MINUTES
Redefine Nursing Home Criteria

Representative Jean Hunhoff, Chair
Representative Rebecca Reimer, Vice Chair

First Meeting, 2019 Interim
Wednesday, July 17, 2019

Room 362 – State Capitol
Pierre, South Dakota

The first interim meeting of the 2019 Redefine Nursing Home Criteria and Build Capacity Task Force was called to order by Representative Jean Hunhoff, Chair, at 10:05 a.m. (CDT), on Wednesday, July 17, 2019.

A quorum was determined with the following members answering roll call: Representatives Chris Johnson, Jean Hunhoff (Chair), and Rebecca Reimer (Vice Chair); Senators Rocky Blare and Susan Wismer; and Public Members Anthony Erickson, Dr. Deepak Goyal (via phone), Amy Iversen-Pollreisz, Jeremy Johnson, Shawnie Rechtenbaugh, Phil Samuelson, and Laura Wilson.

Staff members present included Sakura Rohleder, Fiscal and Program Analyst, and Rachael Person, Senior Legislative Secretary.

NOTE: *For purpose of continuity, the following minutes are not necessarily in chronological order. Also, all referenced documents distributed at the meeting are attached to the original minutes on file in the Legislative Research Council office. This meeting was web cast live. The archived web cast is available on the LRC website at sdlegislature.gov.*

Opening Remarks

Representative Hunhoff welcomed everyone to the meeting and gave a brief history of how the committee originated with the 2018 Access to Mental Health Services interim study which focused on a review of mental health services available in the state and the capacity of the available services, how people with mental illness are treated, and continuum care. The facilities, locations, resources, treatment options, and services available for treatment of persons with mental illness. As well as, the financial costs to the state and its political subdivisions. As that interim study was a very large study, it was recognized that more subdivisions needed to be addressed, and that the solution was not a single solution but a collaborative approach on how access to mental services for the people of South Dakota can be increased. One of the recommendations that came out of the Access to Mental Health study was SCR 2 which provided for legislative task forces to study, report, develop, and consider recommendations for proposed legislation regarding sustainable improvements to the continuum of mental health services available in the state. Representative Hunhoff then briefly discussed the five interim task forces created by SCR 2.

Overview of the Long-Term Care Unit at the Human Services Center

Ms. Amy Iversen-Pollreisz, Deputy Secretary, Department of Social Services, gave an overview of the Human Services Center(HSC) and the history of the geriatric program. The geriatric program began in 1976 when legislature approved funding to renovate the Pierce building. The program became a Medicaid certified nursing facility between 1978 and 1979 with 119 available beds. A move to a new building in 1996 caused a decrease in bed availability bringing the total number of beds down to 91. In 1998 adolescent programming was added to the facility and the number of beds dropped once more, transitioning from 91 beds down to 69 beds which is the number they operate at today. Ms. Iversen-Pollreisz also informed the committee the goal of HSC is to provide care and treatment for patients who cannot be served in community nursing homes. She included additional information on

HSC such as length of stay, how the averages are determined for length of stay, and different areas of funding HSC receives. The operating budget for the HSC Geriatric Unit is approximately $6 million. For State Fiscal Year (SFY) 2019 the estimated revenue from Federal Medicaid is $1.3 million and $700,000 for non-Medicaid revenue. The daily rate for the facility ranges from $19.73, which is the rate for county, to the $550, which is the rate for the private insurance company.

Process of Admission

Mr. Jeremy Johnson, Director of Clinical Services, South Dakota Human Services Center, described the legal process that brings people to the HSC campus, the path to admission to the nursing home once patients arrive at the HSC campus, the common diagnosis treated at HSC, and some of the discharge barriers common for the nursing home program. Referring often to state statutes for specific definitions, Mr. Johnson described two processes in which a person would arrive on the HSC campus. The first being through an involuntary admission, and the second through a voluntary admission.

A person is subject to involuntary commitment if the person has a severe mental illness, and due to that mental illness, they're a danger to themselves or others, or has a chronic disability, and the individual's needs are likely to benefit from treatment. For a voluntary admission, a person needs to be examined by a staff psychiatrist to make sure they still meet the criteria listed in the involuntary commitment process, that they're clinically suitable, or have a need for treatment, and if less restrictive alternatives will not be suitable for the person. The last portion of both paths of admissions is that the person doesn't have medical needs that would exceed HSC's capacity to care for them. Once a patient arrives at HSC they are admitted to the adult psychiatric program. They are assessed and evaluated by the treatment team during this time and from there, depending on the patient's needs, they will either stabilize and discharge from HSC back to a community nursing home, their home environment, or to community assisted living; or, they would be admitted to HSC's geriatric program. Mr. Johnson emphasized that HSC is the most restrictive level of care within South Dakota's mental healthcare system and it should be reserved for those really in need of it.

Senator Wismer asked if cases ever existed of a patient not being admitted to HSC because they would not benefit from treatment. Ms. Iversen-Pollreisz responded when a person is being considered for potential involuntary commitment the county board and the county board chair will order an evaluation by a qualified mental health professional (QMHP). The QMHP will make the decision of whether the person is appropriate for HSC and would benefit from the treatment available at HSC versus potentially benefitting from services somewhere else. They are looking for the least restrictive setting, and if there is another treatment program that would be beneficial for that person.

Senator Wismer inquired if any disagreements between a county mental health board and HSC on whether a patient would be accepted or not, occurred. Ms. Iversen-Pollreisz said no situations of disagreements occur. Once the hold is placed by the county board chair the patient is admitted to HSC and when they arrive at the campus they begin the process of evaluation, providing treatment, and continually reassessing if they continue to meet the criteria to be at HSC on the involuntary commitment. Then, once the patient is doing better and no longer meets that criteria the discharge process can begin.

Ms. Anita Dunham, Systems Director Case Management and Utilization, Rapid City Regional, spoke with the committee on what the commitment process looks like from the Rapid City Regional hospital setting. When a patient enters the emergency department they may or may not already have a hold in process that could have been started by law enforcement or by a family request, but when the patient is being evaluated in the emergency care department the patient has other primary medical issues that will be taken care of first. If they have a behavioral health diagnosis or active behaviors going on, a hold process will be issued in which a QMHP will evaluate the patient

and determine if the mental health hearings can take place while the patients are "in house." Most of the evaluations result in involuntary holds and they will try to place the patient in Rapid City Regional Health, Avera, or HSC. The acute care environment isn't equipped to take care of behavioral health management for patients, so they try to get those patients transferred to the appropriate level of care as soon as possible. Ms. Dunham stated that it can be a struggle to find placement for patients with behavioral issues or other medical management issues such as the need for oxygen, mobility issues, or other medical needs. Availability is a barrier that comes up frequently and sometimes the process of transferring patients can be a lengthy process due to those capacity issues, and other issues such as staffing shortages or the individual's behaviors being beyond a facility's capability.

Barriers for Long-Term Care Facilities

Representative Johnson brought attention to the definitions of 'danger to self' and 'danger to others,' emphasizing the importance and responsibility of protecting the communities of South Dakota and asked if that was factored into the definition of 'danger to others.' Ms. Iversen-Pollreisz commented that it is included in the definition and mental illnesses decompensated to the point of potentially causing an individual to harm another person could be a reason for an involuntary commitment, however, the vast majority are coming to HSC due to being a danger to self, and a big component of that is they are a danger to self due to the inability to care for themselves any longer. With the geriatric population, a lot of admissions come from nursing homes and behaviors are happening within a nursing facility where they are acting out and the facility does not have the ability to care for that person.

Representative Reimer voiced concern over incidents where a patient has an outburst in a facility and the facility faces possible regulatory fines that can be detrimental to facilities and have the power to shut down smaller facilities.

Mr. Tony Erickson said there is always potential for that. When a facility agrees to accept a patient, they accept the person and all the challenges or issues that person may have. If a facility accepts a person who has the potential to harm someone, or themselves, the facility is accountable for that, and if facilities can't meet the needs of the individual or protect the resident, or others, that is where the fines come into play. Unfortunately, it also becomes very difficult to discharge that person out of the facility due to obstacles such as appeal rights and alternate placement issues.

Mr. Phil Samuelson agreed with Mr. Erickson and added that beyond protecting the individual and the others in the facility, when the surveyors or families arrive following the incident, the facilities have to show how they, as providers, are taking steps to make sure safety for the residents is in place and how they will prevent future incidents. Mr. Samuelson said sometimes providers are stuck with what to do. The centers are trying everything they can, they're trying different methods while maintaining the least restrictive measures, but the behaviors still happen. He also pointed out that misconceptions have the potential to cause undue fear from the families who don't always understand what is going on and that causes issues for providers as well.

Mr. Johnson mentioned behavioral changes related to dementia is the most common discharge barrier they face at HSC. Community nursing homes do not always have the staff or the training to deal with those behavioral changes in relation to serving other community members who don't have those behavioral challenges.

Representative Johnson asked if private geriatric care facilities are restricted by any regulations when it involves their right to refuse an application for residency if the patient has a history of being either a danger to themselves or to others. Mr. Johnson replied he did not know of any restrictions for private geriatric care facilities' right to accept a person or not.

Ms. Laura Wilson offered insight into why a private geriatric care facility might refuse a patient with a history of behavioral issues stating, once a patient is accepted into the facility that facility is responsible for the patient from that point on unless they are able to find another placement for the individual. This can be hard for smaller facilities who don't always have the means of caring for the individual's behavior. If behavioral outbursts occur, they are able to send the patient to HSC or another more equipped provider for temporary help, but they can never tell HSC or the other provider they will not take the patient back unless a proper 30-day discharge notice is given, or another long-term environment is secured. So, they do screen new admissions and refuse to accept a patient if they need to.

Mr. Samuelson added, as the admission criteria is assessed, a lot of factors go into the decision of admission and every facility will have different experience and a different lens based on the expertise of the location. If there is a history of behavioral issues, they want to know what underlying issues are present to know if they will be able to work with the patient on an ongoing basis and provide for the patient's needs, keep everyone safe, and provide the highest quality of care possible.

Representative Hunhoff asked about the transition when a person leaves HSC and goes back to a facility and how HSC and the facility work together to ensure the psychiatric services are maintained. Mr. Johnson responded HSC works with the community provider and ensures the community providers have the records from the patient's stay at HSC or any communication needed for the continuity of care.

Mr. Erickson said if a facility runs into a situation with a patient, they confer to the notes provided by HSC. However, problems do arise with more challenging patients even when procedures are in place. Many times, when a patient starts acting out it is immediate and access to psychological services on an immediate type basis is very difficult and this challenges and stresses facilities out. Mr. Erickson stated psychological services on an emergent basis is probably the biggest challenge long-term care facilities face.

Dr. Deepak Goyal added that accessibility is important. When someone in a facility calls the prior provider for information to help a patient, the other provider may not be available and there may be no way to reach that provider. Many times, when facilities need help, they need help right away or within an hour. So, if there are ways to improve accessibility between providers, that would be an area to look at. Another issue circles around the level of training people have. As people do not always have the same levels of training, Dr. Goyal said good communication and maybe two to three weeks of overlapping care or cross training of staff could be another area that could be looked at for improvement.

Ms. Dunham agreed and added on-site security also plays a factor in these situations. Many times, facilities must call 911 and then wait for the police department to arrive because they do not have someone in the facility to help with safety.

Representative Hunhoff asked what options existed that could benefit or deescalate patients in these situations if the emergent psychological or security services were not available. Mr. Samuelson responded intervention training for all staff members in the facility can be a very useful tool. Mr. Erickson agreed that staff competency is a big factor in how successful a facility is in those situations, and having smaller units is also successful. However, adding more training and reconfiguring the current facilities in South Dakota brings about the issue of funding which is not usually available.

Another area of concern for long-term care facilities is the issue of guardianship. Ms. Dunham stated the long-term care environments need a guardianship in place to complete consent for admission, treatment plans, Medicaid applications, and payment. She said it can sometimes be problematic to locate a willing family member or acquaintance who is willing to pursue guardianship for the patients and, unfortunately, not a lot of state-assisted

options exist. She also commented that working through the process to find and obtain guardianship can be quite labor intensive for facilities.
Representative Hunhoff asked what percentage of patients have the quandaries with guardianship and what the committee members have seen in their own facilities regarding the issue. Ms. Dunham respond she is usually searching for a guardian for two or three patients at any given time.

Ms. Wilson said it is a barrier she has seen in her facility as well. Becoming a guardian can cost anywhere from $700 to $1000 and many don't have the financial means to go through the process.

Mr. Samuelson responded guardianship is an issue, as is getting Medicaid applications in. He mentioned seeing an increase of families not having the information, or not caring, which leaves the facilities with no payment, therefore they're looking at the referrals and individuals have no financial means in place, and while they try to assist as much as they can, the success rates are limited.

Mr. Erickson expanded on this pointing out that many families are dispersed, estranged, or second marriages have occurred resulting in two sets of families, and these situations result in additional write offs because there is not a clear path to get Medicaid approved for an individual. If challenging behaviors or situations exist, many times the patients have estranged their family and the family doesn't necessarily want to get involved any more and all of this affects placement of the individual. If facilities don't have guardianship worked out from day one, the facilities are on the hook.

Representative Hunhoff asked about the process of guardianship, what facilitates it and if the issue has ever been looked at. Ms. Shawnie Rechtenbaugh replied that an application process exists when people apply for guardianship by the state. The state does serve as a guardian for individuals, but it is an absolute last resort. She also mentioned the Department of Human Services (DHS) has a guardianship establishment program which offers up to $500 of financial assistance to establish a guardianship. Representative Hunhoff asked for more information on the guardianship process for the next meeting.

Throughout the meeting the committee frequently discussed different areas of funding that pose problems for HSC and other facilities and asked if numbers for daily rates, allocation of funds, cost of admission for counties, Medicaid costs, and other funding areas could be provided at the following meeting.

Representative Hunhoff pointed out the intent and purpose of the task force is not to eliminate nursing homes and that a new, different model from the one currently in place needed to be looked at. She then asked the committee to think of what a new model could look like that would enhance facilities across the state, prevent mental health crises in nursing homes, and provide community nursing homes with resources which allow them to keep patients in their home communities.

State Approaches for Geropsychiatric Care

Ms. Alicia D. Smith, MHA, President, Vorys Health Care Advisors, presented the committee with current efforts underway in the states of Tennessee and Virginia related to Geropsychiatric systems of care, older adult population trends, some common barriers to effective transitions across settings, and some solutions the states have enacted to combat the growing needs.

The trend towards adults living longer who need care and services to address their complex conditions including mental illness is growing in the nation. Ms. Smith said Virginia and Tennessee experienced many of the same issues South Dakota faces such as overcrowding that caused an increase in demand in services and longer lengths of stay resulting in no capacity for additional entrance into the system. They also experienced issues with patients being

deemed ready for discharge but ended up facing barriers to discharge. Patients can be ready to be discharged from state facilities, but it is difficult to find placement for them due to their psychiatric needs and facilities not having the ability or enough trained staff to take them. Medicaid reimbursement for facilities is also a common challenge.

To help solve some Medicaid issues, Tennessee created a subacute discharge initiative which started bi-weekly calls between the state and the health plan to individually talk about care needs. On the non-Medicaid side, the state created the Move Initiative which allows a person to be discharged from a facility and moved into the community with a set of services still available to that person.

Ms. Iversen-Pollreisz commented that South Dakota has a system in place similar to the Move Initiative. The teams are called Impact teams in South Dakota. The program started as a component of HSC but is not a component today. Ms. Iversen-Pollreisz state it is a very successful model. Currently, six out of the eleven community health services operate the Impact teams: Yankton, Sioux Falls, Rapid City, Pierre, Huron, and Aberdeen, and the teams target individuals with serious mental illnesses such as schizophrenia or bipolar disorder who struggle to live independently due to those mental illnesses and who have had repeat hospitalizations. The services are Medicaid eligible through the mental health system as all the services provided are offered through community mental health centers.

Representative Hunhoff asked if the Impact teams were beholden to rules and regulations, or if they had some flexibility in the services they provided, and, if they did face regulations, were they state or federal regulations. Ms. Iversen-Pollreisz replied they do have some regulations but still have a lot of flexibility within the industry to meet the needs of the population they are serving, and the regulations are state regulations and not federal.

Representative Hunhoff pointed out the Impact services might be something to look at for a future model for HSC and putting individuals back in the community working with long-term care.

Public Testimony

Mr. Mark Deak, Executive Director, SD Health Care Association, said this is a very difficult situation and he appreciates the work the committee is doing. He said the main concern he hears from long-term care facilities across the state is when they have an aggressive resident, or a resident who is even perceived as aggressive, in their facility they don't know where to turn and they often look to make a referral to HSC or other behavioral health care centers in the state who are more equipped to handle the individuals but they are often turned away due to no availability.

Committee Discussion and Adjournment

Representative Hunhoff asked the committee for their suggestions and ideas for the next meeting. The committee reiterated ideas for improvement discussed throughout the meeting and finalized the information they would like to receive from HSC for the next meeting.

The next meeting will be held October 1 and 2 in Yankton.

A motion to adjourn was made by Senator Wismer, seconded by Representative Reimer. The motion prevailed on a voice vote.

The committee adjourned at 3:31 p.m.