and new approaches.

New requirements for other nursing homes. Illinois nursing homes cannot admit a person with serious mental illness unless it has been pre-certified by IDPH as having the additional mental health staffing and programming to serve the population.
The Dawn of the SMHRFs

- 24 Specialized Mental Health Rehabilitation Facilities
- Licensure legislation in 2013; Regulations just finalized
- Creates four models of treatment:
  - The Recovery and Rehabilitation model is a modification of existing services and residents.
Transition from current IMD nursing home model for existing consumers

For “consumer’s longer-term symptom management and stabilization while preparing consumers by improving living skills and community socialization”

Community-oriented, goal-setting, resident treatment center – “not your home.” Not mental health housing.

IMR/WMR – Your goals determine your stability – not defined by your mental illness

Identify and develop natural supports in the community

Establish linkage with community mental health agency

Evidence-based practices
Other Three New Models

* 23-hour Triage Center as an alternative to more expensive Emergency Room Utilization for psychiatric crisis, linked with local hospitals and providing immediate attention to crisis rather than sitting in waiting room
* 21-day Crisis Stabilization as a cost-efficient alternative to psychiatric hospitalization
* 120-day Transitional Living Units, with intensive training in community living skills, coping mechanisms, and self care for consumer about to move to the community
Not Nursing Homes – Who’s Different?

* Primary Mental Health Diagnosis
* No Admissions over 60 years old
* Must be “ambulatory” – capable of transfer and self-movement
* No serious medical conditions
* Admissions to all levels based on 24/7 State authorization system and/or managed care organization
* Made possible by the person-centered holistic approach to medical treatment by ACA – Fed match through managed care.
SMRHF vs IMDs – What’s New

* Each of the four programs supervised by doctor-level or master’s level licensed clinician
* Mental health program staff; nurses contribute but not run the show – not a nursing home
* ACA allows – encourages – coordinated case management
* BIG CHANGE - Linkage with mental health community services
SMHRFs - What’s Different

- Evidence Based Treatment
- Same Quality Improvement standards and data as community mental health agencies
- 30 to 70 hours of mental health training for all staff
- Accreditation within three years
- Physical Plant changes over three years:
  - No more 3 and 4 bed rooms
  - 10% private rooms
  - Women’s units
  - Laundry rooms
  - Separate dining in Crisis Residence and Transitional Living
SMHRFs are designed to provide cost-effective residential safety-net support to community living for chronic behavioral health consumers

Easing a burden on the emergency rooms and psychiatric hospitalizations

Essential linkage with community mental health caseworkers

ACA reduces the “siloes” of mental health treatment

The increasing linkage of hospitals, residential treatment and community supports provide an integrated, coordinated case management approach to better mental health treatment