

## The Louisiana Department of Health Office of Behavioral Health - Coordinated Crisis System Plan

### Vision

The Louisiana Department of Health (LDH) is committed to ensuring that individuals in crisis and their families experience treatment and support that is compassionate, effective, resolution-focused, and delivered by a crisis system that is coordinated, responsive and efficient. LDH is committed to addressing the crisis needs of individuals in the target population as detailed in the Agreement. In addition, LDH believes that by addressing the behavioral health crisis needs of all populations, including Louisiana’s most vulnerable citizens (e.g. children and youth in crisis and their families, individuals with co-occurring conditions, and those who are at risk of institutionalization), we can maximize the use of voluntary treatment and reduce the need for law enforcement involvement. In addition, it will allow people to remain in their communities and reduce the need for restrictive levels of care including nursing homes, residential care centers, out of home placements, jails, intermediate care facilities for individuals with intellectual/developmental disabilities, and hospitals. It is LDH’s goal to develop a statewide model for crisis response that maintains regional and geographic relevance and builds upon the unique and varied strengths, resources, and needs of Louisiana’s individual communities.

To achieve this vision, LDH, in consultation with service recipients and key system partners, will develop a modern, innovative and coordinated crisis system. LDH’s vision is a crisis system that:

- Values and incorporates “lived experience” in designing a crisis system and in crisis service delivery;
- Encompasses a continuum of services that includes crisis prevention, acute intervention and post-crisis recovery services and supports;
- Is built on principles of recovery and resiliency, delivering services that are individualized and person-centered;
- Provides interventions to divert individuals from institutional levels of care including inpatient placements, emergency departments utilization, nursing facilities and other out of home settings;
- Provides timely access to a range of acute crisis responses, including locally available home and community-based services and mobile crisis response;
- Provides stabilizing interventions and supports that allow individuals to recover as quickly as possible;
- Delivers resolution-focused interventions and assists individuals in problem-solving and in developing strategies to prevent future crises and enhance their ability to recognize and deal with situations that may otherwise result in crises;
- Supports individuals to increase or improve their network of community and natural supports, as well as their use of these supports for crisis prevention;
- Continuously improves its processes to assure seamless and efficient care;
- Collaborates and innovates with partner systems including healthcare systems, judicial systems, law enforcement, child protective services, educational systems, homeless coalitions, as well as any other system that touches individuals who may experience a behavioral health crisis; and
- Collaborates with the individual’s existing behavioral health service providers, or links individuals to new behavioral health service providers for longer-term treatment when appropriate and desired by the recipient.

A crisis is self-defined and can best be labeled as “need help now” determined by the individual. Therefore, the system, and management of the system, must be flexible and responsive to needs.

### Local Approach to Crisis Services

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The Office of Behavioral Health (OBH) within LDH manages and delivers the services and supports necessary to improve the quality of life for citizens with mental illness and substance use disorders. The agency acts as a monitor and subject matter consultant for Medicaid's Coordinated System of Care contract and the Healthy Louisiana plans, which manage specialized behavioral health services. OBH also delivers direct care through grants, state-owned hospitals, and monitoring of behavioral health community-based treatment programs through the human services districts and authorities, also known as local governing entities (LGEs). Through this system, services are provided for Medicaid and non-Medicaid eligible populations.

The LGEs, classified as a human services district or authority, administer the state-funded behavioral health and developmental disability services in an integrated system within their localities. Because the LGE model increases local control and authority, there is more opportunity for greater accountability and responsiveness to the local communities. Though implementation and focus of direct crisis response services varies by locality, some areas have developed clinically rich crisis services. The history of service delivery through the LGEs gives them unique understanding of the specific needs of their constituency and the services/roles community partners could play in the implementation, maintenance or enhancement of crisis services. This has been demonstrated through niche programming with robust collaboration and buy in from crucial partners such as law enforcement, hospital systems, schools, and local resource centers such as ViaLink/211. It should be noted, however, that even where this expertise exists, these services are localized and have not been built to scale.

The state sees the LGEs as critical local leaders as it develops the Coordinated Crisis System Plan. This local expertise and input will ensure the creation of a system that works through either direct involvement of the LGEs and its Board of Directors as the deliverer of services or as a consultant/guiding voice on needs of the community who will then coordinate with separate local crisis provider(s). Additionally, the continued localization of services combined with a model of implementation intended to ease administrative burdens of localities to bill and seek reimbursement, should ensure the expansion of opportunities to provide and get paid for additional services for LGEs or other entities, thus implementing a full scale continuum of services across the LGE region while ensuring equitability of service implementation throughout the state.

## Process

In compliance with requirements outlined within LDH's Agreement with the United States Department of Justice (DOJ) related to individuals with serious mental illness in nursing facilities, LDH has endeavored to outline a philosophical vision, management structure and programmatic design of a statewide crisis response system. The Department recognized the opportunity to evaluate the existing crisis system of care and service array, and to propose significant new investments in this area. In an effort to achieve this goal, an ongoing internal workgroup was developed comprised of key staff within the Office of Behavioral Health as well as interested stakeholders from sister agencies within LDH. Additionally, LDH via the Technical Assistance Collaborative (TAC) began working with Kappy Madenwald, a nationally recognized expert on crisis systems.

In October, 2018, formal work with Ms. Madenwald began with a series of interviews conducted with key stakeholders throughout the Louisiana system of care including meetings with Executive Directors of each of the state's 10 Local Governing Entities, representatives from psychiatric inpatient facilities, and representatives from the state's Managed Care Organizations. These kick-off meetings culminated with a summary of findings and the crafting of a process intended to guide Louisiana's development of a comprehensive crisis system. Since this time, the workgroup convenes regularly for daylong meetings with Ms. Madenwald on the development of a crisis vision. The workgroup continues to review existing systems, state models and best practice documents from across the country.

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Recognizing the immense scope of the project and its impact on the Louisiana system of care, LDH decided early in the process to seek feedback from community partners and national subject matter experts by way of a Request for Information (RFI). The RFI was published on March 8, 2019, with responses due by midnight on March 29, 2019. The RFI resulted in the receipt of 22 responses from individuals, advocates, managed care organizations, consultants, LGEs, providers, and other entities. The responses received, while varied in scope and content, included some general themes in recommendations for the State to consider the following when developing a crisis system. The recommendations include:

- Development of a recovery oriented system with input from service recipients;
- Crisis administration will be managed by one entity, which will collaborate with existing systems, utilizing regional expertise in the implementation of programming;
- Develop warm hand off capabilities with entities such as Managed Care Organizations or local crisis hubs, which may be a Local Governing Entity;
- Creation of a system of access using a “no wrong door” philosophy;
- Utilization of peers in service delivery network and adequate training of providers;
- Development and implementation of a continuum of services including prevention and post-crisis services;
- Use of technology to streamline and track the provision and quality of services; and
- Development of services in a manner that are attractive to service recipients, insurers and providers.

When developing the crisis plan, LDH utilized the RFI responses while also taking into consideration the DOJ agreement language. This language states crisis services shall be provided in the most integrated setting appropriate (including at the individual’s residence whenever practicable), consistent with community-based crisis plans developed for individuals receiving services, or in a manner that develops such a plan as a result of a crisis situation, to prevent unnecessary hospitalization, incarceration, or institutionalization. Additionally, LDH has solicited feedback and input from a subcommittee of the Advisory group, LGEs who provide crisis services, and more broadly has presented this information to both community partners and providers throughout the state during OBH’s statewide Listening Tour.

## Proposed Design

LDH is designing a statewide crisis response system. Using the DOJ agreement as a catalyst, LDH examined the current continuum of crisis services and proposes the below framework. Implementation and timelines hinge on dedicated state funding and CMS approval for new and revised services. This proposed framework is predicated on the availability of fiscal resources and the ability to properly manage such a robust system.

As referenced earlier, LDH released a Request for Information (RFI) seeking ideas for the design of a behavioral health crisis system of care (inclusive of mental health and/or substance use disorders) as well as ideas for the types of crisis programs, services, and funding models that will best serve the needs of Louisiana. Research was also conducted on other states, such as Washington State. The components in this framework represent an ideal, model system.

LDH envisions a single statewide crisis management entity (CME) to oversee the centralized dispatch of crisis services, track episodes of crisis care, guide the delivery of services within a coordinated crisis system of care, and assure that individuals are linked, as indicated to necessary continued treatment and resources. This system will serve residents in Louisiana further upstream in their mental health challenges in order to avoid institutional type of care such nursing facilities, hospital stays, emergency departments, etc. The CME will be expected to collaborate with LGEs or develop and utilize regional centers of strength, while centralizing the administration, policies, and case management system, assuring continuity in approach. A single CME should be responsible for the entire statewide crisis system. The CME will bring a seamless and consistent approach to managing service access and delivery and will have responsibility for ensuring crisis treatment providers demonstrate necessary competencies in service delivery and in their assertive collaboration with key

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community partners. To this end, the CME will lead and/or enable collaboration with law enforcement, dispatch call centers, and emergency services personnel at the local level; ensure the development and implementation of shared protocols for responding to mental health crises in the community; and offer support for the implementation of Crisis Intervention Teams (CIT). Efforts with local law enforcement agencies will focus on diversion from jail and minimizing the involvement of law enforcement in behavioral health crises when it is avoidable. The CME shall have overall accountability to LDH and each of the regional communities they serve. Services should be delivered by local behavioral health provider(s), responsible for providing all the basic components in a defined area, who operate in a coordinated fashion as overseen by the CME.

## Management

In order to ensure the most efficient and effective coordinated crisis services across the state, LDH proposes to issue an RFP and subsequently award a contract to a single statewide CME. Unlike the MCOs, the crisis CME is not responsible for the full continuum of behavioral health services for the Medicaid population. The crisis CME is only responsible for ensuring the delivery of a subset of non-hospital, crisis-related services. Coordination and flow of information between MCOs and CME is essential. MCOs remain responsible for the full service array of non-crisis behavioral health services covered under Medicaid, which include outpatient and community based services, emergency departments, inpatient, residential care, SUD treatment and medical and primary care services.

While LDH envisions a structure in which the CME ensures capacity and the dispatch of local crisis services, the CME will build upon the existing strengths of the system. The CME will be responsible for ensuring services are implemented locally with an adequate number of high quality providers to meet the needs of the area served. While this implementation may vary by region, it is expected that it will include collaboration with LGEs and other crisis entities that have demonstrated local expertise over the crisis system. In these instances, in which collaboration with LGEs occurs, the CME will support their ability to expand operations through implementation of efficiencies associated with billing and management while not circumventing their role and control over the existing service system.

The vision for this statewide CME includes the following:

- Develop and maintain a behavioral health crisis system comprised of an interconnected network of services, some of which will be available to everyone regardless of payor;
- Embrace the “No Wrong Door” philosophy to help support individuals in crisis and hold accountable a network of local providers and community partners to adopt this approach to delivering community-based crisis services;
- Act with impartiality, ensuring equal access and coordination regardless of health-plan affiliation or benefit status;
- Work with OBH and MCOs to assist individuals that are diverted from nursing facilities (NFs) to address an acute crisis and stabilize their community tenure;
- Oversee key performance metrics, while increasing the accountability and performance of all crisis providers to improve accessibility to least-restrictive crisis services;
- Have both the authority and responsibility to hold the network of crisis service providers’ accountable to this high standard;
- Act as a single system with single point of entry to access;
- Build upon existing strengths and resources of local communities;
- Value the crucial role that interested partners and community stakeholders bring to the table and support, not supplant, the existing crisis infrastructure;
- Bring efficiency and economy of scale, but also reduce the administrative burden on LDH and LGEs;
- Operationalize a robust information technology (IT) system and data tracking and reporting (includes access to crisis plans and outpatient scheduling, 24/7);

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- CME would have two-way access to the broader health care systems, including enhancements as this system continues to mature;
- Manage multiple funding streams to ensure that the network of quality providers can provide services to anyone who presents in crisis, regardless of benefit entitlement;
- Ensure the network of crisis providers are adequately resourced;
- Interface with MCOs and LGEs to ensure coordination of crisis and post-crisis care;
- Proactively work with stakeholders to connect individuals to the community-based crisis system; and
- Convene a consortium or steering committee of key players, likely to include law-enforcement, hospitals, LGEs, coroners' offices, service recipients and their family members, etc.

### Functions of the CME include, but are not limited, to:

- Operate a statewide 24/7 call center/dispatch center maintaining performance metrics like hold time, answer time, warm transfer handoffs, etc. and utilization of screenings to determine need;
- Dispatch mobile crisis teams in real time;
- Crisis system network development and adequacy monitoring;
- Utilization review of services, including providing public dashboards of behavioral health metrics for the city, parish, or state;
- Assure consumer advisory groups are developed and conducted. A single statewide board (or regional boards) comprised of representatives of those impacted by the crisis response delivery system (including service recipients, family members, law enforcement, fire, emergency departments, and other state and parish agencies) should provide oversight and make recommendations for improvements to the system;
- Provide ongoing outreach and education about the crisis system availability;
- Assure the development of a system where there is coordination and collaboration with natural and community supports;
- Coordinate and collaborate with other service systems such as law enforcement, Office of Juvenile Justice, Department of Public Safety and Corrections, Department of Child and Family Services, Local Governing Entities, and Department of Education;
- Coordinate and collaborate with 911, 211, and first responders;
- Assure the development and implementation of post-crisis care coordination;
- Maintain awareness of the entire BH continuum of care and services available (specifically through the Medicaid system); and
- Contract with a peer-run organization that specializes in conducting surveys with service recipients post service utilization.

## Crisis Services

The following crisis services will be sought through the implementation of the Coordinated Crisis System Plan:

1. Statewide 1-800 Crisis System Access Line - A 24-hour toll-free crisis response center to respond to specialized behavioral health needs; 24/7 access to staff; answered by a live voice at all times; assist and triage callers in crisis by resolving the crisis, dispatching mobile crisis, immediately transferring via a warm line to an independently licensed mental health professional (LMHP), connecting callers to peer support services, or taking other necessary actions to assure safety, for example dispatching an ambulance or calling 911. This service will work with existing state and local resource/crisis lines, receiving referrals from, or feeding into these systems to ensure appropriate local response.

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2. **Mobile Crisis** - Mobile crisis available statewide 24-hours a day, 7 days a week, through which immediate intensive assessments are performed and interventions are delivered in an effort to appropriately identify treatment services. Mobile crisis will have the ability to adhere to average response times outlined within the Agreement (one hour in urban settings and two hours in rural settings) and the capacity to establish urgent outpatient appointments and connect to ongoing support for up to 15 days after the initial call.

Pursuant to the findings of the needs assessment, LDH may propose the implementation of additional services such as those found below:

1. **Community Brief Crisis Support (Non-bed)** – An intervention that is designed to maintain the individual in his/her current living arrangement, to prevent repeated emergency department presentations, hospitalizations, nursing facility placements, and other institutional care. This service is initiated within 72 hours following the mobile crisis, or behavioral health urgent care visit, and can be provided up to 15 days.
2. **Behavioral Health Urgent Care** – A 24-hour, 7 days a week, walk-in center which provides short-term behavioral health crisis intervention. The intervention is designed to be time limited, generally addressing a single episode that stabilizes and enables an individual to return home with community-based services for support.
3. **Crisis Stabilization** – Short-term bed-based crisis stabilization service diverting from higher level of care, not intended to be a housing placement, with the recipient returning to intact placement. An assessment could be completed by the mobile crisis team for placement into this level of care.

Peer services are simultaneously being developed and will be incorporated into the crisis continuum services as well as other services.

## Overview of Crisis Service Continuum

A robust crisis system of care encompasses more than just crisis treatment such as psychiatric hospitalizations. It includes a focus on prevention, early and acute intervention, as well as crisis recovery and reintegration. Louisiana recognizes it has an underdeveloped crisis system. Existing crisis services are narrowly focused on acute interventions with an emphasis on emergency department- based evaluations, involuntary commitments and inpatient utilization. In an effort to restructure the system, LDH envisions an expansion of its service array to address the entire crisis continuum and to emphasize community based provision of crisis services and supports. In this model, crisis prevention and early intervention will be emphasized in an effort to stave off higher levels of intervention while care coordination following the crisis events will be strengthened as individuals reintegrate into lower levels of care. Implementation of services across this continuum will allow for the provision of individualized interventions intended to maximize voluntary utilization while keeping individuals out of higher levels of care and in the community.

Crisis Prevention	Early Intervention	Acute Intervention	Crisis Treatment	Crisis Recovery & Reintegration
Statewide 1-800 Crisis System Access Line (Proposed New Service)				
	Mobile Crisis (Proposed New Service)		Crisis Stabilization (Proposed New Service)	
	Behavioral Health Urgent Care Center (Proposed New Service)		Community Brief Crisis Support (Non-bed) (Proposed New Service)	
Strengthening of Crisis Prevention, Early Intervention, Acute Intervention, Crisis Treatment, Recovery and Reintegration: Mental Health Rehabilitation (MHR) Substance Use Disorder (SUD), Assertive Community Treatment (ACT) (Existing Services)				
Free Standing and or Crisis Service Embedded Certified Peer Support Services (New Service)				



## Special Population Strategies

As determined appropriate subsequent to the gap analysis and needs assessment, LDH may consider implementation strategies intended to meet the needs of special populations. A big driver in the efforts to create the crisis system is the DOJ population, but there are other populations that the CME and crisis system, as a whole, may need to address:

- DOJ target population;
- Children/families;
- Individuals with a substance use disorder;
- Individuals with an intellectual disability/developmental disability;
- Elderly individuals;
- Individuals with disabilities (physical/hearing/vision impairments);
- Non-english speaking individuals; and
- Individuals at risk of criminal justice involvement.

Specialized strategies could include but are not limited to access to care standards, shared protocols amongst service providers, care collaboration, training, consultation, tele support, specialty teams, and/or accessible facilities.

## Service Eligibility for Utilization of the Crisis System

Access to front end crisis services (call center, mobile crisis) should happen seamlessly, without requiring advance authorization or eligibility review. Instead, if needed, this function should occur at dispatch or after the service is provided. This would allow “back-end” review and tracking of service utilization by funding stream, population and needs. Other crisis services such as bed based crisis intervention, in home community brief intensive crisis support will require prior authorization completed in a time sensitive manner. A critical component of implementation will be the inclusion of Third Party Liability (TPL) identification requirements in the CME contract (obligates CME to take reasonable measures to determine TPL) and responsibility for submitting information to the MCOs and the CSoC Contractor to coordinate benefits (reference MCO contract 4.13)

## Funding Strategies

Payment for an expanded array of crisis services is proposed from both state general funds and Medicaid service expansion. The CME will be expected to braid state funds for crisis and assist providers to seek other third party payers. Coordination of local funds may also be considered as an option.

- The system requires a braided funding approach that includes both Medicaid and Non-Title XIX funding. Both the CME and its providers should have the ability to work with blended funding sources, to ensure they are able to serve anyone in a crisis, regardless of benefit status.
- The state may explore and leverage new or existing Medicaid authorities to allow for downward substitution of services, that are least-restrictive, community based, and have evidence in improving recovery outcomes.
- By collaborating with existing and potential innovative programs/services, such as locally funded initiatives, the CME can leverage other funding mechanisms that help to develop the “brick and mortar” components necessary for creating a complete system.

## Network Development

The current crisis response network in Louisiana is essentially undeveloped. While pockets of some services exist within Louisiana, no regions provide the continuum of services we anticipate providing. However, we believe some providers and communities stand ready to expand crisis response services. The LGEs play an important role in providing crisis services in some areas of the state, and may choose to expand their services to include the proposed crisis array.

Strategies for network development will include pre-development education across the state, presenting the vision to community stakeholders, as well as gauging interest in providing the array of crisis services. Additionally, decisions will be made regarding whether a phased in implementation of network development and provider training is desired and appropriate. Training will focus on increasing competencies for existing crisis response providers readying them for participation in the proposed crisis system, as well as training for new crisis services when implemented.

## Training

In an effort to ensure its existing crisis system is operating to its fullest capacity, LDH continues to explore and will develop crisis system of care protocols intended to guide the provision of crisis services. Additionally, service competencies for crisis providers including both licensed and unlicensed staff will be identified. LDH is working with consultants on the development of a training model through which sustained initial and ongoing training can be provided to the existing provider network. Given the scope of a statewide training system, LDH or its designee will implement a viable model of training intended to ensure the establishment and maintenance of staff competencies given the reality of staff turnover within the provider networks. This model should include capacity for face-to-face trainings as well as a webinar series for ongoing learning opportunities.

## Strategies for Engaging Key Systems and Stakeholders

LDH recognizes that for the crisis system of care to be successful, engagement of key systems and stakeholders is essential. Ongoing strategies include meetings with key stakeholders as well as presenting the vision to community partners, seeking ideas for improving the vision, and gauging interest in treatment provider participation. Some key partners include the crisis workgroup membership, the Human Services Interagency Council (HSIC), the DOJ stakeholder group, and community members and providers engaged via statewide listening tours. The timeline for activities conducted to date include:

- Small crisis stakeholder group – August 20, 2019
- Large advisory group – August 18, 2019
- Statewide Listening Tour – September 24 – October 4, 2019
- Joint LGE Board Meeting – October 17, 2019

## Administrative Challenges

The successful implementation of this vision for a complete crisis system of care relies on approval of regulatory authorities and budget. Regulatory factors such as credentialing and licensure of new providers and facilities, implementation of administrative rules, contracting, new Medicaid authorities (if needed), etc. all require leadership support and official approvals.

While planning and implementation lie with the Department of Health, funding for additional services and administration of those services is dependent on budget allocation by the Louisiana State Legislature. The fiscal climate for new and expanded services will largely affect a successful implementation.



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### Overall Implementation Timeline

Target Completion Date	Task/Activity for Crisis Management Entity (CME)	Task/Activity for Crisis Services	Task/Activity for Crisis System Development
12/6/2019	Submit Crisis Plan to DOJ		
2/2020			Facilitate crisis training to groups working with individuals being transitioned from NF
5/2020		Finalize proposed service specifications	
7/2020		Finalize rate setting	Engage ongoing dialogue with stakeholders about the crisis system development
11/2020		Develop necessary SPA and Medicaid authority changes	Facilitate information sessions with treatment providers about business opportunities within a new crisis system of care
11/2020		Begin administrative rulemaking process	
1/2021	Draft RFP for a Crisis Management Entity (CME)		Facilitate crisis trainings for existing workforce
6/2021	Obtain final budget approval for SFY 21/22 (pending legislative process)		
7/2021		Submit Rule to Legislative Fiscal Office	Finalize core competencies and training curriculum for new crisis service providers
Summer of 2021	Publish RFP for CME		
8/2021		Submit SPA/Waiver to CMS	
11/2021		Publish final Rule pending budget and CMS approval	
1/2022		Receive CMS approval of SPA/Waiver	
Spring of 2022	Implement initial CME contract go-live (first year focus on network development and structural system design)		
6/2022		Obtain final budget approval for SFY 22/23 (pending legislative process)	
1/2023		Begin full implementation of CME contract (new and revised crisis services go-live)	