# 2006

# SUBCOMMITTEE ON MENTALLY ILL RESIDENTS IN ADULT CARE HOMES

# MINUTES

## ATTENDANCE

### Subcommittee on Mentally Ill Residents in Adult Care Homes

| DATES / MEMBERSHIP | 10/11/06 | 11/14/06 | 12/12/06 | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Representative Verla Insko, Co-Chair | √ | √ | √ | | | | | | | | | | | | | |
| Representative Beverly Earle, Co-Chair | √ | √ | X | | | | | | | | | | | | | |
| Representative Alice Bordsen | X | X | √ | | | | | | | | | | | | | |
| Representative Debbie Clary | √ | X | X | | | | | | | | | | | | | |
| Representative Bob England | √ | √ | √ | | | | | | | | | | | | | |
| Representative Carolyn Justice | √ | √ | √ | | | | | | | | | | | | | |
| Senator Stan Bingham | √ | √ | √ | | | | | | | | | | | | | |
| Senator Charlie Dannelly | √ | √ | √ | | | | | | | | | | | | | |
| Senator Jeanne Lucas | X | X | √ | | | | | | | | | | | | | |
| Senator Vernon Malone | X | X | **X** | | | | | | | | | | | | | |
| **STAFF** | | | | | | | | | | | | | | | | |
| Ben Popkin | √ | √ | √ | | | | | | | | | | | | | |
| Shawn Parker | √ | √ | √ | | | | | | | | | | | | | |
| Andrea Russo | √ | √ | √ | | | | | | | | | | | | | |
| Rennie Hobby | √ | √ | √ | | | | | | | | | | | | | |
| Ann Raeford | X | √ | X | | | | | | | | | | | | | |
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# SUBCOMMITTEE ON
# MENTALLY ILL RESIDENTS IN ADULT CARE HOMES
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# Agenda

## Sub-Committee on Mentally Ill Residents in Adult Care Homes

**Wednesday, October 11, 2006**
**1:30 p.m.**
**Legislative Office Building**
**Room 544**

## I. Welcome and Introductions

*Representative Verla Insko, Cochair*
*Representative Beverly Earle, Cochair*

## II. Continuum of Care

*Bonnie Morell, Division of MH/DD/SAS, DHHS*

## III. Facility Licensing Requirements

*Barbara Ryan, Division of Facility Services, DHHS*

## IV. Report Overview: Mentally Ill Residents of LTC

**(S.L. 2004-124)**
*Julia Bick, Office of the Secretary, DHHS*

## V. Uniform Screening and Other Initiatives

*Lynne Perrin, Divisionof Medical Assistance*

## ATTENDANCE

### Subcommittee on Mentally Ill Residents in Adult Care Homes

| DATES / MEMBERSHIP | 10/11/06 | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Representative Verla Insko, Co-Chair | √ | | | | | | | | | | | | | | | |
| Representative Beverly Earle, Co-Chair | √ | | | | | | | | | | | | | | | |
| Representative Alice Bordsen | X | | | | | | | | | | | | | | | |
| Representative Debbie Clary | √ | | | | | | | | | | | | | | | |
| Representative Bob England | √ | | | | | | | | | | | | | | | |
| Representative Carolyn Justice | √ | | | | | | | | | | | | | | | |
| Senator Stan Bingham | √ | | | | | | | | | | | | | | | |
| Senator Charlie Dannelly | √ | | | | | | | | | | | | | | | |
| Senator Jeanne Lucas | X | | | | | | | | | | | | | | | |
| Senator Vernon Malone | X | | | | | | | | | | | | | | | |
| **STAFF** | | | | | | | | | | | | | | | | |
| Ben Popkin | √ | | | | | | | | | | | | | | | |
| Shawn Parker | √ | | | | | | | | | | | | | | | |
| Andrea Russo | √ | | | | | | | | | | | | | | | |
| Rennie Hobby | √ | | | | | | | | | | | | | | | |
| Ann Raeford | X | | | | | | | | | | | | | | | |
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# SUBCOMMITTEE ON
# MENTALLY ILL RESIDENTS IN ADULT CARE HOMES

**Wednesday, October 11, 2006**
**1:30 PM**
**Room 544, LOB**

The Subcommittee on Mentally Ill Residents in Adult Care Homes met on Wednesday, October 11, 2006, at 1:30 PM in Room 544 of the Legislative Office Building. Members present were: Representative Beverly Earle, Co-Chair; Representative Verla Insko, Co-Chair; Senators Stan Bingham and Charlie Dannelly and Representatives Debbie Clary, Bob England, and Carolyn Justice.

Shawn Parker, Ben Popkin, Andrea Russo, Carol Shaw, and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order, welcoming members and guests. She said that the committee meeting was a joint subcommittee of the Study Commission on Aging and the Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services. She said the goal of the subcommittee was to seek an outcome to the housing situation regarding the adult mentally ill and to recommend legislation to the 2007 General Assembly.

Dr. Bonnie Morrell from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, addressed adult care services and where the adult mentally ill reside. (See Attachment No. 2) She announced that the public mental health system served over 174,000 adults with mental illness last year. Of that number, 1,149 lived in licensed mental health homes; 5,000 lived in adult care homes (ACH); and many lived independently in the community and received services. In order to live independently, these individuals must either receive a rent subsidy or have enough money to pay rent, and they must be able to receive necessary services as appropriate. Nationally, approximately 10% of adults with serious mental illness need specialized housing. Dr. Morrell briefly described how a person in need of help would access services, stating that there was a 24-hour-a-day phone number to call. Their need is screened and assessed as to whether it is an emergency or routine need and they are then connected to the appropriate provider. The number for each LME is posted under "service locator" on the Division website. She said that the new services that began in March were designed so that services would go to the consumer rather than the consumer going to an office to meet with a therapist. She also reviewed existing services for adults. Dr. Morrell said she would provide data regarding where consumers who use crisis services and are admitted to a State facility were living before entering the facility.

Dr. Morrell explained that every person receiving mental health services has a Person Centered Plan. A person that begins to experience difficulties can call the community support provider and staff from the agency would go see that person and offer assistance.

She was asked about service gaps and explained that the scenario just described would be in place once there is an adequate supply of providers in every catchment area across the State. Andrea Russo, Fiscal Research staff, was asked to provide the percentage of federal, State and county dollars going to mental health services, how it affects the LME, and where the money goes.

Dr. Morrell said that there was one mental health licensure category for residential housing for adults with mental illness. In that category, there are supervised living apartments with 488 people, 59 live with families that are paid on a temporary basis, and 594 live in group homes. The total is 1,140 living in licensed mental health settings based on reimbursement data. Housing is paid for with State funds, Medicaid does not pay for this service. She said that there was a gap in the residential treatment setting for adults with mental illness. It is an issue that is currently under study. She said that based on 2005 data, there were 24,831 residents in adult care homes and 5,000 of those had a mental illness of which 1,479 were under 50 years of age. The issue is not necessarily age but rather having a mental illness that is associated with behaviors that do not fit appropriately with the setting the person is in and the people with whom they are interacting. Representative Insko suggested that this was the population that raises the most concern and perhaps there should be a specialized setting for that population. Dr. Morrell also said that reviewing data regarding State hospitals discharging patients to adult care homes showed that in FY 2002, 5.5% of the discharges were to ACH, and in FY 2006 the number had decreased to 3.7% discharges. She said that the numbers indicate that an effort is being made for appropriate placement. For those in need of more serious treatment, a specialized residential facility that incorporates treatment is needed. ACH regulations state that they must provide personal care and support but say nothing about treatment. Patients listed with Alzheimer's and dementias are not listed as having a mental illness.

Barbara Ryan from the Division of Facility Services addressed licensing requirements. She said the definition of an Adult Care Home is a setting that provides room and board, individual personal care and assistance and or supervision. Mental health treatment would be considered an inappropriate placement. For those needing mental health services residing in (ACH), the facility would make arrangements with the LME for residents to receive appropriate treatment. If a person was coming from a State facility to an adult care home, the hospital would notify the LME. Services would most likely be provided by Medicaid. The facility pre-screens each individual to ensure that they can meet the individual's needs. If it is found that the individual needs additional care or has escalating behavior, staff would call the physician, the psychiatrist, a mental health professional, or refer the appropriate person to a magistrate to pursue involuntary commitment of the individual. If a person appears dangerous, then law enforcement would be called. Members of the subcommittee expressed concern that there may now be a need for facilities that are adequately staffed, trained, and paid to handle violent mentally ill patients. Ms. Ryan said that out of the 582 adult care homes that renewed their licenses in September of 2005, 115 had a population of 50% or greater mentally ill residents. Out of the 546 family care homes which have 2-6 beds, 222 had 50% or greater with a diagnosis

of mental illness. She was asked how many of these residents would be considered violent and agreed to locate the information.

Jeff Horton, Chief Operating Officer of the Division of Facility Services, spoke on facilities for the mentally ill. Mr. Horton said that there was no level of care between the hospital inpatient setting, the adult care home setting, and independent living setting. DFS licenses 287 mental health facilities which are categorized as supervised living for adults with mental illness. These facilities are licensed to have 2-6 beds. There are 1,319 facilities for supervised living for adults with developmental disabilities, 300 are special mental retardation homes for adults with DD. Funding was a concern for people moving from an adult care home in the community into a clubhouse setting and then into an independent living setting. Members questioned the ability to track supervised housing. Mr. Horton responded that DFS did not regulate supervised housing since it was typically an independent living arrangement. Andrea Russo responded that there was a way to track the number of units the Housing Finance Agency has financed; and also said that the Division of Community Assistance (under the Department of Commerce) has financed a small number that they report every year. It was requested that an overview with the definitions of the different levels of care be provided. Mr. Horton was asked if there were any successful models across the State where the mentally ill and other adults lived together. Lou Wilson responded that in spite of the fact that there are no rules or guidelines by the State for these facilities, there are a few that have services for residents with mental illness. She offered to gather detailed information for members.

Julia Bick from the Office of the Secretary gave an overview of the (DHHS) report on the *Study of Mentally Ill Residents in Long Term Care Facilities.* (See Attachment No. 3) She emphasized that the diagnosis of mental illness does not mean that a person is dangerous. It is also not an age issue since people of all ages can have behavioral issues. She said that the Department had already implemented pieces of the report. Beginning January 1, 2007, funding will be made available to expand the mental health specialty teams to hire an additional position to focus on the needs of younger adults in long term care setting. The Department is currently developing an RFP to identify/locate the population and the needs of the population within the adult care home system and the mental health system. While this study is going on, Ms. Bick said that the Department was moving forward to develop aspects of the plan focusing on the need for a higher level of supervision and support along with a separate program to provide adequate staffing and treatment to address the needs of this population. A draft service definition (which may be covered as a Medicaid service) has been proposed to address the high end of this continuum. She said this would be a small community-based facility (Residential Treatment Model) if approved by CMS, or funded as a State service if supported by the legislature. The facility, with 12 beds or less, would treat those not meeting the criteria for admittance to a State hospital but having problematic behavior not being adequately treated in the ACH.

Julia Budzinski from the Division of Medical Assistance reported on uniform screening. (See Attachment No. 4) She addressed 3 initiatives that directly affect ACH: 1) A uniform screening program for all Medicaid long term care services; 2) An ACH personal

care services restructuring program; and 3) A future integrated assessment system. Addressing the adult care homes admissions process, she said that the new system would put the PASAR components in effect at the initial assessment. She said that there were many problems with the FL2 process but that the three programs would eliminate that process. There will be one form to replace the multiple forms involved with the eight separate processes. The new form will be a web-based program which should reduce inappropriate placements, reduce paperwork, and provide a better picture of the population's needs. Ms. Budzinski said that the goal was to provide people with the correct service, to increase choice, and to provide appropriate placement.

Ms. Budzinski said that the Adult Care Home/Personal Care Service restructuring is a result of a 2 year process working with CMS (which did not approve of the method of reimbursement of Adult Care Homes for Personal Care Services). As a result, a kick-off meeting with stakeholders was held to look at policy, rate-setting, rules, legislation, and funding for ACH. The desired outcome is to have additional funding for additional services that will meet the needs of residents. She also noted that one Personal Care Service program will apply uniformly to the eight settings which should help streamline the system. She also said the RFP for the Integrated Assessment System should be ready soon. The system will be web-based and the pilot program should be implemented by the first of the year.

There being no further business, the meeting adjourned at 3:50 PM.

Representative Verla Insko, Co-Chair

Rennie Hobby, Committee Assistant

**Attachment 1**

## VISITOR REGISTRATION SHEET

SUBCOMMITTEE ON MENTALLY ILL RESIDENTS IN ADULT CARE HOMES
October 11, 2006
**Name of Committee** **Date**

**VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK**

| NAME | FIRM OR AGENCY AND ADDRESS |
|---|---|
| [signature] | BOA |
| [signature] | MHA-NC |
| Jennifer Mahan | MHA-NC |
| Thomas Goldsmith | NPO |
| Jerry Coopman | NCALA |
| Gail Holden | Wake Human Services |
| Brenda Smith | Wake Human Services |
| Dick Hatch | AARP/NC Coalition on Aging |
| Dee Hatch | AARP |
| Lewis Fisher | Advocate & Member of CAC.P.D |
| Kyle Weir | Charlotte Observer |

## VISITOR REGISTRATION SHEET

SUBCOMMITTEE ON MENTALLY ILL RESIDENTS IN ADULT CARE HOMES
October 11, 2006
**Name of Committee** **Date**

**VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK**

| NAME | FIRM OR AGENCY AND ADDRESS |
|---|---|
| John Owen | Vice Chair of PAIMI AC to GACPD |
| Joe Donovan | Alliance of Disability Advocates |
| Martha Brock | GACPD |
| Robin Huffman | NC Psychiatric Assoc / Coalition 2001 |
| Eugene Bone | Bone & Assoc |
| JACK REGISTER | NASW-NC - Social Work Association Coalition 2001 / |
| Mathieu M. Shyllon | Law office of Mohammed M. Shyllon |
| Mohammed Shyllon | Law office of Mohammed M. Shyllon |
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DMH/DD/SAS

## Description of Mental Health Services for Adults

DMH/DD/SAS

## Screening, Triage, and Referral

- Available 24 hours a day every day
- Purpose is to determine the type of problem a person is experiencing and whether it is an emergency
- Then to link the person to a provider that can further assess and deliver service to meet the identified needs

2

DMH/DD/SAS

## New & Revised Services Adults with Serious Mental Illness

- Diagnostic Assessment
- Community Support
- Community Support Team
- Assertive Community Treatment
- Psychosocial Rehabilitation

3

DMH/DD/SAS

## Additional Services for Adults

- Crisis services such as Mobile Crisis, Facility Based Crisis, Inpatient hospitalization
- Partial hospitalization
- Psychiatric services and medication management
- Outpatient therapy/counseling
- Supported employment
- Supported/supervised housing

4

DMH/DD/SAS

## Diagnostic Assessment

- Definition
  - Intensive, clinical and functional face to face evaluation.
  - Recommendations for treatment and services.
  - Basis of initial Person Centered Plan over next 30 days.

5

DMH/DD/SAS

## Community Support

- Definition
  - Services and supports
  - Achieve and maintain goals
  - Meet needs of recipient
  - Acquire skills and skill building
  - First responder

6

DMH/DD/SAS

## Psychosocial Rehabilitation

- For adults with major mental illness who need a structured day program
- Focus is on individuals' rehabilitation and recovery.
- Activities include community living and personal care skills, social relationship skills, educational activities, and pre-vocational activities

7

DMH/DD/SAS

## Assertive Community Treatment Teams

- Comprehensive Intervention provided by a multidisciplinary team
- To promote symptom stability& appropriate use of medication
- To restore personal, community living & social skills
- To promote & maintain physical health
- To establish access to entitlements, housing, work & social opportunities

8

DMH/DD/SAS

## Service expectations

- If a person is receiving mental health services, he will have a Person Centered Plan that includes a crisis plan that specifies what to do when things are not going well.
- Calls Community Support (1st responder)
- First responder would meet with the person and with staff to stabilize the situation and to arrange for emergency services or to increase the intensity of on going services.

9

DMH/DD/SAS

## Service expectations

- If the person is not receiving mental health services through the public system, a call would be made to the screening/triage phone line.
- An evaluation of the person's needs would be arranged and services would be provided.
- When emergency needs have been addressed, a plan for ongoing services would be implemented

10

DMH/DD/SAS

## Where do adults with mental illness live?

- Most live in homes or apartments in the community either with their families or alone.
- Approximately 1,140 live in supervised living mental health settings

11

DMH/DD/SAS

## Adult care home residents with mental illness

- Of the 24,831 residents in adult care homes, about 5,00 residents had a mental illness.
- Of these 30% were under age 50 and 70% were 50 or older.

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**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 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

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

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.

**VII. Attachments**

A Study Group Members, Meetings and Subcommittees
B Consensus Statements
C 2005 Regional Program Survey by the Long Term Care Ombudsman Program
D Session Law 2005-66
E Detail for Expanding Mental Health Specialty Teams in LTC settings

## Attachment A: Study Group Members, Meetings and Subcommittees

The following persons and agencies were active participants in the Study Group on Long-Term Care Facilities Serving Persons with Mental Illness

| Name | Organization |
|---|---|
| Dr. Ann Louise Barrick | John Umstead Hospital |
| Doug Barrick | Division of Facility Services |
| Mary Bethel | Division of Aging and Adult Services |
| Julia Bick | Office of the Secretary |
| Debbie Brantley | Division of Aging and Adult Services |
| Julie Budzinski | Division of Medical Assistance |
| Sally Cameron | NC Psychological Association and Coalition for Persons Disabled by Mental Illness |
| Laura Clark, Ph. D. | John Umstead Hospital |
| Carol Duncan Clayton | NC Council of Community Programs |
| Jerry Cooper | NC Assisted Living Association |
| Michiele Elliott | Division of Facility Services / Adult Care |
| Bob Fitzgerald | Division of Facility Services |
| Stacy Flannery | NC Health Care Facilities Association |
| Karen McLeod | County DSS Directors Association |
| Karen Gottovi | Division of Aging and Adult Services |
| Dick Hatch | NC Coalition on Aging |
| Robin Huffman | NC Psychiatric Association |
| Ann Johnson | Governor's Advisory Council on Aging |
| Pam Kilpatrick | Dept. of Health and Human Services |
| Kathryn Lanier | Division of Aging and Adult Services |
| Bonnie Morell | Division of MH/DD/SAS |
| Jill Passmore | Friends of Residents in Long-Term Care |
| Lynne Perrin | Division of Medical Assistance |
| Gwen Phillips | Adult Foster Care Association |
| Barbara Ryan | Division of Facility Services |
| Kim Schmidt | NC Mental Health Consumers Organization |
| Jackie Sheppard | Dept. of Health and Human Services |
| Benjamin Staples | NAMI - NC |
| Sam Teruel-Velez | Division of Vocational Rehabilitation |
| Sandra Trivett | Office of Policy and Planning |
| Polly Welsh | NC Health Care Facilities Association |
| Sharon Wilder | Division of Aging – State LTC Ombudsman |
| Belinda Wilson | NC Association of Long Term Care |
| Lou Wilson | NC Association of Long Term Care |
| Maggie McGlynn | Facilitation provided by McGlynn Associates, Inc. |

The Study Group met on the following dates for 2-4 hours each:

| | |
|---|---|
| ➢ December 16, 2004 | ➢ June 27, 2005 |
| ➢ January 24, 2005 | ➢ July 25, 2005 |
| ➢ February 28th, 2005 | ➢ August 22, 2005 |
| ➢ March 28, 2005 | ➢ September 12, 2005 |
| ➢ May 25, 2005 | ➢ September 26, 2005 |

The following Committees were formed or members joined in existing committees to review specific areas. Group members and meeting dates are also shown.

| ***Committee*** | ***Meeting Date(s)*** |
|---|---|
| Guiding Principles<br>*Sally Cameron, Julia Bick, Jill Passmore, Polly Welsh, Belinda Wilson, Lou Wilson, Bonnie Morrell, Barbara Ryan, Michielle Elliott, Ann-Louise Barrick, Robin Huffman, Carolyn Duncan Clayton, Laura Clark* | 4/14 and 5/12 2005 as well as e-mails |
| Mixed Population<br>*Jill Passmore, Gwen Phillips, Sharon Wilder, Karen McLeod, Belinda Wilson, Lou Wilson, Sally Cameron, Ann Louis Barrick, Laura Clark, Julia Bick, Carol Duncan Clayton, Michiele Elliott, Robin Huffman and Sam Teruel-Velez.* | Work done via e-mail and phone calls. |
| Assessment Workgroup and Admissions/Prescreening<br>*Lynne Perrin, Lou Wilson, Jerry Cooper, Bonnie Morell, Julie Budzinski, Robin Huffman, Ann Louise Barrick, Laura Clark, Belinda Wilson, Benjamin Staples, Stacy Flannery, and Sandra Trivett. Others included: Kevin Gwynn, Scott Little, Kathie Smith, , Carol Duncan Clayton, Jean Reaves, Sandy Gegax, Leslie Meilhon, Geoff Santoloquido, Nancy Warren, Kathryn Lanier, Charles Williams, Suzanne Merrill, Ellen Walls, Libby Kinsey, Bruce Habeck, Vicki Hewitt, Pat Jeter, Carolyn Wiser and Carol Robertson.* | 12/29 2004 and 1/6, 2/24, 3/3, 4/5, 4/15, 4/18, 5/5, 6/9, 8/15 and 8/16 2005 as well as e-mails |
| Rules and Statutes<br>*Barbara Ryan, Sally Cameron, Doug Barrick, Lou Wilson, Carol Duncan Clayton, Julie Budzinski, Julia Bick, Sharon Wilder and existing members* | 6/6 2005 as well as e-mails |
| Nursing facilities<br>*Bonnie Morell, Stacy Flannery, Polly Welsh, Lynne Perrin, Julie Budzinski, Margaret Comin, Benjamin Staples and Carol Robertson.* | 8/9 2005 as well as e-mails |

## Attachment B: CONSENSUS STATEMENTS

Both long- and short-term strategies need to be developed to address the range of issues raised by the study bill.

This subject is not an either/or situation in terms of the residential settings – all settings are viable.

There is a current situation that must be addressed with resources and attention to improve quality of life for persons with mental illness in adult care homes.

Attention and direct resources must be devoted to creating a range of residential options for persons with mental illness in the community.

People who are mentally ill should be treated as they would if they lived in any other setting. They should:

- make their own choices with regard to living arrangements
- receive the services and supports they need to live successfully in the setting of their choice

Prior to placement in any community setting, an initial screening would be done to promote health and safety.

There would be an evaluation of those presently living in community residential settings.

There is a need to quantify the actual capacity and the desired capacity for the continuum of care as a part of moving the system forward.

**Attachment C**

**Regional Program Survey by the Long Term Care Ombudsman Program:**
Data compilation for 2003 and 2004 investigated complaints related to residents diagnosed with mental illness.

| | | Jan-05 |
|---|---|---|
| **Adult Care Home Residents** | **2003** | **2004** |
| Total Clients under 60 | 186 | 229 |
| Total Clients with hx MI, MR, SA | 165 | 199 |
| Total Clients with Criminal hx | 14 | 21 |
| **No. Complaints from family, residents, legal rep.** | | |
| Violent Behaviors /assaults in facility | 27 | 40 |
| Threatening(verbal or physical) behaviors toward staff/residents | 31 | 53 |
| Inappropriate Sexual Behaviors | 9 | 23 |
| Not receiving mental health services | 14 | 25 |
| Not receiving medications as ordered/timely | 53 | 44 |
| Not taking medications ordered | 24 | 22 |
| Inappropriate transfers or discharges | 54 | 67 |
| Elopements/wandering | 8 | 8 |
| Inappropriate attempts to commit resident | 6 | 11 |
| Criminal activities within or without facility | 28 | 26 |
| **Complaints from providers** | | |
| Violent Behaviors /assaults in facility | 34 | 4 |
| Threatening(verbal or physical) behaviors toward staff/residents | 25 | 56 |
| Inappropriate Sexual Behaviors | 11 | 18 |
| Not receiving mental health services | 13 | 30 |
| Not receiving medications as ordered/timely | 7 | 13 |
| Not taking medications ordered | 21 | 32 |
| Inappropriate transfers or discharges | 6 | 23 |
| Elopements/wandering | 10 | 7 |
| Inappropriate attempts to commit resident | 3 | 10 |
| Criminal activities within or without facility | 1 | 0 |
| **Client/caller referrals** | | |
| Local Mental Health Agency | 103 | 100 |
| Governors Advocacy Council for Persons w/Disabilities | 55 | 44 |
| ARC of N. C. | 6 | 8 |
| DFS/DSS | 1831 | 1231 |
| Mental Health Geriatric Teams | 8 | 23 |
| State Mental Health Consumer Advocate | 2 | 1 |

**Attachment C**

## Technical Assistance Provided

| | | |
|---|---|---|
| Technical Assistance provided: facility staff | 271 | 251 |
| Technical Assistance provided: residents/families | 795 | 777 |
| Support Sessions for Residents' Councils re: MI,MR,SA | 26 | 29 |
| Specialized Training: Facility Staff | 55 | 62 |
| Specialized Training: Community Groups | 22 | 20 |
| Systemic Advocacy Hours | 997 | 1135 |

**Top Four Advocacy Issues:**

Threatening(verbal or physical) behaviors toward staff/residents
Transfers/Discharges
Staff Training and Education
Appropriate Mental Health Services

**Attachment D**

## GENERAL ASSEMBLY OF NORTH CAROLINA

## SESSION 2005 SESSION LAW 2005-66 SENATE BILL 572

AN ACT to create a licensure category for assisted living communities that serve only elderly adults.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2(a)(1d) reads as rewritten:

"" 131D-2. Licensing of adult care homes for the aged and disabled.

(a) The following definitions will apply in the interpretation of this section:

1d) "Assisted living residence" means any group housing and services program for two or more unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care or hospice agencies. The Department may allow nursing service exceptions on a case-by-case basis. Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or area baths. Assisted living residences are to be distinguished from nursing homes subject to provisions of G.S. 131E-102. Effective ~~October 1, 1995,~~ October 1, 2005, there are two types of assisted living residences: adult care homes and ~~group homes for developmentally disabled adults.~~ adult care homes that serve only elderly persons. As used in this section, "elderly person" means:

a. Any person who has attained the age of 55 years or older and requires assistance with activities of daily living, housing, and services, or

b. Any adult who has a primary diagnosis of Alzheimer's disease or other form of dementia who requires assistance with activities of daily living, housing, and services provided by a licensed Alzheimer's and dementia care unit.

Effective July 1, 1996, there is a third type, multiunit assisted housing with services."

**SECTION 2.** The Medical Care Commission shall adopt rules to implement this act.

**SECTION 3.** This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 18th day of May, 2005.

**Attachment E**

## Detail for Expanding Mental Health Specialty Teams in LTC settings

### Background regarding Geriatric Mental Health Specialty Teams

As part of the overall effort to reduce the number of elderly individuals who are inappropriately admitted to State psychiatric hospitals, the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services has allocated State and Mental Health Block Grant funding to support 21 community-based Geriatric Mental Health Specialty Teams. Nine of the teams serve multiple mh/dd/sa catchment areas. These teams are available to provide support, training, and consultation to long term care facilities and other organizations throughout the State.

### Geriatric Mental Health Specialty Team Purpose and Description

The purpose of the teams is to increase the ability of older adults with mental illness to live successfully in their communities by:

- providing holistic support services and technical assistance to nursing homes, adult care homes, caregivers and other agencies that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization, and
- assisting with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals; and

This is to be accomplished by providing support, training and consultation to the staff serving the identified individuals and developing linkages with community providers serving older individuals.

Each team consists of a registered nurse and a masters prepared therapist. The teams operate on an itinerant basis and thus provide the majority of services to the staff where the individual lives rather than in an office/clinic setting. The geriatric specialty teams are to supplement area authority/county program capacity to serve adults, age 60 and over. Team member duties and activities are assigned based on each team member's professional training, scope of practice, skills and abilities.

### Geriatric Mental Health Specialty Team Focus on Older Adults.[1]

The Geriatric Specialty Teams provide services to or on behalf of individuals who meet the following criteria:

1. Individuals who are 60 years of age or older with mental illness, who are in a State psychiatric hospital and who are preparing to return to the community to reside in a nursing home, adult care home or family residence;

[1] Individuals younger than 60 years of age may be served if their needs require the expertise of a geriatric specialist.

2. Individuals who are 60 years of age or older with mental illness, currently residing in a nursing home or adult care home who have mental health service/treatment needs and who may be at risk for psychiatric hospitalization; and
3. Individuals who are 60 years of age or older with mental illness who have significant mental health service or treatment needs and who may be at risk for psychiatric hospitalization and who are living within their own home or with family members.

**Geriatric Mental Health Specialty Team Activities**

The Geriatric Specialty Teams have a dual focus: reintegration of older adults into the community when they are discharged from a State psychiatric hospital; and assisting long term care facilities and other agencies in preventing/reducing the number of psychiatric hospital admissions for older adults. To carry out this two-fold mission, the teams engage in the following activities:

- train facility staff, caregivers and other agencies on topics such as recognizing symptoms of mental illness, behavioral interventions, communication issues, and medication issues;
- provide resource information and identify ongoing training resources for staff and caregivers;
- provide individual case consultation to staff of long term care facilities or caregiver regarding behaviors that may result in hospitalization or a need for more intensive services;
- provide consultative support to staff or caregiver in the transition of individuals from a State hospital to a long term care facility or other community setting;
- provide consultation to staff or caregiver in identifying and addressing issues that may threaten successful community placement;
- provide training to staff or caregiver on the development and implementation of intervention plans as needed;
- establish linkages with community providers serving the geriatric population for the purpose of increasing community opportunities for the gero-psychiatric population;
- assist in discharge planning with hospital and area program staff or contractors to include the provision of information regarding appropriate placement of an individual into a long term care facility; and
- provide crisis-oriented support, either face-to-face or via telephone to the agency staff or caregiver during normal business hours.

**Need for Increased Capacity.**

The number of Geriatric Mental Health Specialty Teams needs to be increased. Mental Health Specialty Teams are also needed to provide training and technical assistance to Long Term Care facilities regarding younger residents.

There are a total of 87,147 licensed long term care beds in 1,672 facilities that are licensed as either family care homes, adult care homes, or nursing facilities.[2] Table I below shows the distribution by type of facility.

**Table I. Number of Long Term Care Facilities and Number of Beds**

| Type of Long Term Care Facilities | # of Facilities | # of Beds | Location |
|---|---|---|---|
| Family Care Homes | 644 | 3,633 | In 77 of 100 counties |
| Adult Care Homes | 636 | 35,955 | In 91 of 100 counties |
| Adult Care Home beds in Nursing Facilities | | 5,248 | Co-located with some nursing facilities |
| Nursing Facilities | 392 | 42,311 | In 98 of 100 counties |
| | 1,672 | 87,147 | |

Currently 18,964 (76%) residents of Adult Care Homes are 65 or older and 5,867 (24 %) residents are 64 or younger based on the 2005 facility population census. The age distribution in Family Care is composed of 961 (37%) residents who are 65 or older and 1,617 (63%) who are 64 or younger. Tables II and III [3] below show the age distribution in these two types of facilities by age and disability groups.

Residents in nursing facilities are predominantly older adults who have medical problems and many of whom have Alzheimer's disease or dementia. However some of the younger nursing facility residents may also exhibit behaviors that require mental health consultations.

**Table II. Adult Care Home 2005 License Renewal Data**

| *Age* | *Total residents* | % of total in age group | *# with mental illness* | % of age group | *# with MR/DD* | % of age group | *# with Alz/Dem* | % of age group Alz/Dem |
|---|---|---|---|---|---|---|---|---|
| 18-24 | 101 | 0% | 59 | 58% | 28 | 28% | 1 | 1% |
| 25-34 | 392 | 2% | 252 | 64% | 75 | 19% | 4 | 1% |
| 35-49 | 1,857 | 7% | 1,168 | 63% | 307 | 17% | 55 | 3% |
| 50-64 | 3,517 | 14% | 1,638 | 47% | 567 | 16% | 397 | 11% |
| 65-74 | 3,721 | 15% | 950 | 26% | 326 | 9% | 1,048 | 28% |
| 75-84 | 7,435 | 30% | 652 | 9% | 166 | 2% | 3,200 | 43% |
| 85+ | 7,808 | 31% | 287 | 4% | 79 | 1% | 3,381 | 43% |
| Total | 24,831 | | 5,006 | | 1,548 | | 8,086 | |

[2] North Carolina Division of Facility Services: Licensed Facilities as of 10/31/0533
[3] North Carolina Division of Facility Services: Data from 2005 License Renewals

**Table III. Family Care Homes 2005 License Renewal Data**

| *Age* | *Total residents* | % of total age group | *# with mental illness* | % of age group | *# with MR/DD* | % of age group | *# with Alz/Dem* | % of age group Alz/Dem |
|---|---|---|---|---|---|---|---|---|
| 18-24 | 58 | 2% | 36 | 62% | 22 | 38% | 0 | 0% |
| 25-34 | 172 | 7% | 87 | 51% | 53 | 31% | 0 | 0% |
| 35-49 | 659 | 26% | 434 | 66% | 144 | 22% | 6 | 1% |
| 50-64 | 728 | 28% | 381 | 52% | 166 | 23% | 30 | 4% |
| 65-74 | 392 | 15% | 141 | 36% | 66 | 17% | 43 | 11% |
| 75-84 | 333 | 13% | 52 | 16% | 26 | 8% | 122 | 37% |
| 85+ | 236 | 9% | 14 | 6% | 9 | 4% | 104 | 44% |
| Total | 2,578 | | 1,145 | | 486 | | 305 | |

Given the large number of long term care residents and facilities, 12 additional geriatric mental health specialty staff and 25 qualified mental health specialty staff to provide training and consultation should be added to existing teams in order to have at least one team member per approximately 25 long term care facilities.

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.

Attachment 4

# DMA Initiatives Affecting Adult Care Homes

**October 11, 2006**

*Lynne Perrin, Chief*
*Facility and Community Care Section*
*NC Division of Medical Assistance*

# DMA Initiatives Affecting ACH's

- Uniform Screening Program
- ACH/PCS Restructuring
- Future Integrated Assessment System

# Uniform Screening Program

**Replaces Eight Separate Processes**

- Nursing Facility Care;
- Adult Care Homes;
- Community Alternatives Program for Disabled Adults (CAP/DA);
- Community Alternatives Program for Disabled Adults (CAP/CHOICE) Choice Program;
- Community Alternatives Program for Children (CAP/C);
- Private Duty Nursing;
- Personal Care Services (PCS); and
- Personal Care Services Plus (an enhanced PCS program)

# Uniform Screening Program

- Objectives to be achieved
  - Reduce inappropriate placements;
  - Reduce paperwork of referring agencies;
  - Provide a clearer picture of the applicant's needs to providers to whom the applicant shall be referred;
  - Provide recipients a clearer set of service options responsive to their current needs and to encourage choice;

# Uniform Screening Program

- Objectives (Cont'd)
  - Reduce the costs of screening through streamlined processes, procedures, automation, consolidation of screening responsibilities and attendant staffing reductions; and
  - Foster the creation of a more coherent, comprehensive system of long term care services.

# Uniform Screening Program

**Goal -**

Ensure timely, appropriate placement of Medicaid recipients in the right service or setting of care.

# ACH/PCS Restructuring

- CMS does not approve of the way Medicaid has structured the adult care home personal care services program.
- Emphasis must be individual needs and person centered planning.
- Adult care home must be considered as one's home, not substitute home.

# ACH/PCS Restructuring

- Currently In-Home PCS and ACH/PCS have separate policies, processes, regulatory requirements and financial structures.
- DMA must, to the extent possible, have one personal care services program that operates regardless of the setting.
- Focus must be on the quality of the care and the recipient of the services.

# ACH/PCS Restructuring

- Stakeholder's Process
- Kick off meeting held September 26.
- Committees
  - Policy
  - Rate-setting
  - Rules and Legislation

# Integrated Assessment System

- Need improve the tools used by providers in assessing and developing care plans.
- Need to improve the communications among DMA, providers and recipients.
- Need for provider training aids.
- Technology offers a foundation for change.
- Priorities are ACH's and CAP/Children.

# SUB-COMMITTEE ON MENTALLY ILL RESIDENTS IN ADULT CARE HOMES
# AGENDA

November 14, 2006, 9:30 a.m. – Noon
Room 544, LOB
Rep. Beverly Earle, Co-Chair, Presiding

| | |
|---|---|
| **Greetings/Introductions**<br>Representative Beverly Earle, Co-Chair<br>Representative Verla Insko, Co-Chair | **9:30 – 9:45** |
| **Housing Options for the Mentally Ill** | **9:45 – 11:05** |
| *Debra King, Executive Director*<br>*CASA* | *9:45 – 10:05* |
| *John Tote, Executive Director*<br>*Mental Health Association in North Carolina, Inc.* | *10:05 – 10:25* |
| *Tommy Gund, Executive Director*<br>*Adventure House* | *10:25 – 10:45* |
| *Kenneth A. Burrow, Vice President*<br>*Therapeutic Alternatives/Brookstone*<br>*Jay* Poole, Visiting Assistant Professor<br>*University of North Carolina at Greensboro* | *10:45 – 11:05* |
| **New Residential Treatment Model**<br>*Dr. Michael Lancaster*, Chief of Clinical Policy<br>Department of MH/DD/SAS, DHHS | **11:05 – 11:15** |
| **Department Response to Housing Options**<br>*Julia Bick, Office of the Secretary, DHHS* | **11:15 – 11:30** |
| **Member Discussion** | **11:30 – Noon** |
| **Adjourn** | **Noon** |

## ATTENDANCE

### Subcommittee on Mentally Ill Residents in Adult Care Homes

| DATES / MEMBERSHIP | 11/14/06 | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Representative Verla Insko, Co-Chair | √ | | | | | | | | | | | | | | | |
| Representative Beverly Earle, Co-Chair | √ | | | | | | | | | | | | | | | |
| Representative Alice Bordsen | X | | | | | | | | | | | | | | | |
| Representative Debbie Clary | X | | | | | | | | | | | | | | | |
| Representative Bob England | √ | | | | | | | | | | | | | | | |
| Representative Carolyn Justice | √ | | | | | | | | | | | | | | | |
| Senator Stan Bingham | √ | | | | | | | | | | | | | | | |
| Senator Charlie Dannelly | √ | | | | | | | | | | | | | | | |
| Senator Jeanne Lucas | X | | | | | | | | | | | | | | | |
| Senator Vernon Malone | X | | | | | | | | | | | | | | | |
| **STAFF** | | | | | | | | | | | | | | | | |
| Ben Popkin | √ | | | | | | | | | | | | | | | |
| Shawn Parker | √ | | | | | | | | | | | | | | | |
| Andrea Russo | √ | | | | | | | | | | | | | | | |
| Rennie Hobby | √ | | | | | | | | | | | | | | | |
| Ann Raeford | √ | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |

Debra King

# CASA

Quality Affordable Housing
Serving Wake County since 1992

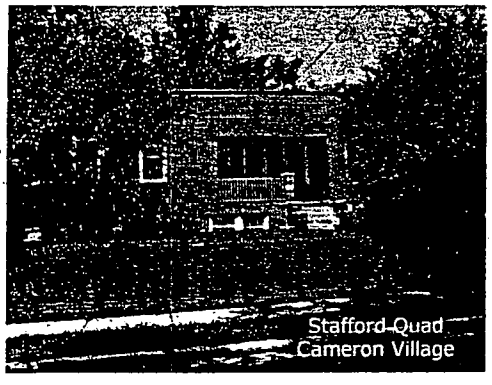
## Today's Discussion

- Range of housing alternatives
- Service needs of target population
- Funding possibilities
- Challenges in affordable housing development
- Opportunities for excellence

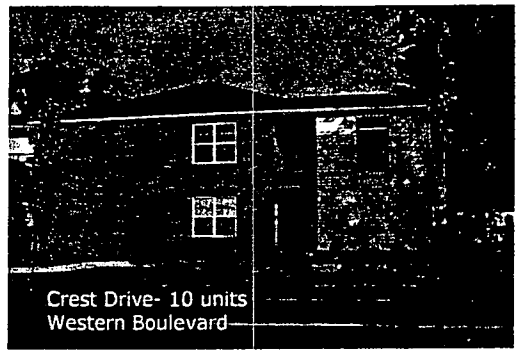
CASA'S OFFICE – Glenwood South apartments upstairs

## CASA's Vision

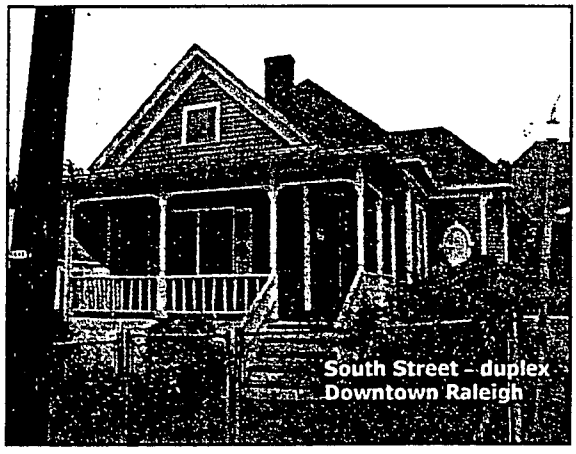
- CASA believes that all people, regardless of income, deserve a decent, safe and sanitary place to call home. CASA believes that people with disabilities, just like anyone else, should be allowed to choose where they will live.



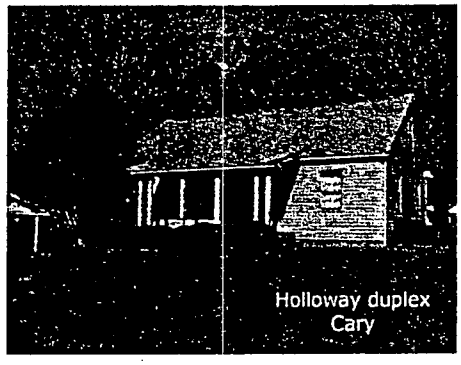
Stafford Quad
Cameron Village



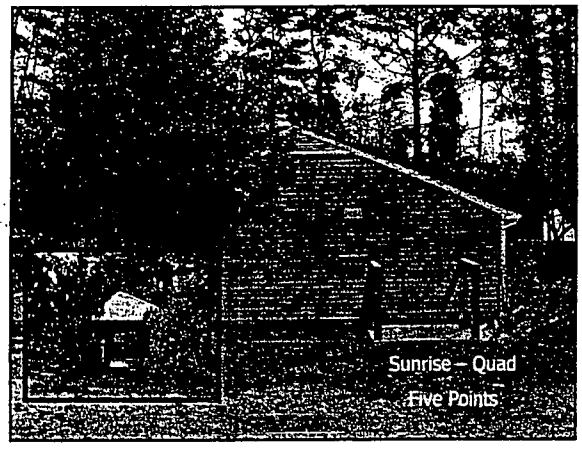
Crest Drive- 10 units
Western Boulevard



South Street – duplex
Downtown Raleigh

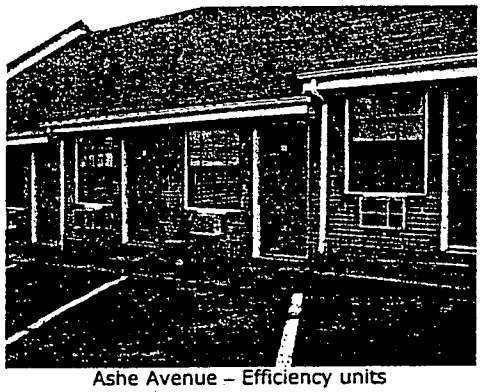


Holloway duplex
Cary

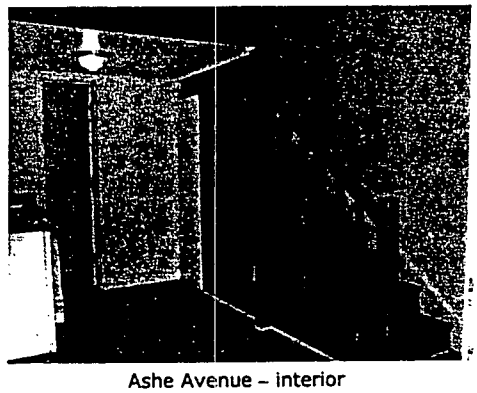


Sunrise – Quad
Five Points

State Street Quad
Edenton Street area



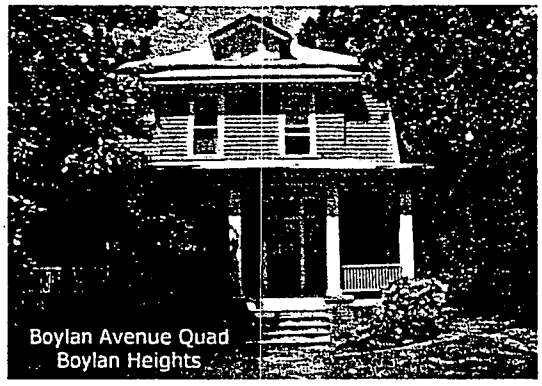
Ashe Avenue – Efficiency units
Western Boulevard



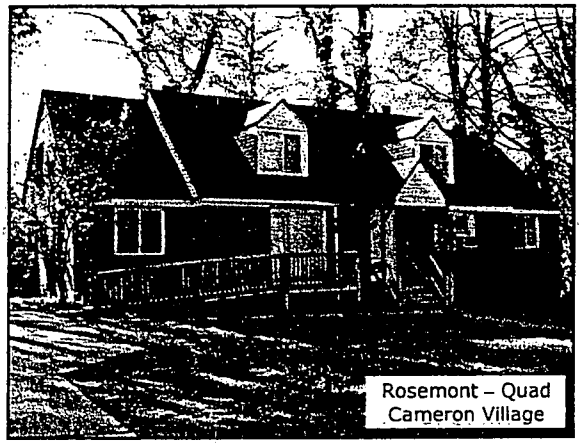
Ashe Avenue – interior

## Changing Lives/Changing Communities

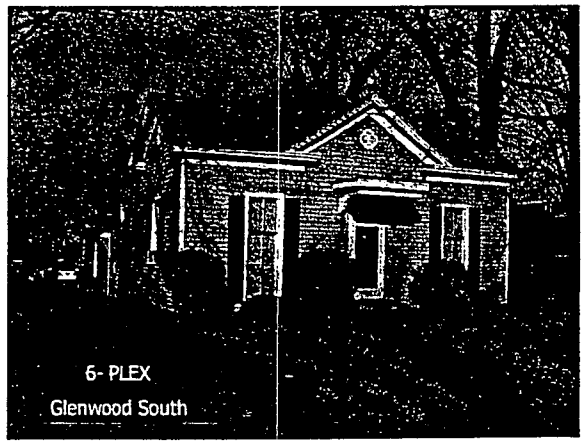
- Affordable housing is a sound investment
- Direct benefit to recipient
- Indirect benefit to community in terms of job creation; material sales; fuels the private market
- Unique opportunity for private/public partnerships



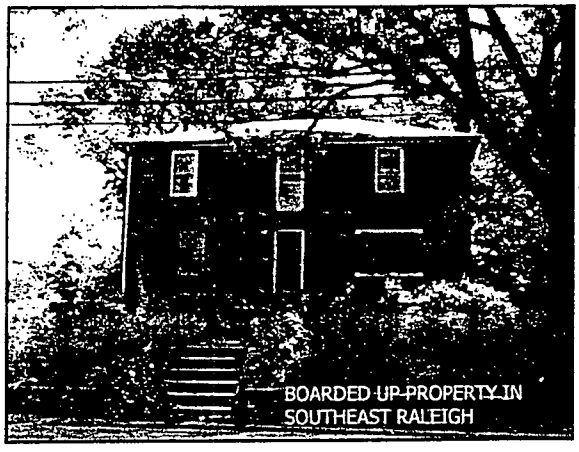
Boylan Avenue Quad
Boylan Heights



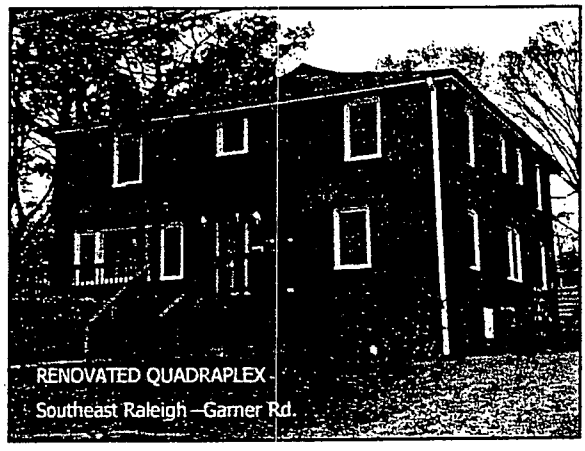
Rosemont – Quad
Cameron Village



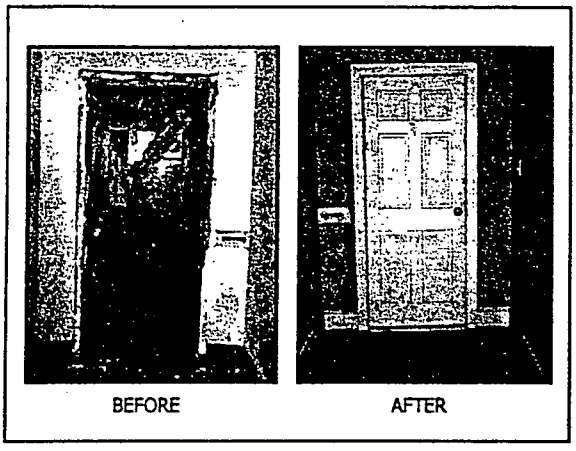
6- PLEX
Glenwood South



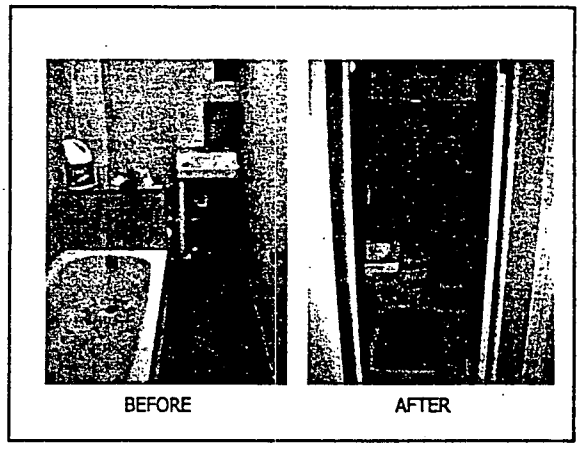
BOARDED UP PROPERTY IN
SOUTHEAST RALEIGH



RENOVATED QUADRAPLEX
Southeast Raleigh – Garner Rd.



BEFORE AFTER



BEFORE AFTER

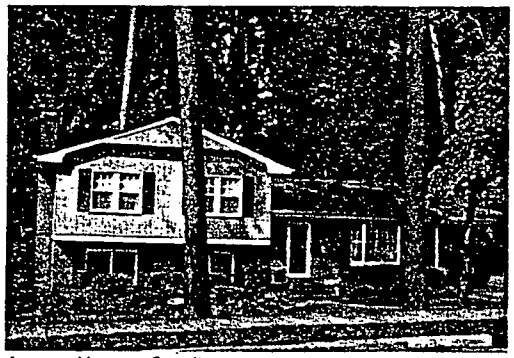
Carlton – 24 units
Western Blvd

## Challenges in Affordable Housing Development

- Adequate funding
- Competing regulations from varied funding
- NIMBY issues
- Local land use policies (scattered site policies)
- On-going operational dollars


24 unit tax credit community
Capital Blvd area

Harrington – 12 Units
Downtown Raleigh



Aurora House 6 units
North Hills

| Spending | Investing |
|---|---|
| • One Day at Dix = $594 | A day of supportive housing = $33.43 |
| • One month at a shelter = $900 | 1 month of a rental voucher = $701 |

Mayview – Triplex
Cameron Village

## Opportunities for Excellence

- Flexible dollars for construction/rehab
- Remove regulatory barriers –scattered site policies
- Recognize Supported Housing as a treatment – create billing code
- On-going operations – rental assistance
- $ follow the person
- Expanded use of Special Assistance program

## Contact Information

- Debra King
- CASA
- 624 W. Jones Street
- Raleigh NC 27603
- 919.754.9960 x 11

# Mental Health Association
in North Carolina, Inc.
3820 Bland Road • Raleigh, NC 27609 • (919) 981-0740 • Fax: (919) 954-7238
www.mha-nc.org TDD 800-735-2962


## BASIC OVERVIEW OF MENTAL HEALTH ASSOCIATION IN N.C. COMMUNITY-BASED RESIDENTIAL OPTIONS

I. **HUD Section 202: The HUD Section 202 Program is one that had previously served both elderly and disabled individuals by providing a comprehensive mortgage for development and start-up along with ongoing rental assistance.**

II. **HUD Section 811: The successor to HUD Section 202 for those with disabilities. The HUD Section 811 Program provides a grant, as opposed to a mortgage, and is comprehensive in providing development and start-up funding along with a forty (40) year rental assistance program.**

III. **HOMES Program: The Mental Health Association in N.C.'s HOMES Program is a HUD financed initiative that provides funding to purchase and renovate existing single family, duplex, triplex, etc. homes and make them available to mental health consumers and their families.**

IV. **Shelter Plus Care Program: This community-based initiative for individuals with mental illness is also designed for those that were homeless or at significant risk of homelessness. Many of these individuals also experienced substance abuse issues. The Shelter Plus Care Program is one that leases community apartments and then sublets them to mental health consumers.**

V. **Support Housing Initiative: This HUD financed initiative is much like the Shelter Plus Care Program. However, most of the individuals do not bring the intensity of need that they do under the Shelter Plus Care Program. This initiative leases apartments and then sublets them to mental health consumers.**

***Please note both the HUD 202 and 811 Programs provide for funding for community-based group home, apartment complex, condo and scattered site housing for persons with severe and persistent mental illness.**

EQUAL HOUSING OPPORTUNITY

## RESIDENTIAL SERVICES PROJECTS

Pre-1985 Fund Reservations 22 beds

| | | |
|---|---|---|
| Orange Group Home | 6 Beds | Operational |
| Orange Group Home | 6 Beds | Operational |
| *Johnston Apartments | 10 Beds | Operational |

1986 Fund Reservations: 46 Beds

| | | |
|---|---|---|
| *Beaufort Group Home | 6 Beds | Operational |
| Catawba Group Home | 6 Beds | Operational |
| Cleveland Apartments | 10 Beds | Operational |
| Craven Group Home | 6 Beds | Operational |
| Gaston Group Home | 6 Beds | Operational |
| *High Point Group Home #1 | 6 Beds | Operational |
| Metrolina Group Home #1 | 6 Beds | Operational |

1987 Fund Reservations: 54 Beds

| | | |
|---|---|---|
| *Ashe Group Home | 6 Beds | Operational |
| Durham Group Home #1 | 6 Beds | Operational |
| *Iredell Group Home | 6 Beds | Operational |
| Triangle Group Home | 6 Beds | Operational |
| *Pitt Group Home | 6 Beds | Operational |
| Rutherford Group Home | 6 Beds | Operational |
| *Richmond Group Home | 6 Beds | Operational |
| *Stanly Group Home | 6 Beds | Operational |
| Wilson Group Home | 6 Beds | Operational |

1988 Fund Reservations: 16 Beds

| | | |
|---|---|---|
| Columbus Group Home | 6 Beds | Operational |
| *Halifax Apartments | 10 Beds | Operational |

1989 Fund Reservations: 32 Beds

| | | |
|---|---|---|
| *Cumberland Group Home | 6 Beds | Operational |
| *Union Group Home | 6 Beds | Operational |
| *Henderson Apartments | 10 Beds | Operational |
| Durham Apartments | 10 Beds | Operational |

1990 Fund Reservations: 56 Beds

| | | |
|---|---|---|
| *Cabarrus Apartments | 10 Beds | Operational |
| Rutherford Apartments | 10 Beds | Operational |
| Durham Group Home #2 | 6 Beds | Operational |
| Metrolina Apartments | 10 Beds | Operational |

| | | |
|---|---|---|
| *Guilford Apartments | 20 Beds | Operational |
| 1991 Fund Reservations: 66 Beds | | |
| *Ashe Apartments (6 Units) | 10 Beds | Operational |
| *Cumberland Apartments | 10 Beds | Operational |
| *Moore Group Home | 6 Beds | Operational |
| Pitt Apartments | 10 Beds | Operational |
| *Rowan Apartments | 10 Beds | Operational |
| *Watauga Apartments | 10 Beds | Operational |
| *Wilkes Apartments | 10 Beds | Operational |
| 1992 Fund Reservations: 51 Beds | | |
| *Alleghany/Burke Group Home | 6 Beds | Operational |
| *Buncombe Group Home | 6 Beds | Operational |
| Carteret Apartments | 8 Beds | Operational |
| Harnett Group Home | 6 Beds | Operational |
| Metrolina Group Home #2 | 6 Beds | Operational |
| *Montgomery Group Home | 6 Beds | Operational |
| *Orange Apartments | 13 Beds | Operational |
| 1993 Fund Reservations: 54 Beds | | |
| *Anson Group Home | 6 Beds | Operational |
| *Cumberland Apartments | 10 Beds | Operational |
| Gaston Apartments | 10 Beds | Operational |
| Metrolina Group Home #3 | 6 Beds | Operational |
| *Randolph Group Home | 6 Beds | Operational |
| *Stanly Apartments | 10 Beds | Operational |
| *Wayne Group Home | 6 Beds | Operational |
| 1994 Fund Reservations: 49 Beds | | |
| *Alamance Apartments | 10 Beds | Operational |
| *High Point Group Home #2 | 6 Beds | Operational |
| *Forsyth Condominiums (8 Units) | 13 Beds | Operational |
| *Burke Apartments | 10 Beds | Operational |
| *Nash-Edgecombe Apartments | 10 Beds | Operational |
| 1995 Fund Reservations: 56 Beds | | |
| *Richmond Apartments | 10 Beds | Operational |
| Metrolina Apartments #2 | 10 Beds | Operational |
| Warren Group Home | 6 Beds | Operational |
| *Surry Apartments | 10 Beds | Operational |
| Catawba Apartments | 10 Beds | Operational |
| Columbus Apartments | 10 Beds | Operational |

| | | |
|---|---|---|
| 1996 Fund Reservations: | 18 Beds | |
| *Lee Group Home | 6 Beds | Operational |
| *Burke Group Home #2 | 6 Beds | Operational |
| Metrolina Group Home #4 | 6 Beds | Operational |
| 1997 Fund Reservations: | 14 Beds | |
| *Wilson Apartments | 8 Beds | Operational |
| *Haywood Group Home | 6 Beds | Operational |
| 1998 Fund Reservations - 22 Beds | | |
| Metrolina Apartments #3 | 8 Beds | Operational |
| *Foothills Apartments | 8 Beds | Operational |
| *OPC Group Home | 6 Beds | Operational |
| 1999 Fund Reservations - 27 beds | | |
| *Hoke Group Home | 6 Beds | Operational |
| *Iredell Apartments | 8 Beds | Operational |
| VWGF Apartments | 8 Beds | Operational |
| *Wilson Apartments Phase II | 5 Beds | Operational |
| 2000 Fund Reservations | | |
| *Forsyth Condominiums | 5 Beds | Operational |
| *Davidson Apts. | 10 Beds | Operational |
| Metrolina Apts. #4 | 9 Beds | Operational |
| Cleveland Apts. | 10 Beds | Operational |
| 2001 Applications - | 34 Beds | |
| *Forsyth Condos | 8 Beds | Operational |
| Metrolina Apts.#5 | 10 Beds | Operational |
| *Orange Group Home | 6 Beds | Operational |
| Rutherford Apts. | 10 Beds | Operational |
| 2002 Applications | 70 Beds | |
| *Orange Apts.Club Nova) | 20 Beds | Operational |
| *Rockingham Apts. | 10 Beds | Operational |
| *Beaufort Apts. | 8 Beds | Operational |
| Mecklenburg #6 | 10 Beds | Operational |
| Durham Apts. (Strobel) | 12 Beds | Operational |

| | | |
|---|---|---|
| 2003 Applications | 30 Beds | |
| Cabarrus Group Home | 6 Beds | Construction |
| Randolph Apartments | 10 Beds | Operational |
| Wilson Apartments | 12 Beds | Operational |
| Metrolina Condominiums #7 | 8 Beds | Operational |
| 2004 Applications | 37 Units | |
| Metrolina Apartments #8 | 8 Beds | Construction |
| Cabarrus Group Home #2 | 6 Beds | Construction |
| Richmond Apartments #2 | 9 Beds | Construction |
| Alamance Apartments #2 | 14 Beds | Construction |
| 2005 Applications | 20 Beds | HUD |
| Haywood Apartments | 14 Beds | HUD |
| Cabarrus Group Home #2 | 6 Beds | HUD |
| 2006 Applications | 5 Beds | Supportive Housing Program |
| New Hanover Apartments | 5 Beds | Supportive Housing Program |

Total: 866 Beds

*On-Site Services

## HOMES
## SHELTER PLUS CARE PROGRAM

### HOME PROGRAM

1993 Fund Reservations: 37 Beds

| | | |
|---|---|---|
| Cabarrus | 4 Beds | Operational |
| Caldwell | 4 Beds | Operational |
| Chatham | 2 Beds | Operational |
| Craven | 2 Beds | Operational |
| Durham | 4 Beds | Operational |
| Iredell | 4 Beds | Operational |
| Moore | 2 Beds | Operational |
| Nash | 4 Beds | Operational |
| Randolph | 4 Beds | Operational |
| Richmond | 3 Beds | Operational |
| Rockingham | 2 Beds | Operational |

| | | |
|---|---|---|
| Wayne | 2 Beds | Operational |

1998 Funds Reservation

| | | |
|---|---|---|
| Guilford | 1 Bed | Operational |
| Cumberland | 1 Bed | Operational |
| Wilkes | 1 Bed | Operational |

TOTAL: 43 Beds

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**SHELTER PLUS CARE PROGRAM**

1993 Fund Reservations: 95 Units

| | | |
|---|---|---|
| Mecklenburg | 30 Units | Operational |
| Winston-Salem | 30 Units | Operational |
| Asheville | 35 Units | Operational |

1994 Fund Reservations: 80 Units

| | | |
|---|---|---|
| Mecklenburg | 80 Units | Operational |

1995 Fund Reservations: 45 Units

| | | |
|---|---|---|
| Gaston-Lincoln | 10 Units | Operational |
| Mecklenburg | 35 Units | Operational |

1996 Fund Reservations: 45 Units

| | | |
|---|---|---|
| Neuse | 20 Units | Operational |
| OPC | 10 Units | Operational |
| Southeastern (Wilmington) | 15 Units | Operational |

1997 Fund Reservations: 26 Units

| | | |
|---|---|---|
| Durham | 26 Units | Operational |

1999 Fund Reservations – 7 Units

| | | |
|---|---|---|
| Surry County | 1 unit | Operational |
| Yadkin County | 3 units | Operational |
| Iredell County | 3 units | Operational |

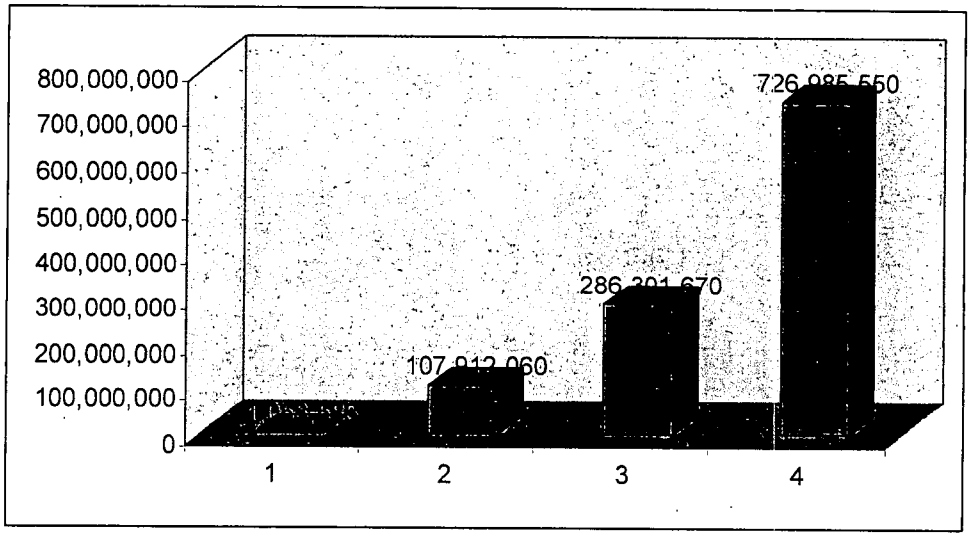
Total: 298 Units

# Mental Health Association
in North Carolina, Inc.

3820 Bland Road • Raleigh, NC 27609 • (919) 981-0740 • Fax: (919) 954-7238
www.mha-nc.org TDD 800-735-2962


## MENTAL HEALTH ASSOCIATION IN NORTH CAROLINA
## RESIDENTIAL SERVICES INITIATIVE

## 811 PROGRAM COST COMPARISON*
## FOR THE PERIOD OF JULY 1, 1987 – JUNE 30, 2006




| 1,053,588 in Kate B. Reynolds Health Care Trust Fund | 107,912,060 in State funding used for 811 | 286,301,670 Federal income derived from 811 | 726,985,550 is the amount NC would have spent w/o MHA/NC Residential Services |
|---|---|---|---|

*Based on 918 beds throughout North Carolina, currently state funding at $42 per day, per person in an 811 program (includes start-up, operation, Medicaid, and special assistance funds) compared to $650 per day, per person in a state hospital. Federal income includes development, rental assistance, and Medicaid funds, which averages $139 per day. Also, this community-based mental health program has created 718 jobs in North Carolina.

EQUAL HOUSING OPPORTUNITY

# Mental Health Association
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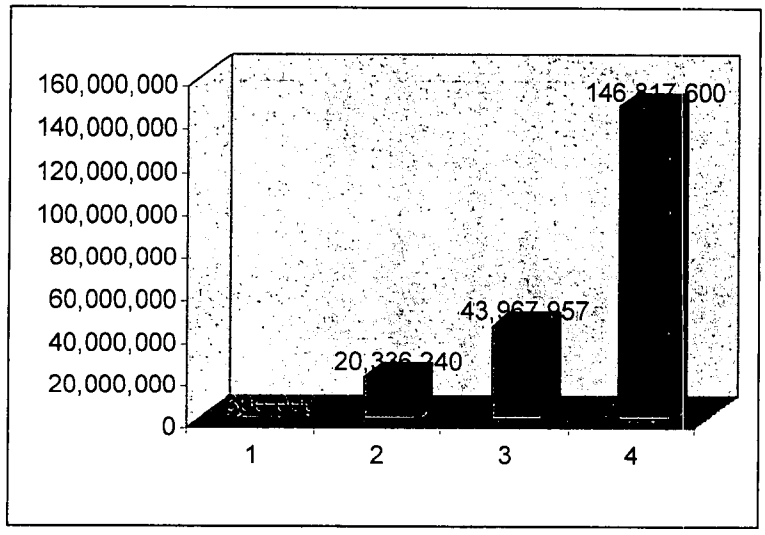
## MENTAL HEALTH ASSOCIATION IN NORTH CAROLINA
## RESIDENTIAL SERVICES INITIATIVE

### CHILD & YOUTH GROUP HOME COST COMPARISON*
### FOR THE PERIOD OF JULY 1, 1996 – JUNE 30, 2006




| | | | |
|---|---|---|---|
| $300,000 in Kate B. Reynolds Health Care Trust Fund | $20,336,240 in State funding utilized for "kids" project | $43,967,957 Federal income derived from kids | $146,817,600 is the amount NC would have spent w/o the MHA/NC "kids" project |

*Based on 114 beds throughout North Carolina, currently state funding is at an average of $61 per day, per person in a "kids" program (includes start-up, operation, Medicaid, and special assistance funds) compared to $725 per day, per person in a state hospital. Federal income includes development, rental assistance, and Medicaid funds which average $211 per day. Also, this community based mental health program has created 188 jobs in North Carolina.

EQUAL HOUSING OPPORTUNITY

## Sub-Committee on Mentally Ill Residents in Adult Care Homes

November 14, 2006

Housing needs of persons with disabilities and the elderly are best met with a range of residential options

Recommendation #3

RFP being issued to conduct a study to inform the development of a continuum of residential services to meet the varied needs of persons with mental illnesses

Study will quantify the need, in terms of projected numbers to be served and the types and designs of alternative residential and treatment settings

MI in LTC Study, in Response to House Bill 1414 Section 10.2.(a) and (b) December 2005

## Supported Housing

Housing model that enables persons with disabilities to successfully select, acquire and maintain decent, safe and affordable housing linked to a variety of individualized, flexible support services

## Olmstead Decision

- "Olmstead vs. LC"
  US Supreme Court 1999
- "unjustified isolation" is a violation of the individual's rights under the Americans with Disabilities Act

## Olmstead Decision

Unjustified isolation:

- "... perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."
- "severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

## Mental Health: A Report of the Surgeon General

The housing preferences of people with schizophrenia and other serious mental disorders are clear: these individuals strongly desire their own decent living quarters where they have control over who lives with them and how decisions are made.

(Owen et al., 1996; Schutt & Goldfinger, 1996; Sohng, 1996)

## Mental Health: A Report of the Surgeon General

When deinstitutionalization led to the need for more community housing, the residential programs that were developed replicated institutional programs.

Although residential programs varied in the degree of oversight and services, they generally proved to be ineffective in meeting consumers' needs. (Carling, 1989)

## Mental Health: A Report of the Surgeon General

Supported housing focuses on consumers having a permanent home that is integrated socially, is self-chosen, and encourages empowerment and skills development.

## Mental Health: A Report of the Surgeon General

- Consumers experienced better mental health and more self-determination when they lived in adequate housing (Nelson et al., 1998).
- One study found that personal empowerment and functioning were enhanced, and hospitalization reduced, after 5 months in a supported housing program (McCarthy & Nelson, 1991).

## Mental Health: A Report of the Surgeon General

- Also, resident control over decisions was directly related to satisfaction and empowerment (Seilheimer & Doyal, 1996).
- Similarly, another study found that having greater choice in housing was associated with greater happiness and life satisfaction (Srebnik et al., 1995).

## Mental Health: A Report of the Surgeon General

Despite these findings, serious housing problems persist for people with schizophrenia and other mental disorders.

Most such individuals are poor and thereby face very limited housing options.

Persons living on SSI cannot afford housing unless there is a way to make up the difference between what they can afford to pay and what it costs to operate the housing.

"One of the major barriers to successfully maintaining frail older adults in home and community settings is the lack of affordable housing, especially those living at or below the poverty level."

North Carolina Institute of Medicine, LTC Plan for NC, 2001

- Overcare: premature entrance into a facility, skilled nursing or adult care, creates dependency, separates people from natural supports.
- Under care: staying in the community without adequate assistance may compromise health and safety.

## Income and Housing Cost

Percentage of SSI income needed to rent a modest one bedroom apartment (2004)

- North Carolina average - 97 %
- Wake County - 124%
- Fayetteville - 84%
- NC non metro areas- 76%

## State and County Special Assistance

$1118 Maximum Rate
+ $46 Personal Needs Allowance

$1,174 Maintenance Amount
- $583 ($603 less $20 disregard)

$591 SA payment

## Federal Rental Assistance

Renting a one bedroom apartment:

$550 rent plus utilities
- $181 tenant share 30% of SSI

$369 per month subsidy

Section 8 used in modest private market housing

## Key Program

$354 one bedroom operating standard
-$150 tenant share 25% of SSI
(rent only tenant pays utilities

$204 Key subsidy

Used in Housing Credit properties where rents are already below market but NOT affordable to extremely low income households

## Housing is Health Care

Supporting the preference of older adults and persons with disabilities to retain their independence, remain a part of their communities and minimize the need for more expensive facility based solutions

# Brookstone Haven

Randleman, NC

## Providing Mental Health Support for People Who Choose to Live in Assisted Living Settings

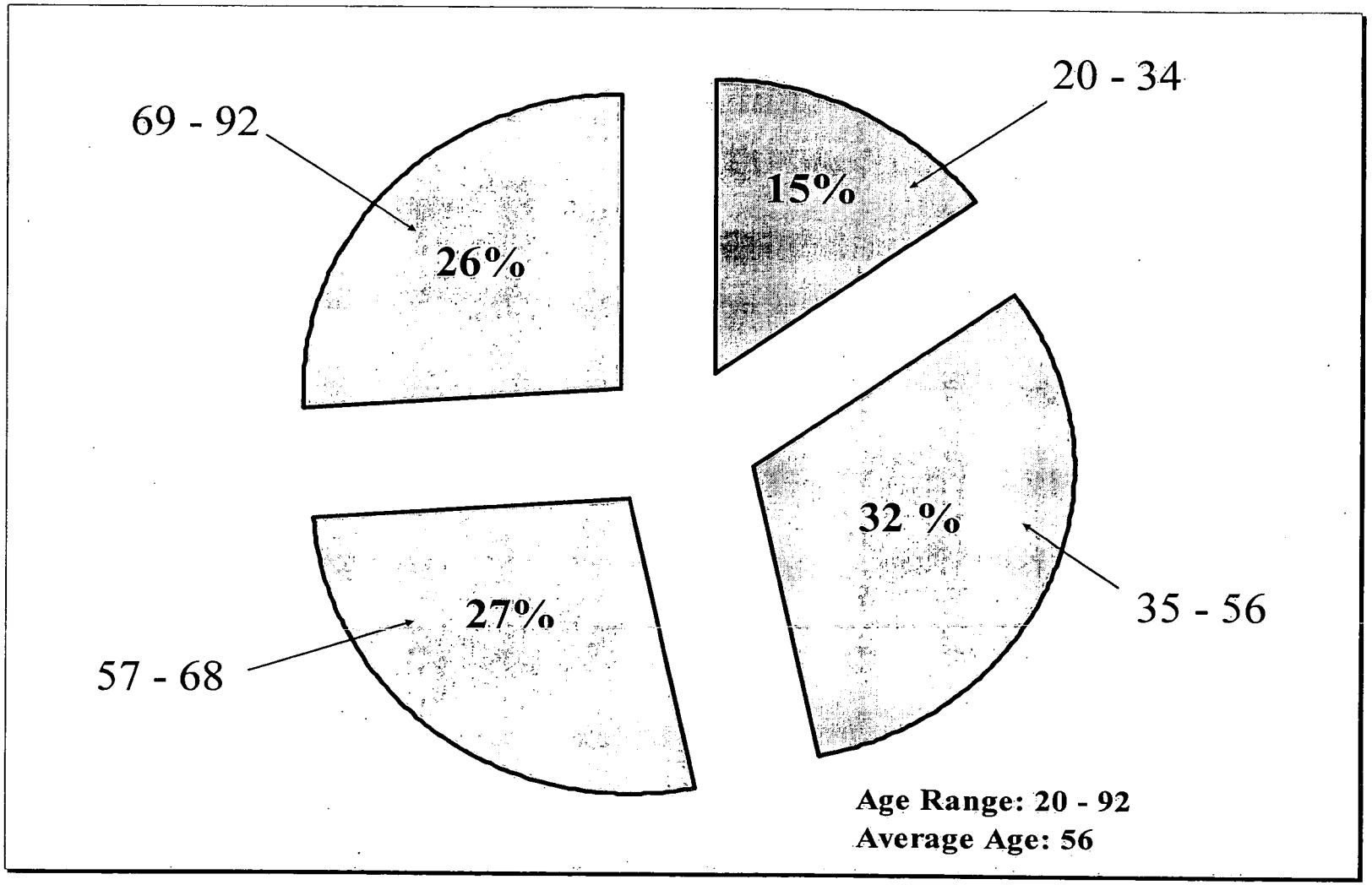
Kenny Burrow & Jay Poole
Alicia LeJeune & Emily Owen

November 14, 2006

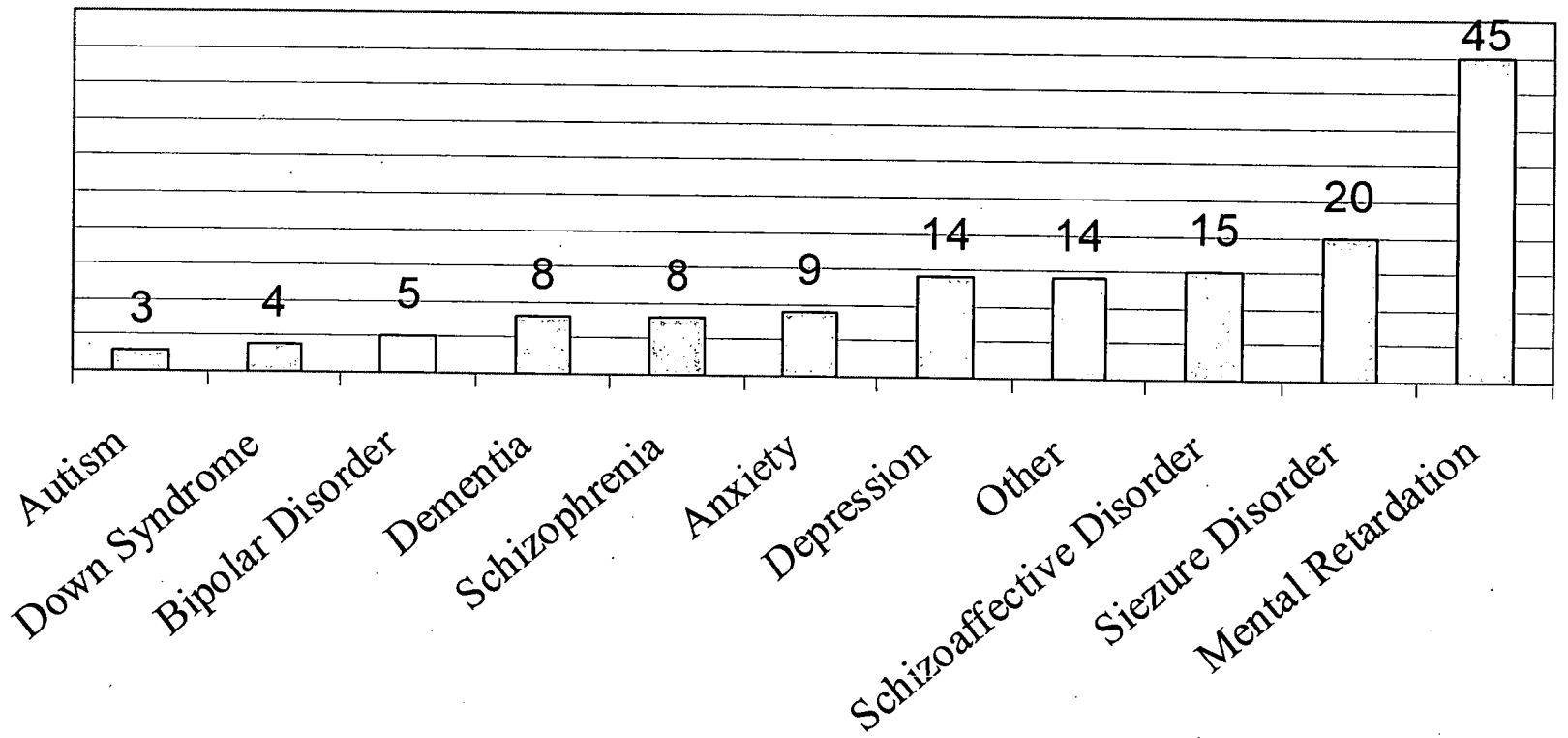
# Where We Came From

- Company started in 1958
- Brookstone Haven opened in 1990
- Followed tradition of providing services in non-segregated setting to diverse population
- Created admissions criteria
- Observed need for mental health supports
- Established goals for obtaining mental health supports
- Developed person centered approach in a larger setting

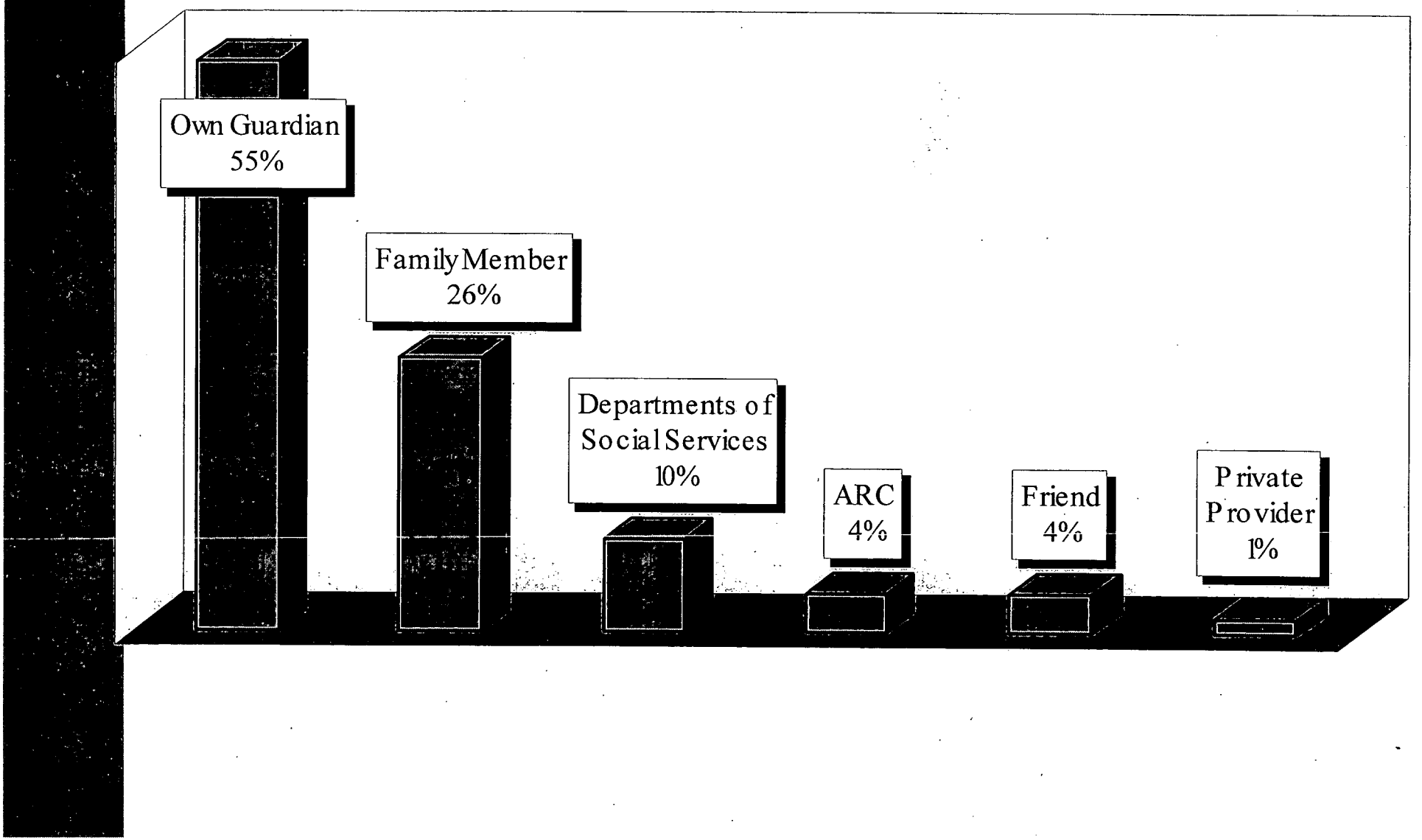
# Age Demographics



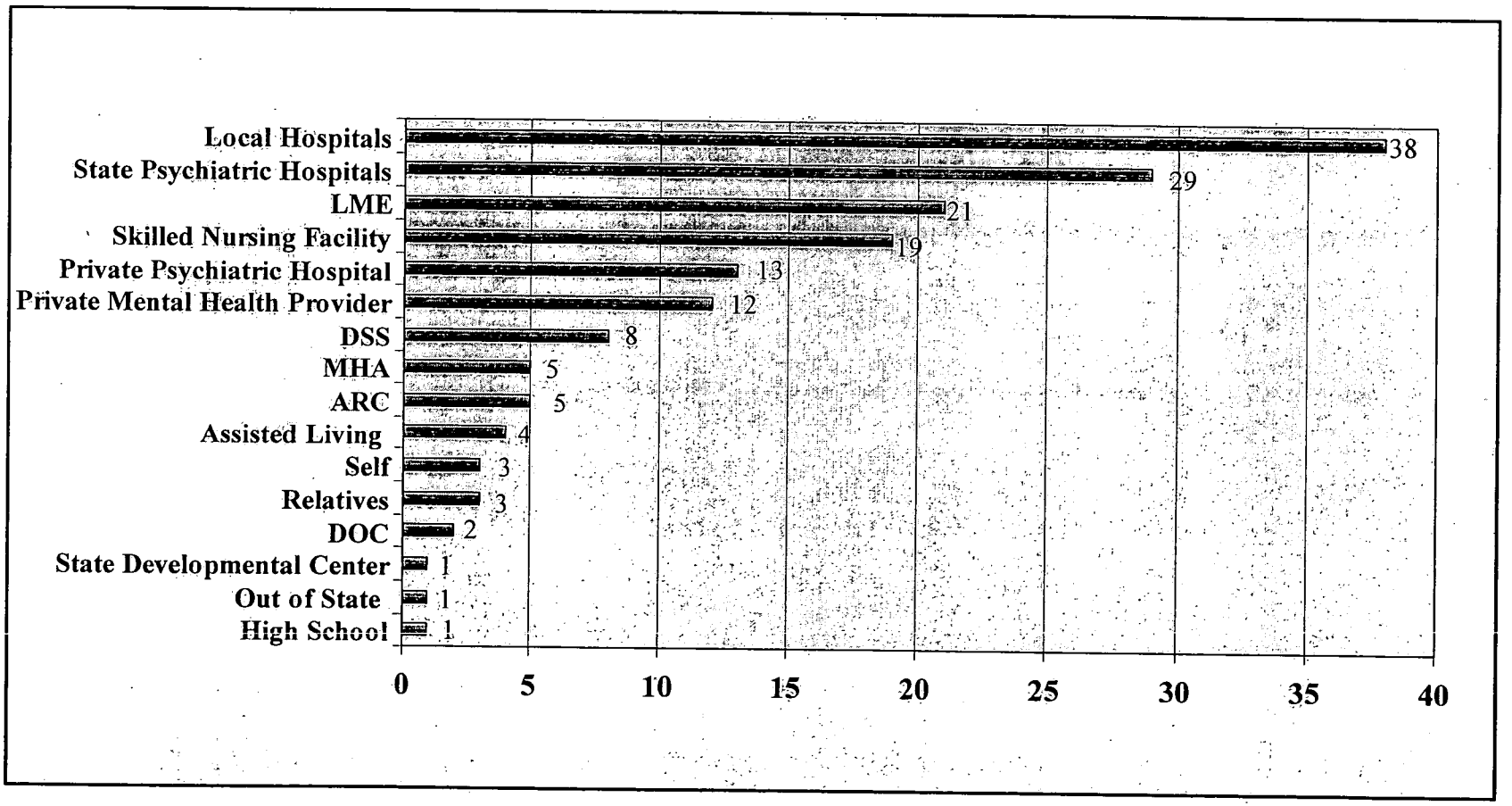
# Diagnoses


3
4
5
8
8
9
14
14
15
20
45
Autism
Down Syndrome
Bipolar Disorder
Dementia
Schizophrenia
Anxiety
Depression
Other
Schizoaffective Disorder
Siezure Disorder
Mental Retardation

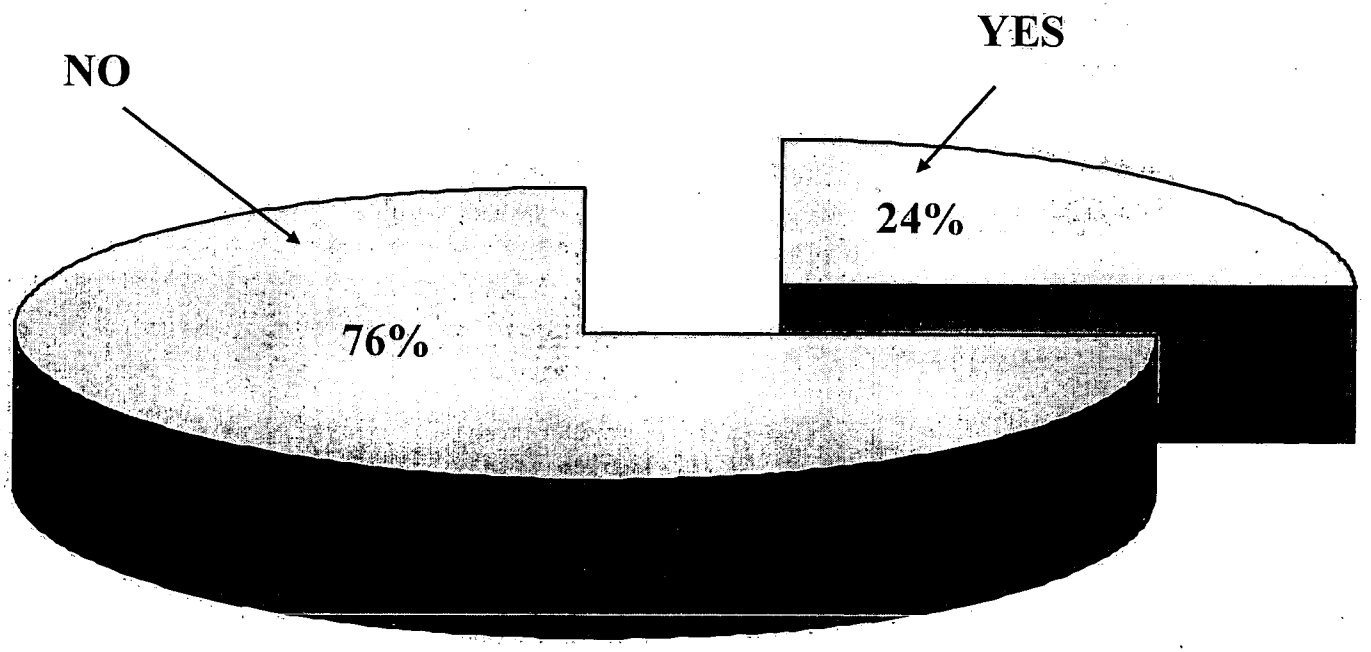
# Legal Guardians



# Referring Entities



# Percentage of Referrals Resulting in Admissions




March 15, 2005 - November 3, 2006

# Staff Support

- Personal Care Assistants
- CAP & Community Support Staff
- Medication Technicians
- Resident Care Coordinator
- Activities Director
- Services Coordinator
- Case Manager
- Shift Supervisors
- Office Manager
- Dietary Manager
- Registered Nurse (part-time)
- On-site Administrator

# Mental Health & Developmental Disabilities Supports

- CAP-MR/DD
- Community Support
- Outpatient Therapy
- Psychiatrists
- Assertive Community Treatment Team
- Psychosocial Rehabilitation
- Psychologist

# Staff Education & Training

- CAP-MR/DD
- Resident/Client Rights
- CPR
- First Aid
- HIPAA
- OSHA
- Person Centered Thinking
- Medication Administration
- NCI (North Carolina Interventions)
- Fire Safety
- Back Safety
- Alternatives to Restraints
- Diabetic Care
- Hoyer Lift
- Crisis Response

# Day Supports & Supported Employment

- Supported Employment
  - 6 people
- Randolph Community College - Compensatory Education
  - 4 people
- Randolph Community College – Computer Classes
  - 1 person
- Vocational Opportunities in the Community
  - 2 people
- Therapeutic Alternatives Day Program
  - 8 people
- Clubhouse
  - 2 people

# Average Daily Rates

- Brookstone Haven
  - $105.69
- Group Homes Operated by Therapeutic Alternatives, Inc.
  - $182.57

# Why Brookstone Haven Works

- Person Centeredness
- Offering Choices
- Mental Health Supports
- Proper Screening
- Careful Planning Upon Admission
- Private Rooms
- Training
- Planning Sessions
- Accommodating Individual Requests
- Close contact with families & guardians
- Day Programs & Supported Employment
- Giving people the opportunity to age in place
- Making it as homelike as possible
- Interns from UNCG Social Work Department
- Non-profit entity
- Family atmosphere
- Helping people achieve their life goals
- Taking time to listen
- Caring staff members who love the people they support

# Where We Are Going

- Continuing to provide individualized supports
- Integrated apartments
- Expanding the intern program
- Researching additional ways to ensure people have choices

www.My*TA*home.com

# Four Themes From the Literature

1. Utilization of Residential Care
2. Choice
3. Options
4. Training & Education

House Bill 1414 Section 10.2 (a) and (b) directed the Department of Health and Human services to answer a series of questions and make recommendations about the presence of persons with mental illness in NC LTC facilities.

DHHS convened a study group made up of long-term care provider associations, advocacy organizations and state government staff.

Issues addressed by the Study Group:
- Health and safety
- Screening and disclosure
- Training of staff
- Services to residents with mental illness

## Long Term Care Facilities

- Nursing Facilities provide care for persons who have health conditions for which medical and nursing care is indicated.
- Adult Care Homes provide residential care for older adults or adults with disabilities whose primary need is a home with the shelter and personal care their age and disability requires.

- Over 40% of the adult care home population carries an active diagnosis of mental illness
  (Adult Care Home Mental Health Needs Assessment Report of Findings, First Health, July 15, 2004)
- Over 40% of the nursing facility population has a psychiatric or mood disorder diagnosis.
  (Based on a limited sample study of nursing facility residents done as part of the Adult Care Home Cost Modeling Report, Myers and Stauffer 2003)

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

NC General Statutes 122C-3(21)

**#1. Expansion of mental health specialty teams to provide training, technical assistance and linkage to local mental health services for long term care facilities.**

FY 05-06 funding increased by 20% to expand capacity for training and consultation to long term care facilities.

January 2007, funding for teams to add an additional position to focus on needs related to younger adults in long term care.

**#2 Design and Implementation of an automated screening, assessment and care planning system to be used prior to admission to long term care services**

DMA is currently working on an integrated, web-based system with the capacity to identify individualized needs for all residents including persons with mental illness prior to admission, Operational in 2007.

**#3 Conduct a study to inform the development of a continuum of residential services to meet the varied needs of persons with mental illnesses.**

•Study would 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.

DHHS is currently drafting an RFP to conduct the study.

AND

Proceeding with development of new service: "Transitional Residential Treatment Program" a 24-hour residential treatment and rehabilitation program for adults who have a pattern of difficult behaviors, related to mental illness, which are not easily re-directed and exceed the capability of a traditional community residential setting.

**Overview of DMHDDSAS Total System Funding: Prepared November 18, 2005 by Phillip Hoffman, DMHDDSAS.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Category | MH | DD | SA | Other Non-Disability Specific | Comments for Other Non-Disability Specific Amounts in Column 5 | Grand Totals | Shaded = % of Grand Total; *Italics* = *% of Shaded Line* | In Budget DMHDDSAS Y or N (6) | Year for Dollar Amount (7) |
| Institutions Total Budget (1) (2) (3) (4) (5) | 268,132,723 | 236,293,021 | 14,792,162 | 39,355,222 | | 558,573,128 | 23.90% | | |
| *Medicaid Funds* | *23,274,019* | *222,170,031* | *8,137* | *33,324,844* | Specialty nursing: BMC and NCSCC (Footnote 5) | *278,777,031* | *49.91%* | *Y* | *SFY 06* |
| *Other Receipts* | *41,444,816* | *3,909,043* | *4,734,275* | *4,119,265* | Specialty nursing: BMC and NCSCC (Footnote 5) | *54,207,399* | *9.70%* | *Y* | *SFY 06* |
| *State Appropriation* | *203,413,888* | *10,213,947* | *10,049,750* | *1,911,113* | Specialty nursing: BMC and NCSCC (Footnote 5) | *225,588,698* | *40.39%* | *Y* | *SFY 06* |
| Community Funds | 639,457,322 | 744,399,314 | 117,707,773 | 241,317,051 | | 1,742,881,460 | 74.57% | | |
| *DMH Allocated State Appropriation* | *122,603,722* | *140,525,248* | *31,710,302* | *57,286,030* | *Consolidated funding Smoky Mt. and Piedmont; LME administration; Contract.* | *352,125,302* | *20.20%* | *Y* | *SFY 06* |
| *DMH Allocated Federal & Misc. Receipts* | *26,781,306* | *8,746,090* | *44,967,279* | *1,745,208* | | *82,239,883* | *4.72%* | *Y* | *SFY 06* |
| *Medicaid (Regular) Paid to LMEs* | *350,319,641* | *121,318,930* | *34,757,041* | *16,799,611* | *$16,799,611 in DMH budget for SFY 06 for LME administration; other amounts are SFY 05 and are not in DMH budget.* | *523,195,223* | *30.02%* | *Y/N* | *SFY 05 & 06* |
| *Medicaid (Regular) to Direct Enrolled Providers* | *139,752,653* | *3,307,644* | *6,273,151* | *0* | | *149,333,448* | *8.57%* | *N* | *SFY 05* |
| *Medicaid CAP-MR/DD* | *0* | *266,945,320* | *0* | *0* | | *266,945,320* | *15.32%* | *N* | *SFY 05* |
| *Medicaid ICF/MR - Community* | *0* | *203,556,082* | *0* | *0* | | *203,556,082* | *11.68%* | *N* | *SFY 05* |
| *County General Funds for LMEs* | *0* | *0* | *0* | *109,253,645* | *Not budgeted disability specific.* | *109,253,645* | *6.27%* | *N* | *SFY 06* |
| *Other LME Funds (Insurance, fees, etc.)* | *0* | *0* | *0* | *56,232,557* | *Not budgeted disability specific.* | *56,232,557* | *3.23%* | *N* | *SFY 06* |
| Central Office Administration & Management | 0 | 0 | 0 | 35,742,337 | | 35,742,337 | 1.53% | | |
| *Medicaid Funds* | *0* | *0* | *0* | *4,273,440* | | *4,273,440* | *11.96%* | *Y* | *SFY 06* |
| *Other Receipts* | *0* | *0* | *0* | *15,342,857* | *Such as block grants, indirect cost.* | *15,342,857* | *42.93%* | *Y* | *SFY 06* |
| *State Appropriation* | *0* | *0* | *0* | *16,126,040* | | *16,126,040* | *45.12%* | *Y* | *SFY 06* |
| GRAND TOTAL | 907,590,045 | 980,692,335 | 132,499,935 | 316,414,610 | | 2,337,196,925 | 100.00% | | |

**Footnotes:**

(1) Excludes disproportionate share funds, settlement funds, and ICF-MR assessment fee.
(2) MH Institutions include: Broughton Hospital, Cherry Hospital, Dix Hospital, Umstead Hospital, Whitaker School & Wright School.
(3) DD Institutions include: Caswell Center, Murdoch Center, O'Berry Center and J. Iverson Riddle Center.
(4) SA Institutions include: JFK ADATC and WBJ ADATC; RJB Blackley ADATC is a unit of Umstead Hospital and is included in Umstead's budget.
(5) Non-Disability Specific Institutions include: Black Mountain Center (BMC) and N.C. Special Care Center (NCSCC).
(6) Column 9 indicates whether the funds indicated on each line appear in DMHDDSAS' budget or not. For example, County General Funds for LMEs are appropriated directly by counties to the LMEs and do not appear in the Division's budget. The Division does, however, track the amount budgeted.
(7) Indicates SFY for funding amounts. SFY 05 amounts are actual payments; SFY 06 amounts are budgeted amounts. For amounts which appear in DMHDDSAS' budget, the budget date is as of 10/31/05. For other SFY 06 amounts which do not appear in DMHDDSAS' budget, the budget date is as of 7/1/05.

Note: Amounts in italics below each shaded/bolded line add up to the total of the shaded/bolded line. These amounts are NOT duplicated in the Grand Total at the bottom of the schedule.

# Agenda

# Subcommittee on Mentally Ill Residents of Adult Care Facilities

**Tuesday, December 12, 2006**
**1:00 p.m.**
**Legislative Office Building**
**Room 643**

## I. Welcome and Introductions

*Representative Verla Insko, Co-Chair*
*Representative Beverly Earle, Co-Chair*

## II. Proposed Subcommittee Recommendations

*Staff, Research Division, NCGA*

## III. Discussion

## IV. Adjourn

## ATTENDANCE

### Subcommittee on Mentally Ill Residents in Adult Care Homes

| DATES / MEMBERSHIP | 12/12/06 | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Representative Verla Insko, Co-Chair | √ | | | | | | | | | | | | | | | |
| Representative Beverly Earle, Co-Chair | X | | | | | | | | | | | | | | | |
| Representative Alice Bordsen | √ | | | | | | | | | | | | | | | |
| Representative Debbie Clary | X | | | | | | | | | | | | | | | |
| Representative Bob England | √ | | | | | | | | | | | | | | | |
| Representative Carolyn Justice | √ | | | | | | | | | | | | | | | |
| Senator Stan Bingham | √ | | | | | | | | | | | | | | | |
| Senator Charlie Dannelly | √ | | | | | | | | | | | | | | | |
| Senator Jeanne Lucas | √ | | | | | | | | | | | | | | | |
| Senator Vernon Malone | X | | | | | | | | | | | | | | | |
| **STAFF** | | | | | | | | | | | | | | | | |
| Ben Popkin | √ | | | | | | | | | | | | | | | |
| Shawn Parker | √ | | | | | | | | | | | | | | | |
| Andrea Russo | √ | | | | | | | | | | | | | | | |
| Rennie Hobby | √ | | | | | | | | | | | | | | | |
| Ann Raeford | X | | | | | | | | | | | | | | | |
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# SUBCOMMITTEE ON
# MENTALLY ILL RESIDENTS IN ADULT CARE HOMES

**Tuesday, December 12, 2006**
**1:00 PM**
**Room 643, LOB**

The Subcommittee on Mentally Ill Residents in Adult Care Homes met on Tuesday, December 12, 2006, at 1:00 PM in Room 643 of the Legislative Office Building. Members present were: Representative Verla Insko, Co-Chair; Senators Stan Bingham, Charlie Dannelly, and Jeanne Lucas, and Representatives Alice Bordsen, Bob England, and Carolyn Justice.

Shawn Parker, Ben Popkin, Andrea Russo, and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order, welcoming members and guests. She asked for a motion to approve the minutes from the November 14th meeting. Representative Justice made the motion and the minutes were approved. Representative Insko said that the purpose of the meeting was to review and approve proposals to be recommended in January to the Commission on Aging and to the Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

Ben Popkin from the Research Division reviewed each of the five recommendations. The recommendations are listed below with changes recommended by subcommittee members listed beneath each proposal.

1. Enact legislation to increase the stock of current housing options available to North Carolinians with mental illness (including independent living units, supported housing units and group homes) and support the development of new options for housing for North Carolinians with mental illness that are appropriate for and meet their needs.

1. *(Revised)*Appropriate funds to the Department of Health and Human Services and the Housing Finance Agency to increase the stock of current housing options available to North Carolinians with mental illness (including independent living units, supported housing units and group homes).

2. *(New)* Support Department of Health and Human Services and Housing Finance Agency efforts to develop new options for housing for North Carolinians with mental illness that are appropriate for and meet their needs.

3. Support the development of a "Transitional Residential Treatment Program" to provide 24-hour residential treatment and rehabilitation for adults who have a pattern of difficult behaviors, related to mental illness, which exceed the capabilities of traditional community residential settings.

3. *(No Revisions)*

4. Authorize the Commission on Aging and the Legislative Oversight Committee on MH/DD/SAS to explore whether there is a need for the General Assembly to enact statutes to govern facilities providing housing in one location to both adults with mental illness and adults without mental illness.
4. *(Revised)* Authorize the Commission on Aging and the Legislative Oversight Committee on MH/DD/SAS to explore the need for the General Assembly to enact statutes authorizing rules to regulate facilities that provide housing for adults with mental illness in the same location with adults without mental illness. Rules authorized shall address at least the following issues: housing of individuals with mental illness in the same bedroom or area of a facility with individuals without mental illness; and training of staff to provide care appropriate to each individual resident's needs with specific training addressing the needs of persons with mental illness.

5. Support ongoing efforts to develop of a Uniform Screening Tool which would include the requirement to notify Local Management Entities (LMEs) of the mental illness status of any individual admitted to any facility within the LME's catchment area.
5. *(Revised)* Support ongoing efforts to develop a Uniform Screening Tool that would include the requirement that the Department of Health and Human Services notify Local Management Entities (LMEs) of the mental illness status of any individual admitted to an adult care home facility within the LME's catchment area. The Department of Health and Human Services shall specify which Division will be responsible for providing the notification and what resources will be required to accomplish the notification.

6. Authorize funds to provide a total of 2,000 slots for use by adults through the State/County Special Assistance In-Home Program for Adults.
6. *(No Revisions)*

Representative Insko asked for a motion to approve the recommendations to the Commission on Aging and the Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, pending final review and approval of the revised recommendations by the Subcommittee Co-Chairs. Senator Dannelly made the motion and the committee approved the recommendations.

There being no further business, the meeting adjourned at 1:35 P.M.

Representative Verla Insko, Co-Chair

Representative Beverly Earle, Co-Chair

Rennie Hobby, Committee Assistant

**Attachment 1**

# VISITOR REGISTRATION SHEET

Subcommittee on Mentally Ill in Adult Care Homes — December 12, 2006

**Name of Committee** — **Date**

**VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK**

| NAME | FIRM OR AGENCY AND ADDRESS |
|---|---|
| Sally Abril | GACPD |
| Bill Wilson | AARP |
| Dave Richard | TAP |
| Joe Donovan | Alliance of Disability Advocates |
| Eric Frazier | Charlotte Observer |
| [illegible] | HHS |
| Jennifer Mahan | MHANC |
| Mary Bernard | AARP-NC |
| Annaliese Dolph | Carolina Legal Assistance |
| Susan Pollitt | Carolina Legal Assistance |
| [illegible] | NAMI WAKE |

# VISITOR REGISTRATION SHEET

Subcommittee on Mentally Ill in Adult Care Homes — December 12, 2006

**Name of Committee** — **Date**

**VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK**

| NAME | FIRM OR AGENCY AND ADDRESS |
|---|---|
| Robin Huffman | NC Psychiatric Association |
| Larry Nixon | DMA |
| Jack Register | NC Social Work Association |
| Bonnie Morell | DMH/DD/SAS |
| Suzanne Merrill | DHHS-DAAS |
| Dennis Streets | DHHS - DAAS |
| [illegible] | NCAHCF |
| [illegible] | Bone Assoc |
| [illegible] | BGA |
| [illegible] | DAAS - State LTC Ombudsman |
| Martha Brock | GACPD |

# VISITOR REGISTRATION SHEET

Subcommittee on Mentally Ill in Adult Care Homes — December 12, 2006

**Name of Committee** — **Date**

**VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK**

| NAME | FIRM OR AGENCY AND ADDRESS |
|---|---|
| Walker Wilson | Office of the Governor |
| Debra Dihoff | NAMI INC |
| Evelyn Hawthorne | NCAA |
| Fred Bore | Bore: Assoc. |
| John Allen | Bore Assoc |
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DRAFT

**Proposed Recommendations –**
**Subcommittee on Mentally Ill Residents of Adult Care Facilities**

The Subcommittee on Mentally Ill Residents in Adult Care Facilities recommends that the Commission on Aging and the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services recommend that the General Assembly:

1. Enact legislation to increase the stock of current housing options available to North Carolinians with mental illness (including independent living units, supported housing units and group homes) and support the development of new options for housing for North Carolinians with mental illness that are appropriate for and meet their needs.
2. Support the development of a "Transitional Residential Treatment Program" to provide 24-hour residential treatment and rehabilitation for adults who have a pattern of difficult behaviors, related to mental illness, which exceed the capabilities of traditional community residential settings.
3. Authorize the Commission on Aging and the Legislative Oversight Committee on MH/DD/SAS to explore whether there is a need for the General Assembly to enact statutes to govern facilities providing housing in one location to both adults with mental illness and adults without mental illness.
4. Support ongoing efforts to develop of a Uniform Screening Tool which would include the requirement to notify Local Management Entities (LMEs) of the mental illness status of any individual admitted to any facility within the LME's catchment area.
5. Authorize funds to provide a total of 2,000 slots for use by adults through the State/County Special Assistance In-Home Program for Adults.


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