

**NC INSTITUTE OF MEDICINE
TASK FORCE ON SUBSTANCE ABUSE SERVICES
APRIL 24, 2008
10:00-3:00
NC Hospital Association**

Meeting Summary

Attendees:

Task Force/Steering Committee: Patrice Alexander, Robert Bilbro, Dewayne Book, Sherry Bradsher, Sonya Brown, Anthony Burnett, Jay Chadhuri, Chris Collins, April Conner, Grayce Crockett, Leah Devlin, Beverly Earle, Robert Gwwyther, Paula Harrington, Carol Hoffman, Larry Johnson, Jinnie Lowery, Sara McEwen, Phillip Moring, Paul Nagy, Will Neuman, Janice Petersen, William Purcell, James Ragan, Jane Schairer, Sally Smith, Flo Stein, Steve Sumerel, Anne Thomas, Leza Wainwright, Cynthia Wiford

Interested Persons: Karen Chapple, Sheila Davies, Steve Day, Kathleen Gibson, Denise Harb, Jessica Herrmann, Lisa Mares, Nidu Menon, Margaret Weller-Stargell, Katherine Wellman, Helen Wolstenholme, Karen Yerby

Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Mark Holmes, Pam Silberman, Daniel Shive, Berkeley Yorkery

VOTE ON PRIORITY RECOMMENDATIONS

The task force convened to discuss the recommendations in the interim report and select which to make priority recommendations. The following recommendations were selected.

Recommendation 4.1

- (a) The North Carolina General Assembly should appropriate \$1,945,000 in SFY 2009 and \$3,722,000 in SFY 2010 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) to develop a comprehensive substance abuse prevention plan for use at the state and local levels, consistent with the Center for Substance Abuse Prevention (CSAP) Strategic Prevention Framework. The plan should increase the capacity at the state level and within local communities to implement a comprehensive substance abuse prevention system, prioritizing efforts to reach children, adolescents, young adults, and their parents. The goal of the prevention plan is to prevent or delay the onset of use of alcohol, tobacco, or other drugs, reduce the use of addictive substances among users, identify those who need treatment, and help them obtain services earlier in the disease process.
 - (1) DMHDDSAS should work with appropriate stakeholders to develop, implement, and monitor the prevention plan at the state and local level. Stakeholders should include, but not be limited to, other public agencies

that are part of the Cooperative Agreement Advisory Board, consumer groups, provider groups, and Local Management Entities (LMEs).

- (2) DMHDDSAS should direct LMEs to involve similar stakeholders to develop local prevention plans that are consistent with the statewide comprehensive substance abuse prevention plan.
- (b) Of the recurring funds appropriated by the North Carolina General Assembly, \$1,770,000 in SFY 2009 and \$3,547,000 in SFY 2010 should be used to fund 6 pilot projects to implement county or multi-county comprehensive prevention plans consistent with the statewide comprehensive substance abuse prevention plan. DMHDDSAS should make funding available on a competitive basis, selecting 1 rural pilot and 1 urban pilot in the 3 MHDDSAS regions across the state. Technical assistance should be provided to the selected communities by the regional Centers for Prevention Resources. LMEs should serve as fiscal and management agencies for these pilots. The 6 pilot projects should:
- (1) Involve community agencies, including but not limited to the following: Local Management Entities, local substance abuse providers, primary care providers, health departments, social services departments, local education agencies, local universities and community colleges, Healthy Carolinians, local tobacco prevention and anti-drug/alcohol coalitions, juvenile justice organizations, and representatives from criminal justice, consumer, and family advisory committees.
 - (2) Be comprehensive, culturally appropriate, and based on evidence-based programs, policies, and practices.
 - (3) Be based on a needs assessment of the local community that prioritizes the substance abuse prevention goals.
 - (4) Include a mix of strategies designed for universal, selective, and indicated populations.
 - (5) Include multiple points of contact to the target population (ie, prevention efforts should reach children, adolescents, and young adults in schools, community colleges and universities, and community settings).
 - (6) Be continually evaluated for effectiveness and undergo continuous quality improvement.
 - (7) Be consistent with the systems of care principles.
 - (8) Be integrated into the continuum of care.
- (c) The North Carolina General Assembly should appropriate \$250,000 of the Mental Health Trust Fund to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to arrange for an independent evaluation of these pilot projects and for implementation of the state plan. The evaluation should include, but not be limited to, quantifying the costs of the projects; identifying the populations reached by the prevention efforts; and assessing whether the community prevention efforts have been successful in delaying initiation and reducing the use of tobacco, alcohol, and other drugs among children, adolescents, and young adults. The evaluation should also include other community indicators that could determine whether the culture of acceptance of underage drinking or other inappropriate or illegal substance use has changed, including but not limited to arrests for driving under the influence, underage

drinking, or use of illegal substances; alcohol and drug related traffic crashes; reduction in other problem indicators such as school failure; and incidence of juvenile crime and delinquency.

- (d) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should use the findings from the independent evaluation of prevention services to develop a plan to implement the successful strategies statewide. The plan should be presented to the Legislative Oversight Committee on Mental Health within 6 months of when the evaluation is completed.

Recommendation 4.4

In order to further reduce youth smoking, the North Carolina General Assembly should increase the tobacco tax per pack to the national average. Increasing the tobacco tax has been shown to reduce smoking, particularly among children and youth. The increased fees should be used exclusively to support prevention and treatment efforts for alcohol, tobacco, and other drugs.

Recommendation 4.6

The North Carolina General Assembly should enact a law which prohibits smoking in all public buildings including, but not limited to, restaurants, bars, and worksites.

Recommendation 4.7

- (a) In order to reduce underage drinking, the North Carolina General Assembly should increase the excise tax on beer. Beer is the alcoholic beverage of choice among youth, and youth are sensitive to price increases.
- (b) The excise taxes on beer and wine should be indexed to the consumer price index so they can keep pace with inflation. The excise tax for beer was last increased in 1969, and wine was last increased in 1979. The increased fees should be used exclusively to support prevention and treatment efforts for alcohol, tobacco, and other drugs.
- (c) The General Assembly should appropriate \$2.0 million of the funds raised through the new taxes to support a comprehensive alcohol awareness education and prevention campaign aimed at changing cultural norms to prevent initiation and reduce underage alcohol consumption and to reduce alcohol abuse or dependence among adults.

Recommendation 4.10

- (a) The North Carolina General Assembly should appropriate \$1.5 million in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS). The funds shall be used to develop a Memorandum of Agreement with the North Carolina Office of Rural Health and Community Care (ORHCC), the Governor's Institute on Alcohol and Substance Abuse, North Carolina Area Health Education Centers (AHEC) program, and other appropriate organizations to educate and encourage healthcare professionals to use evidence-based screening tools and offer counseling, brief intervention, and referral to treatment to help patients prevent, reduce, or eliminate the use of or dependency on alcohol, tobacco, and other drugs as outlined in the SBIRT model.

The DMHDDSAS should work with ORHCC, the Governors Institute on Alcohol and Substance Abuse, AHEC, and other appropriate organizations to develop an implementation plan and for use of these state funds. The plan should include:

- (1) Mental health and substance abuse system specialists to work with the 14 Community Care of North Carolina (CCNC) networks. These staff will work directly with the CCNC practices in development, implementation, and sustainability of evidenced-based practices and coordination of care between primary care and specialty services. This would include but not be limited to the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model allowing for primary care providers to work toward a medical home model that has full integration of physical, mental, developmental, and substance abuse services. In keeping with the SBIRT model, the mental health and substance abuse system specialists would work within communities to develop systems that facilitate smooth bidirectional transition of care between primary care and specialty substance abuse care. These staff should establish - in conjunction with LMEs, CCNC networks, the Governors Institute, and regional AHECs - efficient methods to increase collaboration between providers on the shared management of complex patients with multiple chronic conditions that is inclusive of mental health, developmental disabilities, and substance abuse. An effective system would smooth transitions, reduce duplications, improve communication, and facilitate joint management while improving the quality of care.
- (2) A system for online and office-based training and access to regional quality improvement specialists and/or a center of excellence that would help all healthcare professionals identify and address implementation barriers in a variety of practice settings such as OB/GYN, emergency room, and urgent care.
- (3) Integrated systems for screening, brief intervention, and referral into treatment in outpatient settings with the full continuum of substance abuse services offered through DMHDDSAS.

Recommendation 4.13

- (a) The North Carolina General Assembly should mandate that insurers offer coverage for the treatment of addiction diseases with the same durational limits, deductibles, coinsurance, annual limits, and lifetime limits as provided for the coverage of physical illnesses.
- (b) The North Carolina General Assembly should direct the Division of Medical Assistance, NC Health Choice program, State Health Plan, and other insurers to review their reimbursement policies to ensure that primary care and other providers can be reimbursed to screen for tobacco, alcohol, and drugs, provide brief intervention and counseling, and refer necessary patients for specialty services.
 - (1) Specifically, the plans should provide reimbursement for:
 - i. Screening and brief intervention in different health settings including, but not limited to, primary care practices (including

OB/GYN, federally qualified health centers, rural health clinics, and hospital-owned outpatient settings), emergency departments, Ryan White Title III medical programs, and school-based health clinics.

- ii. CPT codes for health and behavior assessment (96150-96155), health risk assessment (99420), substance abuse screening and intervention (99408, 99409), and tobacco screening and intervention (99406, 99407) and should not be subject to therapy code preauthorization limits.
 - iii. Therapy codes (90801-90845) for primary care providers who integrate qualified mental health professionals into their practices.
 - iv. Appropriate telephone and face-to-face consultations between primary care providers and psychiatrists or other specialists. Specifically, payers should explore the appropriateness of reimbursing for CPT codes for consultation by a psychiatrist (99245).
- (2) Reimbursement for these codes should be allowed on the same day as a medical visit's evaluation and management (E&M) code when provided by licensed mental health and substance abuse staff.
 - (3) Fees paid for substance abuse billing codes should be commensurate with the reimbursement provided to treat other chronic diseases.
 - (4) Insurers should allow psychiatrists to bill using E&M codes available to other medical disciplines.
 - (5) Providers eligible to bill should include licensed healthcare professionals including, but not limited to, primary care providers, mental health and substance abuse providers, emergency room professionals, and other healthcare professionals trained in providing evidence-based substance abuse and mental health screening and brief intervention.
- (c) The Division of Medical Assistance should work with the Office of Rural Health and Community Care (ORHCC) to develop an enhanced Carolina Access (CCNC) per member per month (PMPM) for co-located practices to support referral and care coordination for mental health, developmental disabilities, and substance abuse services.
 - (d) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in collaboration with the ORHCC, should work collaboratively with the Governor's Institute on Alcohol and Substance Abuse, Academy of Family Physicians, North Carolina Pediatric Society, North Carolina Primary Health Care Association, ICARE, and other appropriate groups to identify and address barriers that prevent the implementation and sustainability of co-location models and to identify other strategies to promote evidence-based screening, counseling, brief intervention, and referral to treatment in primary care and other outpatient settings.

Recommendation 4.14

- (a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a plan organized around a recovery-

- oriented system of care to ensure that an appropriate mix of substance abuse services and recovery supports for both children and adults is available and accessible throughout the state. The plan should utilize the American Society of Addiction Medicine (ASAM) levels of care. In developing this plan, DMHDDSAS should:
- (1) Develop a complete continuum of locally and regionally accessible substance abuse crisis services and treatment and recovery supports.
 - (2) Ensure effective coordination of care between substance abuse providers within and between different ASAM levels of care as well as with other health professionals such as primary care providers, emergency departments, or recovery supports.
 - (3) Develop a minimum geographic-based access standard for each service. In developing its plan, DMHDDSAS should identify strategies for building an infrastructure in rural and underserved areas.
 - (4) Include evidence-based guidelines for the number of patients to be served, array of services, and intensity and frequency of the services.
- (b) DMHDDSAS should develop a plan to implement performance-based incentive contracts and agreements to ensure that state-specified performance targets are met. Performance based contracts should include at a minimum:
- (1) Incentives for timely engagement, active participation in treatment, program retention, program completion, and ongoing participation in recovery supports.
 - (2) Data requirements to ensure that program performance is measured consistently across the state.
- (c) DMHDDSAS should develop a plan to implement electronic health records for providers that use public funds.
- (d) DMHDDSAS should develop consistent requirements across the state that will reduce paperwork and administrative barriers including but not limited to:
- (1) Uniform forms for admissions, screening, assessments, treatment plans, and discharge summaries that are to be used across the state.
 - (2) Standard contract requirements and a system that does not duplicate paperwork for agencies that serve residents of multiple Local Management Entities (LMEs).
 - (3) Methods to ensure consistency in procedures and services across LMEs along with methods to enforce minimum standards across the LMEs. Enforcement methods should include, but not be limited to, remediation efforts to help ensure consistent standards.
 - (4) Standardized outcome measures.
- (e) DMHDDSAS should develop a system for timely conflict resolutions between LME and contract agencies.
- (f) DMHDDSAS should work with its Provider Action Agenda Committee to identify barriers and strategies to increase the quality and quantity of substance abuse services and providers in the state. These issues include, but are not limited to, administrative barriers, service definitions, and reimbursement issues.
- (g) DMHDDSAS, in collaboration with the Department of Juvenile Justice and Delinquency Prevention and the Department of Public Instruction, should

- immediately begin expanding the capacity of needed adolescent treatment services across the state including new capacity in the clinically intensive residential programs, consistent and effective screening, assessment, and referral to appropriate treatment and recovery supports for identified youth. In addition, the plan should systematically strengthen early intervention services for youth and adolescents in mainstream settings such as schools, primary care, and juvenile justice venues.
- (h) DMHDDSAS should report the plans specified in Recommendation 4.14.a-b, report on the progress in developing the plan for electronic health records in Recommendation 4.14.c, and report on progress made in implementing Recommendations 4.13.d-g to the NC IOM Task Force on Substance Abuse Services and Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than September 2008.

Recommendation 4.16

The North Carolina General Assembly should appropriate:

- (a) \$650,000 in recurring funds to DMHDDSAS to hire 13 FTE staff to assist in developing and implementing a statewide comprehensive prevention plan, a recovery-oriented system of care, a plan for performance-based incentive contracts, and consistent standards across the state to reduce paperwork and administrative barriers; oversee and provide technical assistance to the pilot programs; and otherwise help implement the Recommendations 4.1-4.16 and Recommendation 5.1, supra.
- (b) \$100,000 in recurring funds to the Department of Public Instruction to hire staff to implement Recommendations 4.1, 4.2, and 4.14 above.
- (c) \$130,000 in recurring funds to ORHCC to hire a statewide coordinator and administrative support to work directly with the regional CCNC quality improvement specialists funded in recommendation 4.10 and to assist in implementing recommendation 4.12.
- (d) \$81,000 in recurring funds and \$50,000 in nonrecurring funds to the Department of Health and Human Services, Division of Medical Assistance, to hire 5 positions to implement Recommendations 4.8-4.10, 4.12, and 4.13-4.15 above.