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 regiments 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.

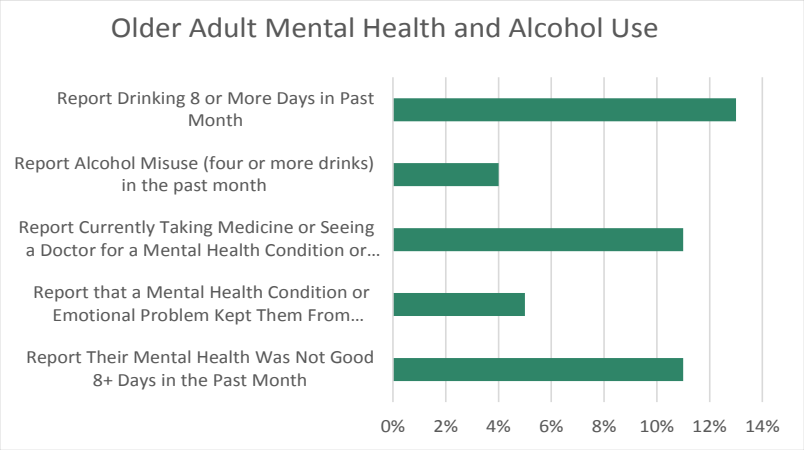
Depression, anxiety, alcohol, and psychoactive medication misuse are the most common types of mental health and substance use disorders among older adults.[2] Approximately 15% of older adults meet the criteria for depression and 14% meet the criteria for anxiety disorder.[7,8] Depression is a major 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.[32] 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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