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

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Any opinion, finding, conclusion, or recommendations expressed in this publication are those of the task force and do not necessarily reflect the views and policies of the Kate B. Reynolds Charitable Trust or the North Carolina Department of Health and Human Services: Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

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The Task Force was chaired by Senator Angela Bryant North Carolina General Assembly, Courtney Cantrell, PhD, Former Director Division of Mental Health, Developmental Disabilities and Substance Abuse Services, North Carolina Department of Health and Human Services, Representative Josh Dobson North Carolina General Assembly, and John Santopietro, MD, FAPA Chief Clinical Officer of Behavioral Health Carolinas Health System. The Task Force's work would not have been possible without their leadership.

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Executive Summary

Mental health and substance use disorders are among the top conditions for disability and burden of disease, as well as cost to families, employers, and publicly funded health systems in the United States and worldwide.^{1,2} In 2014, approximately one in five adults in North Carolina had a diagnosable mental, behavioral, or emotional disorder and one in twelve adults was dependent on or abusing alcohol or illegal drugs.^{a,3}

Mental health and substance use disorders are chronic or recurrent conditions that, like other chronic illnesses, require ongoing care and treatment for individuals to regain health and maintain recovery. While many people report mental health concerns or low levels of substance use, mental health and substance use disorders are uniquely characterized by ongoing signs and symptoms that impair an individual's ability to relate to others and function in their daily lives.⁴ As with any chronic disease, prevention, identification, treatment, and recovery services and supports are essential to ensuring positive health outcomes. These services, when managed and implemented effectively, can minimize costs to individuals, families, businesses, and governments in the long-run.⁵

Effective treatments for mental health and substance use disorders exist and can help individuals with mental health and substance use disorders live, work, learn, and participate fully in their communities.⁶ Unaddressed mental health and substance use disorders can have a variety of negative influences on homelessness, poverty, employment, safety, and the economy.⁷ In North Carolina, access to services and supports for individuals with mental health and substance use disorders varies based on a number of factors, including insurance coverage, specific type of mental health or substance use disorder, and geographic location.¹²

The prevention, diagnosis, and treatment of mental health and substance use disorders is difficult for several reasons. One reason for such difficulty is that there is no single "system" for mental health and substance use services. The 'system' includes a variety of fragmented providers and services and various agencies that provide funding and oversight. The fragmentation of the mental health and substance use service systems contributes to unnecessary disability, school failure, homelessness, and incarceration.⁷ Fragmentation and disarray are primarily driven by payment policies that create huge disparities in access to high-quality, effective prevention, treatment, and recovery services, lack of integration between mental health and substance use services and physical health services, and the nearly constant changes over the past 15 years to North Carolina's public mental health and substance use system. This fragmentation creates significant systemic barriers to delivering the prevention, treatment, and recovery services that are needed.

Mental health and substance use are at the forefront of health policy issues today, both at the national and state levels, due to rising visibility of the costs of not addressing mental health and substance use treatment needs. In 2015, with funding from the Kate B. Reynolds Charitable Trust, the North Carolina Institute of Medicine (NCIOM), in Partnership with the North Carolina Department of Health and Human Services: Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, convened the Task Force on Mental Health and Substance Use, with the goal of developing recommendations to increase and improve community-based and evidence-informed prevention, treatment, and recovery services and supports for individuals with mental health and substance use disorders. The Task Force had three workgroups: cross-cutting, which considered how to support the development of a full continuum of community-based mental health and substance use prevention, treatment, and recovery services for all North Carolinians, and adolescent and older adult workgroups, which looked specifically at the unique needs of these populations.

The Task Force was co-chaired by Angela Bryant, Senator, North Carolina General Assembly; Courtney Cantrell, PhD, former Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services; Josh Dobson, Representative, North Carolina General Assembly; and John Santopietro, MD, FAPA, Chief Clinical Officer of Behavioral Health, Carolinas Health System. They were joined by 67 other task force and steering committee members including legislators, state and local agency representatives, service providers, advocates, and community representatives. The Task Force met five times and each workgroup met four times between June 2015 and July 2016.

a A diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV). Dependence or abuse is based on definitions found in the DSM-IV as well. Illegal drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.

Strengthening North Carolina's Public Mental Health and Substance Use Prevention, Treatment, and Recovery Services and Supports

North Carolina's public mental health and substance use disorder service system has undergone tremendous and nearly continuous change over the past 15 years. No single agency is in charge of the public system today. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the Division of Medical Assistance, and the North Carolina General Assembly wield the most influence over the public system through service contracts and funding. The North Carolina Department of Health and Human Services has identified a number of concerns and gaps in the current service delivery system including: emergency department overutilization, lack of available inpatient beds, mismatch between available services and individual needs, lack of prevention services, fragmentation, underfunding, and a heavy focus on individuals in crisis.⁸

One challenge that continues to plague the public mental health system for adults is heavy reliance on the highest level of care, inpatient services. There is a need to balance the system with more prevention and other community-based services that can decrease the need for higher levels of care.⁸ System balance cannot happen without additional resources in the short-term, because funding cannot be removed from inpatient services if a comprehensive system of lower intensity services is not in place to keep people out of higher level services. Stability of existing funding as well as additional resources are required to correct imbalances in the current public mental health and substance use services system.⁸ **Recommendation 2.1: Support and Expand Availability of a Full Array of Mental Health and Substance Abuse Services through LME/MCOs.** In addition to needing adequate funding, mental health and substance use funds should be spent on services that have been shown to produce positive outcomes or on actual improved outcomes for individuals with mental health and substance use disorders. **Recommendation 2.6: Increase Utilization of Evidence-Based Mental Health and Substance Use Services and Tie Payment to Positive Health Outcomes.**

Successful treatment and recovery cannot happen if people do not access services. However, most North Carolinians do not understand who provides which services, whether services are covered, or how to access services.⁹ Case management services, which provide a bridge to navigate the multiple systems, can improve quality and decrease expenses.¹⁰ **Recommendation 2.2: Create Medicaid Case Management/Recovery Navigation Options.** Currently, state funding for mental health and substance use treatment services is inadequate to meet the mental health and substance use treatment and recovery needs of the uninsured and underinsured. This leaves many of our most vulnerable residents without the services they need to be healthy, safe, productive members of our communities. **Recommendation 2.5: Expand Access to Mental Health and Substance Use Services.**

One of the barriers to improving the delivery of mental health and substance use services is the underutilization of data.¹¹ Cross-agency data sharing is critical to understanding the complex needs of the individuals and families served by these systems and to assess the effectiveness of services provided. To do this well, the state needs to establish metrics and common data points that are tracked across systems in order to assess patient mental health and substance use treatment outcomes. **Recommendation 2.3: Require North Carolina Agencies to Share Data Cross-Agency.** In order to fully understand the gaps and needs in North Carolina's mental health and substance use systems, LME/MCOs should collect and analyze data by age, race/ethnicity, diagnosis, and other factors. **Recommendation 2.4: Assess and Address Disparities in the LME/MCO System.**

Few Understand the Complex Mental Health System

Many people try to access services, but have difficulties navigating the systems, finding a provider who will treat them, or getting a diagnosis and treatment plan. For any system to work, the intended beneficiaries must understand it, however, North Carolina's complex mental health system is not well understood. For these and other reasons, more than half of North Carolinians with mental health and substance use disorders do not receive treatment.¹³ Ongoing education of consumers, providers, and other stakeholders is needed to improve understanding and access.

Recommendation 3.1: Educate Communities on Available Mental Health and Substance Use Services

Recommendation 3.2: Develop a Common Access Point for the Mental Health and Substance Use Prevention, Treatment, and Recovery System

Recommendation 3.3: Increase Number of North Carolinians Trained in Mental Health First Aid

Recommendation 3.4: Involve Consumers and Local Communities in the LME/MCO Service Gaps Improvement Process

Support Collaboration to Meet Mental Health and Substance Use Needs of Consumers and Communities

North Carolina has developed a range of services to meet the needs of individuals experiencing mental health and substance use crisis. In many communities, services are available, but there are not strong collaborative relationships between the key stakeholders in the crisis response system.¹⁴ For crisis services to work best, law enforcement, emergency medical services, crisis response providers, local hospitals, and other providers must work together. **Recommendation 3.5: Support and Encourage Crisis Response Stakeholders to Collaborate** and **Recommendation 3.6 Develop New Payment Models to Support Community Paramedicine Programs with Mental Health and Substance Use Crisis Response.**

A robust, diverse work force is necessary to meet the mental health and substance use needs of North Carolinians. There is a need for an infrastructure to support and improve the consistency and quality of mental health and substance use services statewide, to retain qualified staff, and to sustain evidence-informed practices. **Recommendation 3.7: Strengthen Training and Work Force Development** and **Recommendation 3.8: Develop More Robust Transition to Practice System for Mental Health and Substance Use Professionals.**

Better Coordination Needed Between Mental Health and Primary Health Care

Mental health and physical health are not separate, but they are often treated as such within the medical community. Integrated care has gained prominence across the country and in North Carolina as a health care delivery model that addresses both individuals' physical and mental health needs. Integrated care is one way to provide the prevention, early detection, brief intervention, and, when needed, timely referral to mental health and substance use treatment services that are needed to reduce cost and improve outcomes.¹⁵ However, transforming practices from traditional medical/mental health and substance use practices into integrated care practices often requires substantial technical assistance. **Recommendation 3.9: Support Practice and System Transformation towards Integrated Care.**

Technology Can Improve Access to Mental Health and Substance Use Services

There is a shortage of mental health and substance use professionals in many parts of North Carolina, which restricts consumer access to services in those areas. One way to mitigate the shortage of mental health and substance use professionals in rural areas is to provide services for individuals with mental health and substance use disorders remotely using technology. **Recommendation 3.10: Update DMA's Telepsych Policy** and **Recommendation 3.11: Maintain Adequate Funding for the NC STeP Program** and **Recommendation 3.12: Standardize Credentialing Across Systems.**

Mental Health and Substance Use during Adolescence

Mental health and substance use disorders are the most significant threat to the lifelong health and well-being of youth.¹⁶ Approximately one in five adolescents has a diagnosable mental health or substance use disorder, that, if left untreated, will likely persist into adulthood and contribute to poor lifelong education, employment, and health outcomes.¹⁷ Youth with mental health and substance use disorders are often involved in more than one special service system, including mental health, special education, child welfare, juvenile justice, and health care.¹⁶ Prevention and early intervention are particularly important among adolescents, as are follow-up care and recovery supports after treatment. Ensuring a full continuum of care for adolescents can result in substantially shorter and less disabling experiences with mental health and substance use disorders and create a more positive health trajectory into adulthood.¹⁶

Many youth with mental health and substance use disorders have experienced trauma, including child maltreatment and family dysfunction. Unaddressed trauma increases an individual's risk of developing mental health and substance use disorders, as well as heart disease, obesity, lung disease, diabetes, and other conditions in adulthood.²¹ Identifying and addressing trauma can help improve outcomes for children and youth, including minimizing the likelihood of developing mental health and substance use disorders. **Recommendation 4.5: Support the Implementation of Trauma-Informed Child and Family Serving Systems across North Carolina Counties**

There is a need for better coordination and cross-system collaboration at the local systems level to ensure that information, policies, procedures, and funding are better coordinated to meet the needs of youth and families. At the state and community level, North Carolina uses the System of Care (SOC) framework to bring together child-serving systems to provide care to individual children with mental health needs (and their families). SOC is supported at the local level by Community Collaboratives, which serve as a forum at the local county/regional level for child-serving systems to design protocols and coordinate policy to improve service coordination for special populations, including multi-agency involved children with behavioral health needs. LME/MCOs, as the mental health and substance use service provider for more than half of all children, are well-positioned to lead local cross-systems collaboration efforts.¹⁸ **Recommendation 4.1: LME/MCOs Should Act as Lead Player in Cross-System Collaboration** and **Recommendation 4.2: Support and Further Develop Local System of Care Community Collaboratives.**

The majority of mental health and substance use disorders among adolescents go unrecognized or untreated. If they access services, youth with mental health and substance use disorders are most likely to do so through schools and health care settings.¹⁹ School personnel, in particular, are in a key position to identify youth with mental health and substance use problems and may determine whether an adolescent is identified as needing mental health and substance use services or is identified as having behavioral problems that should be handled through discipline and juvenile justice involvement. Raising awareness of youth mental health and substance use and teaching skills to handle various behaviors can increase school personnel's ability to identify and respond in constructive ways. **Recommendation 4.3: Educate School Personnel on the Behavioral Health Needs of Adolescents.** School districts across the state have increased access to needed services for students with mental health and substance use need through partnering with local LME/MCO and provider communities to bring services into schools. **Recommendation 4.4: Encourage Partnerships between Schools and LME/MCOs.** In addition to more prevention and treatment options for youth changes to Medicaid policy are needed to meet the needs of youth with serious emotional disturbance. **Recommendation 4.6: Submit Medicaid Waiver to Best Serve Youth with Serious Emotional Disturbance**

Mental Health and Substance Use Among Older Adults

Older adult mental health and substance use disorders are not currently at the forefront of public health issues, but the rapidly increasing size of the older adult population indicates the need to address mental health and substance use issues preemptively.²³ Older adults (65 and older) are a particularly complicated population regarding mental health and substance use prevention, treatment, and recovery. Depression, anxiety, alcohol, and psychoactive medication misuse are the most common types of mental health and substance use disorders among older adults.²² While there are effective prevention, treatment, and recovery services and supports for older adults, older adults are significantly less likely to be diagnosed and referred to treatment than younger adults.²² Older adults face additional challenges as well: difficulties understanding available Medicare coverage and what providers can bill for which services, too few providers contracting with traditional Medicare or Medicare Advantage/Replacement plans, and the prevalence of co-morbid conditions. Further complicating these challenges, there is no state agency tasked with ensuring this population's mental health and substance use prevention, treatment, and recovery needs are met. **Recommendation 5.1: Establish Statewide Coordinated Leadership to Oversee Older Adult Health Medicare.** In North Carolina, Geriatric Adult Mental Health Specialty Teams (GASTs) are funded by the state to provide training and consultation to people working in community organizations that provide services and support to older adults with mental health and substance use needs. Historically, GAST focused primarily on adult care homes, family care homes, and nursing home settings. However, GAST teams could also be used to train other community organizations that work with older adults. **Recommendation 5.3: Use GAST Teams to Train Communities on Issues of Older Adult Mental Health.**

Most older adults are eligible to enroll in Medicare when they turn 65.^b Unlike Medicaid, the state does not have any control over the rules and regulations of Medicare.^c Individuals enrolled in Medicare can select traditional Medicare or choose from a number of Medicare Advantage Plans. The Seniors Health Insurance Information Program (SHIIP),^d part of the North Carolina Department of Insurance's Consumer Services

^b Medicare is also available to adults over 18 with permanent disabilities, end stage renal disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

^c Federal law dictates the rules and regulations of Medicare, and the program is administered and paid for by the Centers for Medicare and Medicaid Services.

^d SHIP national program, SHIIP in the state

Group, provides assistance to Medicare beneficiaries in understanding their choices of insurance products and services available, a service referred to as navigation insurance assistance. Without navigation insurance assistance, many seniors stay in ill-fitting plans, overpay for their benefits and do not receive the coverage they need. **Recommendation 5.2: Increase Support for SHIP Program.**

Older adults are less likely to seek specialty care to address mental health and substance use disorders because they may already have a long term relationship with their primary care doctors, fear perceived stigma, face transportation challenges, and/or be unable to find providers with experience treating older adults who accept Medicare.²⁴ Additionally, mental health and substance use concerns are often under-identified by health professionals and older adults themselves.²⁵ For these reasons, integrated care is particularly well-suited to older adults. **Recommendation 5.4: Improve Capacity of Primary Care Practices to Screen, Treat, and Refer Older Adults to Treatment for Behavioral Health Needs.** Furthermore, older adults with mental health and substance use disorders often have additional, co-occurring chronic health conditions. Care management, which involves assessing a patient's needs, developing a care plan, and ensuring care is provided, can help individuals with co-occurring conditions manage their health conditions and reduce overall costs.²³ As of January 1, 2015, Medicare reimburses for non-face-to-face chronic care management (CCM) services furnished to Medicare fee-for-service beneficiaries with multiple chronic conditions.²⁶ Although the CCM code exists, few practitioners are providing care coordination services under this code. **Recommendation 5.5: Increase Care Management Services for Older Adults.**

Increasing Workforce Trained to Provide Mental Health and Substance Use Treatment to Older Adults

Many private practice behavioral health providers do not accept Medicare payment.²⁷ Barriers include the privatization of Medicare through Medicare Advantage plans, anxiety regarding audits, and confusion regarding the new and evolving Merit-based Incentive Payment Systems (MIPS) and Alternative Payment Models.²⁷ In addition to shortages of enrolled providers, Medicare-enrolled mental health and substance use treatment providers are underutilizing both available codes and helpful Medicare outpatient services. The barriers for mental health professionals accepting Medicare patients could be ameliorated with education on how to best file claims, reduce audit anxiety, and bill under health and behavior services codes (which can be used by a wider variety of providers), and availability of outpatient services for Medicare beneficiaries. **Recommendation 5.6: Increase Number of Eligible Behavioral Health Care Providers Billing Medicare**

These recommendations, if implemented, would move the state towards the Task Force's vision of North Carolina continuing to build upon current infrastructure to create an accessible, community-based, flexible system of mental health and substance use treatment services that produces positive outcomes for North Carolinians through a full range of services, provided in a timely manner, at the most appropriate level of care.

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Chapter One: Introduction

Mental health and substance use disorders are among the top conditions for disability and burden of disease, as well as cost to families, employers, and publicly funded health systems in the United States and worldwide.^{1,2} In the spring of 2016, North Carolina’s Governor issued an executive order declaring, “mental illness and substance use disorders are among the biggest health care challenges that our state will face over the next decade.”^a In North Carolina, and across the nation, the means of providing mental health and substance use treatment have undergone tremendous changes over the past 50 years, as the focus has shifted away from institutionalization and towards community-based services and supports. Today, effective prevention, treatment, and recovery are the foundation of publicly funded efforts to ensure that all individuals with mental health and substance use disorders are able to live, work, learn, and participate fully in their communities. Although improvements have led to many more people being able to access services in their communities, the systems remain fragmented, disconnected, and inadequate for many North Carolinians in need of mental health and substance use prevention, treatment, and recovery services and supports. There are many challenges to fully meeting the mental health and substance use needs of North Carolina’s residents, including:

- wide variance in access to services and supports based on insurance status, geographic location, and age;
- long wait times for in-patient mental health care, which leads to extended stays in emergency departments for individuals with mental health and substance use needs;³
- dramatic increases in the percentage of court-involved individuals and inmates in state prisons with mental health and substance use disorders;⁴ and
- the exponential increase in the abuse of opioids, pain medications, and heroin over the past 15 years.⁵

These problems have varied causes, including payment policies that create huge disparities in access to high-quality, effective prevention, treatment, and recovery services, the lack of integration between mental health and substance use services and physical health services, and the move from institutional to community-based care, but the failure to develop a full continuum of services accessible to all North Carolinians is at the root of these problems.

Background

In 2014, approximately one in five adults in North Carolina reported having a diagnosable mental, behavioral, or emotional disorder over the past year and one in twelve adults was dependent on or abusing alcohol or illegal drugs.^{b,6} While many people report mental health concerns or low levels of substance use, mental health and substance use disorders are uniquely characterized by ongoing signs and symptoms that impair an individual’s ability to relate to others and function in their daily lives.⁷

Mental health disorders are defined as any diagnosable mental, behavioral, or emotional disorder, other than a developmental and substance use disorder, that meets DSM-V^c criteria. Mental health disorders involve changes in thinking, mood, and/or behavior and can affect how individuals relate to others and make choices.⁸ Mental health disorders may include anxiety, changes in mood, intrusive thoughts, or reduced ability to manage behaviors at levels that reduce an individual’s ability to relate to others and function in their daily life.

a Executive Order No. 76, The Governor’s Task Force on Mental Health and Substance Use. July 14, 2015. <http://governor.nc.gov/document/executive-order-no-76-governors-task-force-mental-health-and-substance-use>

b A diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSS-SCID), which is based on the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Three categories of mental illness severity are defined based on the level of functional impairment: mild mental illness, moderate mental illness, and serious mental illness. This data includes individuals in any of the three categories. Dependence or abuse is based on definitions found in the DSM-IV as well. Illegal drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.

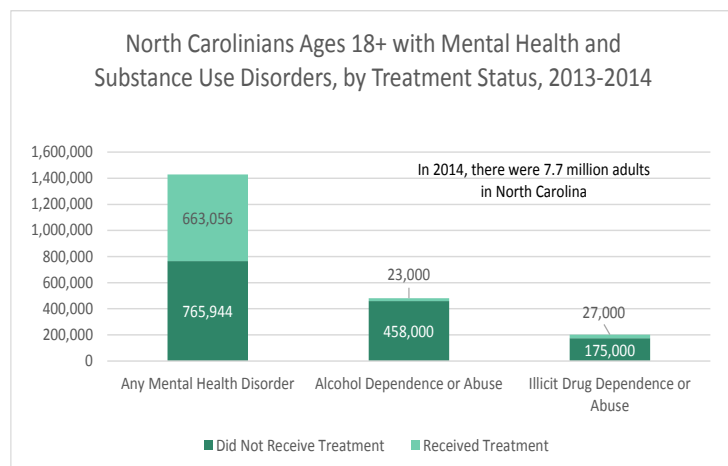
c The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, offers a common language and standard criteria for the classification of mental disorders and is used by mental health professionals in the United States. The DSM is updated periodically, the DSM-V is the most recent version, so the version used is specified.

Substance use disorders are measured on a continuum from mild to severe use of alcohol or illicit drugs including marijuana, cocaine, heroin, other stimulants, opioids, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically. Although some substances are patently illegal, others are illegal only for certain age groups (e.g., alcohol and tobacco), while others are legal per se but are misused (e.g., prescription drugs). For the purposes of this report, “substances” will be the generic term used to describe drugs and alcohol. The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.

There are many causes of mental health and substance use disorders. Research suggests that mental health and substance use disorders are the result of the interplay of numerous genetic, biological, psychological, and environmental factors.⁴ Many mental health disorders emerge during childhood or adolescence, although they can emerge at any point. Some mental health disorders may be precipitated in response to disruptive life events, but most mental health and substance use disorders are chronic or recurrent conditions that, like chronic physical illnesses, require ongoing care and treatment. Although substance use disorders are triggered by the use of substances, there are predisposing genetic and environmental factors that can make some people more susceptible than others. Genetics accounts for approximately one-half of the likelihood that an individual will develop a reliance on substances, a finding similar to other chronic illnesses.⁹

Although many North Carolinians have mental health and substance use disorders, the vast majority do not receive treatment.^{6,10} Mental health and substance use are important public health issues that can have lasting negative impacts on individuals, families, public health care systems, and communities if left unaddressed.

Table 2.1 More than Half of Adults in North Carolina with Mental Health and Substance Use Disorders Do Not Receive Treatment



Source: Substance Abuse and Mental Health Administration, Center for Behavioral Health Statistics and Quality. National Survey on Drug Use and Health 2013 and 2014, Table 77. Rockville, MD: Substance Abuse and Mental Health Administration; 2015. <http://www.samhsa.gov/data/sites/default/files/1/1/NSDUHsaeNorthCarolina2014.pdf>. Accessed July 12, 2016.

The prevention, diagnosis, and treatment of mental health and substance use disorders is difficult for several reasons. Many individuals with mental health and substance use disorders may not recognize that they have a problem. Similarly, many of those who know they have a problem do not seek treatment or they may not have access to affordable treatment.^{6,10,11} Enduring stigmas, negative stereotypes, and prejudice that result from misconceptions about mental illness create barriers to accessing and receiving treatment. Unlike pathways to treatment for physical health concerns, many people do not know how to find appropriate care for mental health and substance use disorders.¹² In North Carolina, the system for accessing mental health and substance use treatment services varies widely based on payment source, age, and geography. The challenges of navigating the systems of mental health and substance use treatment are a huge impediment to care. All of these factors can delay or prevent appropriate care.

Mental health and substance use disorders together carry huge direct and indirect costs to individuals, families, and communities. In addition to the direct costs of prevention, treatment, and recovery supports, there are also indirect costs associated with motor vehicle accidents; premature death; comorbid health conditions; disability and lost productivity; unemployment; poverty; school difficulties; engagement with social service, juvenile justice, and criminal justice systems; homelessness; and a host of other problems. Mental health and substance use disorders together rank as the fourth most costly medical conditions in terms of overall health care expenditure after heart conditions, cancer, and traumatic injury.¹³ Over \$300 billion annually is spent on the direct and indirect financial costs associated with mental health disorders in the United States,¹⁴ while substance use disorders are estimated to cost Americans more than \$600 billion each year.¹⁵ Mental health and substance use disorders are the leading cause of disability in the United States.²

A variety of serious chronic diseases commonly co-occur with mental health and substance use disorders, including diabetes, cardiovascular disease, and cancer. While research continues in the area of understanding

comorbidity, it is known that certain mental health disorders are established risk factors for subsequent substance abuse and contribute to other illness.^{10,16} Similarly, having a chronic disease can be a risk factor for mental health and substance use disorders. Furthermore, mental health and substance use disorders both serve as near universal conditions associated with suicide.¹⁰

Adolescent Mental Health and Substance Use

Mental health and substance use are especially important to address among the adolescent population (defined as ages 12-17 for the purposes of this report), as research shows that brain development and maturation is incomplete during this period and that exposure to substances can cause long-term changes in brain function and a greater likelihood of developing an addiction disorder.¹⁷ Approximately one in nine adolescents in North Carolina experienced a major depressive episode^d in the past year and one in twenty adolescents was dependent on or abusing alcohol or illegal drugs. Similar to adults, most adolescents who have mental health and substance use disorders do not receive treatment.⁶

Older Adult Mental Health and Substance Use

Mental health and substance use disorders affect approximately one in five of North Carolina's 1.5 million older adults (ages 65 and older for the purposes of this report).¹⁸ Depressive and cognitive disorders and symptoms are most common, but substance use is a significant problem as well.¹⁸ The mental health and substance use needs of older adults vary considerably from younger populations, largely because they typically occur along with other health problems. More than 75% of older adults in North Carolina report having one or more chronic diseases.¹⁹ Commonly used medications may worsen mental health disorders and may be dangerous or even deadly when mixed with alcohol and other substance use.^{18,20} Additionally, age alters the way people metabolize alcohol and drugs; for example, older adults tend to have a higher sensitivity to alcohol.²⁰ Furthermore, challenges that often come with age, such as loneliness, poor physical health, and diminished mobility can contribute to mental health and/or substance use disorders.¹⁸ Mental health and substance use disorders among older adults are often not identified, diagnosed, or treated.¹⁸

Mental Health and Substance Use in the Spotlight

These issues are at the forefront of health policy issues today, both at the national and state levels, due to rising visibility of the costs of not addressing mental health and substance use treatment needs. Health care coverage of mental health and substance use treatment has been expanded in recent years under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Patient Protection and Affordable Care Act in 2010. Both laws addressed existing disparities between insurance coverage for physical medical and surgical benefits versus mental health and substance use treatment coverage. Within the last year, President Barack Obama called for the U.S. Department of Health and Human Services and the U.S. Department of Education to launch a national conversation on mental health to reduce the stigma associated with mental illness and to encourage afflicted individuals to seek resources and treatment. Unaddressed mental health issues can have a variety of negative influences on homelessness, poverty, employment, safety, and the economy.¹²

Shortly after the North Carolina Institute of Medicine Task Force on Mental Health and Substance Abuse was convened, the Governor of North Carolina convened a Task Force on Mental Health and Substance Use that focused on the "improvement of the mental health and substance use treatment system as it intersects with the criminal justice system."^e The Governor's Task Force had work groups on opioid abuse and heroin resurgence, as well as special topics on adults, children, youth, and families. Among other topics, the Governor's Task Force focused heavily on opioid and prescription drug use, the courts and criminal justice system, and the impact of mental health and substance use on emergency departments and hospitals. The Governor's Task Force has generated a lot of attention from state government and the press about the impact of mental health and substance use disorders in North Carolina.

The North Carolina Institute of Medicine Task Force on Mental Health and Substance Use

The North Carolina Institute of Medicine (NCIOM) Task Force on Mental Health and Substance Use was funded by the Kate B. Reynolds Charitable Trust, with the goal of developing recommendations to increase and improve community-based and evidence-informed prevention, treatment, and recovery services and

^d Major depressive episode is defined in the DSM-IV as a period of at least two weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms.

^e Executive Order No. 76, The Governor's Task Force on Mental Health and Substance Use. July 14, 2015. <http://governor.nc.gov/document/executive-order-no-76-governors-task-force-mental-health-and-substance-use>

supports for individuals with mental health and substance use disorders. The Task Force focused heavily on recommendations to support the development of a full continuum of community-based mental health and substance use prevention, treatment, and recovery services for all North Carolinians, as these services are essential to keeping people healthy in their home communities and assisting people who are transitioning back into the community after a crisis or in-patient treatment.

The Task Force was divided into three groups: the cross-cutting work group, the older adult work group, and the adolescent work group. The cross-cutting work group addressed topics affecting the whole population, including the array of services available, workforce needs, integrated care, and telebehavioral health. The adolescent working group addressed coordination and system transition issues among the many agencies and organizations that provide services to adolescents. The older adult working group looked at the need to develop a continuum of services for the older adult population.

The Task Force was co-chaired by Angela Bryant, Senator, North Carolina General Assembly; Courtney Cantrell, PhD, former Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services; Josh Dobson, Representative, North Carolina General Assembly; and John Santopietro, MD, FAPA, Chief Clinical Officer of Behavioral Health, Carolinas Health System. They were joined by 67 other task force and steering committee members including legislators, state and local agency representatives, service providers, advocates, and community representatives. The Task Force met five times and each work group met four times between June 2015 and July 2016.

While there are numerous potential areas of focus within North Carolina's mental health and substance use treatment systems, the NCIOM Task Force on Mental Health and Substance Use chose to focus on improving access to and coordination of community-based, evidence-informed prevention, treatment, and recovery services and supports for individuals with mental health and substance use disorders services. In the following chapters, recommendations are presented for the systems providing mental health and substance use services, starting with those around payment, then those that affect all North Carolinians with mental health and substance use disorders, followed by recommendations specifically for adolescents and older adults.

The Task Force made 28 recommendations, which are summarized in the Executive Summary. Chapter 2 provides background information and recommendations on the systems and payers for mental health and substance use services in North Carolina. Chapter 3 covers recommendations that affect all North Carolinians' ability to access effective treatments and services that are easy to navigate. Chapter 4 explores issues affecting adolescents with mental health and substance use disorders. and Chapter 5 looks at issues affecting older adults with mental health and substance use disorders. A full listing of the recommendations is included in the Appendix.

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Chapter Two: Overview of Prevention, Treatment, and Recovery Systems

Effective treatments for mental health and substance use disorders can help individuals with mental health and substance use disorders live, work, learn, and participate fully in their communities.¹ These services, when managed and implemented effectively, can minimize long-term costs to individuals, families, businesses, and governments.² Effective prevention, treatment, and recovery are the foundation of today's publicly funded mental health and substance use system. However for many North Carolinians, mental health and substance use services remain fragmented, disconnected, and often inadequate. The fragmentation of the mental health and substance use service systems contributes to unnecessary and avoidable disability, school failure, homelessness, and incarceration.² Fragmentation and disarray are primarily driven by payment policies that create huge disparities in access to high-quality and effective prevention, treatment, and recovery services; lack of integration between mental health services, substance use services, and physical health services; and the nearly constant changes over the past 15 years to North Carolina's public mental health and substance use system. Access to services and supports for individuals with mental health and substance use disorders also varies based on other factors, including specific type of mental health or substance use disorder, geographic location, and age. This chapter reviews North Carolina's mental health and substance use prevention, treatment, and recovery systems and payers and includes recommendations from the Task Force to improve access to effective, high-quality services.

Prevention, Treatment, and Recovery

Ongoing care and treatment are required for individuals to regain health and maintain recovery from mental health and substance use disorders. Although some mental disorders may be precipitated in response to disruptive life events, most mental health and substance use disorders are chronic or recurrent conditions that, like other chronic illnesses, require ongoing care and treatment. As with any chronic disease, prevention, identification, treatment, and recovery services and supports are essential to ensuring positive health outcomes. Therapy, medication, behavior change, and other treatments can often lead to great improvements in symptoms, however the underlying mental health and substance use disorders are still present and may persist to varying degrees over an individual's lifespan.

The prevention, diagnosis, and treatment of mental health and substance abuse disorders are difficult for several reasons. One reason for such difficulty is that **there is no single system for mental health and substance use services.** The "system" includes a variety of fragmented providers and services and various agencies that provide funding and oversight. Payment for mental health and substance use treatment services comes from federal, state, and local agencies including the Centers for Medicare and Medicaid Services; the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the Division of Medical Assistance; the Division of Social Services; state and federal criminal justice systems; private insurance companies; school systems; housing agencies; and others.³ Each funding source has its own objectives, requirements, and restrictions. This creates a financing approach to mental health and substance use treatment that is complex, fragmented, and inconsistent in coverage.² The result is not a system, but rather a fragmented set of financing mechanisms and service providers. **This fragmentation creates significant systemic barriers to delivering needed prevention, treatment, and recovery services.**

In addition to the systemic barriers to accessing effective treatment, many individuals do not recognize that they have a mental health or substance use disorder, do not seek treatment, or do not have access to affordable and/or evidence-based treatment. Common reasons for not seeking needed mental health and substance use treatment include (listed in order of most common to least common): could not afford the cost of treatment, did not know where to go for services, thought they could handle the problem without treatment, did not have time, belief that treatment would not help, might cause others to have a negative opinion, fears/concerns about diagnosis and confidentiality, and health insurance did not cover treatment.⁴ Enduring stigmas, negative stereotypes, and prejudice that result from misconceptions about mental illness, also create barriers to accessing and receiving treatment. Many people try to access services, but have difficulties navigating the systems, finding a provider who will treat them, or getting a diagnosis and treatment plan. For these and other reasons, more than half of North Carolinians with mental health and substance use disorders do not receive treatment.⁵ This gap in service unnecessarily jeopardizes the health and wellness of individuals and causes a ripple effect in costs. Prevention, treatment, and recovery support services for mental health and substance abuse are essential to ensuring positive health outcomes.

Mental Health and Substance Use Treatment Systems in North Carolina

State efforts that ensure appropriate and evidence-based education, prevention, treatment, and recovery resources can minimize the negative outcomes associated with mental health and substance use disorders and improve the quality of life for individuals and communities statewide. However, this is challenging in North Carolina because the state does not have a single coordinated system aimed at providing comprehensive services and supports to those with mental health and substance use disorders. Instead, there is a public system for addressing the mental health and substance use needs of people with Medicaid and, to a limited extent, those who are uninsured or whose insurance will not cover treatment. Medicare beneficiaries and those with private insurance largely receive care outside of the public system in a system that is more fragmented, may have fewer available resources, and typically include a more limited array of services and supports. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has limited state funding to meet the needs of individuals with mental health and substance use disorders who require assistance with housing and employment. The state and local agencies that address housing, education, and employment operate independently and do not routinely coordinate with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or their local LME/MCO.

To understand the challenges confronting North Carolina's current behavioral health delivery system, it is important to understand the history of behavioral health in the state.

History of Mental Health and Substance Use Disorder Treatment

Throughout the first half of the 20th century, individuals with mental health disorders were typically cared for in state-operated institutions with care paid for by state and local governments. However, by the 1950s and 1960s, a confluence of factors all fueled a national movement towards deinstitutionalization. These factors included rising costs, a growing patient advocacy movement, growing awareness of the poor living conditions and treatment of individuals in state institutions, the development of new and more effective psychiatric medications, and a belief that better and more cost-effective treatment could be provided through community-based services.⁶

Federal policy was a significant driver of deinstitutionalization. In the 1960s, support for community-based treatment and recovery services to prevent or reduce prolonged institutional confinement was prioritized as an alternative to institutionalization through federal legislation. With the creation of Medicare and Medicaid^a and disability programs,^b as well as funding through the 1963 Mental Retardation Facilities and Community Mental Health Centers Construction Act,^c North Carolina and the nation began to rapidly shift away from institutional care towards community-based care. These new federal laws and programs all favored community-based treatment over state mental institutions.

Throughout the 1970s and 1980s, courts also handed down legal decisions that limited the ability to institutionalize individuals and set minimum requirements for care in institutions.⁷ The move towards community-based services was further accelerated following the U.S. Supreme Court's decision in the 1999 case *Olmstead vs. L.C.*, which held that segregation of persons with mental disabilities in institutional settings constituted discrimination under the Americans with Disabilities Act. The ruling effectively required states to provide services for patients with mental disabilities in community-based settings rather than institutions.

While many people with mental health and substance use disorders successfully transitioned from institutional care to community-based treatment and recovery, it is important to recognize the challenges of these transitions. Many individuals with mental health and substance use disorders remain unserved or underserved, and some end up in jail or homeless.^{2,3} The array of services needed to successfully support individuals with mental health and substance use disorders living in community settings is much broader than what was anticipated 60 years ago. In addition to the need for funding to support treatment and recovery services, other supports are needed, such as housing, education, and employment. Just as state mental institutions were plagued by a lack of resources, **comprehensive funding for community-based mental health and substance use services has never been achieved.** Today, funding for community-based mental health services remains a patchwork of funding sources including federal Medicaid dollars, state funds, health insurance programs with limited coverage for mental health and substance abuse, federal block grant dollars, and a

a Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act of 1965 (P.L. 89-97)

b Starting with the 1956 Amendments to the Social Security Act. (P.L. 84-880)

c Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 U.S.C. Public Law 88-164, 77 STAT

variety of smaller funding streams which are not easily coordinated.⁸ This has led to fragmented systems that struggle to provide comprehensive and coordinated services.⁹

Funding for Mental Health and Substance Use Prevention Treatment and Recovery Services and Supports

Historically, funding for mental health and substance use coverage has been more limited than that for other medical benefits. This is true across all payers.² Health care coverage of mental health and substance use treatment under private insurance has been expanded in recent years under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Patient Protection and Affordable Care Act in 2010. Both laws addressed existing disparities between insurance coverage for medical and surgical benefits versus mental health and substance use treatment coverage. Although mental health and substance use coverage parity are now required of most health insurance plans, full parity has not yet been achieved. Among private insurance plans, the most common violations are insufficient benefits, higher financial requirements, more restrictive visit limits, prior authorization requirements, and lower annual dollar limits on benefits.¹⁰

The type of insurance coverage an individual has significantly influences their access to mental health and substance use prevention, treatment, and recovery services. Individuals with Medicaid have better access to a wide range of services (outpatient, enhanced, and inpatient) than those with private or no insurance, but experience higher rates of structural barriers such as transportation or employment requirements.¹¹ Individuals with private insurance may have access to transportation and be adequately employed, but they often have less access to services such as enhanced care, which includes higher levels of treatment that can be critical for a successful recovery. Additionally, many individuals with private insurance have high co-pays and deductibles, which can limit their access to services.¹² Increasingly, these individuals, often referred to as underinsured, are turning to their LME/MCO systems for assistance in receiving needed care. These funding concerns can be addressed in parallel by recognizing the barriers and challenges for each group, identifying alternative funding for those in need of care who are underinsured, and creating mechanisms to fund cross-system collaborations that have worked in the past.

North Carolina's Community-Based System to Address the Mental Health and Substance Use Needs of the Population

Before considering how to improve services and supports for individuals with mental health and substance use disorders, it is important to understand the evolution and current state of our publicly funded mental health and substance abuse system, including history, recent reform, and—most critically—future challenges.

In 1977, the North Carolina General Assembly mandated the establishment of local government area authorities at the county level to manage publicly-funded community-based behavioral health services for community members enrolled in Medicaid or who lacked insurance coverage.¹³ Area authorities were responsible for the delivery of publicly-funded, community-based services either directly or using contracted services. The shift away from institutional care towards community-based care has dramatically changed the provision of services for individuals with mental health and substance use disorders. In North Carolina, this shift has contributed to a 10-fold increase in the number of people served by the public system, from just over 30,000 in FY 1961 to almost 350,000 in FY 2013.¹⁴ In addition to greatly increasing the number of individuals served, the types of services provided has significantly increased. Thirty years ago, North Carolinians with mental health and substance use disorders who were also enrolled in Medicaid received outpatient therapy and hospital services. Today there is a full array of enhanced services which includes mobile crisis management, community treatment teams, intensive in-home services, day treatment, partial hospitalization, intensive outpatient programs, community residential treatment, detoxification, and more.¹¹

Today, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) oversees the administration of publicly-funded care provided to people with mental health, developmental disabilities, and substance abuse needs who are enrolled in Medicaid, uninsured, or underinsured. However, the Division of Medical Assistance provides oversight of the funds spent on services and supports for the Medicaid population, or approximately 80% of the funding for the public mental health and substance use system. This includes the provision of prevention, intervention, and treatment services and supports to children and adults who qualify for services.

Eligibility for services depends on age, diagnosed condition, types of service, income, and other conditions. Services are also offered through, or in collaboration with, the Division of Social Services, the Division of Public Health, the Department of Public Safety, the Administrative Office of the Courts, the Division of Motor Vehicles, the Department of Corrections, the Department of Public Instruction, the North Carolina

Community College System, and the University of North Carolina System.

In the past 15 years, North Carolina has undergone an overhaul of its publicly funded mental health, developmental disabilities, and substance abuse services system from a fee-for-service system to a managed care system. In addition to the impact of the Olmstead case, in 1998, North Carolina's General Assembly asked for a study of the state's mental health delivery system. The resulting state audit proposed major changes in the local level governance and structure of the mental health, substance abuse, and developmental disability systems, as well as a number of operating changes at the state level.¹⁵ In response, the General Assembly passed the 2001 Act to Phase in Implementation of Mental Health System Reform at the State and Local Level,^d which promoted deinstitutionalization and privatized clinical treatment services. Prior to this legislation, local area authorities had managed funding and provided services directly to clients. In 2001, the local area authorities' mission began to change to managing, monitoring, and paying for services by contracted providers. This change in function of area authorities to LMEs, officially codified in 2006, was part of a shift to a managed care system for North Carolina's MH/DD/SAS service system.^e

The move toward managed care has also been driven by changes in funding. Over the past 25 years, Medicaid has gone from the smallest funder of MH/DD/SAS services to the largest (80%).¹⁴ As state legislators looked for ways to contain rising Medicaid costs, MH/DD/SAS managed care became appealing. From 2005-2009, Piedmont Behavioral Healthcare implemented a successful demonstration project of MH/DD/SAS managed care, through a 1915 (b)/(c) Medicaid waiver. This model, passed by the General Assembly in 2011^f under the 1915(b)/(c) Managed Care Waiver law, holds LMEs responsible for controlling quality and cost of public behavioral health services. Through the federal Medicaid waiver, the earlier fee-for-service model was replaced with a capitated model, where the state covers a standard monthly fee for each consumer served. Today, LME/MCOs are private companies that receive a set monthly payment from the state, which comes from state and Medicaid funding, to provide mental health, intellectual and developmental disability and substance abuse services for individuals in their service areas who are enrolled in Medicaid or who are uninsured and qualify as a member of a priority populations (See Table 2.1). LME/MCOs do this by contracting with private providers in the community. These changes have led to the consolidation of LMEs to form MCOs across the state. Since 2001, consolidation has resulted in 39 area mental health authorities becoming 23 LMEs, which then became 11, today 7, and soon to be 4 LME/MCOs.¹⁶ The implementation of the Medicaid Managed Care Waiver has saved the state approximately \$70 million a year.^{g,17}

Funding of North Carolina's Public MH/DD/SAS System

Today, North Carolina's public mental health, developmental disabilities, and substance use services are provided through a partnership between state and local government and the seven private managed care organizations (LME/MCOs). These entities, now known as LME/MCOs, administer and manage mental health and substance use services for individuals in their catchment areas who are enrolled in Medicaid, and those who are uninsured or underinsured and eligible for state-funded services. North Carolina's publicly-funded mental health and substance use treatment services has two delineated service lines, both administered by the LME/MCOs: Medicaid and state-funded services. The Medicaid managed care program is an entitlement program that funds a robust array of mental health and substance use services for those enrolled in Medicaid. State funded services^h cover services and supports for the uninsured, the underinsured,ⁱ and for Medicaid-enrolled individuals who need services and supports that Medicaid does not cover.¹⁸

d S.L. 2001-437.

e S.L. 2006-142.

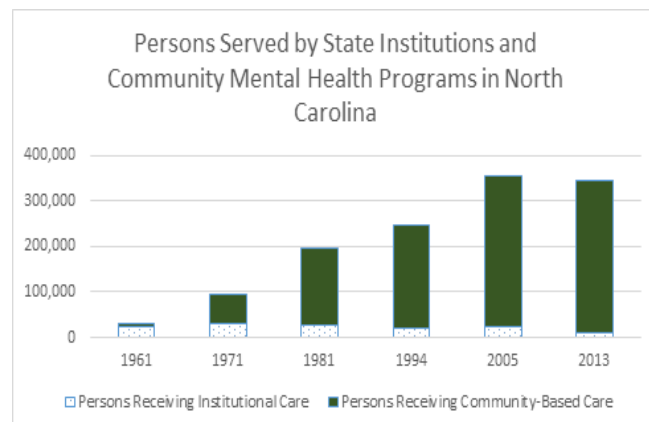
f S.L. 2011-264.

g \$70 million is the amount the state has saved, so the full savings, including federal Medicaid savings, is \$210 million per year.

h Includes single stream state funding and federal block grant dollars.

i Defined as those whose insurance does not pay for a service that they need and cannot afford.

Figure 2.1: Dramatic Increase in Number of Persons with Mental Health and Substance Use Disorders Served by North Carolina's MH/DD/SAS System Over the Past 50 Years



Source: Botts M. Chapter 40: Mental health services. In: *County and Municipal Government in North Carolina*. 2nd ed. Chapel Hill, NC: University of North Carolina; 2014.

Medicaid-eligible patient services are covered by a combination of federal and state Medicaid dollars. Non-Medicaid patient services are funded by a combination of state and county allocations and federal block grant funds which are allocated to the LME/MCOs directly. The state Department of Health and Human Services oversees state and federal funding for mental health and substance abuse services through two contracts:

1. Between each LME/MCO and MH/DD/SAS, which governs the use of non-Medicaid state appropriations (i.e., single-stream funding) and federal block grants.
2. Between each LME/MCO and the Division of Medical Assistance, which governs the use of state Medicaid funds.

MH/DD/SAS and DMA hold LME/MCOs to contractual requirements including enhanced performance requirements such as community engagement (i.e., engaging community partners), building an adequate network of qualified providers to meet the MH/DD/SAS needs of people in their service area, and quality management responsibilities to ensure that high quality services are being delivered.

The LME/MCOs are responsible for managing Medicaid, state, and federal block grant mental health, substance abuse, and developmental disability dollars. MCOs receive a per member per month payment to manage all of the mental health, substance abuse, and developmental disabilities services and supports for the Medicaid recipients in their service area. MCOs also receive an allocation of state and federal block grant funds to help provide services to people who are not eligible for Medicaid and are not covered by private insurance. LME/MCOs receive varying levels of local funding as well. This provides LME/MCOs with the flexibility to invest more of their money on prevention, early intervention, and effective outpatient treatment—especially if these services can help reduce more costly interventions or hospitalizations.

In FY 2015, the LME/MCOs provided over \$1 billion in Medicaid and state-funded MH/DD/SAS services.^j Of this, \$841 million covered mental health and substance use services to 355,000 individuals enrolled in Medicaid while \$168 million in single stream funding provided mental health and substance use treatment services for 96,000 North Carolinians without health care coverage.^{k,l}

Challenges in the LME/MCO System

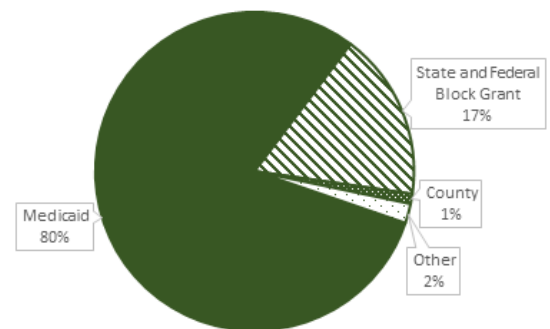
Historically, and still today, the availability of community-based mental health and substance use services and supports fall short of the mental health and substance abuse needs of the state's population, particularly for those who are uninsured, underinsured, and privately insured. Individuals enrolled in Medicaid have funding for services, but may face challenges in getting to services or accessing a particular type of service (e.g., supported employment or multi-systemic therapy). Individuals with private insurance may need enhanced services, which are not typically covered by private insurance, and may be unable to pay for them out-of-pocket. For example, they may have private insurance but be unable to afford the \$3,000 deductible or the \$80 co-pay to see a mental health or substance use specialist.¹⁹ Individuals with no insurance typically cannot cover the out-of-pocket costs of seeing mental health and substance use providers, and access to free and reduced cost services for mental health and substance use disorders is very limited. Many North Carolinians

^j State dollars are only a portion of the funding that LME/MCOs receive. The state pays approximately 1/3 of the cost of care for people enrolled in Medicaid, with the Federal government covering the other 2/3. So the true value of MH/SAS services provided to North Carolinians enrolled in Medicaid in SFY 2015 was approximately \$2.5 billion (\$841 million x 3). North Carolina also funds services through single stream funding. Single stream funding does not have a federal match. The state provided approximately \$1 billion in state-funding (through the Medicaid match and single stream funding), however the full value of care received was approximately \$2.7 billion.

^k Simmons A. Business Systems Analyst. North Carolina Department of Health and Human Services. Written (email) communication. February 29, 2016.

^l Coleman PB. Senior Researcher. North Carolina Department of Health and Human Services. Written (email) communication. July 13, 2016.

Figure 2.2: Medicaid Main Payer for LME/MCO Services

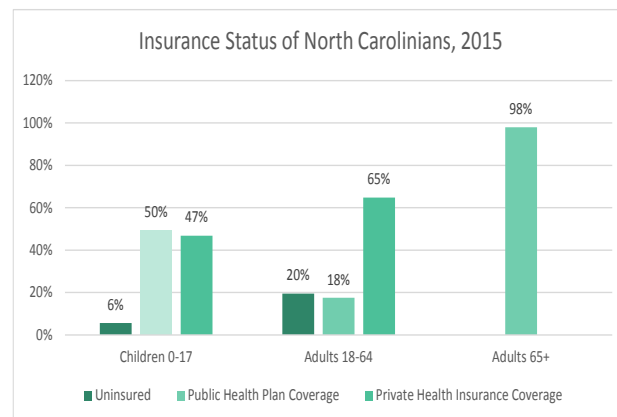


Source: Botts M. The Future of Mental Health Services and Medicaid Reform in North Carolina. Presented to: Health Directors Meeting; April 5, 2016; Raleigh, NC. https://www.sog.unc.edu/sites/www.sog.unc.edu/files/course_materials/Health%20Directors-Mental%20Health-4-2016.pdf. Accessed August 4, 2016.

face challenges with access to affordable, high-quality care and, instead, remain untreated, or in the most unfortunate cases, end up in the criminal justice system. Emergency rooms have become a common substitute for mental health treatment, rather than community-based treatment or behavioral health treatment centers that are designed to support the needs of such patients. **Comprehensive, coordinated community-based prevention, treatment, and recovery services and supports remain an elusive goal for many North Carolinians with mental health and substance use disorders.**

While designed to improve access to behavioral health treatment across North Carolina, managed care has also introduced its share of new challenges for the state. LME/MCOs, under federal Centers for Medicare and Medicaid requirements for North Carolina's Medicaid Managed Care Waiver, impose stricter requirements and higher levels of scrutiny for authorizing care providers, including physicians, social workers, psychologists, and counselors. Since the public health system overhaul, many providers have been dropped from LME/MCOs or have chosen to withdraw from the organization due to new requirements including extended hours, credentialing, and quality and appropriateness of care reviews. Reductions in participating providers may make it more difficult for consumers in some areas to access services.

Figure 2.3: Insurance Status and Payer Influence Access to Prevention, Treatment, and Recovery Services



Source: Cohen RA, Martinez ME, Zammitti EP. Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2015. Atlanta, GA: Centers for Disease Control and Prevention;2016.<http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf>. Accessed September 13, 2016. U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates, Table B27006, Medicare coverage by sex by age.

PORTRAIT OF AN INDIVIDUAL WITH MEDICAID WHO STRUGGLED TOWARDS RECOVERY

Bob is a 44-year-old man living in rural North Carolina. Bob has schizophrenia. Bob's schizophrenia limits his abilities to function socially and complete routine tasks, so Bob receives Social Security disability benefits and, therefore, is eligible for, and enrolled in, Medicaid. Bob has family nearby, but lives on his own in the community. Bob has a long-term history of non-compliance, paranoia, and, occasionally, threatening behaviors. Because he did not stay in compliance with treatment, and frequently changed his address due to paranoia, Bob's Social Security Income was discontinued, which meant he lost Medicaid coverage as well.

Bob is fine for weeks at a time, but when Bob goes off his medication, family members are unable to get him back on track without outside assistance. Unfortunately, due to losing his Medicaid coverage, Bob is only able to qualify for crisis services. However, crisis intervention services are not available until he is a threat to himself or others. When he does become a risk, law enforcement is called and Bob is transferred by police to the local hospital. At the hospital, they put Bob back on his medications. After a few days, Bob is stabilized and he is transferred to the crisis center for a temporary stay to ensure he adheres to his medication routine before being returned to his home.

After many years of increasingly worrisome episodes, family members felt hopeless. They felt the system had been unable to help Bob. Bob's cousin, Lisa, realized that something had to change. Luckily Lisa had an understanding of the various systems that could help Bob as well as the time, energy, and commitment needed to navigate the various systems. First Lisa worked with the Arc of North Carolina, an organization that provides services and advocacy for those with intellectual and developmental disabilities, to get Bob re-enrolled in SSI and Medicaid and set up a system whereby she would help manage Bob's finances so that he would not lose SSI and Medicaid benefits again (this alone involved navigating the requirements of the local Magistrate, the Social Security Administration, and the Clerk of Court). Lisa then helped Bob and his family investigate supportive housing options, although they were limited in his rural community and, ultimately, did not fit his needs. Knowing that continuing in his living situation without any additional supports would result in more encounters with law enforcement and the local hospital if changes were not made, Lisa worked with the local LME/MCO to arrange for support services for Bob. It was determined that an Assertive Community Treatment (ACT) team, a team of community-based medical, behavioral health, and rehabilitation professionals who are trained to work with individuals who actively resist services, would best be able to meet Bob's needs. Bob is now living successfully in the community with support from his ACT team.

Navigating the many facets of North Carolina's public mental health system is not easy. It requires time, dedication, family engagement and advocacy, knowledge of the systems, building trust, and constant communication with individuals in multiple parts of the system. Many individuals with mental health and substance use needs are unable to advocate for themselves or navigate the systems without help. Family members are often similarly challenged in their interactions with the public mental health system.

Medicaid

Medicaid is the largest payer of mental health services in the United States. In North Carolina, the federal government covers 67% of the cost of Medicaid and the state covers 33%.²⁰ In FY 2015, state-match Medicaid dollars paid for \$769 million in mental health services for 312,000 individuals and \$72 million in substance use treatment services for 43,000 North Carolinians.^m Approximately 1.9 million North Carolinians are enrolled in Medicaid,²¹ the vast majority (57%) are children, followed by adults qualifying under the aged, blind, and disabled category (21%), and the remaining 22% are adults who qualify under various categories.^{22,23}

Medicaid covers a wide range of services and supports for individuals with mental health and substance use disorders including health homesⁿ, prevention services, engagement services, outpatient and medication services, community and recovery support services, other recovery support services such as personal care and transportation, intensive support services, out of home residential services, and acute intensive services.²⁴ Of all insurers, Medicaid covers the most robust array of services for individuals with mental health and substance use disorders. Medicaid does not pay for prevention services. Further, LME/MCOs have some flexibility to craft their treatment coverage to meet the needs of their populations.

Medicare

Most adults over 65 receive health care coverage through Medicare. Federal law dictates the rules and regulations of Medicare, and the program is administered and paid for by the Centers for Medicare and Medicaid Services. Under Medicare, individuals have varying levels of coverage for screening, outpatient treatment, and outpatient and inpatient hospitalization. Medicare does not cover enhanced services such as supported employment, supports to people living in their own homes, and community support team services. Individuals enrolled in Medicare can select traditional Medicare, which operates on a fee-for-service model, or choose from a number of Medicare Advantage plans, which operate under a managed care model. Seventy percent of Medicare-enrolled North Carolinians are in traditional Medicare, while 30% are enrolled in Medicare Advantage plans.²⁵ Under both traditional Medicare and Medicare Advantage plans, enrollees can opt to add prescription drug coverage, with premiums that ranging from \$18 to \$100 per month depending on structure and coverage.²⁶

While both traditional Medicare and Medicare Advantage plans provide some coverage for mental health and substance use treatment services, Medicare payments are restricted to certain types of eligible professionals, including psychiatrists, clinical psychologists, social workers, nurse specialists, independently practicing psychologists, and a few others.²⁷ The list of eligible professionals does not include all mental health and substance use treatment professionals in North Carolina (e.g., licensed professional counselors, certified substance abuse counselors, and others), which restricts older adults' access to mental health and substance use services.

Private Health Insurance

Individuals with private health insurance receive services according to the rules of their coverage plan. They may or may not need prior approval for services depending on their insurance plan. Under federal law, health insurance plans must cover treatment for mental health and substance use disorders at the same level as other health conditions. This means that if a health plan covers inpatient or intensive outpatient services for physical health conditions, that plan must cover the same services for mental health conditions. Regulations for mental health parity have increased the range of services available and removed some barriers to services.²⁸ However, **for many individuals with private insurance, the required co-pays or deductibles create a barrier to accessing mental health and substance use services, even when they have health insurance.**

BlueCross BlueShield North Carolina, the largest private health insurance carrier in the state, covers outpatient services including therapy, medication management, telehealth, outpatient detox, and facility-based services, including acute and residential treatment and detox.¹² The specific services covered vary by plan. Generally, under private insurance, home- and community-based services for mental health and substance use prevention, treatment, and recovery are not covered. Examples include mobile crisis management,

^m \$769 million and \$72 million were the state Medicaid costs, so the full cost, including federal Medicaid (which covers 2/3 of the cost of care), was approximately \$2.5 billion per year. (Simmons A. Business Systems Analyst. North Carolina Department of Health and Human Services. Written (email) communication. February 29, 2016.)

ⁿ North Carolina's Medicaid Health Home Program provides care management and wraparound clinical services for enrollees. To be eligible for services, enrollees must have at least two chronic conditions that fall within one of ten diagnostic categories, or one of eight specific chronic conditions. <https://aspe.hhs.gov/sites/default/files/pdf/137856/HHOption2-NC.pdf>

community treatment teams, intensive in-home services, day treatment, partial hospitalization, intensive outpatient programs, and community residential treatment.¹² For patients who have needs that cannot be met by outpatient therapy alone, their only other option is typically inpatient treatment, for however long their insurance will cover, which may or may not correspond to the needs of the individual.

PORTRAIT OF AN INDIVIDUAL WITH PRIVATE INSURANCE STRUGGLING TOWARDS RECOVERY²⁹

Dawn is a 24-year-old woman who has suffered with bipolar disorder since she was a teenager. Dawn has also struggled with cutting, an eating disorder, and substance abuse. Dawn is insured through her parents' private insurance.

Dawn's mental health and substance use struggles first came to light in college, and she willingly entered a mental health facility for 10 days. She was not given a diagnosis and was sent home, where she sought treatment with a therapist. Dawn was recommended for in-patient treatment in a mental health facility, which her private insurance would cover for 30 days. After 30 days, she was discharged without a diagnosis or a transition plan for returning home. In the past 5 years, she has voluntarily been in and out of 22 facilities (each for no more than the maximum covered 30 days). Two years passed between her first visit and a diagnosis of bipolar disorder. Dawn's complex mental health and substance use treatment needs made finding treatment more difficult—some facilities would treat only her mental health needs, while others would only deal with her substance use needs. Because Dawn's insurance will only cover outpatient therapy or short stints in mental health facilities, she has struggled towards recovery for six years without lasting success.

PORTRAIT OF AN INDIVIDUAL WITH PRIVATE INSURANCE WHO CAN'T AFFORD TREATMENT

Steve is a 33-year-old man who has struggled with major depression and alcohol addiction for many years. He works as an auto mechanic making \$53,000/year and purchases health insurance for himself and his family of four through the health insurance marketplace. Steve and his family are enrolled in an average, lower-cost plan. Their monthly premium is \$1138, but they qualify for a \$722 per month subsidy so they pay \$416 per month for health insurance.

Steve takes a generic anti-depressant, prescribed by his primary care doctor, that has a co-pay of \$25/month. However, after the death of his father, Steve, struggling to cope with the pressure of supporting his mother and deal with the loss of his father, starts drinking again. Steve's primary care doctor recommended he visit a therapist. Steve found an in-network psychologist practice, and discovered at his first visit that instead of a \$50 copay for an office visit, the visit was considered outpatient treatment and he would be fully responsible for the cost of the visits (\$100) until he reaches his deductible (\$2,800).¹⁹ Steve's psychologist recommended eight weekly sessions. Unfortunately, Steve cannot afford \$400/month or even \$200/month, so he foregoes treatment.

Uninsured

For decades, North Carolina has faced the challenge of providing high quality care to people with limited access to care who suffer from either substance use disorders, mental health disorders, or both. In 2015, 1.3 million North Carolinians under the age of 65 (16%) did not have health insurance coverage. The gap in service to this population unnecessarily jeopardizes people's health and wellness and causes a ripple effect in costs to our communities.

Individuals without health insurance may receive services through the public mental health and substance use system if they qualify and funds are available. Individuals without health insurance who have a diagnosis of mental health and/or substance use disorder may be eligible for services under single stream funding and/or federal block grant funding. Single stream funding is a way of paying for services for individuals who have a diagnosis of mental illness, a developmental disability, a substance use disorder, or a combination of these who do not have another payer source.³¹ Single stream funding is used to pay for services for people who are uninsured or whose insurance will not cover treatment, as well as individuals enrolled in Medicaid receiving services not covered by Medicaid. The North Carolina General Assembly determines the level of single stream funding each year and the priority populations for the funding (see Table 2.1). The federal government provides funding to states under the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant to provide "prevention, treatment, recovery support, and

other services to supplement Medicaid, Medicare, and private insurance services.”³² North Carolina typically receives more than \$52 million under these two grants, some of which goes towards providing services and supports for individuals without insurance.^{33,34} In SFY 2015, the LME/MCOs provided \$237 million in MH/DD/SAS services under state single stream funding and federal block grant dollars. Of this, \$107 million covered mental health services for 63,335 individuals, while \$61 million provided substance use treatment services for 32,570 North Carolinians.⁹ In SFY 2016, \$271 million was appropriated for single stream funding.³¹

Single stream funding is allocated to LME/MCOs to fund services at their discretion based on population needs and with priority for populations defined by the North Carolina General Assembly.³¹ Service eligibility is determined by an individual’s local LME/MCO. For an individual who is uninsured to get services through their LME/MCO:

1. They must contact their LME/MCO.
2. The LME/MCO must determine, based on an assessment of the individual, if they qualify as a member of a priority population (as defined by the North Carolina General Assembly, See Table 2.1).
3. The LME/MCO must have funding available. If funding is not available, uninsured individuals who fall in the priority populations can be denied services.
4. The LME/MCO must determine what services are appropriate.
5. There must be a service provider who can provide those services.
6. The individual has to be able to access the service provider’s office.

Funding for services for uninsured North Carolinians with mental health and substance use disorders is not enough to meet the current level of need. (See Recommendation 2.4.) The LME/MCO cannot pay for services for individuals who do not meet priority population criteria as determined by the General Assembly. Without other risk criteria, an individual must 3 crisis or inpatient events in 12 months to qualify for services. And even then, only if the LME/MCO has funding available.

Table 2.1 Priority Populations for Single-Stream Funding SFY 2017

Adult Mental Health Priority Populations	Child Mental Health Priority Populations	Substance Use Disorder Priority Populations (Adult and Child)
Individuals at risk of harming self or others	Individuals at risk of harming self or others	Pregnant women who inject drugs
High risk individuals (more than 3 crises and/or inpatient events in 12 months)	High risk individuals (more than 2 crises and/or inpatient events in 12 months)	Pregnant women who use alcohol and/or other drugs
Individuals with severe and persistent mental illness; not stable	Youth who experience first psychosis episode	Individuals who inject drugs
Individuals with co-occurring Mental Health/ Substance Use Disorders (MH/SU) or Mental Health Disorder and Developmental Disability(MI/DD)	Individuals with co-occurring MH/SU or MH/DD	Department of Social Services involved
Homeless or at risk of homelessness	Homeless or at risk of homelessness	Opioid use
Individuals with traumatic brain injury	Individuals with traumatic brain injury	Communicable disease risk/HIV
Criminal or justice system involved	Criminal or juvenile justice system involved	Criminal or juvenile justice involved
Deaf and hard of hearing	Deaf and hard of hearing	Deaf and hard of hearing
Veterans	Department of Social Services involved	Veterans
Individuals with complex medical disorders	Individuals with complex medical disorders	Individuals with complex medical disorders
Department of Justice settlement agreement involvement	Individuals living with an adult with MH or SU Disorder	

Source: Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. NC DMHDDSAS FY17 Benefit Plan Eligibility Criteria. North Carolina Department of Health and Human Services website. <https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/Benefit%20Plan%20Eligibility.pdf>. Accessed 9/13/16.

⁹ Coleman PB. Senior Researcher. North Carolina Department of Health and Human Services. Written (email) communication. July 13, 2016.

Strengthening North Carolina's Public Mental Health and Substance Use Prevention Treatment and Recovery Services and Supports

North Carolina's public mental health and substance use disorder service system has undergone tremendous and nearly continuous change over the past 15 years. The North Carolina Department of Health and Human Services has delegated management authority over the public mental health and substance use disorder system to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for single stream funding and service contracts with the LME/MCOs and to the Division of Medical Assistance for Medicaid funding. In addition to these two Divisions, the North Carolina General Assembly has significant influence over the public system through funding. The North Carolina Department of Health and Human Services has identified a number of concerns and gaps in the current service delivery system including emergency department overutilization, lack of available inpatient beds, mismatch between available services and individual needs, lack of prevention services, fragmentation, underfunding, and a heavy focus on individuals in crisis.¹⁸

One challenge that continues to plague the public mental health system for adults is the continued heavy reliance on inpatient services, which is the highest level of care. Although inpatient services are an integral part of the system, the investment of more than 50% of adult mental health dollars at the highest level of services has resulted in **chronic underfunding of the other levels of community-based care that are essential to reducing the need for higher level of care and more expensive services.**¹⁸ However, people do not OFTEN enter services until they are in crisis, in part because they are uninsured or underinsured. There is a need to balance the system with more prevention and other community-based services that can decrease the need for higher levels of care.¹⁸ System balance cannot happen without additional resources in the short-term because funding cannot be removed from inpatient services if a comprehensive system of lower intensity services is not in place to keep people out of higher level services. **Stability of existing funding as well as additional resources are required to correct imbalances in the current public mental health and substance use services system.**¹⁸

LME/MCOs operate under the state's 1915(b)/(c) Medicaid waiver. Under this waiver, the LME/MCOs receive a set amount of money per month for each person eligible for Medicaid under their management. LME/MCOs also receive single stream funding, which is a set amount of state funding for people without health care (non-Medicaid populations) in their catchment areas. When the current MCO system was designed,^p MCOs were directed to keep any savings (called fund balances) to expand access to services or provide innovative services. One goal with this system was that the public mental health system could achieve the right balance of

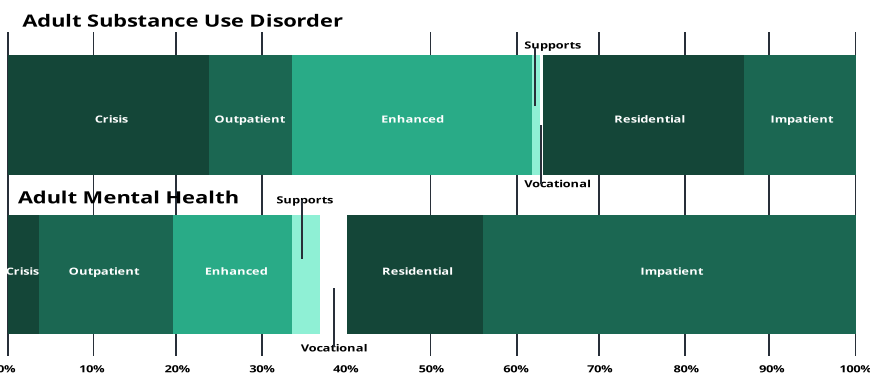
services for each community by way of investing the fund balances in prevention and other community-based services. The MCOs are required by state and federal law to maintain adequate reserves in their fund balances. Fund balances are used to cover system costs if there are delays in reimbursement from the state or federal government. Funds beyond required amounts were available for investment in services, including prevention and community-based programs.

During the 2015 legislative session the MCO fund balances were targeted by the legislature. The legislature passed non-recurring reductions of \$110.8 million and \$122 million to single stream funding, respectively, for the next two budget years, while requiring MCOs to maintain the same level of services. The MCOs were told to cover the cost using the single stream funding fund balances. The LME/MCOs function as

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Figure 2.4: Majority of Dollars in North Carolina's Adult Public Mental Health System Paying for Inpatient Care

FY16 State Fund Expenditures by Age/Disability and Category of Service



Source: Coleman PB. Senior Researcher. North Carolina Department of Health and Human Services. Written (email) communication. October 7, 2016.

private corporations under public rules. The small fund balances available to LME/MCOs for community re-investment were only marginally in excess of the reserves required to make payments on a daily basis to a network of providers and staff. By forcing the LME/MCOs to tap into this limited reserve, the General Assembly has prevented the LME/MCO system from the community re-investment that was the purpose of the fund balance. The fund balances are not being reinvested in the system to expand access or provide innovative services. Therefore, the Task Force recommends:

Recommendation 2.1: Support and expand availability of a full array of mental health and substance abuse services through LME/MCOs.

- 1) The North Carolina General Assembly should:
 - a. Allow LME/MCOs to invest fund balances in expansion of community-based services in future budgets.
 - b. Allocate proceeds from the sale of the Dorothea Dix property to the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services with at least half of the funds going towards providing a full array of mental health and substance abuse services.
- 2) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and Division of Medical Assistance contracts with LME/MCOs should require LME/MCOs to submit plans detailing how they plan to use their fund balances to expand or innovate services over the next year. Plans should require approval from the Secretary of the Department of Health and Human Services before implementation.

Case Management

Case management services are services provided to individuals to gain “access to needed medical, social, educational, and other services.”³⁵ Case management provides a bridge across multiple systems, including physical, mental health, and substance use treatment services, as well as other services, and may include arranging for appointments, referral forms, transportation, reminders, follow-up, and other communication. Case management is especially important for the many individuals with co-occurring conditions who have to navigate multiple systems for their care. For the 70% of individuals with mental health and substance use disorders who also have a chronic health condition, case management can improve clinical outcomes, increase care quality, and reduce costs. Case management is especially important for those with multiple conditions who are also Medicare and/or Medicaid beneficiaries; a 2014 study found that 41% of individuals eligible for both Medicare and Medicaid had one or more mental health conditions, not including substance use disorders.³⁶ The per member per month cost of Medicare and Medicaid increased as the number of comorbid conditions increased, with a sharp increase when an individual had four or more conditions at the same time. Mental health conditions frequently occur alongside other health conditions (39-63%).³⁶ Providing a bridge to navigate the multiple systems can improve quality and decrease expenses.³⁶ Case management is a Medicaid billable service for certain populations in North Carolina, but most individuals with mental health and substance use treatment needs do not currently qualify for case management services.

Recommendation 2.2: Provide case management and recovery navigation.

The state Medicaid agency should create stand-alone billable case management services with well-defined eligibility criteria, as well as navigator and step-down services for individuals needing less intense case management.

Using Data to Drive Mental Health and Substance Use System Improvement

One of the barriers to improving the delivery of mental health and substance use services is the underutilization of data.³ A vast array of data are collected on individuals who access services through the public mental health and substance use system. Currently, each agency and organization collects pieces of the data, but there is no systematic effort to comprehensively evaluate the data collected by all the state agencies that play a role in addressing the mental health and substance use needs of North Carolinians. Data could be used to assess how well our systems meet the needs of those they serve and to guide policy decisions.¹⁸ Cross-agency data sharing is critical to understanding the complex needs of the individuals and families served by these systems and to assess the effectiveness of services provided. To do this well, the state needs to establish metrics and common data points that are tracked across systems in order to assess patient mental health and substance use treatment outcomes.

The North Carolina Government Data Analytics Center (GDAC), which operates across state agencies, departments, and institutions is a data integration and data-sharing initiative that is intended to leverage the data from multiple systems. Backed by legislation, the GDAC is already supporting the Criminal Justice Law Enforcement Automated Data Services, is working to develop the Early Childhood Integrated Data System, and is piloting a program with Child Protective Services data.³⁷ If all of the state agencies that play a role in addressing the mental health and substance use needs of North Carolinians shared their data with the GDAC, the resulting data set would allow for analysis of the connection between investments and outcomes and provide evidence to drive future investments. As this information is being shared, there is a need for these agencies to pay attention to federal laws and state statutes regarding information sharing such as the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), 42 CFR Part 2, and other federal and state regulations. North Carolina should use public dollars to fund services that work. Data, and the information provided through analytical analysis, provides the means to assess if services are effective and whether publicly-funded services provide a positive return on investment. Therefore, the Task Force recommends:

Recommendation 2.3: Require North Carolina agencies to share data cross-agency.

The Department of Health and Human Services, the Department of Public Instruction, the Department of Corrections, and other agencies working to meet the mental health and substance use prevention, treatment, and recovery needs of North Carolinians should:

- 1) Contribute their data to the Government Data Analytics Center and establish a memoranda of understanding to allow cross-agency data sharing.
- 2) Provide funding to support data analysis through the GDAC.
- 3) Use data to guide policy decisions and measure their impact.

Assessing and Addressing Disparities in Mental Health and Substance Use Prevention, Treatment, and Recovery

As previously discussed, access to services and supports for individuals with mental health and substance use disorders varies based on a number of factors, including insurance coverage, specific type of mental health or substance use disorder, and geographic location. National research confirms significant disparities—such as unequal access to care and varying degrees of quality of care—in mental health and substance use services and supports.³⁸ Certain minorities, including American Indians, Alaska Natives, African Americans, Asian Americans, Pacific Islanders, and Hispanic Americans receive less care and lower quality care than other populations. The rate of mental health and substance use disorders is not higher in these populations, but they have higher rates of misdiagnosis, which may contribute to this burden. For instance, African Americans are more likely to be diagnosed with schizophrenia and less likely to be diagnosed with mood disorders.³⁹ For those who are diagnosed, they are less likely to receive the most current prescription drugs.² Asian Americans have low rates of substance use treatment, which is consistent with research that shows that behavioral health services are underutilized by Asian Americans.⁴⁰ Differences in accuracy of diagnosis, receipt of appropriate therapies, and adequate monitoring in both the short- and long-term have been shown to vary by racial, ethnic, geographic, and socioeconomic differences.⁴¹ In North Carolina, unequal distribution of mental health and substance use treatment providers has led to well documented disparities in access to mental health and substance use services.⁴² Among adolescents in North Carolina, there are documented disparities in the gender and race/ethnicity of individuals suspended or expelled from schools and in the juvenile justice system, both of which overlap with the population of adolescents who may need mental health and substance use services and supports.^{43,44}

Currently, as part of their contracts with the LME/MCOs, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services requires each LME/MCO to complete a gaps analysis to assess outpatient, location-based, community, mobile, crisis, inpatient, and specialized services. These analysis focus heavily on the time it takes to access services and distance traveled. The gaps analysis does not look at variation between sub-populations' access to services. If the data is not collected and assessed, differences in access, diagnosis, treatment, and recovery will not be identified or addressed. In order to fully understand the gaps and needs in North Carolina's mental health and substance use systems, LME/MCOs should collect and analyze data by age, race/ethnicity, diagnosis, and other factors. Therefore, the Task Force recommends:

Recommendation 2.4: Assess and address disparities in the LME/MCO system.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services should:

- 1) Require LME/MCO to complete an analysis of type/severity of diagnosis, duration of services, use of psychotropics, and outcomes when available, by demographic data including gender, age, and race/ethnicity as part of the annual gaps analysis.
- 2) Require each LME/MCO to develop strategic plans to address disparities identified in the gaps analysis.

Mental Health and Substance Use Prevention, Treatment, and Recovery Services for Uninsured Residents

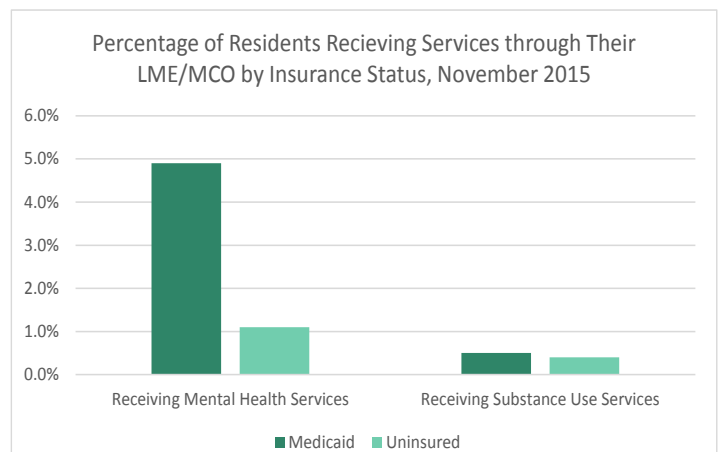
Funding for services for uninsured North Carolinians with mental health and substance use disorders does not meet the current level of need. It is estimated that 17% of adults in North Carolina have mental health and/or substance use disorders and approximately 4% have serious mental health and/or substance use disorders per year. Data from the LME/MCOs in 2015 show that uninsured individuals are much less likely to receive mental health services through their LME/MCO than individuals enrolled in Medicaid. (See Figure 2.2.)

In SFY 2015, \$841 million in state-match Medicaid funds were combined with federal Medicaid dollars to provide \$2.4 billion in mental health and substance use treatment services to approximately 355,000 Medicaid beneficiaries (18% of Medicaid beneficiaries) in North Carolina.^q In the same year, \$168 million in state-funded single stream funding mental health and substance use treatment services were provided to approximately 96,000 uninsured individuals (9% of those without insurance).^r

To provide funding for mental health and substance use treatment services for uninsured residents on par with what Medicaid beneficiaries receive, the state would need to allocate an additional \$482 million annually to single stream funding, assuming no expansion in the population served.^s However, state single-stream funding only serves a portion of the uninsured residents with mental health and substance use needs (see Table 2.1 for priority populations). If the state wanted to fully meet the needs of the uninsured population, the state would need to allocate up to an additional \$1.2 billion.^t

Currently, North Carolina’s Medicaid program covers children 0-21 in families whose income is up to 215% of the federal poverty guidelines (FPG), pregnant women with incomes up to 200% FPG, and adults with children under the age of 18 who live with them and whose family has an income up to 44% FPG, and aged, blind, and disabled.⁴⁵ Since 2014, under the Patient Protection and Affordable Care Act, states have had the

Figure 2.5: Uninsured Individuals are Much Less Likely to Receive Mental Health Services through their LME/MCO than Individuals Enrolled in Medicaid



Source: North Carolina Department of Health and Human Services. LME/MCO Monthly Monitoring Report, November 2015. Adolph Simmons, Jr. M.S., Business Systems Analyst, Division of Medical Assistance, North Carolina Department of Health and Human Services. Written (email) communication on February 29, 2016.

^q \$841 million in state-funded Medicaid costs, so the full amount of services, including federal Medicaid, was approximately \$2.5 billion in 2015. (The state data presented was self-reported by the LME/MCOs to the NC Division of Medical Assistance. According to Dma in SFY 2015, the MCO capitation payments averaged @2.2 billion. Some of the LME/MCOs have “reinvested” prior year earning which could increase their total spending. Adolph Simmons, and September 30, 2016 Medical Assistance, North Carolina Department of Health and Human Services. Written (email) communication on February 29, 2016.) There were 1,992,899 Medicaid beneficiaries in North Carolina. (NC Division of Medical Assistance. NC Department of Health and Human Services. Monthly Medicaid Enrollees from SFY2017 through SFY2009.)

^r Coleman PB. Senior Researcher. North Carolina Department of Health and Human Services. Written (email) communication. July 13, 2016.

^s This calculation holds the number of uninsured served steady at 95,905. \$6,779/Medicaid beneficiary (state and federal funds) - \$1,752/uninsured resident = \$5,027/individual difference *95,505 = \$482 million.

^t If the state were to fund services for uninsured at the same level as for Medicaid recipients (\$6,779), assuming same percentage (18%) would need MH/SU services, total cost would be \$1.3 billion. North Carolina currently contributes \$168 million in single-stream funding to meet the needs of uninsured residents. The state would need to increase single-stream funding by \$1.2 billion to provide services for the uninsured at the same level as for Medicaid recipients.

option to expand Medicaid to cover most adults with incomes up to 138% FPG. Expanding Medicaid would

provide health care coverage to adults who are not currently eligible for Medicaid or for health insurance subsidies through the federal health insurance marketplace. Approximately 512,000 North Carolinians would be newly eligible for Medicaid under expansion.⁴⁶ If these adults enrolled, they would have access to mental health and substance use treatment as needed, including counseling, prescription drug coverage, and other services and supports. Expanding Medicaid coverage to new eligibles is not without costs to the state. The North Carolina Department of Health and Human Services determined that expanding Medicaid to new eligibles would result in a net savings to North Carolina of \$40 million in 2017, with costs increasing over the following years to \$119 million by 2021.⁴⁶

Medicaid expansion would not cover all of the state's 1.3 million currently uninsured people, but it would likely reduce the number of uninsured by half a million. Approximately \$562 million in additional mental health and substance use treatment services would be provided to Medicaid beneficiaries in North Carolina, which amounts to approximately 45% of needed services for the currently uninsured.^u Medicaid expansion would also provide coverage for primary care and other health care benefits in addition to mental health and substance use treatment services.

Currently state funding for mental health and substance abuse treatment services is inadequate to meet the needs of the uninsured. This leaves many of our most vulnerable residents without the services they need to be healthy, safe, and productive members of our communities. There are many possible ways for the state to increase mental health and substance use services for uninsured residents. Therefore, the Task Force recommends:

Table 2.2: Public Funding for Mental Health & Substance Use Services, 2015

Public Funding for Mental Health and Substance Use Services, 2015			
	State + Federal Contribution	Persons Served	Average Value of Services per Beneficiary
Medicaid Mental Health and Substance Use Services ¹	\$2,403,610,489	354,572	\$6,779
Uninsured IDD, Mental Health and Substance Use Services ²	\$168,018,325	95,905	\$1,752
			\$5,027
NC Uninsured Population³			1,103,000
Estimated Percentage of Mental Health and Substance Use Service Need of Uninsured⁴			198,540
Estimate of Cost to State to Provide Medicaid-Equivalent Mental Health and Substance Use Services to Uninsured^{5,6}			\$1,177,865,801

¹State Medicaid funding was self-reported by the LME/MCOs to the NC Division of Medical Assistance. Adolph Simmons, Jr. M.S., Business Systems Analyst, Division of Medical Assistance, North Carolina Department of Health and Human Services. Written (email) communication on February 29, 2016 and September 30, 2016. The North Carolina Institute of Medicine calculated the federal Medicaid contribution was calculated using the state Medicaid contribution, with the assumption that state government contributes 35% of the cost of Medicaid with the federal government contributing 65% of the cost."

²Bowman J. Quality Management Section Chief, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, North Carolina Department of Health and Human Services. Written (email) communication June 27, 2016. Coleman PB. Senior Researcher, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, North Carolina Department of Health and Human Services. Written (email) communication. July 13, 2016.

³U.S. Census Bureau. Health Insurance Coverage in the United States, 2015. Washington, DC. <https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf>. Published September 2016. Accessed October 5, 2016.

⁴The North Carolina Institute of Medicine estimated the percentage of uninsured residents with mental health and substance use service need using the North Carolina Medicaid mental health and substance use services penetration rate of 18%. It is unknown if the penetration rate for the uninsured would be 18%. Their prevalence and penetration rates could be higher, lower, or the same as the current Medicaid population.

⁵The North Carolina Institute of Medicine estimated the cost to the state to provide Medicaid equivalent mental health and substance use services to the uninsured by multiplying the average value of services for Medicaid beneficiaries by the percentage of uninsured residents with mental health and substance use service need and then subtracting the current state and federal contribution.

^u Expanding Medicaid would bring approximately 512,000*18*\$6,779 = \$624 million in mental health and substance use treatment and recovery services to those covered through expansion. If \$1.2 billion is needed to provide funding for mental health and substance use treatment services for uninsured residents on par with Medicaid (see footnote u), then \$624 million would meet approximately 53% of the gap in mental health and substance use treatment and recovery services for uninsured North Carolinians.

Recommendation 2.5: Expand access to mental health and substance use services.

The North Carolina General Assembly should increase access to and utilization of mental health and substance use services for uninsured residents.

Paying for Positive Outcomes

Funding for mental health and substance use services should be spent on services that have been shown to produce positive outcomes or improved outcomes for individuals with mental health and substance use disorders. Increasingly, the United States' health care system is moving away from a fee-for-service system towards a value-based system with reimbursement based on the quality, cost, and outcomes of services.⁴⁷ One of the goals of value-based care is to better align the incentives of patients, providers, and the payers who usually finance care. Value-based payments are already being implemented by Medicare and Medicaid for select physical health conditions. One of the concerns within the mental health and substance use prevention, treatment, and recovery systems is the lack of emphasis within current systems on outcomes.

Ideally, under a value-based system, reimbursement would incorporate outcome data into payment. However, currently such data are unavailable. In the absence of outcome data, insurers have increasingly developed payment models that incentivize evidence-based strategies, or those that have been proven effective in high-quality research studies. There are evidence-based strategies across the continuum of mental health and substance use care that should be incentivized and promoted. The purpose for using evidence-based strategies is that it increases the likelihood that programs, interventions, and policies will produce positive outcomes while also increasing the efficiency of public resources.⁴⁸ In North Carolina, evidence-based services and supports are being offered by many mental health and substance use treatment and recovery providers, however, most services and supports provided are not evidence-based. As payment methodologies in the health care field continue to evolve, funders of mental health and substance use services and supports should develop payment models that support and promote positive outcomes. Therefore, the Task Force recommends:

Recommendation 2.6: Increase utilization of evidence-based mental health and substance use services and tie payment to positive health outcomes.

- 1) Payers, both private and public, should develop service definitions, contracts, and/or value-based payments to reward providers based on:
 - a) Completion of approved training for evidence-based treatment services and consistently providing evidence-based treatment.
 - b) Use of evidence-based screening and assessment instruments to identify people with mental health and substance use conditions.
 - c) Case mix and the severity of patients' needs.
- 2) Insurers, both private and public, should work together to develop mental health and substance use process and outcome measures (or adopt those developed by CMS) and define value-based payments and/or performance-based incentives for improving health outcomes. Value-based payments and/or incentives should be developed to reward providers based on:
 - a) Consistently reporting process and outcome measures.
 - b) Achievement of positive outcomes for patients.
 - c) Severity of need and case mix of patients

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Chapter Three: Improving Prevention, Treatment, and Recovery Services

The North Carolina Institute of Medicine’s Task Force on Mental Health and Substance Use focused on improving access to effective treatments and services that are easy to navigate and have adequate funding. **The Task Force’s vision is that we build upon current infrastructure to create an accessible, community-based, flexible system of mental health and substance use treatment services that produces positive outcomes for North Carolinians through a full range of services that are provided in a timely manner and at the most appropriate level of care.** The Task Force focused heavily on the community-based mental health and substance use treatment services because these services are essential to keeping people healthy in their home and communities and assisting people transitioning back into the community after a crisis or in-patient treatment. In this chapter, the Task Force recommends actions for improving access to and coordination of mental health and substance use services for all populations. Subsequent chapters include recommendations for improving services for adolescents and older adults.

Navigating the Complex Web of Systems and Payers

Although the same variety of payers exists on the physical health side of health care, the pathways to accessing treatment and the various systems—primary care, specialty treatment, emergency care, and hospitals—are much better understood and coordinated. On the mental health and substance use treatment side of health care, the barriers to understanding and accessing treatment are significant and the various systems are more fragmented, as discussed in Chapter 2.

When someone has a physical ailment, the first step is fairly simple—they go to the doctor. While where someone seeks out care for a physical ailment does vary and is often limited by ability to pay, a trip to the doctor for a lingering cough or cold, broken arm, or persistent pain is well understood. However, there is no commonly understood path to treatment for someone who has been feeling depressed, is too anxious to sleep, has been drinking excessively, or is addicted to prescription drugs. Not only are such health problems stigmatized and hard to talk about with friends and family, the average person does not know where to begin to get treatment, who provides such treatment, and how their health insurance plan—if they have one—covers such treatment.

On the physical health side, North Carolina has well developed systems designed to address the full-spectrum of health needs from mild to urgent for those with insurance and without. In contrast, the mental health and substance use treatment service “system” in North Carolina, as in many other states, is less of a system and more of a fragmented set of financing mechanisms and service providers. The set of covered services varies greatly by payer, with Medicaid covering a robust array of services, private insurance covering a more limited array, and the state covering very limited services for some residents without insurance coverage. For consumers trying to access services, this fragmentation creates significant systemic barriers to needed prevention, treatment, and recovery services.

Further complicating access to mental health and substance use services for consumers is the lack of uniformly offered services, even by providers within the same specialty. In the physical health arena, the services an individual podiatrist, dermatologist, or other specialist offers are the same as others of the same medical specialty. In contrast, the services offered by mental health and substance use treatment providers, including psychiatrists, psychologists, professional counselors, marriage and family therapists, clinical social workers, clinical addiction specialists, substance abuse counselors, and others, vary greatly by provider.¹

Most, but not all, mental health professionals can make a diagnosis and provide individual and group counseling; psychiatrists can also prescribe medication; social workers often provide case management, placement services, and other supports; and peer specialists have lived experience. Additionally, mental health professionals often specialize in working with certain populations and providing specific forms of therapy. Unfortunately, most people are not aware of the differences among the many types of mental health professionals and it is often impossible to know what population someone serves or the types of treatment they provide without contacting them first.

Improving Understanding of How to Access Mental Health and Substance Use Services

For any system to work, the intended beneficiaries must understand it; however, **North Carolina’s complex mental health system is not well understood.** National data show that among those with mental health and substance use disorders reporting unmet treatment needs, cost was the primary reason, followed by not

knowing where to go.² This lack of understanding is commonly held by consumers, service providers outside of the mental health and substance use system, and others who interact with individuals with mental health and substance use needs.³

Today, the route by which consumers enter the system varies by mental health and substance use need severity, insurance type, and health literacy level, among other factors. A single point of entry for accessing mental health and substance use treatment is needed, similar to 911 for emergencies. “No wrong door” systems remove the burden on individuals and families having to figure out how to access services.

The Task Force goal is that consumers, health professionals, service providers, and others working in communities will understand how to access mental health and substance use services and how to assist others who may be in need of services. Ongoing education of consumers, providers, and other stakeholders is needed to improve understanding and access. Therefore, the Task Force recommends:

Recommendation 3.1: Educate communities on available mental health and substance use services.

- 1) The Division of Medical Assistance (DMA), in partnership with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), local management entities/managed care organizations (LME/MCOs), private insurance providers, provider organizations, the National Alliance on Mental Illness (NAMI), Care Share Health Alliance, Area Health Education Center (AHEC), and other partners should develop and disseminate model curricula and tools to educate and train patients and family members about the public mental health system including:
 - a) Who is eligible for services
 - b) What types of services are available
 - c) How to access services and navigate the system
 - d) Alternatives to the emergency department for crisis treatment

Trainings should be targeted to local departments of public health and social services, community and faith-based organizations, social workers, agencies serving youth and older adults, and others working in communities.

- 2) DMH/DD/SAS, LME/MCOs, DMA, AHEC, and private insurers should develop trainings for providers who interact with individuals with mental health and substance use needs in their communities (e.g., health providers, pharmacists, public health, emergency medical personnel, local law enforcement, judges, social workers, and the Department of Justice) understand how the mental health and substance use system works, what services are available, who is eligible for services, and how different populations can access services. Specifically these trainings should:
 - a) Work with professional associations, continuing education programs, and local communities to disseminate these training materials.
 - b) Integrate this information into Mental Health First Aid training.

Recommendation 3.2: Develop a common access point for the mental health and substance use prevention, treatment, and recovery system.

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), Division of Medical Assistance (DMA), local management entities/managed care organizations (LME/MCOs), private insurers, first responder systems, and other stakeholders should work together to develop a common access point for the mental health and substance use system, particularly for those in crisis.

Engaging Communities around the Mental Health and Substance Use Needs of Residents

Mental health and substance use play an important role in an individual's overall well-being. For those who are living with mental health and/or substance use disorders, receiving appropriate supports that go above and beyond services and treatment can help improve their health outcomes. However, supports at the community level can be hampered by negative attitudes and beliefs associated with people with

mental illness and substance use disorders. People's underlying attitudes and beliefs about mental illness and substance use disorders can inform how they interact with and support community members managing these conditions. If community members have positive attitudes, they tend to engage in more supportive and inclusive behaviors, whereas, if they have negative attitudes, they are more likely to engage in avoidance, exclusionary, and discriminatory behaviors towards people with mental health and substance use disorders.⁴ Therefore, shifting the attitudes of community members towards more positive engagement with and understanding of the needs of people with mental health and substance use disorders is paramount for the success of improving the quality of life for those with mental health and substance use disorders.

Mental Health First Aid (MHFA) is an evidence-based, population-level training that increases the capacity of community members to recognize, understand, and respond to signs of mental health and substance use disorders in individuals. Community members who are trained in Mental Health First Aid are more likely to provide help to others and are more likely to advise people to seek professional help.⁵ As of 2016, North Carolina had over 18,000 Mental Health First Aid trainees.⁶ Mental Health First Aid is an 8-12 hour course that can be delivered by trainers in a variety of community settings. There are multiple versions of the course, including Youth Mental Health First Aid, Mental Health First Aid, and Mental Health First Aid for Older Adults. Increasing the number of individuals trained in Mental Health First Aid is a goal of the North Carolina Department of Health and Human Services. In 2016, North Carolina was showcased as a best practice program for statewide implementation of Mental Health First Aid.⁶

To ensure those working with vulnerable populations, including adolescents and older adults, receive Mental Health First Aid training, the DMH/DD/SAS needs partners. Therefore the Task Force recommends:

Recommendation 3.3: Increase the number of North Carolinians trained in Mental Health First Aid.

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) should work with LME/MCOs, providers, and others to increase the number of individuals across the state trained in Mental Health First Aid.

- 1) Local Boards of Education, the North Carolina Center for Afterschool Programs, the YMCA, and other organizations serving youth, should encourage school staff and others who work with youth to receive the Youth Mental Health First Aid training.
- 2) The Mental Health, Substance Use, and Aging Coalition should work with DMH/DD/SAS to:
 - a) Encourage existing Mental Health First Aid trainers to become certified as trainers for the Mental Health First Aid for Older Adults program.
 - b) Promote the Mental Health First Aid for Older Adults program among those providing various services to older adults including caregivers, continuing care retirement communities, senior housing, senior centers, senior support programs, local law enforcement, emergency medical services, older adults, and others.

Ensuring Communities Provide Input to their LME/MCO

Currently there is a federally mandated process to assess adequacy of services provided through public mental health and substance use treatment systems. DMH/DD/SAS, in partnership with DMA, performs an annual LME/MCO service gaps analysis to assess the ability of the public mental health system to meet consumer needs. Results from the service gaps analysis are used to continue progress towards developing an accessible community-based system of care that provides a full range of services to meet the range of age, gender, and cultural needs of the community, as well as other conditions, as outlined by the Centers for Medicare and Medicaid Services (CMS). (See Recommendation 2.4.)

As part of the service gaps analysis, LME/MCOs are required to involve consumers, families, providers, and other stakeholders. Every LME/MCO has a process for gathering input, and some have worked hard to ensure that consumers and families participate. However, given the size and scope of the seven LME/MCOs, the process for gathering stakeholder input varies widely across the LME/MCOs. Efforts to involve stakeholders in the service gaps analysis need to be increased and standardized across LME/MCOs. In addition to ensuring consumers and other stakeholders have a voice, involving stakeholders in the service gaps analysis provides an opportunity to inform them about the work of the LME/MCO. Some communities are concerned that LME/MCOs are not providing the full array of services (as defined by CMS) and/or

that LME/MCOs are not fully aware of community needs; involving more community members in the gaps analysis could increase this awareness. Additionally, there is a lack of awareness in communities about the types of services being funded with LME/MCO funds. A rigorous method for collecting stakeholder input could benefit both the LME/MCOs and local communities. Therefore, the Task Force recommends:

Recommendation 3.4: Involve consumers and local communities in the LME/MCO service gaps improvement process.

DMH/DD/SAS should work in partnership with local LME/MCOs to establish best practices for how to involve local communities in the service gaps improvement process. Best practices should include ensuring that special populations are part of the process.

Improving Communities' Crisis Response

North Carolina has developed a range of services to meet the needs of individuals experiencing a mental health or substance use crisis. Those services include mobile crisis teams, Crisis Intervention Teams, emergency departments, and psychiatric facilities, both during and after the crisis. Although not all services are available in all communities, the goal is for all communities to have prevention, early intervention, crisis response, and stabilization services. In many communities, services are available, but there are not strong collaborative relationships between the key stakeholders in the crisis response system.⁷ Poor working relationships cannot be fixed by any one stakeholder, but instead require all the stakeholders involved in crisis response and treatment to work together. Recognizing this, some communities in North Carolina are developing better processes for addressing the needs of individuals in crisis by pulling stakeholders together to develop new solutions.

Almost 13% of emergency room visits are due to mental health and substance use problems.⁸ In many cases, the needs of these individuals can be met in other settings at a lower cost and with more appropriate treatment.⁸ Currently, the emergency department is the default delivery point for all emergency medicine calls; however many mental health crises are not medical emergencies. To address these concerns, 13 counties in North Carolina are currently piloting community paramedicine programs, which use trained paramedics to divert individuals in mental health or substance use crises from unnecessary emergency department visits. Under these programs, supported with start-up funds from the state, emergency medical services can deliver individuals in crisis to specialty mental health and substance use crisis centers, or other outpatient resources when available, rather than to emergency departments.⁹

Mental health and substance use crisis services must be fully integrated into the full continuum of services and tailored to individual need. Finding ways to improve the funding and provision of crisis services can help ensure that people have timely access to appropriate services, without over-burdening providers at the highest levels of care.¹⁰ Therefore, the Task Force recommends:

Recommendation 3.5: Support and encourage crisis response stakeholders to collaborate.

- 1) Hospitals and health care systems, local law enforcement, emergency medical services (EMS), LME/MCOs, community leaders, primary care and specialty providers, patients and families, and others involved in the crisis system in communities should collaborate to improve the response to mental health crises in communities, particularly for adolescents and older adults. These collaboratives should also work together to address other impediments to accessible, timely, quality mental health and substance use services, as well as prevention.
- 2) Community foundations and other philanthropic organizations should support the development of local stakeholder collaboratives to improve collaboration and coordination between all organizations involved in crisis response, or other aspects of the mental health and substance use system, within their community.

Recommendation 3.6 Develop new payment models to support community paramedicine programs with mental health and substance use crisis response.

The North Carolina Department of Health and Human Services should convene a working group including representatives from the Department of Insurance, health care systems, facilities, and public and private payers, including accountable care organizations, managed care organizations, and provider-led entities to develop new payment models to support community paramedicine programs implementing mental health and substance use crisis response.

Increasing North Carolina's Capacity to Provide Mental Health and Substance Use Treatment Services

Increasing understanding regarding how to access mental health and substance use treatment services is one step toward ensuring individuals and families are able to receive effective treatment. Equally important is making sure that North Carolina's health professional workforce is ready to meet the needs of the population with mental health and substance use needs. Doing this will require not only addressing the adequacy of the mental health and substance use professional workforces, but also expanding where and when individual's mental health and substance use needs are addressed.

Mental Health and Substance Use Treatment Providers

A robust, diverse workforce is necessary to meet the mental health and substance use needs of North Carolinians. In North Carolina, a wide range of providers including psychiatrists, psychologists, professional counselors, marriage and family therapists, clinical social workers, clinical addiction specialists, substance abuse counselors, and others provide mental health and substance use services. A study of the workforce in 2013 found that 13 counties in North Carolina did not have any active psychiatrists, psychologists, or psychiatric nurse practitioners.¹¹ Furthermore, 29 do not have any practicing psychiatrists and 22 do not have any active psychologists. Only 30 counties have at least one child psychiatrist and six counties have a geriatric psychiatrist.¹² Unfortunately, data is not available on the distribution of all mental health and substance use professionals. An analysis of the distribution of advanced practice psychiatric nurses, licensed professional counselors, marriage and family therapists, psychologists, and social workers found that, in theory, almost all counties have an adequate workforce to meet the mental health therapy needs of the population.¹³ However, other factors, such as whether providers accept both public and private insurance, see children or older adults, and provide outpatient treatment could not be assessed, so there are likely shortages for certain groups, even where there are theoretically enough professionals available to meet the needs of the community.¹³ For example, data show shortages of mental health and substance use professionals that specialize in treating children and older adults in most counties.¹¹

Aside from psychiatrists, the path through education and training varies significantly across mental health and substance use providers. The licensing boards for each type of professional determine the education and training requirements for that field. Having a diverse field of mental health and substance use professionals is important, but the widely varying requirements contributes to inconsistencies among the workforce. There is a need for an infrastructure to support and improve the consistency and quality of mental health and substance abuse services statewide, to retain qualified staff, and to sustain evidence-informed practices. Therefore, the Task Force recommends:

Recommendation 3.7: Strengthen training and workforce development.

The North Carolina professional associations for the mental health and substance use workforce should work together with LME/MCOs, North Carolina's community colleges, colleges, universities, and AHEC to ensure there are courses and continuing education opportunities for the mental health and substance use workforce to develop:

- 1) Foundational skill training (core competencies) that encompasses a variety of evidence-based models and ranges across disciplines, (e.g., patient-guided practice, cultural and linguistic competence, screening, assessment and referral, treatment planning, systems knowledge, quality improvement).
- 2) Expertise in providing context-specific services to consumers (e.g., brief intervention, crisis).
- 3) The knowledge and skills to provide services in both specialty mental health settings (e.g., mental

health clinics, psychiatric hospitals, rehabilitation/reintegration, crisis centers) and non-specialty mental health settings (e.g., schools, social service agencies, integrated care).

- 4) Expertise and skills needed to work with adolescents, older adults, and/or those with co-occurring mental health and substance use needs.

Recommendation 3.8: Develop a more robust transition to practice system for mental health and substance use professionals.

The North Carolina professional associations for the mental health and substance use workforce should work with the state Medicaid agency, DMH/DD/SAS, Division of Social Services, University of North Carolina System, AHECs, and LME/MCOs to:

- 1) Address barriers to developing an effective workforce to meet the clinical needs of North Carolinians with mental health and substance use needs.
- 2) Develop a plan to create more clinical training sites, with appropriate supervision, in both specialty mental health settings and non-specialty mental health settings and with populations of all ages. Training and supervision are particularly needed for professionals seeing individuals with dual diagnoses, adolescents, older adults, and individuals of all ages with substance abuse concerns.
- 3) Strengthen and improve licensing requirements.

Integrated Care

Mental health and substance use and physical health are not separate. An individual's physical health is impacted by their mental health and substance use; likewise, an individual's physical health impacts their mental health and substance use. The opioid epidemic is a glaring example of how physical health and substance use are related. In our current health systems, physical health and mental health and substance use have been largely separated, even though evidence shows that doing so leads to worse health outcomes and higher spending.¹⁴ National data show that 18% of adults have comorbid chronic physical diseases and mental health disorders, and 68% of adults with a mental disorder have at least one chronic condition.¹⁵ Integrated care, which uses multidisciplinary teams to address a patient's physical and mental health and substance use concerns, is one way to increase individual's access to mental health and substance use services.

Over the past 20 years, integrated care has gained prominence across the country and in North Carolina as a health care delivery model that addresses both individuals' physical and mental health and substance use needs. **Integrated care can successfully address many of the barriers to receiving mental health and substance use treatment services** including limited knowledge about how to access care, not recognizing the need for treatment, and stigma.^{2,16} Integrated care is one way to provide the prevention, early detection, and timely referral to mental health and substance use treatment services that are needed to reduce cost and improve outcomes.¹⁰ Many health systems and practices in North Carolina have moved towards providing integrated care.

Moving traditional systems of health care toward a more integrated care delivery system is challenging. Integrated care requires the delivery of physical and mental health and substance use care in new ways, which often requires health providers to work in new ways and new roles, using new health information technology systems, all while trying to figure out how to get paid while providing care that does not fit the traditional fee-for-service model.

What is Integrated Care?

Integrated care is a model that utilizes a practice team of medical care and mental health and substance use clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address physical health, mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Integrated care as a term covers a wide range of working relationships that aim to better coordinate and address patients physical and mental health and substance use concerns, rather than referring to a single model.

Source: Peek CJ, National Integration Academy Council. *Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus*. Rockville, MD: Agency for Healthcare Research and Quality; 2013. <http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>. Accessed September 19, 2016.

Transforming practices from traditional medical/mental health and substance use practices into integrated care practices is difficult work. To successfully transition to a practice/system providing integrated care requires a lot of technical assistance. Technical assistance may take many forms, but is often required to help identify ways to support integrated care through billing, implementing necessary modifications to workflow, and providing training on new tools.

There are a number of organizations in North Carolina that currently provide, or who may provide, technical assistance to practices/systems moving toward integrated care. In most cases in North Carolina, technical assistance is funded by philanthropic organizations. Technical assistance should support integrated care through training and the application of best- and evidence-based practices. The core concepts of this standard of care include team-based care, practice culture change, population management, screening and intervention protocols, motivational interviewing, comorbidities, billing, and workflow.

Within the Medicaid reform legislation passed by the North Carolina General Assembly, a new center, the Medicaid and NC Health Choice Transformation Innovations Center is to be created within the new Division of Health Benefits. Its purpose is “to assist Medicaid and NC Health Choice providers in achieving the ultimate goals of better health, better care, and lower costs for North Carolinians. The center should be designed to support providers through technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices.”^a

In light of the benefits of integrated care and the challenges faced by health care practices and systems transitioning towards more integrated care models, the Task Force recommends:

Recommendation 3.9: Support practice and system transformation towards integrated care.

- 1) Organizations including the Center of Excellence for Integrated Care, Community Care of North Carolina, AHEC, and others that work directly with providers should provide technical assistance to practices and health systems aiming to provide more integrated care. Technical assistance should be available to both primary care and mental health and substance use providers who are interested in providing integrated care. Technical assistance should include help in identifying ways to support integrated care through billing, implementing necessary modifications to workflow and culture change, training on new tools, and mentoring.
- 2) The North Carolina Department of Health and Human Services should include supporting integrated care as a core goal of the future Medicaid and NC Health Choice Transformation Innovations Center.
- 3) Under Medicaid reform, contracts with future Medicaid managed care organizations and provider-led entities should include a requirement to provide funding for technical assistance to practices providing, or moving toward providing, integrated care.
- 4) North Carolina foundations and philanthropic organizations should provide funding for technical assistance for practices moving toward providing integrated care.

Improving Access through Technology

As discussed, there is shortage of mental health and substance use professionals in many parts of North Carolina, which restricts consumer access to services in many parts of the state. One way to mitigate the shortage of mental health and substance abuse professionals in rural areas is to provide services for individuals with mental health and substance use disorders remotely using technology. Telepsychiatry is the term used to define the exchange of medical information from a provider to a consumer via electronic means with the aim of improving the consumer’s health status. Telepsychiatry focuses on mental health and substance use outcomes and studies have shown its success in improving consumer well-being, in part because it improves the availability and accessibility of mental health and substance use professionals for consumers and their providers. Telepsychiatry is also cost-effective, as it reduces costs associated with poor disease management, low staff coordination, travel time, and hospital stays. Challenges to implementing telemedicine models across North Carolina include the need to provide reliable internet connectivity, videoconferencing equipment to providers, and health insurance integration. Despite these challenges, studies have shown that telepsychiatry can help redistribute mental health and substance use resources and ultimately improve quality of life.

a Session Law 2015-245.

Currently, language in the North Carolina Division of Medical Assistance telepsychiatry policy is vague about the appropriate use of telepsychiatry as a modality of delivering services and exactly when and for what purposes telepsychiatry is billable. The North Carolina Medicaid policy allows for the following providers to bill Medicaid or North Carolina Health Choice (the state children's health insurance program): physicians, advanced practice psychiatric nurse practitioners, advanced practice psychiatric clinical nurse specialists, doctorate level licensed psychologists, licensed clinical social workers, and community diagnostic assessment agencies.^b The current policy is also restricted to Medicaid-enrolled sites, which limits the use of telepsychiatry in community-based settings.

Recommendation 3.10: Update DMA's telepsychiatry policy.

The Division of Medical Assistance should revise Clinical Coverage Policy 1H Section 6.2 to:

- 1) Explicitly state that the policy covers the use of telepsychiatry for the provision of ongoing direct services.
- 2) Expand the list of providers eligible to bill for telepsychiatry professional services to include all providers eligible to bill for outpatient mental health and substance use services under Clinical Coverage Policy 8C.

The Division of Medical Assistance should also explore the implications of certifying alternative telepsychiatry sites and credentialing programs rather than individual providers.

In recent years North Carolina has seen high emergency department admissions related to mental health and substance use issues and extended lengths of stays. The majority of emergency departments across the state do not have access to a full-time psychiatrist. The North Carolina Statewide Telepsychiatry Program (NC-STeP) connects hospital emergency departments across the state to provide psychiatric assessments and consultations to patients linked using telemedicine technology. This has resulted in reducing the length of stay for patients needing psychiatric care. Therefore, the Task Force recommends:

Recommendation 3.11: Maintain adequate funding for the NC-STeP Program.

The North Carolina Department of Health and Human Services should continue to provide adequate funding to support the NC-STeP Program.

Health professionals who provide telepsychiatry services to individuals in hospitals around the state are currently required to be independently credentialed by every hospital where they provide services. This creates an administrative burden that could potentially be avoided or significantly reduced. Additionally, providers must be credentialed to bill an LME/MCO for services. For providers who serve clientele in multiple catchment areas, this creates an administrative burden. While LME/MCOs all want quality control over who can provide services in their area, this may restrict the number of providers available to clients, particularly those living and working around the edges of the LME/MCO. To alleviate this burden and increase the number of potential providers, the Task Force recommends:

Recommendation 3.12: Standardize credentialing across systems.

Hospitals and health systems, the North Carolina Hospital Association, and LME/MCOs should explore strategies to make the process of credentialing in multiple systems less burdensome for providers, including standardizing the requirements for credentialing across systems, and explore opportunities for reciprocal and delegated credentialing.

^b NC Division of Medical Assistance, Medicaid and Health Choice Clinical Coverage Policy 1H Section 6.2

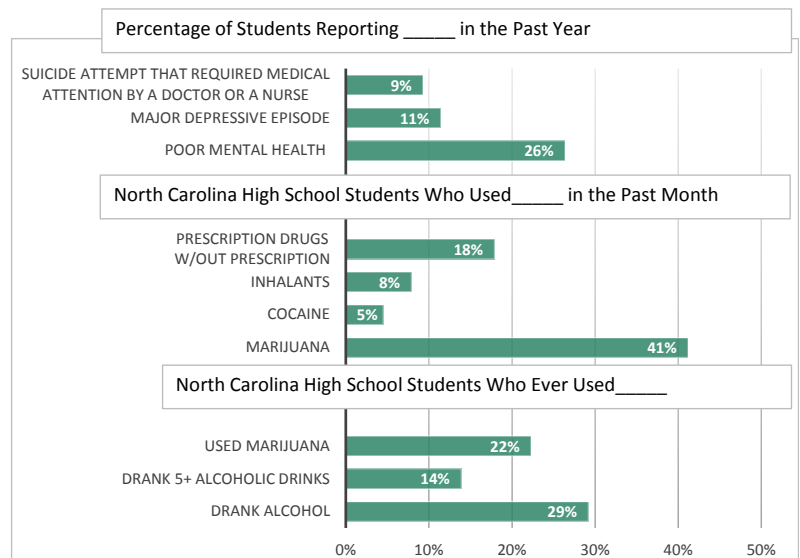
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Chapter Four: Meeting The Needs of Adolescents

Mental health and substance use disorders are the most significant threat to the lifelong health and well-being of youth.¹ Approximately one in five adolescents has a diagnosable mental health or substance use disorder that, if left untreated, will likely persist into adulthood and contribute to poor lifelong education, employment, and health outcomes.² Adolescence, defined in this report as ages 12 to 18,^a is an especially vulnerable time for the onset of mental health and substance use disorders. During this time, youth are maturing physically, cognitively, and sexually, while also developing social and intellectual skills in preparation for taking on adult roles. Although many adolescents experience some level of difficulty with emotional and behavioral regulation, these challenges are normal and most youth are able to develop positive mental health skills—including coping, resilience, and good judgement—that promote overall well-being. Similarly, during this time many youth experiment with drugs and alcohol, but most do not develop

Figure 4.1: Poor Mental Health and Substance Use Are Common Among North Carolina's Adolescents



Source: NC Youth Risk Behavior Survey 2015 and National Survey on Drug Use and Health NC 2013-2014

substance use disorders. However, as previously stated, approximately one in five adolescents does develop diagnosable mental health or substance use disorders.² Adverse experiences, in addition to biological factors and family history with mental health and substance use issues, can increase an adolescent's susceptibility to mental health and substance use disorders.³ Youth with mental health and substance use disorders are often involved in more than one special service system, including mental health, special education, child welfare, juvenile justice, and health care.¹ However, the majority of mental health and substance use disorders among adolescents go unrecognized or untreated. **Developing an improved system of mental health and substance use prevention, screening, and treatment, as well as improved coordination across youth-serving systems, are critical in order to create a more positive health trajectory into adulthood.**

Adolescents with mental health and substance use disorders are more likely to have academic or social problems, be expelled or suspended, become pregnant during adolescence, be convicted of a crime, and attempt suicide.⁴ Furthermore, approximately half of adult mental health disorders start by age 14, and three in four start by the age of 24.⁵ The majority of adults with substance use disorders started using substances during adolescence.⁵ However, national data show that only 20% to 25% of eligible youth receive mental health services.³ In North Carolina, the majority of adolescents with mental health and substance use needs do not receive treatment services.⁵ Prevention and early intervention are particularly important among adolescents, as are follow-up care and recovery supports after treatment. **Ensuring a full continuum of care for adolescents can result in substantially shorter and less disabling experiences with mental health and substance use disorders.¹**

Specific populations among young people are particularly at risk for mental health and substance use disorders, including youth involved with child welfare and juvenile justice systems, as well as disconnected youth. Disconnected youth are adolescents who are not connected to the skills, supports, resources, opportunities, and relationships needed to navigate their environment and succeed, such as those who have dropped out of school.⁶ Mental health and substance use treatment is particularly challenging for youth not integrated within traditional systems. Nearly 1 in 14 North Carolina teenagers, aged 16 to 19, reported that they were not attending school and not working in 2014.⁷ Furthermore, as youth age into being young adults, there is strong evidence that they face significant barriers to accessing care and treatment.⁸

^a Adolescence is a period of development that does not begin or end at the same age for everyone. Adolescence is often considered to last until age 21, but for the purposes of this report we have elected to focus on youth ages 12-18.

Challenges to Meeting the Mental Health and Substance Use Prevention, Treatment, and Recovery Needs of Adolescents

In 2006, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DDMH/DD/SAS) and partners received a grant to identify challenges within the adolescent substance abuse system. While the adolescent substance abuse system was the focus, many of the same challenges exist in regards to mental health services for adolescents. This study found that coordination both within and across systems is a significant barrier to effective treatment; there is a need for better training of clinicians around screening and assessment for adolescents; and utilizing more evidence-based strategies to address adolescent mental health and/or substance use disorders would improve service delivery and health outcomes.⁹ Because youth with mental health and substance use disorders are often involved in more than one special service system, the adolescent workgroup of the Task Force focused its recommendations on improving coordination within and across systems.

Systems Serving Children and Families Need Leadership and Support to Ensure Cross-System Collaboration

Youth with mental health and substance use disorders are often involved in more than one special service system, including mental health, special education, child welfare, juvenile justice, and health care.¹ These youth often have a variety of physical, mental, social, emotional, educational, and developmental needs. For example, in 2015, 21% of youth screened upon entering the juvenile justice system in North Carolina showed moderate or high risk for needing substance use treatment. Youth and their families must navigate and then interact with multiple systems on a regular basis to meet these needs. These systems may include schools, medical and behavioral health care, social services, juvenile justice and the courts, local management entities/managed care organizations (LME/MCOs), and other community organizations working with youth and families. Coordination and cross-system collaboration between these various entities is crucial to best meet the needs of youth and families.

In North Carolina, as in the rest of the nation, no one agency is responsible for these youth.¹ However, meeting the mental health and substance use needs of youth involved in these systems is critical. If adolescents' mental health and substance use disorders are not identified and assessed, and then followed up with effective treatment and recovery supports, these disorders often continue into adulthood, and may lead to school failure, poor employment opportunities, and poverty.¹ In order to address this issue, there is a need for better coordination and collaboration at the systems level to meet the behavioral health needs of children and their families.

At the state and community level, North Carolina has been using a system of care (SOC) framework for the existing systems to come together to provide care to children with mental health needs (and their families) since the 1980s. At the heart of SOC is the value that systems must collaborate to meet the needs of children and families. In a SOC, services are family driven, youth guided, community-based, and culturally competent. SOC is a "spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life."¹⁰ SOC has been shown to decrease the use of inpatient psychiatric and residential treatment, juvenile correction, other out-of-home placements, and health services, including emergency rooms.¹¹

DDMH/DD/SAS has supported the SOC framework as best practice for children with mental health and substance use needs. Beginning in 2001, the Departments of Public Instruction, Child Welfare, Juvenile Justice, and Public Health all committed to the SOC framework. In 2006, the North Carolina General Assembly awarded funding to DDMH/DD/SAS to create a statewide staffing infrastructure (30 local SOC coordinators) to support cross-system networking and local service development. A primary responsibility of the SOC coordinators is to support the membership development and functioning of the local Community Collaboratives. These collaboratives are charged primarily with serving as the guardian for all local system of care development, and are intended to represent all the public child-serving systems in the community, family members of youth who rely on those systems, schools, private and community-based child-serving agencies (both non-profit and for profit agencies), and other community stakeholders concerned about the health, safety, and well-being of children and families in the community. The LMEs that have also become managed care organizations were given contractual responsibility for both the SOC coordinators and the Community Collaboratives.^b

^b Grant T. State System of Care Coordinator, North Carolina Department of Health and Human Services. Written (email) communication. August 14, 2016.

There is a statewide coordinator in the North Carolina System of Care who is financially supported by DMH/DD/SAS. The system is supported at the local level by Community Collaboratives. Community Collaboratives bring together community agencies, families, service providers, organizations, and advocates who are concerned about and committed to children with mental health, substance abuse, and intellectual or developmental needs and their families to provide local leadership within the SOC. Community Collaboratives at the local level serve as a forum at the local county/regional level for child-serving systems to design protocols and coordinate policy to improve service coordination for special populations including multi-agency involved children with behavioral health needs. There are 87 Community Collaboratives across the state. The LME/MCOs typically have staff (usually called SOC coordinators or community care coordinators) who help coordinate the meetings. While SOC has been the framework for providing services to youth with mental health, intellectual, developmental, and substance use needs for a long time, changes in personnel, funding, and systems have limited statewide application of this important framework for serving children and families.

Additionally, no formal authority requires the child-serving systems to utilize a common philosophical and operational framework to ensure that public resources are maximized to support the needs of all children dependent upon public child-serving systems. The many systems serving children and families all have their own processes for identifying the mental health and substance use needs of the children and families they work with, as well as their own strategies for meeting those needs. There is a need for better collaboration at the local systems level (e.g., LME/MCOs, the court system, child welfare, juvenile justice) to ensure that information, policies, procedures, and funding are better coordinated to meet the needs of youth and families. LME/MCOs are well-positioned to lead local cross-systems collaboration efforts, as they are often the front door for mental health and substance use services for youth enrolled in Medicaid and those who are uninsured, which, when taken together, account for 56% of children.¹² Therefore, the Task Force recommends:

Recommendation 4.1: LME/MCOs should act as a lead player in cross-system collaboration.

DDMH/DD/SAS contracts with LME/MCOs should require commitment to the System of Care (SOC) model as well as participation in local Community Collaboratives. As part of this commitment, LME/MCOs should:

- 1) Ensure that LME/MCO leadership (not just SOC coordinators, but also appropriate LME/MCO decision-makers) meet quarterly with leadership from the Department of Social Services, local departments of health, school districts, juvenile courts, primary care providers, and juvenile justice groups (i.e., Reclaiming Futures, Juvenile Crime Prevention Councils, Juvenile Justice Substance Abuse Mental Health Partnerships, and Juvenile Justice Treatment Continuum groups) within their catchment areas.
- 2) Include at least one youth and one youth family member in all Community Collaboratives.
- 3) In counties where there is not a functioning Community Collaborative, partner with a similar collaborative organization (e.g., Juvenile Crime Prevention Councils, Juvenile Justice Mental Health Substance Abuse Partnerships, Reclaiming Futures) and encourage the group to consider acting as a SOC Community Collaborative.
- 4) In partnership with Community Collaboratives, LME/MCOs should establish guidelines for screening youth for mental health and substance use when they encounter any system and develop pathways for youth with positive screens to access assessment and treatment services as indicated.
- 5) In partnership with Community Collaboratives, LME/MCOs should establish guidelines for consolidating case plans when children and families are served by more than one system.
- 6) Lead efforts to enhance coordination of care within and across systems for youth and families and identify pathways for access to care and ongoing case/care management when needed.

Recommendation 4.2: Support and further develop local System of Care (SOC) Community Collaboratives.

1) The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DDMH/DD/SAS) should:

- a) Develop outcome measures to indicate whether or not System of Care (SOC) is working.
- b) Provide training and technical assistance for SOC coordinators to conduct Community Collaborative assessments, strengthen Collaborative membership, use data in creation of priorities, and develop local agreements to increase collaboration for the youth with the most complex needs.
- c) Work with other key public child-serving agencies to inventory existing training and technical resources across public agencies that can be utilized to support the development of local systems of care and Community Collaboratives.

2) LME/MCO SOC/Community Collaborative coordinators should work to:

- a) Strengthen and diversify Community Collaborative membership including increasing family and youth representation.
- b) Develop and monitor progress on data-supported priorities, including disparities in access and treatment by age, gender, race/ethnicity, or other factors.
- c) Develop local agreements to increase coordination of care across public agencies.

Assure that, as LME/MCO consolidation proceeds, SOC coordinator funding and staffing is adequate to meet the needs of a growing number of communities in the catchment area of the LME/MCO.

Schools Can Play a Significant Role in Meeting the Mental Health and Substance Use Prevention, Treatment, and Recovery Needs of Youth

Youth with mental health and substance use disorders are most likely to access services through schools and health care settings.¹³ Adolescents spend a significant amount of their time in school, and teachers and other school personnel are important partners in efforts to identify youth with mental health and substance use needs and route them to appropriate services. In fact, many students in North Carolina receive mental health services at their school through school counselors, social workers, and mental health therapists.¹⁴ North Carolina schools have implemented Positive Behavior Intervention and Support, a schoolwide proactive system of behavior support that defines and teaches appropriate student behaviors and positive school environment; as well as other discipline strategies to ensure that schools are caring and safe places for all children. However, the level of understanding of adolescent mental health and substance use disorders varies greatly across school personnel.

School personnel are in a key position to identify youth with mental health and substance use problems, as the vast majority of youth ages 12-18 are enrolled in school and interact with their teachers daily.¹⁵ School personnel play a large role in whether an adolescent is identified as needing mental health and substance use services or is identified as having behavioral problems that should be handled through discipline and juvenile justice involvement. Raising awareness of youth mental health and substance use and teaching skills to handle various behaviors can increase school personnel's ability to identify and respond in constructive ways. Therefore, the Task Force recommends:

Recommendation 4.3: Educate school personnel on the behavioral health needs of adolescents.

To increase the knowledge and skills of school personnel,

1) The North Carolina Department of Public Instruction should:

- a) Work with local superintendents and schools to publicize the online credits for current professional modules related to student behavioral health.
- b) Work with the public and private institutions of higher education and with educator and school counselor preparation programs to ensure that elective courses on adolescent development and behavioral health qualify towards degree credit.

c) Work with the North Carolina Sheriffs' Education and Training Standards Commission to make Youth Mental Health First Aid a credit-earning course for student resource officers and explore making Youth Mental Health First Aid a requirement for student resource officers. The Department of Public Instruction should work with the Commission to make crisis intervention trainings and courses on adolescent development credit-earning electives as well.

2) Local boards of education should encourage school staff and others who work with youth to receive Youth Mental Health First Aid training and Trauma-Informed Care training. (see Recommendation 3.3 Increase Number of North Carolinians Trained in Mental Health First Aid).

3) Each school district should ensure that at least two staff are trained in Youth Mental Health First Aid, ideally as instructors. These staff serve as the point persons to assist in the event of a crisis and coordinate staff training.

Schools in North Carolina work to meet the mental health and substance use prevention, treatment, and recovery services and supports needs of students in a variety of ways. Many schools have processes in place to assess risk and refer students and families to community-based mental health and substance use supports.¹⁶ Others have resources like a school-based health center that can assist in meeting the mental health and substance use needs of students. However, schools have also identified challenges that prevent them from fully meeting the needs of students, including lack of services (particularly in rural counties), difficulty obtaining services for students with private or no insurance, need for parent training, and more prevention services at all levels of schooling.¹⁶

A handful of school districts across the state have increased access to services for students with mental health and substance use service needs through partnering with local LME/MCO and provider communities to bring services into schools. For example, Buncombe County schools have collaborated with their local provider community to bring services into schools for more than 20 years.¹⁴ The most common service provided is outpatient therapy provided in the school setting.¹⁷ By teaming with local providers to bring services into their schools, schools can increase access to, coordination of, and family engagement in mental health and substance use treatment services.^{14,17} In some cases, providers working in the school also provide training for staff around youth mental health and substance use disorders.¹⁷ School systems that have participated in such partnerships emphasize the importance of this process of being collaborative with the local LME/MCO and provider community and the need for clarity of purpose, services, and structure for providing services in schools. Because of the benefits to students, families, and schools, the Task Force recommends:

Recommendation 4.4: Encourage partnerships between schools and LME/MCOs.

1) The Department of Public Instruction and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should develop models for effective, coordinated efforts between LME/MCOs and schools, school-based health centers, service providers, and school systems. Model memoranda of agreement should be developed and shared with the North Carolina School Boards Association, superintendents, and principals. Memoranda of agreement should not exclude service types, particularly evidence-based programs delivered to fidelity. The agreements should include:

a) Model memorandum of agreement between a school district and their LME/MCO that outlines how these entities can partner to meet the mental health and substance use needs of students and their families.

b) Model memorandum of agreement between a school, LME/MCO, and service providers that outlines how these entities can work together to meet the mental health and substance use needs of students and their families.

2) Local school boards should encourage schools in their district to explore ways to partner with providers to meet the mental health and substance use needs of children and their families.

Creating Trauma-Informed Systems

Adverse childhood experiences (ACEs), including child maltreatment, family dysfunction such as violence in the home, mental illness, substance abuse, and incarceration of a family member, affect children throughout their lives. In North Carolina, more than half of adults reported having experienced at least one ACE, with 20% reporting three or more.¹⁸ Although many children experience traumatic events without lasting negative effects, others will have more difficulty and long-lasting impacts. Unaddressed trauma increases an individual's risk of developing mental health and substance use disorders, as well as heart disease, obesity, lung disease, diabetes, and other conditions in adulthood.¹⁹ Research has shown that with appropriate supports and interventions, people can overcome the negative effects of trauma. In order to address the needs of youth who have experienced trauma, our child- and family-serving systems need to understand the impact of trauma and how service systems can help alleviate or exacerbate trauma-related issues.¹³

Among the many systems that serve youth and their families, North Carolina's juvenile justice and child welfare systems are leading the way in implementing trauma-informed policies and practices. Trauma-informed systems realize the widespread impact of trauma on children and families, recognize the signs and symptoms of trauma among those involved in the system, respond by integrating knowledge about trauma into policies, procedures, and practices, and work to not re-traumatize those within the system.²⁰ The main principles of the trauma-informed approach are safety, trustworthiness, transparency, peer support, collaboration, mutuality, empowerment, and cultural competency.²⁰ Project Broadcast is a five-year federal grant (2011-2016), from the U.S. Department of Health and Human Services Administration for Children and Families, awarded to the North Carolina Division of Social Services with the goal of developing a trauma-informed child welfare system in 12 demonstration counties. The results reported from these counties will be used to inform the best strategies to implement trauma-informed practices and then incorporate these practices statewide. Implementing trauma-informed practices and policies come at a cost: the North Carolina Division of Social Services estimates an allocation of \$800,000 per year in recurring funding in FY 2017-2025 would be needed to support implementation of Project Broadcast in all 100 counties. However, evidence is emerging that such investments reduce both direct and indirect costs substantially.²¹ Identifying and addressing trauma can help improve outcomes for children and youth, including minimizing the likelihood of developing mental health and substance use disorders. Therefore, the Task Force recommends:

Recommendation 4.5: Support the implementation of trauma-informed child and family serving systems across North Carolina counties.

The North Carolina Department of Health and Human Services should:

- 1) Promote the integration of trauma-informed practices and policies across human service and public safety agencies serving youth.
- 2) Introduce trauma-informed services into the core education and training for child and family serving human service and public safety agencies.
- 3) Emphasize interdisciplinary collaboration and relationship-building across child and family serving human service and public safety agencies.
- 4) Develop a Trauma Advisory Council to help oversee efforts to develop trauma-informed systems.

Improving Medicaid for Youth with Serious Emotional Disturbance

The adolescent workgroup of the Task Force also examined potential changes to Medicaid that would help improve services for youth with serious emotional disturbance. Youth with serious emotional disturbance includes those "who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities."²² These are youth with high cost, high intensity mental health and substance use treatment needs.

In 2015, the North Carolina General Assembly asked the Division of Medical Assistance to study the feasibility of implementing a 1915(c) waiver for children and adolescents with serious emotional disturbance who meet the psychiatric inpatient level of care.²³ This waiver would allow children who meet the level of care for placement in a psychiatric residential treatment facility (PRTF) and their families to have a choice of receiving home and community-based services in their home or foster home in the community rather than being placed in a restrictive institutional setting. The Division of Medical Assistance found that an average savings of at least 35% could be achieved by implementing a 1915(c) waiver for serious emotional disturbance.²³ Nine other states have implemented similar waivers and found cost savings of up to 68% over the cost of PRTF admissions, improved school attendance and performance, improved clinical and behavioral outcomes, decreased contact with law enforcement, and other positive outcomes.²³ Therefore, the Task Force recommends:

Recommendation 4.6: Submit a Medicaid waiver to best serve youth with serious emotional disturbance.

The North Carolina General Assembly should instruct the North Carolina Division of Medical Assistance/ Division of Health Benefits to submit a 1915(c) Medicaid waiver to serve children with serious emotional disturbance in home and community-based settings.

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Chapter Five: Meeting The Needs of Older Adults

Adults aged 65 and older (defined as “older adults” for this report) are a particularly complicated population in terms of mental health and substance use prevention, treatment, and recovery. Approximately 20% of adults 50 years and older have mental health concerns and older men have the highest suicide rates.¹ Depression, anxiety, alcohol, and psychoactive medication misuse are the most common types of mental health and substance use disorders among older adults.² While there are effective prevention, treatment, recovery services, and supports for older adults, they are significantly less likely to be diagnosed and referred to treatment than younger adults.² The Task Force found challenges related to prevention, identification, treatment, and recovery among older adults. Not only do older adults face the same challenges as younger adults, but there are also additional difficulties in understanding available Medicare coverage and what providers contract for what services, too few providers contracting with traditional Medicare or Medicare Advantage/replacement plans, and the prevalence of co-morbid conditions. All of these factors present challenges to prevention, identification, treatment, and recovery among older adults. Unlike adolescents and younger adults, older adults with mental health and substance use needs face additional difficulties accessing services because there is no state agency tasked with ensuring this population’s needs are met. Older adult mental health and substance use disorders are not currently at the forefront of public health issues, but the rapidly increasing size of the older adult population indicates the need to address mental health and substance use issues preemptively.³

For older adults, access to services and supports, is often limited due to lower reimbursement rates, limited covered services, and restrictions on the types of services health professionals are able to bill for under Medicare. For those who are screened and referred to treatment, prescribed treatment and medication may or may not be available under or covered by their Medicare plan. Private practice mental health and substance use treatment providers may not accept patients on Medicare and/or Medicare Advantage plans because of the added administrative burden coupled with lower reimbursement rates. This greatly reduces access for a substantial portion of older adults in North Carolina.⁴ Additionally, older adult mental health and substance use disorders frequently co-occur alongside other health issues: more than 50% of North Carolinians age 65 and older report having two or more chronic conditions, and 75% report having at least one.⁵ Furthermore, medication used to address physical health concerns may exacerbate mental health issues and can contribute to, or be complicated by, substance use. Overall, older adults use three times as many medications as younger adults.³ Although generally more adherent than younger adults,⁶ older adults have complex medication regimens that can increase the difficulty of adhering to prescription directions. Studies show that between 40% to 90% of older adults do not follow prescribers’ directions.³ In addition to being more likely to have co-occurring health issues, older adults are also more likely to experience loneliness, loss of loved ones, diminished mobility, and a decline in independence, all of which can contribute to mental health and substance use disorders.

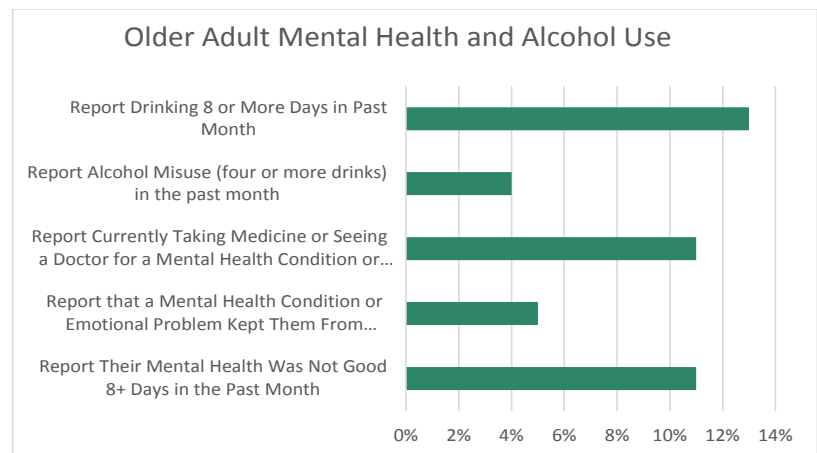
Depression, anxiety, alcohol, and psychoactive medication misuse are the most common types of mental health and substance use disorders among older adults.² Approximately 15% of older adults meet the criteria for depression and 14% meet the criteria for anxiety disorder.^{7,8} Depression is a major public health issue that places older adults at risk for poor outcomes, including decreased functional status, premature institutionalization, and suicide, which is primarily caused by depression. Even subsyndromal levels of depressive symptoms (mild levels not qualifying for a diagnosis) lower quality of life by contributing to low morale, low self-efficacy, and negative perceptions of life. Any increase in depressive symptoms is a major predictor of impairments in quality of life.⁹ In the U.S., clinically significant depressive symptoms are reported in about 8% to 16% of older adults living in the community.¹⁰ In North Carolina, state agencies and academic institutions do not collect depression prevalence data specifically among the older adult population. Survey data indicate that at least 10% of older adults have poor mental health and/or take medication for mental health conditions (see Figure 5.1).

Substance use among adults aged 60 and over, particularly of alcohol and prescription drugs, is one of the fastest growing health problems in the United States.³ Data from North Carolina show that more than one in every ten adults aged 65 and over report poor mental health and regular consumption of alcohol.¹¹⁻¹⁵

Alcohol use at any age can result in motor vehicle crashes, memory impairment, head and neck cancer, cardiomyopathy, hepatitis, cirrhosis and liver failure, pancreatitis, gastritis, confusion, slurred speech, aspiration, and vomiting.¹⁶ However, alcohol use by older adults can be particularly problematic because the physical changes that come with aging lower alcohol tolerance.³ Among older adults, alcohol use is associated

with 6% to 24% of falls that resulted in fractures.¹⁶ In fact, more older adults were admitted to hospitals for alcohol problems than for heart attacks.³ In addition to alcohol use, drug use, both prescription and over the counter, is common among older adults. Eighty-five percent of older adults take at least one prescription drug, 20% use tranquilizers daily, and 70% use over the counter medications daily.³ Physiologic changes due to aging result in older adults having higher sensitivity to over the counter and prescription medicine; additionally alcohol can negatively interact with their medications.³ Levels of substance use among aging baby boomers are leading to huge increases in the level of substance use disorders among older adults; if estimates of expected levels of mental health and substance use disorders are correct, the state will require double the available treatment services by 2020.³

Figure 5.1: More than One in Ten Older Adults Report Poor Mental Health and Substance Use



Source: North Carolina State Center for Health Statistics, Behavioral Risk Factor Surveillance Survey 2013 and 2014. North Carolina Department of Health and Human Services website. <http://www.schs.state.nc.us/units/stat/brfss/>. Accessed on August 29, 2016.

Leadership

Many state and local agencies oversee funding or provide services to older adults, however, none of these agencies focus exclusively on older adult mental health and substance use. Unlike adolescents and younger adults, older adults with mental health and substance use needs face additional difficulties accessing services because there is no state agency tasked with ensuring this population’s needs are met; neither the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) nor the Division on Aging and Adult Services see older adults with mental health and substance use needs as being primarily their responsibility. At the local level, the local management entities/managed care organization (LME/MCO) systems are not tasked with meeting the needs of the older adult population and are unfamiliar with Medicare and its requirements. The lack of coordination among state-level agencies, community-based organizations, and other providers means that the mental health and substance use needs of older adults are often overlooked.

Currently, the Division of Aging and Adult Services, DMH/DD/SAS, the Division of Medical Assistance, the Division of Health Services Regulation, Emergency Medical Services, LME/MCOs, and the Area Agencies on Aging all serve older adults. Each of these agencies provide funding or services that are part of the continuum of services for older adults with mental health and substance use disorders. While the goals of these agencies overlap, each agency works independently to meet their responsibilities to this population. Unlike other populations, such as adolescents, there are no cross-agency coordination efforts for this age group. With division of responsibilities across numerous agencies, North Carolina lacks a coordinated, statewide approach for meeting the mental health and substance use treatment needs of older adults. Therefore, the Task Force recommends:

Recommendation 5.1: Establish statewide coordinated leadership to oversee older adult health.

- 1) In order to develop a more robust and coordinated behavioral health system for older adults, it is recommended that the North Carolina General Assembly:
 - a) Appoint a subcommittee of the Joint Legislative Oversight Committee to focus on the mental health and substance use needs of older adults during the next legislative session.
 - b) Re-establish the North Carolina Study Commission on Aging, with a mission to study and evaluate the existing public and private delivery systems for state and federal services for older adults and make recommendations to improve these systems to meet the present and future needs of older adults. The study commission should be charged with examining the mental health and substance

use system for older adults as one of its first areas of focus.

2) The Secretary of the Department of Health and Human Services (DHHS) should establish a working group within DHHS to address older adult mental health and substance use. This group should include leadership from the Division of Mental Health, the Developmental Disabilities and Substance Abuse Services, the Division of Medical Assistance, the Division of Aging and Adult Services, the Division of Public Health, and the Department of Transportation. This group should also include older adults in recovery from mental health and substance use disorders and should focus on developing a comprehensive system of care that delivers high quality, timely, and accessible care to meet the mental health and substance use needs of older adults in the most appropriate settings across the state. The working group should report to the Joint Legislative Oversight Committee or Study Commission on Aging annually, before the beginning of the General Assembly's session.

Medicare Coverage of Mental Health and Substance Use Services

Most older adults are eligible to enroll in Medicare when they turn 65. Federal law dictates the rules and regulations of Medicare, and the program is administered and paid for by the Centers for Medicare and Medicaid Services. Unlike Medicaid, the state does not have any control over the rules and regulations of Medicare. Individuals enrolled in Medicare can select traditional Medicare, which operates on a fee-for-service model, or from a number of Medicare Advantage plans, which operate under a managed care model. Seventy percent of Medicare-enrolled North Carolinians are in traditional Medicare, with 30% enrolled in Medicare Advantage plans.¹⁷ Under both traditional Medicare and Medicare Advantage plans, enrollees can opt to add prescription drug coverage, with premiums that range \$18-\$100 per month depending on structure and coverage.¹⁸ Under Medicare, individuals have varying levels of coverage for screening, outpatient treatment, and outpatient and inpatient hospitalization.

Access Challenges for Individuals Enrolled in Medicaid Aging into Medicare

Older adults who had been covered by Medicaid due to an existing, persistent mental illness prior to turning 65 typically become dually eligible for Medicaid and Medicare. This dual eligibility presents challenges as Medicare becomes the primary payer, potentially causing disruptions in care because Medicaid has multiple acceptable licensed mental health providers while Medicare has a more limited list. As a result, individuals who are dually enrolled in Medicare and Medicaid may experience disruptions to their care due to differences in the two programs' regulations.¹⁹

While both traditional Medicare and Medicare Advantage plans provide some coverage for mental health and substance use treatment services, Medicare payments are restricted to certain types of eligible professionals, including psychiatrists, clinical psychologists, social workers, and nurse specialists, independently practicing psychologists, and a few others.¹⁹ The list of eligible professionals does not include all mental health and substance use treatment professionals in North Carolina (e.g., licensed professional counselors, certified substance abuse counselors, and others), which restricts older adults' access to mental health and substance use services. Additionally, although the Affordable Care Act provided mental health parity to Medicare in terms of coverage, some providers decline to participate with Medicare and/or the privately-administered Medicare Advantage plans.²⁰ This may result in frequent changes of providers or difficulty accessing any provider.

Individuals enrolled in Medicare can select traditional Medicare, which operates on a fee-for-service model, or from a number of privately-administered Medicare Advantage or Replacement plans, which operate under a managed care model. Adults 55 and over who qualify for nursing home level of care but can still live safely at home may also opt for PACE (Program of All-Inclusive Care for the Elderly), which is a Medicare and Medicaid program.²¹ This option is only available in certain counties.

Assistance for Older Adults in Selecting Medicare Plans that Fits their Need

An individual must select traditional Medicare or Medicare Advantage upon enrolling, however, each year during Medicare's Open Enrollment Period (October 15–December 7), individuals can revisit their decision. They can also decide if they want a drug benefit in traditional Medicare (as a stand-alone drug plan) or incorporated in the Medicare Advantage plan. Most individuals can only move between traditional fee-for-service Medicare and Medicare Advantage plans during this seven week open enrollment period. Plans differ in what they cover, what they cost, and when the money needs to be paid (i.e., before or after the visit).

There is significant confusion around Medicare coverage options and related expenses. Research shows that 75% of Medicare beneficiaries are not in the lowest cost Medicare plan, that most beneficiaries are not utilizing resources to help compare plans, (leading to decision-making paralysis), and that beneficiaries, on average, pay 30% more for their medicines than necessary.²² Not only are seniors overpaying for coverage and medications, they may also not be enrolled in the coverage that works well with their providers, especially in regards to mental health and substance use services. It is very important that seniors verify that the plan they choose covers the drug they need to manage their mental health condition. Medicare covers a wide variety of treatment services, however, there are restrictive rules that limit coverage and reimbursement. Medicare’s coverage for physical health problems is more extensive than coverage for mental health and substance use disorders, although the Mental Health Parity and Addiction Equity Act of 2008 was designed to help address this gap.²³ For instance, Medicare Part D covers outpatient prescription drugs, and may cover the drugs needed to treat a mental health condition either as a stand-alone prescription drug plan or as part of a Medicare Advantage plan.²⁴ Generally, privately-administered stand-alone drug plans or Medicare Advantage plans that include medicines are not required to cover all drugs, although they must cover most anti-depressants, anticonvulsants, and antipsychotic medications.²⁴ However, even though the medicines are covered, they are not necessarily affordable. Beneficiaries are often unaware of services that assist individuals with limited resources to pay for prescription medications, such as (federal assistance or the low-income subsidy), Medicare premiums, deductibles, and the Part B coinsurance (MQB or Medicare Savings Programs).²⁴

PORTRAIT OF AN OLDER ADULT BENEFITTING FROM SHIIP ASSISTANCE

A 63-year old female contacted Senior PharmAssist, Durham’s SHIIP coordinating site, in April because her Medicare was set to start in July due to her disability status. She wanted guidance on selecting the best plan. During her initial screening, she seemed eligible for the federal low-income subsidy and completed her application. When she came in for her appointment, she was approved for a full low-income subsidy. This subsidy eliminated her monthly drug plan premium and lowered the cost of her medicines so that the brand name drugs would cost no more than \$7.40 (and the generic even less). She learned about the various types of Medicare coverage and chose the plan that allowed her to see her doctors. While there was an HMO with lower co-payments, some of her providers did not contract with the current plan, so she selected a PPO that did not place restrictions on the professionals she could visit.

The Seniors’ Health Insurance Information Program (SHIIP), part of the North Carolina Department of Insurance, assists Medicare beneficiaries in understanding their choices of available insurance products and services, a service referred to as navigation insurance assistance. Without navigation insurance assistance, seniors may stay in ill-fitting plans, overpay for their benefits, and not receive the coverage they need. Navigation insurance assistance also benefits seniors by ensuring that they have access to the providers they need. There are local navigation insurance assistance coordinating sites in every county in North Carolina, usually located in community-based organizations like senior centers, cooperative extension offices, area agencies on aging, and councils of government. For example, during the 2016 Annual Election Period alone (October 15-December 7) counselors at Senior PharmAssist, the SHIIP-coordinating site in Durham, helped 1,240 people, 60% of whom needed to switch plans to both save a significant amount of money and to obtain better coverage.²²

Recommendation 5.2: Increase support for SHIIP program.

- 1) The North Carolina Congressional Delegation should advocate to maintain or increase funding to the State Health Insurance Assistance Program.
- 2) The North Carolina General Assembly should allocate adequate recurring funding for the North Carolina SHIIP program to support community-based coordinating sites that provide assistance to older adults. This funding should take into account the federal funding level and the increases in the senior population.
- 3) Senior centers and primary care providers should partner with the local SHIIP coordinating sites to ensure that the Medicare population receives education on how to contact the North Carolina SHIIP program.

Preparing Communities to Meet the Needs of Older Adults with Mental Health and Substance Use Disorders

Depression, anxiety, alcohol, and psychoactive medication misuse are the most common types of mental health and substance use disorders among older adults.² Approximately 15% of older adults meet the criteria for depression and 14% meet the criteria for anxiety disorder.^{7,8} Among older adults receiving services, these percentages rise to approximately 30%.^{7,8} **Mental health disorders are often unrecognized and undertreated in older adults**, in part because diagnosis is complicated by co-occurring medical illness, cognitive decline, and changes in life circumstances. Among older adults, excessive alcohol consumption is the most common substance use disorder.³ Of medical inpatients who screened positively for alcohol misuse, 21% were over age 60 and 15% were over age 70.¹⁶ Generally speaking, it is much harder for staff to recognize misuse in older adults. In one study only 37% of older adults with alcohol issues were identified by staff (compared to 60% of younger adults).¹⁶ This is largely due to the limitations of alcohol use screening tools for older populations. Most tools were developed for younger adults, and thus do not address the following issues: memory loss may inhibit recall of alcohol-related consequences, and the screening tools do not address the fact that an older adult's positive screen may require different benchmarks than a younger adults.¹⁶ Additionally once the older adults were identified, intervention or care was only recommended for 24% of the older adults (compared to 50% of the younger adults).¹⁶

As discussed in Chapter 3, Mental Health First Aid (MHFA) is an evidence-based, population-level training that increases the capacity of community members to recognize individuals with mental health and substance use needs and connect them to services. As recommended, it is critical that the MHFA for older adults training is disseminated among programs that provide services to older adults and their caregivers, and that the appropriate services exist for patients once their mental health needs are identified. (See Recommendation 3.3.) Healthy Ideas is another evidence-based service delivery model recommended for dissemination by the Centers for Disease Control and Prevention and the National Administration on Aging. It extends the reach of current community-based aging services by integrating depression awareness and self-management into ongoing delivery of case management and social services. Healthy Ideas includes training for community-based staff to learn how to screen and educate older adults and caregivers about depression; how to refer and link to health or mental health professionals; how to conduct behavioral activation; and how to follow-up to assure depressive symptoms are decreased.²⁶ Healthy Ideas is one of a handful of evidence-based programs to address depression among older adults that is currently being disseminated in communities in North Carolina.

Given the rapid growth in North Carolina's older adult population, adults 60 and older are projected to grow from 1.7 to 3.1 million from 2010 to 2030. Of this number, at least 310,000 will have mental health needs. Aging service providers in North Carolina are unprepared to meet the mental health care needs of this population. There is a paucity of adequately trained mental health professionals who have specific training and experience working with older adults. Additionally, providers of community- and home-based care often have insufficient knowledge and training about mental health and aging.

In North Carolina, Geriatric Adult Mental Health Specialty Teams (GASTs) are funded by the state to provide training and consultation to people working in community organizations that provide services and support to older adults with mental health and substance use needs. When they began, GAST focused primarily on adult care homes, family care homes, and nursing home settings. However, because the needs of the community have shifted over the years, with an increase in the number of people over the age of 60 with mental health and substance use issues who have chosen to live in the community, the GAST teams are expanding their focus. Many older adults interact with local organizations and frequent community facilities as part of their daily lives. However, those with mental health and/or substance use disorders may be unable to utilize or maintain involvement with these institutions due to the staff's lack of understanding of these disorders. It is essential for the staff to have an understanding of these issues, possess the skills to prevent and diffuse crisis situations, and have the ability to support older adults. In response, GAST teams are increasingly training staff in senior centers, home health agencies, departments of social services, faith-based organizations, law enforcement, the judicial system, and other groups that work with older adults. GAST teams can help staff in these organizations understand, recognize, and properly respond to individuals with mental health and substance use disorders. The Task Force supports GAST teams in their efforts to provide training to community organizations that work with older adults. Therefore, the Task Force recommends:

Recommendation 5.3: Use GAST teams to train communities on issues of older adult mental health.

The GAST teams should provide training on the behavioral health needs of older adults to adult and family care homes, nursing facilities, and organizations that work with older adults in the community such as senior centers, adult day programs, faith-based organizations, law enforcement, the judicial system, and veteran affairs centers. GAST programs should market the training they provide to as many organizations the team is able to contact.

Primary Care and Integrated Care

Although mental health and substance use disorders are prevalent among older adults, older adults are less likely to seek specialty care to address these health problems because they may already have a long-term relationship with their primary care doctors, fear perceived stigma, face transportation challenges, and/or have troubles finding providers with experience treating older adults who accept Medicare.²⁷ Additionally, mental health and substance use concerns are often under-identified by health professionals and older adults themselves.¹⁶ Unfortunately, many primary care clinicians are poorly equipped to identify and address behavioral health issues, especially complex conditions, severe and persistent conditions, or co-morbid conditions. The U.S. Preventive Services Task Force recommends screening for depression in adults, including older adults, who receive care in clinical practices that have adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up after screening.²⁸ In North Carolina, practices serving Medicare-enrolled populations can receive technical assistance from Alliant Quality, a health care consulting organization, as well as Community Care of North Carolina, the Center of Excellence for Integrated Care, and others that provide technical assistance to primary care practices. In order to increase primary care providers’ ability to screen, provide brief interventions, and refer patients to appropriate treatment, the Task Force recommends:

Recommendation 5.4: Improve capacity of primary care practices to screen, treat, and refer older adults to treatment for behavioral health needs.

Alliant Quality, along with Community Care of North Carolina, the Center of Excellence for Integrated Care, and others who provide education and technical assistance to primary care practices, should provide education and training to primary care providers and practices on:

- 1) Using evidence-based methods to screen for mental health and substance use among older adults, with a particular focus on depression,
- 2) Providing brief intervention, and
- 3) Referring patients to treatment for behavioral health needs. The percentage of older adults receiving screening for depression and substance use disorder should increase by 25% per year.

Integrated care is particularly promising for increasing screening, brief intervention, and referral to treatment for older adults with mental health and substance use disorders. Integrated care is the systematic coordination of general and behavioral health care. Integrating mental health, substance abuse, and primary care services is the most effective method for caring for people with multiple health care needs and produces the best outcomes.²⁹ A model that integrates mental health care into a primary care setting allows the patient to receive screening and treatment from their trusted provider and a behavioral health specialist on the team.²⁹ There are three operationalized models, the most integrated of which is the Primary Care Behavioral Health Model, with different program variations within this model. Two programs are Improving Mood, Promoting Access to Collaborative Treatment (IMPACT) and Screening, Brief Intervention, and Referral to Treatment (SBIRT). PACE provides integrated care for its participants, utilizing these and other approaches, but even most integrated health care delivery program is challenged with meeting the behavioral health needs of the older population due to problems within the mental health and substance use treatment delivery system. As discussed in Recommendation 3.9 in Chapter 3, practices and health systems need to be supported to transform toward integrated care.

Care Management

Older adults with mental health and substance use disorders often have additional, co-occurring chronic health conditions. Care management, which involves assessing a patient's needs, developing a care plan, ensuring preventive care services are provided, medication reconciliation, managing care transitions between providers/settings, and coordinating with home- and community-based providers, can help individuals with co-occurring conditions manage their health conditions and reduce overall costs.³⁰ As of January 1, 2015, Medicare is reimbursing for non-face-to-face chronic care management (CCM) services provided to Medicare fee-for-service beneficiaries with multiple chronic conditions.³⁰ The CCM billing code may be used by physicians, certified nurse midwives, clinical nurse specialists, nurse practitioners, and physician assistants.³⁰

Although the CCM code exists, few practitioners are providing care coordination services under this code. Practices face a number of roadblocks to billing the CCM code, including not knowing that it exists, not understanding the requirements, determining if Medicare will cover the cost, and incorporating CCM into their existing billing and workflow. These roadblocks could be ameliorated by involving organizations in North Carolina that educate providers, including Alliant Quality, Community Care of North Carolina, the Area Health Education Centers, and other similar entities. These groups have strong existing relationships and knowledge about best practices for providers. In order to increase the provision of CCM services to older adults, the Task Force recommends:

Recommendation 5.5: Increase care management services for older adults.

Organizations including Alliant Quality, Community Care of North Carolina, the Area Health Education Centers, professional associations, and others that work with providers should provide education and technical assistance to practices and health systems to help them increase chronic care management services for older adults.

Increasing Workforce Trained to Provide Mental Health and Substance Use Treatment to Older Adults

Many private practice behavioral health providers do not accept assignment or bill Medicare for services.⁴ Recently identified barriers include the privatization of Medicare through Medicare Advantage plans, which have resulted in lower fees relative to reimbursement in traditional Medicare, anxiety regarding audits because of limited information about documentation requirements and the need for compliance plans, and confusion regarding the new and evolving Merit-Based Incentive Payment Systems (MIPS) and alternative payment models that focus on value, not volume.⁴ Other barriers are restrictions by the regional carriers, who set the local coverage determinations as to which mental health disciplines can be Medicare providers, as well as a lack of training in the geriatric field generally, and integrated primary care specifically.⁴ These barriers all lead to a lack of access for older adults.

In addition to shortages of enrolled treatment providers, Medicare enrolled mental health and substance use treatment providers are underutilizing both available codes and helpful Medicare outpatient services. Many older adults with a physical health diagnosis have related behavioral, social, and psychological problems. Treatment for these related problems can be addressed and services can be paid for under health and behavior service codes, which are covered by Medicare as well as some private insurance companies.³¹ Medicare health and behavior services codes cover “intervention services for improving a patient’s health by modifying cognitive, emotional, social, and behavioral factors that affect prevention, treatment, or management of a specific health problem or symptom.”³¹ These underutilized codes could be used to provide care to many older adults to address mental health and substance use concerns that affect the management of physical health problems.

There are other underutilized Medicare services, such as intensive outpatient programs and partial hospital programs, that could be used to provide needed services to older adults as well. Intensive outpatient programs include depression screening, individual and group psychotherapy, psychiatric evaluation, medication management, and diagnostic tests. Partial hospitalization is a short-term, structured program of outpatient psychiatric services provided to patients as an alternative to inpatient psychiatric care.⁵² It is meant for acutely mentally ill adults and provides a range of approaches including therapy (group, individual, or recreational) and community living skills training, and is aimed at increasing the individual’s ability to function appropriately by offering coping skills and medical services.³²

Many of these barriers could be overcome with education by the various professional groups that provide technical assistance and education in North Carolina. The barriers for mental health professionals accepting Medicare patients could be ameliorated with education on, the availability of outpatient services for Medicare beneficiaries and the best practices for filing claims, reducing audit anxiety, using underutilized health and behavior services codes (which can be used by a wider variety of providers and billing). Therefore, the Task Force recommends:

Recommendation 5.6: Increase number of eligible behavioral health care providers billing Medicare.

- 1) The primary care and behavioral health specialty associations (or coordinating council) in partnership with the Center of Excellence for Integrated Care and Area Health Education Centers should work with members to:
 - a) Provide continuing education around the special needs in behavioral health care of older adult populations.
 - b) Provide practice level technical assistance to facilitate credentialing, quality measurement, and billing, including health and behavior services codes.
 - c) Increase health and behavioral code billing. The professional associations should work with the North Carolina chapter of the National Association of Social Workers to allow social workers to bill under health and behavioral codes.
 - d) Advocate to the American Medical Association’s Relative Update Committee (an advisory group to CMS) to review the health and behavioral codes and their work value.
- 2) Alliant Quality, Community Care of North Carolina, the Area Health Education Centers system, professional associations, and others that provide education and technical assistance should provide educational opportunities on how to manage Medicare patients and develop referral networks, as well as host learning collaboratives to share best practices, in order to increase the number of behavioral health care providers billing Medicare.
- 3) Private insurers should reimburse for health and behavior services codes if they do not already cover them.

In addition, the professional associations for the mental health and substance use workforce should collaborate with local community colleges, colleges, universities, and Area Health Education Centers to ensure that there are training courses and classes to continue to develop this workforce. Training should include foundational skills and information on how to provide services in different contexts (such as brief intervention or crisis), how to provide services in both specialty mental health settings and non-specialty mental health settings, and how to work with patients of various ages. (See Recommendation 3.7.)

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Appendix A: Full Recommendations of the Task Force on Mental Health and Substance Use

Recommendation 2.1: Support and expand availability of a full array of mental health and substance abuse services through LME/MCOs.

- 1) The North Carolina General Assembly should:
 - a. Allow LME/MCOs to invest fund balances in expansion of community-based services in future budgets.
 - b. Allocate proceeds from the sale of the Dorothea Dix property to the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services with at least half of the funds going towards providing a full array of mental health and substance abuse services.
- 2) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and Division of Medical Assistance contracts with LME/MCOs should require LME/MCOs to submit plans detailing how they plan to use their fund balances to expand or innovate services over the next year. Plans should require approval from the Secretary of the Department of Health and Human Services before implementation.

Recommendation 2.2: Provide case management and recovery navigation.

The state Medicaid agency should create stand-alone billable case management services with well-defined eligibility criteria, as well as navigator and step-down services for individuals needing less intense case management.

Recommendation 2.3: Require North Carolina agencies to share data cross-agency.

The Department of Health and Human Services, the Department of Public Instruction, the Department of Corrections, and other agencies working to meet the mental health and substance use prevention, treatment, and recovery needs of North Carolinians should:

- 1) Contribute their data to the Government Data Analytics Center and establish a memoranda of understanding to allow cross-agency data sharing.
- 2) Provide funding to support data analysis through the GDAC.
- 3) Use data to guide policy decisions and measure their impact.

Recommendation 2.4: Assess and address disparities in the LME/MCO system.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services should:

- 1) Require LME/MCO to complete an analysis of type/severity of diagnosis, duration of services, use of psychotropics, and outcomes when available, by demographic data including gender, age, and race/ethnicity as part of the annual gaps analysis.
- 2) Require each LME/MCO to develop strategic plans to address disparities identified in the gaps analysis.

Recommendation 2.5: Expand access to mental health and substance use services.

The North Carolina General Assembly should increase access to and utilization of mental health and substance use services for uninsured residents.

Recommendation 2.6: Increase utilization of evidence-based mental health and substance use services and tie payment to positive health outcomes.

- 1) Payers, both private and public, should develop service definitions, contracts, and/or value-based payments to reward providers based on:
 - a) Completion of approved training for evidence-based treatment services and consistently providing evidence-based treatment.

- b) Use of evidence-based screening and assessment instruments to identify people with mental health and substance use conditions.
 - c) Case mix and the severity of patients' needs.
- 2) Insurers, both private and public, should work together to develop mental health and substance use process and outcome measures (or adopt those developed by CMS) and define value-based payments and/or performance-based incentives for improving health outcomes. Value-based payments and/or incentives should be developed to reward providers based on:
- a) Consistently reporting process and outcome measures.
 - b) Achievement of positive outcomes for patients.
 - c) Severity of need and case mix of patients

Recommendation 3.1: Educate communities on available mental health and substance use services.

- 1) The Division of Medical Assistance (DMA), in partnership with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), local management entities/managed care organizations (LME/MCOs), private insurance providers, provider organizations, the National Alliance on Mental Illness (NAMI), Care Share Health Alliance, Area Health Education Center (AHEC), and other partners should develop and disseminate model curricula and tools to educate and train patients and family members about the public mental health system including:
- a) Who is eligible for services
 - b) What types of services are available
 - c) How to access services and navigate the system
 - d) Alternatives to the emergency department for crisis treatment
- 2) DMH/DD/SAS, LME/MCOs, DMA, AHEC, and private insurers should develop trainings for providers who interact with individuals with mental health and substance use needs in their communities (e.g., health providers, pharmacists, public health, emergency medical personnel, local law enforcement, judges, social workers, and the Department of Justice) understand how the mental health and substance use system works, what services are available, who is eligible for services, and how different populations can access services. Specifically these trainings should:
- a) Work with professional associations, continuing education programs, and local communities to disseminate these training materials.
 - b) Integrate this information into Mental Health First Aid training.

Recommendation 3.2: Develop a common access point for the mental health and substance use prevention, treatment, and recovery system.

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), Division of Medical Assistance (DMA), local management entities/managed care organizations (LME/MCOs), private insurers, first responder systems, and other stakeholders should work together to develop a common access point for the mental health and substance use system, particularly for those in crisis.

Recommendation 3.3: Increase the number of North Carolinians trained in Mental Health First Aid.

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) should work with LME/MCOs, providers, and others to increase the number of individuals across the state trained in Mental Health First Aid.

- 1) Local Boards of Education, the North Carolina Center for Afterschool Programs, the YMCA, and other organizations serving youth, should encourage school staff and others who work with youth to receive the Youth Mental Health First Aid training.
- 2) The Mental Health, Substance Use, and Aging Coalition should work with DMH/DD/SAS to:
 - a) Encourage existing Mental Health First Aid trainers to become certified as trainers for the Mental Health First Aid for Older Adults program.
 - b) Promote the Mental Health First Aid for Older Adults program among those providing various services to older adults including caregivers, continuing care retirement communities, senior housing, senior centers, senior support programs, local law enforcement, emergency medical services, older adults, and others.

Recommendation 3.4: Involve consumers and local communities in the LME/MCO service gaps improvement process.

DMH/DD/SAS should work in partnership with local LME/MCOs to establish best practices for how to involve local communities in the service gaps improvement process. Best practices should include ensuring that special populations are part of the process

Recommendation 3.5: Support and encourage crisis response stakeholders to collaborate.

- 1) Hospitals and health care systems, local law enforcement, emergency medical services (EMS), LME/MCOs, community leaders, primary care and specialty providers, patients and families, and others involved in the crisis system in communities should collaborate to improve the response to mental health crises in communities, particularly for adolescents and older adults. These collaboratives should also work together to address other impediments to accessible, timely, quality mental health and substance use services, as well as prevention.
- 2) Community foundations and other philanthropic organizations should support the development of local stakeholder collaboratives to improve collaboration and coordination between all organizations involved in crisis response, or other aspects of the mental health and substance use system, within their community.

Recommendation 3.6: Develop new payment models to support community paramedicine programs with mental health and substance use crisis response.

The North Carolina Department of Health and Human Services should convene a working group including representatives from the Department of Insurance, health care systems, facilities, and public and private payers, including accountable care organizations, managed care organizations, and provider-led entities to develop new payment models to support community paramedicine programs implementing mental health and substance use crisis response.

Recommendation 3.7: Strengthen training and workforce development.

The North Carolina professional associations for the mental health and substance use workforce should work together with LME/MCOs, North Carolina's community colleges, colleges, universities, and AHEC to ensure there are courses and continuing education opportunities for the mental health and substance use workforce to develop:

- 1) Foundational skill training (core competencies) that encompasses a variety of evidence-based models and ranges across disciplines, (e.g., patient-guided practice, cultural and linguistic competence, screening, assessment and referral, treatment planning, systems knowledge, quality improvement).
- 2) Expertise in providing context-specific services to consumers (e.g., brief intervention, crisis).
- 3) The knowledge and skills to provide services in both specialty mental health settings (e.g., mental

health clinics, psychiatric hospitals, rehabilitation/reintegration, crisis centers) and non-specialty mental health settings (e.g., schools, social service agencies, integrated care).

- 4) Expertise and skills needed to work with adolescents, older adults, and/or those with co-occurring mental health and substance use needs.

Recommendation 3.8: Develop a more robust transition to practice system for mental health and substance use professionals.

The North Carolina professional associations for the mental health and substance use workforce should work with the state Medicaid agency, DMH/DD/SAS, Division of Social Services, University of North Carolina System, AHECs, and LME/MCOs to:

- 1) Address barriers to developing an effective workforce to meet the clinical needs of North Carolinians with mental health and substance use needs.
- 2) Develop a plan to create more clinical training sites, with appropriate supervision, in both specialty mental health settings and non-specialty mental health settings and with populations of all ages. Training and supervision are particularly needed for professionals seeing individuals with dual diagnoses, adolescents, older adults, and individuals of all ages with substance abuse concerns.
- 3) Strengthen and improve licensing requirements.

Recommendation 3.9: Support practice and system transformation towards integrated care.

- 1) Organizations including the Center of Excellence for Integrated Care, Community Care of North Carolina, AHEC, and others that work directly with providers should provide technical assistance to practices and health systems aiming to provide more integrated care. Technical assistance should be available to both primary care and mental health and substance use providers who are interested in providing integrated care. Technical assistance should include help in identifying ways to support integrated care through billing, implementing necessary modifications to workflow and culture change, training on new tools, and mentoring.
- 2) The North Carolina Department of Health and Human Services should include supporting integrated care as a core goal of the future Medicaid and NC Health Choice Transformation Innovations Center.
- 3) Under Medicaid reform, contracts with future Medicaid managed care organizations and provider-led entities should include a requirement to provide funding for technical assistance to practices providing, or moving toward providing, integrated care.
- 4) North Carolina foundations and philanthropic organizations should provide funding for technical assistance for practices moving toward providing integrated care.

Recommendation 3.10: Update DMA's telepsychiatry policy.

The Division of Medical Assistance should revise Clinical Coverage Policy 1H Section 6.2 to:

- 1) Explicitly state that the policy covers the use of telepsychiatry for the provision of ongoing direct services.
- 2) Expand the list of providers eligible to bill for telepsychiatry professional services to include all providers eligible to bill for outpatient mental health and substance use services under Clinical Coverage Policy 8C.

The Division of Medical Assistance should also explore the implications of certifying alternative telepsychiatry sites and credentialing programs rather than individual providers.

Recommendation 3.11: Maintain adequate funding for the NC-STeP Program.

The North Carolina Department of Health and Human Services should continue to provide adequate funding to support the NC-STeP Program.

Recommendation 3.12: Standardize credentialing across systems.

Hospitals and health systems, the North Carolina Hospital Association, and LME/MCOs should explore strategies to make the process of credentialing in multiple systems less burdensome for providers, including standardizing the requirements for credentialing across systems, and explore opportunities for reciprocal and delegated credentialing.

Recommendation 4.1: LME/MCOs should act as a lead player in cross-system collaboration.

DDMH/DD/SAS contracts with LME/MCOs should require commitment to the System of Care (SOC) model as well as participation in local Community Collaboratives. As part of this commitment, LME/MCOs should:

- 1) Ensure that LME/MCO leadership (not just SOC coordinators, but also appropriate LME/MCO decision-makers) meet quarterly with leadership from the Department of Social Services, local departments of health, school districts, juvenile courts, primary care providers, and juvenile justice groups (i.e., Reclaiming Futures, Juvenile Crime Prevention Councils, Juvenile Justice Substance Abuse Mental Health Partnerships, and Juvenile Justice Treatment Continuum groups) within their catchment areas.
- 2) Include at least one youth and one youth family member in all Community Collaboratives.
- 3) In counties where there is not a functioning Community Collaborative, partner with a similar collaborative organization (e.g., Juvenile Crime Prevention Councils, Juvenile Justice Mental Health Substance Abuse Partnerships, Reclaiming Futures) and encourage the group to consider acting as a SOC Community Collaborative.
- 4) In partnership with Community Collaboratives, LME/MCOs should establish guidelines for screening youth for mental health and substance use when they encounter any system and develop pathways for youth with positive screens to access assessment and treatment services as indicated.
- 5) In partnership with Community Collaboratives, LME/MCOs should establish guidelines for consolidating case plans when children and families are served by more than one system.
- 6) Lead efforts to enhance coordination of care within and across systems for youth and families and identify pathways for access to care and ongoing case/care management when needed.

Recommendation 4.2: Support and further develop local System of Care (SOC) Community Collaboratives.

1) The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DDMH/DD/SAS) should:

- a) Develop outcome measures to indicate whether or not System of Care (SOC) is working.
- b) Provide training and technical assistance for SOC coordinators to conduct Community Collaborative assessments, strengthen Collaborative membership, use data in creation of priorities, and develop local agreements to increase collaboration for the youth with the most complex needs.
- c) Work with other key public child-serving agencies to inventory existing training and technical resources across public agencies that can be utilized to support the development of local systems of care and Community Collaboratives.

2) LME/MCO SOC/Community Collaborative coordinators should work to:

- a) Strengthen and diversify Community Collaborative membership including increasing family and youth representation.
- b) Develop and monitor progress on data-supported priorities, including disparities in access and treatment by age, gender, race/ethnicity, or other factors.
- c) Develop local agreements to increase coordination of care across public agencies.
- d) Assure that, as LME/MCO consolidation proceeds, SOC coordinator funding and staffing is

adequate to meet the needs of a growing number of communities in the catchment area of the LME/MCO.

Recommendation 4.3: Educate school personnel on the behavioral health needs of adolescents.

To increase the knowledge and skills of school personnel,

- 1) The North Carolina Department of Public Instruction should:
 - a) Work with local superintendents and schools to publicize the online credits for current professional modules related to student behavioral health.
 - b) Work with the public and private institutions of higher education and with educator and school counselor preparation programs to ensure that elective courses on adolescent development and behavioral health qualify towards degree credit.
 - c) Work with the North Carolina Sheriffs' Education and Training Standards Commission to make Youth Mental Health First Aid a credit-earning course for student resource officers and explore making Youth Mental Health First Aid a requirement for student resource officers. The Department of Public Instruction should work with the Commission to make crisis intervention trainings and courses on adolescent development credit-earning electives as well.
- 2) Local boards of education should encourage school staff and others who work with youth to receive Youth Mental Health First Aid training and Trauma-Informed Care training. (see Recommendation 3.3 Increase Number of North Carolinians Trained in Mental Health First Aid).
- 3) Each school district should ensure that at least two staff are trained in Youth Mental Health First Aid, ideally as instructors. These staff serve as the point persons to assist in the event of a crisis and coordinate staff training.

Recommendation 4.4: Encourage partnerships between schools and LME/MCOs.

- 1) The Department of Public Instruction and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should develop models for effective, coordinated efforts between LME/MCOs and schools, school-based health centers, service providers, and school systems. Model memoranda of agreement should be developed and shared with the North Carolina School Boards Association, superintendents, and principals. Memoranda of agreement should not exclude service types, particularly evidence-based programs delivered to fidelity. The agreements should include:
 - a) Model memorandum of agreement between a school district and their LME/MCO that outlines how these entities can partner to meet the mental health and substance use needs of students and their families.
 - b) Model memorandum of agreement between a school, LME/MCO, and service providers that outlines how these entities can work together to meet the mental health and substance use needs of students and their families.
- 2) Local school boards should encourage schools in their district to explore ways to partner with providers to meet the mental health and substance use needs of children and their families.

Recommendation 4.5: Support the implementation of trauma-informed child and family serving systems across North Carolina counties.

The North Carolina Department of Health and Human Services should:

- 1) Promote the integration of trauma-informed practices and policies across human service and public safety agencies serving youth.
- 2) Introduce trauma-informed services into the core education and training for child and family serving human service and public safety agencies.
- 3) Emphasize interdisciplinary collaboration and relationship-building across child and family serving human service and public safety agencies.
- 4) Develop a Trauma Advisory Council to help oversee efforts to develop trauma-informed systems.

Recommendation 4.6: Submit a Medicaid waiver to best serve youth with serious emotional disturbance.

The North Carolina General Assembly should instruct the North Carolina Division of Medical Assistance/ Division of Health Benefits to submit a 1915(c) Medicaid waiver to serve children with serious emotional disturbance in home and community-based settings.

Recommendation 5.1: Establish statewide coordinated leadership to oversee older adult health.

- 1) In order to develop a more robust and coordinated behavioral health system for older adults, it is recommended that the North Carolina General Assembly:
 - a) Appoint a subcommittee of the Joint Legislative Oversight Committee to focus on the mental health and substance use needs of older adults during the next legislative session.
 - b) Re-establish the North Carolina Study Commission on Aging, with a mission to study and evaluate the existing public and private delivery systems for state and federal services for older adults and make recommendations to improve these systems to meet the present and future needs of older adults. The study commission should be charged with examining the mental health and substance use system for older adults as one of its first areas of focus.
- 2) The Secretary of the Department of Health and Human Services (DHHS) should establish a working group within DHHS to address older adult mental health and substance use. This group should include leadership from the Division of Mental Health, the Developmental Disabilities and Substance Abuse Services, the Division of Medical Assistance, the Division of Aging and Adult Services, the Division of Public Health, and the Department of Transportation. This group should also include older adults in recovery from mental health and substance use disorders and should focus on developing a comprehensive system of care that delivers high quality, timely, and accessible care to meet the mental health and substance use needs of older adults in the most appropriate settings across the state. The working group should report to the Joint Legislative Oversight Committee or Study Commission on Aging annually, before the beginning of the General Assembly's session.

Recommendation 5.2: Increase support for SHIP program.

- 1) The North Carolina Congressional Delegation should advocate to maintain or increase funding to the State Health Insurance Assistance Program.
- 2) The North Carolina General Assembly should allocate adequate recurring funding for the North Carolina SHIP program to support community-based coordinating sites that provide assistance to older adults. This funding should take into account the federal funding level and the increases in the senior population.
- 3) Senior centers and primary care providers should partner with the local SHIP coordinating sites to ensure that the Medicare population receives education on how to contact the North Carolina SHIP program.

Recommendation 5.3: Use GAST teams to train communities on issues of older adult mental health.

The GAST teams should provide training on the behavioral health needs of older adults to adult and family care homes, nursing facilities, and organizations that work with older adults in the community such as senior centers, adult day programs, faith-based organizations, law enforcement, the judicial system, and veteran affairs centers. GAST programs should market the training they provide to as many organizations the team is able to contact.

Recommendation 5.4: Improve capacity of primary care practices to screen, treat, and refer older adults to treatment for behavioral health needs.

Alliant Quality, along with Community Care of North Carolina, the Center of Excellence for Integrated Care, and others who provide education and technical assistance to primary care practices, should provide education and training to primary care providers and practices on:

- 1) Using evidence-based methods to screen for mental health and substance use among older adults, with a particular focus on depression,
- 2) Providing brief intervention, and
- 3) Referring patients to treatment for behavioral health needs. The percentage of older adults receiving screening for depression and substance use disorder should increase by 25% per year.

Recommendation 5.5: Increase care management services for older adults.

Organizations including Alliant Quality, Community Care of North Carolina, the Area Health Education Centers, professional associations, and others that work with providers should provide education and technical assistance to practices and health systems to help them increase chronic care management services for older adults.

Recommendation 5.6: Increase number of eligible behavioral health care providers billing Medicare.

- 1) The primary care and behavioral health specialty associations (or coordinating council) in partnership with the Center of Excellence for Integrated Care and Area Health Education Centers should work with members to:
 - a) Provide continuing education around the special needs in behavioral health care of older adult populations.
 - b) Provide practice level technical assistance to facilitate credentialing, quality measurement, and billing, including health and behavior services codes.
 - c) Increase health and behavioral code billing. The professional associations should work with the North Carolina chapter of the National Association of Social Workers to allow social workers to bill under health and behavioral codes.
 - d) Advocate to the American Medical Association's Relative Update Committee (an advisory group to CMS) to review the health and behavioral codes and their work value.
- 2) Alliant Quality, Community Care of North Carolina, the Area Health Education Centers system, professional associations, and others that provide education and technical assistance should provide educational opportunities on how to manage Medicare patients and develop referral networks, as well as host learning collaboratives to share best practices, in order to increase the number of behavioral health care providers billing Medicare.
- 3) Private insurers should reimburse for health and behavior services codes if they do not already cover them.

APPENDIX B: RECOMMENDATIONS BY RESPONSIBLE AGENCY/ORGANIZATION

Recommendation	Responsible Agency/Organization											
	DHHS (overall)	DHHS Divisions					Other Government Department	NCCA	LME/MCOs	Health Insurance Providers	Advocacy organizations	Health professional and trade organizations
	DMH/DD/SAS	State Medicaid Agency	DAAS	DPH	DSS							
CHAPTER 2												
Recommendation 2.1: Support and Expand Availability of a Full Array of Mental Health and Substance Abuse Services through LME/MCOs.	X	X	X					X	X			
Recommendation 2.2: Create Medicaid Case Management/Recovery Navigation Options.			X									
Recommendation 2.3: Require North Carolina Agencies to Share Data Cross-Agency.	X	X	X	X	X	X	Department of Corrections		X			
Recommendation 2.4: Assess and Address Disparities in the LME/MCO System.		X							X			
Recommendation 2.5: Expand Access to Mental Health and Substance Use Services.								X				
Recommendation 2.6: Increase Utilization of Evidence-Based Mental Health and Substance Use Services and Tie Payment to Positive Health Outcomes.			X						X	X		
CHAPTER 3												
Recommendation 3.1: Educate Communities on Available Mental Health and Substance Use Services		X	X	X	X				X	X	NAMI	Care Share Health Alliance, the Area Health Education Centers
Recommendation 3.2: Develop a Common Access Point for the Mental Health and Substance Use Prevention, Treatment, and Recovery System	X	X	X						X	X		First Responders
Recommendation 3.3: Increase Number of North Carolinians Trained in Mental Health First Aid		X							X			Local Boards of Education, North Carolina Center for Afterschool Programs, YMCA, Mental Health, Substance Use and Aging Coalition, and service providers
Recommendation 3.4: Involve Consumers and Local Communities in the LME/MCO Service Gaps Improvement Process		X							X			Local community members
Recommendation 3.5: Support and Encourage Crisis Response Stakeholders to Collaborate									X		Hospitals and health care systems	Local law enforcement, emergency medical services, community leaders, primary and specialty providers, patients and families, and philanthropic organizations
Recommendation 3.6: Develop New Payment Models to Support Community Paramedicine Programs with Mental Health and Substance Use Crisis Response	X		X				Department of Insurance		X	X	Health Care Systems and Facilities	

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Recommendation	Responsible Agency/Organization												
	DHHS (overall)	DMH/DD/SAS	State Medicaid Agency	DAAS	DPH	DSS	Other Government Departments	NCGA	LME/MCOs	Health Insurance Providers	Advocacy organizations	Health Care Providers	Other
Recommendation 3.7: Strengthen Training and Work Force Development									X			Professional associations of mental health and substance use workforce	North Carolina's community colleges, colleges, and universities, the Area Health Education Centers
Recommendation 3.8: Develop More Robust Transition to Practice System for Mental health and Substance Use Professionals		X	X			X			X				Professional associations of mental health and substance use workforce, the Area Health Education Centers, University of North Carolina System
Recommendation 3.9: Support Practice and System Transformation towards Integrated Care	X												Center for Excellence for Integrated Care, Community Care of North Carolina, the Area Health Education Centers, and other technical assistance providers, philanthropic organizations
Recommendation 3.10: Update DMA's Telepsych Policy			X										
Recommendation 3.11: Maintain Adequate Funding for the NC STeP Program	X												
Recommendation 3.12: Standardize Credentialing Across Systems									X		NC Hospital Association	Hospitals and health care systems	
CHAPTER 4													
Recommendation 4.1: LME/MCOs Should Act as Lead Player in Cross System Collaboration		X					Local Departments of Social Services		X			Primary care providers	Community Collaboratives, local Departments of Health, local education agencies, juvenile courts, youth and families, and others
Recommendation 4.2: Support and Further Develop Local System of Care Community Collaboratives		X							X				Community Collaboratives
Recommendation 4.3: Educate School Personnel on the Behavioral Health Needs of Adolescents							Department of Public Instruction						Local Education Agencies, local school boards, Superintendents, schools, North Carolina Sheriffs' Education and Training Standards Commission
Recommendation 4.4: Encourage Partnerships between Schools and LME/MCOs		X					Department of Public Instruction		X				Local school boards
Rec 4.5: Support the Implementation of Trauma-Informed Child and Family Serving Systems across North Carolina Counties	X												
Rec 4.6: Submit Medicaid Waiver to Best Serve Youth with Serious Emotional Disturbance			X						X				

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	DHHS (overall)	DHHS Divisions					Other Government Departments	NCGA	LME/MCOs	Health Insurance Providers	Advocacy organizations	Health Care Providers
	DMH/DD/SAS	State Medicaid Agency	DAAS	DPH	DSS							
CHAPTER 5												
Rec 5.1: Establish Statewide Coordinated Leadership to Oversee Older Adult Health	X	X	X	X	X	Department of Transportation	X					
Rec 5.2: Increase Support for SHIP Program							X				X	North Carolina Congressional Delegation, senior centers
Recommendation 5.3: Use GAST Teams to Train Communities on Issues of Older Adult Mental Health		X						X				
Recommendation 5.4: Improve Capacity of Primary Care Practices to Screen, Treat, and Refer Older Adults to Treatment for Behavioral Health Needs											X	Alliant Quality, Community Care of North Carolina, the Center of Excellence in Integrated Care, and other technical assistance providers
Recommendation 5.5: Increase Care Management Services for Older Adults												Alliant Quality, Community Care of North Carolina, the Area Health Education Centers, professional associations
Recommendation 5.6: Increase Number of Eligible Behavioral Health Care Providers Billing Medicare												Primary care and behavioral health specialty associations, Community Care of North Carolina, the Center of Excellence in Integrated Care, Alliant Quality, the Area Health Education Centers