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TASK FORCE ON MENTAL HEALTH AND SUBSTANCE ABUSE

NORTH CAROLINA INSTITUTE OF MEDICINE
630 DAVIS DRIVE, SUITE 100
MORRISVILLE, NC 27560

OCTOBER 23, 2015
10:00 am - 3:00 pm

Task Force members in attendance: Kenny Burrow, Brenden Hargett, Mary Edwards, Dawn Lillard, Paul Nagy, Ellen Schneider, Gina Upchurch, Tana Hartman Thorn, Adrienne Mims, Mary Lynn Piven,

Co-Chairs in attendance: Representative Josh Dobson

Steering Committee members in attendance: Jehan Benton-Clark

Guests/Speakers in attendance: Debbie Webster, Leslie Breen

NCIOM staff in attendance: Adam Zolotor, Berkeley Yorkery, Michelle Ries, Diana Dayal

NOTE: PDF copies of all presentations available online at
http://www.nciom.org/events/?task-force-on-mental-health-and-substance-abuse

INTRODUCTION AND WELCOME TO THE TASK FORCE

Our Task Force co-chairs will bring the meeting to order and facilitate member introductions. We ask that each Task Force member introduce him/herself with name, title, and organization.

Representative Josh Dobson
North Carolina General Assembly

MENTAL HEALTH, SUBSTANCE ABUSE, AND AGING

Debbie A. Webster, MS , Mental Health Program Manager
Division of Mental Health, Developmental Disabilities & Substance Abuse Services
North Carolina Department of Health and Human Services

Ms. Webster introduced the state of mental health and substance abuse across the older adult population in North Carolina. Projected population growth by age group indicates that while the total population will only grow by 17% through 2030, the age group of 55 and up will grow by 35%, while the 95 to 100 group will grow by 54%. By 2025, 90 of North Carolina's 100 counties will have more people over 60 years old than people under 18 years old. The veteran population faces similar challenges; 50% of NC veterans are over 60.

It is important to note that a larger number of older adults with depression are living in nursing homes than living in community (29-54% vs. 1-5%) – implying the need for community-based solutions. Suicide is especially concerning among this population: adults aged 65 and older accounted for 16% of suicides, while they only account for 13% of the population. Elderly white men over 85 are at greatest risk. For the aging population, firearms are most common method of suicide at 72.1%. Substance abuse is prevalent in this age group, as the baby boomers are the first American cohort with a majority having used illicit drugs sometime in their lives. 4.8 million adults report having used illicit drugs in 2012, with marijuana as most common, and prescription drugs next. Among older adults admitted for treatment, alcohol is the most common primary substance of abuse. Trends indicate that cocaine and heroin use continue to rise among older adults.

While many mental health and substance abuse services are available to eligible older adults, many do not actually receive them. Primary care offers many services where the service array falls short, such as medication management. Crisis services are paid for by the state (regardless of insurance status) and therefore covered for all North Carolinians, even with private insurance. As a result of mental health parity through the Affordable Care Act, copays remain at the same cost but higher-level services may not be available. The full mental health service array is offered to patients without insurance through LME/MCOs; medication management and outpatient treatment can be received by some patients through Medicare or private insurance (only 10% of Medicare recipients eligible, and many receive this service via phone).

NC Geriatric Adult Mental Health Specialty Teams (GAST) are small teams (3-5 people) found in every county, consisting of therapists, mental health professionals, and registered nurses. They provide services and education for healthcare workers from community agencies and organizations in providing appropriate services to older adults with mental health and substance abuse issues. They address mental health symptoms, substance abuse, cognitive disorders, medications and side effects of behavioral health conditions. GAST is especially important for communication, crisis prevention, suicide indicators, communication with other HCPs, behavior assessment, understanding LME/MCO system and referrals to services.

However, while GAST is effective for training service providers, the Task Force was interested in learning more about how patients gain access to necessary intensive services.

Screening, Brief Interventions, and Referral to Treatment (SBIRT) is a public health approach to early intervention and treatment currently being implemented for older adults in PCPs, ERs, trauma centers, and community settings. Community Care of North Carolina is conducting an SBIRT pilot using SAMSHA funding. The annual health assessment asked two questions regarding alcohol use and drug use. Task Force members discussed the concern that while the screening indicated serious substance abuse, it is unclear how many patients received intervention services after screening; it was also concerning that the survey was self-reported.

Medicare Advantage covers 30% of Medicare recipients for patients to use HMO networks; many can't receive in-network services, creating a huge access problem for Medicare recipients. Licensed professional counselors and licensed clinical addiction specialists also cannot receive payment from Medicare (can bill "incident to", but only if physician is also present at the time of service). Furthermore, Medicare part A only covers 190 days (lifetime) of mental health services if in a psychiatric hospital, while there exists no limit to the number of benefit periods for mental health care in a general hospital.

Discussion issues included which of the mental health and substance abuse services are available for undocumented immigrants. The discussion centered on the divide between eligibility and access to services/treatment, including for dual-eligible patients for Medicaid and Medicare.

SENIOR SERVICES AND FUNDING

Leslee Breen, Senior Center Development and Transportation Consultant
Division of Aging and Adult Services
North Carolina Department of Health and Human Services

Ms. Breen provided an overview of the Older Americans Act of 1959, particularly Title III, which authorizes grants for state and community programs on aging. This includes support services, senior nutrition, disease prevention, health promotion, and caregiver support programs. These programs are only funded by 0.066 percent of the federal budget – of this, a majority goes to meals and nutrition services. Funding has been dropping since 2010, while the population aged 60 and older continues to grow annually.

Home and Community Care Block Grant (HCCBG) funds are the primary funding source for non-Medicaid based services for older adults. In North Carolina, every county has a Block Grant committee that is responsible for choosing what services will be funded in that county. There are 18 allowable HCCBG services, including key areas such as mental health counseling, care management, and in-home aide. However, these are decided based on local priorities and are often consistently allocated towards the same services annually. All potential

services at competition with each other to be selected for funding by counties as funding shrinks annually.

HCCBG services are administered through NC Division of Aging and Adult Services (DAAS) and Area Agencies on Aging (AAA) and available to adults 60 and older. Discussion centered on the concern that currently over 10 thousand seniors are on the waiting list for Block Grant Services across the state. The North Carolina Initiative bundles federal, state, and local match: 33.5 million is state; 21.5 million is federal; federal funding deviates year-to-year. From all sources combined, the HCCBG is a total of 55 million dollars currently. The North Carolina House and Senate restored $950 thousand to HCCBG this legislative session.

Task Force members discussed how much excess funding might be needed to address the waiting list population, for issues such as nutrition, home-aide, etc. While funding is allocated through the federal, state, and local levels, 3B money without means test could be administered on sliding scale to seniors based on ability to pay out of pocket. It was also mentioned that some agencies are not even making waiting lists out of concern of false expectations of receiving services and need ranking. Other systems are advocating for a new push for reliable waiting list consistency and an inquiry list protocol. Discussion centered on the importance of creative investment in-home services to save dollars and improve efficiency.

Senior Center General Purpose Funds are equally distributed to all recognized senior centers in North Carolina for 163 total centers. Extra shares are allocated to certified centers (Excellence, Merit, Uncertified). This source has provided consistent funding for the last 10 years, around $3 million total. General Purpose Funds are especially appealing as an unrestrictive funding pot for senior centers; however, there are none in Henderson, Hoke, Gates, and Union counties.

Social Services Block Grant is a source of federal funding authorized under Social Security Act, at a capped allocation to each state. Services relevant to the aging population are strictly administered through the Area Agencies on Aging (AAA). Other mandated services through the grant include adjustment services for blind and visually impaired, adoption services, child care services, in-home aide services for blind, family planning services, adult placement services, etc.

State Adult Day Care Funds is a source of state funding for adults aged 18 and older, administered by each county's Department of Social Services. Special Assistance / In-Home (SA/IH) is a program for only Medicaid-eligible patients, also administered by each county's Department of Social Services. This is aimed at preventing unnecessary or premature placement in a nursing home or for residents wishing to move back home.

Adult Day Care is managed on a provider-basis according to their own enrollment and discharge criteria. Likewise, Senior Centers develop their own policies and procedures for eligibility. These programs play a huge role in prevention of mental health issues through social opportunities for older adults.

Discussion by Task Force members centered on examining the ideal continuum of services in the community and finding a lead agency for older adults with behavioral health needs. The Missouri State Plan was suggested as good model for North Carolina to follow with the pressing need for a central accountable department at the state level. The current system provides LME/MCO services for the Medicaid population, while DMH / DAAS is responsible for coordinating services and community level work, though not providing direct services. In North Carolina, the state government is not responsible for providing services, though there exist multiple mental health systems – public, correctional, educational, and private systems.

While early childhood and educational groups meet regularly to communicate between stakeholders, it appears that no such model exists among older adults for mental health and substance abuse. Since 2011, a group called the Mental Health and Substance Abuse Aging Coalition brings together lead agencies, DMH, DAAS, healthcare leaders, academics, deaf and hearing, and the Governor's Task Force on Substance Abuse to address 'low-hanging fruit' issues in older adult population. This coalition hosts workshops on education (funded by KB Reynolds) and a statewide symposium, spearheaded by Ellen Schneider and Mary Edwards. While the group promotes Healthy IDEAS and evidence-based practices, it has not developed a formal list of goals, deficits, or recommendations. They meet four times a year and stress the need to expand. Task Force members discussed the need for a formal collaborative structure from state level. This potential group would need to engage law enforcement, EMS, among other ACO's and health systems as mental health patients are known to often 'clog' the system for these organizations.

In Durham, CCNC is responsible for care coordination in mental health. It was noted that overall, Medicare screening codes are underutilized in primary care. A need for a promotion program was stressed, as some primary care physicians argue that they avoid screening because they do not know about breadth of services offered. On the other hand, many primary care physicians actually do handle mental health on regular basis, as 40% of psychiatrists in North Carolina do not accept Medicare. Task force members emphasized that older adults with long-term relationships with primary care physician are more likely to discuss mental and behavioral health needs; clearly, a need exists to inform and train primary care physicians on screening tools and the breadth of mental health services available.

BEHAVIORAL HEALTH SYSTEM FOR OLDER ADULTS: CURRENT VS. IDEAL

Mary Lynn Piven, PhD, PMHCNS/NP-BC
Clincial Associate Professor
UNC School of Nursing
UNC Chapel Hill

Dr. Piven discussed the issues of a rapidly growing older adult population and the shortage of mental health providers for a foreseeable future. According to The Mental Health and Substance Use for Older Adults: In Whose Hands 2012 report from the Institute of Medicine,

there exists a serious workforce need to address the growing mental health needs of the rapidly increasing older adult population. National initiatives are focused on improving access to home and community services and support, as well as evidence-based chronic care interventions for depression, substance abuse, and dementia. Self-management is also being emphasized as well.

States are enhancing systems to educate and refer to appropriate services for older adults, whether living in the community, in adult care homes, or nursing homes. Key depression management programs include PEARLS in a community care setting, IMPACT in primary care, and Healthy IDEAS, an evidence-based practice for older adults. An ideal system integrates mental health and aging systems and follows patients across their lifetimes. This also requires an increase in the number of trained professionals and non-experts in behavioral health.

BUILDING STATE CAPACITY TO ADDRESS OLDER ADULT MENTAL HEALTH AND SUBSTANCE ABUSE

Ellen Schneider, MBA
Associate Director of Operations and Communications
Center for Health Promotion and Disease Prevention
University of North Carolina at Chapel Hill

Ms. Schneider covered the strategies, programs, and policies currently in place and needed to address older adult mental health needs. Across sectors, collaboration is required from agencies on aging, public health, and mental health. Issues persist across inadequate MH/SA care delivery and an inadequately small geriatric MH/SA workforce. Discussion mentioned the struggles faced by primary care physicians to address behavioral health issues. Questions included whether an actual burden exits on these physicians for screening and what obstacles are at play such as time, reimbursement, or education.

Approaches for providing more accessible high quality mental health care are necessary on all levels of policy: state, local, and organizational. It is especially important to increase state level data on incidence/characteristics, interventions, and outcomes. There exists a need for systematic distribution of information, particularly on working with special populations, addressing stigma, and educating the community on available resources.

DISCUSSION

The issue of expert specialists and reimbursement was discussed, particularly concerns of an unwillingness to accept lower payment for services. Other issues include licensing terms for Medicare, which exclude LPCs. It may be useful to look into APA data on how many MH providers exist and a database from Psychology Today on MH providers accepting Medicare.