December 2009 Publication 322

Public Mental Health Care in Louisiana

An Analysis of Louisiana's Fragmented System of Care and Options for Reform

Public Affairs Research Council of Louisiana

Executive Summary

Louisiana's system of public mental health care is biased toward expensive institutional care, thereby reducing the adequacy of funding for tens of thousands of persons, both adults and children, who suffer from mental, addictive or other behavioral health disorders. The state ranks poorly (50th in the U.S.) in per-capita funding of community-based treatment services and poorly (46th) in access to services for the population in need of treatment. Solutions will not be easy or simple.

Persons with behavioral health needs have a pronounced tendency to also have multiple co-occurring health conditions, such as untreated hypertension, diabetes, cancer and other problems that reduce their lifespan by an average of 25 years. National studies have reached a consensus that the best solution is to improve collaboration between primary medical care and behavioral health care in order to assure diagnosis and treatment of both behavioral and physical health problems.

This brief provides an overview of the Louisiana public behavioral health system. It focuses primarily on the public mental health care delivery system and highlights several issues that are barriers for those who seek treatment for mental illness. It recommends pragmatic solutions that are within current reach of policymakers and austere budgets. While acknowledging that the preferred solution would include a massive injection of much-needed funding for public mental health services, the brief is also grounded in the reality that there is little money available for that purpose. The impending fiscal crisis should be viewed as an opportunity to reorder priorities and advance more efficient and cost-effective models of care delivery, rather than protect the outdated system that contributed to the debacle.

The nationwide public system that delivers care for persons with mental illness has evolved over the past 50 years from a mostly inpatient hospital structure to a predominantly community-based arrangement that provides better treatment and allows more personal freedom for most patients. The trade-off for this progress is that the current system is underfunded, fragmented and difficult for the patient (and often the provider) to navigate.

Compared to most other states, Louisiana's system of care is even more fragmented with respect to community-based care and has a very pronounced bias toward institutional spending for state mental hospitals that provide intermediate to long-term inpatient care. Nationwide, spending on mental health services in 2006 included 28 percent for state or county psychiatric hospitals, 70 percent for community-based care and 2 percent for administrative costs. For Louisiana, the split was 56 percent for state psychiatric hospitals, 30 percent for community-based care and 13 percent for administrative costs.

Persons with chronic mental illness frequently seek non-emergency primary care services in emergency rooms throughout the state, because they do not have private insurance or Medicaid coverage and cannot afford to pay. These patients would benefit from having the continuity of treatment available from a single non-emergency source of routine primary care.

The advanced or patient-centered medical home (PCMH) model of primary care ideally would provide the proper array of medical and behavioral services required to diagnose and treat both physical and mental illness. Preferably, primary care providers and behavioral specialists would be co-located and work in conjunction to lend their specific knowledge to the task of caring for patients with complex problems and co-existing conditions (e.g., depression and cardiovascular disease). Considerable progress has been made in establishing medical homes with integrated behavioral health services in the New Orleans area, as well as other parts of the state, making the PCMH model a viable option especially for large clinics and some hospitals. Smaller primary care physician practices and providers such as mental health centers may be able to pursue other options.

A promising pilot project in the capital region could be replicated to serve as a short-term solution to the problem of poor coordination of care. The Capital Area Human Services District (CAHSD) has expanded its menu of services, which includes outpatient mental health care and treatment for addictive disorders to more than 9,000 clients in the seven-parish Baton Rouge region. Collaboration among area agencies has produced highly effective innovative services: crisis intervention teams with specially trained law enforcement personnel; specialized emergency rooms in local hospitals with mental health professionals trained to handle behavioral crisis situations; medical case managers to help the mentally ill keep appointments and take medication; and mobile health clinics for those who lack access to primary medical care services.

Current Medicaid rules are another barrier to the provision of more timely and comprehensive health care for patients with mental illness. Physician reimbursements for office visits are restricted to a maximum of 12 annually with few exceptions, and those are subject to a cumbersome prior authorization process. Similarly, payments to primary care physicians for additional diagnoses cannot be made on the same visit, therefore requiring more visits. This payment structure, meant to rein in excess volume in the fee-for-service payment system, is a disincentive for both the provider and the patient to address all aspects of medical needs, particularly routine behavioral problems and even severe mental illness.

The following recommendations propose meaningful change in the management and oversight of the Louisiana public mental health care delivery system.

Recommendation 1: Sustained funding should be provided to expand patient-centered medical homes for primary care and integrated behavioral health services, including replacement for the expiring Greater New Orleans Primary Care Access and Stabilization Grant.

Recommendation 2: Public systems of medical care and behavioral health care should be integrated through regional care networks modeled after a successful community-based pilot project in the Capital Area Human Services District.

Recommendation 3: The Louisiana Medicaid program should review and revise its method of paying for treatment of patients diagnosed with mental illness or behavioral problems in order to encourage physicians to integrate primary and mental health care services and treatment plans.

Recommendation 4: The Legislature should establish an ongoing appropriation for payment of primary care treatment for uninsured persons with co-existing medical and behavioral health problems.

Recommendation 5: The DHH Office of Mental Health should focus on decreasing institutional costs where possible, including (a) downsizing existing state psychiatric hospitals by reducing bed capacity, staffing or excess land and (b) reducing administrative costs. Any savings incurred should be transferred to community-based outpatient care.

Various collaborative models for integrating primary care and behavioral health could be applied throughout the state, improving both physical and behavioral treatment for persons diagnosed with mental illness or addictive disorders, as well as expanding diagnostic and treatment capacity for both behavioral and physical health problems. Notwithstanding the difficult budget climate, the state should implement these proposals because they provide significant long-term savings by improving access and quality of care, thereby reducing hospitalizations and other expensive treatment.

Just prior to publication of this report, the Louisiana Department of Health and Hospitals (DHH) outlined a broad plan to overhaul the public delivery system for behavioral health care, including major components that are in line with the recommendations in this report. Although more detail is needed on how these goals would be achieved, the plan demonstrates a commitment to modernizing the delivery system by improving access and quality. DHH acknowledges that implementation will be difficult in the context of a multi-year budget crisis. No information has been provided yet regarding the strategy to be used for financing new initiatives in the face of massive budget cuts. A consensus among administration officials, legislators and community stakeholders in favor of reordering priorities will be necessary to create a high quality health care system that is accessible, cost-effective and financially sustainable.

The plan would require a lasting commitment to be successful. Other state programs like the Louisiana Children's Health Insurance Program (LaCHIP) have enjoyed success that transcended changes in administrations and have been spared significant budget cuts. A sustained effort to improve the public system of care for those with mental illness and addictive disorders should be a top priority.

Introduction

Unlike other diseases and medical conditions, mental illness is difficult to define and treat. The root causes of mental illness are not well understood and "cures" are often elusive. Throughout history, persons with mental disorders have been stigmatized and shunned from society or placed in asylums. These institutions were transformed into "mental hospitals" in the early 20th century but conditions remained primitive and often inhumane.

More enlightened attitudes toward the mentally ill emerged in the 1950s with the introduction of antipsychotic medications that controlled symptoms of various disorders and enabled many patients to leave the confines of the hospital to lead near normal lives. The medications launched a deinstitutionalization trend, which reduced the number of people living in mental hospitals from more than 550,000 nationwide in 1956 to approximately 45,000 in 2008, a reduction of 92 percent (see Table 1). Over the past 50 years attitudes have shifted in favor of community integration for the mentally ill with treatment, rehabilitation and recovery in outpatient, community-based settings whenever possible.

The evolution of mental health programs in Louisiana followed a different path than the nation as a whole. While Louisiana reduced its resident inpatient population at a rate approximating nationwide reductions, the state did not close any of its long-term mental hospital facilities. Counter to the trend in other states, Louisiana expanded the number of state psychiatric institutions from five to six in the mid-1980s with the opening of the New Orleans Adolescent Hospital.

This brief provides an overview of the Louisiana public mental health care system. It focuses on several issues that are barriers for those who seek treatment for mental illness and recommends pragmatic solutions that are within current reach of policymakers and austere budgets. While acknowledging that the preferred solution would include a massive injection of much-needed funding for public mental health services, the brief is also grounded in the reality that there is little money available for that purpose. The impending fiscal crisis should be viewed as an opportunity to reorder priorities and advance more efficient and cost-effective models of care delivery, rather than protect the outdated system that contributed to the debacle.

Table 1. State mental hospital resident population, 1945-2008

	Louisiana			United States		
	Residents	Population	Res./100,000	Residents	Population	Res./100,000
1945	7,266	2,429,000	299.1	508,400	139,928,165	363.3
1956	8,264	3,032,000	272.6	552,005	168,903,031	326.8
1984-87 (avg.)	1,707	4,389,916	38.9	110,125	239,042,626	46.1
1988-91 (avg.)	1,247	4,250,272	29.3	94,948	248,233,925	38.2
1992-95 (avg.)	1,122	4,297,519	26.1	74,507	258,985,651	28.8
1996-99 (avg.)	1,051	4,356,237	24.1	57,763	268,987,749	21.5
2000-03 (avg.)	771	4,479,581	17.2	49,437	286,287,325	17.3
2004	847	4,487,830	18.9	51,379	292,892,127	17.5
2005	793	4,495,627	17.6	45,561	295,560,549	15.4
2006	777	4,243,634	18.3	44,137	298,362,973	14.8
2007	773	4,373,310	17.7	44,901	301,290,332	14.9
2008	923	4,410,796	20.9	45,008	304,059,724	14.8

SOURCE: 1945 and 1956 estimates, "Problems in the Interpretation of Trends in the Population Movement of Public Mental Hospitals," Kramer and Pollack, American Journal of Public Health 1958, Vol. 48, No. 58; 1984-2003 four-year average increments from "State Psychiatric Hospital Census After the 1999 Olmstead Decision: Evidence of Decelerating Deinstitutionalization," Salzer et al, Psychiatric Services Journal, October 2006, Vol. 57, No. 10; 2004-2008, Center for Mental Health Services Uniform Reporting System Output Tables for each year.

Louisiana in Context

Louisiana, which housed in excess of 8,200 residents in state psychiatric hospitals by 1956, had reduced that number to a total of 923 in 2008, a reduction of 89 percent. Table 1 details the drop in the state mental hospital resident population from 1945 to 2008 for Louisiana compared to the nation. While the resident population has dropped significantly in tandem with national levels, a rise in beds since 2004 has brought the state's per-capita resident rate above the national average.

that Louisiana resources are skewed toward institutional care is found in the Office of Mental Health (OMH) budget that shows 80 percent of the office's 3,000 plus staff employed at state mental hospitals and 20 percent at outpatient mental health clinics and other community-based services. National workforce averages are not available.

The high level of institutional spending is not balanced by a robust level of funding for community-based care in line with national spending patterns. Instead, the NASMHPD data

Table 2. State Mental Health Spending, 2006

	U.S. spending			LA spending		
	Total*	Allocation	Per Capita	Total*	Allocation (rank)	Per Capita (rank)
Total state spending	$30,978.5	100%	$104.10	$256.8	100%	$60.89 (42)
State psychiatric hospitals	$8,547.0	27.6%	$28.72	$145.0	56.4% (2)	$34.31 (18)
Community-based programs	$21,714.0	70.1%	$72.97	$78.0	30.3% (51)	$18.57 (50)
Prevention, research & training	$113.4	0.4%	$0.89	$0.0	0.0%	$0.0
Program administration	$603.9	1.9%	$2.14	$33.8	13.2% (1)	$8.01 (4)

**Total spending in millions of dollars.*
SOURCE: 2006 data from National Association of State Mental Health Program Directors Research Institute

The most striking difference between Louisiana and most other states is the high level of spending for state mental hospitals that provide intermediate to long-term inpatient care. According to data reported by states to the National Association of State Mental Health Program Directors (NASMHPD), national spending on mental health services in 2006 included 28 percent for state mental hospitals and 70 percent for community-based care (see Table 2). For Louisiana, the spending distribution was 56 percent (second highest in the United States) for state mental hospitals and 30 percent (worst in the U.S.) for community-based care. Further evidence

show that Louisiana ranks 50th in spending for community-based care at $18.57 per capita. The national average for all states is $72.97 per capita.

Louisiana is also an outlier with respect to program administration. According to national data reported by each state, Louisiana ranks fourth in administrative costs at $8.01 in per-capita spending. The national average is $2.14. Table 3 offers a comparison of Louisiana's spending by category over a three-year period. The state's expenditures on administrative services nearly doubled from 2005 to 2006.

Table 3. State Total and Per-Capita Spending by Category, 2004-2006

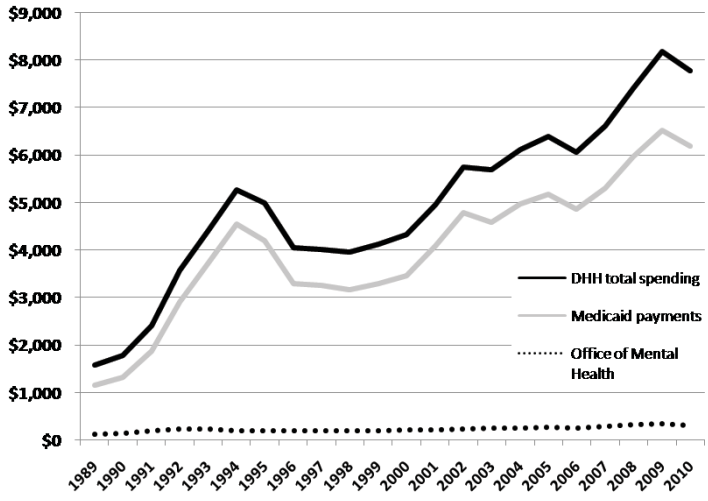
	2004		2005		2006		2004-2006
	Amount ($ millions)	Per capita	Amount ($ millions)	Per capita	Amount ($ millions)	Per capita	Amount % change
State psychiatric hospitals	$123.0	$27.30	$135.0	$30.08	$145.0	$34.31	17.9%
Community-based services	$103.0	$23.01	$106.0	$23.68	$78.0	$18.57	-24.3%
Administrative	$10.4	$2.32	$17.2	$3.83	$33.8	$8.01	225.1%
Total spending	$236.4	$52.63	$258.2	$57.59	$256.8	$60.89	8.6%

SOURCE: National Association of State Mental Health Program Directors Research Institute

Mental health system status

Although the state has rejected warehousing of the mentally ill in favor of treatment, recovery and community placement, it lags well behind many other states in providing access to vital services for the mentally ill. Spending levels for mental health services are woefully short of needs and have fallen well behind the pace of increase in budgets for other health programs (see Figure 1). Spending for the Office of Mental Health (OMH) has grown an average of 4.6 percent per year, from $117 million in 1989 to $315 million for this year's budget. Compare that to growth in the Medicaid program at 8.4 percent, nearly twice the rate for OMH.

Figure 1. Office of Mental Health spending compared to DHH & Medicaid, 1989-2010 ($ in millions)



SOURCE: DHH and OMH budget data

Although the number of persons served by public mental hospitals has declined significantly since the 1950s, the state has failed to realign spending patterns to improve access and quality of care for the overwhelming majority of persons with mental illness who need vital services but are not institutionalized. In many cases, due to inadequate funding and limited funding sources, failure to provide adequate community-based outpatient care to diagnose and treat mental illness will lead to costly acute episodes requiring inpatient care and possibly long-term institutionalization.

According to a 2003 DHH issue brief, 85,000 adults and 110,000 children in Louisiana are severely mentally ill. Yet, only 7 percent of children and 45 percent of adults are provided treatment. While underfunded public mental health agencies struggle to provide services, persons with mental illness who have private insurance coverage also face considerable challenges in getting treatment. Private insurers often impose special limits and much higher cost-sharing on mental health treatment than they do for physical health treatment, according to the New England Journal of Medicine, July 2008. Mental health advocates have sought for years to advance mental health parity in the private insurance market. Parity would enable insured mentally ill patients to access treatment services that are covered by their insurance policy as easily as they access physical health providers and treatments.

The FY 10 budget for OMH was hit hard with 93 personnel to be laid off and a net reduction of $87 million in state funds and $31 million overall. The large reduction in state funds was partially offset by $69 million in one-time federal Social Services Block Grant funds, setting the stage for a large budget gap in FY 11. In a move toward achieving greater efficiency, the New Orleans Adolescent Hospital was closed and consolidated with Southeast Louisiana State Hospital (SELH) in Mandeville. Those hospital beds were transitioned to SELH, and a children's system of community-based services has been implemented in the New Orleans region using evidence-based practices to keep children/adolescents in the community.

Another promising DHH proposal that received approval during the 2009 legislative session is the consolidation of the DHH Office of Addictive Disorders with the Office of Mental Health. The incidence of substance abuse and other addictive disorders is very high in the population with mental illness, with an estimated 50 percent to 85 percent of persons with mental health problems also having addictive disorders. Merging these agencies is expected to allow treatment resources to be better coordinated for the benefit of the affected population.

A fiscal crisis provides an opportunity to reorder priorities in order to make long-term improvements. New priorities may emerge from the administration's effort to "streamline" mental health and addictive disorder services, as well as other government programs, but it is not yet clear whether any resulting savings will be fully reinvested in treatment for the population with mental illness.

Table 4 shows current-year funding for OMH compared to the prior fiscal year. State general fund dollars in the OMH FY 10 budget constitute

about 28 percent of total spending, compared to 50 percent of the total in the prior year. The predominant sources of financing (64 percent) are Medicaid payments for those eligible (mostly children), Disproportionate Share Hospital (DSH) funds for institutional care, including acute psychiatric units and long-term mental hospitals, and a one-time infusion of federal dollars from the Social Services Block Grant.

The institutional resources of OMH include five general psychiatric hospitals and one forensic psychiatric hospital. Feliciana Forensic Facility in Jackson, La., operates 235 of the 743 adult, non-acute beds in the OMH hospital system and an additional 144 beds in other hospitals are designated for forensic patients. Altogether 379 beds are designated for forensic patients or 51 percent of the 743 adult non-acute beds. The total may be higher when additional civil beds are used for forensic patients.

While most state hospitals are occupied by patients admitted through voluntary or involuntary civil commitment, forensic hospitals are populated by patients committed by the criminal court system for several reasons: their competency to stand trial has been questioned, they have been found incompetent and have not regained competency, or they were adjudicated as not guilty by reason of insanity. Over the past 15 years, Louisiana OMH hospitals have seen a significant increase in the admission rate of forensic patients. This mirrors a nationwide trend with major implications for states: criminal courts, not state mental health agencies, govern forensic admissions but the steadily increasing cost of housing a difficult and often dangerous patient population remains the responsibility of the states. (Health Affairs, May 2009)

In addition to the six state-operated inpatient hospitals (listed in Table 5), OMH operates 48 outpatient mental health clinics and five inpatient

Table 4. Office of Mental Health Budget, FY 08-09 & FY 09-10

	FY08-09	FY09-10	Change	% Change
State general fund	$174,081,724	$87,111,388	($86,970,336)	-50%
Interagency transfer	$140,125,732	$200,660,119	$60,534,387	43%
Self-generated revenues	$5,573,293	$4,229,891	($1,343,402)	-24%
Statutory dedications	$178,000	$0	($178,000)	-100%
Federal funds	$26,034,380	$23,335,993	($2,698,387)	-10%
Total means of financing	$345,993,129	$315,337,391	($30,655,738)	-9%
Positions authorized	3,127	3,034	(93)	-3%
Program	**FY08-09**	**Positions**	**FY09-10**	**Positions**
State Office Administration	$7,108,852	36	$7,118,481	36
Community Services	$49,055,443	78	$39,214,863	58
Area A*	$81,462,833	848	$69,194,461	834
Area B**	$139,699,549	1,537	$135,380,508	1,530
Area C***	$68,666,452	628	$64,429,078	576
Total	$345,993,129	3,127	$315,337,391	3,034

**Area A includes regions 1, 3, and 9, Southeast LA Hospital, New Orleans Adolescent Hospital, and the acute psychiatric units operated in those regions.*
***Area B includes regions 2, 4 and 5, Eastern LA Mental Health System, which includes Feliciana Forensic, East LA and Greenwell Springs Hospital, and the acute psychiatric units operated in those regions.*
****Area C includes regions 6, 7, and 8, Central LA Hospital, and the acute psychiatric units operated in those regions.*
SOURCE: Office of Mental Health

Table 5. State Mental Hospital Beds & Acute Psychiatric Beds (March 2009)

System/Facility	Adult acute psych beds	Adult civil beds[2]	Adult forensic beds[2]	Child and adolescent beds	Total	Cost per day[4]
Office of Mental Health						
Central State Hospital - Pineville	0	60	56	16	132	$645
Eastern Louisiana Mental Health System:						
Jackson campus	0	210	88	0	298	$387
Feliciana Forensic Facility	0	0	235	0	235	$443
Greenwell Springs campus	66	0	0	0	66	$568
Subtotal ELMHS	*66*	*210*	*323*	*0*	*599*	
Southeast Louisiana Hospital - Mandeville	29	94	0	30	153	$778
New Orleans Adolescent Hospital[3]	20	0	0	15	35	$1,298
Total	**115**	**364**	**379**	**61**	**919**	
LSU - Health Care Services Division						
Washington-St. Tammany - Bogalusa[1]	10	0	0	0	10	
W.O. Moss Hospital - Lake Charles[1]	10	0	0	0	10	
University Medical Center - Lafayette[1]	20	0	0	0	20	
Leonard Chabert Hospital - Houma	24	0	0	0	24	
University Hospital - New Orleans	38	0	0	0	38	
Total	**102**	**0**	**0**	**0**	**102**	
LSU - Shreveport Health Sciences Center						
E.A. Conway Medical Center - Monroe	27	0	0	0	27	
Huey P. Long Hospital - Pineville	16	0	0	0	16	
LSU Medical Center - Shreveport	51	0	0	0	51	
Total	**94**	**0**	**0**	**0**	**94**	
Grand Total	**311**	**364**	**379**	**61**	**1,115**	

[1]Staffed by Office of Mental Health; [2]Designated forensic beds = 379 or 51percent of all adult beds; forensic patients occupy 484 or 65 percent of all adult beds; [3]New Orleans Adolescent Hospital scheduled for closure in FY 09-10; [4]Cost per day for OMH hospitals from FY 07-08 data
SOURCE: Office of Mental Health

acute psychiatric units within the LSU hospitals. The cost of care in each of the inpatient hospitals varies widely and each operates at a high occupancy rate. Table 5 presents data regarding where the state's mental health inpatient beds are located and which type of patients they serve. Table 6 lists the 69 community mental health centers and clinics statewide that are operated either by OMH or by local governing authorities. Local authorities include four regional human services districts designated in state law to provide outpatient care for persons with mental illness, developmental disabilities or addictive disorders. The four districts include Capital Area Human Services District (Baton Rouge region), Jefferson Parish Human Services Agency, Metropolitan Human Services District (Orleans Region) and Florida Parishes Human Services District. Services in the remaining five regions are provided directly by the Office of Mental Health.

Impact of Disaster

Like many components of the Louisiana public health care system, mental health services were in serious disrepair before the hurricanes of 2005. Hurricane Katrina effectively destroyed the delivery system for the mentally ill in the New Orleans area, causing persons already in need of intensive treatment to become stressed to the

Table 6. Persons Served by Outpatient Community Mental Health Centers and Clinics, FY2009

Region/Location (# parishes)	Jurisdiction	Outpatient Facilities	Persons Served*
1/Orleans (3)	Metropolitan Health Services District	6	10,932
1/Jefferson Parish (1)	Jefferson Parish Human Services Authority	2	4,457
2/Baton Rouge (7)	Capital Area Human Services District	9	9,126
3/Houma (7)	Office of Mental Health	8	6,672
4/Lafayette (7)	Office of Mental Health	11	5,930
5/Lake Charles (5)	Office of Mental Health	3	1,702
6/Alexandria (8)	Office of Mental Health	7	3,482
7/Shreveport (9)	Office of Mental Health	7	3,130
8/Monroe (12)	Office of Mental Health	12	2,982
9/Hammond-Slidell (5)	Florida Parishes Human Services Authority	4	4,480
Total for all regions		**69**	**52,893**

**"Persons served" defined as unduplicated count for each region.*
SOURCE: Office of Mental Health

breaking point and, in many cases, dislocated to other parts of the state without reallocation of funds needed for treatment.

The storms' impact on children became a particular concern that required a renewed and more intensive policy focus. A Kaiser Foundation survey of New Orleans indicated that severe emotional or behavioral problems were the second most common chronic condition affecting children in the households surveyed, with 6 percent reporting a child who had been diagnosed with such problems. Additionally, the survey showed that significant numbers of households reported children who had not been diagnosed but were exhibiting either borderline or abnormal emotional symptoms. Survey data showed that 11 percent of economically disadvantaged households reported children with symptoms compared to only 6 percent of non-disadvantaged households.

In 2006 the U.S. Centers for Disease Control and Prevention surveyed storm survivors of all ages and found that 49.8 percent exhibited levels of emotional distress that indicated a need for mental health care. Although the state tried to marshal resources to restore services for the New Orleans area, the response was anemic when compared with the scope of the disaster.

The hurricanes of 2005 rendered an already dysfunctional mental health care system almost inoperable, but it also provided a significant and rare opportunity to reorganize and rebuild. In many cases, severe episodes of mental illness requiring hospitalization can be prevented if early diagnosis is made and appropriate treatment and medications are provided. Priorities were reset and, to a degree, spending was redirected toward more efficient outpatient and community-based services in order to reduce the need for acute and long-term inpatient hospitalization for both adults and children.

Four years after Katrina, there is evidence that improvements are being made in building outpatient capacity. Yet, it is still not evident that the state has established a clear vision for a reformed mental health system that will efficiently and effectively serve significantly more of the mentally ill in need of treatment than the broken system that preceded it. In all too familiar fashion, strategic plans developed by one administration have been replaced by a new and different approach in the succeeding administration. Earlier this year, plans developed by the current administration were scrapped while severe budget cuts are implemented. Further cuts in mental health services, especially if community-based care is targeted, will erode the limited progress made over the past three years.

In the wake of Hurricane Katrina, the Department of Health and Hospitals, Office of Mental Health, was directed by Executive Order from Gov. Kathleen Blanco to develop a plan to improve access to mental health services for the state. In June 2007, the department announced a thorough and detailed proposal for a master plan that would bring the Louisiana public mental health care system up to national standards and increase the rate of per-capita spending from $26 to the national average of $73.

The ambitious plan included six broad goals, 32 strategies and 157 objectives and was estimated to cost $209 million annually after a five-year phase-in period. Only a fraction of the $209 million needed to fund the components of the plan has been budgeted to OMH since 2007. In fact, the average annual increase for the OMH budget from FY 07 to the current fiscal year has been only 2 percent, well

below inflation. Gains of $40 million in FY 08 and $19 million in FY 09 were mostly wiped out by mid-year budget cuts during FY 09 and deeper cuts that became effective for FY 10.

In February 2008, Gov. Bobby Jindal issued an Executive Order of his own directing DHH to implement another plan to focus on the mental health needs of the New Orleans area, as well as to lead a "transformation" of the Metropolitan Human Services District, the entity responsible for outpatient mental health services in the New Orleans area. Some of the key elements of the new plan included assertive community treatment teams, housing subsidies, child and adolescent response teams, crisis respite care, crisis intervention teams, mobile clinical treatment teams and mental health staffing at the Orleans Parish Prison. This plan was estimated to cost $18.1 million and was originally funded at $13.8 million for FY 09. Funding was reduced by $4 million due to mid-year budget cuts last year and current funding totals $10.8 million.

Quality of Care Compared

The most recent comparative data report on mental illness and treatment for the 50 states shows Louisiana with predictably poor performance. The state received a grade of "D" in every category in a 2009 review of the performance of the adult mental health system by the National Alliance on Mental Illness (NAMI). As bad as this may appear to be, Louisiana is tied with 20 other states in terms of system performance as measured by NAMI. Furthermore, Louisiana scored higher than six states that had overall scores of "F." Eighteen states scored "C" and only six scored a "B." No "A" grades were bestowed by NAMI, which is clearly unhappy with the state of mental health care throughout the country. Table 7 shows the survey results for 16 southern states.

NAMI notes that Louisiana's grade has not changed at all since the last survey in 2006, just after Hurricane Katrina devastated New Orleans and much of the resources devoted to health care and mental health care in the area. The report points out that although Louisiana has been slow to move toward system reform (both before and after Katrina), there are signs that things are improving. A major shortcoming noted by NAMI is that the state has been slow to use Medicaid funds for community-based behavioral services and supports.

Table 7. NAMI State Report Cards

Southern States 2006-2009*	2006	Trend	2009
Maryland	C	↑	B
Oklahoma	D	↑	B
Missouri	C		C
Virginia	D	↑	C
Alabama	D		D
Florida	C	↓	D
Georgia	D		D
Louisiana	D		D
North Carolina	D		D
South Carolina	B	↓	D
Tennessee	C	↓	D
Texas	C	↓	D
Arkansas	D	↓	F
Kentucky	F		F
Mississippi	D	↓	F
West Virginia	D	↓	F
U.S. - 50 states	D		D

**States shown are members of the Southern Legislative Conference*
SOURCE: National Alliance on Mental Illness, 2009

As evidence of progress, NAMI notes several items included in the plan announced by Jindal and DHH in February 2008. It also recognizes assertive community treatment teams, rent subsidy vouchers with mental health supports, better provider training and increasing use of telemedicine as signs of improvement for a state that lags significantly behind the nation in providing community-based care for those with mental illness. NAMI also points to innovations, such as the use of a privately-funded mobile health unit by the Capital Area Human Services District and the Road Home program supported housing allocations (PSH) for persons with serious mental illness. Although this is encouraging, there is no assurance that these signs of progress will survive the budget crisis expected over the next two years after a precipitous drop in the federal share of Medicaid funds.

The NAMI report notes that there are 182,593 adults with serious mental illness in Louisiana. According to DHH data, only 36,513—about 20 percent—are receiving care through the public system. In light of the difficulty in acquiring private insurance coverage and the expense of accessing private sector treatment for mental illness, an obvious conclusion is that a 20 percent public treatment rate leaves a large number of persons with severe and untreated mental illness.

The extent of the problem, however, is difficult to quantify with any accuracy because of the tendency of the mentally ill to forgo treatment for both physical and mental health issues. Identification and diagnosis are forgone nearly as often as treatment. It should be noted also that the public mental health clinics have capacity and funding to serve only the most serious and chronic illnesses, not surprising in light of Louisiana's 2006 rank of 50th in the U.S. in per-capita spending on community-based care ($18.57 per capita compared to a national average of $72.97).

The NAMI report points out that Louisiana has several urgent needs that should be high priorities, including the need to:

- Expand crisis prevention and community services;
- Finance mental health services under Medicaid; and
- Address the mental health workforce shortage.

With respect to the last point, the already short supply of mental health professionals was worsened after Hurricane Katrina when numbers of behavioral specialists, including psychiatrists, declined to the point that the system could not begin to keep up with the surge in demand. Contributing to the problem is the state's failure to utilize Medicaid to pay social workers for behavioral health services, which is counter to the policy of most states. According to the federal Health Resources and Services Administration (HRSA), Louisiana ranks first in the nation with 35 percent of the population in primary care Health Professional Shortage Areas (HPSA) and fourth in the nation with 48 percent in mental health HPSAs. Both primary care providers and mental health specialists are in short supply. Payment incentives and a renewed focus by medical schools on this problem is needed.

NAMI lists five broad areas for nationwide reform, each of which has specific implications for Louisiana in its efforts to address the more targeted reforms suggested above:

- Increase public funding for mental health care services;
- Improve data collection, outcomes measurement and accountability;
- Integrate medical and physical health care;
- Promote recovery and respect; and
- Increase services for people with serious mental illness who are most at risk.

Integrating Mental and Physical Health Care

The public system that delivers care for persons with mental illness has evolved over the past 50 years from a mostly inpatient hospital structure to a predominantly community-based arrangement that provides better treatment and allows much more personal freedom for most patients. The trade-off for this progress is that the current system is underfunded, fragmented and difficult for the patient (and often the provider) to navigate. For example, providers that accept the uninsured mentally ill are few and far between. An ideal model of behavioral health care that maximizes a community-based continuum of services and minimizes institutionalization has yet to be achieved in the United States although some states have seen substantial progress. Unfortunately, Louisiana ranks near the bottom of the scale due to its historic bias toward inpatient institutions and its failure to properly fund outpatient care.

In the health care infrastructure that exists today, patients seek care wherever they can find it. Primary care providers furnish about half of the mental health treatment in the United States and about 25 percent of all primary care recipients have diagnosable mental disorders, according to the Bazelon Center for Mental Health Law. An estimated 75 percent of primary care visits deal with some aspect of behavioral health problems, with depression being the most frequent diagnosis. Yet a substantial number of primary care patients with mental illness remain undiagnosed or untreated.

Primary care physicians are comfortable diagnosing, treating and prescribing relatively common problems, such as depression. However, they are unaccustomed to dealing with severe mental illness, such as schizophrenia and bipolar disorder, which often require relatively "exotic" medications known as atypical anti-psychotics. When identified by a primary care practice, patients with serious mental illness need referral to specialty care. A major complaint of primary care doctors is the lack of resources available to treat their patients with severe mental illness. The challenge for the health care system, both primary

and specialty care, is to identify, diagnose and treat these persons, focusing on cases with serious behavioral problems.

Another aspect of this issue is the number of persons in treatment for mental illness who have serious undiagnosed medical problems, such as diabetes or cardiovascular disease. People with serious mental illness tend to receive insufficient medical care, resulting in an estimated 25-year reduction in lifespan on average. To illustrate the problem, an estimated 57 percent of adults with mental illness have untreated hypertension.

Progress for various collaborative care models

The success of efforts to improve the treatment of mental health problems will depend on how effectively the barriers that separate general medicine and behavioral health can be eliminated. The problem is nationwide but more acute in Louisiana, a state where 48 percent of the population lack access to mental health care (fourth worst in the U.S.) and 34 percent lack access to primary medical care (worst in the U.S.), according to the U.S. Department of Health and Human Services Division of Shortage Designation report released in 2008.

Improving access to each type of care, while desirable, is not a substitute for consolidation and collaboration of treatment models and service providers. In 2006 the President's Commission on Mental Health, acknowledging decades of research findings and recommendations, proposed widespread implementation and financing of collaborative care models in primary care settings and better coordination of funding and clinical care in federal and state-supported mental health clinics. Although these recommendations have yet to be realized at the federal level, Louisiana has introduced an array of collaborative models for very different settings. Those that have significant potential to improve access and treatment for persons in need of both behavioral health care and primary medical care are summarized below.

The advanced or patient-centered medical home (PCMH) model of primary care ideally would provide an optimal array of medical and behavioral services required to diagnose and treat both physical and mental illness. Preferably, primary care providers and behavioral specialists would be co-located and work in conjunction to lend their specific knowledge to the task of caring for patients with complex problems and co-morbid conditions. The current reality is that most medical practices do not follow the PCMH paradigm, although there is considerable interest in both the primary care and behavioral health communities to move toward wide-scale adoption.

While primary care physicians are enthusiastic adopters of this paradigm, other segments of the medical establishment have expressed doubts. There are indications of significant problems that need to be resolved, including the complexity of the changes required to co-locate staff, lack of interoperability of electronic health records and undercapitalization of demonstration projects. Yet there are multiple studies that have demonstrated significantly improved clinical outcomes for chronic diseases and a corresponding reduction in costs such as hospital readmissions.

A further stimulus for PCMH advancement was establishment of the Louisiana Health Care Quality Forum (LHCQF) in 2007 as an independent, nonprofit organization with the mission of leading evidence-based quality improvement initiatives to improve the health of people in Louisiana. The organization formed a medical home committee in January 2008 to promote the PCMH model of care. The committee works with clinics and physician practices to provide guidance on meeting PCMH qualifying criteria, addressing PCMH payment reforms and advising DHH on Medicaid PCMH development. LHCQF lists approximately 45 participating practices statewide with more than 500 participating physicians.

Louisiana is a national leader in the number of clinics and physicians meeting standards for the PCMH as established by the National Committee on Quality Assurance (NCQA). The five top-ranking states are Pennsylvania with 409 clinics or physician practices, New York with 309, Louisiana with 230, Minnesota with 201, and New Jersey with 179. Louisiana tops the southern region with two-thirds of all PCMH participants recognized by NCQA being located within the state. Progress has also been demonstrated with other very different models in use by LSU hospitals and by regional human services districts operating mental health agencies. Those models may be appropriate in many situations for different providers.

Other prototypes, including school-based health centers (SBHCs) and rural health clinics (RHCs),

may have significant relevance in the future. SBHCs number approximately 70 in Louisiana and provide primary care to schoolchildren. Some of them also employ or contract with a mental health professional for behavioral health needs. There are more than 100 rural health clinic sites statewide, many of them operated by one of 40 or more small rural hospitals. Each of these networks has the potential to assist in providing improved access to behavioral health care, either through collaborative referral agreements or added staff resources or both. Adequate financing and staffing would be key to encouraging formal plans to move forward with implementation.

Greater New Orleans Primary Care Access and Stabilization Grant (GNOPCASG)

A federal grant provided for the New Orleans region has enabled a significant and promising recent expansion in the state's use of the PCMH model for health care. In response to Hurricane Katrina and the devastation of health care services in the New Orleans area, the federal government provided a $100 million three-year grant to Louisiana effective September 2007. The Greater New Orleans Primary Care Access and Stabilization Grant is directed by the Louisiana Public Health Institute, which is headquartered in New Orleans, and the Louisiana Department of Health and Hospitals. The stated goals of the program are to develop a primary-care-focused delivery system with integrated behavioral health care. Participating clinics include those operated by the LSU Health Sciences Center, LSU Health Care Services Division, Tulane Educational Fund, Children's Hospital, Daughters of Charity, and community health centers and mental health centers throughout the New Orleans region.

Prior to the effective date of the grant, 25 public and private organizations, including 67 delivery sites, had enlisted to participate. Significant progress has been made in terms of numbers of sites in operation and patients covered. The number of delivery sites expanded from 67 in September 2007 at grant start-up to 81 by July 2008 and to 91 by July 2009. The types of sites in operation in mid-2008 included 48 primary care clinics, 26 behavioral health clinics, three dental clinics and four school-based health centers. Of the 81 sites, 72 were fixed and nine were mobile. LPHI estimates that 160,000 persons currently receive care through the network.

In March 2009 the National Committee for Quality Assurance (NCQA) announced that 36 of the clinics participating in the grant had received Level 1 status as patient-centered medical homes. The clinics are operated by 13 of the 25 participating organizations. NCQA is a nonprofit credentialing organization that sets standards for patient-centered medical homes. NCQA provided supplemental incentive payments totaling $4 million for the 36 clinics awarded recognition.

In the first two years of operation, the grant has produced a clear record of achievement in establishing a system of care that focuses on quality, care coordination and the use of health information technology. The network of clinics throughout the four-parish New Orleans area is a substantial improvement over the disarray of pre-Katrina delivery that relied primarily on hospital emergency departments to tend to the uninsured. Primary care through the patient-centered medical home will reduce expensive hospitalizations and specialty care.

But the success that has been realized will be at risk if alternate financing cannot be found after the grant expires in 2010. LPHI and DHH are searching for ways to replace the grant funds in order to maintain a similar scope of services. Among participating organizations, 25 percent of total operating expenditures are financed by grant funds and some rely on the grant for 50 percent or more of expenses. Unless substitutes can be found for grant funds, the capacity of the clinic network will contract and substantial numbers of patients will revert to high-cost emergency departments for treatment.

Federally Qualified/Community Health Centers (FQHC/CHC)

A promising platform available to launch the PCMH model statewide is the federally-qualified health center (FQHC), also known as the community health center (CHC). In the early 1980s a nationwide safety net of FQHC/CHCs was started to provide access to care primarily for the low-income population, including those who are uninsured and those with private or public coverage. CHCs were designed to be local or neighborhood clinics that provide a range of primary and preventive care services, including behavioral health care and treatment for substance abuse problems. New clinics are required to provide

behavioral services or refer patients to appropriate providers. Though initiated well before the term became widespread, CHCs neatly fit the definition of "medical home" as a location for patients to receive a wide range of vital primary and preventive care services.

Louisiana currently has 24 FQHC/CHC "grantees" operating a total of 76 sites where services are delivered. Louisiana has lagged behind most other southern states in terms of the number of sites in operation, averaging three sites per grantee, which is half the southern average. Nevertheless, considerable progress in expanding delivery sites has been made in recent years, with sites increasing from 44 in 2004 to 76 currently, thanks in part to a $41 million state appropriation that provides funding for up to 49 percent of capital costs for expansion. Total operating revenue for Louisiana FQHC/CHCs has increased from about $35 million in 2003 to almost $70 million by 2007, including federal grants totaling $24 million for the uninsured and other under-served groups. The proportion of CHCs in Louisiana that provide behavioral health services is 82 percent, well above the national average. The total number of patients has increased from about 90,000 to 149,000 during the same period. Additionally, the number of patients receiving behavioral health/mental health services has increased by 133 percent (see table below).

Table 8. Louisiana Federally Qualified/Community Health Centers (FQHC/CHC)

	2003	2007	% change 2003-07
Number of grantees*	16	22	38%
Number of clinic sites	37	70	89%
Total number of patients	90,585	149,264	65%
Mental health patients	3,617	8,424	133%
% of total patients	4%	6%	2%
Total patient encounters	300,356	453,976	51%
Total revenue (in millions)	$35.2	$68.9	96%
Medicaid reimbursements	27%	35%	8%
Federal grant for uninsured	44%	42%	-2%
Other revenues	29%	23%	-6%

**Number of clinics qualified as FQHC/CHCs to receive federal grants*
A FQHC/CHC may operate multiple clinic sites.
SOURCE: Louisiana Primary Care Association and National Association of Community Health Centers

It appears that the statewide network of community health centers is poised to assume a key role in the effort to establish medical homes to bring access to primary care for a significant portion of the population. In fact, FQHC/CHCs have served as medical homes for those who would otherwise have difficulty gaining access to primary medical care, as well as behavioral health services, dental care and a host of other vital services not commonly found even in large physician practices or clinics. The wide scope of services FQHC/CHCs provide can make a significant contribution to integrating primary care and behavioral health services. Many FQHC/CHCs have also participated for the past two years in two large post-Katrina medical home projects: the GNOCASG and the LHCQF medical home initiative in New Orleans, Baton Rouge, Lake Charles and Shreveport.

According to a 2009 study by the Kaiser Commission on Medicaid and the Uninsured, community health centers display attributes of medical homes, including an emphasis on "coordination and comprehensiveness of care, the ability to manage patients with multiple health care needs, and key practice characteristics such as the use of appropriate health information technology and the provision of information about health care quality."

The study cautions, however, that FQHC/CHCs face significant challenges, including financial constraints that make it difficult to attract and retain clinical staff; problems with adoption and use of health information technology where only 13 percent of centers can meet electronic medical record criteria; and Medicaid reimbursement rules that restrain levels of service and inhibit care coordination and management. On a more positive note, federal economic stimulus funds provide temporary incentives for providers, including community health centers, to purchase, implement and maintain health information technology systems.

The national concerns listed above pale in comparison to potential budget reductions in Louisiana stemming from state revenue shortfalls coupled with a possible dramatic decline in federal Medicaid dollars. The total decline in Medicaid spending is estimated by DHH to total almost $2 billion over a two-year period beginning January 2010. Health care spending should be strictly prioritized so that vital initiatives are protected from budget cuts, including further development

of promising models of care delivery that integrate primary medical care and behavioral health. These would include the PCMH, which provides an array of medical and behavioral resources to serve the low-income population. Failure to do so will delay implementation of initiatives that will produce better care and significant long-term savings.

LSU HCSD Clinics

The LSU Health Care Services Division operates seven of the 10 hospitals in the LSU health care system. Several of these hospitals have recently received recognition for their outpatient clinics by the National Committee for Quality Assurance (NCQA). In each case the clinics met NCQA requirements as Physician Practice Connections – Patient-Centered Medical Homes (PPC-PCMH), a relatively rare distinction that has been conferred on only a small number of hospitals nationwide. The awards were granted to the following facilities:

- Leonard J. Chabert Medical Center Outpatient Clinic (Houma), Level I Patient-Centered Medical Home (PCMH), February 2009
- Interim LSU Public Hospital (New Orleans), nine outpatient clinics, Level I PCMH, February 2009
- Bogalusa Medical Center, three outpatient clinics, Level I PCMH, May 2009
- Lallie Kemp Regional Medical Center Outpatient Clinic (Independence), Level III PCMH, June 2009
- Earl K. Long Medical Center Pediatric Clinic & Family Medicine Clinic, Level 1 PCMH, November 2009
- University Medical Center, Lafayette, Pediatric Clinic, 2009
- W.O. Moss Regional Medical Center (Lake Charles), Primary Care Clinic, 2009

In order to attain PCMH status, a health care entity must meet criteria delineated by NCQA according to three separate levels of recognition. The Level III status granted to Lallie Kemp Medical Center is the highest level of recognition and has been achieved by only nine practices in Louisiana and by 58 nationwide as of June 2009. The NCQA criteria for medical homes are aligned with the joint principles of national physician organizations oriented toward primary medical care. The medical home model is defined as a model of care in which a physician-led care team is responsible for providing the patient's health care needs and for coordinating additional specialty or hospital care if needed.

Hospitals and hospital systems have the advantage of a full array of clinical services at their disposal, something not ordinarily available to most physician practices. Important resources are diagnosis and treatment for behavioral health and substance abuse needs. LSU hospitals typically have a range of these services available, which facilitates coordination of care for those patients with co-existing conditions. The Earl K. Long Medical Center in Baton Rouge (EKL), like most LSU hospitals, operates an outpatient clinic for children, including both primary care and behavioral health care.

The LSUHSC School of Public Health's Juvenile Justice Program (LSUHSC JJP) has applied the medical home model to the state's three secure care juvenile correctional facilities for nearly a decade. In partnership with the Louisiana State Office of Juvenile Justice, secure care youth have access to comprehensive medical, mental and dental health services. For many of these youth, this is their first experience receiving dental care. The mental health needs of this population of youth are significant. Of the 225 youth admitted to the two southern Louisiana secure care facilities in 2008, 107 (47.6 percent) were identified as having a serious mental illness (SMI) during their custody. Many of these youth, as is typical of persons with behavioral issues in this age group, had multiple problems and a complex diagnostic picture. In fact, more than 73 percent of SMI youth had at least three mental health diagnoses. Of the SMI youth, 48.5 percent were diagnosed with some type of mood disorder, and 9.1 percent had some type of anxiety disorder. Three percent of youth had a psychotic disorder. While the LSUHSC JJP is meeting the needs of an atypical population, the program serves as a model to be replicated as an efficient, patient-centered approach.

Targeting troubled youth for comprehensive medical and behavioral care and addictive disorder treatment could provide long-term preventive benefits and reduce the costs of expensive hospitalization and even incarceration. EKL officials have indicated there is great interest in expanding comprehensive services using the medical home model to reach an at-risk population

in desperate need of attention. Interagency agreements and state/city-parish governmental relationships will have to be established to make this need a reality.

Capital Area Human Services District (CAHSD)

Public mental health agencies and human service districts do no currently have the full range of resources needed to assemble full-scale PCMHs. However, there is a low-cost solution at hand, which has been implemented by the Capital Area Human Services District (CAHSD) to enhance its menu of services, including outpatient mental health care and treatment for addictive disorders to more than 9,000 clients in the seven-parish Baton Rouge region annually.

The collaborative model brings together an array of services vital to the behavioral and physical health of persons with mental illness. Integrating all necessary resources at a single location to provide a "one-stop shop" for patients, while desirable, is unrealistic and cost-prohibitive for the foreseeable future. Instead, a cost-effective system can be achieved by developing strong referral networks and emphasizing case management to ensure patient compliance. In addition to mental health and addiction specialists, hospitals and medical providers, other community collaborators would typically include law enforcement personnel, local jails, mental health advocates and attorneys, emergency transportation, emergency call centers and housing specialists.

Some key components of the behavioral health emergency services continuum as designed by CAHSD include the following:

- Crisis Intervention Team (CIT). Includes law enforcement officers trained to handle behavioral crises in their communities. CAHSD coordinates training for these personnel. Local law enforcement agencies in the seven-parish area handle 3,350 behavioral crisis calls and transport 5,300 people in crisis to emergency treatment annually.
- Mental Health Emergency Room Extension (MHERE). A specialized emergency department staffed by mental health professionals to manage behavioral health crises safely and effectively. Some 8,000 individuals in the seven-parish area need emergency crisis care each year for a behavioral crisis. CAHSD has constructed a specialized on-site unit scheduled to open in late 2009 at EKL in Baton Rouge. Staff will provide emergency crisis care, then refer patients to outpatient care at mental health clinics or to inpatient hospital care if needed.
- Medical Case Management. Persons with chronic mental illness often access primary care medical services through public or private hospital emergency rooms. Providing medical social workers as case managers has produced an estimated 77 percent compliance rate for appointments for mentally ill patients at primary care clinics. This is significantly higher than the compliance rate without case management.
- Mobile Health Clinics. Through a partnership with Our Lady of the Lake Regional Medical Center, a mobile clinic makes weekly visits to the Center for Adult Behavioral Health for clients who do not have insurance or a primary care provider. Similar ventures have been established in Ascension Parish and other communities in cooperation with St. Elizabeth's Hospital. These services can be negotiated in other regions between public mental health clinics and hospitals or other providers with appropriate resources.
- Referral Vouchers. Linkage to community-based physical health and behavioral health providers. CAHSD provided vouchers to clients to access primary care services at local health clinics, including FQHC/CHCs. This was made possible by a national Red Cross grant and additional funding is being sought through a federal grant. The program has been suspended until funding is re-established.

In a difficult budget climate, this collaborative model for integrating primary care and behavioral health can be applied without great expense throughout the state. It can improve both physical and behavioral treatment for persons diagnosed with mental illness, as well as expand diagnostic and treatment capacity for both mental illness and physical health problems. CAHSD was a finalist for an Innovations Award by the Council of State Governments for this initiative, known officially as the "Behavioral Health and Primary Care Integration Program."

Operating on an annual budget of about $550,000 (including a grant from the national Red Cross) for this collaborative care coordination initiative,

CAHSD operates a "local system of care" utilizing three community mental health clinics and a mobile clinic to collaborate with seven Parish Health Units run by the Office of Public Health and a number of FQHC/CHCs throughout the region. These types of resources are available in all regions of the state and can be utilized to extend the reach of mental health agencies by working with other public physical health providers, such as parish health units, FQHC/CHCs and charity hospitals. In the seven-parish capital region, CAHSD provided the following services as part of its Integrated Behavioral/Physical System of Care outreach program in 2008:

- 654 clients participating in tobacco cessation
- 2,699 clients receiving medical screening
- 505 primary care referrals made
- 206 clients seen in mobile unit
- 976 prescriptions with vouchers
- 129 clients served in FQHC/CHCs with vouchers
- 359 clients served by social workers in Parish Health Units

Noteworthy is the number of medical screenings performed, referrals made and the use of vouchers to provide access for clients to primary care clinics and to obtain low-cost prescriptions through a national grocery store pharmacy chain. Performing screenings and referring patients to other providers may increase costs but will also result in savings from avoidance of hospitalization and emergency room care. Such savings from early diagnosis and treatment are real but hard to quantify.

Agenda for Change

Addressing the widespread chronic problems of Louisiana's public mental health system will require time, effort, funding and, most of all, commitment. Integration of mental health services with primary care will be a key component of any solution. Although progress is being made in upgrading the primary care system through the enhanced patient-centered medical home and other models of collaborative care, there is still much work to be done. Budget austerity will be top priority for the next few years, as it should be.

The following recommendations are focused not only on developing a high quality and accessible system of behavioral health care, but also on reducing the need for costly specialty, inpatient hospital and emergency services. The fragmented, disorderly and ineffective arrangement of disparate services now in place is expensive. DHH and the Legislature should assign the highest priority to correcting these problems through a sustained approach that would include the following recommendations.

Recommendation 1: Sustained funding should be provided to expand patient-centered medical homes for primary care and integrated behavioral health services, including replacement for the expiring Greater New Orleans Primary Care Access and Stabilization Grant.

The patient-centered medical home may provide the best opportunity for expanding access to an integrated model of primary care and behavioral health services. While there are numerous problems to be solved, the promise of improved health outcomes with reductions in expensive hospital and specialty care cannot be ignored. In the nationwide effort to build the medical home infrastructure, Louisiana is definitely a competitor. The New Orleans area, in particular, has produced nearly 40 delivery sites that have been designated by a national credentialing organization as a "Physician Practice Connection—Patient-Centered Medical Home (PPC-PCHMH).

Much of this progress has been driven by a $100 million three-year federal grant known as the Greater New Orleans Primary Care Access and Stabilization Grant (GNO PCASG), which is directed by the Louisiana Public Health Institute. The grant was made in 2007 for the purpose of developing a more efficient and cost-effective primary care infrastructure in the four-parish New Orleans region to replace the haphazard non-system of disconnected clinics and emergency rooms that was disrupted by Hurricane Katrina. Although rapid progress has been recognized, the benefits of a medical home infrastructure for the low-income population may not survive after the federal grant expires in 2010. Grant funding has enabled the number of primary care and behavioral health delivery sites to expand from a pre-grant total of 67 to 91 currently. The additional capacity provides expanded access to primary care and reduces overcrowding in hospital emergency departments.

The Department of Health and Hospitals and the Legislature should work together to ensure that $30 million in funding is made available annually on a sustained basis to maintain the network of primary care clinics currently in operation in the New Orleans region. An equal or greater amount should be provided to expand patient-centered medical homes, including clinics that deliver integrated primary care and behavioral health services, in other areas of the state. Total funding of $60 million or more should be provided in a permanent fund to be established by the Legislature. Despite the austere budget climate that will prevail for the next few years, this fund would represent a significant step toward cost containment, as well as improved patient care.

Recommendation 2: Public systems of medical care and behavioral health care should be integrated through regional care networks modeled after a successful community-based pilot project in the Capital Area Human Services District.

In cases where advanced medical homes are not yet feasible, public systems of care for physical health and mental health should be integrated in order to (1) provide access to primary and preventive care for persons with mental illness and (2) provide a ready referral to mental health specialists when primary care providers identify behavioral problems. Coordinating care between physical health and mental health providers has been proven effective. For example, the benefits of early screening, diagnosis and treatment are clear. Early detection and treatment of health conditions and problems, whether physical or behavioral, will reduce illness, improve quality of life and reduce costs by avoiding expensive hospitalization and specialty care. In many cases, patients who otherwise would be unable to hold jobs can return to being productive members of society.

Cost should not be a huge factor if an approach similar to that undertaken by the Capital Area Human Services District is adopted. That effort has been highly effective with costs of about $550,000 per year to pay primary care providers to treat indigent mentally ill clients with physical health problems. The statewide impact for similar initiatives in each region would be approximately $10 million total or approximately $1 million on average for each of the nine DHH geographical regions. The more populous regions, such as Baton Rouge and New Orleans, would require a higher funding level while rural areas would need less.

DHH should work with special districts and the DHH Office of Mental Health and Addictive Disorders to try to find sufficient funds for every region. Collaboration with other entities would also be useful. In addition to Community Mental Health Centers and Parish Health Units, valuable allies in this effort could be FQHC/CHCs, Rural Health Clinics, School-Based Health Centers, LSU hospitals and private hospitals.

Recommendation 3: The Louisiana Medicaid program should review and revise its method of paying for treatment of patients diagnosed with mental illness or behavioral problems in order to encourage physicians to integrate primary and mental health care treatment plans.

Current rules published by Louisiana Medicaid restrict reimbursement for physician office visits to a maximum of 12 annually (15 visits per year for FQHC/CHCs) with few exceptions, and those are subject to a cumbersome prior authorization process. Similarly, payments to primary care physicians for additional diagnoses cannot be made on the same visit, therefore requiring extra visits. In some cases, routine physician office visits and behavioral health care are not allowable for reimbursement if the visits occur on the same day. This payment structure, meant to rein in excess volume in the fee-for-service payment system, is a disincentive for both the provider and the patient to address all aspects of medical needs, particularly routine behavioral problems and even severe mental illness.

A short-term solution would be to change the physician fee schedule to allow additional annual visits in certain cases, including certain diagnoses of mental illness that may require more frequent attention. Likewise, exceptions should be made to allow payment for primary care physicians to address more than a single diagnosis during one office visit. The current system discourages doctors from addressing all patient needs and, at best, forces patients to return for another visit. Either patients are motivated to return for another visit, thereby incurring additional costs, or they ignore the need for treatment. Additionally, if more primary care settings were certified as mental health rehabilitation centers, Medicaid could pay

for some behavioral health services and enable better access to care.

A long-term reimbursement solution would be to adopt reimbursement systems intended to reward and promote good outcomes, rather than volume of services. These may include bundled payments for physicians. Such a system would provide combined payments for treatment of a disease, rather than separate payments for each and every service related to treatment for that disease. Also, pay-for-performance reimbursements could provide a "bonus" payment for favorable patient outcomes.

Careful study would be required prior to implementing such measures. The federal government is likely to introduce payment reform as a component of overall health care reform, possibly with a range of options that could be adopted by state Medicaid programs. These payment mechanisms would make available a wider array of reimbursement options than the current prevailing choices, which include fee-for-service or managed care capitation payments. The former rewards volume of service at the expense of quality while the latter rewards service reductions at the expense of good patient care.

Recommendation 4: The Legislature should establish an ongoing appropriation for payment of primary care treatment for uninsured persons with co-existing medical and behavioral health problems.

Persons with chronic mental illness frequently seek non-emergency primary care services in emergency rooms throughout the state, because they do not have private insurance or Medicaid coverage and cannot afford to pay. These patients would benefit from having the continuity of treatment available from a single non-emergency source of routine primary care, such as an FQHC/CHC or other clinic. However, clinics have only limited access to special subsidies, such as Disproportionate Share Hospital (DSH) funds, to pay for uninsured patients. FQHC/CHCs receive a relatively small stipend of $650,000 per year for care of the uninsured but this is inadequate to cover all patients who present without insurance.

The coordination of care that is possible in a system like the one developed by CAHSD would be instrumental in reducing excess emergency room usage by persons with mental illness. Use of case managers to provide referrals and follow-up could reduce emergency room visits significantly. Case managers could also help to assure a better compliance rate for patients in keeping medical appointments or attending various treatment programs. According to CAHSD data, more than 40 percent of patients with chronic mental illness have four or more co-occurring health conditions that will require treatment.

DHH is the recipient of a grant to help divert patients seeking routine primary care in emergency departments to more cost-effective venues for treatment. Assuming a 10 percent diversion of Medicaid clients from emergency room usage to primary care clinics could save $25 million or more, which could be used to help finance a pool for primary care for the uninsured mentally ill. These amounts could be augmented in some cases by contributions from local jurisdictions or private foundation grants or by direct state appropriation.

Additional funds may be made available from other sources. However, the program could prove to be funded with savings from emergency room diversions, provided a portion of those savings were reinvested in the OMH budget. Benchmarking utilization data for the mentally ill (both Medicaid eligible and uninsured) and tracking case management and care coordination should provide reliable data to calculate eventual savings. Medicaid programs have documented the high emergency department utilization rate by the mentally ill due to their complex physical health needs.

Recommendation 5: The DHH Office of Mental Health should focus on decreasing institutional costs where possible, including (a) downsizing existing state psychiatric hospitals by reducing bed capacity, staffing or excess land and (b) reducing administrative costs. Any savings incurred should be transferred to community-based outpatient care.

National data show that Louisiana ranks second in the nation in the proportion of the mental health budget devoted to state psychiatric hospitals but ranks 51st in the proportion of spending for community-based care. Data on per-capita spending also reinforce the conclusion that the state fails to properly fund non-institutional care.

- Louisiana spent only $18.57 per state resident on community-based programs, ranking 50th in

the nation. The national average for spending in this category is $72.97 per state resident.

- Spending for state psychiatric institutions in 2006 averaged $34.31 per state resident compared to $28.72 for the national average.
- Administrative costs for the Office of Mental Health in 2006 were $33.8 million or $8.01 per state resident, nearly four times as high as the national average.
- Total spending for all three categories shows the state spent $60.89 per resident in 2006, 60 percent less than the national average of $104.10. (Source: National Association of State Mental Health Program Directors Research Institute)

Louisiana can begin to rectify the disparity between institutional and community spending by taking action to right-size state institutions and reduce administrative costs. While there is justification for providing long-term inpatient care for persons with certain types of behavioral disorders, it is clear that Louisiana compares unfavorably to other states in terms of numbers of patients, staffing ratios and administrative costs. Furthermore, each of the state psychiatric hospitals is located on tracts of land that are significantly larger than necessary, a throwback to the early 20th century when persons deemed to be mentally ill were warehoused out of sight in large institutions.

The Legislature should conduct a study in concert with the Office of Mental Health to determine the extent of overspending on state psychiatric hospital care and how reductions in each of five facilities can be accomplished. The problem is complicated by the fact that more than half of institutional capacity is occupied by forensic patients. Any study therefore should engage the judiciary to help determine why Louisiana has such a high proportion of forensic patients and what can be done about it.

Savings achieved by reducing the size, staffing and administrative cost of state psychiatric hospitals should be retained by OMH to increase community-based outpatient services. A proposal to outsource some institutional services for the OMH population has been suggested by DHH. The Legislature should study closely the unfortunate record of other states, such as Texas, North Carolina and others, that followed a similar prescription. Most states continue to operate psychiatric institutions, though on a much smaller scale, and have resisted the urge to transfer the responsibility to a contractor. Reforming the system as a state-operated network of smaller hospitals with improved oversight can produce better efficiency and quality at reduced costs.

Conclusion

Louisiana's system of public mental health care is biased toward expensive institutional inpatient care, which does not have the capacity to treat the full population of those with mental illness. A successful experiment in aggressive case management and outpatient care coordination has been demonstrated in the capital area region of the state. This innovative approach should serve as a cost-efficient model to be replicated statewide. With a modest investment of $1 million for each of the state's nine regional health care districts, the state could make significant progress toward modernizing its system of care for the mentally ill by providing a medical home.

Significant progress has recently been made with implementation of patient-centered medical homes that provide primary care integrated with behavioral health services. Approximately $60 million is needed to maintain existing networks of primary care providers, many of which have been designated patient-centered medical homes. While most of these clinics are located in the New Orleans area, there are other PCMH initiatives being developed across the state. Failure to maintain these clinics will reverse progress and return the state to a dysfunctional non-system of primary care provided too often and at great expense in hospital emergency rooms.

In addition to implementing the recommendations offered by this report, state leaders should begin to develop long-term plans for reorganizing the financing and delivery of mental health services. Funding for OMH is inadequate to provide treatment for more than a fraction of those in need of extensive care, yet the state operates a vast and expensive institutional system. Funding for Louisiana's public mental health system should be increased to improve quality and broaden access to community-based services for the seriously mentally ill population. Louisiana's public mental health system lags well behind most other states in terms of funding and performance, especially in terms of outpatient community-based care. Within the state, funding for OMH has not kept pace with that of other health agencies. The annual average

growth rate for OMH over the past two decades has been 4.6 percent compared to 7.9 percent for all DHH agencies.

Because of the tight budget climate for the near future, an alternative source of funding could be provided with savings from downsizing existing state-operated mental hospitals. Downsizing would likely produce more savings than would consolidations, which have generally been administrative in nature with few bed closures and scant cost reductions. Effective downsizing would require the development of a cost-effective and sustainable plan to shift resources from institutional to community-based care, which would be a logical first step toward making significant improvements in the mental health care delivery system.

The plan would require a lasting commitment to be successful. Starting from scratch with each new administration is a recipe for failure rather than success. Other state programs such as LaCHIP have enjoyed success that transcended changes in administrations and have been spared significant budget cuts. A sustained effort to improve the public system of care for those with mental illness and addictive disorders should be added to the list.

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Primary author of this report is David W. Hood, Senior Health Policy Research Analyst. Funding for this research was provided by the Louisiana Disaster Recovery Foundation.

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