

**NORTH CAROLINA INSTITUTE OF MEDICINE
2011 TASK FORCE ON SHORT- AND LONG-TERM SOLUTIONS
FOR CO-LOCATION IN ADULT AND FAMILY CARE HOMES REPORT
2016 UPDATES TO RECOMMENDATIONS**

Introduction

In 2009, the North Carolina General Assembly requested that the North Carolina Institute of Medicine (NCIOM) study the co-location of the frail elderly with individuals with disabilities who may have behavioral problems in adult care homes. NCIOM convened a statewide Task Force to assist in developing comprehensive recommendations on co-location in adult care homes. The Task Force on the Co-Location of Different Populations in Adult Care Homes was chaired by Maria Spaulding, then Deputy Secretary for Long-Term Care and Family Services in the North Carolina Department of Health and Human Services, Representative Jean Farmer-Butterfield of the North Carolina General Assembly, and then Senator John Snow. The full Task Force consisted of an additional 35 members including legislators, state and local agency officials, adult and family care home representatives, consumer representatives, and other interested stakeholders. Six additional individuals served in a Steering Committee that shaped the meeting agenda and provided feedback on the recommendations and overall report. The Task Force met once a month between February 2010 and December 2010. The final report entitled, “*Short- and Long-Term Solutions for Co-Location in Adult and Family Care Homes*,” was released in January 2011.

The Task Force reviewed the following: (1) examining the challenges created by the co-location of different populations in adult or family care homes (ACH) in the current system; (2) identifying ways to appropriately identify/screen people for behavioral health problems; (3) improving the training of ACH staff; and (4) increasing housing and support options for people with disabilities so they can live more independently.

The Task Force on the Co-Location of Different Populations in Adult Care Homes made a total of nine recommendations including improving and strengthening ACHs, and expanding options for affordable housing and supports for individuals with disabilities. Two recommendations were designated as priority: developing a pilot program and requiring standardized preadmission screening, level of services, and assessment instruments in adult and family care homes and 122C facilities. Seven of the nine recommendations (67%) have been partially or fully implemented while two have had no action taken.

The following document describes the progress on the recommendations of the NCIOM Task Force on the Co-Location of Different Populations in Adult Care Homes. This report includes the original recommendations in bold, along with a description of the progress to date, on the implementation of the recommendations. Progress is noted towards the goals of the recommendations, regardless of whether the recommendation was followed or progress was achieved through other means. Likewise, progress is evaluated based on the intent of the recommendation.

ACKNOWLEDGEMENTS

The NCIOM would like to thank the following people and organizations for providing information for the 2016 Update to the Short- and Long-Term Solutions for Co-Location in Adult and Family Care Homes.

We would like to thank the following people within DHHS: Doug Barrick, Family Care Home Administrator, Adult Care Licensure Section; Beverly Bell, Waiver Contract Manager, Division of Medical Assistance, Community Based Services; Courtney Cantrell, Assistant Director of Behavioral Health Services, Secretary's Office; Christopher Egan, Executive Director, NC Council on Developmental Disabilities; Steve Freedman, Chief, Section Operations Section, Division of Aging and Adult Services; Jesse Goodman, Section Chief, Division of Health Service Regulation; Megan Lamphere, Chief, Adult Care Licensure Section; Kathryn Lanier, Section Chief, Elder Rights Section; Sabrena Lea, Assistant Director of Facility, Home and Community Based Services, Division of Medical Assistance; Joyce Massey-Smith, Chief, Adult Services Section; Johnnie McManus, PASRR Coordinator, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Suzanne Merrill, Acting Division Director, Division of Aging and Adult Services; Sharon Nelson, Division of Public Health; Holly Riddle, Policy Advisor, Office of the Director; Steven Strom, Systems Change Manager, NC Council on Developmental Disabilities; Jason Vogler, Assistant Division Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; and Debbie Webster, Mental Health Program Manager, Community Mental Health Section.

We would also like to thank Kenny Burrow, member of the North Carolina Association of Long Term Care Facilities.

TOTAL RECOMMENDATIONS: 9

- **FULLY IMPLEMENTED: 3 (33%)**
- **PARTIALLY IMPLEMENTED: 3 (33%)**
- **NOT IMPLEMENTED: 3 (33%)**

Recommendation 3.1 (Priority Recommendation)

FULLY IMPLEMENTED

Pilot Program

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

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

and for those who have not yet entered an ACH but who meet the level of need criteria.

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

In July 2012, in response to the U.S. Department of Justice and State of North Carolina settlement, North Carolina agreed to an 8-year plan to develop community-based housing and services for 3,000 individuals with disabilities living in ACHs. In October 2015, Martha Knisley released the first annual report detailing the progress towards establishing compliance with the settlement (Knisley, 2015). The State of North Carolina implemented the settlement agreement through the Transition to Community Living Initiative (TCLI). The TCLI is coordinated primarily by LME/MCOs¹ and provides education efforts and support services designed to accurately and fully inform adults with serious mental illness or a serious persistent mental illness residing in ACHs and state psychiatric hospitals about community-based mental health services and supportive housing options (NCDHHS, 2016). Information offered to adults includes, but is not limited to, the availability of tenancy support services and rental assistance. TCLI also implements the In-Reach and Transition program. The goal of the In-Reach and Transition program is to successfully transition 3,000 individuals from ACHs and state psychiatric hospitals to community-based living options by 2020. In 2014, 250 individuals were transitioned to community-based living options, and in 2016 the NC Department of Health and Human Services aims to have transitioned an estimated 1,166 individuals since 2012.

As the State of North Carolina was mandated by the U.S. Department of Justice to account for the large number of older adults residing in ACH, the North Carolina General Assembly appropriated \$39 million to facilitate the transition of residents with no identified mental health conditions from adult care homes into community-based housing options. However, this appropriation amount did not cover individuals with disabilities. Disability Rights North Carolina received a \$75,000 three year grant from the North Carolina Council on Developmental Disabilities for a pilot study. The information derived from this pilot study would assist with the developing a blue print to transition the 18,000 individuals currently in ACHs. The pilot identified and followed up with six individuals transitioning from ACHs to community-based living and highlighted limited community resources as a potential barrier for independent living.

¹ State and Medicaid funded Local Management Entities/Managed Care Organizations, which provide mental health, intellectual and developmental disability, and substance use services across the state of North Carolina.

In 2015, the Department of Health and Human Services launched a pilot initiative – the Transitions Institute – with North Carolina State University’s College of Education and the North Carolina Money Follows the Person program. The goal of the Transitions Institute is to address long-term care needs for individuals transitioning from ACHs to their homes and communities through enhanced professional networks and partnerships across North Carolina. The Transitions Institute disseminates relevant, practice-based information, and strengthens participants’ knowledge and use of person-center techniques (NCCTI, 2016).

There have been no further evaluations or state appropriations for additional programs focused on transitions from ACHs for individuals with disabilities.

Recommendation 3.2 **PARTIALLY IMPLEMENTED**
Increase funding for housing for individuals with disabilities

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

An objective of the Transitions to Community Living Initiative (TCLI) was to identify individual ACHs and conduct a pilot program to explore the feasibility of transitioning individuals from ACHs to supportive housing options in their communities.

The North Carolina Housing Finance Agency established a Housing Trust Fund in 1987 to offer flexible financing to address the housing needs of North Carolinians, including independent living apartments for older adults and supportive housing for persons with disabilities. Currently, the General Assembly appropriates \$7 million in recurring funding to the Housing Trust Fund (down from \$10 million recurring in SFY 2011).

The North Carolina Housing Finance Agency is in the process of identifying potential properties suitable as supportive housing units. The goal is to increase the number of properties participating in the Targeting Program under the TCLI, from 10% to 20% (State of North Carolina, 2015). The North Carolina Housing Finance Agency is collaborating with the departments of Rural Development and Housing and Urban Development (HUD) to determine the feasibility of developing a preferential waitlist for people with disabilities, specifically for those in identified in the Olmstead case (State of North Carolina, 2015). In addition, the Agency added the Olmsted Settlement Initiative Section [IV(F)(5)] to the 2016 Qualified Allocation Plan. This section detailed incentive points for one-bedroom units and the development of units in high-demand counties (State of North Carolina, 2015).

Recommendation 3.3

FULLY IMPLEMENTED

Create an Inventory of Community Housing Options for Individuals with Disabilities

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

In 2011, the Department of Health and Human Services, DMHDDSAS and Local Management Entity-Managed Care Organization (LME/MCOs) worked in collaboration to capture their permanent, affordable housing options via a statewide excel housing workbook that included 122Cs.

In March 2012, DMHDDSAS launched the DMHDDSAS Bed Availability Database, meeting the LME/MCO requirements outlined in House Bill 677². This database is accessible to the public. The LME/MCOs must determine a discharge destination for residents with primary unmet needs related to mental health, development disabilities, or substance use disorders and who met the criteria for the target population. It was the responsibility of the LME/MCO housing staff to update the Bed Availability Database until August 2015.

Beginning in July 1, 2012, the contract between DMHDDSAS and the LME/MCO provided detailed directions for LME/MCO Housing Coordination Activities to develop and maintain an inventory of housing stock inclusive of affordable, existing permanent supportive housing units.

In May 2016, DHHS' contractor Socialserve launched a residential finder locator service, to capture Supervised Living and Family Care Home housing availability. This created a "one stop shop" for housing and provided owners the ability to update available housing through the service. This locator service complements their rental housing locator service. The Socialserve online residential finder service is found at <https://www.socialserve.com/>.

Recommendation 4.1 (Priority Recommendation)

FULLY IMPLEMENTED

² NC House Bill 677 § 2011-272: Provides ACHs with greater flexibility in the transfer and discharge of residents and to enact appeal rights for ACH residents and ACHs with respect to discharge decisions and to create ACHs resident discharge teams within every county, which contains an ACH licensed under Chapter 131D of the General Statutes.

Requiring Standardized Preadmission Screening, Level of Services, and Assessment Instruments in Adult and Family Care Homes and 122C Facilities

- a) The North Carolina General Assembly should direct the Department of Health and Human Services (DHHS) to require adult care homes and family care homes (ACHs), and 122C mental health, developmental disability, and substance abuse group homes (122C) to use standardized preadmission screenings, level of services determinations, assessments and care planning instruments. DHHS can designate different instruments for different types of licensed facilities, regardless of payment source.**
- b) For adult and family care homes**
 - 1. The screening, assessment and care planning process should be redesigned:**
 - i. The level of services preadmission screening tool should be revised to replace the current FL-2. The tool should be automated and should capture information on diagnosis (including, but not limited to, physical condition, mental health, substance use disorders, cognitive impairments, intellectual and other disabilities, and other health conditions), functional capacity with activities of daily living and instrumental activities of daily living, need for supervision and medication supervision, and conditions that could pose a threat to the health or safety of self or others.**
 - ii. Individuals who have been identified as having a mental health problem, substance use disorder, cognitive impairment, or intellectual and other disability as part of the level of services preadmission screen should receive a more complete independent screening assessment by a trained mental health, substance abuse, or developmental disability professional. DHHS should develop a system to ensure that individuals who cannot be appropriately served in an adult care home are provided other appropriate housing and/or treatment options, and that all individuals with mental health problems, intellectual and developmental disabilities, or addiction disorders are provided appropriate supports and services designed to maximize their independence.**
 - iii. Once a resident is admitted, facilities should be required to administer standardized care planning assessment instruments (as identified by DHHS) to obtain more detailed information that can be used in developing a person-centered care plan.**
 - iv. DHHS should develop appropriate time standards to conduct the screening and assessment to ensure that admissions to ACHs are not being unreasonably delayed by this two-level screening process.**
 - v. Existing residents of adult and family care homes should all receive screening, assessment, and care planning following this new process within one year of implementation of the new process.**

- c) **The instruments may be different for different types of facilities, but the data collected in the instruments should be consistent across types of settings and should be automated. The data collected as part of the level of services preadmission screening and assessment instruments should be consistent with existing data collection efforts. Data collected should include demographic characteristics; diagnoses; and physical health, mental health, substance use, and cognitive and behavioral functioning of the different populations housed in ACHs and 122Cs, regardless of payer source. This information should be available and accessible to SHHS as well as shared with other state and local entities, including but not limited to the Division of Aging and Adult Services, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the Division of Health Service Regulation, Local Management Entities, the Department of Social Services, and local Division of Social Services.**
- d) **The North Carolina General Assembly should appropriate \$900,000 in recurring funds in state fiscal year (SFY) 2012, \$228,000 in non-recurring funds in SFY 2012, and \$205,000 in non-recurring funds in SFY 2013 to DHHS to support the implementation of the automated level of services preadmission screen, assessment instrument, and prior approval for people seeking admission to ACH and 122C facilities.**
- e) **DHHS should report annually to appropriate legislative committees that address the needs of older adults or of people with mental illness, intellectual and developmental disabilities, or addition disorders on the data gathered about needs identified in the level I and level II screenings, placement of individuals with disabilities, and outcomes for individuals with disabilities living in ACHs.**

As of March 1, 2013 admission into ACHs now requires a Pre-Admission Screening and Annual Review (PASRR). The PASRR process, which was limited to nursing homes, was adapted and expanded to ACHs as part of an agreement between North Carolina and the US Department of Justice. PASRR is "a required screening of any individual who is being considered for admission into a Medicaid Certified Nursing Facility or Adult Care Home regardless of the sources of payment." On March 1, 2013, with the adoption of temporary rule 10A NCAC 14K.0101, the expanded PASRR process requires that any ACH licensed under G.S. 131D-2.4 must assure that prior to admission, any individual admitted to the home for care and services undergo a set of screenings.

For ACH resident screening, North Carolina uses the Medical Uniform Screening Tool (MUST), a state-owned screening system. There is a two-tiered screening system for ACH residents. The first is the North Carolina PASRR Medicaid Level 1 (Level 1) screening that is to be completed by an independent, certified health professional, who screens all applicants of Medicaid-certified nursing facilities or adult care homes for serious mental illness and/or intellectual disability. The Level 1 is comprised of a four-page document containing demographic, behavior, medication, and medical care information. For applicants with no evidence of the above, the Level 1 screen remains valid unless there is a significant change in health status.

For applicants who are flagged for any of the screened mental or developmental health conditions, the MUST triggers a Level 2 assessment. Level 2 screenings are performed on-site by contracted evaluators and current medical history is reviewed by Hewlett Packard Enterprise Services a (HPES) clinical reviewer. Evaluators assess activities of daily living, functionality, social history, and current location. If the evaluator deems the applicant to be medically and psychologically stable for discharge, then residents are offered a variety of housing options. Evaluators upload assessment results, including recommended housing options, if applicable, to the MUST and the HPES PASRR reviews the documentation and forwards their final recommendation to the Division of Medical Assistance (DMA). DMA reviews this information to determine if they are in agreement with the assessment. If in agreement, the State sends this information to LME/MCOs describing which services (e.g., in-reach, diversion process) applicants are eligible for. For additional information please review:

<http://www.ncmust.com/pasarr/pasarrsummary.jsp>

The North Carolina General Assembly has not appropriated additional funds.

Recommendation 4.2

NOT IMPLEMENTED

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

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

LME outreach to adult and family care home staff is not tracked.

Recommendation 4.3

NOT IMPLEMENTED

Case-Mix Adjusted Payments

The North Carolina Department of Health and Human Services should use the information obtained from validated assessment instruments to develop case-mix adjusted payments for

adult care homes, family care homes, and 122C facilities. Payments should be adjusted on the basis of the acuity of a person's needs for services and supports, and this basis should include, but not be limited to, the following:

- a) The person's underlying physical health, mental health, intellectual and other developmental disability, substance use disorder, or cognitive impairment.**
- b) The level of a person's functional abilities including their ability to perform activities of daily living, instrumental activities of daily living, and communication and their need for supervision and medication administration.**
- c) The extent to which a person manifests inappropriate verbal, sexual, or physical behaviors that can pose a threat to self or others.**

NC DHHS has not implemented case-mix adjusted payments.

Recommendation 5.1

NOT IMPLEMENTED

Use Geriatric/Adult Mental Health Specialty Teams (GASTs) to Provide Training in all ACHs

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

The North Carolina General Assembly has not required adult care homes to receive GAST training.

The Geriatric Adult Mental Health Specialty (GAST) Program has been providing training to ACHs and Nursing Homes since 2003. As a result of the recommendation, GAST staff added training in person-centered approaches and de-escalation skills. However, there is no mandate for ACHs to accept training from the GAST Program. Each year, the Teams market to long-term care facilities in which they are not currently providing training. Some of these facilities have never received training and continue to decline. Some of the facilities have had a change in owner, administrator, or charge nurse and currently decline GAST training although the facility accepted training in the past. The number of trainings GAST provides varies with some facilities receive one training a year to four or more a year. As the needs in the community have changed

with the efforts of the Transition to Community Living Initiative, GAST has expanded training locations to include: Senior Centers, Home Health Agencies, Home Care Agencies, Meals-on-Wheels Programs, Adult Day Care, Veteran Affairs, NC Community Resource Connections, Departments of Social Services, Faith-Based organizations, and Law Enforcement and Judicial system.

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

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

At present, neither NCI training are being provided at ACHs by state agencies nor is there legislation enacted to require such training. The Adult Care Licensure Section (ACLS) was consulted by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to determine feasibility of implementing NCI training. It was decided that NCI training is not appropriate for adult care homes. While the first portion of NCI training, including de-escalation skills, may hold some value for ACHs, the second portion of the training related to therapeutic holds is not permitted in ACH facilities. Therefore NCI trainings as a whole were not implemented. In addition, the competencies targeted by this training were not generalizable to all populations served by ACHs so training was not deemed necessary for all ACH staff.

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

- a) **The North Carolina Division of Health Service Regulation (DHSR), in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) and the Division of Medical Assistance, should develop a standardized curriculum and competency test for new direct care workers as part of the federal Personal and Home Care Aide State Training Program (PHCAST) grant. The core training should include, but not be limited to, the following:**
- 1. Knowledge and understanding of the people being served, including the impact of aging on different populations.**
 - 2. Recognizing and interpreting human behavior.**
 - 3. Recognizing the effect of internal and external stressors that may affect people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders.**

4. **Strategies for building positive relationships with persons with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders and for recognizing cultural, environmental, and organizational factors that may affect people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders.**
5. **Recognizing the importance of and assisting in the person's involvement in making decisions about his or her life.**
6. **Skills in assessing individual risk for escalating behavior.**
7. **Communication strategies for defusing and de-escalating potentially dangerous behaviors.**
8. **Positive behavioral supports providing means for people with mental illness, dementia, cognitive impairments, intellectual and other developmental disabilities, and substance use disorders to choose activities that directly oppose or replace behaviors that are unsafe.**
9. **Information on alternatives to the use of restrictive interventions.**
10. **Guidelines on when to intervene (understanding imminent danger to self and others).**
11. **Emphasis on safety and respect for the rights and dignity of all persons involved, including least restrictive interventions and incremental steps in an intervention.**
12. **Knowledge of prohibited procedures, including but not limited to abuse, neglect, and exploitation.**
13. **Debriefing strategies, including their importance and purpose, particularly after resident deaths.**
14. **Documentation methods/procedures.**

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

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

The Division of Health Service Regulation (DHSR), with input from a broad-based Partner Team comprised of internal agency and external members used the Personal and Home Care Aide State Training (PHCAST) grant to develop and implement statewide a comprehensive four-phase training and competency framework in North Carolina's community colleges and high schools for direct care workers, and select ACHs. The training was developed, piloted, and implemented

during the fall of 2013. Through the PHCAST grant, a series of in-service modules based on content included in Phases II and IV (see below) were selected for in-service use by adult care homes and home care agencies. Grant funds did not enable the development of specific Behavioral Health course. However, all developed modules for use in adult care homes were approved for continuing education credits by DHSR. Additionally, the PHCAST curricula and/or individual modules can be used by ACH agencies to address star rating licensure requirements. Phase II builds upon the skills introduced in Phase I and progresses to include skills development in home management, personal care tasks using limited assistance, and interpersonal and soft skills associated with direct care work. Phase IV (Home Care Nurse Aide) builds on the Nurse Aide I competencies, focusing on enhancing specific skills needed when working in a home setting including person-centered care , patient and personal safety, hydration/nutrition, mental health, dementia, behavioral changes, and pain management.

Despite of the development of the trainings through the PHCAST grant, the full recommendation was not able to address the behavioral health component. DHSR submitted a request to CMS to utilize civil monetary penalty funds to research and update the federal nurse aid training requirements for the first time since the 1980s. At present, the civil monetary penalty funds have not been approved for this effort.

References

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