

# Short- and Long-Term Solutions for Co-Location in Adult and Family Care Homes:

A Report of the NCIOM Task Force on the Co-Location of Different Populations in Adult Care Homes

January 2011

**North Carolina  
Institute of Medicine**

A report requested by the  
North Carolina General Assembly

Supported by funding from the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Abuse Services through the North Carolina Substance Abuse Prevention and Treatment Block Grant from the Substance Abuse & Mental Health Services Administration





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## North Carolina Institute of Medicine

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The North Carolina Institute of Medicine (NCIOM) is a nonpolitical source of analysis and advice on important health issues facing the state. The NCIOM convenes stakeholders and other interested people from across the state to study these complex issues and develop workable solutions to improve health, health care access, and quality of health care in North Carolina.

The full text of this report is available online at <http://www.nciom.org>

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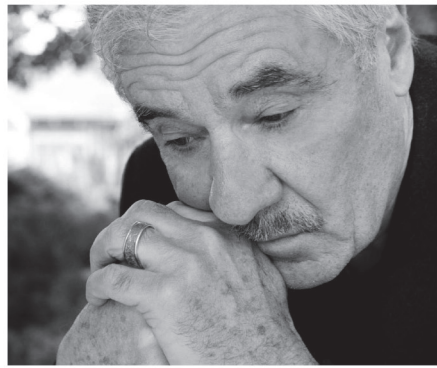
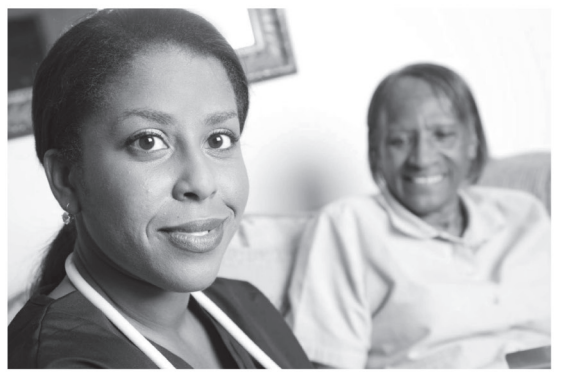
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# Table of Contents

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<i>Acknowledgements</i> .....	<b>5</b>
<i>Task Force Members</i> .....	<b>7</b>
<i>Executive Summary</i> .....	<b>11</b>
Chapter 1: Introduction .....	<b>19</b>
Chapter 2: Understanding Co-Location.....	<b>23</b>
Chapter 3: Increasing Options for Individuals with Disabilities .....	<b>31</b>
Chapter 4: Restructuring the Current System.....	<b>43</b>
Chapter 5: Training Requirements for Adult Care Homes and 122C Facilities .....	<b>57</b>
Chapter 6: Conclusion .....	<b>69</b>
<i>Appendix A: Full Recommendations of the Task Force on the Co-Location of Adult Care Homes</i> .....	<b>75</b>
<i>Appendix B: FL-2 Screening Form</i> .....	<b>83</b>
<i>Appendix C: MR2 Screening Form</i> .....	<b>85</b>
<i>Appendix D: North Carolina PASARR Level I Screen</i> .....	<b>87</b>
<i>Appendix E: Resident Register</i> .....	<b>89</b>
<i>Appendix F: DMA 3050-R</i> .....	<b>93</b>
<i>Appendix G: Comparison of Nurse Aide I Training and Competency Evaluation to Direct Care Support Worker</i> .....	<b>99</b>





# Acknowledgements

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The North Carolina Institute of Medicine's (NCIOM) Task Force on the Co-Location of Different Populations in Adult Care Homes was created at the request of the North Carolina General Assembly in 2009. The North Carolina General Assembly directed the NCIOM to study the co-location of the frail elderly with individuals with disabilities who may have behavioral problems in adult care homes and to present the final report and recommendations to the 2011 General Assembly. The Task Force on the Co-Location of Different Populations in Adult Care Homes was chaired by Maria Spaulding, Deputy Secretary for Long-Term Care and Family Services, North Carolina Department of Health and Human Services; Representative Jean Farmer-Butterfield, North Carolina General Assembly; and Senator John Snow, North Carolina General Assembly. There were 35 additional Task Force members including legislators, state and local agency officials, adult and family care home representatives, consumer representatives, and other interested people. Task Force members dedicated approximately one day a month between February and December of 2010 to study this important issue. Another six individuals participated in the Task Force's work as Steering Committee members. The Steering Committee members helped shape the meeting agendas and identify speakers and gave important input into the report and recommendations. The accomplishments of this Task Force would not have been possible without the combined effort of the Task Force and Steering Committee members. For a complete list of Task Force and Steering Committee members, please see pages 7-9 of this report.

The NCIOM Task Force on the Co-Location of Different Populations in Adult Care Homes heard presentations from state and national experts on issues related to the co-location of different populations in adult care homes, North Carolina's assisted living system, and providing options for individuals with disabilities. We would like to thank the following people for sharing their expertise and experiences with the Task Force: Alan Ackman, VieBridge, Inc.; Doug Barrick, Policy Coordinator, Division of Health Service Regulation, North Carolina Department of Health and Human Services; Cathie Beatty, MSW, Social Work Supervisor, Buncombe County DSS; Julie Budzinski, MA, Medicaid Program Services Chief, Adult Care Homes, Home and Community Care Section, Division of Medical Assistance, North Carolina Department of Health and Human Services; Kenny Burrow, MS, Member, North Carolina Association of Long Term Care Facilities; Margaret Comin, RN, BSN, MPA, Facility Services Unit Manager, Facility and Community Care Section, Division of Medical Assistance, North Carolina Department of Health and Human Services; Michiele Elliott, Eastern Branch Manager, Mental Health Licensure and Certification Section, Division of Health Service Regulation, North Carolina Department of Health and Human Services; Chris Estes, Executive Director, North Carolina Housing Coalition; Jesse Goodman, Acting Chief Operating Officer, Division of Health Service Regulation, North Carolina Department of Health and Human Services; Angela Harper, Housing Specialist,

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In addition to the above individuals, the staff of the North Carolina Institute of Medicine contributed to the Task Force's study and the development of this report. Pam Silberman, JD, DrPH, President and CEO guided the work of the Task Force. Berkeley Yorkery, MPP, Project Director, served as project director for the Task Force and greatly contributed to the report. Interns Crystal Bowe, MD; Lindsey Haynes, MHA; and Lauren Short, MSPH candidate also contributed to the report. Thalia Fuller, Administrative Assistant, assisted in coordination of Task Force meetings. Adrienne Parker, Director of Administrative Operations, handled the business operations of the Task Force.



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# Executive Summary

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**A**lthough most people think of North Carolina’s adult and family care homes (ACH) as residents for the frail elderly, more than 60% of residents have a mental illness, intellectual or developmental disabilities, or Alzheimer disease/dementia diagnosis.<sup>1</sup> The placement of individuals with mental illness, substance abuse problems, intellectual and developmental disabilities, and other disabilities<sup>a</sup> that may result in serious behavioral problems in ACHs can pose a threat to the health and safety of other residents, especially the frail elderly, other people with disabilities, and staff. Problems reported in North Carolina ACH over the past five years have included physical harm, sexual assault, and verbal and psychological abuse.<sup>b,2</sup>

Individuals with disabilities often require services and supports in their daily lives. Most individuals with disabilities live on very limited incomes and need assistance with daily activities. Due to a shortage of more appropriate community options for individuals with disabilities and the financial incentives embedded in the system, many individuals with disabilities move into ACHs to gain access to needed supports.<sup>3</sup> Today ACHs serve more than 18,000 individuals with disabilities by providing a place to live, assistance with activities of daily living (i.e. dressing, cooking, eating), and medication management.<sup>1</sup> In doing so, ACH have become a critical part of North Carolina’s mental health, developmental disability and substance abuse system. Without substantial increases in community alternatives for individuals with disabilities this population will continue to constitute a large portion of the adult and family care home population.

To address these issues, the North Carolina General Assembly asked the North Carolina Institute of Medicine to convene a task force to study the co-location of the frail elderly with individuals with disabilities who may have behavioral problems in adult care homes. The Task Force on the Co-Location of Different Populations in Adult Care Homes was chaired by Maria Spaulding, Deputy Secretary for Long-Term Care and Family Services, North Carolina Department of Health and Human Services; Representative Jean Farmer-Butterfield, North Carolina General Assembly; and Senator John Snow, North Carolina General Assembly. There were 41 additional Task Force and Steering Committee members. The Task Force developed nine recommendations including recommendations to improve and strengthen the current system as well as recommendations to increase housing and support options for people with disabilities so they can live more independently. Two recommendations were designated as priority recommendations.

**More than 60% of residents of adult and family care homes have a mental illness, intellectual or developmental disabilities, or Alzheimer disease/dementia diagnosis.**

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a Individuals with mental illness, substance abuse problems, intellectual and developmental disabilities, and other disabilities are referred to collectively as individuals with disabilities throughout this report.

b Ryan B. Chief, Adult Care Licensure Section, Division of Health Service Regulation, North Carolina Department of Health and Human Services. Written (email) communication. April 20,2010.

**The placement of [individuals with disabilities] that may result in serious behavioral problems in ACHs can pose a threat to the health and safety of other residents, and staff.**

### **Improving the Current System While Maintaining a Long-Term Vision of Prevention**

The problems of co-location could be prevented if individuals with disabilities and the frail elderly were not housed together in ACHs. While ACHs may be suitable residences for the frail elderly, they may be insufficient to meet the needs of other individuals with disabilities who also have behavioral problems. Currently, many individuals with disabilities have few other viable options if they need housing and support services. To address this problem, the Task Force's recommendations had both long-term and short-term goals.

Over the long term, the Task Force recommended expansion of housing and support services to enable people with disabilities to live more independently in their communities. However, developing appropriate housing assistance programs and expanding the array of community-based services and supports will take time. Thus, the Task Force also developed shorter-term recommendations to improve the ability of ACHs to handle the co-located populations. Although the recommendations are discussed individually, it is important to consider them as a whole to understand the Task Force's vision. While each recommendation is an important piece to fixing the problem of co-location of different populations in ACHs, taken as a whole they represent a plan that would improve residents' experiences in ACHs today and prevent the problems associated with co-location in the future. Additionally, given the challenges facing North Carolina's mental health system and state budget, the Task Force recognized that changes requiring major new investments are not likely in the immediate future. Therefore, the Task Force focused not only on what needs to be done, but also how modest investments and reallocations of existing funds could be used to achieve these goals.

### **Providing Choices**

Ideally the Task Force would like to see individuals with disabilities, particularly those ages 18-64, provided with a range of options for living independently in their community with care and support services aimed at recovery and self-sufficiency. North Carolina does not have the right mix of affordable supports in place to ensure that individuals with disabilities have the opportunity to live in housing that is integrated into the community and promotes their maximum independence, as recommended by the U.S. Surgeon General and the U.S. Department of Health and Human Services.<sup>4,5</sup>

Making funding for housing more flexible, developing more subsidized housing for individuals with disabilities, and greatly increasing community-based services and supports are all critical to ensuring that individuals with disabilities have choices about where they live and the kinds of services and supports they receive. Developing such options on the scale needed to meet the need will take considerable time and sustained investment in the mental health system, particularly community-based services and supports. However, such investments are critical to ensuring that individuals with disabilities have



a range of appropriate options for housing, supports, and services. Therefore, the Task Force recommends:

### **Recommendation 3.1: Pilot Program (PRIORITY RECOMMENDATION)**

The North Carolina Department of Health and Human Services (DHHS) should develop a pilot program to evaluate the costs, quality, consumer satisfaction, and patient outcomes of a program that supports individuals who would otherwise be in an adult or family care home and who want to move into independent supported housing.

### **Recommendation 3.2: Increase Funding for Housing for Individuals with Disabilities**

To help individuals with disabilities better afford housing, the North Carolina General Assembly should appropriate \$10 million in additional recurring funding beginning in state fiscal year 2011 to the North Carolina Housing Finance Agency to increase funding to the North Carolina Housing Trust Fund. A significant portion of the funding should be targeted for housing for individuals with disabilities. The North Carolina Department of Health and Human Services should work with the Housing Finance Agency to explore options to create transitional housing for people who need short-term stabilization options to help them make a transition to more independent living in the community.

### **Recommendation 3.3: Create an Inventory of Community Housing Options for Individuals with Disabilities**

Local management entities should develop a real-time inventory of community housing options including 122C therapeutic mental health, substance abuse and developmental disability group homes, adult and family care homes, supported living arrangements, and independent living options, and make this inventory available to families.

#### **Improving the Current System**

In addition to increasing options for individuals with disabilities, North Carolina must also work to ensure ACHs are better prepared to meet the needs of individuals with disabilities who currently reside in ACHs. With more than 18,000 individuals with disabilities currently living in ACHs and few community alternatives available, individuals with disabilities will continue to enter ACHs.<sup>1</sup> The current ACH system does not have adequate screening, assessment, care planning procedures, and staff training requirements in place to ensure ACHs

can meet the needs of those entering their facilities. To better serve individuals with disabilities, as well as ensure the safety of staff and other residents, North Carolina needs to update the rules and regulations governing ACHs.

Thorough screening, assessment, and care planning tools are critical to ensuring that individuals can be appropriately cared for in any type of assisted living arrangement. The lack of information on the screening, assessment, and care planning tools currently used in North Carolina's ACHs do a disservice to both facilities and residents. Increasing the type and quality of information gathered would help prevent inappropriate placement, assure facilities were knowledgeable about the care needs of prospective residents and better prepared to provide necessary services to residents, and ensure that other appropriate agencies or organizations are included in the care planning process. All of these elements are critical to ensuring successful placements and the safety of residents and staff. To meet these goals, 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)**

The North Carolina General Assembly should direct the Department of Health and Human Services to require adult care homes and family care homes, and 122C mental health, developmental disability, and substance abuse group homes to use standardized preadmission screenings, level of services determinations, assessments and care planning instruments.

### **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.

In addition to system changes, improving the current system of care for individuals with disabilities in ACHs will require better coordination between the ACHs that house and care for individuals with disabilities and local management entities (LMEs), the local agencies charged with managing, coordinating, and facilitating the provision of mental health, developmental disabilities, and substance abuse services for residents in their area.<sup>6</sup> The current lack of understanding between ACHs and LMEs often prevents them from working together. 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. To help improve the relationship between ACHs and LMEs, the Task Force recommends:

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

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.

#### **Increasing Staff Training on How to Interact with Individuals with Disabilities**

Due to their history and perception as providing care to the frail elderly, the training requirements for staff of ACH include little, if any, training on working with individuals with disabilities. As the majority of residents in ACHs have a mental health, intellectual or developmental disorder, or Alzheimer disease/dementia diagnosis, there is a need to train staff to more effectively work with individuals with disabilities. While not all individuals with these diagnoses manifest inappropriate behavioral problems, many of them do exhibit aggressive or combative behaviors that pose a threat to the safety of other residents and staff.<sup>4</sup> Such behavioral problems can often be safely managed by well-trained staff. Unfortunately, workers in ACHs are not required to receive specific training in managing individuals with behavioral problems, such as de-escalation skills during a crisis. This lack of formal training for staff contributes to the safety risks associated with co-locating older individuals with personal care needs with individuals who manifest aggressive or combative behaviors. To improve the training of ACH staff, the Task Force recommends:

### **Recommendation 5.1: Use Geriatric/Adult Mental Health Specialty Teams to Provide Training in all ACHs**

NCGA should enact legislation to require all adult and family care homes to receive geriatric/adult mental health specialty teams training at least three times per year. The training should be tailored to the needs of the specific ACH but should, at a minimum, cover person-centered thinking and de-escalation skills.

## **Recommendation 5.2: Require Adult and Family Care Home Staff to Be Trained and to Exhibit Competency in Person-Centered Thinking and Crisis Prevention**

The North Carolina General Assembly should require all adult and family care home direct care workers, personal care aides, medication aides, and supervisors to be trained and to have passed the competency exam for state-approved crisis intervention training by June 2013.

In September 2010, North Carolina was awarded a three year federal Personal and Home Care Aide State Training Program (PHCAST) grant to develop, pilot test, implement, and evaluate the impact of a comprehensive training and competency program for direct care workers. As part of this work, the Task Force recommends:

## **Recommendation 5.3: Pilot New Behavioral Health Training and Competency Examination Requirements for New Direct Care Workers**

The North Carolina Division of Health Service Regulation, in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the Division of Medical Assistance, should develop a standardized curriculum and competency test for new direct care workers as part of the federal Personal and Home Care Aide State Training Program grant.

The current practice of co-locating the frail elderly and others with disabilities with individuals who have behavioral problems poses a threat to the safety of residents and staff of ACHs. Improving North Carolina's current ACH system and making changes to the overall mental health system so that individuals with disabilities have a range of options—from facility-based care for those who need it to living independently in their community with care and support services—are critical to improving the care and well-being of some of our most vulnerable citizens. The recommendations in this report provide a roadmap both to addressing the challenges associated with co-location in ACHs and to increasing the options available to individuals with disabilities which would reduce co-location in ACHs in the long-run. Implementing these recommendations would improve the safety and well-being of residents and staff of ACHs as well as individuals with disabilities in North Carolina.

# Executive Summary

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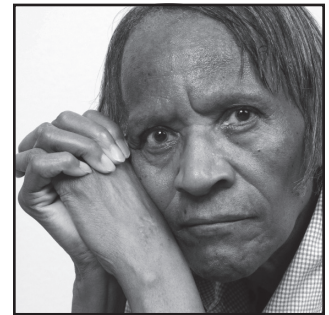




**I**n North Carolina, more than 28,000 people live in adult or family care homes (ACH). The purpose of ACHs is to provide the frail elderly and people who have a temporary or chronic physical condition or mental disability with a place to live, supervision, and assistance with personal care needs.<sup>a</sup> ACHs do not provide *treatment* for mental illness or alcohol and drug abuse, and regulations specify that individuals who pose a *direct* threat to the health and safety of others should not to be admitted as residents of ACHs.<sup>b</sup> Data collected by the Division of Health Services Regulation suggest that more than 60% of all residents in ACHs had a primary diagnosis of mental illness, intellectual and developmental disabilities, or Alzheimer disease/dementia in 2009.<sup>1</sup> The placement of individuals with mental illness, substance abuse problems, intellectual and developmental disabilities, and other disabilities<sup>c</sup> that may result in serious behavioral problems can pose a threat to the health and safety of other residents, especially the frail elderly, and the staff of ACHs. Problems may include physical harm, sexual assault, and verbal and psychological abuse.

The precursors to ACHs—boarding homes, rest homes, and convalescent homes—formally began caring for “aged or mentally or physically infirm” in 1945.<sup>d</sup> The primary purpose of these residences was to provide personal care and not “medical care or diagnostic treatment.”<sup>2</sup> The population of individuals with disabilities has increased during the past 60 years as the care of these individuals has shifted from large state hospitals to the local community. Since this practice began, the approach to housing and providing services for individuals with disabilities has evolved. Today, best practice research in this field has demonstrated that living in one’s home community in affordable, supportive housing and receiving community-based support services is the best option for most individuals with disabilities.<sup>3</sup>

Although ACHs may be suitable residences for the frail elderly, they may be insufficient to meet the needs of other individuals with disabilities that may result in behavioral problems. Because of a shortage of more appropriate community alternatives for these individuals and because of financial incentives embedded in the system, these individuals continue to be placed in ACHs even when their wishes or needs could be better supported in their community. Without substantial increases in community alternatives for individuals with disabilities, this population will continue to constitute a large portion of the ACH population. In addition to the concerns raised by housing these individuals in homes that may not be designed to care for their needs, the co-location of older individuals who have personal care needs with individuals who may have behavioral problems poses a safety risk to staff and residents.<sup>4</sup>



**Although ACHs may be suitable residences for the frail elderly, they may be insufficient to meet the needs of other individuals with disabilities that may result in behavioral problems.**

a G. S. 131D-10.10, 10 NCAC 13F.0701, and 10NCAC 13G.0701

b 10 NCAC 13F.0701 and 10 NCAC 13G.0701

c Individuals with mental illness, substance abuse problems, intellectual and developmental disabilities, and other disabilities are referred to collectively as individuals with disabilities throughout this report.

d G.S. 108-3 (1945)

**The primary charge to the Task Force was to examine the problems that can be created by the co-location of people with behavioral problems with the frail elderly or other people with disabilities.**

In 2009, the North Carolina General Assembly asked the North Carolina Institute of Medicine (NCIOM) to convene a Task Force to study the co-location in ACHs of the frail elderly with individuals with disabilities who may have behavioral problems. The Task Force on the Co-Location of Different Populations in Adult Care Homes was chaired by Maria Spaulding, Deputy Secretary for Long-Term Care and Family Services, North Carolina Department of Health and Human Services; Representative Jean Farmer-Butterfield, North Carolina General Assembly; and Senator John Snow, North Carolina General Assembly. There were 41 additional Task Force and Steering Committee members. The Task Force on the Co-Location of Different Populations in Adult Care Homes was supported by funding from the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Abuse Services through the North Carolina Substance Abuse Prevention and Treatment Block Grant from the Substance Abuse & Mental Health Services Administration.

In examining the co-location of different populations in ACHs, the NCIOM was asked to consider:

1. The problems created by the co-location of different populations in ACHs.
2. Ways to appropriately identify/screen people for behavioral health problems.
3. The training of ACH staff.
4. Other options to ensure that people with mental illness, those with behavioral health problems, the frail elderly, and others with disabilities are receiving appropriate care.

The Task Force initially focused on people with mental illness, substance abuse problems, or intellectual and developmental disabilities who also display behavioral problems (including physical, verbal, or sexual behaviors that can cause harm to themselves or others). The Task Force recognized that not every person with disabilities acts in ways that can create a threat to themselves, other residents, or staff. The primary charge to the Task Force was to examine the problems that can be created by the co-location of people with behavioral problems—whatever the underlying cause—with the frail elderly or other people with disabilities. However, in exploring this issue, the Task Force necessarily was faced with the larger question of how to best provide services to all individuals with disabilities who currently reside in ACHs. In their work, the Task Force focused on system issues, such as housing options that are available to individuals with disabilities, placement and care coordination, staff training, system functionality, and financing. The Task Force did not focus on the infrastructure of ACHs (e.g., buildings, room size, or number of individuals per room) or on the internal workings of ACHs (e.g., the way that meals are provided, residents' ability to structure their own days, or transportation options).

The Task Force was asked specifically to focus on the issue of co-location, which led to a major examination of whether ACHs meet the needs of individuals with disabilities. Although the discussion often addressed ACHs, such homes are part of a larger system that has failed to provide adequate options and supports for individuals with disabilities. For many decades, ACHs have stepped in to provide housing and basic support services for individuals with disabilities who have no other housing and support options. The Task Force does not wish to diminish in any way the valuable role that ACHs have played for individuals with disabilities. However, best practices for providing supports and services for individuals with disabilities have evolved, and North Carolina's system for individuals with disabilities needs to evolve to reflect best practices.

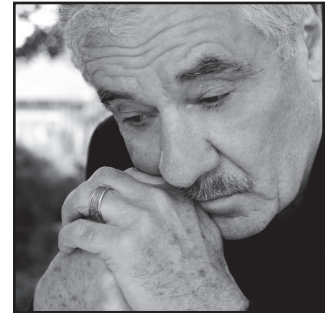
It will take time to provide individuals with disabilities real choices about where they live and the types of supports they can access. Therefore, the Task Force's recommendations had two goals: in the short term, to improve the ability of ACHs to appropriately serve these co-located populations; and in the long term, to provide more viable options to live in their home communities for people with disabilities whose needs are not met by ACHs, thus preventing co-location. The Task Force developed nine recommendations, with two designated as priorities: improving and strengthening ACHs, and expanding options for affordable housing and ways and places to access services and supports for individuals with disabilities.

**The Task Force's recommendations had two goals: to improve the ability of ACHs to appropriately serve these co-located populations and, in the long term, to expand the array of housing and support services for people with disabilities.**

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**N**orth Carolina's adult and family care homes (ACH)<sup>a</sup> provide lodging and personal care services for more than 18,000 individuals with mental illness, intellectual and developmental disabilities, or Alzheimer disease/dementia.<sup>b</sup> In 2009, these individuals accounted for 64% of all residents in ACHs and more than 75% of residents aged 18 to 64 years.<sup>1</sup> Although ACHs are often thought of as providing care for the frail elderly, they have become a critical part of the mental health system by providing housing and personal care services to large numbers of individuals with disabilities, many of whom do not have other housing and support service options.



## Deinstitutionalization and the Move to Community-Based Services and Supports

Before the 1970s, most individuals with mental illness, substance abuse problems, intellectual and developmental disabilities, or other disabilities (referred to collectively as individuals with disabilities in this report) received services in large residential institutional settings or lived with their families with very little support from the government. This began to change as advocates, families, and individuals with disabilities began to challenge the idea that people with disabilities could receive services only in large congregate settings. States began to move people out of large, state-run residential facilities and into more community-based settings. The federal government has supported this shift by providing funding options to support community-based care. In 1981, the federal government established home- and community-based services (HCBS) waivers, which augmented the services already covered by Medicaid.<sup>c</sup> These waivers gave states the option of offering more comprehensive home- and community-based services for individuals who would otherwise qualify for institutional services.<sup>2</sup> This shift was further supported by the case titled *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999).<sup>d</sup> The Supreme Court held in this case that states must offer community-based services for individuals with mental disabilities who might otherwise be institutionalized if their physician believes that community-based services are appropriate, the individuals do not object, and the services can be accommodated by the state. Although the ruling

**ACHs have become a critical part of the mental health system by providing housing and personal care services to large numbers of individuals with disabilities.**

a For the purposes of this report, unless otherwise specified, the abbreviation ACH will be used to refer to both adult and family care homes.

b The state collects data on the number of residents in adult care homes with a primary diagnosis of mental illness, intellectual or developmental disability, or Alzheimer disease/dementia. The state does not collect data on the number of people in adult care homes with a substance use disorder. For the purposes of this report, people with disabilities refers to anyone with either a mental health, intellectual or other developmental disability, or substance use disorder.

c See chapter 3 for a more detailed discussion of HCBS.

d The Court found that under certain circumstances, the unjustified institutionalization of people with disabilities could constitute unlawful discrimination under the Americans with Disabilities Act (ADA). Specifically, the Supreme Court held that “under Title II of the ADA, States are required to provide community-based treatment of persons with mental disabilities when the State’s treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the treatment can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.”



**Many individuals with disabilities move into ACHs to gain access to needed services and supports.**

does not explicitly address ACHs as an institutional setting, it emphasizes the belief that, in many cases, individuals with disabilities have the right to be treated in their home communities.

The Olmstead case spurred further mental health reforms in 2001 in North Carolina that called for closing many of the remaining centralized residential facilities. This move further increased the need for housing at the community level for individuals with disabilities. Caring for individuals in their home community in the least restrictive setting possible is the goal for most individuals aged 18 to 64 years who have disabilities. However, many individuals with disabilities do need some level of services and supports, and these supports are not always available to individuals living independently in their community. Because of a shortage of more appropriate community options for individuals with disabilities and the financial incentives embedded in the system, many individuals with disabilities move into ACHs to gain access to the needed services and supports<sup>3</sup> (see Chapter 3 for more details).

### **Pathways into Adult and Family Care Homes**

Residents come to live in ACHs in various ways: some move to ACHs directly from their own home or the home of a family member; others move into an ACH after spending time in a hospital, state psychiatric hospital, or community hospital psychiatric unit; a smaller number move into ACHs after spending time in prison or jail. Some residents decide which facility to move into on their own or with the help of family. In other cases, staff at the local department of social services (DSS), local management entity (LME), or hospital (if the individual is being discharged to an ACH directly from the hospital) help the individual or family find an appropriate placement.

### **The Role of Placement Workers**

Although everyone involved in the placement process would prefer to find a placement for each individual that can meet all of his or her needs, in reality placement decisions for individuals with disabilities are often a compromise. Finding a bed in a long-term care facility for an individual with disabilities can be quite difficult, depending on their diagnosis, care needs, and history. In looking for a placement for someone with long-term care needs, screening and assessment can help determine the most appropriate care setting (see Chapter 4 for more details).

Ideally, everyone would have a choice about where to live and would be placed only in an appropriate care setting. However, in reality, the availability of beds, willingness of facilities to take an individual, and timing all play into the decision. Because of differences in the number, size, and types of long-term care facilities in each county and region, the availability of beds in different types of long-term care facilities varies greatly by county and region. No private



residential facility—whether it is a nursing facility, 122C group home,<sup>e</sup> or ACH—is required to admit any individual into their facility. Thus, the willingness of facilities to take an individual is particularly influential when dealing with residents with high needs. Often the process to place an individual in a nursing home or 122C takes longer than the process to place an individual in an ACH (largely because of differences in rules and regulations around screening and assessment). Timing can play a major role when determining placement for individuals who need an immediate placement or who are in a medical facility waiting to be discharged. In addition, hospital discharge planners and others assisting individuals with placement decisions may not know about other available housing options. For these reasons and others discussed throughout the report, the Task Force heard from placement workers and others involved in the placement process that some people with significant behavioral difficulties are placed in ACHs even when another type of facility or a community-based placement might better suit the individual’s needs.

### **The Role of the Adult or Family Care Home**

ACHs vary in the ways that they decide to admit patients. Ideally, ACH staff would do a thorough screening before admission to determine the individual’s medical condition, mental health, and cognitive and physical functional abilities, as well as any behavioral problems the individual may exhibit. On the basis of the findings of this screening, the ACH would determine whether they could care for the potential resident. Some ACHs currently attempt to gather such information, but it is not always easy for ACHs to obtain all this information before placement. As described more fully in Chapter 4, the screening tool that ACHs are required to use before admission does not capture all the relevant information. Furthermore, people who are helping others find a placement may not know this information or may not be forthcoming about prospective residents with acute behavioral problems. In addition, the financial reality of operating an ACH requires that a certain percentage of a facility’s beds be occupied. In 2009, North Carolina’s ACH administrators reported an occupancy rate of approximately 65%.<sup>f1</sup> Thus, some facilities may decide to admit individuals whom they would not otherwise admit in order to maintain optimal occupancy.

**Placement decisions for individuals with disabilities are often a compromise.**

<sup>e</sup> 122C group homes are “24-hour facilities which provide residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals 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: North Carolina Institute of Medicine Task Force on the Co-Location of Different Populations in Adult Care Homes; March 3, 2010; Morrisville, NC.

<sup>f</sup> The 2009 Occupancy Rates for all HAL Facilities report from the North Carolina Department of Health and Human Services Office of the Controller found that adult care homes with 7 or more beds had an average occupancy rate of 79%.

**North Carolina has more than 1,200 ACHs that can provide lodging and personal care services for up to 40,000 residents.**

### The Population in Adult and Family Care Homes

North Carolina has more than 1,200 ACHs that can provide lodging and personal care services for up to 40,000 residents.<sup>g</sup> North Carolina's ACHs are assisted living facilities that are designed to "provide room, board, and care for more than two unrelated adults who, because of a temporary or chronic physical condition or mental disability, need a substitute home and the availability of 24-hour scheduled and unscheduled personal care services."<sup>4</sup> Personal care services that are provided include assistance with activities of daily living (e.g., dressing, bathing, toileting, eating, or moving from one place to another), help taking medications, or other health care-related needs. Adult care homes house seven or more residents, whereas family care homes provide a residential setting for two to six residents. It is important to note that ACHs are not a uniform group; the number of residents, mix of resident needs, ages, disabilities, location, and sources of financing vary tremendously across North Carolina.

Unfortunately, although the state collects some information on the number of people in ACHs who have a primary diagnosis of mental illness, intellectual and developmental disabilities (IDD), or Alzheimer disease/dementia, it does not specifically collect information on the number of people who exhibit inappropriate verbal, sexual, or physical behaviors that pose a threat to themselves or others. Therefore, the size of the population that this Task Force was most interested in, those individuals with disabilities who exhibit behavior problems, could not be determined. Instead, the numbers below reflect the size of the population that is at risk for behavioral problems because of their diagnosis.<sup>5-7</sup>

Basic data on the population in ACHs is collected through the annual license renewal process. When facilities complete the paperwork to renew the license, they must provide information on the demographic characteristics of residents in their facility (including information about the number of residents who have mental illness, IDD, or Alzheimer disease/dementia). In August of 2009, ACH administrators reported that more than 26,000 residents were living in adult care homes in North Carolina, and approximately 2,500 were living in family care homes.<sup>h,1</sup> Most residents in both adult and family care homes are older adults (age 65 or older). Of the 26,000 residents living in adult care homes in 2010, most (62.4%) had a mental illness, IDD, or Alzheimer disease/dementia.<sup>1</sup> Similarly, 80.4% of the residents in family care homes had one of these conditions<sup>1</sup> (see Table 2.1). As a general rule, older residents were more likely to have Alzheimer disease, whereas younger residents were more likely to have a mental illness. The state does not collect information on the number of residents with a primary diagnosis of substance use disorder.

<sup>g</sup> North Carolina's 1,258 adult and family care homes have beds for 40,098 residents; however, facilities are not full all the time. In December 2009, ACHs reported that approximately 35% of bed spaces were empty. Adult Care Licensure Section, Division of Health Service Regulation, North Carolina Department of Health and Human Services. Diagnosis Data by Age Groups 2009, 2010 License Renewal Application.

<sup>h</sup> Data come from the License Renewal forms completed by ACH administrators and submitted to the North Carolina DHHS.

**Table 2.1**  
Diverse Needs of Residents of Adult Care Homes and Family Care Homes (2010)

Characteristic	Adult Care Homes	Family Care Homes
<b>Total residents</b>	<b>26,040</b>	<b>2,535</b>
Total with mental illness, intellectual and developmental disability, or Alzheimer disease or dementia	16,272 (62.5%)	2,038 (80.4%)
Mental illness	6,435 (24.7%)	1,283 (50.6%)
Intellectual and other developmental disability	1,315 (5.0%)	444 (17.5%)
Alzheimer disease or dementia	8,522 (32.7%)	311 (12.3%)
<b>Residents aged 18-64 years</b>	<b>6,156 (23.6%)</b>	<b>1,490 (58.8%)</b>
Total with mental illness, intellectual and developmental disability, or Alzheimer disease or dementia	77.5%	85.1%
Mental illness	57.7%	62.9%
Intellectual and other developmental disability	13.5%	20.7%
Alzheimer disease or dementia	6.3%	1.5%
<b>Residents aged ≥65 years</b>	<b>19,884 (76.4%)</b>	<b>1,045 (41.2%)</b>
Total with mental illness, intellectual and developmental disability, or Alzheimer disease or dementia	57.8%	73.7%
Mental illness	14.5%	33.1%
Intellectual and other developmental disability	2.4%	12.9%
Alzheimer disease or dementia	40.9%	27.7%

Source: NCIOM analysis of Adult Care Licensure Section, Division of Health Service Regulation, North Carolina Department of Health and Human Services. Diagnosis Data by Age Groups 2009, 2010 License Renewal Application.

These data illustrate that although many people think that ACHs are primarily for the frail elderly, these homes provide care for a diverse population. Furthermore, many residents of ACHs have significant mental health, behavioral health, rehabilitative, or other needs in addition to their personal care needs.

### Co-Location Can Be a Problem

The Task Force tried, unsuccessfully, to get more information about residents and their needs to capture the extent of the problem of co-location of people with behavioral problems with the frail elderly or other people with disabilities. Documenting problems due to co-location of different populations is difficult. There are a number of systems that gather information, such as local law enforcement, the Division of Health Service Regulation (DHSR), the Ombudsman program, and DSS, that collect information about problems in ACHs, including problems related to co-location. However, these data sources

**The best solution to preventing the problems that can occur when these populations are co-located is to ensure that there are other viable options for individuals with disabilities in terms of their living arrangements and support services.**

are not linked and some, such as local law enforcement, cannot be aggregated in any way to show the prevalence of problems. Using a number of different data sources provides the best picture of the population in ACHs and the problems that arise from housing people with such diverse needs together.

One way to look at the types of problems that can occur is to review complaints against ACHs. Complaints, by residents, family members, guardians, or others, can be made to the complaint intake unit of a county DSS or the DHSR Complaint Intake Unit. This triggers an investigation by the county DSS. The county DSS may refer serious conditions that affect the quality of care or that place residents in danger to the Adult Care Licensure Section of the DHSR. Regional ombudsmen can assist residents with informal grievances mediation.<sup>i,4</sup>

When serious complaints are referred to the Adult Care Licensure Section of the DHSR, a complaint investigation takes place. The DHSR penalty records show that 64 of the serious violations resulting in penalties from 2006 to 2010 were related to problems of co-location. In the majority of cases (44 [69%]), an individual with mental health problems was unsupervised. In 12 (19%) of the 64 cases, an individual with mental health problems physically or sexually assaulted another resident; in 13 (20%) of the 64 cases, an individual with mental health problems harmed themselves, or the lack of supervision resulted in conditions that could have resulted in serious harm to the individual or other residents.<sup>j</sup>

Regional long-term care ombudsmen, professionals who advocate for residents in long-term care facilities, often help resolve less serious complaints. As a first step in resolving the complaint, the regional ombudsmen visits the resident in the ACH and then works with the resident, other representatives of the resident, and the facility to resolve the complaint. Ombudsman complaint records are not aggregated and are not reported in detail; however, a 2005 analysis showed that from 2003 to 2004 “adult care residents younger than 60 who had documented mental health problems generated more than 380 instances of criminal activities and violent, threatening, or inappropriate sexual acts.”<sup>8</sup>

### **Long- and Short-Term Solutions to Co-Location**

In considering the issue of co-locating different populations in adult care homes, the Task Force discussed both long- and short-term solutions. The best solution to preventing the problems that can occur when these populations are co-located is to ensure that there are other viable options for individuals with disabilities in terms of their living arrangements and support services (see Chapter 3). The Task Force would like to see individuals with disabilities provided with a range of options for living independently in their community with care and support services aimed at recovery and self-sufficiency, but they

<sup>i</sup> In 2009, the 17 regional ombudsmen assisted in resolving 1,661 complaints.

<sup>j</sup> Ryan B. Chief, Adult Care Licensure Section, Division of Health Service Regulation. Written (email) communication April 20, 2010.

recognize that this will take time. In order to meet some of the more immediate needs of the residents and staff of ACHs, the Task Force considered ways to restructure the current screening, assessment, and care planning process as well to ensure that staff of ACHs receive training about the populations they serve and their behavioral health needs (see Chapters 4 and 5). Although the recommendations are discussed individually, it is important to consider them as a whole to understand the Task Force's vision. Each recommendation is an important piece in fixing the problem of co-location of different populations in ACHs. Taken as a whole, they represent a collection of recommendations that could improve residents' experiences in ACHs today and prevent the problems associated with co-location in the future.

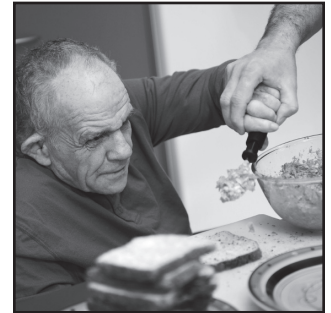
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# Increasing Options for Individuals with Disabilities

## Chapter 3



In looking at the issue of co-location in adult and family care homes (ACH), the Task Force found that large numbers of individuals with disabilities are being served in ACHs even though best practices research indicates that these individuals may be better served in different settings.<sup>1,2</sup> This led to a major focus on ways to increase the options for individuals with disabilities. By increasing options for these individuals, over time, fewer would be placed in ACHs, thus reducing the problems associated with co-location of individuals with disabilities, who may have behavior problems, and the frail elderly.

The long-term goal for individuals with disabilities, particularly those aged 18 to 64 years, should be recovery-oriented and habilitative care and supports so that individuals with disabilities can live and work in community settings of their choice.<sup>1,2</sup> A wider array of housing options and community-based services and supports is necessary to achieve this vision in North Carolina. To live successfully in communities of choice, individuals with disabilities often need clinical and personal care support services as well an array of appropriate housing and housing assistance options. Those with intense needs may need around-the-clock support or specialized medical/therapeutic services, whereas others may need services to assist in the development of skills of daily living.<sup>1</sup> This need for additional supports and services often limits an individual's choice of places to live. In North Carolina's current system, certain services and supports are not available in the community or are limited in their availability. Other types of services and supports are not financially viable options for individuals who wish to live on their own or with family members. North Carolina needs to develop more housing and community-based services options, so that individuals with disabilities have real choices in terms of where and with whom they live and the types of services and supports they choose to access. Increased availability of these appropriate options for individuals with disabilities could substantially alleviate the issue of co-location with the frail elderly. As stated earlier in the report, individuals with disabilities often end up, sometimes inappropriately, in ACHs because there is no place else for them to go.

In a January 14, 2000, letter to US governors, US Department of Health and Human Services Secretary Donna Shalala stated, "We can agree that no American should have to live in a nursing home or state institution if that individual can live in a community with the right mix of affordable supports."<sup>3</sup> Ten years later, North Carolina does not have the right mix of affordable supports in place to ensure that individuals with disabilities have the opportunity to live in housing that is integrated into the community and that promotes their maximum independence. As outlined by the Surgeon General, a comprehensive, effective service system includes "integrated community-based services, continuity of providers and treatments, family support services (including psychoeducation), and culturally sensitive services. Effective service delivery for individuals with the most severe conditions also requires supported housing and supported

**Large numbers of individuals with disabilities are being served in ACHs even though research indicates that these individuals may be better served in different settings.**

**A wider array of housing options and community-based services and supports is necessary.**

employment.”<sup>2,4</sup> The Task Force believes that this must be the long-term vision of North Carolina’s service system for all individuals with disabilities.

### North Carolina’s Institutional Bias

Although individuals with disabilities in theory have the option to live independently, funding for supports and services is more easily obtained by individuals living in facilities because many funding streams, services, and supports are bundled to the place the individual lives. Most people with disabilities are living on Supplemental Security Income (SSI); in 2010, SSI benefits were \$674 per month or \$8,088 per year.<sup>5</sup> SSI does not provide enough monthly income for individuals in most communities to purchase non-subsidized housing or support services. People who enter an ACH or other type of facility can obtain certain financial assistance, services, and supports that are not equally available to people with similar levels of disability and financial need who choose to remain in their own homes.

### Cost Comparison of State-County Special Assistance for Recipients in ACHs and in Their Own Homes

Individuals can receive assistance in paying for an ACH if their income is below 145% of the federal poverty guidelines, or \$1,228 per month.<sup>8</sup> Older individuals and individuals with disabilities who live in or are entering an ACH and who meet the age/disabilities standards as well as the income standard receive an income supplement called State-County Special Assistance (SA). SA is used to pay for room and board. Individuals receiving SA are automatically eligible for Medicaid, which is used to cover health care costs and the cost of personal care services.<sup>a,6</sup> The maximum SA payment for an individual with no other income would be \$1,182 per month; however, most individuals have other sources of income to help pay for the care in the ACH.<sup>7</sup> SA is calculated by taking the maximum value and subtracting net monthly income (e.g., SSI and veteran’s benefits).<sup>8</sup> The average value of SA for individuals in ACHs is \$435 per month, or \$5,220 per year.<sup>7</sup> This money is used by the individual to pay for their room and board at an ACH. The average Medicaid payment for personal care services per recipient in an ACH or supervised living facility in 2006, the last year for which comparable data are available, was \$6,667 per year.<sup>9</sup> Thus, on average, ACH residents receive \$11,890 per year in funding for housing and services (including personal care, health care, food, medication administration, activities, transportation services, and housekeeping and laundry services).

In contrast, people living at home in the community can qualify only for the SA-IHP and for Medicaid with incomes up to \$903 per month (\$325 per month less than the income qualifications for assistance in paying for an ACH).<sup>8,10</sup> In addition, they are not entitled to the full SA payment level. The maximum in-home SA payment is \$887 per month, or 75% of what they would receive if living in an adult care home; like SA, the SA-IHP monthly amount is calculated

<sup>a</sup> Many of the people living in ACHs automatically qualify for Medicaid because they are receiving SSI payments. However, some of the people living in ACHs have slightly higher incomes and would not qualify for Medicaid were it not for the receipt of SA benefits.

**People who enter an ACH or other type of facility can obtain certain financial assistance, services, and supports that are not equally available to people with similar levels of disability and financial need who choose to remain in their own homes.**

by subtracting the individual's own income from the maximum amount.<sup>11</sup> The average value of SA in-home is \$359 per month, or \$4,308 per year in 2010. The average Medicaid payment for personal care services per SA in-home recipient was \$6,979 per year.<sup>9</sup> Thus, on average, SA in-home recipients receive \$11,290 per year (\$600 less than SA recipients in ACHs) in funding for housing and personal care services.

Directly comparing the average SA and Medicaid payments of SA recipients in ACHs and SA in-home recipients does not include all costs for SA recipients. In 2007, the North Carolina Division of Aging and Adult Services (DAAS) completed a comparison of the costs for SA recipients in ACHs (SA ACH) and SA in-home recipients (SA-IHP) recipients, looking at all federal, state, and county costs for providing care for SA recipients.<sup>b</sup> DAAS found that when including federal, state, and county costs, SA ACH recipients cost 38.5% more per month, on average, than do SA-IHP recipients. Over the course of a year, SA ACH recipients cost \$30,768 and SA-IHP recipients cost \$22,224, on average. SA-IHP recipients cost, on average, \$8,544 less per year. The majority of the savings are in federal funds (\$4,572); however, the state saves \$1,944 and the county \$2,028 on average per year for SA-IHP recipients versus SA ACH recipients.<sup>9</sup>

The difference in program rules between SA and Medicaid for those who live in ACHs and those who choose to remain at home or in their communities creates an “institutional bias”—providing greater financial coverage and health benefits for those who move into an ACH. Unbundling services and supports from the place an individual lives could go a long way toward helping individuals with disabilities afford to live in the community of their choosing. Additionally, the DAAS analysis shows that federal, state, and county governments could save money by providing services and supports to individuals in their homes versus in an ACH.

### The Move toward Supported Housing

Over the past 50 years of deinstitutionalization, our knowledge of the types of housing and supports needed to help people with disabilities live independently has evolved. Initially, people who left larger state psychiatric hospitals and/or developmental centers might be placed in larger Intermediate Care Facilities for the Mentally Retarded (ICF-MRs) (with 16 or more beds) or in larger 122C group homes for people with mental illness, developmental disabilities, or substance abuse. Today, most people who are living in a 122C facility are in smaller group homes that house 6 or fewer individuals.<sup>12</sup> Some people with disabilities may be disqualified from living in certain group homes, if these homes were built with federal Housing and Urban Development (HUD) funds; some HUD programs explicitly preclude participants with prior criminal

**Federal, state, and county governments could save money by providing services and supports to individuals in their homes versus in an ACH.**

<sup>b</sup> The cost to serve a typical SA in-home recipient included Medicaid, SA, Food Stamps, Home and Community Care Block Grant, and Social Services Block Grant funds. The cost to serve a typical SA ACH recipient included Medicaid and SA.

**Over the past decade, the concept of supported housing has emerged as the best practice model, individuals choose where they live, have tenancy rights, and have access to flexible support services to enable people to live independently, in housing that is safe, accessible, and affordable.**

convictions, depending on the amount of time elapsed and the severity of the crime. Also, restrictions may also be placed on those actively using substances.<sup>c</sup> Thus, because of the limited housing options, many people with disabilities live in ACHs even though these residences do not meet all their needs. Although these types of living arrangements do help people who might otherwise be institutionalized live closer to their home communities, these residences are not optimal for community integration. Residents of ACHs may be cut off from active participation in the local community because of the lack of transportation and the structured format (i.e., the schedule of meals and personal care) of many residential care homes.<sup>2,4</sup>

Over the past decade, the concept of supported housing has emerged as the best practice model for providing supports and services to individuals with disabilities. In this model, individuals choose where they live, have tenancy rights, and have access to flexible support services to enable people to live independently, in housing that is safe, accessible, and affordable.<sup>1,13</sup> There are two prerequisites for the success of this model. First, a person must have access to affordable housing. Most people with disabilities, many of whom currently reside in ACHs, are living on SSI. Because of this limited income, it is almost impossible for most people with disabilities who currently reside in ACHs to find affordable nonsubsidized housing. Second, the person must have access to services and supports to help him or her to live independently. By definition, people living in ACHs need assistance with activities of daily living (e.g., bathing, eating, ambulation, dressing, and/or toileting), and many need medication management or help with instrumental activities of daily living (e.g., light housework, preparing meals, using the telephone, shopping for groceries, and money management).<sup>14</sup> ACHs currently provide personal assistance and help with medication management. Thus, in addition to housing, many people with disabilities who are living in ACHs will need services and supports to help them live more independently. Support services need to be individualized, flexible, and responsive to an individual's changing needs. In this model, individuals are not "placed" in a residential facility but are able to choose where they want to live and to receive support services.<sup>1</sup>

### **Making Funding for Housing More Flexible**

As discussed, most individuals with disabilities cannot afford independent housing without some sort of housing subsidy. In 91 counties in North Carolina, individuals who need an ACH level of care or who are in an ACH but would like to return home may be eligible for the SA-IHP.<sup>d</sup> This funding can be used to help pay for expenses such as rent, food, and clothing.<sup>15</sup> However, SA-IHP is not as readily available to individuals as SA ACH. As previously discussed, it is more difficult for individuals to qualify for SA-IHP (due to stricter income eligibility rules). In addition, North Carolina has limited the number of SA slots used to

<sup>c</sup> 24 CFR §982.533. Denial of admission and termination of assistance for criminals and alcohol abusers.

<sup>d</sup> Counties can choose whether to offer residents the SA-IHP program, and nine North Carolina counties have opted not to offer SA-IHP to residents.



provide SA-IHP to 15% of the total number of slots for SA.<sup>e,16</sup> Although this limit has not caused major problems in most communities to date, the artificial limit on the number of SA-IHP slots would prevent a large-scale effort to support people with disabilities in more independent community placements.

SA is an important funding tool for making housing more affordable for individuals with disabilities. Currently, North Carolina's SA programs are biased toward those individuals in or entering ACHs. Eliminating this bias would widen the range of affordable housing options for individuals with disabilities.

### **Increasing Housing Options**

As noted earlier, access to services in the community and to funding to pay for housing will only work if there are affordable housing options for individuals with disabilities in the community. Affordable housing is defined by HUD as housing that costs no more than 30% of the household's income. This amounts to \$202 per month for a single individual with disabilities who is living solely off SSI benefits.<sup>5,17</sup> To afford the average rent for a modest 1-bedroom apartment in North Carolina (\$627 per month) under HUD's affordable housing definition, an individual must have an income of \$2,090 per month, which amounts to \$1,416 more than an individual with disability's SSI benefit.<sup>18</sup> This is why it is crucial that North Carolina increase the flexibility of the current SA-IHP, as discussed above. Although there are some affordable housing options in some North Carolina communities, if housing subsidies, such as the SA-IHP, were available to large numbers of individuals with disabilities, their needs could not be met by the current housing stock.

One opportunity for expanding affordable housing options is through the Housing Trust Fund, begun in 1987 by the North Carolina General Assembly. Since its creation, the General Assembly has appropriated up to \$19 million in annual, generally non-recurring, funds to the North Carolina Housing Finance Agency for the Housing Trust Fund. The Fund helps to leverage private development funds in order to lower the costs of building single homes, multi-unit buildings, and apartment complexes so that housing becomes more affordable to populations who need it.<sup>19</sup> Low-income families, seniors, individuals with disabilities, as well as homeless individuals and victims of domestic violence might all benefit from such affordable housing. The Housing Trust Fund has the opportunity to have a significant impact on access to housing in North Carolina, because it is not subject to the same rent restrictions as federally funded projects through HUD, as previously described. Despite its potential benefit, however, funding constraints have limited the impact of the Housing Trust Fund. The North Carolina General Assembly should expand the volume of recurring funds appropriated to the Housing Trust Fund. One option for expansion would be to capture the interest from housing security deposits and to dedicate the funds to the Housing Trust Fund.

<sup>e</sup> Session Law 2007-323.

**There is a need for more affordable housing options for individuals with disabilities in the community.**

In addition to augmenting the funding to increase housing options for individuals with disabilities, North Carolina needs to better understand the demand for housing alternatives to ACHs. As discussed, the Task Force faced difficulties gathering information about the size of the population and the needs of individuals with disabilities in ACHs; future planning efforts would benefit from information on how many individuals in ACHs are interested in returning to the community. Currently, individuals in nursing homes are asked questions about their interest in returning to the community, whether they have a discharge plan in place, and whether they would like to talk to someone about returning to the community. North Carolina should include similar questions for individuals living in ACHs as part of the planned automated data collection system for ACHs (discussed more in Chapter 4).

Another way to increase housing options for individuals who may be able to live successfully in their home community with appropriate housing, supports, and services is for ACHs to branch out into providing other forms of housing and support. There are a number of models that support people to live more independently in the community, such as, but not limited to, multi-unit supported housing, shared housing, recovery-based scattered housing, and transitional housing.<sup>2,20</sup> With appropriate support and technical assistance, some ACHs may be interested in transitioning to some of these newer evidence-based models of housing for individuals with disabilities.

### **Increasing Community-Based Supports**

One approach to increasing the supply of affordable community-based supports is to expand the availability of Medicaid home and community-based services (HCBS). Historically, the federal Medicaid law allowed states to provide additional HCBS to people who would otherwise need an institutional level of support (i.e., nursing facility, intermediate care facilities for people with developmental disabilities, and/or long-term hospitalization). For example, North Carolina operates a 1915(c) HCBS waiver that provides services and supports to people with intellectual and other developmental disabilities who would otherwise be eligible for ICF-MR placement (called the Community Alternatives Placement program for people with mental retardation/developmental disabilities or CAP/MR-DD). Some of the CAP/MR-DD-covered services include service coordination, case management, in-home supports, vocational services, day habilitation services, and respite care.<sup>21</sup> Unlike the situation for the regular Medicaid program—which is an entitlement to everyone who meets the states' eligibility rules—states have been allowed to limit the number of people it would serve under a HCBS waiver. It is also important to note that while HCBS funds can be used to pay for attendant services and supports, and other services needed to help a person live independently, the funds cannot be used to pay for housing.<sup>22</sup>



**North Carolina 1915(i) State Plan Amendment**

More recent changes in the federal waiver rules, along with changes under the federal Patient Protection and Affordable Care Act (PPACA), give states additional options to expand HCBS to additional people under the 1915(i) option. Before 2005, HCBS services could be provided under 1915(c) Medicaid waiver only to individuals meeting institutional level of care criteria (i.e., hospital care, nursing facility, or intermediate care facilities for people with developmental disabilities). Under the 1915(i) option, enacted as part of the 2005 Deficit Reduction Act, states can develop eligibility criteria that are less stringent than institutional level of care.<sup>7</sup> This opens the door for providing HCBS to a much wider range of individuals, including those with disabilities living at home or in an ACH. Under the 1915(i) option, states can cover HCBS such as case management, home health aides, personal care services, respite care, adult day health services, and other type of services and supports. States can also expand the income eligibility limit for people to qualify for HCBS.<sup>6,7</sup>

The PPACA expanded the availability and funding for the 1915(i) program in order to provide an incentive to states to increase the amount of Medicaid long-term care funding spent on HCBS rather than on institutional care. North Carolina could qualify for a 2-percentage-point increase in the federal match for HCBS by expanding the 1915(i) program. As part of the PPACA, states can expand the types of people it serves and the types of HCBS offered.<sup>8</sup> However, if the state chooses this option, it is no longer allowed to limit the number of people served. Anyone who qualifies on the basis of the state's standard of need (i.e., income limits, resource limits, and functional limitations) would be eligible for the state-specified HCBS.<sup>7</sup> These services—including personal care services and supports—could help someone live more independently in the community.

**Increasing Options for Individuals with Disabilities**

The Task Force believes that in order to ameliorate the problem of co-location of individuals with disabilities with the frail elderly, options for individuals to remain in or return to their homes should be increased. The Task Force has developed short- and long-term recommendations for ways to increase options for individuals with disabilities. In the short-term, the Task Force recommends a pilot program to test ways of increasing supports and services for individuals with disabilities so that they have more independent living options. The Task Force also recommends that the state begin to work with ACHs that are interested in converting to other models of services and supports to assist individuals in living more independently.

**Under the 1915(i) option, enacted as part of the 2005 Deficit Reduction Act, states can develop eligibility criteria that are less stringent than institutional level of care. This opens the door for providing HCBS to a much wider range of individuals, including those with disabilities living at home or in an ACH.**

<sup>f</sup> Under Section 10202 of the Patient Protection and Affordable Care Act, states can expand coverage for HCBS for people with incomes from 150% of the federal poverty guidelines (FPG) up to 300% of the SSI limits, or approximately 220% of the FPG. In contrast, the current NC income eligibility limit to qualify for SA is approximately 135% of the federal poverty guidelines. Thus, anyone who currently is receiving SA would be income-eligible for HCBS through a 1915(i) HCBS waiver.

<sup>g</sup> North Carolina has submitted a 1915(i) state plan amendment targeted to individuals in adult care homes. This waiver was submitted to address concerns raised by the Centers for Medicaid and Medicare Services (CMS) about the provision of different levels of personal care services in adult care homes versus in-home personal care services. More information about the state plan amendment is included in Chapter 4.

### Recommendation 3.1: Pilot Program (PRIORITY RECOMMENDATION)

The North Carolina Department of Health and Human Services (DHHS) should develop a pilot program to evaluate the costs, quality, consumer satisfaction, and patient outcomes of a program that supports individuals who would otherwise be in an adult or family care home and who want to move back into independent supported housing. As part of this, DHHS should:

- a) Submit a Medicaid 1915(i) state plan amendment or 1915(c) HCBS waiver to support individuals living in adult or family care homes (ACH) for 90 or more days who would like to move back to more independent living arrangements. The 1915(i) state plan amendment should be modeled after the state's Money Follows the Person<sup>h</sup> initiative for people in nursing facilities. The Medicaid 1915(i) state plan amendment should provide home and community-based services, including, but not limited to, personal care services, adult day care, and case management, and should pay for reasonable one-time transitional costs, including but not limited to security deposits, first month rent, or home modification.
- b) DHHS should develop a process to evaluate people living in ACHs to determine whether people can appropriately live independently in the community with services and supports, and should provide counseling and transition services to appropriate individuals who want to move to more independent living arrangements.
- c) The pilot program should initially be limited to 1,000 individuals who want to, and can appropriately, move to more independent living arrangements with services and supports. Individuals who move out of an ACH should continue to receive the same level of State-County Special Assistance (SA) payment in the community as they were receiving in the ACH. These SA in-home payments should be exempt from the SA in-home limits established as part of Session Law 2007-323.
- d) DHHS should conduct an evaluation to examine costs, quality, individual satisfaction, and patient outcomes of this demonstration in supporting people with disabilities and the frail elderly who would otherwise need ACH level of care to live more independently in the community. The results of the evaluation should be shared with the appropriate legislative committees that address the needs of older adults and of people with mental illness, intellectual and developmental disabilities, and addiction disorders no later than fall 2013

<sup>h</sup> Money Follows the Person is a nursing facility transition program that identifies consumers in institutions who wish to transition to the community and allows Medicaid funds budgeted for institutional services to be spent on home and community services when individuals move to the community. Centers for Medicare & Medicaid Services. *Real Choice Systems Change Grant Program: Money Follows the Person Initiatives*. US Department of Health and Human Services; 2006.

and annually thereafter. If the program is found to be successful, the North Carolina General Assembly should implement the program statewide both for individuals who are residing in ACHs and for those who have not yet entered an ACH but who meet the level of need criteria.

- e) The North Carolina General Assembly should appropriate \$100,000 non-recurring funds in state fiscal years 2012-2014 to the North Carolina Department of Health and Human Services to provide technical assistance to help interested ACHs create financially viable models that support people to live more independently in the community, such as, but not limited to, multi-unit supported housing, recovery-based scattered housing, transitional housing, and adult day care. DHHS should strive to work with rural, urban, large, and small ACH facilities.
- f) DHHS should continue its work to remove statutory and regulatory barriers to independent living options for people with disabilities who receive services in the community.

The Task Force also recommends increasing funding for the NC Housing Trust fund to support the development of housing for individuals with disabilities. These funds should be allocated in the short term, because developing new or even modifying current housing stock is a long-term project that must start as soon as possible to ensure that needs can be met in the long run. Therefore the Task Force recommends:

### **Recommendation 3.2: Increase Funding for Housing for Individuals with Disabilities**

- a) To help individuals with disabilities better afford housing, the North Carolina General Assembly should appropriate \$10 million in additional recurring funding beginning in state fiscal year 2011 to the North Carolina Housing Finance Agency to increase funding to the North Carolina Housing Trust Fund. A significant portion of the funding should be targeted for housing for individuals with disabilities.
- b) DHHS should work with the Housing Finance Agency to explore options to create transitional housing for people who need short-term stabilization options to help them make a transition to more independent living in the community.

### **Housing Inventory**

In addition to a need for increased housing options for individuals with disabilities, there is a need for an inventory of all community housing options,

including 122C therapeutic mental health homes, substance abuse and developmental disability group homes, adult and family care homes, supported living arrangements, and independent living options. Such an inventory is important for planning purposes as the state works to increase independent living options for individuals with disabilities. Additionally, such an inventory should be available to placement workers and individuals with disabilities and their families so that they are fully informed about the housing options in their community. Some local management entities (LMEs) do an inventory as part of the community assessment they are required to do every three years, but this information is not always available to consumers and not all LMEs do this. (See Chapter 4 for more information on LMEs.) Therefore, the Task Force recommends:

### **Recommendation 3.3: Create an Inventory of Community Housing Options for Individuals with Disabilities**

As part of the local management entity's (LME) performance contract with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), DMHDDSAS should require LMEs, working with DMHDDSAS, the Division of Health Services Regulation, and the North Carolina Department of Health and Human Services housing specialists, to develop a real-time inventory of community housing options, including 122C therapeutic mental health homes, substance abuse and developmental disability group homes, adult and family care homes, supported living arrangements, and independent living options, and make this inventory available to families. The lists should be collected and aggregated at the state level and should be made available both online and in person through the LMEs.

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**M**ore 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.

## 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.<sup>1</sup> 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)<sup>a</sup>; 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



**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.**

<sup>a</sup> 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 individuals 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.

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

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.

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.<sup>2</sup> 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.<sup>3</sup> 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.

### 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<sup>b</sup> (see Appendix E). A more thorough assessment, the DMA 3050-R (see Appendix F), must be completed within 30 days of admission.<sup>4</sup> 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.

**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.**

<sup>b</sup> 10A NCAC 13G .0703

**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.**

## **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.

### **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.<sup>c</sup> 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<sup>d</sup> 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.”<sup>5</sup>

<sup>c</sup> 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.

<sup>d</sup> 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<sup>d</sup>—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.<sup>6</sup>

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.<sup>7</sup> 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.<sup>7</sup>

**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.

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.<sup>8</sup>

#### **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.<sup>8</sup> 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.

**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.**

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.<sup>7</sup>

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.<sup>8</sup> 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<sup>e</sup> 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:

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<sup>e</sup> 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.



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## Homes and 122C Facilities

### Overview

Individuals living in adult and family care homes (ACH) are there because they need assistance with activities of daily living (e.g., bathing, dressing, or eating) or medication management and supervision. As discussed in earlier chapters, these individuals may be frail elderly or they may be individuals with disabilities. In ACHs, they receive assistance with these activities. Workers in ACHs receive varying degrees of training and specialization, but most of the training is focused on providing basic personal or medical care to individuals. Training requirements for most ACH staff provide very limited or no information on working with individuals with disabilities. Because individuals with disabilities account for more than 60% of residents of ACHs, more training on ways to interact with and to care for individuals with disabilities is needed to ensure the safety and well-being of residents and staff.

Although data from 2009 show that more than 60% of individuals in ACHs have a mental health problem, intellectual and developmental disability, or Alzheimer disease/dementia, very little of the training for workers in ACHs focuses on the specific needs of these populations.<sup>1</sup> Although not all individuals with these diagnoses manifest inappropriate behavior, many of them do exhibit aggressive or combative behaviors that pose a threat to the safety of other residents and staff. Such behavioral problems can often be safely managed by well-trained staff. Unfortunately, workers in ACHs are not required to receive specific training in managing individuals with behavioral problems, such as de-escalation skills to use during a crisis. This lack of formal training for staff contributes to the safety risks associated with co-locating older individuals with personal care needs with individuals who manifest aggressive or combative behaviors.<sup>2</sup>

### Types of Workers in Adult and Family Care Homes

ACHs employ various types of workers with different levels of training based on their job responsibilities and interactions with residents. The most common type of staff is referred to as a “direct care worker.” The North Carolina Office of Long-Term Services and Supports defines direct care workers as certified nursing assistants, personal care aides, and other unlicensed paraprofessionals who help individuals with disabilities and elderly adults with activities of daily living and other personal care tasks.<sup>3</sup> For a more comprehensive list of the various types of workers in adult care homes, see Table 5.1 below.



**Training requirements for most ACH staff provide very limited or no information on working with individuals with disabilities.**

**Table 5.1**  
**Types of Health Professionals Who Could Work in an Adult or Family Care Home and Their Training Requirements**

Type of Staff	Degree Requirements	Certification/Licensure Requirements	State Required Training Curriculum	State Examination Required to Practice?
Personal Care Aides in Adult and Family Care Homes	No degree required	No licensure or certification required	25 or 80 hours of state-approved educational curriculum and training	No, however, 70% or higher required on written or oral examination and competency evaluation (developed and administered by approved training program)
Nursing Assistant I	High school diploma or equivalent	Certification required	75 hours of state-approved educational curriculum and training	Yes
Nursing Assistant II	High school diploma or equivalent	Certification required	160 hours of state-approved educational curriculum and training	Yes
Medication Aide	No degree required	Competency validation and state exam	24 hours of state-approved educational curriculum	Yes
Geriatric Aide	Certified Nursing Assistant	Certification required	State-approved geriatric aide training course	Yes
Licensed Practical Nurse	Completion of appropriate nursing program	Licensure required	State-approved programs and curricula	Yes
Registered Nurse	Completion of appropriate nursing program	Licensure required	State-approved programs and curricula	Yes
Activity Director	High school diploma or equivalent, or by passage of an alternative exam established by the Department of Health & Human Services.	No licensure or certification required	50 hours of state-approved educational curriculum and training	No

Sources: 10A NCAC 13G/F .0501, .0502, 21 NCAC 36 .0403, 21 NCAC 36 .03, 10A NCAC 13F .0404.

and 122C Facilities

**Training Requirements for Adult Care Home Staff**

In North Carolina, direct care workers working in ACHs are called personal care aides. Personal care aides provide personal care, such as assistance with bathing, dressing, or eating, to residents. ACH personal care aide training and competency requirements are divided into two groups: workers with 25 hours of training and workers with 80 hours of training. The 25 hour training and competency evaluation is required for personal care aides working in family care homes with seven or fewer beds and without heavy-needs residents.<sup>a,b</sup> Personal care aides working in adult care homes with seven or more beds or those working in family care homes with heavy-needs residents must complete the 80-hour personal care training and competency evaluation.<sup>c</sup> Not all staff are required to take the 25- or 80-hour training course. Staff can apply for an exemption if they qualify under one of the two categories listed below:

1. They are already a licensed health professional or certified nursing assistant (CNA); or
2. They have been employed to perform comparable tasks in a comparable long-term care setting for at least one year during the three years prior to January 1, 1996, or the date they are hired, whichever is later.

Most staff that qualify for exemption are licensed health professionals or CNAs.

If they do not qualify for an exemption, personal care aides in adult care homes must complete training within six months of being hired by an ACH through either through the North Carolina Community College System or under a licensed nurse with at least two years of clinical experience. Course training using a state-approved curriculum must be conducted by an instructor (a licensed nurse) and a program coordinator. The program coordinator should be a licensed nurse, physician, gerontologist, social worker, psychologist, mental health professional, or other health professional with at least two years of experience in adult education or long-term care or a four-year college graduate with four years of experience in aging or long-term care.<sup>d</sup> Because most community colleges do not regularly offer the 25- or 80-hour training course, direct care workers usually receive training from a licensed nurse within the ACH that hired them.<sup>4</sup> Nurses who want to be able to teach personal care training must submit an application to the Division of Health Service Regulation.

**More [staff] training on ways to interact with and to care for individuals with disabilities is needed to ensure the safety and well-being of residents and staff.**

a For the purposes of this Rule, personal care tasks which require an 80-hour training program are as follows: assist with feeding residents with swallowing difficulty; assist with gait training using assistive devices; assist with or perform range of motion exercises; empty and record drainage of catheter bag; administer enemas; bowel and bladder retraining to regain continence; test urine or fecal specimens; use of physical or mechanical devices attached to or adjacent to the resident which restrict movement or access to one's own body used to restrict movement or enable or enhance functional abilities; nonsterile dressing procedures; force and restrict fluids; apply prescribed heat therapy; care for noninfected pressure ulcers; and vaginal douches.

b 10 NCAC 13G .0501 and 13G .0502

c 10A NCAC 13G .0501, 10A NCAC 13F .0501.

d 10A NCAC 13G .0502 (c).

Training includes both classroom instruction and supervised practical training. As specified by North Carolina law, both training courses cover personal care tasks such as toileting; mobility and transferring of residents; personal hygiene; feeding; basic first aid; and taking and recording temperature, pulse, blood pressure, and routine height and weight measurements.<sup>e</sup> The 80-hour training course covers the personal care competences required for the 25-hour course as well as personal care tasks such as use of physical or mechanical devices used by residents, assisting with or performing range of motion exercises, caring for noninfected pressure ulcers, and forcing and restricting fluids.<sup>f</sup> In addition, at least five hours of classroom instruction must focus on interpersonal skills and behavioral interventions, which include recognition of residents' usual patterns of responding to people as well as interpersonal distress and behavior problems; knowledge of and use of techniques as alternatives to the use of restraints; and knowledge of procedures for obtaining consultation and assistance regarding safe, humane management of residents' behavioral problems.<sup>g</sup>

Upon completing the 25- or 80-hour course of training, students must score at least 70% on a written examination of classroom content (or oral examination if the worker has limited reading or writing abilities).<sup>h</sup> In addition to showing knowledge of classroom content, students also complete a competency requirement. During the competency exam, students must satisfactorily perform *all* the personal care skills and interpersonal and behavioral intervention skills required in the training program without assistance from the instructor, as well as explain the procedure to the instructor and the reason it is being done.

### **Training Requirements for Certified Nurse Aides**

As mentioned above, CNAs are exempt from personal care training. Rather than hiring direct care workers who require training, many ACHs turn to CNAs to fill staff positions because they are deemed to have met the requirements of the 80-hour training course by virtue of their CNA training. Currently 6,946 (or 6%) of CNAs are employed by adult or family care homes.<sup>5</sup> Certified nurse aides are certified health professionals who must satisfy certain state and federal requirements before practicing. Federal requirements for Nurse Aide I Training (NAT) include a minimum of 75 hours of training, including 16 hours in communication skills, infection control, safety procedures, promoting residents' independence, and residents' rights *before* having contact with residents and 16 hours of supervised practical training with residents. In addition to the subject areas listed above, NAT programs must include basic nursing skills, personal care skills, mental health and social service needs, care of cognitively impaired residents, and basic restorative services. All of North Carolina's state-approved

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e For a full list of personal care tasks covered under the 25-hours course requirements see 10A NCAC 13G .0501(h).

f For full list see of personal care tasks covered under the 80-hour course requirements, see 10A NCAC 13G .0501 (i).

g For full list of interpersonal skills and behavioral interventions, see 10A NCAC 13G .0501 (j).

h 10A NCAC 13G .0502 (c).



## and 122C Facilities

NAT programs meet, or exceed, federal training requirements. North Carolina NAT programs require proficiency in 69 skills.<sup>5</sup>

Upon completion of training, CNA students are required to take the nurse aide I competency evaluation established by the federal government. The evaluation includes a choice of written or oral exam (offered in English and Spanish) and a competency exam (involving successful skill demonstration of five randomly drawn skills that are usually performed by CNAs). For the written/oral component of the evaluation, North Carolina uses the National Nurse Aide Assessment Program (NNAAP) exam, which is administered by a nationally recognized provider of assessment services to regulatory agencies and national associations, Pearson VUE. For the competency exam component, a registered nurse with at least three years experience, with one or more years of experience caring for the elderly or chronically ill, serves as the evaluator. If a student fails any part of the competency exam or evaluation, they fail the entire exam—students have three opportunities to pass the exam. In addition, CNAs in adult care homes are required to have 12 hours of continuing education annually.<sup>5</sup>

In North Carolina, the state is required to review and to approve (or disapprove) all NAT programs. The state can revoke a program if it fails to meet any of the federal requirements or if a NAT program fails to allow the state to review its program. Nurse aide I training programs are offered in nursing homes, home care agencies, hospitals, community colleges, high schools, and nursing schools. The majority of programs are housed within high schools, community colleges, and nursing schools. The NAT program coordinator must be a registered nurse with a minimum of three years experience, one of which was spent in a skilled nursing facility—or a director of nursing in a skilled nursing facility. Faculty must be registered nurses with at least two years experience and have met at least one of the following requirements: 1) completed a course in teaching, 2) have experience teaching adults, or 3) have experience supervising nurse aides.<sup>5</sup>

As shown in Appendix 7, CNAs receive a more thorough and standardized training regimen than either the 25- or 80-hour ACH staff training. However, both programs lack a comprehensive overview and training for behavioral health care.

**Training Requirements for 122C Staff**

Staff of 122C facilities include qualified professionals, associate professionals, and paraprofessionals. Qualified professionals are required to have at least a bachelor's or master's degree and, depending on their degree field, from one to four years of experience in working with populations that have mental health, developmental disabilities, or substance abuse (MA/DD/SA) issues, or they can be a substance abuse professional with one to four years of supervised experience in alcoholism and drug abuse counseling, or a registered nurse with four years of experience in MA/DD/SA.<sup>i</sup> Qualified professionals with a clinical background

<sup>i</sup> 10A NCAC 27G .0104 (19)

**In 2002, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services funded 20 Geriatric/Adult Mental Health Specialty Teams to help provide additional training for staff of adult care homes and nursing homes with at least one resident with a mental illness at the request of the facility.**

provide supervision for associate professionals and paraprofessionals. Associate professionals are required to have at least a bachelor's or master's degree and, depending on their degree field, from two to four years of experience in MA/DD/SA, or they can be a registered nurse with less than four years of experience working in MA/DD/SA.<sup>j</sup> Paraprofessionals must have either a GED or high school diploma—if they do not have a GED or diploma, they must have been employed before November 1, 2001, in the field of MA/DD/SA—and must complete core training requirements described below.<sup>k</sup> Paraprofessionals are responsible for providing direct care to the facility's residents.<sup>6</sup>

As opposed to training requirements for ACH staff and certified nurse aides, training requirements for staff of 122C facilities are not medically based.<sup>6</sup> Core training for staff includes, at a minimum, general orientation to the 122C; training on client rights and confidentiality; training to meet the mental health, developmental disability, and substance abuse needs of the clients; and training on infectious diseases and bloodborne pathogens.<sup>l</sup> The competencies of qualified and associate professionals are loosely defined; the law requires that they “demonstrate the knowledge, skills, and abilities required by the population being served.”<sup>m</sup> There is no standardized training curriculum for 122C staff and no strict guideline as to who can conduct training. Currently, there is no competency exam required for 122C staff, although work has begun on a competency-based requirement that would require specific skills.<sup>6</sup>

Because a competency-based requirement does not exist for 122C facilities, the Division of Health Service Regulation (DHSR) is responsible for determining staff competency through an annual review. Each year, DHSR assembles teams to survey and to review all 122C facilities. The annual review teams observe staff interactions with clients at the facility and also interview clients about the quality of care they are receiving to determine whether the facility is meeting client needs.<sup>6</sup>

### **Geriatric/Adult Mental Health Specialty Teams**

In 2002, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services funded 20 Geriatric/Adult Mental Health Specialty Teams (GASTs) to help provide additional training for staff of adult care homes and nursing homes with at least one resident with a mental illness at the request of the facility.<sup>n,7</sup> Each county in North Carolina is assigned to a GAST. Each team comprises at least one nurse and a master's-level mental health clinician with experience in geriatric care. Each month, the GAST will contact facilities in its county and offer training services, which facilities may accept or decline. Training topics range from specific mental illnesses, to crisis

<sup>j</sup> 10A NCAC 27G .0104 (1)

<sup>k</sup> 10A NCAC 27G .0104(15)

<sup>l</sup> 10A NCAC 27G .0202 (g)

<sup>m</sup> 10A NCAC 27G .0203

<sup>n</sup> Caregivers for a person over the age of 65 years can also receive training if they are caring for an individual with a mental illness who is at imminent risk for psychiatric hospitalization.

## and 122C Facilities

prevention and response, to medication side effects. In addition, a GAST can also develop specific training modules to meet needs of staff of a given facility, within the scope of mental health and substance abuse topics.<sup>8</sup>

GASTs provide a cost-effective means of educating large numbers of ACH staff and administrators on issues tailored to their needs. The Task Force noted that GAST teams are a valuable but underutilized tool for improving the care for individuals with disabilities living in ACHs. GASTs could be used to provide basic training around working with individuals with mental health needs to large numbers of staff working in ACHs. GASTs could provide training around the kind of “person-centered” approach to caregiving recommended for those providing care to individuals with mental health needs, intellectual and developmental disabilities, and those with Alzheimer disease/dementia.<sup>9</sup> A person-centered approach to care has developed from the belief that caregiving should be based on a concern for the quality of care *and* quality of life for patients.<sup>9,10</sup> For an adult care facility, this means that staff would be trained to treat residents as family or peers in a home-like environment.<sup>10</sup> Emphasis should be placed on treating residents with respect and personal integrity, despite their age or level of infirmity. Thus, any care that was offered would take into account the opinions, values, and preferences of individual residents in addition to a medical standard of care.<sup>7</sup> For direct care workers who work with patients with mental illness, GAST training would instruct caregivers to use respectful and supportive communication to encourage rather than to force compliance with a task. Training on using a patient-centered approach to caregiving focuses on encouraging workers to establish a connection with patients before working toward task completion and teaches that successful connections between caregivers and patients may be established through supportive and calm communication and through the use of visual, verbal, and tactical cues. In addition, caregivers should try to identify the level and type of care for each patient on the basis of the perceived level of the patient’s functioning and his or her level of need.<sup>7</sup>

Although GAST training aims to teach direct care workers about handling the majority of care for ACH residents with disabilities, direct care workers still may not have the specialized expertise to deal with crisis or emergency situations. In these cases, ACHs can elicit support from NC START teams or Mobile Crisis Teams that offer specialized care. NC START is targeted to adults with developmental disabilities and provides 24/7 crisis response, consultation, and crisis planning for each of three regions across North Carolina.<sup>11</sup> Mobile Crisis Teams offer services to individuals with mental health problems, intellectual and developmental disabilities, or substance abuse by professionals and medical practitioners experienced in crisis management.<sup>12</sup>

**Geriatric/adult mental health specialty teams provide a cost-effective means of educating large numbers of ACH staff and administrators on issues tailored to their needs.**

The Task Force supports the current work of GASTs and believes they could provide additional value by training staff in all ACHs. GASTs, NC START teams, and Mobile Crisis Teams all provide valuable support to ACHs that house individuals with disabilities. Therefore, the Task Force recommends:

### **Recommendation 5.1: Use Geriatric/Adult Mental Health Specialty Teams to Provide Training in all ACHs**

- a) The North Carolina General Assembly should enact legislation to require all adult and family care homes (ACH) to receive geriatric/adult mental health specialty team (GAST) training at least three times per year. The training should be tailored to the needs of the specific ACH but should, at a minimum, cover person-centered thinking and de-escalation skills. Staff on all three shifts (including supervisors, administrators, personal care assistants, medication aides, and any other workers who have direct hands-on contact with residents) should receive this training at least once per year.
- b) The North Carolina Department of Health and Human Services should evaluate and report back to appropriate legislative committees that address the needs of older adults or people with mental illness, intellectual and developmental disabilities, or addiction disorders by fall 2012 information on whether there are enough GAST resources to meet the new training requirements and whether there are sufficient mobile crisis teams and START crisis teams to meet the needs of ACHs in the event of behavioral health crises.

### **Overall Behavioral Health Training for Staff**

As mentioned in Chapter 2, a majority of residents living in ACHs have a mental illness, intellectual and other developmental disabilities, or Alzheimer disease/dementia (64% in 2009).<sup>1</sup> Although not all individuals with these diagnoses manifest inappropriate behaviors, many of them do exhibit aggressive or combative behaviors. Such behavioral problems can often be safely managed by well-trained staff. Direct care workers and other staff in ACHs are not required to receive specific training in crisis prevention and must rely on the support of NC START and Mobile Crisis Teams (as described above) after the individual's situation escalates to full crisis. This lack of formal training for staff contributes to the safety risks associated with co-locating older individuals with personal care needs with individuals who manifest aggressive or combative behaviors. In order to better prevent crises and to ensure the safety of caregivers and residents, caregivers should receive training in crisis prevention.<sup>2</sup> For all service delivery, including crisis prevention, direct care workers should employ patient-centered thinking and approach to care. Therefore, the Task Force recommends:

## **Recommendation 5.2: Require Adult and Family Care Home Staff to Be Trained and to Exhibit Competency in Person-Centered Thinking and Crisis Prevention**

The North Carolina General Assembly should require all adult and family care home direct care workers, personal care aides, medication aides, and supervisors to be trained and to have passed the competency exam for state-approved crisis intervention training by June 2013.

In September 2010, North Carolina was awarded a three year federal Personal and Home Care Aide State Training Program (PHCAST) grant to develop, to pilot test, to implement, and to evaluate the impact of a comprehensive training and competency program for direct care workers. Although the grant focuses on training for home care aides, one type of direct care worker, training modules will be developed also for personal care aides working in adult care homes. The training curriculum developed as part of the PHCAST grant will be available both as a full training curriculum that can be taken from start to finish and as modules that can be used for in-service training programs—thus allowing both students and current workers access to the curriculum. The goal is to develop and to pilot test this curriculum and then to implement it statewide. When fully implemented, the new training and competency program will add new modules and competencies to the current requirements for personal care aides working in adult care homes. The major content areas for which training and competencies will be developed are as follows:

- addressing consumer-specific needs training pertaining to specific care populations, such as the elderly, children, and individuals with disabilities;
  - consumers' rights, ethics, and confidentiality;
  - interpersonal skills;
  - safety and emergency training; and
  - dementia and patient abuse prevention training.
- The Task Force believes the PHCAST grant provides an excellent opportunity to develop new training and competency requirements for direct care workers in adult care homes. As part of this process, the Task Force recommends:

**In September 2010, North Carolina was awarded a three year federal Personal and Home Care Aide State Training Program grant to develop, to pilot test, to implement, and to evaluate the impact of a comprehensive training and competency program for direct care workers.**



### **Recommendation 5.3: Pilot New Behavioral Health Training and Competency Examination Requirements for New Direct Care Workers**

- a) The North Carolina Division of Health Service Regulation (DHSR), in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) and the Division of Medical Assistance, should develop a standardized curriculum and competency test for new direct care workers as part of the federal Personal and Home Care Aide State Training Program (PHCAST) grant. The core training should include, but not be limited to, the following:
- 1) Knowledge and understanding of the people being served, including the impact of aging on different populations.
  - 2) Recognizing and interpreting human behavior.
  - 3) Recognizing the effect of internal and external stressors that may affect people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders.
  - 4) Strategies for building positive relationships with persons with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders and for recognizing cultural, environmental, and organizational factors that may affect people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders.
  - 5) Recognizing the importance of and assisting in the person's involvement in making decisions about his or her life.
  - 6) Skills in assessing individual risk for escalating behavior.
  - 7) Communication strategies for defusing and de-escalating potentially dangerous behaviors.
  - 8) Positive behavioral supports providing means for people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders to choose activities that directly oppose or replace behaviors that are unsafe.
  - 9) Information on alternatives to the use of restrictive interventions.



### and 122C Facilities

- 10) Guidelines on when to intervene (understanding imminent danger to self and others).
- 11) Emphasis on safety and respect for the rights and dignity of all persons involved, including least restrictive interventions and incremental steps in an intervention.
- 12) Knowledge of prohibited procedures, including but not limited to abuse, neglect, and exploitation.
- 13) Debriefing strategies, including their importance and purpose, particularly after resident deaths.
- 14) Documentation methods/procedures.

The competency test developed should include both written and skills-based evaluation of training related to working with individuals with disabilities.

- b) To encourage retention of qualified staff, staff who undergo additional training and who demonstrate additional competencies should be rewarded with higher salaries.
- c) The DHSR should evaluate and make recommendations about whether this training should be mandatory for all direct care workers. DHSR should report its findings to the appropriate legislative committees that address the needs of older adults or people with mental illness, intellectual and developmental disabilities, or addiction disorders by the end of the three-year PHCAST pilot.

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**A**lthough most people think of adult and family care homes (ACH) as homes for the frail elderly, actually the ACHs in North Carolina serve more than 18,000 residents with mental illness, intellectual and developmental disabilities, or Alzheimer disease/dementia. These residents comprise 64% of all ACH residents and more than 75% of residents aged 18 to 64 years.<sup>1</sup> These data show there are large numbers of individuals with disabilities that may result in behavioral problems who are living in facilities with frail elderly populations. The residents are being cared for by staff who, for the most part, are not trained to work with individuals with disabilities. This co-location of different populations in ACHs poses a threat to the health and safety of both residents and staff.

Individuals with disabilities often require services and supports in their daily lives, including assistance with activities of daily living, such as eating, bathing, or dressing. This is why some people choose to live in ACHs, which provide lodging and personal care services. This need for supports and services often limits an individual's choice of place to live because, in North Carolina's current system, certain services and supports are not available in the community, are limited in their availability, or are not financially viable options for individuals living independently in communities. However, individuals with disabilities, particularly those aged 18 to 64 years, may need additional clinical, rehabilitative, or other support services that are recovery-oriented to support long-term goals of living and working as independently as possible in community settings.<sup>2</sup> ACHs are neither designed, nor licensed, to provide this level of services.

North Carolina's system for caring for the needs of individuals with disabilities has changed considerably over the past 60 years. Unfortunately, the system has not kept up with evidence-based research about what is best for individuals with disabilities. As outlined by the Surgeon General, individuals with disabilities should have the opportunity to live in housing that is integrated into the community and that promotes their maximum independence and access to integrated community-based services and, in some cases, supported housing and supported employment.<sup>2,3</sup> The current set of rules and regulations in North Carolina does not provide individuals with disabilities real choices in terms of where and with whom they live. Access to community-based services, supported housing, and supported employment are extremely limited.

In addition to increasing options for individuals with disabilities, North Carolina must work to ensure that ACHs are better prepared to meet the needs of individuals with disabilities who currently reside in ACHs. With more than 18,000 individuals with disabilities currently living in ACHs and few community alternatives available, individuals with disabilities will continue to make up a sizeable proportion of the ACH population. The current ACH system does not have adequate screening, assessment, care planning procedures, and staff training requirements in place to ensure that ACHs can meet the needs of those entering their facilities. To better serve individuals with disabilities as well as to



**North Carolina must work to both ensure that ACHs are better prepared to meet the needs of individuals with disabilities who currently reside in ACHs and to increase options for individuals with disabilities.**

ensure the safety of staff and other residents, North Carolina needs to update the rules and regulations governing ACHs.

The North Carolina General Assembly asked the North Carolina Institute of Medicine to convene the Task Force on the Co-Location of Different Populations in Adult Care Homes to examine the problems that can be created by the co-location of people with behavioral problems—whatever the underlying cause—with the frail elderly or other people with disabilities. In addition, the Task Force was asked to look at ways to appropriately identify/screen people entering ACHs for behavioral health problems, the adequacy of training for adult care home staff, and other options by which individuals with disabilities could receive appropriate care. The Task Force was asked to develop short-term and long-term strategies to address these issues related to the co-location of different populations in ACHs. This final report provides 9 recommendations that provide a roadmap both to addressing the challenges associated with co-location in ACHs and to increasing the options available to individuals with disabilities, which would reduce co-location in ACHs in the long run.

Below is an abridged list of the Task Force recommendations, along with the agencies or organizations charged with addressing the recommendation. The grid also includes the costs of implementing the recommendations, when known. A list of the complete Task Force recommendations can be found in Appendix 1. Given the state’s limited budget, the Task Force only included two priority recommendations that would need additional state appropriations. However, all of the recommendations should be implemented to ensure the safety of existing ACH residents and staff, to expand the availability of housing and services to enable people with disabilities to live as independently as possible in the community, and to more effectively use existing resources to meet the needs of individuals with disabilities.

	NCGA	DHHS	LMEs	ACHs	Others
<p><b>Recommendation 3.1: Pilot Program (PRIORITY RECOMMENDATION)</b>                      The North Carolina Department of Health and Human Services should develop a pilot program to evaluate the costs, quality, consumer satisfaction, and patient outcomes of a program that supports individuals who would otherwise be in an adult or family care home and who want to move into independent supported housing.</p>	\$100,000 non-recurring in each of SFY 2012-2014	✓ (Secy's Office, DMA)			

## Conclusion

	NCGA	DHHS	LMEs	ACHs	Others
<p><b>Recommendation 3.2: Increase Funding for Housing for Individuals with Disabilities</b></p> <p>To help individuals with disabilities better afford housing, the North Carolina General Assembly should appropriate \$10 million in additional recurring funding beginning in state fiscal year 2011 to the North Carolina Housing Finance Agency to increase funding to the North Carolina Housing Trust Fund. A significant portion of the funding should be targeted for housing for individuals with disabilities. The North Carolina Department of Health and Human Services should work with the Housing Finance Agency to explore options to create transitional housing for people who need short-term stabilization options to help them make a transition to more independent living in the community.</p>	\$10M recurring in SFY 2012				✓ (HTF)
<p><b>Recommendation 3.3: Create an Inventory of Community Housing Options for Individuals with Disabilities</b></p> <p>Local management entities should develop a real-time inventory of community housing options including 122C therapeutic mental health, substance abuse and developmental disability group homes, adult and family care homes, supported living arrangements, and independent living options, and make this inventory available to families.</p>		✓ (Secy's Office, DMHDDSAS)	✓		
<p><b>Recommendation 4.1: Requiring Standardized Preadmission Screening, Level of Services, and Assessment Instruments in Adult and Family Care Homes and 122C Facilities (PRIORITY RECOMMENDATION)</b></p> <p>The North Carolina General Assembly should direct the Department of Health and Human Services to require adult care homes and family care homes, and 122C mental health, developmental disability, and substance abuse group homes to use standardized preadmission screenings, level of services determinations, assessments and care planning instruments.</p>	\$900,000 recurring in SFY 2012; \$228,000 non-recurring in SFY 2012; and \$205,000 non-recurring in SFY 2013	✓ (Secy's Office)	✓	✓	✓ (ACH)
<p><b>Recommendation 4.2: Local Management Entity Outreach and Education for Adult and Family Care Home Staff</b></p> <p>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.</p>		✓ (DHSR, DMHDDSAS, DMA, DAAS)	✓	✓	✓ (ACH)

	NCGA	DHHS	LMEs	ACHs	Others
<p><b>Recommendation 4.3: Case-Mix Adjusted Payments</b></p> <p>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.</p>		✓			
<p><b>Recommendation 5.1: Use Geriatric/Adult Mental Health Specialty Teams to Provide Training in all ACHs</b></p> <p>The North Carolina General Assembly should enact legislation to require all adult and family care homes (ACH) to receive geriatric/adult mental health specialty team training at least three times per year. The training should be tailored to the needs of the specific ACH but should, at a minimum, cover person-centered thinking and de-escalation skills.</p>	\$*	✓ (Secy's Office, DHHSR)		✓	✓ (ACH)
<p><b>Recommendation 5.2: Require Adult and Family Care Home Staff to Be Trained and to Exhibit Competency in Person-Centered Thinking and Crisis Prevention</b></p> <p>The North Carolina General Assembly should require all adult and family care home direct care workers, personal care aides, medication aides, and supervisors to be trained and to have passed the competency exam for state-approved crisis intervention training by June 2013.</p>		✓ (DHHSR)	✓	✓	✓ (ACH)
<p><b>Recommendation 5.3: Pilot New Behavioral Health Training and Competency Examination Requirements for New Direct Care Workers</b></p> <p>The North Carolina Division of Health Service Regulation, in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the Division of Medical Assistance, should develop a standardized curriculum and competency test for new direct care workers as part of the federal Personal and Home Care Aide State Training Program grant.</p>		✓ (DHHSR, DMHDDSAS, DMA)			

a The Task Force recommends the North Carolina Department of Health and Human Services study and report to the appropriate legislative committees on whether there are currently enough resources to meet these new training requirements.

- ACH                    Adult and family care homes
- DAAS                North Carolina Division of Aging and Adult Services
- DHHSR              North Carolina Division of Health Service Regulation
- DMA                 North Carolina Division of Medical Assistance
- DMHDDSAS        North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services
- HTF                 North Carolina Housing Trust Fund
- Secy's Office       North Carolina Department of Health and Human Services Secretary's Office



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## Task Force on the Co-Location of Different Populations in Adult Care Homes

### Chapter 3: Increasing Options for Individuals with Disabilities

#### Recommendation 3.1: Pilot Program (PRIORITY RECOMMENDATION)

The North Carolina Department of Health and Human Services (DHHS) should develop a pilot program to evaluate the costs, quality, consumer satisfaction, and patient outcomes of a program that supports individuals who would otherwise be in an adult or family care home and who want to move into independent supported housing. As part of this, DHHS should:

- a) Submit a Medicaid 1915(i) state plan amendment or 1915(c) HCBS waiver to support individuals living in adult or family care homes (ACH) for 90 or more days who would like to move back to more independent living arrangements. The 1915(i) state plan amendment should be modeled after the state's Money Follows the Person<sup>a</sup> initiative for people in nursing facilities. The Medicaid 1915(i) state plan amendment should provide home and community-based services, including, but not limited to, personal care services, adult day care, and case management, and should pay for reasonable one-time transitional costs, including but not limited to security deposits, first month rent, or home modification.
- b) DHHS should develop a process to evaluate people living in ACHs to determine whether people can appropriately live independently in the community with services and supports, and should provide counseling and transition services to appropriate individuals who want to move to more independent living arrangements.
- c) The pilot program should initially be limited to 1,000 individuals who want to, and can appropriately, move to more independent living arrangements with services and supports. Individuals who move out of an ACH should continue to receive the same level of State-County Special Assistance (SA) payment in the community as they were receiving in the ACH. These SA in-home payments should be exempt from the SA in-home limits established as part of Session Law 2007-323.

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<sup>a</sup> Money Follows the Person is a nursing facility transition program that identifies consumers in institutions who wish to transition to the community and allows Medicaid funds budgeted for institutional services to be spent on home and community services when individuals move to the community. Centers for Medicare & Medicaid Services. *Real Choice Systems Change Grant Program: Money Follows the Person Initiatives*. US Department of Health and Human Services; 2006.

- d) DHHS should conduct an evaluation to examine costs, quality, individual satisfaction, and patient outcomes of this demonstration in supporting people with disabilities and the frail elderly who would otherwise need ACH level of care to live more independently in the community. The results of the evaluation should be shared with the appropriate legislative committees that address the needs of older adults and of people with mental illness, intellectual and developmental disabilities, and addiction disorders no later than fall 2013 and annually thereafter. If the program is found to be successful, the North Carolina General Assembly should implement the program statewide both for individuals who are residing in ACHs and for those who have not yet entered an ACH but who meet the level of need criteria.
- e) The North Carolina General Assembly should appropriate \$100,000 non-recurring funds in state fiscal years 2012-2014 to the North Carolina Department of Health and Human Services to provide technical assistance to help interested ACHs create financially viable models that support people to live more independently in the community, such as, but not limited to, multi-unit supported housing, recovery-based scattered housing, transitional housing, and adult day care. DHHS should strive to work with rural, urban, large, and small ACH facilities.
- f) DHHS should continue its work to remove statutory and regulatory barriers to independent living options for people with disabilities who receive services in the community.

### **Recommendation 3.2: Increase Funding for Housing for Individuals with Disabilities**

- a) To help individuals with disabilities better afford housing, the North Carolina General Assembly should appropriate \$10 million in additional recurring funding beginning in state fiscal year 2011 to the North Carolina Housing Finance Agency to increase funding to the North Carolina Housing Trust Fund. A significant portion of the funding should be targeted for housing for individuals with disabilities.
- b) DHHS should work with the Housing Finance Agency to explore options to create transitional housing for people who need short-term stabilization options to help them make a transition to more independent living in the community.

### **Recommendation 3.3: Create an Inventory of Community Housing Options for Individuals with Disabilities**

- a) As part of the local management entity's (LME) performance contract with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), DMHDDSAS should require LMEs, working with DMHDDSAS, the Division of Health Services Regulation, and the North Carolina Department of Health and Human Services housing specialists, to develop a real-time inventory of community housing options, including 122C therapeutic mental health homes, substance abuse and developmental disability group homes, adult and family care homes, supported living arrangements, and independent living options, and make this inventory available to families. The lists should be collected and aggregated at the state level and should be made available both online and in person through the LMEs.

## **Chapter 4: Restructuring the Current System**

### **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 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.
- 2) 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.
  - 3) 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.
- a) 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.

- b) 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<sup>b</sup> 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.
- c) 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.

## **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.

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<sup>b</sup> 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 4.3: 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.

## **Chapter 5: Training Requirements for Adult Care Homes and 122C Facilities**

### **Recommendation 5.1: Use Geriatric/Adult Mental Health Specialty Teams to Provide Training in all ACHs**

- a) The North Carolina General Assembly should enact legislation to require all adult and family care homes (ACH) to receive geriatric/adult mental health specialty team (GAST) training at least three times per year. The training should be tailored to the needs of the specific ACH but should, at a minimum, cover person-centered thinking and de-escalation skills. Staff on all three shifts (including supervisors, administrators, personal care assistants, medication aides, and any other workers who have direct hands-on contact with residents) should receive this training at least once per year.
- b) The North Carolina Department of Health and Human Services should evaluate and report back to appropriate legislative committees that address the needs of older adults or people with mental illness, intellectual and developmental disabilities, or addiction disorders by fall 2012 information on whether there are enough GAST resources to meet the new training requirements and whether there are sufficient mobile crisis teams and START crisis teams to meet the needs of ACHs in the event of behavioral health crises.

### **Recommendation 5.2: Require Adult and Family Care Home Staff to Be Trained and to Exhibit Competency in Person-Centered Thinking and Crisis Prevention**

The North Carolina General Assembly should require all adult and family care home direct care workers, personal care aides, medication aides, and supervisors to be trained and to have passed the competency exam for state-approved crisis intervention training by June 2013.

### **Recommendation 5.3: Pilot New Behavioral Health Training and Competency Examination Requirements for New Direct Care Workers**

- a) The North Carolina Division of Health Service Regulation (DHSR), in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) and the Division of Medical Assistance, should develop a standardized curriculum and competency test for new direct care workers as part of the federal Personal and Home Care Aide State Training Program (PHCAST) grant. The core training should include, but not be limited to, the following:
- 1) Knowledge and understanding of the people being served, including the impact of aging on different populations.
  - 2) Recognizing and interpreting human behavior.
  - 3) Recognizing the effect of internal and external stressors that may affect people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders.
  - 4) Strategies for building positive relationships with persons with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders and for recognizing cultural, environmental, and organizational factors that may affect people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders.
  - 5) Recognizing the importance of and assisting in the person's involvement in making decisions about his or her life.
  - 6) Skills in assessing individual risk for escalating behavior.

- 7) Communication strategies for defusing and de-escalating potentially dangerous behaviors.
- 8) Positive behavioral supports providing means for people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders to choose activities that directly oppose or replace behaviors that are unsafe.
- 9) Information on alternatives to the use of restrictive interventions.
- 10) Guidelines on when to intervene (understanding imminent danger to self and others).
- 11) Emphasis on safety and respect for the rights and dignity of all persons involved, including least restrictive interventions and incremental steps in an intervention.
- 12) Knowledge of prohibited procedures, including but not limited to abuse, neglect, and exploitation.
- 13) Debriefing strategies, including their importance and purpose, particularly after resident deaths.
- 14) Documentation methods/procedures.

The competency test developed should include both written and skills-based evaluation of training related to working with individuals with disabilities.

- b) To encourage retention of qualified staff, staff who undergo additional training and who demonstrate additional competencies should be rewarded with higher salaries.
- c) The DHSR should evaluate and make recommendations about whether this training should be mandatory for all direct care workers. DHSR should report its findings to the appropriate legislative committees that address the needs of older adults or people with mental illness, intellectual and developmental disabilities, or addiction disorders by the end of the three-year PHCAST pilot.

FL-2 (86)

## NORTH CAROLINA MEDICAID PROGRAM LONG TERM CARE SERVICES

INSTRUCTIONS ON REVERSE SIDE

PRIOR APPROVAL

UTILIZATION REVIEW

ON-SITE REVIEW

### IDENTIFICATION

1. PATIENT'S LAST NAME	FIRST	MIDDLE	2. BIRTHDATE (M/D/Y)	3. SEX	4. ADMISSION DATE (CURRENT LOCATION)
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5. COUNTY AND MEDICAID NUMBER	6. FACILITY ADDRESS	7. PROVIDER NUMBER
-------------------------------	---------------------	--------------------

8. ATTENDING PHYSICIAN NAME AND ADDRESS	9. RELATIVE NAME AND ADDRESS
---	------------------------------

10. CURRENT LEVEL OF CARE <input type="checkbox"/> HOME <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> SNF <input type="checkbox"/> SNF (REST HOME) <input type="checkbox"/> ICF <input type="checkbox"/> OTHER <input type="checkbox"/> HOSPITAL	11. RECOMMENDED LEVEL OF CARE <input type="checkbox"/> HOME <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> SNF <input type="checkbox"/> SNF (REST HOME) <input type="checkbox"/> ICF <input type="checkbox"/> OTHER	12. PRIOR APPROVAL NUMBER	14. DISCHARGE PLAN <input type="checkbox"/> SNF <input type="checkbox"/> HOME <input type="checkbox"/> ICF <input type="checkbox"/> DOMICILIARY (REST HOME) <input type="checkbox"/> OTHER
		13. DATE APPROVED / DENIED	

### 13. ADMITTING DIAGNOSES - PRIMARY, SECONDARY, DATES OF ONSET

1.	5.
2.	6.
3.	7.
4.	8.

### 16. PATIENT INFORMATION

DISORIENTED <input type="checkbox"/> CONSTANTLY <input type="checkbox"/> INTERMITTENTLY	AMBULATORY STATUS <input type="checkbox"/> AMBULATORY <input type="checkbox"/> SEMI-AMBULATORY <input type="checkbox"/> NON-AMBULATORY	BLADDER <input type="checkbox"/> CONTINENT <input type="checkbox"/> INCONTINENT <input type="checkbox"/> INDWELLING CATHETER <input type="checkbox"/> EXTERNAL CATHETER	BOWEL <input type="checkbox"/> CONTINENT <input type="checkbox"/> INCONTINENT <input type="checkbox"/> COLOSTOMY <input type="checkbox"/> RESPIRATION
INAPPROPRIATE BEHAVIOR <input type="checkbox"/> WANDERER <input type="checkbox"/> VERBALLY ABUSIVE <input type="checkbox"/> INJURIOUS TO SELF <input type="checkbox"/> INJURIOUS TO OTHERS <input type="checkbox"/> INJURIOUS TO PROPERTY OTHER:	FUNCTIONAL LIMITATIONS <input type="checkbox"/> SIGHT <input type="checkbox"/> HEARING <input type="checkbox"/> SPEECH <input type="checkbox"/> CONTRACTURES ACTIVITIES SOCIAL <input type="checkbox"/> PASSIVE <input type="checkbox"/> ACTIVE <input type="checkbox"/> GROUP PARTICIPATION <input type="checkbox"/> RE-SOCIALIZATION <input type="checkbox"/> FAMILY SUPPORTIVE	COMMUNICATION OF NEEDS <input type="checkbox"/> VERBALLY <input type="checkbox"/> NON-VERBALLY <input type="checkbox"/> DOES NOT COMMUNICATE SKIN <input type="checkbox"/> NORMAL OTHER: DECUBITI-DESCRIBE:	NUTRITION STATUS <input type="checkbox"/> DIET <input type="checkbox"/> SUPPLEMENTAL <input type="checkbox"/> SPOON <input type="checkbox"/> PARENTERAL <input type="checkbox"/> NASOGASTRIC <input type="checkbox"/> GASTROSTOMY <input type="checkbox"/> INTAKE AND OUTPUT <input type="checkbox"/> FORCE FLUIDS <input type="checkbox"/> WEIGHT <input type="checkbox"/> HEIGHT
PERSONAL CARE ASSISTANCE <input type="checkbox"/> BATHING <input type="checkbox"/> FEEDING <input type="checkbox"/> DRESSING <input type="checkbox"/> TOTAL CARE	PHYSICIAN VISITS <input type="checkbox"/> 30 DAYS <input type="checkbox"/> 60 DAYS <input type="checkbox"/> OVER 180 DAYS	NEUROLOGICAL <input type="checkbox"/> CONVULSIONS/SEIZURES <input type="checkbox"/> GRAND MAL <input type="checkbox"/> PETIT MAL <input type="checkbox"/> FREQUENCY	

17. SPECIAL CARE FACTORS	FREQUENCY
<input type="checkbox"/> BLOOD PRESSURE	
<input type="checkbox"/> DIABETIC URINE TESTING	
<input type="checkbox"/> PT (BY LICENSED PT)	
<input type="checkbox"/> RANGE OF MOTION EXERCISES	
	SPECIAL CARE FACTORS
	FREQUENCY
	BOWEL AND BLADDER PROGRAM
	RESTORATIVE FEEDING PROGRAM
	SPEECH THERAPY
	RESTRAINTS

### 18. MEDICATIONS NAME & STRENGTHS, DOSAGE & ROUTE

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

19. X-RAY AND LABORATORY FINDINGS / DATE:

20. ADDITIONAL INFORMATION:

21. PHYSICIAN'S SIGNATURE \_\_\_\_\_ 22. DATE \_\_\_\_\_

372-124 (12-92)

EDS - DMA COPY





MR2-11/87  
INSTRUCTIONS ON BACK

## NORTH CAROLINA MEDICAID PROGRAM MENTAL RETARDATION SERVICES

PRIOR - APPROVAL       ON-SITE       UTILIZATION REVIEW

### PATIENT INFORMATION PA

1. PATIENT NAME (LAST, FIRST, MIDDLE)			7. FACILITY			8. PROVIDER NUMBER		
2. BIRTH DATE (M/D/Y)		3. SEX	4. ADMISSION DATE (CURRENT LOCATION)		9. TYPE OF FACILITY		10. CURRENT LEVEL	11. REC. LEVEL OF CARE
5. COUNTY	MEDICAID NUMBER				12. PRIOR APPROVAL NUMBER		13. DATE APPROVED/DENIED	
6. RELATIVE				14. ATTENDING PHYSICIAN				

<b>DIAGNOSIS</b>			
15. MENTAL RETARDATION		16. CAUSE OF MENTAL RETARDATION	
COGNITIVE LEVEL	ADAPTIVE LEVEL	_____	
_____ MILD	_____ MILD	_____	
_____ MODERATE	_____ MODERATE	_____	
_____ SEVERE	_____ SEVERE	_____	
_____ PROFOUND	_____ PROFOUND	_____	
17. CURRENT MEDICAL DIAGNOSIS _____			

18. HEIGHT _____	WEIGHT _____	BP _____	19. BOWELS: _____	CONT. _____	INCONT. _____	20. URINARY: _____	CONT. _____	INCONT. _____	CATHETER _____
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### PATIENT EVALUATION

21. MEDICAL CONCERNS		22. FUNCTIONAL LIMITATIONS			
_____ OSTOMY CARE	_____ DIABETIC	VISION	HEARING	SPEECH	
_____ ESOPHALGEAL REFLUX	_____ HYPERTENSION	_____ NORMAL	_____ NORMAL	_____ NORMAL	
_____ HX OF DECUBITUS ULCER	_____ INSOMNIA	_____ IMPAIRED	_____ DEAF	_____ NON-COMMUNICATIVE	
_____ CONTRACTURES	_____ OTHER _____	_____ BLIND	_____ OTHER	_____ GESTURES	
				_____ ECHOLALIC	
23. NUTRITION		24. SKIN	25. PERSONAL CARE		26. AMBULATION
DIET: _____	_____ NORMAL	_____ OTHER _____	BATHING	DRESSING	_____ INDEPENDENT
_____ FEEDS INDEPENDENTLY			_____ INDEPENDENT	_____ INDEPENDENT	_____ AMB: W/ASSISTANCE
_____ W/ASSISTANCE			_____ W/ASSIST.	_____ W/ASSIST.	_____ NON AMB/MOBILE
_____ PARENTERAL			_____ TOTAL ASSIST.	_____ TOTAL ASSIST.	_____ NON-AMB/NON MOBIL
_____ TUBE					
27. BEHAVIORAL PROBLEM		28. BEHAVIORAL CONTROL		29. SUPPORTIVE/PROTECTIVE DEVICES	
_____ VERBAL ABUSE	_____ BEHAVIORAL PLAN	_____ NONE	_____ WHEELCHAIR	_____ SUPPORTIVE BELTS	
_____ COMBATIVE	_____ MODERATE/MILD	_____ WALKER/CRUTCHES/BRACES	_____ HEARING AID	_____ BEDRAILS	
_____ INAPPROPRIATE BEHAV.	_____ SEVERE/PROFOUND	_____ GLASSES	_____ ADAPTIVE CLOTHING	_____ LAP TRAYS	
_____ WANDERER	_____ PSYCHOTROPIC MEDS	_____ ADAPT EATING UTENSILS	_____ HELMET	_____ MODIFIED SHOES	
_____ RUN AWAY	_____ PHYSICAL RESTRAINTS			_____ MITTENS/SPLINTS	
_____ INJURIOUS	_____ TIME OUT			_____ OTHER _____	
_____ PROPERTY					
_____ SELF					
_____ OTHERS					

30. CURRENT NEEDS		<b>PLAN OF TREATMENT</b>		32. PHYSICIAN VISITS		33. MEDICATIONS: DOSAGE, ROUTE, FREQUENCY.	
_____ NURSING	_____ RESTRAINTS _____	31. LENGTH OF CARE	DISCHARGE PLAN	_____ 90 DAYS	_____ OTHER	_____	
_____ SEIZURE CONTROL	_____ PHYSICAL THERAPY	_____ OVER 180 DAYS	_____ 60-180 DAYS	_____ 30-60	_____ OTHER	_____	
_____ OCCUPATIONAL THERAPY	_____ SPEECH THERAPY	_____ OTHER _____					_____
34. HABILITATION PLAN		35. DIAGNOSTIC PROCEDURES				_____	
GOALS/OBJECTIVES/ACTIVITIES _____		_____				_____	
_____		_____				_____	
_____		_____				_____	
36. REHABILITATION POTENTIAL						_____	
_____						_____	
37. REASON FOR LEVEL OF CARE/OTHER COMMENTS:						_____	
_____						_____	
_____						_____	

38. M.D. SIGNATURE \_\_\_\_\_ MA- 2280 Figure 4b 39. DATE \_\_\_\_\_

**NORTH CAROLINA MEDICAID PROGRAM**

**Instructions for Completion of MR-2**

To be used for prior approval, utilization/continued care review and on-site medical review. Complete or check (✓) ONLY those blocks appropriate to the patient at the time the form is completed. Check (✓) the appropriate block to indicate the type of review.

**INFORMATION**

**Identification**

- 1. **Patient Name:** Print last name, first name, middle initial. If no middle name, indicate NMN.
- 2. **Birthdate:** Enter month, day and year.
- 3. **Sex:** Enter Capital F to indicate female or M to indicate male.
- 4. **Admission Date:** (current location): Enter month, day and year.
- 5. **County and Medicaid Number:** Enter 2 digit county number and 9 digit and alpha suffix Medicaid number.
- 6. **Relative Name and Address:** Enter complete name and address.
- 7. **Facility Name and Address:** Enter complete name of facility and street address.
- 8. **Provider Number:** Enter 7 digit number for current level of care.
- 9. **Type of facility:** Enter ICF/MR, ICF, SNF or hospital, etc.
- 10. **Current Level of Care:** Enter current level of care provided.
- 11. **Recommended Level of Care:** Enter the level of care that is recommended.
- 12. **Prior Approval Number:** Enter 9 digit number for current level of care. Leave blank when requesting Prior Approval.
- 13. **Date Approved/Denied:** Leave blank for internal processing.
- 14. **Attending Physician and Address:** Enter complete name and address.

**DIAGNOSIS**

- 15. **Mental Retardation Level:** Check (✓) the degree of cognitive and adaptive retardation.
- 16. **Cause of Mental Retardation:** Enter the cause of retardation.
- 17. **Current Medical Diagnosis:** Enter medical diagnosis that are pertinent currently.

**PATIENT EVALUATION**

- 18. **Height:** Enter height or length (infants), if available; weight, blood pressure.
- 19. **Bowels:** Check (✓) continent or incontinent.
- 20. **Urinary:** Check (✓) continent, incontinent or catheter.
- 21. - 33. **Check (✓)** or complete those blocks appropriate to patient at this time.

**PLAN OF TREATMENT**

- 34. **Habilitation Plan:** Enter briefly the programs planned and/or implemented with goals / objectives.
- 35. **Diagnostic Procedures:** Enter procedure, date and results (for Utilization Review, enter procedures since last UR).
- 36. and 37. **Enter reason(s)** the patient requires placement at the recommend level of care: rehabilitation potential, and other pertinent comments about the patient's condition not indicated above.
- 38. **Physician's Signature:** The Physician must validate by signature the care needs presented on this patient.
- 39. **Date:** The MR-2 must be dated by the physician who signs the form.

**MAILING INSTRUCTIONS**

Utilization/Continued Care Reviews  
Division of Medical Assistance  
Attn: Utilization Control Section  
1985 Umstead Drive  
Raleigh, North Carolina 27603

Prior Approval  
EDS  
Attn: Prior Approval  
Post Office Box 31188  
Raleigh, NC 27622

MA2280 Figure 4b

<b>Please Print</b>	<b>NORTH CAROLINA LEVEL I SCREENING FORM</b> <b>THIS MUST REMAIN IN THE INDIVIDUAL'S RECORD</b>	<b>CONFIDENTIAL</b>
---------------------	--	---------------------

Patient Name: _____ Mailing Address: _____ Referring Facility: _____ Facility Address: _____ Telephone: _____ Submitted By: _____ Submitter's Signature & Title: _____	SS #: _____ Medicaid # _____ Sex _____ DOB: _____ Pmt. Status: _____ Marital Status: _____ Admit Date to Nursing Facility: _____ Admitting Facility: _____ Address: _____ Contact Person: _____ Telephone: _____ Patient's Current Location: _____ Address: _____ County: _____
--	---

Does the individual desire NF services?  Yes  No

<p style="text-align: center;"><b>SECTION I: MENTAL ILLNESS SCREEN</b></p> <p><b>1.A. Psychiatric Diagnoses <u>excluding</u> Dementia, Alzheimer's, and/or Organic Brain Disorders</b></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Anxiety/panic disorder</td> <td><input type="checkbox"/> Psychotic disorder</td> </tr> <tr> <td><input type="checkbox"/> Bipolar Disorder</td> <td><input type="checkbox"/> Somatoform disorder</td> </tr> <tr> <td><input type="checkbox"/> Delusional Disorder</td> <td><input type="checkbox"/> Schizophrenia</td> </tr> <tr> <td><input type="checkbox"/> Schizoaffective disorder</td> <td><input type="checkbox"/> Major Depression</td> </tr> <tr> <td><input type="checkbox"/> Eating disorder (specify) _____</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Personality disorder (specify) _____</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td></td> </tr> </table> <p><b>1.B. Psychiatric Medication</b>                      <b>Diagnosis / Purpose</b></p> <table style="width: 100%;"> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	<input type="checkbox"/> Anxiety/panic disorder	<input type="checkbox"/> Psychotic disorder	<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Somatoform disorder	<input type="checkbox"/> Delusional Disorder	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizoaffective disorder	<input type="checkbox"/> Major Depression	<input type="checkbox"/> Eating disorder (specify) _____		<input type="checkbox"/> Personality disorder (specify) _____		<input type="checkbox"/> Other: _____		_____	_____	_____	_____	_____	_____	<p><b>3.C. Significant problems adapting to typical changes within 6 months due to MI (<u>excluding</u> medical problems, Dementia Alzheimer's, and/or Organic Brain D/Os)</b></p> <p>Y N Requires mental health intervention due to increased symptoms</p> <p>Y N Requires judicial intervention due to symptoms</p> <p>Y N Symptoms have increased as a result of adaptation difficulties</p> <p>Y N Serious agitation or withdrawal due to adaptation difficulties</p> <p>Y N Other _____</p> <p>Notes: _____</p>
<input type="checkbox"/> Anxiety/panic disorder	<input type="checkbox"/> Psychotic disorder																				
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Somatoform disorder																				
<input type="checkbox"/> Delusional Disorder	<input type="checkbox"/> Schizophrenia																				
<input type="checkbox"/> Schizoaffective disorder	<input type="checkbox"/> Major Depression																				
<input type="checkbox"/> Eating disorder (specify) _____																					
<input type="checkbox"/> Personality disorder (specify) _____																					
<input type="checkbox"/> Other: _____																					
_____	_____																				
_____	_____																				
_____	_____																				

<b>NC Medicaid USE ONLY: Meets diagnosis criteria for diagnosis/chronicity?</b> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UTD	<b>MI Decision: Meets criteria for SMI?</b> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UTD	<b>Meets criteria for disability?</b> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UTD
---	---	---

<p><b>2.A. Psychiatric treatment received in past 2 years (<u>excluding</u> treatment for Dementia, Alzheimer's and/or Organic Brain D/O's) Include dates of the hospitalization(s)</b></p> <p><input type="checkbox"/> Inpatient psych. hosp. _____</p> <p><input type="checkbox"/> Partial hosp./day treatment _____</p> <p><input type="checkbox"/> Outpatient treatment _____</p> <p><b>2.B. Intervention(s) to prevent hospitalization(s). Include date(s)</b></p> <p><input type="checkbox"/> Supportive living (due to MI) _____</p> <p><input type="checkbox"/> Housing intervention (due to MI) _____</p> <p><input type="checkbox"/> Legal intervention (due to MI) _____</p> <p><input type="checkbox"/> Other: _____</p>	<p style="text-align: center;"><b>SECTION II: MENTAL RETARDATION SCREEN</b></p> <p><b>1.A. MR diagnosis:</b> _____ N _____ Y Mild Moderate Severe Profound</p> <p><b>1.B. Undiagnosed but suspected MR:</b> _____ N _____ Y _____ N/A</p> <p><b>1.C. History of receipt of MR services:</b> _____ N _____ Y _____</p> <p>(if yes, specify): _____</p> <p><b>1.D. Onset before age 18:</b> _____ N _____ Y (if yes, specify age): _____</p> <p><b>1.E. Education Level</b></p> <p><b>History of gainful employment?</b> _____ N _____ Y</p> <p><b>Ability to handle finances?</b> _____ N _____ Y</p>
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<b>NC Medicaid USE ONLY: Meets criteria for duration?</b> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UTD	<b>NC Medicaid USE ONLY: Meets criteria for MR?</b> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UTD
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<p><b>Role limitations in past 6 months due to MI (<u>excluding</u> medical problems, Dementia, Alzheimer's and/or Organic Brain D/O) :</b> Indicate: "F" Frequently, "O" Occasionally, or "N" Never</p> <p><b>3.A. Interpersonal Functioning (<u>excluding</u> medical problems, Dementia, Alzheimer's and/or Organic Brain D/O)</b></p> <table style="width: 100%;"> <tr> <td>F O N Altercations</td> <td>F O N Social isolation/avoidance</td> </tr> <tr> <td>F O N Evictions</td> <td>F O N Excessive irritability</td> </tr> <tr> <td>F O N Fear of strangers</td> <td>F O N Easily upset/anxious</td> </tr> <tr> <td colspan="2">_____</td> </tr> <tr> <td>F O N Suicide attempt/ideations</td> <td>_____ difficulties</td> </tr> <tr> <td colspan="2">Please note dates: _____</td> </tr> </table> <p><b>3.B. Concentration/Task limitations within past 6 months due to MI (<u>excluding</u> medical problems, Dementia, Alzheimer's and/or Organic Brain D/O)</b></p> <table style="width: 100%;"> <tr> <td>F O N Serious difficulty completing age related tasks</td> </tr> <tr> <td>F O N Serious loss of interest in things</td> </tr> <tr> <td>F O N Serious difficulty maintaining concentration/attention</td> </tr> <tr> <td>F O N Numerous errors in completing tasks which she/he should be physically capable</td> </tr> <tr> <td>F O N Requires assistance with tasks for which she/he should be physically capable of accomplishing</td> </tr> <tr> <td>F O N Other</td> </tr> </table>	F O N Altercations	F O N Social isolation/avoidance	F O N Evictions	F O N Excessive irritability	F O N Fear of strangers	F O N Easily upset/anxious	_____		F O N Suicide attempt/ideations	_____ difficulties	Please note dates: _____		F O N Serious difficulty completing age related tasks	F O N Serious loss of interest in things	F O N Serious difficulty maintaining concentration/attention	F O N Numerous errors in completing tasks which she/he should be physically capable	F O N Requires assistance with tasks for which she/he should be physically capable of accomplishing	F O N Other	<p style="text-align: center;"><b>SECTION III: RELATED CONDITIONS SCREEN</b></p> <p><b>1.A. Related Condition diagnosis which impairs intellectual functioning or adaptive behavior:</b> _____ Blindness _____ Cerebral Palsy _____ Autism _____ Epilepsy _____ Deafness _____ Closed Head Injury _____ Other _____</p> <p><b>1.B. Substantial functional limitations 3 or more of the following secondary to Related Condition and not a medical condition:</b></p> <p>_____ Mobility _____ Learning _____ Capability for independent living Understanding/use of language? _____ N _____ Y specify if yes: _____</p> <p><b>1.C. Was the condition manifested prior to the age 22?</b> _____ N _____ Y</p> <p><b>NC Medicaid USE ONLY: Meets criteria for Related Condition?</b> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UTD</p> <p><b>Comments related to applicant's MI, MR, and/or RC:</b></p> <p>_____</p> <p>_____</p> <p>_____</p>
F O N Altercations	F O N Social isolation/avoidance																		
F O N Evictions	F O N Excessive irritability																		
F O N Fear of strangers	F O N Easily upset/anxious																		
_____																			
F O N Suicide attempt/ideations	_____ difficulties																		
Please note dates: _____																			
F O N Serious difficulty completing age related tasks																			
F O N Serious loss of interest in things																			
F O N Serious difficulty maintaining concentration/attention																			
F O N Numerous errors in completing tasks which she/he should be physically capable																			
F O N Requires assistance with tasks for which she/he should be physically capable of accomplishing																			
F O N Other																			

Please Print	North Carolina Level I Screening Form Page Two	Confidential
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Patient Name: \_\_\_\_\_

Patient Social Security Number: \_\_\_\_\_

**STOP HERE IF THERE IS NO EVIDENCE OF MI, MR, and/or RC. OTHERWISE, CONTINUE.**

**SECTION IV: DEMENTIA (complete for both MI & MR)**

1.A. Does the individual have a primary diagnosis of Dementia or Alzheimer's?  
 \_\_\_\_\_ N \_\_\_\_\_ Y (specify) \_\_\_\_\_

1.B. Does the individual have any other organic disorders?  
 \_\_\_\_\_ N \_\_\_\_\_ Y (specify) \_\_\_\_\_

1.C. Is there evidence of undiagnosed Dementia or other organic mental disorders?  
 Y N disoriented to time Y N disoriented to situation  
 Y N disoriented to place Y N paranoid ideation  
 Y N severe ST memory deficit

1.D. Is there evidence of affective symptoms which might be confused with Dementia?  
 Y N frequent tearfulness Y N severe sleep disturbance  
 Y N frequent anxiety Y N severe appetite disturbance

1.E. Can the facility supply any corroborative information to affirm that the dementing condition exists and is the primary diagnosis?  
 \_\_\_\_\_ Dementia work-up \_\_\_\_\_ Thorough mental status exam  
 \_\_\_\_\_ Medical / functional history prior to onset of dementia  
 Other \_\_\_\_\_

**Documentation must be provided to support diagnosis of Primary Dementia**

**NC Medicaid USE ONLY:**  
 Does the individual have a primary dementia diagnosis?  
 Dementia decision: \_\_\_\_\_ Y \_\_\_\_\_ N

**SECTION V: CATEGORICALS**

**Convalescent Care Exemption**

1. Does the admission meet all of the following criteria?  
 \_\_\_\_\_ Admission to a NF directly from a hospital after receiving acute medical care in the hospital; and  
 \_\_\_\_\_ Need for NF care is required for the condition for which care was provided in the hospital; and  
 \_\_\_\_\_ The attending physician has certified prior to NF admission that the individual will require less than 30 calendar days NF services.

**\* Individuals meeting all criteria are exempt for Level II screens for 30 calendar days. The receiving facility must update Level I screen at such time that it appears the individual's stay will exceed 30 days and no later than the 25th calendar day.**

**NC Medicaid USE ONLY:**  
 Meets convalescent exemption? \_\_\_\_\_ Y \_\_\_\_\_ N  
 Expiration Date: \_\_\_\_\_

The following decisions indicate the individual does meet NF eligibility and does not require specialized services for the time limit specified. An updated Level I Screen is required if the stay is expected to exceed 7 calendar days & no later than the 5th calendar day.

2.A. \_\_\_\_\_ Emergency protective service situation for MI/MR/RC individual needing 7 calendar day NF placement

2.B. \_\_\_\_\_ Delirium precludes the ability to accurately diagnose. An updated Level I is required at such time that the delirium clears and/or no later than 5 calendar days from admission

2.C. \_\_\_\_\_ Respite is needed for in-home caregivers to whom the MI/MR/RC individual will return within 7 calendar days

**NC Medicaid USE ONLY:**  
 Meets categorical determination? \_\_\_\_\_ Y \_\_\_\_\_ N  
 Expiration Date: \_\_\_\_\_

If the individual chooses admission to a NF, she/he meets the North Carolina Level of Care criteria for placement.  
 \*Further evaluation requirements are specified below:

3.A. \_\_\_\_\_ Terminal illness with life expectancy of 6 months or less (Level II evaluation will be completed via paper based review)

3.B. \_\_\_\_\_ Coma or persistent vegetative state (Level II evaluation will be completed via paper based review)

**NC Medicaid USE ONLY:**  
 Approval for Categorical/Exempted Admission: \_\_\_\_\_ Y \_\_\_\_\_ N

**Mailing Information - Please Print:**

Legal representative's name and address:  
 Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State & Zip Code: \_\_\_\_\_

Primary physician's name and address:  
 Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State & Zip Code: \_\_\_\_\_

**NC MEDICAID SUMMARY - OFFICE USE ONLY**

Date and Time Received: \_\_\_\_\_

\_\_\_\_\_ Level I approved  
 \_\_\_\_\_ Requires Level II MI evaluation  
 \_\_\_\_\_ Requires Level II MR/RC evaluation  
 \_\_\_\_\_ Requires paper review  
 \_\_\_\_\_ Time limited approval  
 Expiration Date: \_\_\_\_\_  
 \_\_\_\_\_ Status Change  
 \_\_\_\_\_ Early ARR required  
 \_\_\_\_\_ Categorical ARR

\_\_\_\_\_  
 NC Medicaid Reviewer Date



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## RESIDENT REGISTER

The following resident information is to be completed and signed by the Administrator or Supervisor-in-Charge/Administrator-in-Charge and the resident or his/her responsible person within 72 hours of admission and kept in the resident's record in the home. Put "NA" if the requested information is not applicable to the resident.

NAME OF HOME/FACILITY \_\_\_\_\_

### A. IDENTIFYING INFORMATION

1. NAME: \_\_\_\_\_  
 (first) (middle) (last) (what resident prefers to be called)

2. DATE OF ADMISSION: \_\_\_\_\_  
 (month) (day) (year)

3. FORMER ADDRESS \_\_\_\_\_ COUNTY: \_\_\_\_\_

ADMITTED FROM:  Own Residence  Another's Residence

A facility: \_\_\_\_\_  
 (Name) (Address)

Other: \_\_\_\_\_

4. BIRTHDATE \_\_\_\_\_ BIRTHPLACE \_\_\_\_\_ SS# \_\_\_\_\_

5. MEDICARE # \_\_\_\_\_ MEDICAID # \_\_\_\_\_ OTHER INSURANCE #'S \_\_\_\_\_

6. MARITAL STATUS:  Single  Married  Partnered  Widowed  Divorced  Separated

7. GENDER:  Female  Male

8. RACE:  Caucasian  African-American  Native-American  Hispanic  Other \_\_\_\_\_

9. FAMILY: Father \_\_\_\_\_ Mother \_\_\_\_\_  
 (include maiden name)

CHILDREN: \_\_\_\_\_

SIBLINGS: \_\_\_\_\_

SPOUSE/PARTNER (Address if applicable) \_\_\_\_\_

10. RESPONSIBLE PERSON (if applicable) \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Nature of Responsibility:  Guardian  Power of Attorney  Payee

11. CONTACT PERSON (If responsible person is not designated) \_\_\_\_\_

Address: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

### B. RESOURCE INFORMATION

1. ATTENDING PHYSICIAN: \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

2. PREVIOUS PHYSICIAN \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

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PLANS MADE FOR PAYMENT OF: Personal Needs \_\_\_\_\_

Other \_\_\_\_\_

**C. PERSONAL INFORMATION**

1. ASSISTANCE REQUIRED FOR: (Check all that apply)

- Dressing                                       Correspondence                                       Mouth Care
- Bathing     Getting In/Out of Bed                                       Feeding
- Nail Care     Toileting     Positioning/Turning
- Shaving     Hair/Grooming     Scheduling Appointments
- Ambulation     Skin Care     Orientation to Time and Place
- (other) \_\_\_\_\_

**If different from information contained on the FL-2, home must contact resident’s physician for clarification.**

2. MEMORY:     Adequate     Forgetful – Needs Reminders     Significant Loss – Must Be Directed

3. SPECIAL AIDS: (Check all that apply)

- Walker     Hearing Aid     Wheelchair
- Eyeglasses     Dentures (Type) \_\_\_\_\_     Other \_\_\_\_\_

4. PERSONAL HABITS:     Smoking     Alcohol     Other \_\_\_\_\_

5. **KNOWN ALLERGIES OR SUBSTANCES NOT TO BE ADMINISTERED (Drug, Food, or Otherwise):**

\_\_\_\_\_

6. FOOD PREFERENCES: If special diet, please describe: \_\_\_\_\_

\_\_\_\_\_

	FAVORITE	LEAST FAVORITE
Vegetable		
Fruit		
Meats		
Meat Substitutes		
Cereals and Breads		
Milk or Buttermilk		
Other Beverages		

7. COMMUNITY INVOLVEMENT

a. FAITH COMMUNITY \_\_\_\_\_ PASTOR \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

b. CLUB, GROUP OR ORGANIZATIONAL MEMBERSHIPS \_\_\_\_\_

c. SPECIAL SKILLS OR TALENTS \_\_\_\_\_



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d. PAST WORK AND VOLUNTEER SERVICE \_\_\_\_\_

e. HOBBIES \_\_\_\_\_

f. ACTIVITY INTERESTS: (Review *Listing of Suggested Activities with resident*).  
 Favorite \_\_\_\_\_

Games \_\_\_\_\_

Music \_\_\_\_\_

Exercises \_\_\_\_\_

Outdoor Activity \_\_\_\_\_

Crafts \_\_\_\_\_

Outings \_\_\_\_\_

Social Activity \_\_\_\_\_

Work Type/Volunteer Activity \_\_\_\_\_

Intellectual Activity \_\_\_\_\_

g. ACTIVITIES STRONGLY DISLIKED OR TO BE AVOIDED: \_\_\_\_\_

If there is a question about a resident’s ability to participate in an activity, the home must obtain a statement from the resident’s physician regarding the resident’s capabilities.

**D. REQUEST FOR ASSISTANCE**

Below are some areas in which the home can assist a resident upon the request of the resident or his/her responsible person. The administrator or supervisor-in-charge/administrator-in-charge must explain and complete each statement with the resident or his/her responsible person. The resident or his/her responsible person may subsequently change his/her mind and make a new request in writing at any time using Section H or some other notice. An equivalent signed record can be substituted for Section D.

1. I, as resident or the resident’s responsible person, request that pertinent information be secured from the facility from which I just left. Signature: \_\_\_\_\_

2. I, as resident or the resident’s Legal guardian/payee, request that the management of this home handle my personal funds. I understand that the funds are available for my use during regular office hours and that I have the right to examine my account or to withdraw this request at any time. Signature: \_\_\_\_\_

3. I, as resident or the resident’s responsible person, request the use of lockable space for the security of personal valuables. I understand that I am entitled to one key at no charge and this space is accessible only to me, the administrator or supervisor-in-charge. Signature: \_\_\_\_\_

4. I, as resident or the resident’s responsible person, request that the management of this home –  
 a. Open my personal mail in my presence to read and explain the contents to me;  
 b. and assist in handling my mail that pertains to my financial or medical affairs.  
 Signature: \_\_\_\_\_

**E. RECEIPT OF MATERIALS**

I, as resident or the resident’s responsible person, acknowledge receipt of the following information which the management of the home reviewed with me:

Home’s resident contract specifying rates for the resident services and accommodations

House Rules which include policies on refunds, smoking, alcohol consumption visitation, and reasons for discharge.

DHSR/AC 4207 (Rev. 06/03) NCDHHS

Declaration of Residents' Rights.

Home's grievance procedures for residents to present complaints and make suggestions as to the home's policies and services.

Home's willingness to comply with Title VI of Civil Rights Act.

Other: \_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_

F. SIGNATURES

The resident or his/her responsible person should be asked to sign this form only after Sections A-E have been completed. The administrator or supervisor-in-charge/administrator-in-charge is to review this form with the resident or his/her responsible person at least once a year and revise it as needed using Section H. Section G is to be completed at the time the resident is discharged or transfers from the facility.

\_\_\_\_\_  
(Resident or Resident's Responsible Person) (Date)

\_\_\_\_\_  
(Administrator or Supervisor-in-Charge/Administrator-in-Charge) (Date)

G. DISCHARGE/TRANSFER INFORMATION

1. NOTICE OF DISCHARGE/TRANSFER \_\_\_\_\_  
(Month) (Day) (Year)

2. INITIATED BY:  Administrator  Other \_\_\_\_\_  
Reason(s) \_\_\_\_\_

3. DATE OF DISCHARGE/TRANSFER \_\_\_\_\_  
(Month) (Day) (Year)

To:  Own Residence  Another's Residence (Name) \_\_\_\_\_  
 A Facility  Other \_\_\_\_\_

4. New Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

I acknowledge the above information to be complete and accurate.

\_\_\_\_\_  
(Resident or Resident's Responsible Person) (Date)

\_\_\_\_\_  
(Administrator or Supervisor-in-Charge/Administrator-in-Charge) (Date)

H. REVIEW/REVISION

The space below may be used to revise the information contained on the form.

Changes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
(Resident or Resident's Responsible Person) (Date)

\_\_\_\_\_  
(Administrator or Supervisor-in-Charge/Administrator-in-Charge) (Date)

ADULT CARE HOME  
PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN

Assessment Date ___/___/___
Reassessment Date ___/___/___
<input type="checkbox"/> Significant Change ___/___/___

RESIDENT INFORMATION

(Please Print or Type)

RESIDENT \_\_\_\_\_ SEX (M/F) \_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ MEDICAID ID NO. \_\_\_\_\_

FACILITY \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ PROVIDER NUMBER \_\_\_\_\_

DATE OF MOST RECENT EXAMINATION BY RESIDENT'S PRIMARY CARE PHYSICIAN \_\_\_/\_\_\_/\_\_\_

ASSESSMENT

1. MEDICATIONS – Identify and report all medications, including non-prescription meds, that will continue upon admission:

Name	Dose	Frequency	Route	(✓) If Self-Administered
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

2. MENTAL HEALTH AND SOCIAL HISTORY: (If checked, explain in "Social/Mental Health History" section)

<input type="checkbox"/> Wandering <input type="checkbox"/> Verbally Abusive <input type="checkbox"/> Physically Abusive <input type="checkbox"/> Resists care <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Disruptive Behavior/ Socially Inappropriate	<input type="checkbox"/> Injurious to: <input type="checkbox"/> Self <input type="checkbox"/> Others <input type="checkbox"/> Property  Is the resident currently receiving medication(s) for mental illness/behavior? <input type="checkbox"/> YES <input type="checkbox"/> NO  Is there a history of: <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Developmental Disabilities (DD) <input type="checkbox"/> Mental Illness	Is the resident currently receiving Mental Health, DD, or Substance Abuse Services (SAS)? <input type="checkbox"/> YES <input type="checkbox"/> NO  Has a referral been made? <input type="checkbox"/> YES <input type="checkbox"/> NO  <u>If YES:</u>  Date of Referral _____ Name of Contact Person _____ Agency _____
Social/Mental Health History: _____ _____ _____ _____ _____ _____ _____		

DMA-3050-R

Resident \_\_\_\_\_

3. AMBULATION/LOCOMOTION:  No Problems  Limited Ability  Ambulatory w/ Aide or Device(s)  Non-Ambulatory  
 Device(s) Needed \_\_\_\_\_

Has device(s):  Does not use  Needs repair or replacement

4. UPPER EXTREMITIES:  No Problems  Limited Range of Motion  Limited Strength  Limited Eye-Hand Coordination  
 Specify affected joint(s) \_\_\_\_\_  Right  Left  Bilateral  
 Other impairment, specify \_\_\_\_\_

Device(s) Needed \_\_\_\_\_ Has device(s):  Does not use  Needs repair or replacement

5. NUTRITION:  Oral  Tube (Type) \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Dietary Restrictions: \_\_\_\_\_

Device(s) Needed \_\_\_\_\_

Has device(s):  Does not use  Needs repair or replacement

6. RESPIRATION:  Normal  Well Established Tracheostomy  Oxygen  Shortness of Breath  
 Device(s) Needed \_\_\_\_\_ Has device(s):  Does not use  Needs repair or replacement

7. SKIN:  Normal  Pressure Areas  Decubiti  Other \_\_\_\_\_  
 Skin Care Needs \_\_\_\_\_

8. BOWEL:  Normal  Occasional Incontinence (less than daily)  Daily Incontinence  
 Ostomy: Type \_\_\_\_\_ Self-care:  YES  NO

9. BLADDER:  Normal  Occasional Incontinence (less than daily)  Daily Incontinence  
 Catheter: Type \_\_\_\_\_ Self-care:  YES  NO

10. ORIENTATION:  Oriented  Sometimes Disoriented  Always Disoriented

11. MEMORY:  Adequate  Forgetful - Needs Reminders  Significant Loss - Must Be Directed

12. VISION:  Adequate for Daily Activities  Limited (Sees Large Objects)  Very Limited (Blind); Explain \_\_\_\_\_  
 Uses:  Glasses  Contact Lens  Needs repair or replacement  
 Comments \_\_\_\_\_

13. HEARING:  Adequate for Daily Activities  Hears Loud Sounds/Voices  Very Limited (Deaf); Explain \_\_\_\_\_  
 Uses Hearing Aid(s)  Needs repair or replacement  
 Comments \_\_\_\_\_

14. SPEECH/COMMUNICATION METHOD:  Normal  Slurred  Weak  Other Impediment  No Speech  
 Gestures  Sign Language  Writing  Foreign Language Only \_\_\_\_\_  Other  None  
 Assistive Device(s) (Type \_\_\_\_\_) Has device(s):  Does not use  Needs repair or replacement

Resident \_\_\_\_\_

DMA-3050-R

**CARE PLAN**

15. IF THE ASSESSMENT INDICATES THE RESIDENT HAS MEDICALLY RELATED PERSONAL CARE NEEDS REQUIRING ASSISTANCE, SHOW THE PLAN FOR PROVIDING CARE. CHECK OFF THE DAYS OF THE WEEK EACH ADL TASK IS PERFORMED AND RATE EACH ADL TASK BASED ON THE FOLLOWING PERFORMANCE CODES: **0** - INDEPENDENT, **1** - SUPERVISION, **2** - LIMITED ASSISTANCE, **3** - EXTENSIVE ASSISTANCE, **4** - TOTALLY DEPENDENT. (PLEASE REFER TO YOUR ADULT CARE HOME PROGRAM MANUAL FOR MORE DETAIL ON EACH PERFORMANCE CODE.)

<u>ACTIVITIES OF DAILY LIVING (ADL)</u>	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	PERFORMANCE CODE
<i>DESCRIBE THE SPECIFIC TYPE OF ASSISTANCE NEEDED BY THE RESIDENT AND PROVIDED BY STAFF, NEXT TO EACH ADL:</i>								
EATING								
TOILETING								
AMBULATION / LOCOMOTION								
BATHING								
DRESSING								
GROOMING / PERSONAL HYGIENE								
TRANSFERRING								

**OTHER:** (Include Licensed Health Professional Support (LHPS) Personal Care Tasks, as listed in Rule 42C .3703, and any other special care needs)


**ASSESSOR CERTIFICATION**

I certify that I have completed the above assessment of the resident's condition. I found the resident needs personal care services due to the resident's medical condition. I have developed the care plan to meet those needs.

Resident/responsible party has received education on Medical Care Decisions and Advance Directives prior to admission.

\_\_\_\_\_  
Name Signature Date

**PHYSICIAN AUTHORIZATION**

I certify that the resident is under my care and has a medical diagnosis with associated physical/mental limitations warranting the provision of the personal care services in the above care plan.

The resident may take therapeutic leave as needed.

\_\_\_\_\_  
Name Signature Date

**INSTRUCTIONS FOR COMPLETING THE *REVISED* ADULT CARE HOME PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN (DMA-3050-R)**

The block in the upper right hand corner of the form denotes the type of assessment that is completed: Include Assessment date, Reassessment date, or Significant Change. Refer to the glossary in the Adult Care Home Services manual for the definition of significant change.

**RESIDENT INFORMATION:** In the Resident Information area include the resident's name as it appears on the blue Medicaid ID card. Complete all information.

**DATE OF MOST RECENT EXAMINATION:** Includes a yearly physical by the resident's attending physician.

**ASSESSMENT:**

1. **MEDICATIONS:** List the name of each medication, include non-prescription meds that the resident will continue upon admission. Check appropriate box for self-administered.
2. **MENTAL HEALTH AND SOCIAL HISTORY:** Identify by checking the appropriate box. Review records from discharging facility to monitor if there was any indication about history of injury to self, property, or others. Include meds for mental illness/behavior, and include if there is a history of Mental Illness, Developmental Disabilities, or Substance Abuse.
  - **Is the resident currently receiving Mental Health (MH), Developmental Disabilities (DD), or Substance Abuse Services (SAS)?** If a referral has been made for an evaluation, indicate the date of referral, name of contact person at the agency, and the agency name.
  - **Social/Mental Health History:** Include any history that can be gathered from assessment by the resident, family, friends, etc. that provide information about the resident's preferences, activities and living status. This is also an area that needs to identify any Mental Health history such as institutionalization, out patient, compliance history, police record, etc.

**TOP OF SECOND PAGE: RESIDENT \_\_\_\_\_:** Place name as on Medicaid ID card in this blank.

3. **AMBULATION/LOCOMOTION:** Check applicable block and list devices needed.
4. **UPPER EXTREMITIES:** Check applicable box and list devices needed.
5. **NUTRITION:** Check appropriate box. Indicate height and weight. Include any restrictions to diet, i.e. NAS, soft, etc.
6. **RESPIRATION:** Check appropriate box. Indicate any devices needed.
7. **SKIN:** Check appropriate box. Explain in detail treatment necessary and include any MD orders for skin care.
8. **BOWEL:** Check appropriate box. Indicate if the resident is independent of activity. Explain what resident needs from staff.



9. **BLADDER:** Check appropriate box. Indicate if the resident is independent of activity. Explain what residents need from staff.
10. **ORIENTATION:** Check appropriate box.
11. **MEMORY:** Check appropriate box.
12. **VISION:** Check appropriate box. Expand on concerns in comments area.
13. **HEARING:** Check appropriate box. Expand on concerns in comments area.
14. **SPEECH/COMMUNICATION METHOD:** Check appropriate box.

**TOP OF THIRD PAGE: RESIDENT** \_\_\_\_\_ : Place name as on Medicaid ID card in this blank.

**CARE PLAN:**

15. Refer to the Adult Care Home Services manual for more detail on Performance Codes.

**ACTIVITIES OF DAILY LIVING:** Include a description of the specific type of assistance provided by staff next to each ADL and code the activity in the Performance Code area. In Other, list any Licensed Health Professional Support tasks as well as any special care needs in this area.

**ASSESSOR CERTIFICATION:** Check box for Medical Care Decisions and Advance Directives education. Signature of assessor certifies that the care plan is developed based on assessment findings.

**PHYSICIAN AUTHORIZATION:** The form is forwarded to the attending physician. The physician's authorization certifies that the individual is under the physician's care and has a medical diagnosis that warrants the provision of personal care services as indicated in the care plan. The physician prints his/her name, signs, and dates the form. The physician also may indicate and provide standing orders for an individual to take therapeutic leave by checking the block.



# Comparison of Nurse Aide I Training and **Appendix G**

## Competency Evaluation to Direct Care Support Worker

Comparison of Nurse Aide I Training and Competency Evaluation to Direct Care Support Worker (the most common type of adult and family care home staff) Training and Competency Evaluation

	Nurse Aide I Training		Direct Care Support Worker	
	Federal/State Mandate		State Mandate	
	75 Hour Program	25 Hour Program	25 Hour Program	80 Hour Program
<b>Coordinator/Faculty</b>				
RN with 2 years experience	≈		≈	≈
Completed a course in teaching adults OR	≈	∅	∅	∅
Experience teaching adults OR	≈	∅	∅	∅
Supervising nurse aides	≈	∅	∅	∅
1 year experience in SNF/NF	≈	∅	∅	∅
Two years direct care with "some" mental health or geriatric care	∅	≈		≈
<b>Curriculum Requirements</b>				
Number of hours required	75 hours	25 hours		80 hours
Number of skills taught	69	64		78
Level of competency required	Skills performed in safe/competent manner	"Satisfactory performance"		"Satisfactory performance"
<b>Content Topics</b>				
Unit 1: Introduction to health care	≈		≈	≈
Unit 2: Communications & interpersonal skills	≈		≈	≈
Unit 3: Infection control	≈	∅		∅
Unit 4: Safety & emergency	≈		≈	≈
Unit 5: Ethical/legal issues	≈		≈	≈
Unit 6: Nutrition/hydration	≈	∅		≈
Unit 7: Common diseases & conditions of body systems (11 systems total)	≈	∅		∅
Unit 8: Patient environment	≈		≈	≈
Unit 9: Personal care/grooming	≈	∅		∅
Unit 10: Basic nursing skills	≈	∅		∅
Unit 11: Patient care procedures	≈	∅		∅
Unit 12: Death and dying	≈	∅		∅
Unit 13: Basic restorative services	≈	∅		∅
Unit 14: Prevention of pressure ulcers	≈		≈	≈
Unit 15: Restraints	≈		≈	≈
Unit 16: Psychological effects of aging	≈		∅	≈

## Appendix G

# Comparison of Nurse Aide I Training and Competency Evaluation to Direct Care Support Worker

	Nurse Aide I Training		Direct Care Support Worker	
	Federal/State Mandate		State Mandate	
	75 Hour Program	25 Hour Program	25 Hour Program	80 Hour Program
<b>Competency Evaluation Requirements</b>				
<b>Evaluator</b>				
RN with 2 years experience with 1 year care of elderly or chronically ill of all ages	≈	≈	≈	≈
Minimum number of opportunities to take exam	3	Not stated	Not stated	Not stated
<b>Examination</b>				
Written	Standardized competency exam	No standardized competency exam	No standardized competency exam	No standardized competency exam
Oral	Standardized competency exam	Oral and skills demonstration in lab or clinical site	Oral and skills demonstration in lab or clinical site	Oral and skills demonstration in lab or clinical site
Demonstration of randomly selected items drawn from pool of tasks generally performed by NAs	≈	∅	∅	∅

≈ = Topics are comparable but not necessarily exact  
 ∅ = Topic is not comparable to Nurse Aide I Training (a specific skill or content is not included)



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