The Philadelphia Model: Addressing Serious Mental Illness in Long-term Care
Behavioral Health Structured Supplemental Services Description

Background

The number of adults over 65 years old has increased by 33% in the last decade and is projected to double by 2060. Between 3% and 9% of all older adults over age 65 live in institutional settings, most commonly nursing facilities, with Black and Hispanic individuals admitted to nursing facilities at a higher rate than white individuals. The prevalence of individuals with serious mental illness (SMI), serious emotional disturbances (SED), substance use disorder (SUD) and co-occurring disorder (COD) living in nursing facilities has risen by 54% between 2007 and 2021. This group of conditions, collectively, is hereafter referred to as SMI for the purpose of this application. According to the World Health Organization (WHO), approximately 15% of adults aged 60 and over suffer from a mental disorder and by the age of 85, it is estimated that at least 50% of older adults will have a behavioral health issue. In addition, over 50% of nursing home residents have mental disorders other than dementia.

Nursing facility staff knowledge gaps about the care of older adults with SMI and national workforce shortages create risks for staff and residents. Facilities with high severe mental illness rates among residents have lower Nursing Home Compare star ratings compared to all other nursing homes. Older adults with SMI living in nursing facilities can become verbally disruptive, physically aggressive, and socially inappropriate. Regulatory citations for the inappropriate use of psychotropic medications are more likely in nursing facilities with lower staffing levels.[12] Nursing facilities with high rates of residents with SMI are more likely to be cited for resident abuse and neglect than all other nursing facilities.

In Philadelphia, it has become evident that there are significant gaps in the care for frail older adults who have complex behavioral health needs, substance use disorders, and/or prior criminal history – and need long-term skilled nursing services. This vulnerable population has struggled with accessing long-term care services due to inefficiencies in the referral process, stigma, lack of funding for structured supplemental behavioral health services in nursing facilities, lack of staff core competencies, and the lack of regulatory support to provide the necessary behavioral health care and services needed. State and Federal regulations prohibit nursing homes from accepting residents for whom they cannot provide the necessary care and services, thus, nursing homes have denied these individuals without hesitation.

Philadelphia's DBHIDS and CBH fund care within Long Term Structured Residences (LTSR) and other community residential facilities for individuals with serious mental illness. Philadelphia was home to Philadelphia State Hospital ("Byberry"), which closed in 1990. Long term structured residences and other community residential facilities were developed for individuals transitioning from Byberry or who would have previously been determined to require state hospital level of care. It is important to consider that the LTSRs and other community settings differ from hospitals in that they are not permitted the use of restraint. These facilities are staffed 24 hours per day. Individuals transferred from Byberry to these facilities or admitted to these facilities in the absence of a state hospital, have aged in place over the last three decades,

many qualifying for long term skilled nursing level of care. LTSRs and other community residential settings cannot provide those additional skilled medical and personal care individuals need.

The Centers for Medicare and Medicaid Services (CMS) regulations pertaining to behavioral health services in the final rule requires nursing homes to develop and implement an individual plan of care that encompasses a residents' whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Although these regulations are in place, nursing homes are denying referrals, citing they cannot meet their complex behavioral health needs due to limited staffing levels and staff competencies and federal regulations placing limits on psychotropic medications use and medications for opioid use disorder (MOUD).

CMS released in April 2022, new behavior health strategies that covers multiple elements including access to prevention and treatment services for substance use disorders, mental health services, crisis intervention and pain care; and further enable care that is well-coordinated and effectively integrated. This new initiative by CMS sets the stage for DBHIDS to obtain the governmental/regulatory supports and funding needed to address the significant numbers of those frail adults diagnosed with serious mental illness living in shelters, non-congregate homes, LTSRs, Community Residential Rehabilitation (CRR), Norristown State Hospital and other city-funded housing options that are not designed to meet the complexities of the physical, mental, spiritual, and emotional aspects of the whole person.

This new initiative for frail older adults who are diagnosed with a serious mental illness – and need long-term skilled nursing services will incorporate best practices from LTSRs, CRRs, extended acute inpatient behavioral health models, and other DBHIDS programs to the skilled nursing environment. This framework/model will address complex behavioral health needs and medical needs in a safe and stabilized living environment with enhanced supplemental services. These services will be trauma-informed, culturally relevant, embrace and engage diversity, and address the whole persons' needs, thus avoiding transfer trauma with unnecessary trips to the acute care settings. This framework will include identifying and overcoming barriers of acceptance to skilled nursing facilities, stigmas, nursing facility staff education and competency, regulation gaps, funding streams, staffing models, and best practice recommendations to care for frail older adults with serious mental illness in skilled nursing centers.

Description of Service:

Services will be provided in a 28-bed unit with an average occupancy rate of 85% for an average occupancy rate of 24. There is a complement of behavioral health staff and other ancillary staff that will be required over and above the skilled nursing facility staffing model to provide the expertise to care for this population. The daily behavioral health staff incorporated into this service will include mental health workers, registered nurses, master's prepared clinical social workers, life enrichment staff, a master's prepared director with a clinical background, an admissions liaison, a program support specialist, a psychiatrist unit director and physician on-

call services. All residents will receive direct behavior health services as defined in individualized care plans. The masters-prepared clinical social workers will address resident psychosocial needs including providing a minimum of one 30-minute weekly clinical session for each resident. The clinical social workers will be available for interdisciplinary care planning coordination including community and family support.

The expert behavioral health staff will provide supervision, support and interventions related to de-escalation consistent with resident individualized care. Participants may require intermittent intensive supervision and support, such as 1:1 supervision, as ordered by the psychiatric physicians who will be available 24 x 7 via an on-call schedule. These one-on-one services will be individualized, trauma-informed care with the goal of reducing distress and re-traumatization and advancing recovery. This Supplemental Services program includes the equivalent funding to support an average of one resident requiring 1:1 supervision around the clock every day of the year. The total direct and indirect care “hours per patient day” (HPPD) for this unit is 8.1 per below, of which 5.3 hours will be attributable to the behavioral health services covered within this service description.

DIRECT CARE: Regarding direct health care over the course of each day, it is anticipated that 6.5 direct care hours per patient day (HPPD) will be needed to support this population. Of this, 2.8 HPPD will be provided within the based nursing home regulated staffing pattern and not included in this supplemental service. The base nursing home HPPD will be augmented by an average of 3.7 HPPD of specialty behavioral health direct care as defined in this plan. It is anticipated that the residents in this unit will require individualized psycho-social support through behavioral coaching and group facilitation. For this reason, in addition to the standard Certified Nursing Assistant (CNA) and LPN staff on a standard nursing home unit, this unit would have mental health workers and a Registered Nurse to address the complexities of this population.

<u>Mental health worker direct care responsibilities</u>:

- Provide additional behavioral coaching to support residents’ day-to-day routine including but not limited to relationship/community support, socialization, nutritional, environmental, religious, and cultural needs
- Monitor residents’ conditions and assist in administering therapeutic care including medication compliance
- Facilitate healthy and socially acceptable behaviors while living in a community environment
- Reinforce positive behaviors to ensure boundaries are maintained with other residents, staff, and visitors and intervene as needed to maintain a safe environment
- Support residents in meeting their clinical goals as outlined by the resident and treatment team in the individualized care plan

- Conduct independent and group activities with residents, including educational and social programs
- Provide de-escalation techniques and trauma informed interactions as needed related to behaviors
- Document in resident's charts and collaborate with interdisciplinary team
- Accompany residents to interdisciplinary care conference and appointments
- Supervise family visits if appropriate

INDIRECT CARE: An additional 1.6 HPPD of indirect care staff will be needed to support this unit. The unit will have dedicated social workers to address psychosocial needs including trauma-informed care and be available for family support. The Life Enrichment Staff will specifically address the social, recreational, and cultural needs inclusive of diversity. The Program Director will have responsibility for the overall management of the treatment team and delivery of care and services. A part-time Psychiatric Medical Unit Director will consult on individualized treatment/care plans and medication regimen. In addition, a consulting pharmacist will review all medical records for compliance. All behavioral health staff in the facility will meet regulatory and CBH Credentialing requirements. Residents in this unit will be offered peer support programs and psychoeducational group programming on a routine basis.

Anticipated Units of Service per Person:

All participants admitted to this demonstration unit will require 24/7 staffing at the current nursing home per patient day (PPD) parameters, in addition to the enhanced supplemental behavioral health treatment defined above. Care plans will be individualized for each person depending on where they are in their healing or stabilization process. These individuals will not be admitted in an "acute" state; however, some may require intensive therapy daily to normalize them to their environment. Treatment and rehabilitation services will be evaluated based on the individual's comprehensive resident centered assessments and care plan.

While individualized to each individual's daily needs, it is anticipated that the average amount of specialized care via billable staff described herein will be 21 fifteen minutes of service per day (5.3 hours).

Targeted Length of Service:

All residents are expected to stay a minimum of three to six months since they will meet eligibility for nursing home level care, but most will stay longer. While always considering other community-based options, many residents are expected to stay in this unit for the rest of their lives. Residents will be evaluated at a minimum quarterly for eligibility to be transitioned to another care setting that is less restrictive and more inclusive such as the general nursing home population or a community setting.

Information About Population to be Served:

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Primary population will be frail adults with an average age of 60 years old meeting a Level 1 or 2 PASRR Assessment determination and diagnosed with a serious mental illness (SMI) from the DSM 5. The National Institute of Mental Health (NIMH) defines SMI as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities." SMI includes disorders such as bipolar disorder, major depressive disorder, schizophrenia, and schizoaffective disorder. A licensed psychiatrist must determine the individual's diagnosis causes significant functional and psychosocial impairment.

INCLUDED ON A CASE-BY-CASE BASIS:

- Philadelphians with a history of a sex offense (s)
  - Considerations include tier of offense, legal oversight (if applicable), risks for future violence, and location of facility (proximity to a school)
- Individuals less than 60 years of age
  - Must meet the skilled nursing facility eligibility criteria
  - Consideration includes appropriateness for the care setting
- Individuals with a brain injury
  - Considerations include severity of brain injury symptoms and whether all other resources have been exhausted in current living situation to allow for individuals to live in the community
- Individuals with Intellectual Disabilities
  - Considerations include whether all other resources have been exhausted in current living situation to allow for individuals to live in the community
- Prescribed MOUD
  - Considerations include: the availability of MOUD treatment in the facility and/or the capacity for the resident to travel to a certified clinic to obtain MOUD treatment
  - It is recommended that the individual and the individual's care team develop a care plan prior to admission to reduce or discontinue the use of MOUD.
- Individuals with co-occurring dementia
  - Considerations include severity and complexity of dementia
  - A separate program is being considered for individuals with moderate to severe dementia and SMI

SUB-POPULATIONS EXCLUDED:

- High or medium risk to harm self, property, or others
- Active SUD of any illegal substance
- Currently experiencing an acute psychiatric episode including but not limited to active suicidality and actively homicidal
- Open/pending legal charges
- Individuals with a forensic history that are on parole outside Philadelphia County
- Ventilator-dependent

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Program Philosophy, Goals and Objectives:
The supplemental services will provide highly structured therapeutic residential behavioral healthcare and treatment for frail adults who are eligible for skilled nursing level of care who also have serious mental illness and who have reached maximum benefit from the mental health resources available elsewhere in the community or hospital. This is evidenced by a psychiatric and medical physician confirmation that the individuals' behavioral health, medical and personal care needs are most appropriately met in a skilled nursing facility.

The program philosophy is to create a welcoming, safe, and supportive environment where frail older adults with SMI that may include other complex behavioral health needs and/or prior criminal history – and need long-term skilled nursing services-can receive the care and services needed to address their holistic needs free of stigma.
PROGRAM GOALS:

1. Implement a high-quality evidence-based program to provide the least restrictive and most-inclusive care setting for frail older adults with SMI that need long-term skilled nursing services.
2. Increase the awareness, knowledge, and skills of the nursing facility participating in this program
3. Foster alliances in Philadelphia among culturally diverse practitioners, researchers, policy makers, family members, and residents of nursing facilities to assist in the successful implementation of nursing facilities that promote the care management of residents with SMI.
4. Create capacity in LTSR, CRR and EAC's for others requiring that level of care.

PROGRAM OBJECTIVES:

Goal #1: Implement a high-quality evidence-based program to provide the least restrictive and most-inclusive care setting for frail older adults with SMI that need long-term skilled nursing services.
The following metrics will be used by CBH to gauge progress:

1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-ICP)
2. Initiation rate*
3. Engagement rate*
4. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-ICP) *
5. Combined behavioral health and physical health Inpatient 30-Day Readmission Rate for Individuals with SPMI (REA-ICP) **
6. Emergency Department Utilization for Individuals with SPMI (EDU-ICP) ** defined in member months (MM)
7. Combined behavioral health and physical health Inpatient Admission Utilization for Individuals with SPMI (IPU-ICP) ** defined in MM

8. Diabetes Screening for People with SPMI who are using Antipsychotic Medications (SSD-ICP) *
9. Diabetes Care for People with SPMI: Hemoglobin A1c (HbA1c) Poor Control (>9/0%) (HPCMI-ICP) **
10. Cardiovascular Monitoring for People with Cardiovascular Disease and SPMI (SMC-ICP) *
11. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence for individuals with SPMI (FUA-ICP) *
12. Follow-Up After Emergency Department Visit for Mental Illness for individuals with SPMI (FUM-ICP) *

Note: The ICP P4P measures are subject to change due to changes in the specifications made by the measurement steward.
*CMS Core Measure /NCQA measure

In addition, the following measures will be maintained by the provider and nursing facility:

13. Beginning 3 months after program launch, the program will maintain a 95% occupancy rate.
14. Community Health Choices will report a savings annually for each member residing in the new program.
15. Individuals with SMI will have a similar resident satisfaction as those individuals without SMI residing in the same facility.
16. CMS Long Stay Quality measure outcomes for this program will be equal to or better than the other units in the facility
17. Number of Hospitalizations per 1,000 Long-Stay Resident Days
18. Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days
19. Percent of Residents Who Received an Antipsychotic Medication
20. Percent of Residents Experiencing One or More Falls with Major Injury
21. Percent of High-Risk Residents with Pressure Ulcers
22. Percent of Residents with a Urinary Tract Infection
23. Percent of Residents who Have or Had a Catheter Inserted and Left in Their Bladder
24. Percent of Residents Whose Ability to Move Independently Worsened
25. Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased
26. Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine
27. Percent of Residents Who Received the Seasonal Influenza Vaccine*
28. Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine*
29. Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine*
30. Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine
31. Percent of Residents Who Received the Pneumococcal Vaccine*
32. Percent of Residents Who Were Offered and Declined the Pneumococcal Vaccine*

33. Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Pneumococcal Vaccine*
34. Percent of Residents Who Were Physically Restrained
35. Percent of Low-Risk Residents Who Lose Control of Their Bowels or Bladder
36. Percent of Residents Who Lose Too Much Weight
37. Percent of Residents Who Have Symptoms of Depression
38. Percent of Residents Who Used Antianxiety or Hypnotic Medication

Goal #2: Increase the awareness, knowledge, and skills of the nursing facility workforce participating in the program.

1. 80% of staff will verbalize an increase in knowledge, and confidence regarding caring for residents with SMI upon completion of the CBH training modules through pre/posttest.
2. The state survey for this program will result in no violations.

EXPECTED OUTCOMES:

- Improve quality of life for frail older Philadelphians with complex medical and behavioral health needs in a least restrictive most inclusive environment
- Navigate current benefits, Medicare & Medicaid for participants
- Decrease monies spent for those “living in” acute care settings and other inappropriate/restrictive settings due to discharge barriers
- Support skilled nursing homes in providing behavioral health care services with supplemental services and supplemental funding
- Provide a meaningful quality of life and sustainable housing for frail older adults with SMI who need long term care.

Clinical Staffing Pattern: Submit this information in the table format below

Staff Position	**Qualifications**	**Total FTEs**
Medical Unit Director	Licensed as a board-certified Psychiatrist in the state of Pennsylvania. 10+ years’ experience working with older adults and in a director’s role.	.5
Mental Health Worker	High School diploma or GED is required. Associates degree or college credits in mental health preferred with 3-5 years’ experience working with older adults.	11.2
Social Worker	Master’s prepared licensed clinical social worker with 3-5 years’ experience in long term care mental health required.	1.4
RN	Licensed in PA required. 3-5 years’ experience in mental health required.	4.2

Life Enrichment Assistant Staff	Bachelor's degree in health-related field preferred. Previous long-term care experience required	2.8
MH Specialist/ Unit Manager / Program Director	Master's level clinical leader; preferred with 5-10 years' clinical experience with older adults and 3 years' experience in supervisory position	1.0
Clinical Liaison / Admissions Coordinator	Licensed Practical Nurse (LPN) with 3-5 years' experience in long term care and mental health required.	1.0
Program Support Specialist	High school diploma required. Associate degree or college credits preferred. Clerical and customer service experience preferred	1.0