**Bobby Jindal**
GOVERNOR

**Bruce D. Greenstein**
SECRETARY

# State of Louisiana

## Department of Health and Hospitals
## Office of the Secretary

July 19, 2011

The Honorable Joel T. Chaisson, II, President
Louisiana State Senate
P.O. Box 94183, Capitol Station
Baton Rouge, LA 70804-9183

The Honorable Jim Tucker, Speaker
Louisiana State House of Representatives
P.O. Box 94062, Capitol Station
Baton Rouge, LA 70804-9062

The Honorable Kay Katz, Chairwoman
House Health and Welfare Committee
Louisiana State House of Representatives
P.O. Box 44486, Capitol Station
Baton Rouge, LA 70804-4486

The Honorable Willie L. Mount, Chairwoman
Senate Health and Welfare Committee
Louisiana State Senate
P.O. Box 94183, Capitol Station
Baton Rouge, LA 70804-9183

Dear President Chaisson, Speaker Tucker, and Honorable Chairs:

In response to Act 384 of the 2009 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. Act 384 merged the Offices of Addictive Disorders and Mental Health within the Department of Health and Hospitals (DHH) to form the Office of Behavioral Health (OBH), effective July 1, 2010. Act 384 requires a written status report to be submitted to the House and Senate committees on health and welfare that details the progress of the implementation of OBH.

Act 384 created the OBH Implementation Advisory Committee, whose task was to recommend to DHH a specific plan for implementation of OBH. Specific focus areas of the committee recommendations included the consolidation of the administrative infrastructure of OBH, improvement of performance measures and outcomes for providers, improvement of access to services for clients, implementation of cost-effective, innovative funding strategies, development of licensing, training and workforce standards, and coordination of local, state, and federal initiatives. OBH has demonstrated successful advancement in all six of these areas. Further, the Louisiana Behavioral Health Partnership (La-BHP), a new approach to delivering and financing behavioral health services for Louisiana's children and adults, leverages Medicaid funding to support integrated access to behavioral health care. With fewer dollars spent, OBH can maintain, and even expand, an integrated service menu and still fund a safety net of service delivery for those individuals in need of mental health services, addictive disorders services, or both.

Thank you for allowing us to present information to you regarding the progress of the implementation of OBH. Pete Calamari, DHH's assistant secretary of the office of behavioral health, is available to discuss this report with you should you have any questions or comments. Please feel free to contact him at (225) 342-5236 with any questions or comments that you may have.

Sincerely,

Bruce D. Greenstein
Secretary

Enclosures

Cc: The Honorable Members of the House Health and Welfare Committee
The Honorable Members of the Senate Health and Welfare Committee
David R. Poynter Legislative Research Library

DEPARTMENT OF HEALTH AND HOSPITALS

# OFFICE OF BEHAVIORAL HEALTH IMPLEMENTATION STATUS REPORT

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REPORT PREPARED IN RESPONSE TO ACT 384 OF THE 2009 REGULAR SESSION

**JULY 2011**

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## EXECUTIVE SUMMARY

On July 1, 2010, Louisiana merged the Offices of Addictive Disorders and Mental Health within the Department of Health and Hospitals (DHH) to form the Office of Behavioral Health (OBH), pursuant to Act 384 of the 2009 Regular Session. Act 384 created the OBH Implementation Advisory Committee, whose task was to recommend to DHH a specific plan for implementation of OBH. Specific focus areas of the committee recommendations included: Infrastructure; Performance Measures and Outcomes; Access; Funding Strategies; Licensing, Training and Workforce; and Local, State and Federal Coordination. OBH has taken direction and guidance from the aforementioned recommendations and has demonstrated successful advancement in all six areas. Act 384 requires a written status report to be submitted to the House and Senate committees on health and welfare that details the progress of the implementation of these recommendations by OBH.

### 1) *Infrastructure*

The Office of Behavioral Health set two FY 11 top priorities related to infrastructure: to consolidate the administrative structure within OBH central office and to consolidate local mental health and addictive disorders clinics in order to provide integrated, holistic, accessible care. At this juncture in the evolution of OBH, the office has achieved all of its ambitious first year reorganization benchmarks at the state office level and at the regional clinic level, while reducing spending by 20%.

### *2) Performance Measures and Outcomes*

OBH utilization management activities helped providers define the target population and appropriate service mix to deliver the "right type of service to the right client, at the right time and at the right intensity". Process improvement activities to increase client initiation, engagement and retention resulted in a 25% to 35% improvement in show rates for treatment appointments and approximately 30% decreases in drop-out rates in some OBH clinics.

### *3) Access*

In spite of the large scale system redesign as well as staff reduction and reorganization, the OBH system of care was able to provide essential services and treat approximately the same proportion of citizens as in previous years. Implementing centralized screening and scheduling, as well as walk-in appointments in some clinics, reduced waiting lists from weeks to days. In addition, the integration of mental health and addictive disorder clinics greatly enhances clinic capacity to provide treatment for co-occurring disorders.

### 4) *Funding Strategies*

OBH at the central office level has entered into a new era of Medicaid reform that better leverages federal Medicaid funding and positions Louisiana to expand Medicaid reimbursement for addictive disorders, which will create a shared mental health and addictive disorder funding stream and broaden access to services. Entitled the ***Louisiana Behavioral Health Partnership (La-BHP)***, this is a comprehensive Medicaid reform package that integrates mental health and addictive disorder services, making them more accessible and efficient through the 1915i, 1915b, and 1915c Medicaid waivers, in addition to expansive state plan amendments. To date, DHH has: prepared the criteria necessary to seek a qualified company as a Statewide Management Organization (SMO); submitted documentation for approval of the changes in

the Louisiana Medicaid program; and has initiated numerous workgroups addressing La-BHP operational strategies necessary for project implementation. An important facet of the Louisiana Behavioral Health Partnership is the Coordinated System of Care (CSoC), which institutes a Wraparound Model of care for children and youth at risk for out-of-home placement. CSoC is best thought of as a state-of-the-art intensive community-based service system that is a part of the overall Medicaid transformation of behavioral health services in the state. It is a specialty system in that it is a multi-agency collaborative with a shared funding pool across OBH, DCFS, OJJ, and DOE. It is designed to specifically target youths at risk for out-of-home placement.

### 5) *Licensing, Training and Workforce*

The workforce development process for transitioning OBH behavioral health clinics into competent, qualified La-BHP network providers has included defining the populations to be served and the array of services to be provided. These defined services and populations have informed the necessary provider training, credentialing, and certification standards upon which to certify both licensed behavioral health professionals and provider agencies, who will then be credentialed by the La-BHP Statewide Management Organization as enrolled providers. OBH is currently developing provider training to successfully transition its providers into the new managed care system. In addition, the CSoC workforce development committee created a comprehensive Workforce Development Plan to assure that providers within the Coordinated System of Care initial implementing communities are competently prepared to meet the needs of youth and their families. Training, credentialing, and certification for these two initiatives will provide the foundation for ongoing OBH Workforce development activities.

### 6) *Local, State and Federal Coordination*

The Substance Abuse Mental Health Services Administration (SAMHSA) has issued new requirements for integrated behavioral health planning that will be used to direct an integrated application process for SAMHSA supported block grants, i.e. the Substance Abuse Prevention & Treatment Block Grant (SAPT) and the Mental Health Block Grants (MHBG). With the integration of the Offices of Addictive Disorders and Mental Health, OBH is well aligned with the direction that SAMHSA is taking.

OBH has achieved the most critical benchmark related to the powerful strategic driver behind the merge, the integration of the infrastructure of both mental health and addictive disorders, committing OBH to the provision of service delivery that is holistic and person-centered. This integration has reduced expenditures annually by 20% and readied the office for a number of impending opportunities to leverage care, including health care reform, Medicaid reform and movement to an integrated managed care system.

# OFFICE OF BEHAVIORAL HEALTH IMPLEMENTATION STATUS REPORT

## BACKGROUND

During the 2009 Regular Legislative Session, Act 384 was passed, which merged the Offices of Addictive Disorders and Mental Health to form a single Office of Behavioral Health. An Office of Behavioral Health Implementation Advisory Committee was formed, including representatives from both former mental health and addictive disorders agencies, the Department of Health and Hospitals, the Human Services Districts, and consumers, providers and advocates of mental health and addiction services. The purpose of the Implementation Advisory Committee was to make recommendations upon which to build a successful merger.

In this process of assessing need, the Advisory Group shared concerns about the preservation of the system of care related to the three distinct behavioral health target populations: those persons with mental health disorders, those with addictive disorders and those with co-occurring disorders. The concerns of stakeholders were that, with this merger, services for persons with mental health and addictive disorders needed to be preserved, maintaining their integrity and effectiveness in reference as stand-alone services. It was determined that the third target population of persons challenged with co-occurring mental health and addictive disorders was largely underserved by the historically non-integrated service delivery systems of the past.

OBH has simultaneously remained sensitive, in all aspects of implementation, to meeting the unique needs of both mental health and addictive disorders, while increasing the capacity to provide co-occurring services. Persons with co-occurring disorders are more prevalent in the population than one may be aware of and the treatment gap in services has been large. However, co-occurring disorders are the expectation in a behavioral health system, rather than the exception. Estimates suggest that at least half of persons presenting for addictive disorders will require assistance with a co-occurring mental health disorder, and a third to half of persons presenting for mental health disorders will require treatment for a co-occurring substance use disorder. Substantial agreement with the published research literature indicates that providing co-occurring treatment services, or treating both disorders at the same time produces better outcomes. Consistent with these finding, Louisiana's merger of the Offices of Addictive Disorders and Mental Health to form the Office of Behavioral Health addresses this disparity in service access for persons with co-occurring disorders.

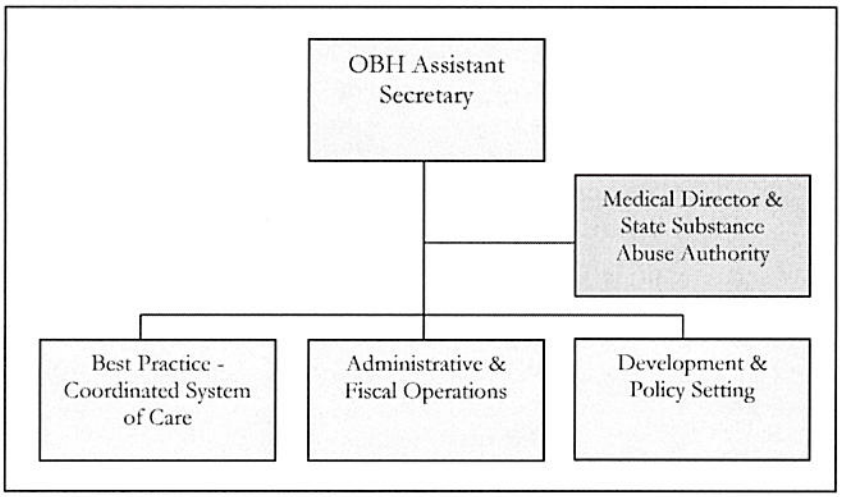
In addition to improving access to services for persons with co-occurring disorders, the Behavioral Health Implementation Advisory Committee Report to the legislature recommended the following areas of focus be addressed through the consolidation of the Office for Addictive Disorders and the Office of Mental Health: 1) Infrastructure; 2) Performance Measures and Outcomes; 3) Access; 4) Funding Strategies; 5) Licensing, Training and Workforce; and 6) Local, State and Federal Coordination. Below is the synopsis of activities undertaken and outcomes achieved through June 2011.

## 1) *Infrastructure*

### Central Office Systems Re-Organization

In a manner consistent with the guidance from the OBH Advisory Committee, the office has proceeded in its implementation of organizational reform to support an integrated and more efficient behavioral health system. In conjunction with expert consultation, OBH redesigned the central office administrative structure to eliminate duplication and align with the recommended functional areas that would support an integrated and co-occurring informed care model, while maintaining the unique features of mental health and addictive disorder stand-alone services. Three OBH divisions, consistent with the Advisory Group recommendations, were created to support integrated care. These divisions include: 1) the Administrative Division (human resources, fiscal, operational); 2) the System of Care Division (mental health and addictive disorder prevention and treatment); and 3) the Development Division (research and design, integrated policy and planning, business intelligence/information technology, quality assurance) (see Figure 3 below). Staff with respective addictive disorders and mental health specializations were assigned and redistributed throughout the organization. Previously non-integrated addictive disorder and mental health "siloed" organizational tracks were completely merged within the three primary organizational areas. Redundancy was removed and the organizational table was streamlined.

**Figure 1: OBH Central Office Administrative Reorganization**




A benefit from this reorganization was the cost savings produced, on the order of 20% of the office's budget. This included the elimination of 11 positions. Based on the national trends examined, a mistake that other re-organizing states made was the loss of leadership and the minimization of addictive disorders in the overarching structure of a behavioral health agency. Often times, a State Substance Abuse Authority (SSA) with limited influence was overshadowed by the corresponding mental health authority with the larger budget, stronger Medicaid ties, and perception of greater authority. To minimize this impact in Louisiana, the decision was made to appoint the SSA as the chief Medical Director for OBH. In this capacity, the voice and needs associated with substance use disorders would remain strong and intact.

### Regional Administrative and Clinic Level Systems Re-Organization

In the five regions of the state that are still managed through the central office of OBH, similar administrative reorganization was undertaken. Prior to this organization change, both addictive disorders and mental health programs maintained separate management, separate budgets, and separate oversight and utilization management functions. Re-organization at the regional levels resulted in a consolidated management structure with a single regional administrator for overall behavioral health operations in that locale. Fiscal functions, administrative support functions and clinical management functions were

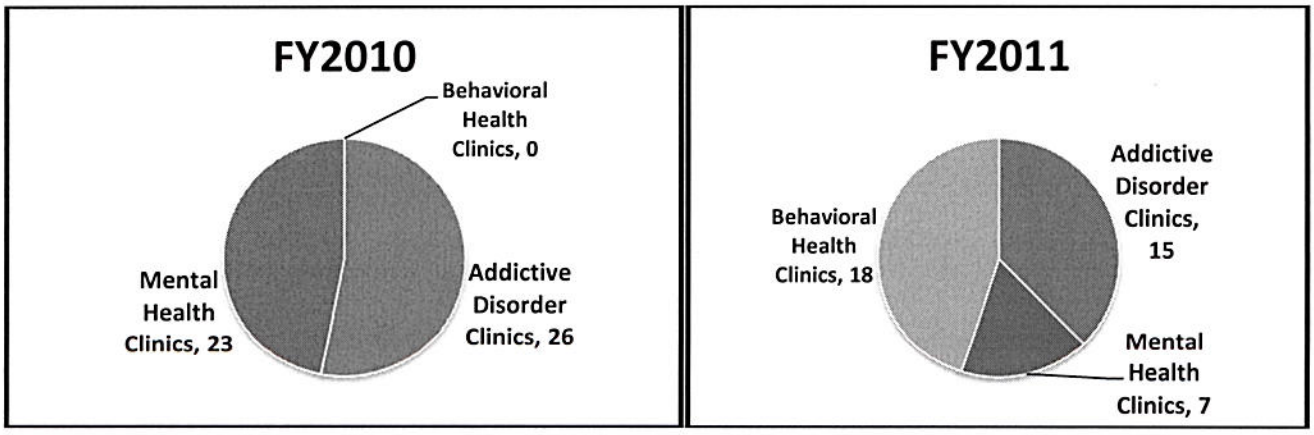
redesigned to build in efficiencies and eliminate duplications. Efforts to balance the needed expertise were made, in an effort to ensure continuity of operations in the midst of the massive system changes and to ensure a balance of representation between mental health and addictive disorders. Similar to the OBH central office, there were cost savings that provided for the elimination of 178 positions, 111 of which were authorized Table of Organization (TO) positions and 67 of which were non-TO positions. This resulted in an annual savings of $7.5 million, which was realized in the OBH FY 2012 budget. The elimination of the aforementioned 11 positions from the central office integration produced an associated annual savings of $804,804.

**"Bricks and Mortar" Co-location and Creation of Regional Behavioral Health Clinics and Administrative Offices**

OBH headquarters and regional staff worked strategically to co-locate the largest outpatient clinics by prioritizing the potential to increase access to care and develop a behavioral health model of care. A workgroup at the regional and executive management level developed an organizational structure by function consisting of the following: Regional Administrator, Medical Director/Services, Clinical Services, Operations and Special Programs. Regional Administrators were also asked to assess staff and facility needs and to integrate facilities wherever possible. Decisions about integrating physical space were based on several factors, such as bus line proximity; acessiblility; square footage and operational needs; which buildings were state owned; distance to other facilities in the region; and cost efficiencies to maintain.

The graph below illustrates the substantial change in clinic type across the regions since the creation of an integrated OBH (FY 2011) as compared to the clinic type prior to the integration (FY 2010). Not all sister addictive disorder and mental health clinic services could be co-located, as not all mental health clinics could accommodate the integration of an addictive disorders clinic, in terms of physical space and operational needs. In some instances, contracted programs could not be released from leases, or because of their rural location and part-time service delivery, could not merge. The goal is that these logistical barriers to co-location will be resolved and all OBH services will be integrated. All regional administrative office buildings have undergone consolidation and are co-located.

**Graph 1: Comparison of Regional Clinic Type Pre and Post to OBH Integration**



***Pharmacy Consolidation Plan***

Additional integration activities included those related to the Pharmacy Consolidation Plan, which simultaneously increases access to behavioral health medications and lowers cost. OBH began by examining its regional pharmacy delivery system and developed strategies to ensure increased access and cost-effective service delivery. With this in mind, Central Louisiana State Hospital and OBH implemented the Pharmacy Consolidation Plan. Effective April 25, 2011, Central Louisiana State Hospital, through the Shamrock Street Pharmacy, began providing comprehensive pharmacy services for OBH in Region 6. This initiative, when fully implemented in Regions 4, 5, 6, 7 and 8, is expected to achieve a FY 2012 budget reduction of $1,000,000 along with the elimination of one TO position. This will be achieved by reducing the upward trend of pharmacy costs in the following ways:

- Reducing purchase of medications using State General Funds from 17% to 8%
- Increasing client enrollment in the Patient Assistance Program (PAP), which currently provides an average of 83% of medications received by clients in the regions
- Streamlining use of fiscal and human resources

The Pharmacy Consolidation Plan was initialized in Region 6 on April 25, 2011. By November, 2011, Regions 4, 5, 7 and 8 will be incorporated into the plan. Through this initiative, a central pharmacy is charged with inventory management of medications and filling prescriptions, and the consumer now has the option of having medications received through mail or having the medications transported to their local clinic. System wide initiatives such as this pharmacy consolidation plan demonstrate OBH's commitment to ensure services are available and delivered to individuals in need of behavioral health services in the most efficient and cost effective manner.

## 2) *Performance Measures and Outcomes*

Implementation of utilization management strategies has been the core approach to supporting and maintaining behavioral health clinic operations. Many OBH providers use the Service Process Quality Management System (SPQM) that instructs providers on the clinical resource management strategies of service capacity barriers, diagnostic variability, referral patterns, cost predictability, payer mix implications and improvements in functioning levels of consumers. Use of SPQM has improved engagement and treatment completion rates, as well as helped spread evidence-based practices, i.e. Wellness Clinics, WRAP Training, Assertive Community Treatment, Intensive Case Management, Peer Mentoring, Recovery Supports and Dialectical Behavioral Therapy. Through these efforts, programs have been able to "do more with less," which has become particularly important during the current climate of economic duress and the need to maximize all available resources by ensuring the efficiency and effectiveness of our programs.

Another viable process improvement model that is producing very positive outcomes is the Network for the Improvement of Addiction Treatment (NIATx) process improvement model, whose current focus is improved client initiation, engagement and retention. Through use of this model and the SPQM system, providers have realized a 25% to 35% improvement in show rates for treatment appointments and achieved approximately 30% decreases in drop-out rates.

**Electronic Health Records and Information Management Systems**

OBH has historically maintained a comprehensive data warehouse that receives data from existing data input portals in both the outpatient and inpatient areas. This information can generate on-the-fly reports through an online query engine using a menu of pre-determined variables. This data warehouse provides performance information for quality assurance and quality improvement functions; for reporting on performance measures for review by the legislature; and for federal reporting.

As OBH moves toward a greatly expanded Medicaid environment and the need to interface with a managed care entity, the office is in the midst of an electronic systems overhaul and upgrade. On the immediate horizon, OBH will undergo a selection process for an electronic healthcare records system (EHR) that will need to meet the needs of the changing healthcare environment and link to the Statewide Management Organization for reimbursement. The Request for Proposals (RFP) is in motion, and soon the state supported behavioral health clinics will be involved in the implementation of an EHR to support their service delivery system. Simultaneously, OBH will need to develop internal and advanced data warehousing capabilities that allow for interoperability and data sharing across all state entities. While undergoing this systems transformation, OBH will need to maintain its current reporting capacity.

## 3) *Access*

Barriers to accessing coordinated care for co-occurring disorders have been virtually eliminated because services for both mental health and addictive disorders are now provided by one organization. OBH's implementation of the aforementioned process improvement strategies have increased access to care, helping providers deliver the "right type of service to the right client, at the right time and at the right intensity." By defining the target population and appropriate service mix, along with implementing centralized screening and scheduling, and instituting walk-in appointments, wait lists for services have been dramatically reduced. In some cases, clinics maintain no wait lists, and in others wait lists have been reduced from months to weeks or days. These activities have expanded access, improved provider productivity, and have generally moved the behavioral health clinics toward a higher practice standard.

Most importantly, throughout the year of streamlining activities, the critical quality assurance index was to ensure that a basic maintenance effort was achieved for the persons served in Louisiana. In spite of the large scale system redesign, staff reduction and reorganization, the public sector behavioral health system was able to provide essential services and treat approximately the same proportion of citizens as in previous years.

**Table 2: Persons Served in Regions 4, 5 6, 7 and 8 - FY 2010 and FY 2011**

| Program Type | # of Persons Served | |
|---|---|---|
| | FY 2010 | FY 2011 to date (6-30-11) |
| OBH Community (Outpatient and Residential) | 26,304 | 25,515 |
| Hospital-Based | 3,770 | 3,238 |
| **TOTAL:** | **30,074** | **28,753** |

## *4) Funding Strategies*

The consolidation of OBH has readied the office for a number of impending opportunities to leverage care, including health care reform, Medicaid reform and movement to an integrated managed care system. Consistent with fiscal models for integrated, co-occurring care, Louisiana is positioned to expand Medicaid reimbursement for addictive disorders, which will create a shared funding stream and broaden access to services. This statewide transformation of behavioral health services that better leverages Medicaid funding through the 1915i, 1915b, and 1915c Medicaid waivers, as well as state plan amendments, is entitled the Louisiana Behavioral Health Partnership (La-BHP). Conceptually, the La-BHP took state general funded behavioral health programs and made a substantial part of it a Medicaid funded integrated program that, in spite of the reduced dollars, could expand, to some extent, an integrated service menu. Under the La-BHP umbrella, specialty behavioral health services will be effectively managed through a State Management Organization (SMO) which, through cost savings achieved with the better management of care, will fund a significant portion of the planned expansion in behavioral health care.

Ultimately, this entirely new Medicaid reform for Louisiana will assist in the much needed rebalancing of community-based versus inpatient/residential treatments. Louisiana has been reliant on inpatient levels of care and particularly had built a significant portion of its large mental health budget on the Disproportionate Share Hospital (DSH) program through the Centers for Medicare and Medicaid Services (CMS). Immediately prior to the development of the La-BHP, OBH was engaged in active initiatives of de-institutionalization and the development of high intensity community based services (like Assertive Community Treatment and Intensive Case Management) to support persons who had previously been maintained in restrictive levels of inpatient care. Although solely supported through state general funds, this initiative served as a stepping stone in reducing reliance on inpatient care, readying the communities for this new type of care, and moving away from fiscal support through DSH. This de-institutionalization project has allowed for the successful discharge of approximately 185 persons from state inpatient units into appropriate levels of community based treatment. Through the La-BHP, the state will be afforded the opportunity to transition broader, more effective types of community-based care for mental health, addictive, and co-occurring disorders into Medicaid reimbursable services.

An important facet of the Louisiana Behavioral Health Partnership is the **Coordinated System of Care (CSoC)**, which institutes a Wraparound Model of care for children and youth at risk for out-of-home placement. The CSoC not only leverages federal Medicaid dollars but is also comprised of a multi-agency collaborative involving the Office of Juvenile Justice, the Department of Education, the Department of Children and Family Services, and OBH. Each of these agencies has pooled resources that will support the CSoC, and these shared funding pools will be used as state match. Louisiana is the first state to embark on a statewide wraparound initiative that has multiple agencies approaching this from an "all in" perspective.

## *5) Licensing, Training and Workforce*

OBH has prioritized development of Behavioral Health State Licensing standards, which would retain, through quality standards, the unique features and best practices of mental health, addictive disorder and co-occurring treatment. OBH has already begun the process of receiving technical assistance through its federal partners to assist in building this license, which would qualify one provider to treat all three target populations.

The next step in the La-BHP transformation is the transition of OBH behavioral health clinics into competent, qualified La-BHP network providers. Work done so far has included the provision of technical assistance in drafting the waiver documents for the managed care system for adults and youth not covered under the Coordinated System of Care (CSoC) implementation. These waiver documents defined the populations to be served, the array of services to be provided, and have been the guiding documents to assist in identifying necessary training, credentialing, and certification standards for providers and provider agencies. Providers in the current system will require orientation and training to new infrastructure and operational requirements in order to successfully transition into the new managed care system, and training for this level of organizational orientation is currently under development.

Training curricula and certification standards for the topics listed below are currently under development by OBH and other agency partners to assure readiness and the successful transition of providers to the La-BHP.

Training

- Research based trauma informed care
- Respite Care
- Treatment Planning
- Youth Support
- Independent Living Skills

Certification

- Wraparound Facilitator
- Other selected trainings will require certification

The CSoC workforce development workgroup created a comprehensive workforce development plan to assure that providers within the System of Care initial implementing communities were able to access specialized training and were competently prepared to implement the CSoC model with a youth and family-driven philosophy. It was recognized that many of the more progressive strategies and interventions associated with CSoC would have to be developed and the workforce created. The workgroup, made up of multi-agency participants, coordinated their efforts with other CSoC workgroups and utilized national technical assistance to 1) identify a set of pre-service competencies and accompanying e-learning resources, and 2) design a plan of training for foundational courses including Wraparound Process/ Planning, Cultural Linguistic Competency and Family Service Organization planning to be made available to providers and stakeholders in the development of the local systems of care. National experts providing these training will include the Maryland University Innovations Institute and Georgetown University.

In addition to these initial CSoC trainings, OBH has submitted a proposal to collaborate with the Louisiana State University School of Public Health, Institute of Justice to assist in assuring the sustainability of these initial implementing communities by providing technical assistance for the implementation of evidence based practices and the development and implementation of the family support organizations.

Training, credentialing, and certification for LaBHP and CSoC will provide the foundation for ongoing OBH workforce development activities statewide, until the implementing communities and existing providers are properly prepared to deliver quality services within the identified service array, inclusive of promising and evidence based practices. OBH will develop and implement the infrastructure, policies and processes necessary to facilitate the successful creation of the La-BHP.

From a management perspective, OBH's management is actively examining its current OBH clinic-based business model, which identifies staff roles, business processes and competencies that will re-align clinic functions to accommodate service delivery under LaBHP. The training mechanisms described above will be put in place to help OBH's workforce and its contracted workforce make this transition. Following training and implementation, the NIATx process improvement model and the Service Process Quality Management System (SPQM) will be used by OBH provider management to review the effectiveness of efforts and identify deficits to provide a process for remediation and for building in-house capacity. Further support to this process includes the varied and multi-level array of federal technical assistance that have been secured to address the aforementioned important and complex workforce development objectives for FY 12, and to support OBH central office transition to its new role as authority and monitor of the La-BHP Statewide Management Organization.

## *6) Local, State and Federal Coordination*

The Substance Abuse Mental Health Services Administration (SAMHSA) has issued new requirements for integrated behavioral health planning that will be used to direct an integrated application process for SAMHSA supported block grants, i.e. the Substance Abuse Prevention & Treatment Block Grant (SAPT) and the Mental Health Block Grants (MHBG). Part and parcel of the SAMHSA direction is guidance to the states in preparation for the new national fiscal landscape ushered in by the Affordable Care Act (ACA) and the expanded Medicaid population, with a continued eye for managing the remaining indigent or uninsured populations that will continue to exist. The current landscape of OBH is perfectly aligned with the direction that SAMHSA is taking.

OBH currently receives $30 million dollars annually in federal block grant funding. Planning efforts are underway to examine how Louisiana will manage block grant funded services in a seamless fashion with the La-BHP system and the associated State Management Organization. Current projections are that the block grant funds will still be needed to provide a "safety net" of services.

## CONCLUSION

The consolidation of the Offices of Mental Health and Addictive Disorders into the Office of Behavioral Health (OBH) has positioned the state to take advantage of funding and program innovations which will result in better access to services and treatment. The newly developed overarching Louisiana Behavioral Health Partnership (La-BHP) leverages federal Medicaid funding to support integrated access to behavioral health care, inclusive of Medicaid reimbursement for substance abuse services. Conceptually, the La-BHP takes behavioral health services paid for by state general funds and makes these services a substantial part of the Medicaid funded integrated service delivery system. With reduced dollars spent, OBH can maintain, and even expand, to some extent, an integrated service menu and still fund a "safety net" of service delivery not funded by insurance.

Under the La-BHP umbrella, behavioral health services will be effectively managed through a State Management Organization (SMO), which will provide a network of expanded providers in behavioral healthcare statewide. OBH will have authority over the SMO, which helps assure that the needs of its recipient populations will be met. As the transformation of service delivery brought on by Medicaid and the new era of health care reform brings even greater access, OBH's role will change to one of purchaser of services and evaluator of outcomes.

Throughout the opportunities, challenges and complexities that the future brings, the Louisiana Office of Behavioral Health will continue to pursue its goals with the simple but critical philosophy that people can and do recover from mental illness, addictive disorders and co-occurring disorders when given the proper care and a supportive environment.


## Acknowledgments

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## BIBLIOGRAPHY


Center for Substance Abuse Treatment. *Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders.* COCE Overview Paper 2. DHHS Publication No. (SMA) 07-4164 Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

Center for Substance Abuse Treatment. *Systems Integration.* COCE Overview Paper 7. DHHS Publication No. (SMA) XX. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2006.

Center for Substance Abuse Treatment. *The Epidemiology of Co-Occurring Substance Use and Mental Disorders.* COCE Overview Paper 8. DHHS Publication No. (SMA) 07-4308. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

Center for Substance Abuse Treatment. *Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders.* COCE Overview Paper 3. DHHS Publication No. (SMA) 07-4165 Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007.

Office of Behavioral Health Implementation Recommendations: PURSUANT TO ACT 384 OF 2009 http://new.dhh.louisiana.gov/assets/docs/BehavioralHealth/publications/OBHIAC_Final_Report.pdf

Fixsen, D. L., Naoom, S. F., Blasé, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature (FMHI Publication #231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network. Retrieved January 25, 2006, from http://nirn.fmhi.usf.edu/resources/publications/Monograph/

Lutterman, T.C.; Berhane, A.; Phelan, B.E.; Shaw, R.; Rana, V.; Organization, Operation, Funding and Expenditures of The State Mental Health Agencies; Rockville, MD: Substance Abuse and Mental Health Services Administration, DRAFT 2008.

Minkoff, K. & Cline, C. A. (2004). Changing the world: The design and implementation of comprehensive continuous, integrated systems of care for individuals with co-occurring disorders. Psychiatric Clinics of North America, 27 (4), 727–743.

**ENROLLED**

Regular Session, 2009

# ACT No. 384

HOUSE BILL NO. 837

BY REPRESENTATIVE MILLS AND SENATOR WALSWORTH

Prefiled pursuant to Article III, Section 2(A)(4)(b)(i) of the Constitution of Louisiana.

AN ACT

To amend and reenact R.S. 28:21(A) and (B) and 771(A) and (B)(5)(c) and R.S. 36:251(C)(1) and 258(C), to enact R.S. 28:4 and 771(B)(9) and (10), and to repeal R.S. 28:21(E) and R.S. 36:258(E), relative to the office of behavioral health; to provide for the office of behavioral health in the Department of Health and Hospitals; to provide for the office's purposes and functions; to provide for an implementation advisory committee and its membership; to dissolve the office of mental health and office for addictive disorders and transfer relevant purposes and functions to the office of behavioral health; to provide for copayments; to provide for appropriations; to provide for an effective date; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 28:4 is hereby enacted to read as follows:

§4. Office of behavioral health; legislative findings; creation of behavioral health implementation advisory committee

A. The legislature finds that:

(1) People can recover from both mental illness and addictive disorders when given the proper care and a supportive environment.

(2) The consequences of mental illness and addictive disorders affect all citizens of Louisiana, and it is essential to merge the administrative and planning functions of the state as they relate to mental health and addictive disorders in order to have a comprehensive health care system.

(3) Consolidation of the administrative functions of the state offices of mental health and addictive disorders is consistent with federal administration of such programs and has been adopted by other states.

(4) Consolidation of administrative functions shall allow the office of behavioral health to maximize available state, federal, and grant funding for the provision of services for persons with a mental illness or an addictive disorder or co-occurring disorders.

(5) Consolidation of administrative functions shall allow the office of behavioral health to pursue best practices to maximize available professionals to serve persons with mental illness, addictive disorders, and co-occurring disorders in accordance with their respective licensing statutes.

B. An implementation advisory committee, hereinafter referred to as "committee", shall recommend to the secretary a specific plan for implementation of the consolidated administrative functions of the office of behavioral health. The committee shall meet as needed and submit a report to the secretary of the Department of Health and Hospitals with final recommendations on the implementation plan which may be adopted no later than January 31, 2010. Thereafter, the committee shall continue to meet and advise the secretary on matters regarding implementation until the committee automatically dissolves on July 1, 2011. The Department of Health and Hospitals shall submit to the Senate Committee on Health and Welfare and the House Committee on Health and Welfare on September 1, 2010, and June 30, 2011, a written status report that details the progress of the implementation of the provisions of this Section. The following persons shall be members of the committee:

(1) The secretary of the Department of Health and Hospitals or his designee, who shall be the chairperson of the committee.

(2) The assistant secretary of the office for addictive disorders or his designee.

(3) The assistant secretary of the office of mental health or his designee.

(4) One representative from the addictive disorder professional community, chosen by the secretary from a list of names provided by the addictive disorder professional associations.

(5) One representative from the mental health professional community, chosen by the secretary from a list of names provided by mental health stakeholder community.

(6) One consumer of addictive disorder services, chosen by the secretary from a list of names provided by the Louisiana Commission on Addictive Disorders.

(7) One consumer of mental health services, chosen by the secretary from a list of names provided by the Louisiana Mental Health Planning Council.

(8) One representative from the addictive disorder professional community, chosen by the speaker of the House of Representatives.

(9) One representative from the addictive disorder professional community, chosen by the president of the Senate.

(10) One representative from the mental health professional community, chosen by the speaker of the House of Representatives.

(11) One representative from the mental health professional community, chosen by the president of the Senate.

(12) One representative selected by the Human Services Interagency Council who currently serves as the executive director of an existing human services district or authority.

C. The implementation advisory committee shall have the authority to create subcommittees to assist in the development of recommendations for consolidation of the administrative offices for mental health and addictive disorders) The implementation advisory committee shall consider at a minimum the following factors in developing its plan for recommendation to the secretary:

(1) The recommended procedures and time lines for the initial year of the merger of the office of mental health and the office for addictive disorders.

(2) The recommended consolidated administrative structure and staffing at the state and regional level.

(3) The recommended mission statement and vision for the office of behavioral health.

(4) The recommended performance measures and expected outcomes for persons with a mental illness or an addictive disorder or co-occurring disorders within the office of behavioral health.

(5) The recommended establishment of a single point of entry for services offered by the office of behavioral health.

(6) The recommended strategy to coordinate with the local human services districts and authorities.

(7) The recommended strategy to coordinate with the addictive disorder and mental health licensing boards and professional services providers to increase access to appropriate behavioral health care services and further workforce development.

(8) The recommended strategy to maximize available state, federal, and grant funding to increase access to appropriate behavioral health care services.

(9) The recommended strategy to coordinate with other state and federal agencies to increase access to appropriate behavioral health care services.

(10) The recommended ongoing internal monitoring upon dissolution of the implementation advisory committee.

D. On or before March 1, 2010, the secretary of the Department of Health and Hospitals shall present the implementation plan for approval by majority vote of the Senate Committee on Health and Welfare and the House Committee on Health and Welfare, meeting jointly. Action by the joint committee of health and welfare is limited to approval or disapproval of the implementation plan in its entirety.

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Section 2. R.S. 28:21(A) and (B) and 771(A) and (B)(5)(c) are hereby amended and reenacted and R.S. 28:771(B)(9) and (10) are hereby enacted to read as follows:

§21. State hospitals for ~~the mentally ill and inebriate~~ persons with mental illness and addictive disorders

A. The hospital at Jackson, known as the East Louisiana State Hospital, the hospital at Pineville, known as the Central Louisiana State Hospital, and the hospital

at Mandeville, known as the Southeast Louisiana Hospital, are designated as the ~~institutions~~ hospitals for ~~the mentally ill and inebriate~~ persons with mental illness and addictive disorders until such time as separate or other ~~institutions~~ hospitals are established. ~~If the facilities permit, the superintendent of each shall maintain within the framework of the hospital separate wards for the treatment of the inebriate.~~ The assistant secretary of the office of ~~mental~~ behavioral health of the department may reorganize and consolidate the administration of the ~~institutions~~ hospitals or facilities, including the Feliciana Forensic Facility, the Greenwell Springs Hospital, and the New Orleans Adolescent Hospital as necessary to comply with the provisions of the State Mental Health Plan.

B. The assistant secretary of the office of ~~mental~~ behavioral health of the department may establish ~~community cottages~~ residential settings as satellite facilities to these ~~institutions~~ hospitals from funds presently allocated or to be allocated to these institutions by the legislature.

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§771. Office ~~for addictive disorders~~ of behavioral health; functions related to addictive disorders

A. The office ~~for addictive disorders~~ of behavioral health of the Department of Health and Hospitals, hereinafter referred to as the "office", shall perform the functions of the state relating to the care, training, treatment, and education of persons suffering from addictive disorders and the prevention of addictive disorders. It shall administer residential and outpatient care facilities of the state for addictive disorder patients and administer the addictive disorders programs in the state.

B. The office shall additionally perform the following duties and responsibilities:

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(5)

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(c) The copayment provided for in this Paragraph shall be deposited in the state treasury pursuant to R.S. 39:82 and shall be accounted for by the commissioner

of administration through appropriations control pursuant to R.S. 39:334(B)(6). The commissioner of administration shall establish a separate cost center in the office of ~~mental~~ behavioral health and the office for citizens with developmental disabilities for revenue generated pursuant to this Paragraph. All funds not obligated shall revert to the state general fund at the end of the fiscal year.

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(9) Provide a twenty-four-hour, toll-free telephone service to provide information regarding available services to assist with compulsive or problem gambling behavior.

(10) Require any patient who is given a urine drug screen in a state-operated outpatient or inpatient alcohol or drug abuse facility as part of his treatment by the office of behavioral health to pay a copayment of not more than twelve dollars per screen to the provider of the screen if he is able to pay such copayment based on a sliding fee scale) Such copayments shall be charged and collected by the provider. The office of behavioral health shall promulgate rules and regulations to establish a sliding fee scale and criteria for determining a patient's ability to pay. Any patient eligible to receive Medicaid shall be exempt from the provisions of the copayment requirements. The copayments shall be exempt from the provisions of R.S. 49:971(A)(3) which provide that no state agency shall increase any existing fee or impose any new fee unless the fee increase or fee adoption is expressly authorized pursuant to a fee schedule established by statute or specifically authorized by federal law, rules, or regulations for the purpose of satisfying an express mandate of such federal law, rule, or regulation.

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Section 3. R.S. 36:251(C)(1) and 258(C) are hereby amended and reenacted to read as follows:

§251. Department of Health and Hospitals; creation; domicile; composition; purpose and functions

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C.(1) The Department of Health and Hospitals shall be composed of the executive office of the secretary, the office of management and finance, the office of public health, the office of ~~mental~~ behavioral health, the office for citizens with developmental disabilities, ~~the office for addictive disorders,~~ the office of aging and adult services, and such other offices as shall be created by law.

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§258. Offices; purposes and functions

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C. The consolidation of the administration of the offices for mental illness and of addictive disorders into the office of behavioral health will offer less redundancy and greater benefits to Louisiana citizens in need of these services. The office of ~~mental~~ behavioral health shall perform the functions of the state which provide services and continuity of care for the prevention, detection, treatment, rehabilitation, and follow-up care of mental and emotional illness in Louisiana and shall perform functions related to mental health. It shall also perform the functions of the state relating to the care, training, treatment, and education of those suffering from addictive disorders and the prevention of addictive disorders and administer the addictive disorders programs in the state. It shall administer residential and outpatient care facilities of the state for persons who are mentally ill, persons suffering from addictive disorders, and persons suffering from co-occurring mental illness and addictive disorders.

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Section 4. R.S. 28:21(E) and R.S. 36:258(E) are hereby repealed in their entirety.

Section 5. The Louisiana State Law Institute is hereby authorized and requested to review all statutes which contain phrases being changed by this Act and in all locations it deems appropriate change said references, particularly those to the office of mental health and office for addictive disorders.

Section 6. Sections 1 and 7 and this Section shall become effective upon signature of the governor, or, if not signed by the governor, upon expiration of the time for bills to become law without signature by the governor, as provided in Article III, Section 18 of the

Constitution of Louisiana. If vetoed by the governor and subsequently approved by the legislature, this Act shall become effective on the day following such approval.

Section 7. Sections 2, 3, 4, and 5 of this Act shall become effective July 1, 2010, upon approval of the implementation plan submitted by the secretary of the Department of Health and Hospitals to the Senate Committee on Health and Welfare and the House Committee on Health and Welfare, meeting jointly, as provided in R.S. 28:4. If the Senate Committee on Health and Welfare and the House Committee on Health and Welfare, meeting jointly, fail to approve the implementation plan then these Sections shall be null and void.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____