

Transformation of the Louisiana Mental Health System: Next Steps

**Based on Recommendations Developed During a Site Visit
In Baton Rouge by NRI Staff
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**Center for Mental Health Quality and Accountability
NASMHPD Research Institute**

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INTRODUCTION

This report is the third and final of a series of reports developed by staff at the Center for Mental Health Quality and Accountability (CMHQA), NASMHPD Research Institute, under contract with the State of Louisiana Department of Health and Hospitals, office of Mental Health. Specific activities required under this contract included: assessing the current status of implementation of “best practices” in the state; a review of the current research and implementation experiences of states related to specific practices; and the development of recommendations for next steps in Louisiana to improve access to and the quality of these best practices.

To accomplish these tasks, CMHQA staff initially met with state mental health authority managers and representatives from local mental health authorities to identify key issues and activities. These included:

1. Project Legacy, a major state health reform initiative which also included mental health reform
2. Accreditation of community mental health agencies by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
3. Project Pelican, a Mental Health Rehabilitation Strategy
4. The development of a recovery-orientation culture within the system
5. Several specific programmatic projects, including programs for persons with co-occurring disorders (mental health and substance abuse), pilot initiatives related to medication algorithms, and cultural competence

This was essentially a meeting that provided background and context for subsequent contract activities.

The first report was based on focus groups conducted at the regional level to identify current activities, needs and barriers related to best practices. To gather this information, these focus groups were conducted with all regions via the satellite videoconferencing capacity of the state mental health system on March 21 – 22, 2005. Key staff from each region discussed and reviewed issues related to current status of implementation of best practice and the infrastructural needs and priorities in their region. While the report covers these in greater detail, the major themes that emerged were:

1. There is a lack of broad based implementation of evidence-based practices (EBPs) in the state.

While there are some initiatives related either to competitive Federal grants that the state mental health system has succeeded in obtaining or to initiatives in specific geographic regions, there has not been broad based uptake of EBPs. The limited start to implementing EBPs appears to be based on two factors: 1) the lack of information / training related to EBPs, and 2) systemic infrastructural issues that thwart EBP implementation. Besides the lack of awareness and training related to EBPs, high caseloads, the lack of adequate data systems and reports,

and administrative demands and paperwork were cited as factors affecting EBP uptake.

2. Some staff have a keen awareness and understanding of the mental health system's movement toward recovery, quality and accountability. However, the various state initiatives have left others with the impression that they are silo approaches targeting inconsistent, if not conflicting, goals.

The major disconnects cited were related to transforming the system from a “medical model” to a recovery-oriented system, the lack of consensus on changes that need to take place, the fit of JCAHO accreditation activities with both recovery and EBP implementation, and unclear priorities related to who should receive services and outcomes that need to be targeted. Almost every focus group asked to have a model describing what the future system should look like so they could have a guide to help them navigate state initiatives and other changes. They asked that the model not only include *what* the system should look like, but also include *how* changes might be implemented.

That is, there appeared to be a lack of clarity regarding system goals and some confusion regarding the means and mechanisms in place to achieve what may be needed. This is partly caused by the multiplicity of initiatives related to reform that, from the perspectives of the regime, are seemingly disconnected.

3. Administrative demands and the lack of adequate infrastructure and supports were identified as barriers.

Demands related to paperwork and data reporting were viewed as taking time away from direct services. While data systems were considered critical, there were several comments regarding difficulties in obtaining needed information from information systems by both managers and clinicians. Issues related to multiple databases, outcomes definitions, and the usefulness of reports being produced were also identified.

4. Financing was not the primary issue identified as affecting reform. Some of the factors and issues identified above were noted as having precedence. The underlying premise was that if some of the needs identified above were addressed, this would provide a better focus and targeting of the resources that were currently available.

Even though financing was not identified directly, many of the issues that were cited as problem areas could be construed as related to a lack of resources (e.g., large caseloads, lack of training, and a crisis orientation.) Also, as transitions and changes were occurring or being expected, support for these transitions was lacking.

Also, while there was recognition that implementing EBPs produced cost-effectiveness interventions, the benefits of such implementation did not necessarily accrue to the implementing organization. In this sense, implementing EBPs at the local level was perceived as a cost rather than an investment.

Nevertheless, there was discussion of using Medicaid to fund evidence-based and other promising practices, including peer support services. Other states have developed mechanisms to fund such services. Subsequent reports produced under this contract will identify and propose such mechanisms for Louisiana to pursue.

The second report was a program literature review of best practices identified by OMH staff. The purpose of this report was to provide a brief summary of the state-of-the-art related to specific evidence-based and promising practices so that this information can be incorporated into the system transformation process currently underway in Louisiana. These summaries provide an overview of the rationale and benefits for implementing the specific evidence-based practice, the evidence, the target population, the program components, expected outcomes and considerations for implementation. Clearly there are more detailed descriptions and guidelines available. However, the idea for this paper was to make the key aspects for each practice easily accessible for policymakers, managers, clinicians and consumers to understand the components, benefits and implementation issues.

The specific best practices addressed were:

- Assertive Community Treatment
- Supported Employment
- Case Management / Intensive Case Management
- Crisis Intervention
- Family Psychoeducation
- Illness Management and Recovery
- Supported Housing
- Peer Support / Peer-Provided Services

The focus of this third report on recommendations for next steps in transforming the Louisiana is to make the mental health system more recovery-oriented, outcomes-driven and evidence-based. To develop these recommendations, CMHQA staff met with key state and local mental health authority leaders and managers. Both previous reports were reviewed and discussed, with a specific emphasis on implications for the next steps to be taken and the management of the change process. Major aspects of the discussion were the integration of the various reform initiatives – for example, Project Legacy, accreditation initiatives and COSIG – into a coherent approach to transformation and using the introduction of EBPs as a mechanism for instigating system change.

This report first reviews priorities identified at the meeting on the last site visit on August 25th and 26th and then presents recommendations for next steps to implementing mental health system transformation in Louisiana.

SYSTEM PRIORITIES

Key leaders and managers reiterated and validated the findings in the first report but, at the instigation of Commissioner Bowers-Stephens, the focus of the discussion was on the development of an action plan and identifying priorities for implementation rather than an elaboration of system problems and issues. System priorities identified were:

- Recovery-orientation / stigma reduction – These were discussed as overarching constructs that would permeate and guide all system initiatives and activities
- Work force development / leadership training – Given the findings of the previous site visit, there was a clear need to emphasize work-force development, both in terms of training current staff and in terms of the long-term, developing pre-service programs so that system expectations could be programmed into university and community college curricula. Areas identified included core competencies, recovery-orientation, evidence-based practices and quality improvement tools.

Proposed workforce development covered all levels of staff, including leadership training for executive directors and senior managers, as well as front-line supervisors. A focus of this leadership training needed to be on how to properly direct, supervise and model systems change.

- Defining performance expectations and incentives – Accountability at all levels was identified as a key priority. As part of this accountability thrust, performance expectations of districts and regimes needed to be clearly articulated so that the system was uniformly aligned to optimize outcomes. The role of the state authority, mechanisms for the transition of local entities from state to local control, were specifically identified as areas in which additional work needed to occur.

The reward and incentives structure was also considered critical to move forward with the desired transformative practices and policies. The incentives included regions to have control over their budgets so to design services as best needed for their population and geographic area. The group also discussed incentives for good job performance in the form of data feedback to clinicians that was tied to a performance measurement system tied to financial incentives for achievement and excelling of job performance standards that would be developed. Other incentives can be reaching for small wins that are visible at the local level and produce motivation for continued accomplishment.

The use of data was of particular concern. The managerial group asked for assistance in understanding if the National Outcome Measures (NOMS) are recovery-oriented and to identify other recovery-oriented measures. The districts need training and guidance in how to use these measures so they are clear in how to administer, how to use the data and make it part of the recovery process. This process needs to be integrated into the everyday life of managers and clinicians.

Consumers must be part of the development process. Whatever the process, the data collected must not be duplicative.

- Building partnerships with universities – One key area to move these recommendations along is forming partnerships with other state agencies and universities. These partnerships can draw resources, collaboration and expertise needed to create an informed system that is streamlined and draws on the latest technology and research. Partnerships can also facilitate the transfer of knowledge and do it in a way that tailors the information and delivery of it for the target audience.

NEXT STEPS

The state mental health authority (SMHA) is currently in the process of transitioning the public mental health system to one that provides services with a recovery orientation and emphasizes both quality and accountability. Towards this end, the SMHA is providing leadership on various initiatives, including Project Legacy, JCAHO accreditation, Project Pelican and EBP implementation initiatives. The regime and local mental health authorities understand the need for this transition and have their own ideas as to how to implement improvements in their service areas. That is, there appears to be a high degree of consonance regarding the need for transformation. At the same time, the nature and configuration of the transformed system is unclear and the actual process of implementing the changes so that the system can move in the desired direction remains to be defined. There are several initiatives underway but, for the most part, these activities have more of a project rather than a systemic status, lacking broad-based ownership at different levels for system transformation.

The recommendations proposed in this section are an attempt to catalyze change more at a broad-based systemic level to help build and promote a culture of change and quality improvement, so that the goals and objectives of the system are clear to all stakeholders, and that there is broad participation in defining and implementing the mechanisms to get there. These steps imply long-term commitment to this change process: building this transformed culture will be based not only in articulating visions and developing tools and strategies, but also on actions taken to move the system forward in a realigned fashion.

Step 1: Develop a strategic vision for the future of the State's mental health system.

At one level, the development of this vision may be viewed as tantamount to developing yet another strategic plan. While there will be some elements of such a plan, key components of this vision of the transformed system are:

- Differences between the transformed system and the existing system

- Activities to transition the existing system to a system that is more recovery-oriented (including training and consensus building)
- The fit of existing initiatives with the vision of the transformed system
- The roles of the state mental health authority and local mental health authorities in the transformed system, including performance expectations at both levels
- The role of the state mental health authority vis-à-vis other state agencies

Key to the development of this vision is that it be participatory and broad-based and that it must then be marketed and used as the basis for actions initiated and taken, especially in allocation of resources.

Step 2: Build an evidence-based culture.

One aspect that there appeared to be consensus on was implementing services that were known to be effective and efficient. But, as pointed out above, knowledge about EBPs and their implementation was spotty. Regions requested information about EBPs and promising practices in the following areas:

- What is an EBP? How do you find out about EBPs?
- How do you size the system to meet the model? How do you implement EBPs?
- What are staff requirements to implement the EBP?
- How do you recruit, organize staff and provide training for EBPs?
- What is OMH looking for in regards to EBPs?

Beyond such information was promoting EBPs within a quality improvement and data-based framework.

Step 3: Identify priorities for infrastructure development and improvement.

Again, one of the key areas is to optimize the potential of the existing information and data systems. While modifications and improvements may be needed, the first step may be to explore the outputs that could be currently generated to confirm transformation.

At the same time, consensus should be developed around the following issues:

- Which processes and outcome indicators the state will require
- Which instruments will be used or recommended
- What are the state's reporting requirements
- Suggested models of data use and feedback for quality improvement

Step 4: Develop a training / workforce development strategy.

Key components of this step are:

- Leadership training for SMHA and regional managers
- Ongoing training for supervisors and frontline staff regarding recovery, EBPs, data use

Step 5: Develop partnership with universities / community colleges and other State agencies.

To implement some of the steps identified, partnerships with universities and other State agencies are critical. There are various models for SMHA – university collaboration that can be explored to help the ongoing dissemination and consultation around EBPs, data and evaluation initiatives, and training / workforce development initiatives.

Step 6: Develop priorities and plans for EBP implementation.

Critical to EBP implementation is the notion that they are a tool and an effective and efficient means for achieving desired outcomes for specified populations. Once these have been identified, the partnerships described above can be used to promote such implementation.

Step 7: Developing resources and financing for both transformation and EBP Implementation.

The Center for Medicaid and Medicare Services (CMS) has recently developed guidelines for how Medicaid can be used to support EBPs. Louisiana should explore whether these guidelines fit Louisiana's transformation agenda to optimize resources.

At the same time, based on the momentum already in place to implement reform and transformation, the state should position itself and prepare itself to apply for a CMHS Transformation State Infrastructure Grant (TSIG) that may be forthcoming. Louisiana is clearly the type of state that CMHS would like to fund and the state should explore the potential of this opportunity.