Action Plan - Louisiana Integrated Treatment Services

Principle #1 - *Dual diagnosis is an expectation, not an exception.* "Implies the need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address individuals with co-occurring disorders who present in each component of the system already" (Focus on system planning)

Strategy 1 Re-establish the Behavioral Healthcare Taskforce as the policy making body to oversee the planning and change process, as outlined in the Co-occurring State Incentive Grant (COSIG) and the Co-occurring Policy Academy Plan.

- Action A Formalize Deputy Secretary of Department of Health and Hospitals (DHH) as chair of Taskforce
- Action B Established membership of Taskforce to include Governor Health Policy Advisor, Assistant Secretary of Office of Mental Health (OMH), Assistant Secretary of Office for Addictive Disorders (OAD), Director of Bureau of Health Financing, Chair of Mental Health Planning Council, Chair of Governor's Commission on Addictive Disorders, Executive Director of Capital Area Human Services District, Private Provider representative (currently filled by LA Association of Ambulatory Healthcare representative), representative from Client Advisory Board, Assistant Secretary of Office of Public Health
- Action C Taskforce will utilize committees to develop recommendations and implement detailed work plans to carry out the planning and change process. Committees to include: Funding, Clinical Protocol, Workforce Development and Management Information Systems/ Evaluation. Committees will be charged by the Taskforce and committee chairs will attend Taskforce meetings and provide additional staff support as needed.
- Action D Primary staff to the Taskforce will include COSIG Project Directors, COSIG Project Coordinator, and COSIG Administrative Assistant.
- Action E Additional key staff are encouraged to attend Taskforce meetings.

Strategy 2 Develop statewide written strategic plan and timeline to support the implementation and operation of Co-occurring Disorder Capability (CODC).

- Action A Adopt CODC definition
- Action B Revise current agency mission statements, target populations, and planning and service development activities to reflect CODC.
- Action C Adopt 'no wrong door' policy to include the development of integrated screening, assessment, MIS, referral, follow up, and evaluation of the no wrong door concept (more detail provided in breakdown of principles 5, 7, 8).
- Action D Assess current service system for gaps through the following:
  1 use of the Comprehensive, Continuous Integrated Systems of Care Outcome Fidelity and Implementation Tool (COFIT), the Comorbidity Program Audit and Self-survey (COMPASS), and the Co-occurring Disorders Education Competency Assessment Tool (CODECAT)
  2 local focus groups convened by Gov. Commission on Addictive Disorders
  3 input from Client Advisory Board
  4 work of the Clinical Protocol Committee
  5 consultations with experts in the field of co-occurring.

Action E Adopt and mandate set of core competencies and guiding principles (more detail provided in Principle 7)
Action F Refinement of existing services and development of specialized programs to obtain CODC (more detail provided in Principle 7)

Strategy 3 Assure program resources equally support CODC for currently served target population. Because plan targets CODC for current caseloads and no expansion into the unserved population is expected, limited fiscal impact is to be expected.

Action A Maximize COSIG funds to ensure appropriate initial training and ongoing competency development.
Action B Identify resources to support drug screening within OMH system.
Action C Identify resources to provide psychiatric services and medications, primarily within OAD system.
1 Evaluate Medicaid funding through establishment of Addictive Disorder (AD) clinics as satellite Mental Health (MH) clinics
2 Expand Patient Assistant Programs within AD and MH systems
Action D Explore additional possible funding streams.

Strategy 4 Support Local Systems of Care** and Local Steering Committees in development and implementation of CODC at the local level.

Action A Through COSIG funds, provide group facilitators to serve as staff to the local committee, provide training, and technical assistance as needed.
Action B Assure development and implementation of local CODC plan which will address administration and management, policy and funding, staffing and supervision, interagency service network, cross training, quality and outcomes management, management information systems.
Action C Develop mechanism to ensure direct consistent flow of communication from the state level Taskforce to the Local Systems of Care & Local Steering Committees and from the Local Systems of Care & Local Steering Committees to the direct service staff, and visa versa. For the Human Service Districts and Authorities, flow of information occurs through the Executive Directors.

Principle #2 - ***All individuals with co-occurring psychiatric and substance disorders (ICOPSD) are not the same; the national consensus four quadrant model for categorizing co-occurring disorders (NASMHPD, 1998) can be used as a guide for service planning on the system level***. With resources and requirements of the COSIG, Quadrants 2 and 3 have been prioritized for action. Activities in Quadrants 1 and 4 remain as long-term goals. (Focus on organizing actions by quadrant model)

Strategy 1 Focus on Quadrant 2 – Hi MH, Lo SA (currently in Mental Health System)

Action A Ensure that current agency mission statements encompass the treatment of persons with co-occurring disorders.

**The use of 'Local System of Care' in this document is to signify that statutorily created local governance entities (LGE's) are the recognized authority in the designated geographic area. The LGE executive director is responsible for operations and meeting/exceeding outcomes as established by DHH. The board and executive director comprise the local governance structure (Current LGE's are CAHSD, FPHSA, JPHSA, and MHSD).

Action B Revise definition of target population to include those with co-occurring substance use disorders, provided agency level of severity criteria is met.
Action C Charge the Division of Research, Evaluation and Information Technology to ensure that all service planning initiatives support CODC.
Action D Develop a mechanism to ensure all new and existing programming supported by OMH resources (fiscal and/or personnel) supports CODC.
Action E Incorporate developed core competencies into job descriptions and annual Planning and Performance Reviews (PPR).
Action F Development of needed specialized programs to attain CODC (see Principle 7 for detailed plan)
1 Identify target population whose needs exceed the scope of adopted clinical practice guidelines due to co-occurring disorders
2 Obtain expert consultation regarding program development, including service design, funding streams, and potential cross-agency partnerships.
3 Charge Division of Program Development to manage development and implementation process.
Action G Coordinate services with medical care
1 Incorporate queries regarding health status and access to medical care into intake process
2 Refer/link to appropriate medical home (primary care physician, Federally Qualified Health Centers) if no current access
3 Ongoing coordination with medical service provider

Strategy 2 Focus on Quadrant 3 – Lo MH, Hi SA (currently served in Addictive Disorder System)
Action A Ensure that current agency mission statements encompass the treatment of persons with co-occurring disorders.
Action B Revise definition of target population to include those with co-occurring mental disorders, provided agency service criteria is met.
Action C Charge the Division of Research, Evaluation, and Information Technology to ensure that all service planning initiatives support CODC.
Action D Develop a mechanism to ensure all new and existing programming supported by OAD resources (fiscal and/or personnel) supports CODC.
Action E Incorporate developed core competencies into job descriptions and annual Planning and Performance Reviews (PPR).
Action F Development of needed specialized programs to attain CODC (see Principle 7 for detailed plan)
1 Identify target population whose needs exceed the scope of adopted clinical practice guidelines due to co-occurring disorders
2 Obtain expert consultation regarding program development, including service design, funding streams, and potential cross-agency partnerships.
3 Charge Division of Program Development to manage development and implementation process.
Action G Coordinate services with medical care
1 Incorporate queries regarding health status and access to medical care into intake process
2 Refer/link to appropriate medical home (primary care physician) if no current access
3 Ongoing coordination with medical service provider

Strategy 3 Focus on Quadrant 1 - Lo MH, Lo SA (currently served in primary care settings)

Action A Collaboration and support of Primary Care Initiative (Closing the Gap)

1 Maintain Taskforce representation in Closing the Gap activities

2 Ensure plan development within each initiative is complimentary, not contradictory or duplicative of the other

Action B Collaboration with current prevention initiatives

Strategy 4 Focus on Quadrant 4 – Hi MH, Hi SA (currently presenting in emergency rooms, jails, homeless shelters)

Action A Engage and collaborate with LSU, Louisiana Hospital Association, and Coroner's Office and local systems of care to develop comprehensive response system for referral and follow-up

Action B Collaboration, within local systems of care, with law enforcement and justice system, including the Louisiana Association of Sheriffs

Action C Identify and support current initiatives focused on crisis intervention services.

Principle #3 ***Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.*** (Focus on treatment relationship between client and clinic staff)

Strategy 1 Develop and adopt 'no wrong door' philosophy for service.

Action A Establish "welcoming" policy that is culturally sensitive

1 Develop and adopt welcoming policy that is applicable to every level of client interaction

2 Train staff on policy and expected customer service behaviors

3 Monitor adherence to policy through program evaluation, PPR's and customer satisfaction surveys.

Action B Provide expected baseline level of initial treatment intervention and relationship building mechanism no matter the place of entry or provider.

1 Develop clear scope of clinical practice guidelines regarding initial treatment interaction through Clinical Protocol Committee.

2 Develop the knowledge base, skills and practice patterns consistent with evidence based practices (see detailed plan in Principle 7).

Strategy 2 To provide ongoing treatment interventions for which there is consistent scientific evidence showing that these interventions that improve client outcomes and are person centered and culturally sensitive (more detail in principle 7).

Principle #4 ***Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.*** (Focus on meeting client need for external support services)

Strategy 1 Incorporate case management function into service delivery system

Action A Define specific case management activities

Action B Revise staff job descriptions to include defined activities

Action C Monitor provision of case management services through annual Planning and Performance Reviews (PPR) and customer satisfaction surveys.

Action D Explore implications of case management services on Medicaid reimbursement

Strategy 2 Support expanded relationships with external entities, including Federal Qualified Health Clinics and primary healthcare providers, Department of Social Services, Education, Justice System, Faith-based groups, Housing Authorities, Law Enforcement, Private and Public Hospitals for purposes of linkage and referrals to support and sustain resilience and recovery.

Action A Utilize the following state level activities to achieve buy-in, support linkages, and provide education and clinical information to consumers, agencies, family members, and other stakeholder groups:

1 Leadership Summit
2 Educational Conference
3 Social marketing campaign
4 Client Advisory Board

Action B Support the utilization of the following activities through local systems of care:

1 Annual focus groups
2 Community networking groups
3 Integrated service trainings

Principle #5 ***When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.*** (Focus on screening and assessment)

Strategy 1 Develop integrated screening and assessment process that promotes the no wrong door philosophy.

Action A Develop policy to ensure all individuals presenting for treatment are screened for COD, and all individuals who triggered positive on screen are assessed and recommended for appropriate treatment and/or referred with follow-up as needed.

Action B Participation in Interdepartmental Consensus Conference to identify and adopt an integrated screening process and tool.

Action C Utilize Clinical Protocol Committee to build on work of consensus conference to develop an integrated assessment process, tool/s, or uniform data elements that
1 increase access to service
` 2 reduce redundancy of data collection
3 facilitate continuity of care across settings
4 increase a person-centered, holistic approach to service
5 support clinical and administrative efficiency within districts and regions.
Action D Ensure MIS can support the documentation of both substance and mental health as primary disorders.

Strategy 2 Ensure that all levels of staff are trained to the appropriate level of competency needed to implement the adopted screening and assessment process (see detailed training plan in Principle 7).

Strategy 3 Address the perceived barrier that Medicaid reimbursement is at risk if substance abuse or dependence diagnosed or documented.

Principle #6 ***Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.*** (Focus on disease and recovery model as foundation for treatment)

Strategy 1 Build consumer support in adoption of model (thru mechanisms identified in Principle #9)

Strategy 2 Build staff support in adoption of model
1 Promote no wrong door philosophy
2 Utilize CODECAT to assess clinician's current treatment philosophy
3 Train staff on disease and recovery model which includes phases of recovery and stages of change
4 Utilize local systems of care and local steering committees and integrated treatment specialist to lead local culture shift

Principle #7 ***There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.*** (Focus on development of clinical practice guidelines and training for CODC)

Strategy 1 Through our clinical protocol committee, develop clinical practice guidelines based on the disease and recovery model to direct appropriate treatment interventions. for which there is consistent scientific evidence showing that these interventions/ practices improve client outcomes that are person centered and culturally sensitive.

- Action A Identify processes to ensure information is obtained regarding each client's quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change.
- Action B Identify range of published Evidence Based Practices across cultural, ethnic, racial, developmental stage and socio-rural status.
- Action C Develop a decision tree to guide appropriate treatment intervention.
- Action D Recommend practices across specific disciplines (i.e., nurses, psychiatrists, social workers, etc.) and across specific clinical treatment interventions (screening and assessment, crisis intervention, treatment planning, family therapy, discharge planning, etc.)

Strategy 2 Development of organized system of care which supports continuity of care in that all services are dual programs, but all programs are not the same – programs are designed to meet the varying needs of the co-occurring client.

- Action A Define continuity of care guidelines for determining need of referral to specialized programs, other agencies, or external supports
- Action B Develop clear policies and procedures for referral process.
- Action C Develop clear policies and procedures for referral follow-up.

Strategy 3 Develop an informed**,** well-trained and competent staff in regards to knowledge base and skills and practice patterns consistent with evidence based practices

- Action A Require all workforce staff to be trained on core competencies, clinical practice guidelines, and continuity of care guidelines to ensure fidelity to adopted model of treatment.
- Action B Develop advanced curriculum for specific disciplines (i.e., nurses, psychiatrists, social workers, etc.) consistent with licensing / professional ethics standards, or accreditation in coordination with academic institutions.
- Action C Develop a method of disseminating information (e.g., workshops, web based training, etc.) to expand knowledge base among staff.
- Action D Develop a certification program that utilizes testing as a means to ensure skills development to practice at specified level of competency utilizing a person centered approach; raise professional standards & resolve licensure and credentialing conflicts.
- Action E Develop mechanism for follow-up 'refresher' trainings
- Action F Develop program of organized clinical supervision and quality improvement to ensure sustainability of skill levels.
- Action G Ensure information flow to direct care staff from regional, district and state leadership

Principle #8 ***Clinical outcomes for Individuals with Co-occurring Psychiatric and Substance Disorders must also be individualized, based on similar parameters for individualizing treatment interventions.*** (Focus on MIS and evaluation)

Strategy 1 Build administrative structure to support the measurement of system and client outcomes with participation of districts

- Action A Review status of OMH and OAD MIS systems and development plans, as well as other states MIS
- Action B Develop MIS standards and procedures, re: MIS uniform data dictionary, structures and model; data warehouse; access/security system; electronic client record; PPG and Program Performance Improvement reports
- Action C Coordinate with MIS related work occurring at the DHH level.
- Action D Develop mechanism for cost/benefit analysis within and across public and private systems and departments
- Action E Provide needs assessments to support local implementation (i.e. staff surveys, focus groups) and include diverse client/consumer participation into all levels of program evaluation
- Action F Develop mechanism for ongoing monitoring and measurement of fidelity to Evidence Based Practices (EBPs) adopted for implementation
- Action G Develop and implement on-going monitoring to assure continued adherence to program policy

Strategy 2 Document that appropriate integrated treatment services are easily accessible and efficient.

- Action A Through adopted screening and assessment procedures, identify prevalence of people with COD in current system.
- Action B Ensure those identified with COD receive services and supports plan for integrated services
- Action C All providers receiving public funds to serve adults and c/y with COD can demonstrate core competence and cultural competence to serve this population
- Action D Demonstrate cost benefit of the EBP adopted for implementation
- Action E Demonstrate provision of individualized treatment and resilience and recovery support and promote recovery

Strategy 3 Document that adults and children and youth with co-occurring disorders have sustained resiliency and recovery.

- Action A Preplan for outcome evaluation (identify outcome goals, instruments, procedures for collection, analysis and reporting based on program implementation plan
- Action B Train field staff on procedures for data collection and effective data management
- Action C Prepare quarterly evaluation reports

Principle #9 ***The system of care operates in partnership with consumers, family members and concerned significant others (CSOs) and a continuous effort is made to involve the individual and the family at the system, program and individual levels.*** (Focus on consumer involvement at state and local level)

Strategy 1 Involve the target population and advocacy groups in development and implementation of the Louisiana Integrated Treatment Services (LITS) project at the state level.

- Action A Encourage active participation of Chair of Mental Health Planning Council and Chair of Governor's Commission on Addictive Disorders within Taskforce
- Action B Seek input from established Client Advisory Board in regards to the work of the Taskforce and its committees, i.e. development of screening and assessment protocols, development of treatment outcomes, etc.
- Action C Invite target population to annual Leadership Summit
- Action D Contract with Hope Networks to develop and maintain a web-based consumer driven network of outreach, information, education, and referral systems of available statewide support services for those with both mental health and substance abuse needs.
- Action E Contract with NAMI-La to host statewide educational meeting designed to educate consumers, families, advocates, community stakeholders and mental health and substance abuse professionals about effective treatments and leading trends in the field of co-occurring disorders.
- Action F Contract with Mental Health Association of Louisiana (MHAL) to implement a statewide public education campaign focused on issues relevant to co-occurring mental illness and substance abuse disorders.

Strategy 2 Involve the target population and advocacy groups in development and implementation of the LITS project within and through the local systems of care.

- Action A Encourage active participation in local steering committees.
- Action B Support the Governor's Commission on Addictive Disorders plan to hold annual, local focus groups in order to obtain input from clients, consumers, family members, advocates, private providers, other agency representatives and community leaders to use in adaptation of LITS to local region.
- Action C Support the Governor's Commission on Addictive Disorders plan to organize local networking groups, respectful of local systems of care, which will work to identify community needs and strengths, provide on-going input to regional LITS adaptation process.
- Action D Contract with Set Free Indeed to conduct targeted educational activities to local churches and other faith-based organizations.
- Action E Contract with Building Recovery of Individual Dreams & Goals through Education and Support (BRIDGES) to promote local consumer involvement and education.
- Action F Identify process to support co-occurring support groups, i.e. Dual Recovery Anonymous (DRA) and Double Trouble

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