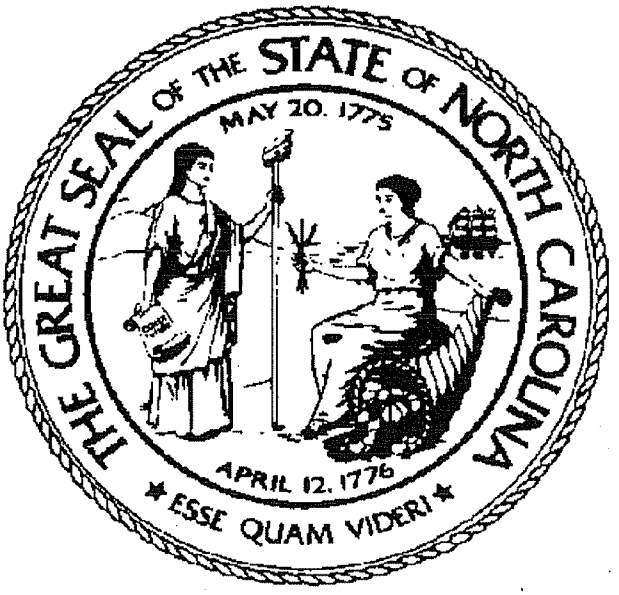

Study of Rules and Regulations Regarding Housing Individuals with Mental Illness in the Same Facility Vicinity as Individuals without Mental Illness

General Assembly of NC Session 2007
Session Law 2007-156
Senate Bill 164

Prepared For:
The North Carolina Study Commission on Aging

March 1, 2008

Study of Rules and Regulations Regarding Housing Individuals with Mental Illness in the Same Facility Vicinity as Individuals without Mental Illness

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March 1, 2008

Final Report and Recommendations

I. Summary

The Department of Health and Human Services is submitting this study pursuant to Session Law 2007-156, "An Act to Direct the Department of Health and Human Services to Study Rules and Regulations Regarding Housing Individuals with Mental Illness in the Same Facility Vicinity as Individuals without Mental Illness, and to Recommend Staff Training Requirements for Direct Care Workers in Adult Care Homes to Provide Appropriate Care to Residents with Mental Illness, as Recommended by the North Carolina Study Commission on Aging." Session Law 2007-156 states:

> **Section 1.(a)** The Department of Health and Human Services, Division of Facility Services, Division of Aging and Adult Services, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall study rules and regulations in North Carolina and other states regarding the provision of appropriate care and housing of individuals with mental illness in the same facility vicinity with individuals without mental illness and shall make recommendations relating to the housing of these individuals.
>
> **Section 1.(b)** The Department of Health and Human Services, Division of Facility Services, Division of Aging and Adult Services, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall study the need for training direct care workers in adult care homes to provide appropriate care to facility residents with mental illness and facility residents without mental illness and shall make recommendations for appropriate training of these workers. The study shall address the fiscal impact that the implementation of training requirements would have on these facilities and the amount of funding needed to support a successful training model.
>
> **Section 1.(c)** The Department of Health and Human Services shall present its findings and recommendations in response to the studies authorized in subsections (a) and (b) of this section, along with any required statutory or rule changes, to the Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before March 1, 2008.

Over the past several years, the Department of Health and Human Services has worked to improve the care to individuals who have mental illness and are residing in adult care homes, while acknowledging that other housing and treatment options need to be available to serve this population. During the 2005 Session of the General Assembly, a report entitled "Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities" was presented to the General Assembly in response to HB 1414 Section 10.2(a) & (b) (see Attachment 1). This report references the 2005 Study, expands upon a description of the system needed to support individuals with mental illness residing in facilities and makes additional recommendations.

The Department is making recommendations for a comprehensive system of screening, assessment, planning, and services for individuals with mental illness who present or are referred for services in adult care homes. The details are outlined in this report; the recommendations are summarized below:

- Develop and automate a comprehensive assessment and care plan system for adult care homes.
- Expand required minimum training levels for adult care home staff.
- Require initial screening, and follow-up mental health assessments for adult care home residents or potential residents referred through the initial screening, as well as annual reassessments.
- Expand capacity to provide local mental health rehabilitative services to individuals with mental illness residing in adult care homes who need these services.
- Implement a project to pilot a new service definition for a Transitional Residential Treatment Program to provide 24-hour residential treatment and rehabilitation of adults who have a pattern of difficult behaviors related to mental illness. The service would exceed the capabilities of traditional community residential settings (recommendation also submitted to the Joint Legislative Oversight Committee on MH/DD/SAS on October 25, 2007 by the Department).

II. Background and Accomplishments

In this report Adult Care Homes include facilities licensed as either adult care homes (seven or more beds) or family care homes (six or fewer beds).

A. Data of Individuals with Mental Illness in Adult Care Homes

For over sixty years licensed adult care homes have provided the citizens of North Carolina a place for assistance with activities of daily living and 24-hour supervision. These services have been provided, not only for those aging and failing in health, but also for younger individuals who have mental illness.

Data submitted by adult care homes on annual licensure renewal application denotes the number of individuals with a primary diagnosis of mental health residing in the home on September 30 of the preceding year. See Table 1.

Table 1: Number of Individuals with Primary Diagnosis of Mental Illness Residing in Adult Care Homes by License Type

	2002			2003			2004		
License Type	Total Number of MI Residents	Total Number of Residents in Facility	Percentage of Residents with MI	Total Number of MI Residents	Total Number of Residents in Facility	Percentage of Residents with MI	Total Number of MI Residents	Total Number of Residents in Facility	Percentage of Residents with MI
Adult Care Home	4,495	24,633	18.2%	4,918	17,766	27.7%	4,450	14,442	30.8%
Family Care Home	1,093	2,871	38.1%	1,200	2,277	52.7%	1,258	2,096	60.0%
	2005			2006			2007		
License Type	Total Number of MI Residents	Total Number of Residents in Facility	Percentage of Residents with MI	Total Number of MI Residents	Total Number of Residents in Facility	Percentage of Residents with MI	Total Number of MI Residents	Total Number of Residents in Facility	Percentage of Residents with MI
Adult Care Home	5,006	24,831	20.2%	5,068	25,100	20.2%	5,079	26,706	19.0%
Family Care Home	1,145	2,578	44.4%	1,202	2,644	45.5%	1,155	2,495	46.3%

Source: Facility Reported September 30 Census data on Annual License Renewal Applications, Division of Health Services Regulation

No information on residents with a mental heath diagnosis was collected in the licensure renewal application prior to 2002.

B. Recommendations from the 2005 "Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities"

The 2005 report on "Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities" to the North Carolina Study Commission on Aging included the recommendation to address several regulatory areas. Recommendations identified the need to increase staff training and to evaluate staffing requirements. Currently staffing requirements average a staff-resident ratio of 1:17-20 on the first and second shifts and 1:25-30 on the third shift. Staffing should be based on the ability of staff to manage specific needs of the individuals residing in each facility, rather than a standard staffing ratio with no consideration of the facility's unique populations. Additionally, three recommendations referenced the following:

(1) the common need for each potential resident to have a pre-admission screening identifying the appropriateness for placement in an adult care home with the facility to review and evaluate this information prior to any admission;
(2) the need to assure that residents (who in the past year had been served in inpatient mental health treatment settings) be seen by a mental health professional if no current services were in place; and
(3) the need for facilities to disclose their expectations and policies for residents and responsible parties.

The need for additional funds to implement these changes was identified.

C. Implementation of Recommendations from the 2005 Study

A stakeholder review of the Adult Care licensure rules was implemented in the fall of 2006 through the Division of Medical Assistance's (DMA) Adult Care Restructuring Committee. This committee was convened to address funding and service concerns held by the U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Services (CMS) in relation to home based care. A subcommittee was established representing home care and adult care home providers, provider associations and the DHHS Divisions of Mental Health, Developmental Disabilities and Substance Abuse Services, Aging and Adult Services, Health Service Regulation, and Medical Assistance to review current requirements and recommend changes to meet the needs of the current population residing in adult care homes. While the review process has resulted in identifying some preliminary rule changes, further work is needed.

Since the 2005 study recommendations were made, a pre-admission screening tool and a comprehensive resident assessment have been developed. These screening and assessment processes would meet the identified needs in the 2005 study to promote appropriate placement and identify care, service and referral services needed. Funding is not available for full implementation.

Revising the focus of staffing rules to determine the minimum number of staff present in the building based on the needs of the facility's population rather than a resident census number would require a change in the funding and reimbursement mechanism. To implement staffing changes, DMA would need to have historical data collected and analyzed to determine residents' needs at admission and as they age in place. The Division would then correlate these data to staff hours required to provide those services. One reimbursement mechanism is a case-mix system based on a prospective payment system (PPS) currently utilized by the Medicare program in nursing homes. Based on analysis of assessment data, utilization groupings were determined and reimbursement rates were established based on resident service need characteristics reported on the comprehensive assessment.

Changes in funding formulas and resultant increases in payments to facilities would need to occur to implement further increases in required staffing. Currently DMA is reviewing this and other payment methodologies.

As a result of the recommendation in the 2005 report on "Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities" and Senate Bill 164's mandate to study North Carolina staff training needs, a stakeholder workgroup (See Attachment 2) convened to identify the kind of training needed to meet the needs of caring for residents who have mental illness in adult care homes. The focus of the meeting included the identification of staff who should be trained, the frequency of the training, and qualifications of the trainers and the content of programs. Since many of the stakeholders were those involved in daily interactions with mentally ill residents in adult care homes, consensus on identified needs and approaches was reached. See Section IV. below for the group's recommendations.

A recommendation was made by the Department of Health and Human Services in its 2005 "Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities" to conduct a study to inform the development of a residential continuum designed to meet the needs of persons with mental illness. The Department (through Division of Mental Health, Developmental Disabilities, and Substance Abuse) followed through on its recommendation by developing a contract with the Technical Assistance Collaborative, Inc., which will be in effect until 12/30/08, to study and develop recommendations to be included in a report to the Legislative Oversight Committee as required by SL 2007-0323 Section 10.49 (h1). This contract will initially provide information about North Carolina's housing needs and current resources, identify best practice housing and service models that have been shown to be effective in other states, and provide recommendations and a plan for implementation for additions and/or changes to North Carolina's residential service array that will maximize available federal and state resources. The study will provide a report to address specifically the following:

(1) the need in terms of numbers to be served and range of residential and treatment settings to meet these needs; assess the current population in long term care facilities and identify specific service needs of persons with cognitive disabilities and behavioral issues that current long term care options are not designed to address; and, quantify the need, types and functionality of residential and treatment settings to create a spectrum of options to meet the variety of needs as identified above;
(2) identify housing and service models meeting the criteria of evidence-based best practices being used in other states to address the needs not currently being met in long term care settings in North Carolina, including a description of the population(s) being served, the scope, nature and type of residential service(s), and the funding mechanisms used to provide both

the supportive service and housing components in the development and ongoing operations.

III. Rules and Regulations Regarding Appropriate Care and Housing of Individuals with Mental Illness in the Same Facility Vicinity as Individuals without Mental Illness

A. Study of Rules in Other States

A review of other states' policies and rules regarding the care of residents diagnosed with mental illness in assisted living facilities proved to be problematic in that assisted living is defined differently in every state, thereby impacting the effectiveness of any comparisons. A number of states have different levels of assisted living which further complicates meaningful comparisons. In addition, funding sources for assisted living vary significantly among states.

In order to focus the scope of the study, a review of the Assisted Living State Regulatory Review 2007 was conducted. Each state was reviewed by searching for the common denominators of mental health or mental illness and Medicaid funding for comparison purposes. States that matched were contacted. Eight states replied by telephone or e-mail to questions regarding population mix, specific rules for residents with mental illness, additional training, case management by the mental health system, assessment and care plan by a mental health professional, and staffing. The states queried were Arizona, Colorado, Florida, Idaho, Michigan, Texas, Washington, and Wisconsin. Table 2 entitled "State Regulatory Responses to Residents with Mental Illness in Assisted Living Facilities" categorizes and compares the responses. All of these states except Arizona allow for mixed populations, which according to this study means that residents with mental illness diagnoses can be admitted to an assisted living facility. Only a few states, such as Arkansas, do not allow admission of persons with a mental illness to an assisted living facility. The rest of this report summarizes additional information from the review.

Arizona

There are three licensed levels of care in assisted living facilities: Supervisory Care Services - general supervision only; Personal Care Services - assistance with activities of daily living; and Directed Care Services - programs and services provided to persons who are incapable of recognizing danger, summoning assistance, expressing need, or making basic care decisions. Admission requirements prohibit acceptance or retention of residents requiring physical or chemical restraints, or requiring behavioral health residential services or services the assisted living residence is not licensed or able to provide. Residents with diagnoses of mental illness are not mixed with other populations in assisted living facilities.

Colorado
While there are no additional rules specifically addressing the population with mental illness, staff training must be provided based on specific needs of the population served including residents in secured environments and individuals with severe and persistent mental illness. Within one month of hire, facilities must provide adequate training to staff in several areas including identifying and dealing with difficult situations and behaviors.

Florida
Populations are mixed but there is a limited mental health license category when facilities serve three or more residents with chronic mental illness. There are specific rules for this type of assisted living facility which include additional training requirements, case management through the state's mental health system and an assessment and care plan developed by a mental health professional.

Idaho
Policies and procedures on behavior management are required. These policies and procedures must address evaluation of behavior management and development of interventions for each behavioral symptom. The resident's medication regime must be evaluated every six months to assure medications to treat behavioral symptoms are necessary and at lowest possible doses. Training for facility staff admitting residents with mental illness diagnoses must include an overview of mental illnesses: address symptoms and behaviors specific to the mental illness, resident's adjustment to the new living environment, behavior management, communication, activities of daily living, integration with rehabilitation services and stress reduction for facility personnel and resident. In addition, there are requirements for mental health contracted beds which state that a facility may enter into an agreement with the Department to provide short-term care to certain residents designated by the mental health program of the Department who are temporarily distressed and unable to meet their basic needs. These rules address personnel, written contract, resident assessment and staff orientation and training.

Michigan
Homes for the Aged provide supervised personal care to homes serving 21 or more residents who are 60 years of age or older. These homes may not accept anyone with a mental condition disturbing to other residents or personnel, and a resident who shows serious mental disturbances must be removed from the home. Adult Foster Care facilities provide 24-hour personal care, protection and supervision for individuals who have mental illness, physical handicaps or those who are aged who cannot live alone but do not need continuous nursing care. These facilities can be certified to provide specialized services for residents with mental illness and are required to meet specific rules addressing the population being served. Licensed

facilities certified to provide a specialized program for persons with mental illness are required to meet a higher standard of training. Case management is typically provided by local mental health authorities through contracts with private agencies for this function, including assessment and care planning.

Texas

There are four types of assisted living facilities categorized according to evacuation ability of residents, ability to follow directions under emergency conditions, need for attendance during sleeping hours, assistance with activities of daily living versus medication supervision only, transfer assistance and contracted services. Facility policies must address the types of clients admitted and how they will be served. There is no specific training for residents with mental illness diagnoses but staff must receive on-the-job training in behavior management such as prevention of aggressive behavior and de-escalation techniques.

Washington

Boarding Homes are licensed to provide domiciliary care for seven or more residents or for three to six residents if licensed prior to or on July 1, 2000. These homes may provide optional services which include care for residents with mental illness for which special rules apply. Each home is required to disclose on a standardized form the scope of care and services it offers, including services for persons with mental illness. Caregivers must complete skill-based special needs training whenever the home serves a resident with mental illness.

Wisconsin

Three programs fall under the umbrella term of assisted living and are categorized according to level of resident independence, nursing hours required, physical plant arrangement and number of residents. Residents with mental illness diagnoses are not prohibited from admission to any of these types of facilities but admission depends on assessment, including level of independence. The facilities providing care, treatment and other services to five or more unrelated adults who need supportive or protective services or supervision because they cannot or do not wish to live independently and do not require more than three hours of nursing care per week are categorized by size, ability to evacuate and disability/condition,(including mental illness). Some rules specific to the population being served apply, including training requirements. These facilities must ensure that residents of different ages, development levels or behavior patterns, as identified in their assessment and service plans, are compatible. If there is regulatory evidence of incompatibility among different populations of residents, the state can restrict whom the facility can serve, the regulatory agency reports this is done rarely and has proven to be problematic in its implementation.

B. Rules in North Carolina

North Carolina is unique in having rules for adult care home special care units for residents with mental health disorders. These rules, however, are only for those facilities that advertise themselves as providing special care to residents with mental health disorders as mandated by G.S. 131D-8. No additional funding was provided for operation of these special care units. One facility did establish and operate such a special care unit and has since closed.

All direct care staff and their supervisors in licensed facilities in North Carolina are required to be trained and competency validated. Personal care aides and their direct supervisors receive a five-hour training module on behavioral interventions as a part of the required personal care aide training program (10A NCAC 13F/G .0501).

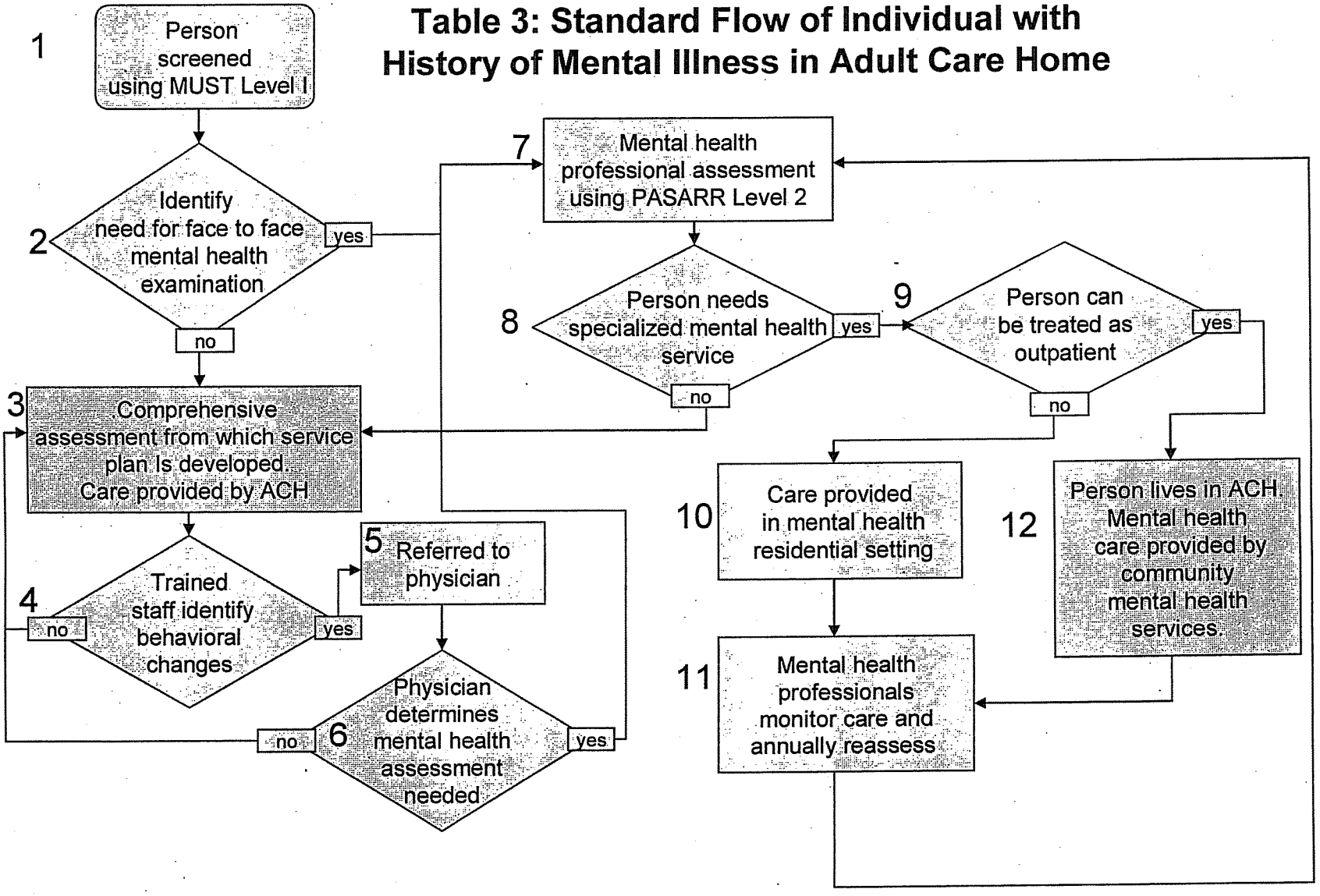
Following are other rules related to care and management of residents with mental illness:

- 10A NCAC 13F/G .0902(d)(2): This rule states, "When the resident cannot remain under the care of the chosen physician or physician service, the facility shall assure that arrangements are made with the resident or responsible person for choosing and securing another physician or physician service within 45 days or prior to the signing of the care plan as required in Rule .0802 of this Subchapter."
- 10A NCAC 13F/G .1002: 10A NCAC 13F/G .1002: This rule requires personal care aides and their direct supervisors to receive annual training on the effects of psychotropic medications, including alternative behavior interventions. In addition, the rule requires psychotropic medications ordered "as needed" by a prescribing practitioner, to be administered only "if the following have been provided by the practitioner or included in an individualized care plan developed with input by a registered nurse or licensed pharmacist: (1) detailed behavior-specific written instructions, including symptoms that might require use of the medication; (2) exact dosage; (3) exact time frames between dosages; and (4) the maximum dosage to be administered in a twenty-four hour period." [Paragraph (g)]
- 10A NCAC 13F .1212(g) and 13G .1213(g): This rule on accident and incident reporting requires referral of a resident who is threatening or assaultive to the Local Management Entity (LME) for Mental Health Services or mental health provider for emergency treatment. It also requires cooperation of the facility with assessment personnel assigned to the case by the LME or mental health provider to enable them to provide the earliest possible assessment.
- 10A NCAC 13F/G .1211: This rule requires facilities to have written policies and procedures on the management of physical aggression or assault by a resident.

Table 2: State Regulatory Responses to Residents with Mental Illness In Licensed Assisted Living Facilities

State	Population Mix Allowed	Specific Rules for Individuals with Mental Illness	Additional Training Requirements for Serving Individuals with Mental Illness	Case Management by Mental Health System	Assessment/Care Plan by Mental Health Professional	Staff Ratio/ Meet the Needs
ARIZONA	No	No	No	No	No	Meet needs
COLORADO	Yes	No	Yes	No/Medicaid Case Management	No	Meet needs
FLORIDA	Yes	Yes, when 3 admitted	Yes	Yes	Yes	Ratios
IDAHO	Yes	Yes	Yes	No	No	Meet needs
MICHIGAN	Yes	Certification Process w/ funding through community mental health	Yes	Yes	Yes	Ratios
NORTH CAROLINA	Yes	Mental Health Special Care Units 10A NCAC 13F .1401-1410	Mental Health Special Care Units 10A NCAC 13F .1409	No	Mental Health Special Care Units 10A NCAC 13F .1407	Meet needs
TEXAS	Yes	No	No	No	No	Meet needs
WASHINGTON	Yes	Yes	Yes	No	Yes	Meet needs
WISCONSIN	Yes Compatibility rule	No	Yes	No/Medicaid Case Management	No	Meet needs

Table 3: Standard Flow of Individual with History of Mental Illness in Adult Care Home



C. Recommended System for Supports to Individuals with Mental Illness in Adult Care Homes

A system that is designed to meet the needs of individuals with mental illness in adult care homes has multiple service processes and components, including the development of additional resources to serve the needs of these individuals in other community and home settings. Table 3 shows the recommended flow of service provision to a person with mental illness who is screened for adult care home admission. The numbers below correspond to the numbers on Table 3.

1. Person screened using (Medicaid Uniform Screening Tool) MUST Level I

The Division of Medical Assistance (DMA) currently has a mandated "level of care" form (FL-2) which must be signed by a physician designating the appropriate level of care for the potential resident. DMA will introduce the MUST screening tool by October 1, 2008, The MUST primarily will replace the existing FL-2 and FL-2e forms to screen for level of care for several of the long term care programs. The MUST Level 1 will be implemented for Adult Care Homes as soon as funding is available and a contract can be executed. Those programs initially using the MUST will be the nursing facilities, the Pre-Admission Assessment Screening and Annual Resident Review (PASARR) Program, adult care homes, Personal Care Services, Personal Care Services Plus, Community Alternatives for Disabled Adults (CAP/DA and CAP Choice), Community Care Alternatives for Fragile Children (CAP/C) and Private Duty Nursing (PDN). Other programs will be added at a later date. The tool will indicate which of the mentioned Medicaid Programs best fit the individual's profile and any alternative program fits that may be available.

Eligible screeners for the MUST program include:

a. Professionals making a referral to Medicaid for long-term care services and supports, including
   1) Physicians;
   2) Physician Assistants, Family Nurse Practitioners, and other mid-level practitioners;
   3) RNs and LPNs;
   4) Medical/Clinical Social Workers, Qualified Professionals and Psychologists;
   5) Hospital discharge planners and case managers;
   6) Case managers from regional, local and community organizations.
b. Staff of Aging Disability Resource Centers (ADRCs), Departments of Social Services and other providers, agencies and networks whose administrator determines the potential screener has the experience and informal training needed to complete the screenings.

All MUST Screeners are to be Medicaid-approved by participating in the MUST training and by demonstrating competency in the use of the tool as

evidenced by passing the MUST Online Test. Ongoing approval will be monitored through several of DMA's quality assurance initiatives. Authority to screen may be revoked.

All persons (no matter the payer source) seeking admission to an adult care home will be screened using MUST. If the prospective resident's choice is to enter an adult care home then he will be screened utilizing the Pre-admission Screening and Annual Resident Review (PASARR) function of the MUST to assess whether the individual has mental health, mental retardation or related conditions which may need specialized services to meet the person's needs.

2. **Identify need for face to face mental health examination**
   YES--If MUST screening identifies one or more of the conditions described in #1, a face to face comprehensive mental health evaluation is arranged (see #7 below).
   NO--If MUST screening results indicate that a face to face mental health evaluation is not necessary then the recipient will be approved to enter an adult care home and the MUST will have the PASARR number entered and this number will be included in the MUST letter and screening form.

3. **Comprehensive assessment from which service plan is developed. Care provided by Adult Care Home**
   If the results of the MUST Level 1 screening (see #1 and #2 above) or the Pre-Admission Assessment Screening Annual Resident Review (PASARR) Level 2 assessment (see #7) reveal that the potential resident does not need specialized Mental Health Services then he can be admitted to the adult care home of his choice. The adult care home will complete a comprehensive assessment from which a service plan will be developed. Care is provided to the resident by adult care home staff.

4. **Trained staff identify behavioral changes**
   While persons residing in adult care homes may initially be assessed as not needing a comprehensive mental health evaluation or specialized mental health service, some individuals may present with signs or symptoms of mental illness after admission. Staff persons in adult care homes need training to enable them to identify those signs and symptoms that might represent a change in mental health status. This step assumes that staff has training as identified in Section IV of this report.
   YES—If a trained staff person identifies that a resident has behavioral changes, he/she will refer the resident to a physician for further assessment. See #5.
   NO—If trained staff do not notice any behavioral changes, the adult care home continues providing care and staff continue to observe.

5. **Referred to physician**

Some signs and symptoms that present as potential mental illness may actually be caused by physical illness, medications or other reasons. For this reason, when adult care home staff notices behavioral or symptom changes, the individual will be referred to his or her physician for assessment.

6. **Physician determines mental health assessment needed**
   YES—If a physician determines that a mental health assessment is needed, the physician will refer the individual to a mental health professional for an assessment using the PASARR Level 2. See #7
   NO—If a physician determines that a mental health assessment is not needed, the adult care home staff continues to provide care and observes the resident.

7. **Mental health professional assessment using PASARR Level 2**
   If MUST Level 1 Screening (see # 2 above) results indicate that a face to face mental health evaluation is necessary then the potential adult care home resident will meet with a mental health professional to complete the PASARR Level 2 Assessment. No admission to an adult care home can happen until the results of the assessment are complete. Persons who are already admitted to the facility will not routinely receive MUST Level 1; however, if signs and symptoms are shown by a person residing in the facility, the physician will make a determination regarding whether a PASAAR Level 2 assessment by a mental health professional is needed (see # 4, 5 and 6).

8. **Person needs specialized service**
   The PASARR Level 2 Assessment will determine whether the individual needs a specialized mental health service.
   YES— If a PASAAR Level 2 assessment of an individual choosing to reside in an adult care home indicates that specialized mental health services are needed, this information will be sent to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). The individual's service needs (either rehabilitative services in the community or care provided in a specialized mental health setting) will be communicated to the Local Management Entity (LME) that is responsible for services in the catchment area where the individual lives. The LME then contacts the individual and determines which of the providers of the needed mental health service(s) he prefers. A referral to the chosen provider(s) is made and the needed services are delivered.
   NO--If the person does not need a specialized service, the person can be admitted to the adult care home of his choice. The adult care home will then complete the comprehensive assessment from which a care plan will be developed. Care is provided to the resident by adult care home staff (see #3).

9. **Person can be treated as outpatient**

The types of specialized mental health services that would most commonly be needed by people who qualify for and choose to live in an adult care home are services such as community mental health treatment services, monitoring and management of medications prescribed to treat mental illness, psycho-social rehabilitation services, and individualized plans to address the illness and to promote recovery as described in more detail in # 12.

Yes--If the results of the PASARR Level 2 assessment (#7) indicate that the potential resident does not need specialized mental health residential services but does need and can benefit from community mental health services such as those described above, then the potential resident can be admitted to the adult care home after appropriate services are deemed available and have been scheduled by the LME and chosen mental health provider. The person would receive annual PASAAR Level 2 screening to assure that the setting continues to be appropriate.

NO--If the results of the PASARR Level 2 assessment reveal that the potential resident does need specialized mental health residential services then he may not be admitted to the adult care home. Appeal Rights will be issued.

10. Care provided in mental health residential, supervised living or other setting

Individuals who are identified as needing care in a residential mental health setting will be diverted from adult care homes into licensed mental health homes or other settings that meet their needs.

11. Mental health professionals monitor care and annually reassess the need for specialized mental health services within the PASAAR Level 2.

The assessment described in # 7 needs to be done when there is a significant change in behavior or at least annually because people's needs change over time. DMH/DD/SAS will have ongoing responsibility for working with the LME so that individuals who have a mental illness for which they need specialized mental health services continue to receive those services. The goal is that these individuals have access to service providers who can most appropriately address their needs through community treatment and rehabilitative services or specialized residential services.

12. Person lives in Adult Care Home. Mental health care provided by community mental health services.

Individuals with mental illness may reside in an adult care home with appropriate community mental health services arranged and/or provided by the Local Management Entity and mental health provider of choice (see #9).

D. Needs for Implementation of Recommended System

The section above describes the recommended system for screening, assessment and care planning, and needed mental health service coordination for individuals who have mental illness and who are entering adult care homes. It also addresses the diversion of individuals who are determined inappropriate for residing in adult care homes into other more appropriate mental health settings. While some of the processes are in place or are pending, some of the recommendations require additional processes and funding. Table 4 summarizes the estimated financial resources.

Table 4: Summary of Needs to Implement Recommended System

Item Number from Table 3	Description	Recurring Costs	Nonrecurring Costs
Item 3	Develop and automate a comprehensive assessment and care plan system for residents in adult care homes.	$580,000	
Item 4	Expand required minimum training levels	$4,500,000	
Item 7	Require PASAAR level II assessments of adult care home residents or potential residents who are referred for this level of evaluation	$281,840	$1,764,000
Item 8	Determination of specialized mental health care needed based on PASAAR Level II assessment	$334,000	
Item 12	Develop additional capacity to serve residents in adult care homes who need mental health services	$14,860,000	
Item 10	Pilot program to develop a residential program for people with mental illness currently in adult care homes but who require a different residential setting (1 six-bed facility)	$378,056	
TOTAL		$20,933,896	$1,764,000

1. A rule change is needed to require MUST Level 1 screening as described in C.1 above.

2. A rule change is needed to require adult care home staff to complete a comprehensive assessment (as described in C.3 above) of a resident to evaluate and plan for his needs upon admission, upon significant changes and annually This cannot be implemented until funded. This comprehensive assessment tool is a critical component to ensure that needs are identified and care and necessary referrals for specialized services can be planned, implemented and communicated. This tool needs to be implemented as soon as possible.

   An estimated $580,000 funding will be required for the Department to continue development and automation of a comprehensive assessment and care plan system.

3. A rule supported by funding would be necessary to expand required minimum training levels as mentioned in C.4 above and as described in more detail in Section IV in this report.

   An estimated $4,500,000 would be required annually to implement the recommended training system in adult care homes.

4. The Division of Medical Assistance currently provides PASAAR Level 2 assessments for nursing facility patients through a contract. It is anticipated that this contract would be expanded to conduct PASAAR Level 2 assessments for adult care home residents or potential residents who are referred for this level of evaluation (see C.7 above). A new rule would require the PASAAR Level 2 assessment for individuals referred by the MUST Level 1 screening process.

   It is anticipated that $1,764,000 initially and $281,840 annual funding is needed to implement the PASAAR Level 2 assessment in adult care homes.

5. After the PASAAR Level 2 assessment is completed, DMH/DD/SAS staff will make the final determination about whether the individual needs specialized mental health screening, contact the LME to arrange for services and follow up to be sure services are provided. This will be done both at the initial PASAAR Level 2 assessment and annually for those individuals residing in adult care homes who are determined to need mental health services, as described in C.7 and C.11. Currently this is done for nursing facility residents. Additional staff will be needed in DMH/DD/SAS because of the anticipated large increase in the number of individuals in adult care homes who will require specialized services when compared to the number who are currently in nursing facilities.

   An estimated $334,000 funding annually for at least five additional DMH/DD/SAS positions would be needed.

6. The ability of an individual to reside in an adult care home and receive appropriate services as described in C.9 above depends upon the capacity and resources of local mental health providers. "The availability of mental health resources, the capacity to perform timely and thorough evaluations, development of person centered plans, and access to the broad array of services and supports needed for persons with mental illness varies greatly across the state. The types of mental health services that are often needed by some residents in long term care settings include: evaluation and assessment of residents who are exhibiting behaviors that appear to be related to mental illness; development of person centered plans that include consideration of the individual's needs

for a wide range of services or supports; and provision of ongoing treatment and rehabilitative services, and cooperation and support for others who are providing service and support for the individual." (From Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities; General Assembly of NC Session 2004; House Bill 1414 Section 10.2(a) & (b); Prepared For: The North Carolina Study Commission on Aging December 2, 2005).

An estimate of funding required for additional capacity to serve residents in adult care homes who need mental health services is **$14,860,000 to provide psychiatry, medication checks and rehabilitative services**.

6. The Department recognizes that there are serious concerns about residents with mental illness who are currently in assisted living facilities and who exhibit behaviors related to their illness. This makes it necessary to begin developing a new type of residential facility on a pilot basis that is designed to provide treatment and supervision at a level that is not currently available in community based residential services in North Carolina.

   As specified in SL 2007-0323 Section 10.49 (i), the Division of MH/DD/SAS has developed "a service definition for a Transitional Residential Treatment Program to provide 24-hour residential treatment and rehabilitation of adults who have a pattern of difficult behaviors related to mental illness, which exceed the capabilities of traditional community residential settings." This definition, an operating cost estimate, and daily rate were submitted to the co-chairs of the Joint Legislative Oversight Committee on MH/DD/SAS on October 25, 2007 by the Department.

   The estimated annual operating cost of each 6 bed facility of this type is $378,056. The Division of MH/DD/SAS had planned to implement one such facility as a pilot project contingent upon the ability to identify State funds. A separate report about this service definition and funds needed is being submitted to the Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services by March 1, 2008 as required by SL 2007-0323. Development of this type of specialized facility is contingent on funding.

   The Division of MH/DD/SAS continues to explore the types of housing and residential services that can appropriately meet the varied needs of adults with mental illness. As described in Section II.B of this report, the Department has entered into a contract to study housing needs that will specifically identify housing and service models meeting the criteria of evidenced based best practices being used in other states to address the needs of persons not currently being met in long term care settings in North Carolina. The results will be used to explore and implement,

contingent upon funding availability, additional housing alternatives for individuals whose needs can not be met within current assisted living facilities. When this study is completed by December 2008, it will be possible to provide a realistic description and estimated costs for the development of more appropriate housing alternatives for residents with mental illness who are currently living in assisted living facilities. Currently, Medicaid is not a major reimbursement source for residential service for adults with mental illness. If housing and residential alternatives are to be developed, it is anticipated that additional state funding would be required.

IV. Need for Training Direct Care Workers in Adult Care Homes for Appropriate Care of Individuals with Mental Illness

A. Training Currently Available

Personal care aides and their direct supervisors receive a five-hour training module on behavioral interventions as a part of the required personal care aide training program. This training is a one time requirement for this staff category and can occur prior to or during the first six months of employment. Additionally, personal care aides and their supervisors are required to have annual training on the effects of psychotropic medications including alternative behavior interventions.

B. Proposed Training Requirements

A stakeholder workgroup meeting was held on January 4, 2008 to discuss the training needs of staff caring for residents with mental illness residing in licensed adult care homes (see Attachment 2 for participants). The focus of the meeting was to generate recommendations for training requirements for staff to ensure appropriate care for and response to residents with mental illness. Agreement was reached on the following recommendations.

1. Types of Training

Three types of training were identified as being needed:

- Basic Orientation Training: Provide to all staff in all facilities within the first week of employment.
- Specialized Training (Phase Two): Provide to all personal care aides and their direct supervisors when a facility admits a resident who has a mental illness as a primary diagnosis or when a new staff is hired by a facility serving one or more individuals with mental illness as primary diagnosis.
- Annual Training: Provide an in-service training addressing needs and care of residents with mental illness for personal care aides and their direct supervisors in facilities serving at least one resident with a primary diagnosis of mental illness.

Discussion concluded that this approach would help ensure that each adult care home and every resident with a current mental health diagnosis

is in an environment where staff would have the knowledge and competence to identify significant changes as well as be able to respond to the resident in a manner which would de-escalate the likelihood of conflict and physical harm to residents or staff. Staff with basic competence in understanding certain behaviors of residents with mental illness and responding to conflict resulting from those behaviors should improve the facility environment. Staff would have a protocol of responses for their own use and know when to obtain assistance from mental health providers or law enforcement. Standardized training would help ensure that each staff member knows the acceptable and appropriate response to residents with mental illness, thereby promoting an appropriate environmental culture for staff.

2. **Content**

   Training would include the nature/needs of residents based on:

   Diagnosis
   Behaviors
   Escalation - symptoms/signs

   A subcommittee with leadership by DMH/DD/SA and staff from Therapeutic Alternatives will convene a group of experts to develop recommendations for training program components. Data available would include facility staff response to DMH/DD/SA Geriatric and Adult Mental Health Specialty Team staff questionnaires. Discussion included development of train the trainer programs for designated facility staff through DMH/DD/SA Geriatric and Adult Mental Health Specialty Teams contracts with other mental health professionals or persons of expertise in the mental health field, creating a Quality Improvement program through the Division of Aging and Adult Services, accessing online training materials and media possibly through university libraries, and training available through current programs including North Carolina Intervention.

3. **Training Requirements and Trainer Qualifications**

   Table 5 summarizes the training recommendations.

Table 5: Training Requirements, Time Frames, and Teacher Qualifications

Training Type	When Required	Class Duration	Staff to be Trained	Qualifications of Trainer
Basic Orientation	All facilities; within first week of employment	2 hours	All facility staff	Trained and competency validated staff
Specialized (Phase Two)	All facilities serving one or more persons with mental illness within six months of first admittance (existing employees) or start date (new employees)	12 hours	Aides and Direct Supervisors	Mental Health Professional
Annual Training	All facilities serving one or more persons with mental illness	4 hours	Aides and Direct Supervisors	Mental Health Professional
Based on recommendations of ACH-MI Training Workgroup, January 4, 2008				

4. **Estimated Costs**
   The workgroup agreed there would be substantial cost due to staff turnover, the number of staff to be trained, and cost of trainers. Estimated costs were subsequently determined based on the assumption of 100 % staff turnover. Estimated cost to provide required training including staff coverage for resident care during training would be $4,500,000 annually.

Attachment 1

Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities
General Assembly of NC Session 2004
House Bill 1414 Section 10.2(a) & (b)

Prepared For: The North Carolina Study Commission on Aging
December 1, 2005.

Final Report and Recommendations

I. Summary of Recommendations

Over the past year, the NC Department of Health and Human Services has worked closely with a Study Group, comprised of long term care provider associations, advocacy organizations and state government staff, convened in response to the Special Provision at Section 10.2(a) & (b) of HB 1414. The following report represents the Department's effort to summarize the work of the Study Group and prioritize their recommendations to support ongoing efforts within the Department to improve both long term care services and support persons with mental illness with appropriate treatment and services.

The Department is making the following recommendations, discussed in detail within the report as indicated:

- Expansion of mental health specialty teams to provide training and technical assistance to long term care facilities. (page 12)
- Design and implementation of an automated screening, assessment and care planning system to be used prior to admission to long term care services.(page 13)
- Conducting a study to inform the development of a residential continuum designed to meet the needs of persons with mental illness. (page 14)
- Strengthening training curriculums in all law enforcement training programs to improve law enforcement response in long term care settings. (page 15)
- Further evaluation of a number of statutes and rules to provide appropriate guidance to long term care facility operators according to the needs and characteristics of residents served.(page 10-11)

II. Introduction

On February 10, 2004, the North Carolina Study Commission on Aging heard presentations regarding people with mental illness who live in long-term care facilities.

The Commission considered many questions regarding this issue, including:

- Are adult care homes appropriate housing options for persons with mental illness?
- Is staffing and training at both nursing facilities and adult care homes adequate to meet the needs of diverse population groups?
- Do existing laws and rules provide the best guidance to those who operate these facilities?
- Does mixing younger people with mental illness with the frail elderly in adult care homes and nursing facilities compromise the health and safety of residents?

To address these issues, the Commission recommended that the General Assembly require the Department of Health and Human Services (DHHS) to work with long-term care providers and advocates to study these and other related issues.

During its 2004 session, the legislature approved House Bill 1414, which included the Special Provision at 10.2(b) directing the Department of Health and Human Services to convene a Study Group to provide recommendations on the following study areas:

1. Do current State statues and Departmental rules adequately address the populations served by long-term care facilities?
2. Would the development of separate licensure categories for adult care homes and nursing facilities improve care for the various populations served in those facilities?
3. Are adult care home rules easy to understand, attainable under current staffing patterns and include appropriate guidance to facility operators to best serve the needs of their residents?
4. Do these rules support residents' freedom of choice, as well as their autonomy, dignity, and independence?
5. What is the most effective way to identify mentally ill individuals that have mental health treatment needs?
6. Can the criteria for admission of mentally ill individuals to long-term care facilities be improved to ensure that the health and safety of all residents are safeguarded?
7. What changes need to be made to improve the quality of care for mentally ill individuals in adult care homes and nursing facilities? What is the potential cost associated with implementing these recommendations?
8. What specific problems exist as a result of mixing aging and mentally ill populations?

DHHS was also asked to include in this report how it defines "mentally ill" for purposes of this study.

For purposes of this study, the definition of mental illness is drawn directly from General Statute 122C-3(21):

> Mental illness means an illness which so lessens the capacity of the individual to use self control, judgment and discretion in the conduct of his affairs and social relations so as to make it necessary or advisable to be under treatment, care, supervision, guidance or control.

This is a functional definition that can include a broad spectrum of conditions including serious depression, schizophrenia, bipolar disorder and other psychiatric diagnoses where functioning can be improved or restored with appropriate medication and rehabilitative treatment. Dementia also meets this functional definition and is a progressive brain dysfunction that leads to a gradually increasing restriction of daily activities. The most well known type of dementia is Alzheimer's disease.

Developing the Study

NC DHHS Assistant Secretary for Long Term Care Jackie Sheppard convened the Study Group in December, 2004. The Study Group met for ten sessions and included representation of long term care provider associations, advocacy organizations and state government staff. A number of committees were formed to address particular study issues, some of which joined with existing DHHS committees to build on existing discussions and Department efforts. (See Attachment A: Study Group Members, Meetings and Subcommittees)

The Study Group reached agreement on statements of consensus (Attachment B: Consensus Statements) and presented a draft report to the Department in September 2005.
The draft report included lengthy discussion of the issues and a number of recommendations.

This report represents the Department's effort to summarize the work of the Study Group and prioritize their recommendations to support ongoing efforts within the Department to improve both long term care services and support persons with mental illness with appropriate treatment and services.

III. Scope and Context of the Report

The issue of serving the mental health needs of long term care residents is not new and pre-dates the current re-design of the publicly funded MH/DD/SAS system. In fact, state agencies and long-term health care providers have been engaged in a discussion of how best to provide this care for a decade or more.

Long term care facilities as referenced in the Special Provision include adult care homes and nursing facilities. The two are designed to meet different needs and operate under different statutes and rules. A nursing facility provides care for persons who have ailments for which medical and nursing care is indicated, but are not sick enough to

require general hospital care. Nursing care is their primary need, but they also require continuing medical supervision.

An adult care home is a facility which provides residential care for older adults or adults with disabilities whose principal need is a home with the shelter and personal care their age or disability requires. Medical care in an adult care home is usually occasional, incidental, and/or short term intermittent, but includes the supervised administration of medication.

While neither of these types of care is designed to provide for the mental health needs of their residents, many residents of both adult care homes and nursing homes have mental health issues.

While comparing results from different population studies is complicated by the difference in parameters and indicators used, a report commissioned by the Department in 2004 found that over 40% of the adult care home population carried an active diagnosis of mental illness. (Adult Care Home Mental Health Needs Assessment Report of Findings, First Health, July 15, 2004).

A limited sample study of nursing facility residents done as part of the Adult Care Cost Modeling Report found a similar percentage, 41.8%, to have a psychiatric or mood disorder diagnosis (Myers and Stauffer 2003). Comprehensive national studies indicate that as high as 80% of nursing facility residents have diagnosable psychiatric disorders, with dementia being the most prevalent condition. (Mental Health Services in Nursing Homes: Models of Mental Health Services in Nursing Homes: A Review of the Literature Psychiatric Services, November 1, 2002)

When the locus of care for persons with mental illness first shifted from the large state hospitals to the community decades ago, there were few residential options available to persons with mental illness, and many adult care homes stepped forward to fill that gap, providing shelter for those who had none.

North Carolina's current mental health reform effort is designed to improve the state's capacity to meet the needs of persons with mental illness according to evidence based practices, but many with mental illnesses continue to live in long term care settings because there are not yet more appropriate alternatives available to them in their communities.

As a result, long term care facilities have been an unavoidable choice for many individuals with mental illness, despite the fact that these facilities are not designed to provide psychiatric treatment or the rehabilitative services to allow persons with mental illnesses, particularly younger adults, to achieve a greater measure of independence.

Members of the committee agreed that without a large investment of new resources into community-based services, people facing the challenge of mental illness are likely to continue to be served in adult care homes and nursing facilities.

The Department has taken steps in addressing some of the challenges posed by this issue.
Since 2001, for example, the Department has been engaged in a Department-wide effort to improve the quality of long term care services as outlined in the Institute of Medicine's Long Term Care Plan for NC. While the resources to implement the full range of changes suggested by the report have not been available, the Department has implemented a number of the recommendations and other initiatives in an ongoing effort to improve long term care services for all residents.

The NC DHHS Division of Medical Assistance has also undertaken population studies to assess the needs, both physical and behavioral, of current long term care populations and is moving forward with an automated screening and assessment tool that will be used for Medicaid providers and recipients needing long term care services. Further information on this effort is included in Recommendation B.

In addition, the NC DHHS Division of MH/DD/SAS has funded 21 geriatric mental health specialty teams. These teams provide training and case consultation to adult care homes and nursing facilities to help staff understand and manage some of the challenging behaviors of older adults.

The Division is also piloting a specialized long term geriatric behavioral unit for nursing facility residents and a Special Care Unit in an adult care home. These pilots are designed to serve persons who exhibit persistent behaviors that pose potential danger to the individual and/or to other residents. Expanding both of these initiatives are included in Recommendations A and C.

The NC DHHS Division of Aging and Adult Services is also involved in a wide variety of initiatives targeted at improving the long term care delivery system, including:

- Implementing the Aging and Disability Resource Center Grant to create a coordinated system of information and access for all persons seeking long-term support.
- Convening a multidisciplinary taskforce called SAFE-in-Long Term Care composed of individuals in the fields of law enforcement, long term care, advocacy and state government to raise awareness regarding appropriate responses to crimes occurring in long term care settings.
- Initiating the Quality Improvement Consultation Program for Adult Care Homes as directed by recently passed legislation "to promote better care and improve quality of life in a safe environment for residents in adult care homes through consultation and assistance with adult care home providers."

In addition, the Department has implemented North Carolina's response to the 1999 US Supreme Court's Olmstead decision by coordinating Department wide efforts to reduce reliance of institutional care by addressing a variety of system issues including

transportation, strengthening the direct care work force and expanding the availability and improved access to affordable community housing.

IV. Summary of Study Group Discussions

The Study Group's discussions covered a gamut of issues and concerns raised in the Special Provision that can be captured under four themes:

- Health and safety
- Screening and disclosure
- Training of staff, and
- Services to residents with mental illness.

A. Health and Safety

While many persons with a diagnosis of mental illness reside in long term care settings without difficulties, others, because of the nature of their illness, inadequate treatment, or lack of expertise among facility staff, can exhibit behaviors that can impact other residents and/or pose a potential safety risk to staff and residents.

Licensed skilled nursing facilities in NC are well-equipped to care for the frail older adult, medically complex residents that they serve. Many of these residents have age-related dementia or Alzheimer's disease, and some have mental illness that is effectively managed. However, industry representatives report that these facilities are increasingly struggling with safety issues related to a growing number of residents with challenging behaviors that have an impact on the safety of residents in the facilities.

In adult care homes some older adult residents and their significant others cite concerns about the safety and the vulnerability of other older adults due to reports of behavior problems such as verbal/physical/sexual abuse by some younger residents. The facilities, however, have found that the needed services and alternative placements to address these unexpected acute challenging behaviors are not widely available or accessible.

While there is currently no comprehensive information available as to the scope and breadth of these problems, the NC DHHS Long Term Care Ombudsman Program receives and investigates complaints made by or on behalf of long term care residents. The Ombudsman Program is an advocacy program, not a regulatory agency. In the course of their work, the program's staff have reviewed situations in which persons exhibit aggressive behaviors, engage in illicit drug use and/or alcohol abuse that negatively impact the health and safety of other residents. The Ombudsman staff also report concerns that the needs of persons with mental illness are not always being met. These reports include the inappropriate use of infringement of the patient rights as a

behavior modification tool and even reports by some residents with mental illness that their health concerns are often disregarded and not reported to health professionals.

It was also noted that law enforcement must be called by the facility when the safety of residents or staff are in danger. Complaints received by the Ombudsman Program indicate law enforcement officials can be hesitant to arrest or detain residents who commit criminal acts. The law enforcement response is complicated by the need to carefully assess and differentiate between a criminal act and psychosis requiring treatment. (See Attachment C: 2005 Regional Program Survey by the Long Term Care Ombudsman Program)

B. Screening and Disclosure

Members of the Study Group agreed that a good screening mechanism is a critical component to appropriate placement but that current tools are either inadequate or not used appropriately. They agreed that while a framework for this approach is already established through assessment and care planning requirements, the critical component of screening persons for appropriate placement within a continuum of long-term care is missing. The Study Group felt that this is the area in greatest need of attention from a regulatory standpoint. Such a tool would allow for the adequate evaluation by the facility of the needs of the potential resident and the determination by the facility of its ability and resources to meet those needs.

The Study Group also felt that disclosure by facilities of what services can and cannot be provided and disclosure by referral sources of resident history, condition and needs are not adequately addressed in statute or rule. In addition, facilities report that some residents who were initially admitted were later found to have persistent behaviors that pose a potential threat to themselves or other residents. In many cases these individuals have not responded to interventions and services that are available to the facility, yet do not meet the statutory criteria for involuntary commitment to a psychiatric hospital.

1. Nursing facilities Currently, nursing facilities are subject to stringent Federal regulations related to Medicare and Medicaid. All nursing facility residents are subject to the Pre-admission Screening and Annual Resident Review regulations, commonly called the PASARR. The PASARR Program was established by Congress to ensure that every individual seeking admission to a Medicaid certified nursing facility (NF) is properly assessed to determine if he/she requires nursing facility care and if he/she has a major mental illness (MI), mental retardation (MR) or a related condition (RC) that requires specialized services.

Every new admission to a certified nursing facility, regardless of payment source, is subject to a Level I screening prior to admission, with the exception of individuals readmitted after treatment in a hospital unless there has been a significant change in status. After receiving the Level I screen, if individuals are suspected of having either mental illness or mental retardation or a related condition, a Level II evaluation must be

completed with the recipient by a qualified professional to assess whether nursing facility services and specialized services are needed. Recommendations based on the Level II evaluations are forwarded to the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services for final determination of services and placement for the individual. All persons identified as MI or MR/RC by this process receive an annual resident review designed to assess their care needs or whenever there is a significant change in the resident's condition. It should be noted that PASARR does not include screening and evaluation for nursing facility residents who have dementia and who may have significant challenging behaviors.

The PASARR process is not without some flaws for persons with psychiatric illness, however, particularly in the admission screening process. For example, the PASARR by regulation excludes screening for dementia. Dementia and certain related challenging behaviors can pose immense concerns for Nursing facilities and the residents for whom they care. Also, at the time of the PASARR screening, behaviors may not always be evident. Current or long–term residents may develop dementia and related behavior issues that are not related to the primary reason for admission to the nursing facility. A limited number of nursing facilities have the ability to deal with ambulatory residents with more challenging behaviors, such as a person who roams and rummages in other resident rooms. Although this person is not violent, he/she is at risk of being injured by other residents who react strongly to having someone handling his/her possessions. Additionally, over time, a resident may develop a new psychiatric illness and /or develop behavior/symptoms related to another diagnosis. Facility operators also stated that often there is an inability to get appropriate services for these long-term residents who develop new psychiatric disorders, and once these problems manifest there are limited discharge/care and/or treatment opportunities available.

2. Adult Care Homes Similarly for persons entering an adult care home, the facility will review the FL2 (the current screening tool) and if the home feels it can meet the needs of the individual and has a vacancy the person is admitted. Study Group members agreed that in some instances the FL2 does not include all the information it could/should contain in order for the adult care home to make a sound admission decision. The home may decide to meet the potential resident before deciding whether they can meet the individual's needs, however, it may be days before the symptoms of the illness manifest. The home then cannot meet the needs of the resident, is not trained in handling those specific behaviors and/or has no place to refer the resident or get support. They have now accepted a resident with no viable options available for assistance. This resident may even be a danger to himself or others. Additionally, as the resident "ages in place" exacerbation of old conditions may develop, as well as new conditions.

A program similar to PASARR for adult care homes is not currently available. Study Group members indicated that this inconsistency in systems has been used by referring agencies or doctors to by-pass the assurances required by nursing facilities, by placing the resident in an adult care home who only have exclusionary criteria rather than defined admission criteria. As a result, the adult care home has no way of knowing that a person should have received such a screening, and subsequently the resident may

not receive services or needed support from trained staff. The true picture of resident needs may only come to light after they are placed and the challenging behaviors emerge.

C. Training of Staff

Typically, mental health crisis situations are unpredictable, although at times there is evidence of a person's escalating behaviors. Members of the Study Group were in agreement that presently there is not enough trained staff, particularly nursing assistants, personal care and medication aides, to care for residents with mental illness. Training is most important for monitoring behavior changes and responding with appropriate interventions when dealing with challenging behaviors exhibited by some residents with mental illness. An understanding of mental illness and how it impacts behavior can result in more effective interventions and prevention of crisis situations.

The current training requirements for direct care staff, including aides and supervisors, in adult care homes are focused primarily on personal care with little emphasis on training related to the additional skills that are needed to care for residents who also have cognitive impairment and/or mental illness. It was also noted that instructors, who provide the training that is currently required, usually do not have the experience and/or education that is directly related to the care of residents who have cognitive impairment and/or mental illness. Likewise, nursing facility direct care staff, while highly trained to manage clinical issues of facility residents, do not receive training specific to managing and de-escalating challenging behaviors.

Nursing assistants, personal care and medication aides in adult care homes often have not had the training needed for appropriate interaction with residents based on their particular mental illness, and specifically to administer and/or monitor the side effects of psychotropic medications. When there is a need for facility staff to be involved in implementing an appropriate behavior plans, this does not routinely occur because the plans are not developed and agreed upon with participation by the resident and approval by the attending physician or supervision of a qualified mental health professional.

D. Services to residents with mental illness

The Local Management Entities (LMEs) for the public mental health, developmental disabilities and substance abuse system of services have responsibility for access to the available services by providing screening, triage, and referral to appropriate provider agencies. LME's also have a responsibility to assure crisis services. These responsibilities include responding to the needs of their communities including the needs of residents in long term care facilities. The types of mental health services that are often needed by some residents in long term care settings includes: evaluation and assessment of residents who are exhibiting behaviors that appear to be related to mental illness; development of person centered plans that include consideration of each individual's needs for a wide range of services or supports; and provision of ongoing

treatment and rehabilitative services, and cooperation and support for others who are providing service and support for the individual.

The Study Group found that statute and rules related to both adult care homes and nursing facilities do not address coordination or linkages to these resources that would provide a more systematic and operational framework for meeting the needs of residents who require additional services.

Long term care providers report that greater involvement of mental health professionals is needed to do evaluations; to assist in the development of care plans; to provide treatment for some residents; and to provide consultation, training, and support for facility staff who are caring for residents with challenging behaviors related to cognitive impairment or mental illness. They also report that access to psychiatric consultation, evaluations, and treatment is difficult particularly if it is not provided on site and that the availability of gero-specialists, social workers, psychologists and psychiatrists is extremely limited.

Other concerns raised related to activities that are offered for older adults frequently do not meet the diverse needs of younger residents, and are often not an integral part of the personal care plan. It was also noted that there are not alternative residential options for providing stabilization of acute behavior that becomes problematic in the nursing facility or adult care home but does not meet the criteria for involuntary commitment to a psychiatric hospital.

Finally, the Study Group agreed that at the current time, the availability of mental health resources, the capacity to perform timely and thorough evaluations, development of person centered plans, and access to the broad array of services and supports needed for persons with mental illness varies greatly across the state. Poor coordination, unavailable transportation to rehabilitation activities, and few on-site mental health services were identified as additional barriers to assure the provision and coordination of needed services in many areas.

V. Rules and Statute Review

A. Discussion

Subcommittee members were asked to complete charts to gauge opinion on whether the statutes and rules adequately address the population served in adult care homes. The results collected served as a basis for discussion of the issues by a majority of subcommittee members and the Adult Care Home Mental Health Workgroup.

Statutes and rules governing adult care homes do not make direct references to the specific populations served such as persons with mental illness, those who are medically frail and those of advanced age. Addressing the needs of these populations is encompassed, in part at least, in the context of an array of care and services mandated by statute and promulgated in rule, and in the requirements for admission, assessment, care planning and training.

Addressing specific populations and their particular needs in law and rule has a number of pitfalls, not the least of which is the inevitable failure to take into account the wide range of persons being served and their wide range of needs. In addition, singling out one group of residents should not be done at the expense of another group who may have some of the same needs but also a number of other specialized needs as well. Rules would inevitably become more complex and extensive without necessarily promoting attention to the particular needs of individual residents. The primary concern should be one of adequately addressing needs of individuals rather than generically addressing populations.

Subcommittee members felt that well-designed screening, assessment and care planning instruments would better accomplish the intention of the current adult care admission rule:

> "Any adult (18 years of age or over) who, because of a temporary or chronic physical condition or mental disability, needs a substitute home may be admitted to an adult care home when, in the opinion of the resident, physician, family or social worker, and the administrator, the services and accommodations of the home will meet his particular needs." (Rules 10A NCAC 13F and 13G .0701 Admission of Residents.)

There was no clear indication from results of Subcommittee discussions that adult care home rules were not understandable and not supportive of residents' freedom or the autonomy, dignity and independence philosophy of assisted living. Based on the Adult Care Home Cost Modeling Report (December, 2004), current staffing patterns are insufficient to meet all the requirements in rule. Again, the Subcommittee felt that the combination of improved screening and disclosure would help assure appropriate admission of residents so that facilities are able to meet residents' needs, make residents and their responsible persons aware when residency in a facility will no longer be viable, and protect the health and safety of all residents in the home.

A number of rules and statutes were identified as needing further evaluation and attention in relation to providing appropriate guidance to facility operators according to needs and characteristics of residents served. These are listed in detail below:

B. Recommendations: NC General Statutes 131D and 131E

The Department of Health and Human Services recommends to the NC General Assembly the following:

1. Assure definitions of abuse, neglect and exploitation are consistent with definitions of these terms in other statutes that impact adult care homes or types of residents in these homes.(GS131D-2(a))

2. Qualify "provide services" as "services established by rule" to provide greater clarity and avoid the possible misconception that these facilities provide any and all services "to assure quality of life...." etc. Coordination of services provided by community resources needs to be addressed since facilities cannot be expected to be providers of all services that may be needed. Additional funds would be needed to implement this coordination. (GS131D-4.1)
3. Evaluate current staffing requirements that are based on requiring specific amounts of staff time per resident in relation to a more "outcome" orientation to staffing which would focus greater attention on whether the needs of residents are being met rather than number of staff present. (GS131D-4.3)
4. Address coordination of services to take into account services needed that the facility cannot directly provide (see #2 above). (GS131D-4.4)
5. Establish a mandate for screening of potential adult care home residents. Additional funds would be necessary for the development and implementation of this screening.(GS131D-4.5)
6. Establish a mandate for:
   - full disclosure in writing by all facilities to residents and their responsible persons such as required of special care units in 131D-8; and
   - full disclosure of information about potential residents to the facility so that facilities are fully aware of the resident's history and care needs in order to make informed decisions about admitting residents. (GS131D-2)

The study group also discussed the possibility of suggesting that there be exceptions to a Resident's and Patient's Bill of Rights in situations where they may make implementation of specific behavior plans difficult. However, deleting any of these Rights would risk changing the nature and character of these facilities. Rights may now be restricted in accordance with approved plans of care. If the deletion of Rights are necessary in order to provide appropriate treatment to a particular individual in an adult care home or nursing home, that individual would likely be more appropriately placed in a licensed mental health facility.

C. Recommendations: Administrative Rules for Adult Care Homes of Seven or More Beds (10A NCAC 13F) and Family Care Homes (10A NCAC 13G)

The Department of Health and Human Services recommends that the NC Medical Care Commission:

1. Strengthen training on caring for residents with cognitive impairments and/or mental health needs. Training should include specific methods for de-escalation of challenging behaviors and the implementation of appropriate behavior plans for residents with challenging behaviors. Training by qualified instructors is critical to enabling staff to meet resident needs. Additional training of staff upon employment and on an annual basis needs to be considered. This would require additional funds for trainers and staff time for training, including staff coverage while staff is being trained. Any mandatory requirements for additional training

should be conditioned upon the availability of necessary resources. The use of mental health specialty teams like the geriatric specialty teams should be explored. (10A NCAC 13F and 13G .0501-.0502: Personal Care Training)

2. Evaluate the feasibility of a more outcome-based orientation to staffing and explore outcome-based measures. Staffing ratios are not directly related to residents receiving appropriate care and services and reliance on this kind of staffing requirement may even have a negative impact on care. Greater attention should be given to assuring staffing to meet the needs of residents. Increased funds will be needed to increase staff time. Thorough screening, assessment and care planning processes are critical to the effectiveness of an outcome-oriented approach. (10A NCAC 13F .0604-.0605: Staffing)

3. Require that admission of residents be dependent on facility review and evaluation of the results of a pre-admission screening process and all other information regarding the resident's mental and physical condition, needs and history provided to the facility. (10A NCAC 13F and 13G .0701: Admission of Residents)
4. Require that the examination of a resident who has been an inpatient of a psychiatric facility within 12 months prior to admission and does not have a current plan for psychiatric care be examined by a mental health professional. The allowance of 30 days for the examination should be considered for possible reduction. (10A NCAC 13F .0703(e) and 13G .0702(e):TB Test and Medical Examination)
5. Include requirements regarding facility disclosure to residents and responsible persons here or in a separate rule. (10A NCAC 13F and 13G .0704:Resident Contract)

VI. Recommendations for improving the quality of care for persons with mental illness in long term care facilities

A. The Department of Health and Human Services recommends the expansion of mental health specialty teams to provide training and technical assistance to long term care facilities.

The Department and the Study Group believe that the quality of care for persons with mental illness in long term care facilities can be supported and improved by making it possible for facility staff to have access to training, technical assistance, case consultation, and assistance with referrals to mental health treatment services. A geriatric mental health specialty team model has been a successful strategy to address needs of both long term care staff and residents with mental illness. However, current funding has been made available to fund only 21 such teams and the staffing qualifications and focus of these teams are on the specific needs and issues of older (age 60 and over) long term care residents. The current small number of these teams makes it impossible for them to meet the needs of all long-term care facilities for this kind of consultation and training.

Mental health specialty team staff with the training, experience, and skills would be needed to help long term care staff address the challenging behaviors of younger residents in long term care are also needed. For example, 5,867 or 24% of all adult care home residents are under the age of 65, However 3,117 or 62% of adult care home residents under age 65 have a mental health diagnosis.[1]

In order to increase the availability of mental health specialty teams to address behavioral issues presented by long term care residents of all ages, proposed initial steps are:

1. To add 12 additional geriatric mental health specialty staff to existing teams. These staff would supplement the capacity of current teams that are serving areas with large number of long term care facilities. These staff will be qualified mental health professionals who have experience working with older adults with mental illness. These staff will focus on training, consultation and support to facilities for residents 60 and older who may present behavioral challenges that are related to dementia or other mental health diagnoses. The cost per staff is approximately $65,000 per year for staff, travel, and training materials.

2. To add 25 qualified mental health specialty staff that are mental health clinicians who have training and experience about the needs of younger individuals who have major mental illness some of whom may exhibit behaviors that are not consistent with the expectations of staff and other residents in long term care settings. These staff will focus on training, consultation and support to facilities for residents under the age of 60 years old. The cost of one person would be approximately $65,000 per year for staff, travel, and training materials.

Currently the cost of a two person Geriatric Mental Health Specialty Team is $130,000 per year or $65,000 to cover the costs of each team member. This includes staff salaries and benefits, transportation/travel costs associated with travel to long term care facilities throughout the geographic area served, and a small amount of money for training materials and supplies used when providing training to long term care facility staff.

The cost of implementing this recommendation to fund a total of 37 additional team members would be approximately $2,405,000 per year. Additional background information, data about the number, type and location of long term care facilities that was used to develop the proposed action steps is included in Attachment E.

B. The Department of Health and Human Services requests support of the design and implementation of an automated screening system to be used prior to admission to a nursing facility, adult care home, or other home and community

[1] 2005 Adult care home population census information from the NC Division of Facility Services

based services; and the design and implementation of an automated assessment and care planning system to be used once the setting of care is determined.

The Department is currently working on an integrated, web-based system that will streamline the screening and assessment processes for Medicaid providers and recipients needing long term care services. The overall design of the new system will include among other things, the capacity to identify persons with mental illness, substance abuse and/or mental retardation prior to admission to a nursing facility, an adult care home or before receiving other home and community services. The Division of Medical Assistance will work with the Division of MH/DD/SAS to see that the design complements the diagnostic assessment process underway for persons who meet the DMH/DD/SA target population criteria.

The new process will meet the requirements of the federally mandated Pre-Admission and Annual Resident Review (PASARR) program. If the mental health portion of the screening identifies the need for a more thorough mental health evaluation, then a qualified mental health professional should perform the evaluation and determine needed mental health services or supports. Overall, the new automated screening and assessment system should promote one's independence, self-management of health, and be formed around person-centered planning concepts.

The detailed work plan for the integrated access and management system for Medicaid will be available December 2005. The estimated resources required to implement the system will be determined through a formal bid process, but it is estimated to cost $1 million for design and development and $2.3 million for annual operating costs. At this time it is anticipated that current expenditures will be redirected to support this system. The need for additional resources, primarily for ongoing operations and training to implement the new system are estimated at $248,000 per year.

C. The Department of Health and Human Services requests $620,000 for a study to inform the development of a residential continuum designed to meet the needs of persons with mental illness.

The Department believes that there is a need to increase choice and treatment options for people with mental illness of all ages, particularly those who would benefit from more than the residential care and personal assistance than adult care homes are designed and funded to provide - and those with both medical and behavioral issues that nursing facilities are not equipped to manage. Improved screening and background disclosure of residents will inevitably result in persons being found inappropriate for either adult care or a nursing facility. Without alternative settings to meet these needs the state will remain dependent upon more costly care in the State psychiatric hospitals.

At this time the Department does not support creating a separate licensure category for adult care homes that serve persons with mental illness. On October 1, 2005 the General Assembly ratified SB 572 - An Act To Create A Licensure Category For Assisted Living Communities That Serve Only Frail Older Adults (see Attachment D).

Assisted Living Communities that wish to serve only the frail elder population are now able to acquire a license that designates them as communities that serve only the frail elder population. While facilities wishing to serve only a population of persons with mental illness do not have that option as either an adult care home or nursing facility, they can apply for license as a mental health facility.

The Department believes that attention and resources must be devoted to creating a range of housing and treatment options that meet the needs of persons with mental illness that are consistent with evidenced based treatments. As a first step, a study should be undertaken to quantify the need, in terms of projected numbers to be served and the types and designs of alternative residential and treatment settings. The scope of this study would include a review of models used in other states, applicable Federal and State policies and regulations, potential funding sources, and development of cost estimates to develop a continuum of residential services, including, but not limited to:

- Community based residential options for providing stabilization of acute behavior that does not meet the criteria for involuntary commitment to a psychiatric hospital, including facilities that can provide both the nursing care and the psychiatric stabilization and treatment that are needed before return to a nursing facility is considered, as well as facilities that can provide both the personal care and psychiatric stabilization and treatment that are needed before return to an adult-care home is considered.
- Long term acute care hospitals specializing in the care of older people who have both medical and acute behavioral or psychiatric care needs or "swing beds" designed specifically for people with nursing care needs and acute behavioral or psychiatric care needs. The average length of stay of a long-term acute hospital is approximately 28 days. This length of stay would lend itself to the observation, stabilization, and intervention time necessary to return the older adult to the nursing facility
- Specialized long term geriatric behavioral units for nursing facility residents who exhibit persistent behaviors that pose potential danger to the individual and/or to other residents. A single pilot of this model has recently begun operations.
- Specialized long term geriatric behavioral units for adult-care home residents who exhibit persistent behaviors that pose potential danger to the individual and/or to other residents, including a review of the current ACH- 12 bed special MH unit rules (10A NCAC 13F Section .1400) to determine if there needs to be any changes in staffing requirements and other areas
- Community based supportive housing, housing with supportive services, for adults with mental illness in their communities.

D. The Department of Health and Human Services supports strengthening training curriculums in all law enforcement training programs to improve law enforcement response in long term care settings.

The Department will work with key officials in the Training and Standards Division of the Department of Justice in order to promote the use of N.C. Intervention Training and to

facilitate the development of new mental health training curricula for law enforcement officers. The new curriculum should include identification of major mental illnesses, action steps for crisis response by law enforcement officers and alternatives to involuntary commitments. Officers at every level should be afforded access to available and newly developed training modules addressing their response to individuals with mental illness.

With appropriate and adequate training, law enforcement officers can develop skills to address the safety issues confronting staff and residents while de-escalating the situation. This training is highly encouraged for "first responders." Facilities are encouraged to have a "crisis plan" in place in order to avoid unnecessary demands on emergency hospital resources.

These efforts will build upon the Division of Aging and Adult Services' multidisciplinary taskforce called SAFE-in-Long Term Care. S.A.F.E. is an acronym that stands for Strategic Alliances For Elders in Long Term Care. SAFE is composed of individuals in the fields of law enforcement, long term care, advocacy and state government. This taskforce was convened to raise awareness regarding appropriate responses to crimes occurring in long term care settings and ensuring that justice is served. SAFE seeks to eliminate this lack of knowledge and awareness about these crimes by providing education and training to the general public and especially those professionals who have an obligation to protect society's most vulnerable from harm.

Attachment 2

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