More than 18,000 individuals with disabilities currently live in adult and family care homes (ACH) in North Carolina. As discussed, co-locating individuals with disabilities, who may exhibit behavior problems, with the frail elderly can pose a threat to the health and safety of residents and staff of ACHs. Although the ultimate hope of the Task Force is that individuals with disabilities would be served in their homes or smaller community settings with access to an array of support services (as discussed in Chapter 3), the Task Force feels it is important to work on improving the current system in the short run, because there are individuals living in ACHs now for whom community-based alternatives are not readily available. These individuals will remain in ACHs for the foreseeable future; therefore, planning should include ways to improve the screening, assessment, and care coordination processes to better meet the needs of individuals with disabilities. Changes to the system should apply both to those individuals with disabilities who are entering ACHs and to those who currently reside in ACHs.

The current system for screening residents before entry into ACHs, assessing their needs upon entry, and determining a treatment plan or coordinating treatment services is inadequate.

Screening, Assessment, and Care Planning

Successfully meeting the needs of individuals with disabilities who live in community-based and facility-based settings requires a well-coordinated service system. How well the service system as a whole operates is one of the critical determinants of the outcomes of treatment.[1] Currently, North Carolina's service system for individuals with disabilities who live in ACHs or who are entering ACHs is very fragmented—with multiple organizations, agencies, and regulatory bodies being responsible for different components of the screening, assessment, and care planning for individuals entering ACHs. The current system for screening residents before entry into ACHs, assessing their needs upon entry, and determining a treatment plan or coordinating treatment services is inadequate.

Every individual must be screened before he or she can be housed in a long-term care facility, whether it is an ACH; a group home for people with mental illness, developmental disabilities, or substance use disorder (licensed under North Carolina General Statute 122C)[a]; or a skilled nursing facility (SNF). The screening tool is used to determine the level of need a person has and whether the facility can provide the appropriate level of care. In addition to an initial screening, the individual should be assessed, so that the long-term care facility can obtain additional information about a person's daily needs and preferences. The information from the comprehensive assessment should be used to develop

a A 122C facility is defined as a "24 hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuations who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder and require supervision when in residence." Elliott M. Making The Rules Work For People: Licensed Supervised Living for Persons with Mental Illnesses, Intellectual Disabilities and Substance Abuse. Presented to: The North Carolina Institute of Medicine Task Force on the Co-Location of Different Populations in Adult Care Homes; March 3, 2010; Morrisville, NC.

a person's care plan, which is a comprehensive plan to meet the individual's social, functional, medical, and emotional needs while in the care setting. The FL-2, MR-2, DMA-3050, PASRR, and resident register constitute the standard instruments used today by the long-term care industry in North Carolina. However, many of these instruments are outdated and do not meet the needs of residents and providers.

Screening

Every individual must have a screening completed before admission to an ACH, 122C, or SNF. The purpose of the screening is to ensure that the placement provides an adequate level of care. Unfortunately, limitations of the current screening process can make it difficult to assess the appropriate placement and level of care for residents, particularly those with disabilities that can lead to behavioral problems. The level of preadmission screening for mental health, substance use, intellectual and developmental disability, cognitive functioning, or specific behavioral problems varies depending on whether the individual is being placed in an ACH, 122C, or SNF. ACHs require the lowest level of screening of any of the long-term care facilities.

Limitations of the current screening process can make it difficult to assess the appropriate placement and level of care for residents.

Within the adult care home system, an individual is screened using the FL-2 (see Appendix B). Individuals who may meet the requirements for a 122C or an ICF-MR, an intermediate care facility for people with intellectual and developmental disabilities (formerly referred to as a facility for people with mental retardation), can be screened using the FL-2 or the MR-2 (see Appendix C), a less commonly used form that is more detailed than the FL-2. The MR-2 is used to screen people with intellectual and other developmental disabilities to determine the level of care needed to see if they should be admitted to 122C or an ICF-MR.[2] People who are seeking admission to a SNF undergo a more thorough federally mandated screening using the Pre-Admission Screening and Resident Review (PASRR) (see Appendix D).

For most patients entering an ACH, the FL-2 is the only screening done before entry. The FL-2 can be initiated by a county DSS social worker, hospital discharge planner, or a individual's attending physician. The form must be completed by the individual's attending physician or licensed psychologist.[3] The FL-2 form is outdated and, of greater importance to this study, the FL-2 does not adequately screen for potential behavioral problems. The patient information part of the FL-2 form has two sections in which a physician can indicate that a patient may have a potentially disruptive behavioral disorder (the sections for disoriented and inappropriate behavior). However, the information provided is cursory, with only a check box and no additional space to enter details of the condition. The form does not collect information about the severity of the problem. Within these domains, the physician may mark whether the patient is constantly or intermittently disoriented and whether the patient is a wanderer or is verbally abusive or injurious to self, others, or property. There is no space to elaborate on any of these behaviors or to indicate whether other behaviors are present.

The lack of information about residents' behavioral health needs at a system level makes it difficult to assess, and to respond to, the true needs of the population. If the behavioral needs of ACH residents were more thoroughly understood, the path to meeting those needs would be more clear. For residents and ACHs, the lack of information does a disservice, because it can lead to improper placement in an ACH of individuals who may pose a threat to themselves or other residents. More thorough information about residents' physical health, mental health, substance use disorders, cognitive impairments, and intellectual and other disabilities is important for improving the current system and giving both residents and ACHs a better chance for successful placements.

The current assessments do not provide enough information to meet the needs of individuals with disabilities, many of whom have additional service needs, particularly behavioral health needs.

Assessment

Each resident receives an assessment to better identify his or her medical condition, psychosocial needs, and preferences after admission to any long-term care facility. For residents admitted to an ACH, an initial assessment must be completed within 72 hours of admission by use of the Resident Register[b] (see Appendix E). A more thorough assessment, the DMA 3050-R (see Appendix F), must be completed within 30 days of admission.[4] The Resident Register must be completed by an administrator or supervisor. It includes basic identifying information (i.e., date of birth, family members, and contact person), resource information (i.e., physician information and source of payment), problems with any activities of daily living (use of aids, food preferences, community involvement, and activities), and a written request for assistance. The DMA 3050-R is required by Medicaid. It includes additional information, including all current medications, mental health and social history, and any medical needs the resident may have. The DMA 3050-R also provides a brief care plan for basic activities of daily living.

Although the current assessments may meet the care planning needs of residents of ACHs who are frail elderly, they do not provide enough information to meet the needs of individuals with disabilities, many of whom have additional service needs, particularly behavioral health needs. In addition, the care plans for all individuals with disabilities in ACHs who are younger than 65 years (i.e., not elderly) should include plans for recovery and self-sufficiency. Care plans for individuals with disabilities should include information on services, such as mental health, developmental disability, and substance abuse services, that local management entities (LMEs), not ACHs, have the responsibility to ensure (see below for more information on LMEs). Therefore, although the ACH assessment should include information that allows for the identification of individuals with disabilities, more comprehensive care planning should be the responsibility of the LME.

b 10A NCAC 13G .0703

Comprehensive Care Planning for Individuals with Disabilities

ACHs plan ways to meet the personal care needs of their residents, but it is unclear to what extent care planning is performed to meet the behavioral health, rehabilitation, vocational, or other needs of residents. This is particularly troubling because more than 60% of residents of ACHs are individuals with disabilities who likely need additional services to ensure that they are on the road to recovery and self-sufficiency. However, providing such services, or even providing coordination of such services, is outside the responsibility and expertise of ACHs.

Although ACHs provide support services, they are not licensed or staffed, and do not have the expertise, to provide treatment, such as counseling, medical treatment, or therapy for residents.

Behavioral Health Services for Individuals in ACHs

Although ACHs provide support services, such as assisting residents with activities of daily living, they are not licensed or staffed, and do not have the expertise, to provide treatment, such as counseling, medical treatment, or therapy for residents.[c] Residents, including those with disabilities, with needs beyond support services for personal care must turn to outside providers for additional supports and treatment. ACHs often do not have sufficient staff to coordinate behavioral services for residents. Some ACHs have resident care coordinators to provide case management, but the position is not required by the state and its existence varies by facility. A resident care coordinator within an ACH may also be responsible for coordination of medical care, supervision of personal care services, and scheduling resident activities in the ACH. Often these coordinators receive little or no specific training on effectively accessing and maneuvering through the mental health system.

Role of LMEs in Helping Individuals with Disabilities

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) is the state agency charged with coordinating the prevention, treatment, and recovery supports for individuals who meet the diagnostic criteria[d] for mental health, intellectual and other developmental disabilities, or substance abuse problems in North Carolina. Services are typically provided through private providers under contract with local management entities (LMEs). LMEs in North Carolina operate as portals to behavioral health services within North Carolina communities. As defined by the DMHDDSAS, LMEs are "responsible for managing, coordinating, facilitating, and monitoring the provision of mental health, developmental disabilities, and substance abuse services in the catchment area served. LME responsibilities include offering consumers 24/7/365 access to services, developing and overseeing providers, and handling consumer complaints and grievances."[5]

c In contrast to ACHs, which are charged with providing supervision and personal care services, North Carolina's 122C facilities are charged with "provid[ing] services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers." Elliott M. Making the rules work for people: licensed supervised living for persons with mental illnesses, intellectual disabilities, and substance abuse. Presented to: North Carolina Institute of Medicine Task Force on the Co-Location of Different Populations in Adult Care Homes; March 3, 2010; Morrisville, NC.

d Full diagnostic criteria can be found online at http://www.ncdhhs.gov/mhddsas/iprsmenu/index.htm.

LMEs are designed to offer an initial screening to triage the individual's needs, to determine whether the person needs emergent or urgent care and whether the person belongs to one of the target populations, and to refer appropriate individuals to other sources of care. If an individual is determined to need mental health or substance abuse services, then the LME will refer him or her to a community provider. If it is determined that an individual meets LME target population criteria[d]—which include all individuals with intellectual and developmental disabilities, individuals with severe and persistent mental illness as well as those who meet alternative criteria, and individuals with substance abuse problems in need of treatment for a primary alcohol or drug abuse disorder who meet additional criteria—the individual can be referred to a qualified mental health, substance abuse, or developmental disability professional to conduct an assessment that will then be used to develop a person-centered plan. The person-centered plan is a personalized plan, developed with the client, to identify necessary services, supports, and treatment.

Following are examples of services to which LMEs connect individuals:

- Assertive community treatment (ACT), in which a team of professionals provides 24/7 treatment, support, and rehabilitation services to individuals with severe mental illness within a community setting;
- Case management, in which patients are assisted by one professional who strives to meet their educational, vocational, residential, and mental health needs by scheduling appointments, searching for benefits, and monitoring service use;
- Community support team (CST), in which a team of professionals helps mental health or substance abuse patients to reintegrate into community living and to develop interpersonal skills;
- Crisis management services, in which professionals help direct and deploy emergency services for those individuals with behavioral health illness in a crisis situation, including 24/7 phone screenings and walk-in services; and
- Developmental therapy, in which patients with intellectual and other developmental disabilities receive intervention activities to build a base of developmental skills, including self-help, language, cognitive development, and psychosocial skills.[6]

Linking individuals with disabilities to LMEs would ensure that eligible residents of ACHs receive clinical assessments and have a person-centered plan with the goals of recovery and self-sufficiency and, whenever possible, reintegration into the community of choice for that individual. An additional benefit of involving LMEs in care coordination for individuals with disabilities who live in ACHs is that the LME and the state have the opportunity to track behavioral health needs within a given community.

Linking individuals with disabilities to LMEs would ensure that eligible residents of ACHs receive clinical assessments and have a person-centered plan with the goals of recovery and self-sufficiency and, whenever possible, reintegration into the community of choice for that individual.

Lack of Trust and Understanding between ACHs and LMEs

Although the current system is designed for individuals to use their LME as a portal to services, many residents of ACHs do not access services through their local LME. Relationships between specific LMEs and ACHs are dependent upon the region and the particular entities. The Task Force identified the successful integration of LMEs into the assessment and care planning process for individuals with disabilities as a critical part of the redesign of screening, assessment, and care planning. Strengthening the partnership between ACHs and LMEs would create a more seamless system for those within ACHs to receive necessary assessment and care coordination by taking advantage of the existing expertise of the LMEs. Similarly, individuals being assessed for placement in a long-term care facility could benefit from the help of LMEs for placement determination. For a future partnership to function correctly, ACHs and LMEs should work to better understand each other's role for providing services and supports for individuals with disabilities. Unfortunately, the Task Force heard from both LME representatives and ACH representatives that, in many areas around the state, LMEs and ACHs do not have a close working relationship, often fail to communicate effectively, and do not have a good understanding of the services provided or populations served by the other entity.

Changes Underway in North Carolina

North Carolina is planning to submit a 1915(i) waiver targeted to individuals in ACHs to address concerns raised by the Centers for Medicaid and Medicare Services (CMS) about the provision of personal care services in ACHs versus in-home personal care services.[7] The 1915(i) waiver would require independent assessments of a patient's condition, development of a person-centered service plan, and quality improvement efforts by participating providers. In the short term, implementation of the waiver in North Carolina will enhance the current system of providing care to people with disabilities in ACHs. Service assessments will be conducted using existing FL-2 and MR-2 forms. Personal care will continue to be provided at "basic," "enhanced," and "Special Care Unit/Alzheimer" levels. Current care coordination techniques used by ACHs will be employed to meet person-centered planning requirements (see Chapter 4 for more on care coordination and person-centered planning). The Division of Medical Assistance (DMA) will maintain authority over quality improvement, operations, and oversight of the program. In the long term, services under the 1915(i) waiver will include use of an automated independent assessment (similar to the Preadmission Screening Annual Resident Review [PASARR] used in nursing homes). Under the waiver, the Division of Social Services (DSS) will conduct these assessments and ACHs and Supervised Living Facilities (SLFs) will continue to offer care coordination.[7]

Designing a System to Better Meet Needs

As described, the current system of screening, assessment, and care planning in ACHs is inadequate to meet the needs of residents, facilities, and the state. In developing recommendations about ways to redesign the current system to

better meet these needs, the Task Force acknowledged that in the short run many individuals with disabilities will remain in ACHs and many will continue to be placed in ACHs. Changes are needed not only to provide more options for individuals with disabilities who need access to services and supports (as discussed in Chapter 3), but also to improve the well-being and safety of individuals with disabilities living in ACHs, other residents, and staff.

In redesigning the current system, the necessity of more thorough screening, assessment, and care planning was clear. The Task Force also considered the data—the size and needs of the populations in ACHs, the service needs of residents, the types of services and supports received, and outcomes related to services and supports—that is desired by the state, local management entities, and counties. This type of data is largely unavailable at the county or state level and would be extremely useful for planning purposes. It is difficult to fully assess the size of the population of individuals with disabilities and their needs without this type of information.

Changes are needed not only to provide more options for individuals with disabilities but also to improve the well-being and safety of individuals with disabilities living in ACHs, other residents, and staff.

One of the Task Force goals for a redesigned system is to create a data entry system that would allow community providers, payers, and others who work with or manage the care of residents in ACHs to see select parts of a resident's profile and to provide information needed to appropriately provide services and supports to ACH residents. Having one coordinated system for all resident information would better serve both residents and providers by making complete medical and behavioral health records available to providers as necessary. In addition, this function would facilitate robust data collection by gathering input from providers, hospitals, and others who may interact with a resident as well as by providing a much more detailed and rich resident history that can be used to improve care. This ability to share information would also facilitate better communication among ACH staff and community providers who serve ACH residents. For these reasons, the ACH industry has already begun a collaboration with Viebridge Inc. to develop an online screening and assessment tool, ACHieve, to better meet the needs of ACHs and their residents.[8]

ACHieve: A Potential Screening Tool for Adult Care Homes

ACHieve is an online data system, designed and developed by a consortium of ACH providers facilitated by the North Carolina Association, Long-Term Care Facilities (NCALTCF), to improve resident care and to strengthen ACH provider capacities through the collection and use of standardized data about resident conditions, service provision, and outcomes.[8] Currently, ACHieve includes assessment and care management components, as well as a number of other functions that help in the care and management of residents of ACHs. ACHieve has many other management functions that help in the daily operations of the facility, as well as modules for staff education and support. Also, ACHieve has the ability to become a long-term case management tool for ACHs. ACHieve allows ACH staff to input information about a resident's medical and psychosocial needs as well as a resident's history of care and services received.

For example, previous hospital admissions or incarcerations would be included. Medical conditions would be listed, as would psychotropic medications the resident is currently receiving or has previously taken. The long-term plan for the Medicaid 1915(i) option previously discussed includes plans to expand, to pilot, and to implement ACHieve for all ACHs.[7]

This test version of ACHieve has been developed, but in order to meet the needs of the state, the LMEs, the service providers, and the hospitals, a more robust version would need to be developed, piloted, and implemented.[8] In addition to meeting the goals of ACHs, an integrated, online data portal would meet many state and local needs as well as would improve resident care coordination between ACHs, service providers, hospitals, and others who may provide service or supports for individuals in ACHs. Implementation of ACHieve would support state and county oversight and monitoring, provide much needed data about the needs of residents and ways those needs are being met, support implementation of new payment methodologies (see Recommendation 4.3), and provide a means to improve the coordination and use of services and supports. Because ACHieve is an online data system, users can access the system as long as they have an Internet connection. The program can be set up to allow community providers, payers, and others who work with or manage the care of residents in ACHs the ability to input data or to see select parts of a resident's profile.

Overall, a more thorough and uniform system for screening, assessing, and care planning for individuals in the ACH system would help prevent inappropriate placement, ensure that facilities were knowledgeable about the care needs of prospective residents and better prepared to provide necessary care to residents, and ensure that other appropriate agencies or organizations were included in the care planning process. Better screening could also help reduce the number of resident discharges to other facilities, such as hospitals or jails, caused by inappropriate placement. Obtaining information about the person's acuity level and needs for services and supports could also help the state in developing a case-mix payment whereby facilities receive higher payments for individuals with more complex medical, functional, and psychosocial needs (see Recommendation 4.3.) Finally, a uniform system will provide much real-time and necessary data about the needs of residents of ACHs, the care planning for residents, the specific services residents are using, and the outcomes for residents. In addition, this information could be used to determine the training needs of staff, occupancy rates by resident needs, and overall resident needs, all of which could help the state and county agencies tasked with overseeing ACHs and developing the rules and regulations that govern them. Therefore, the Task Force recommends:

Recommendation 4.1: Requiring Standardized Preadmission Screening, Level of Services, and Assessment Instruments in Adult and Family Care Homes and 122C Facilities (PRIORITY RECOMMENDATION)

a) The North Carolina General Assembly should direct the Department of Health and Human Services (DHHS) to require adult care homes and family care homes (ACH), and 122C mental health, developmental disability, and substance abuse group homes (122C) to use standardized preadmission screenings, level of services determinations, assessments and care planning instruments. DHHS can designate different instruments for different types of licensed facilities, regardless of payment source.

b) For adult and family care homes:

1) The screening, assessment and care planning process should be redesigned:

i. The level of services preadmission screening tool should be revised to replace the current FL-2. The tool should be automated and should capture information on diagnosis (including, but not limited to, physical condition, mental health, substance use disorders, cognitive impairments, intellectual and other disabilities, and other health conditions), functional capacity with activities of daily living and instrumental activities of daily living, need for supervision and medication supervision, and conditions that could pose a threat to the health or safety of self or others.

ii. Individuals who have been identified as having a mental health problem, substance use disorder, cognitive impairment, or intellectual and other disability as part of the level of services preadmission screen should receive a more complete independent screening assessment by a trained mental health, substance abuse, or developmental disability professional. DHHS should develop a system to ensure that individuals who cannot be appropriately served in an adult care home are provided other appropriate housing and/or treatment options, and that all individuals with mental health problems, intellectual and developmental disabilities, or addiction disorders are provided appropriate supports and services designed to maximize their independence.

iii. Once a resident is admitted, facilities should be required to administer standardized care planning assessment instruments (as identified by DHHS) to obtain more detailed information that can be used in developing a person-centered care plan.

iv. **DHHS should develop appropriate time standards to conduct the screening and assessment to ensure that admissions to ACHs are not being unreasonably delayed by this two-level screening process.**

v. **Existing residents of adult and family care homes should all receive screening, assessment, and care planning following this new process within one year of implementation of the new process.**

c) **The instruments may be different for different types of facilities, but the data collected in the instruments should be consistent across types of settings and should be automated. The data collected as part of the level of services preadmission screening and assessment instruments should be consistent with existing data collection efforts. Data collected should include demographic characteristics; diagnoses; and physical health, mental health, substance use, and cognitive and behavioral functioning of the different populations housed in ACHs and 122Cs, regardless of payer source. This information should be available and accessible to DHHS as well as shared with other state and local entities, including but not limited to the Division of Aging and Adult Services, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the Division of Health Service Regulation, Local Management Entities, the Department of Social Services, and local Divisions of Social Services.**

d) **The North Carolina General Assembly should appropriate $900,000 in recurring funds in state fiscal year (SFY) 2012, $228,000 in non-recurring funds in SFY 2012, and $205,000 in non-recurring funds in SFY 2013[e] to DHHS to support the implementation of the automated level of services preadmission screen, assessment instrument, and prior approval for people seeking admission to ACH and 122C facilities.**

e) **DHHS should report annually to appropriate legislative committees that address the needs of older adults or of people with mental illness, intellectual and developmental disabilities, or addiction disorders on the data gathered about needs identified in the level I and level II screenings, placement of individuals with disabilities, and outcomes for individuals with disabilities living in ACHs.**

As discussed, for this recommendation to work, ACHs and LMEs need to understand one another's mission and roles. In fact, the Task Force believes that having such an understanding is important regardless of whether Recommendation 4.1 is implemented, because barriers to the care of individuals with disabilities develop from the current lack of understanding. Concerted efforts by both entities would improve delivery to consumers of behavioral health services who live in ACHs. Therefore, the Task Force recommends:

e Cost estimates from the Division of Medical Assistance, North Carolina Department of Health and Human Services. Walton, J. Waiver Development Chief, Division of Medical Assistance, North Carolina Department of Health & Human Services. Written (email) communication December 17, 2010.

Recommendation 4.2: Local Management Entity Outreach and Education for Adult and Family Care Home Staff

a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should require local management entities (LME) to hold an informational forum at least twice a year for staff of adult and family care homes (ACH) and geriatric adult specialty teams (GASTs). The LME forum should help ACH and GAST staff understand the LME's purpose and function, as well as the resources and services accessible through the LME, including crisis services. In addition, the forum should provide the opportunity for LME staff to learn about the types of clients served in community facilities and the concerns of community facilities. These forums should facilitate linkages between adult care homes, family care homes, LMEs, mobile crisis teams, geriatric adult specialty teams, and other appropriate community agencies to ensure that the physical health, mental health, substance abuse, and cognitive and behavioral needs of the clients with behavioral problems can be appropriately addressed.

b) The Division of Health Service Regulation should encourage all supervisors and managers in adult care homes and family care homes to attend at least one LME forum.

Case-Mix Adjusted Payments

In addition to benefitting both residents and ACHs, the implementation of an automated, validated assessment instrument to capture more detailed information about an individual's underlying health, mental health, and addiction disorders, the level of their functional abilities and need for services and supports, and the extent to which the person manifests inappropriate behaviors that pose a threat to themselves or others would help the state create a tiered funding system, or case-mix adjusted payments, for individuals in AHCs and 122Cs. Tiered payment or case-mix adjustment systems help to more closely align the level of funding to the needs of the residents. Facilities that serve a higher proportion of high-need individuals would receive higher payments, and those that serve a resident population with fewer needs for services and supports would receive lower payments. Currently, Medicaid uses a similar system to pay nursing homes. Not only would this type of payment system help ensure that payments to ACHs and 122Cs more accurately reflect the actual needs of their residents, but also this system would encourage 122C treatment facilities to provide services and supports to those who have the highest need for services and supports (thus potentially expanding the array of placement options for people with the most significant mental health problems,

developmental disabilities, or addiction disorders). Creating such a system is a complex undertaking, but one that the Task Force feels would benefit both residents and facilities by ensuring that payments more accurately reflect the needs of the population being served. Therefore the Task Force recommends:

Recommendation 4.3: Case-Mix Adjusted Payments

The North Carolina Department of Health and Human Services should use the information obtained from validated assessment instruments to develop case-mix adjusted payments for adult and family care homes and 122C facilities. Payments should be adjusted on the basis of the acuity of a person's needs for services and supports, and this basis should include, but not be limited to, the following:

a) **The person's underlying physical health, mental health, intellectual and other developmental disability, substance use disorder, or cognitive impairment.**

b) **The level of a person's functional abilities including their ability to communicate, perform activities of daily living and instrumental activities of daily living, and their need for supervision and medication administration.**

c) **The extent to which a person manifests inappropriate verbal, sexual, or physical behaviors that can pose a threat to self or others.**

References

1. Substance Abuse and Mental Health Services Administration. Mental health: a report of the Surgeon General. US Public Health Service; 1999. http://www.surgeongeneral.gov/library/mentalhealth/home.html. Accessed September 22, 2010.

2. Division of Medical Assistance. North Carolina Medicaid Program mental retardation services. North Carolina Department of Health and Human Services. http://info.dhhs.state.nc.us.libproxy.lib.unc.edu/olm/manuals/dma/abd/man/MA2280f4b.pdf. Accessed March 3, 2010.

3. North Carolina Department of Health and Human Services. Adult Medicaid Manual MA-2770 Long-term care need and budgeting. November 2007. http://info.dhhs.state.nc.us/olm/manuals/dma/abd/man/MA2270-01.htm. Accessed December 14, 2010.

4. Division of Medical Assistance. Adult care home personal care physician authorization and care plan. North Carolina Department of Health and Human Services. http://info.dhhs.state.nc.us/olm/forms/dma/dma-3050r.pdf. Accessed December 14, 2010.

5. Division of Mental Health, Developmental Disabilities and Substance Abuse Services. LMEs by county. North Carolina Department of Health and Human Services. http://www.ncdhhs.gov/mhddsas/lmedirectory.htm. Accessed December 14, 2010.

6. Holliman E. The relationship between LMEs and adult and family care homes. Presented to: North Carolina Institute of Medicine Task Force on the Co-Location of Different Populations in Adult Care Homes; May 5, 2010; Morrisville, NC.

7. Larson T. Medicaid funding and adult and family care homes. Presented to: North Carolina Institute of Medicine Task Force on the Co-Location of Different Populations in Adult Care Homes; October 4, 2010; Morrisville, NC.

8. Ackman A. ACHieve: a proposed web service model to enhance quality of service in adult care homes. Presented to: North Carolina Institute of Medicine Task Force on the Co-Location of Different Populations in Adult Care Homes; March 3, 2010; Morrisville, NC.