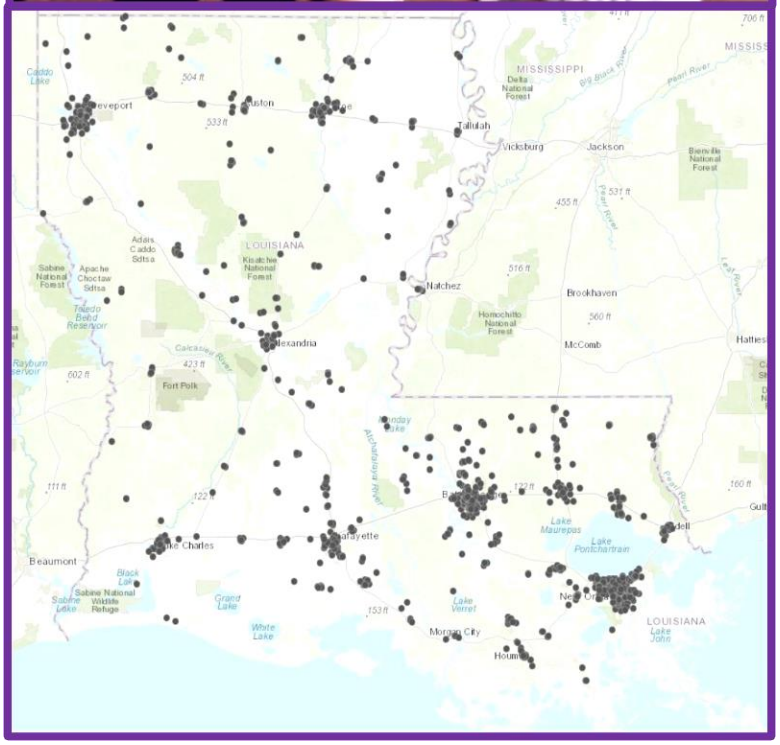
LOUISIANA BEHAVIORAL HEALTH PROVIDER SURVEY OF ADULT SERVICES:

Results from the 2018 Self-Report Survey of Louisiana Medicaid and State Contracted Providers



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Funding provided by Louisiana Department of Health

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INTRODUCTION

Significant research advances have led to an improved understanding of effective treatments and interventions. This includes the development of demonstrated, effective interventions, commonly referred to as evidence-based practices (EBPs). In general, the term Evidence-Based Practices refers to clinical treatments, preventive programs, or service practices that have been carefully evaluated using rigorous research designs, and which have demonstrated effectiveness. The availability of EBPs represents a real opportunity for improving the behavioral health system's effectiveness, while simultaneously improving the lives of people and the communities in which they live.

In partnership with the Louisiana Department of Health- Office of Behavioral Health and the state's many service providers and stakeholders, the LSUHSC Institute for Public Health and Justice revised its behavioral health provider survey to focus on Medicaid and state contracted providers for adults. The goal of the survey was to provide an inventory of existing services and programs, the capacity of providers, and the perception of needs from the vantage point of practitioners. This information was used to identify gaps in services and provide critical understanding in order to develop a plan for the adoption and expansion of EBPs in our state. The information collected will help to guide future planning and decision making around evidence-based practices.

SURVEY METHODS

Behavioral healthcare provider practices were surveyed via a web-based instrument. The survey was delivered to targeted participants identified by OBH, Louisiana Medicaid Managed Care Organizations (MCOs), as well as Regional LGE contracted providers. The instrument, the "Behavioral Health System Treatment Services Inventory", was developed by the Institute for Public Health and Justice at the Louisiana State University Health Sciences Center- School of Public Health. The survey is a web-based survey using REDCap. The survey is housed on LSUHSC servers in New Orleans, Louisiana.

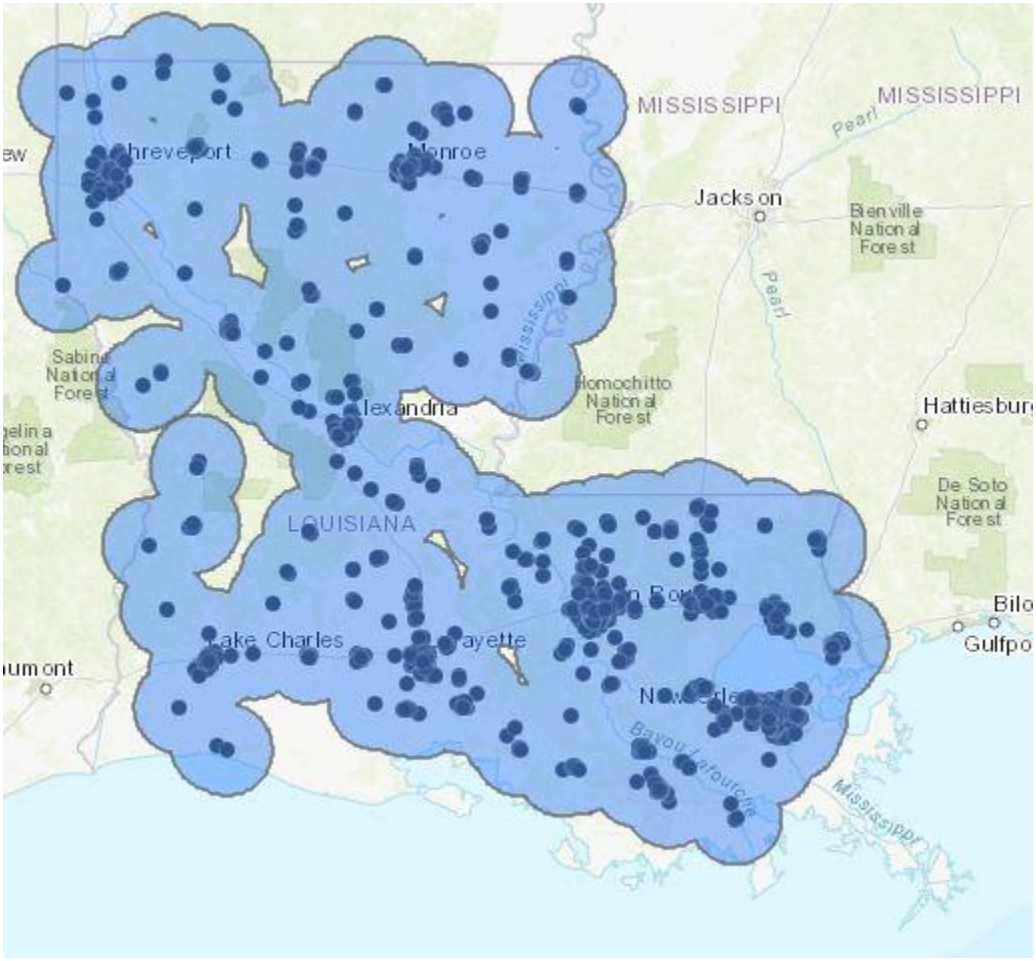
Activities for this regional administration of the survey began January 2018, with the actual survey being distributed July 31st and concluding August 15th 2018. Provider lists received from the Louisiana's five MCOs, OBH, and state contracted providers were merged to remove duplicate provider entries using unique NPI numbers. After cleaning, 3,243 providers were identified. Of these providers…

- 24 providers provided information that they were not taking Medicaid, did not receive state contract money for services, and/or did not currently serve the adult population being targeted
- 2 providers refused to participate
- 443 were invalid email address (i.e., were not deliverable), had incorrect email address format, and/or were duplicated email addresses

Removing the above listed providers that said they did not service the adult population being targeted resulted in an unduplicated list of **3,219 unique Medicaid providers identified from the MCO lists**. These are providers believed to be serving Louisiana's adults. The map below (**see Graph A**) shows that, within a 15-mile radius, the **highest concentration of those providers in New Orleans, followed by Baton Rouge and Shreveport**. According to Louisiana Medicaid, accessibility in rural areas is defined as a 30-mile radius. **Graph B** shows a map defined by the

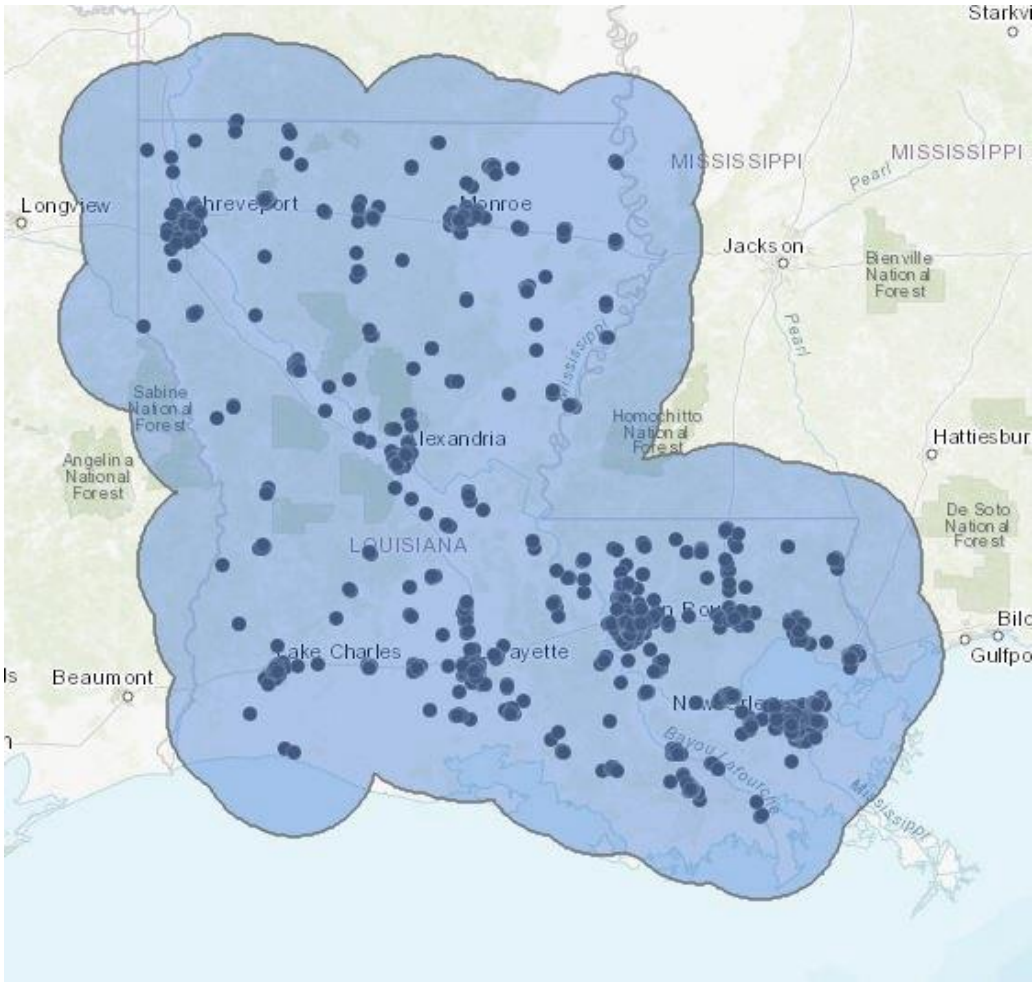
30-mile parameters and suggests some level of behavioral health access is available throughout the state. The type of provider and quality are not defined by these maps, thus these graphs should not be used to determine the adequacy of the provider network.

GRAPH A: 15-mile Access Distribution of Medicaid Behavioral Health Service Providers Identified by Louisiana MCOs (n= 3,219)



Note: Map generated using ArcGIS software to determine approximately 15-mile access for the distribution of provider services of Medicaid-insured adults (18 and over) in the state of Louisiana. Ten to fifteen miles is described as accessible in urban/suburban areas by Louisiana Medicaid standards.

GRAPH B: 30-mile Access Distribution of Medicaid Behavioral Health Service Providers Identified by Louisiana MCOs (n= 3,219)



Note: Map generated using ArcGIS software to determine approximately 30-mile access for the distribution of provider services of Medicaid-insured adults (18 and over) in the state of Louisiana. Thirty miles is described as accessible in rurual areas by Louisiana Medicaid standards.

Removing the 443 invalid email addresses and the two providers that refused to participate, left a **final sample of 2,774 Louisiana providers for the survey.** In addition to the provider survey, the research team worked with de-identified Louisiana Medicaid claims data. Diagnosis categories for adult Medicaid claims were analyzed to provide an estimate of the prevalence of current behavioral health issues being seen by providers at the state, region, and parish level. Results of both the Medicaid claims analysis and the provider survey are detailed below.

REPORT FORMAT

This report is organized to first describe Medicaid diagnosis prevalence followed by the findings of the provider survey. The provider survey findings are presented by identifying the question the providers were asked, followed by a graphical depiction of the findings and a written summary. This is done for each survey question and presented at the state level of findings in the body of this report. Regional findings are offered in the appendices.

STUDY FINDINGS

Medicaid Diagnosis Prevalence

Adult population and prevalence estimates of Medicaid served behavioral health disorders are described in **Table 1**. Medicaid data were provided from the state, via all claims considered "paid" for the year 2017. Participants ages ranged from 18 to 96 years old. Denied claims and unpaid encounters were excluded. Disorders in the state data set represented primary diagnoses. Prevalence in this table included all patients that were treated in only one region of Louisiana (N=160,133) in order to accurately portray regional data. This resulted in exclusion of 3,130 patients (accounting for 1.9% of the original dataset), who were treated in multiple regions. Diagnosis counts were then divided by the total number of adults enrolled in Medicaid (data taken from December 2017 Medicaid Enrollment Report, LDH) in order to determine prevalence. Parish data were combined in order to display regional data concisely. Prevalence comparison data were obtained from national estimates presented in the DSM-5 Handbook of Differential Diagnosis, published by the American Psychiatric Association in 2013, the National Institute of Mental Health, updated in 2017, and the medical reference source "UpToDate". Parish data have been combined into state Regions as follows:

Region 1: Jefferson, Orleans, Plaquemines, St. Bernard
Region 2: Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupe, West Baton Rouge, West Feliciana
Region 3: Assumption, Lafourche, St. Charles, St. James St. John, St. Mary, Terrebonne
Region 4: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermilion
Region 5: Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis
Region 6: Avoyelles, Catahoula, Concordia, Grant, Lasalle, Rapides, Vernon, Winn
Region 7: Bienville, Bossier, Caddo, Claiborne, Desoto, Natchitoches, Red River, Sabine, Webster
Region 8: Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, West Carroll
Region 9: Livingston, St. Helena, St. Tammany, Tangipahoa, Washington

Table 1: Prevalence Estimates for Medicaid Insured Adults with Mental Health Diagnoses in 2017

Louisiana Region	Diagnostic Category	Diagnosis Category Frequency	LA Adult Population of Medicaid Enrollees	LA Adult Prevalence	National Prevalence*
Region 1	Substance Use Disorders	7679	197589	3.89%	8.5%
	Schizophrenia/ Psychotic disorders	4389	197589	2.22%	0.7%
	Mood/Affective Disorders	15473	197589	7.83%	9.7%
	Anxiety/Stress Disorders	10637	197589	5.38%	18.1%
	Disorders associated with physiologic/physical stress	495	197589	0.25%	10.0%
	Personality Disorders	541	197589	0.27%	9.1%
	Behavioral/emotional disorders with usual pediatric onset	2806	197589	1.42%	4.0%
	Peripartum substance use disorders	390	197589	0.20%	3.9%

Region 2	Substance Use Disorders	4173	109132	3.82%	8.5%
	Schizophrenia/ Psychotic disorders	2234	109132	2.05%	0.7%
	Mood/Affective Disorders	7929	109132	7.27%	9.7%
	Anxiety/Stress Disorders	6011	109132	5.51%	18.1%
	Disorders associated with physiologic/physical stress	488	109132	0.45%	10.0%
	Personality Disorders	272	109132	0.25%	9.1%
	Behavioral/emotional disorders with usual pediatric onset	2116	109132	1.94%	4.0%
	Peripartum substance use disorders	195	109132	0.18%	3.9%
Region 3	Substance Use Disorders	3496	77953	4.49%	8.5%
	Schizophrenia/ Psychotic disorders	1440	77953	1.90%	0.7%
	Mood/Affective Disorders	7859	77953	10.08%	9.7%
	Anxiety/Stress Disorders	6001	77953	7.70%	18.1%
	Disorders associated with physiologic/physical stress	353	77953	0.45%	10.0%
	Personality Disorders	153	77953	0.20%	9.1%
	Behavioral/emotional disorders with usual pediatric onset	1243	77953	1.60%	4.0%
	Peripartum substance use disorders	382	77953	0.49%	3.9%
Region 4	Substance Use Disorders	3976	120295	3.31%	8.5%
	Schizophrenia/ Psychotic disorders	2175	120295	1.81%	0.7%
	Mood/Affective Disorders	11115	120295	9.24%	9.7%
	Anxiety/Stress Disorders	9607	120295	7.99%	18.1%
	Disorders associated with physiologic/physical stress	501	120295	0.42%	10.0%
	Personality Disorders	206	120295	0.17%	9.1%
	Behavioral/emotional disorders with usual pediatric onset	3520	120295	2.93%	4.0%
	Peripartum substance use disorders	344	120295	0.29%	3.9%
Region 5	Substance Use Disorders	2277	52620	4.33%	8.5%
	Schizophrenia/ Psychotic disorders	1034	52620	1.97%	0.7%
	Mood/Affective Disorders	5582	52620	10.61%	9.7%
	Anxiety/Stress Disorders	4669	52620	8.87%	18.1%
	Disorders associated with physiologic/physical stress	165	52620	0.31%	10.0%
	Personality Disorders	149	52620	0.28%	9.1%
	Behavioral/emotional disorders with usual pediatric onset	1488	52620	2.83%	4.0%
	Peripartum substance use disorders	120	52620	0.23%	3.9%
Region 6	Substance Use Disorders	2249	63264	3.56%	8.5%
	Schizophrenia/ Psychotic disorders	1076	63264	1.70%	0.7%
	Mood/Affective Disorders	5300	63264	8.38%	9.7%
	Anxiety/Stress Disorders	5235	63264	8.28%	18.1%

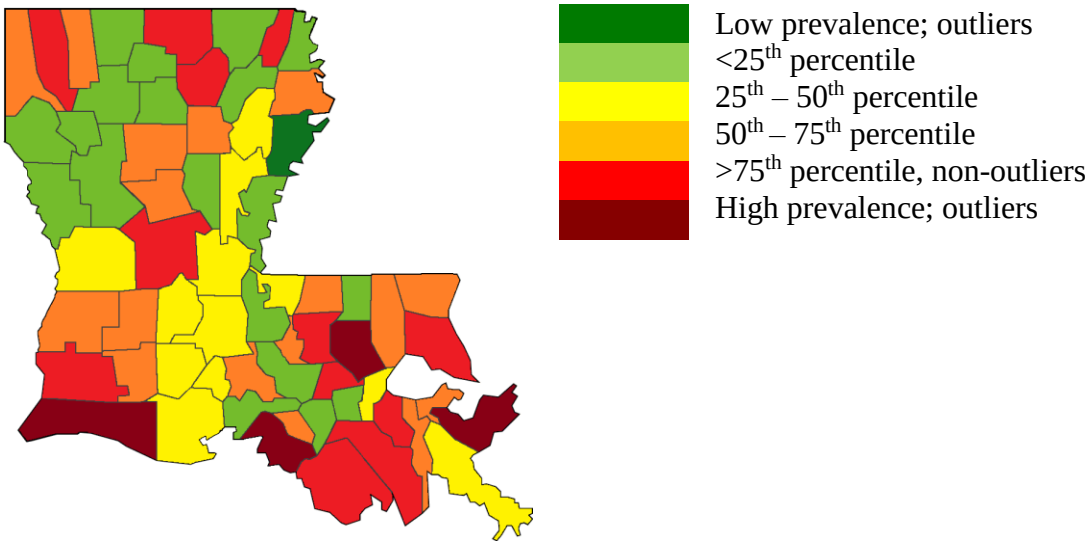
	Disorders associated with physiologic/physical stress	163	63264	0.26%	10.0%
	Personality Disorders	160	63264	0.25%	9.1%
	Behavioral/emotional disorders with usual pediatric onset	1021	63264	1.61%	4.0%
	Peripartum substance use disorders	112	63264	0.18%	3.9%
Region 7	Substance Use Disorders	3652	108705	3.36%	8.5%
	Schizophrenia/ Psychotic disorders	2131	108705	1.96%	0.7%
	Mood/Affective Disorders	8566	108705	7.88%	9.7%
	Anxiety/Stress Disorders	5924	108705	5.45%	18.1%
	Disorders associated with physiologic/physical stress	279	108705	0.26%	10.0%
	Personality Disorders	334	108705	0.31%	9.1%
	Behavioral/emotional disorders with usual pediatric onset	1491	108705	1.37%	4.0%
	Peripartum substance use disorders	115	108705	0.11%	3.9%
Region 8	Substance Use Disorders	2982	83102	3.59%	8.5%
	Schizophrenia/ Psychotic disorders	1464	83102	1.76%	0.7%
	Mood/Affective Disorders	5945	83102	7.15%	9.7%
	Anxiety/Stress Disorders	5492	83102	6.61%	18.1%
	Disorders associated with physiologic/physical stress	316	83102	0.380256	10.0%
	Personality Disorders	264	83102	0.32%	9.1%
	Behavioral/emotional disorders with usual pediatric onset	1492	83102	1.80%	4.0%
	Peripartum substance use disorders	296	83102	0.36%	3.9%
Region 9	Substance Use Disorders	4394	95200	4.62%	8.5%
	Schizophrenia/ Psychotic disorders	1349	95200	1.42%	0.7%
	Mood/Affective Disorders	8440	95200	8.87%	9.7%
	Anxiety/Stress Disorders	7180	95200	7.54%	18.1%
	Disorders associated with physiologic/physical stress	403	95200	0.42%	10.0%
	Personality Disorders	224	95200	0.24%	9.1%
	Behavioral/emotional disorders with usual pediatric onset	2421	95200	2.54%	4.0%
	Peripartum substance use disorders	203	95200	0.21%	3.9%

Note: National data estimates from the DSM-5 Handbook of Differential Diagnosis (2013)- https://doi.org/10.1176/appi.books.9780890425596.dsm02), the National Institute of Mental Health (updated in 2017)- https://www.nimh.nih.gov/health/statistics, and the medical reference source Uptodate- https://www.uptodate.com/contents/substance-use-by-pregnant-women.

Maps

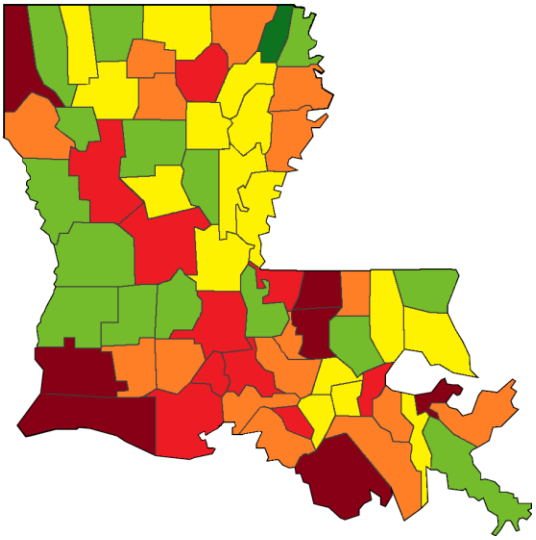
Each diagnostic category was examined individually in conjunction with parish data in order to yield an overall state median prevalence and interquartile range. This median was used to categorize all parishes in the state in comparison to these reference values and was illustrated via map form in order to clarify clusters of disease burden. Such areas may be most in need for immediate assistance. National data were taken from estimates presented in the DSM-5 Handbook of Differential Diagnosis, the National Institute of Mental Health, and the medical reference source "UpToDate."

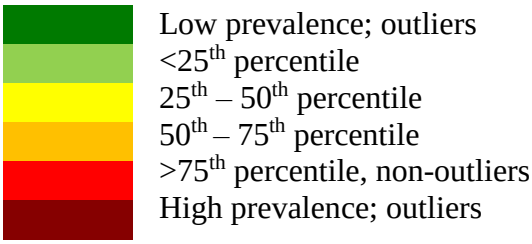
Substance Use Disorders



The Louisiana state median for diagnoses that were categorized as substance use disorders is 3.42% for adults 18 years and older who are insured by Medicaid. The interquartile range (25th to 75th percentile) is 3.01% - 3.96%. Patients with these conditions are relatively widely distributed, although Southern Louisiana appears to have the highest disease burden. According to the Diagnostic Statistical Manual Library and the National Institute of Mental Health, the US national prevalence of substance use disorder is as high as 8.5%.

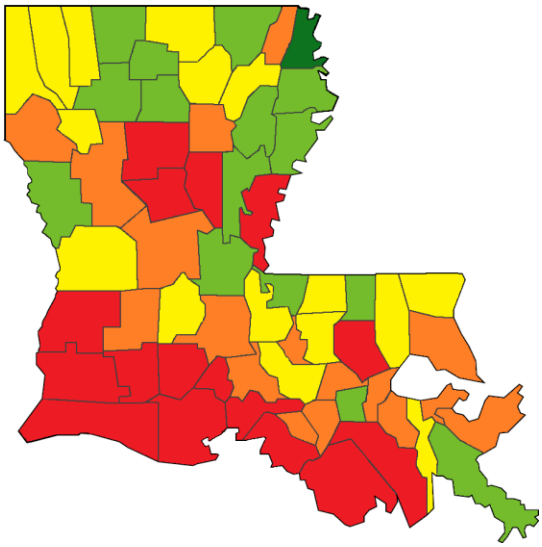
Schizophrenia/ Psychotic disorders

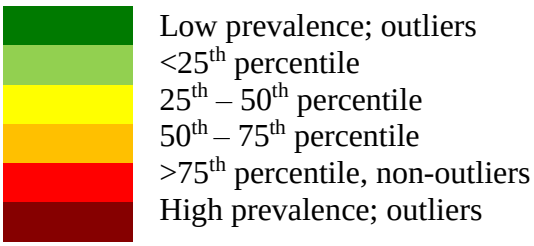




The Louisiana state median for diagnoses that were categorized as schizophrenia/other psychotic disorders is 1.54% for adults 18 years and older who are insured by Medicaid. The interquartile range (25th to 75th percentile) is 1.37% - 1.70%. Patients with these conditions appear to be spread throughout the state, with some regional clustering in the south and central area. According to the Diagnostic Statistical Manual Library and the National Institute of Mental Health, the US national prevalence of schizophrenia and other psychotic disorders is as high as 0.7%.

Mood/Affective Disorders

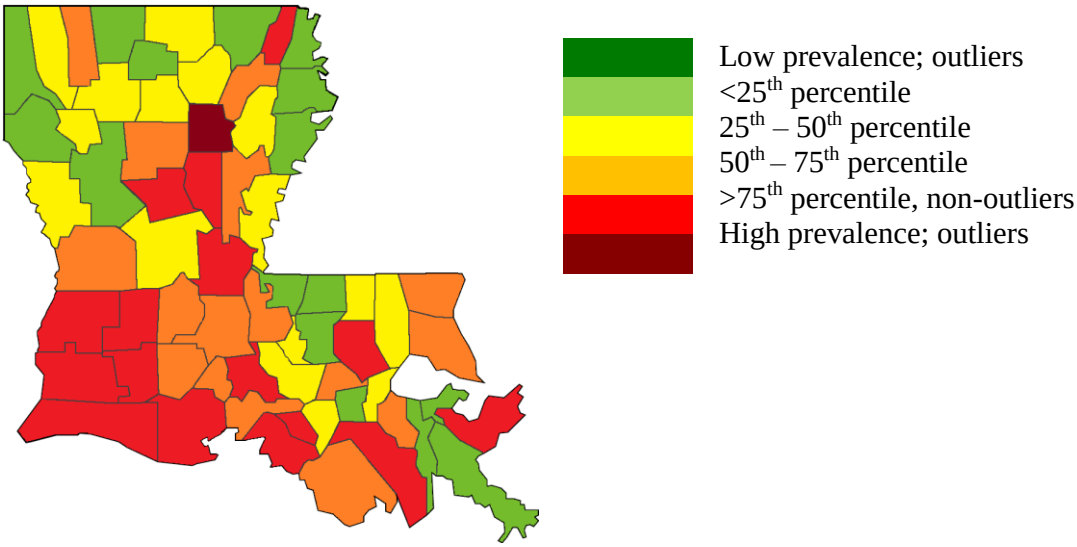




The Louisiana state median for diagnoses that were categorized as mood/affective disorders is 8.13% for adults 18 years and older who are insured by Medicaid. The interquartile range (25th to 75th percentile) is 7.04% - 9.27%. Parishes with the highest prevalence are localized to the

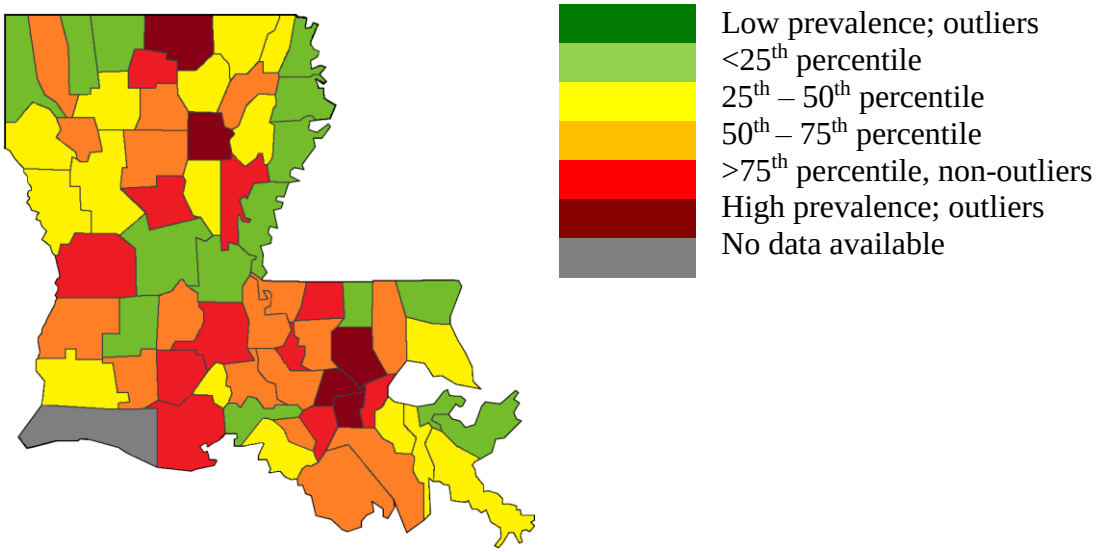
south/southwest region of Louisiana. According to the Diagnostic Statistical Manual Library and the National Institute of Mental Health, the US national prevalence of mood/affective disorders is as high as 9.7% of the adult population.

Anxiety/Stress Disorders



The Louisiana state median for diagnoses that were categorized as anxiety/stress disorders is 7.25% for adults 18 years and older who are insured by Medicaid. The interquartile range (25th to 75th percentile) is 5.97% - 8.45%. Parishes with the highest prevalence are localized to the southwest region of Louisiana. According to the Diagnostic Statistical Manual Library, the US national prevalence of anxiety/stress disorders is as high as 11% in the adult population. According to the National Institute of Mental Health, the US national prevalence of anxiety/stress disorders is as high as 18.1%

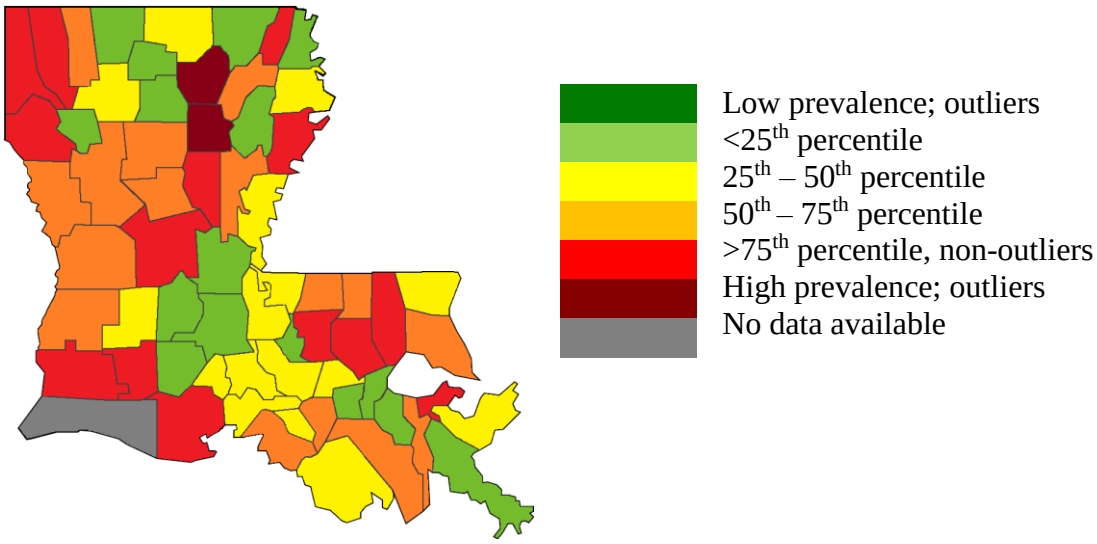
Disorders associated with physiologic/physical stress



The Louisiana state median for diagnoses that were categorized as disorders associated with physiologic/physical stress is 0.34% for adults 18 years and older who are insured by Medicaid.

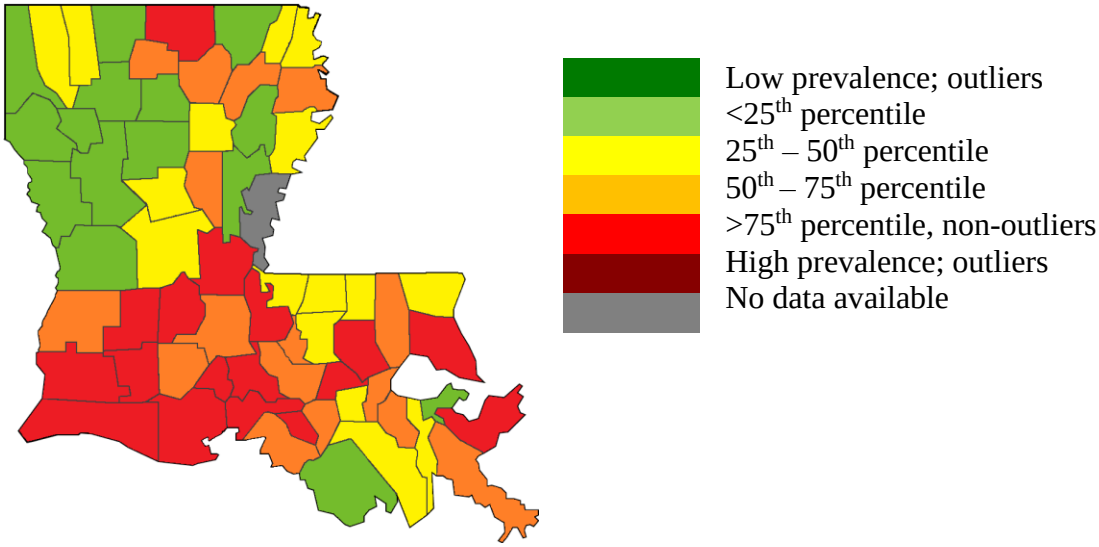
The interquartile range (25th to 75th percentile) is 0.27% - 0.47%. Relative prevalence is well-distributed throughout the state. Data were not available for Cameron parish. According to the Diagnostic Statistical Manual Library, the US national prevalence of disorders associated with physiologic/psychologic stress is as high as 10.0% of the adult population.

Personality Disorders



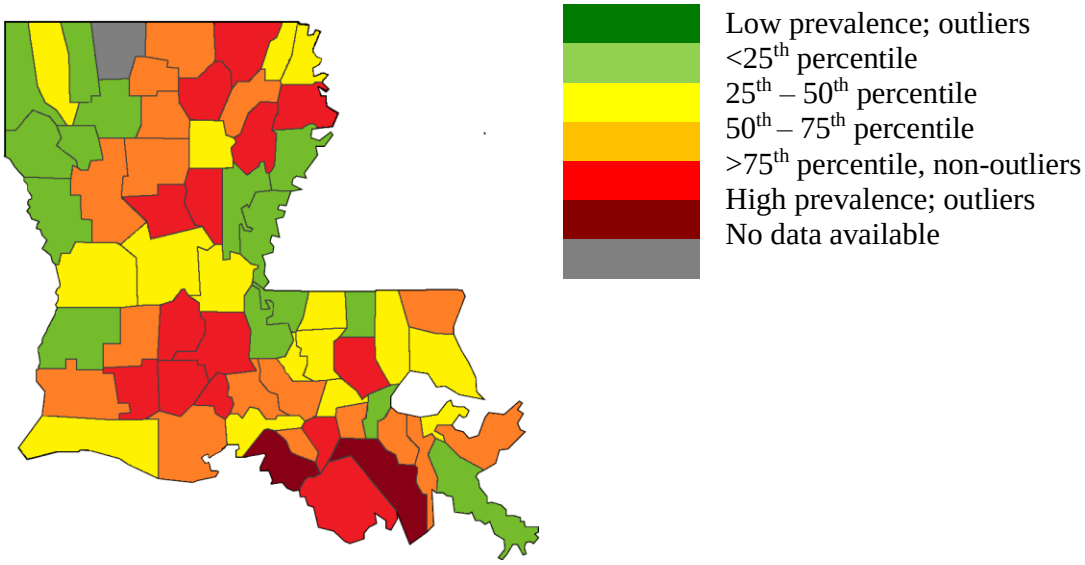
The Louisiana state median for diagnoses that were categorized as personality disorders is 0.20% for adults 18 years and older who are insured by Medicaid. The interquartile range (25th to 75th percentile) is 0.15% - 0.26%. Patients with these conditions are relatively localized to the western border of the state. Data were not available for Cameron parish. According to the National Institute of Mental Health, the US national prevalence of personality disorders may be as high as 9.1% in the adult population.

Behavioral/emotional disorders with usual pediatric onset



The Louisiana state median for diagnoses that were categorized as behavioral/emotional disorders with typical pediatric onset is 1.83% for adults 18 years and older who are insured by Medicaid. The interquartile range (25th to 75th percentile) is 1.43% - 2.57%. The highest relative prevalence can be found in the southwest region of the state. Data were not available for Concorida parish. According to the Diagnostic Statistical Manual Library, the US national prevalence of behavioral/emotional disorders with usual pediatric onset may be as high as 4.0% in adult populations.

Peripartum substance use disorders



The Louisiana state median for diagnoses that were categorized as peripartum substance use disorders is 0.20% for adults 18 years and older who are insured by Medicaid. The interquartile range (25th to 75th percentile) is 0.12% - 0.28%. Prevalence is relatively varied throughout the state. Data were not available for Claiborne parish. According to the medical reference source UpToDate, national peripartum substance use disorder prevalence may be as high as 3.9%.

Provider Survey Findings

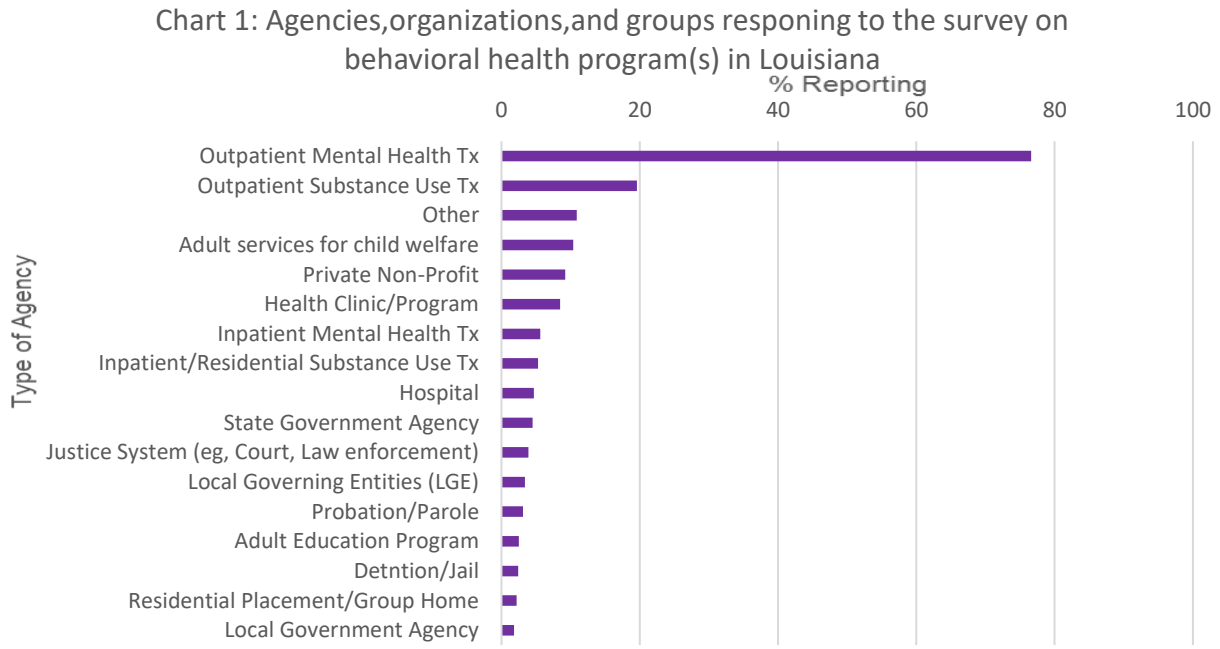
The survey was distributed to a range of stakeholders, identified as serving in some capacity a function of the wide range of services offered as part of the continuum of behavioral health services in Louisiana. With a **33.8% completed response rate** from those providers eligible (N=2,774) for the 2018 email survey, **937 Louisiana providers submitted completed information on 782 programs and services spanning each of Louisiana's 64 parishes**. Summaries of those providers' responses are included in this report.

Note- Professional services and agency functions vary widely in the behavioral health system, so the survey was designed so not all respondents were required to answer every question in each section of the survey. Therefore, the following data are summarized at the individual survey item level. Response rates and percentages are based upon the number of providers answering a question applicable to their particular area of service.

Programs and Services

Types of Organizations

Providers were asked, "Which of the following best describes your agency, organization or group that implements behavioral health program(s)? (select all that apply)" (n=937)

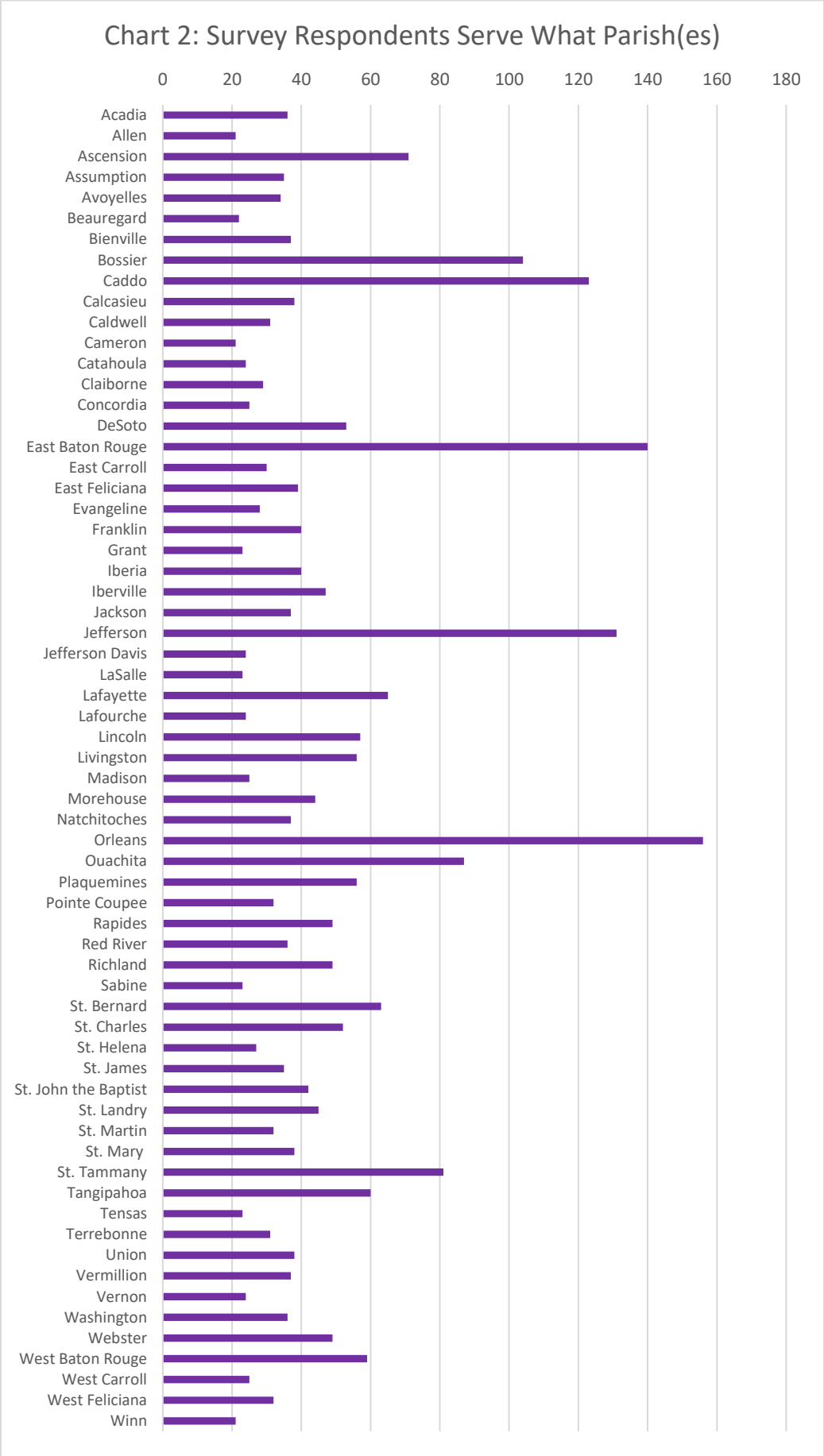


The **majority of programs described their agency** or organization that implements behavioral health services for Louisiana adults **as "outpatient mental health treatment." (See Chart 1)**.

Parishes Served

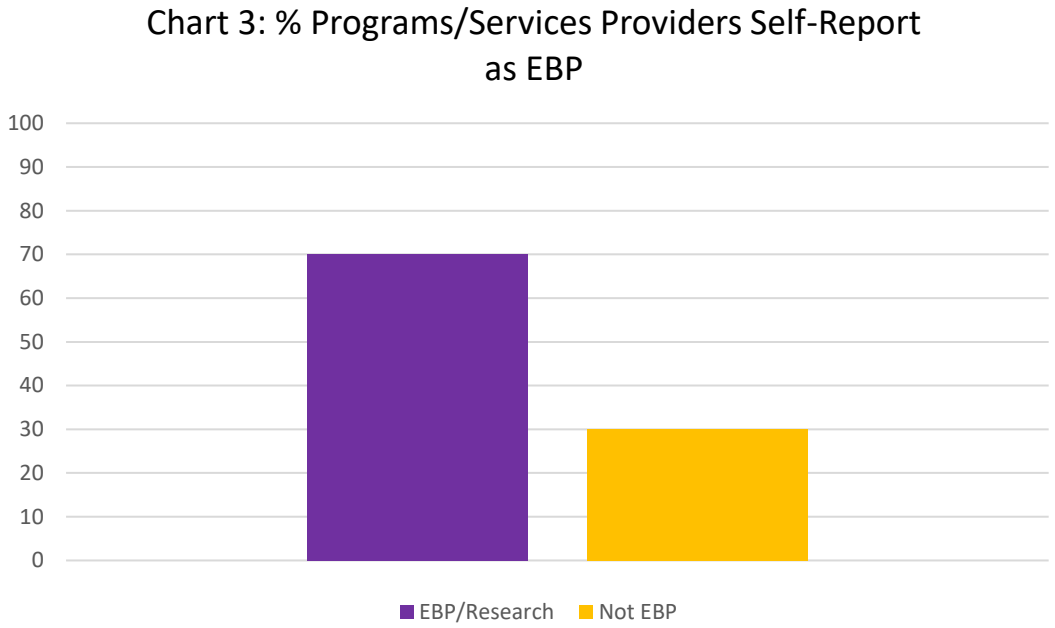
Respondents were asked to self-report, "In which parish(es) is/are your programs offered? (select all that apply)" (n=732)

As illustrated in **Chart 2**, providers responding to this survey self-reported that their **services were most frequently offered in Orleans, East Baton Rouge, Jefferson, and Caddo Parishes**. **Allen, Beauregard, Cameron, and Winn Parishes were reported least served**. This is consistent with Graph A (the map of all providers identified) suggesting that the survey respondents reflect a well distributed sample from the entire group of providers available.



Evidence-based and Research-based Practices

Survey participants were asked if their identified intervention(s)/service(s)/or practice(s) was/were grounded in research. Specifically, given definitions supplied in the survey**, respondents were questioned, "Is the intervention/service/practice model considered to be an evidence-based practice or research-based practice?" (n=773)



**An EBP is a program or practice that has had multiple site, randomized, controlled trials demonstrating that the program or practice is effective for specific populations. A research-based practice is one that has some published research, demonstrating effectiveness, but does not meet the higher empirical standard of an EBP.

Based on this study's sample of 782 programs and services described by providers, **just over two-thirds (70% / n=544) were self-reported as either evidence-based (n=462) or research-based (n=82) and that there exists external, nationally published research supporting usage**. **Chart 3** illustrates the division of those self-reporting their service as evidence-based or research-based and just under one-third (30% / n=189) describing themselves as neither.

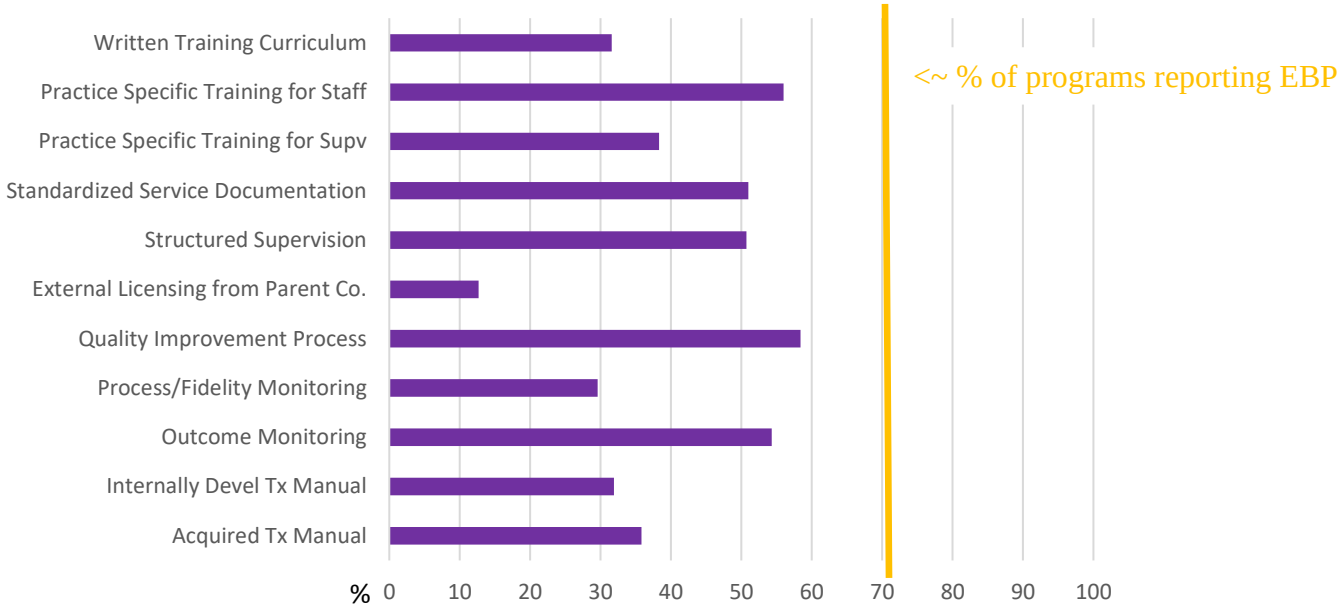
Qualities of Programs and Services

As a secondary measure, the survey asks a series of questions about certain components of programs and services common in evidence-based or promising behavioral health practices that have been disseminated nationally. This offers a confirmation of the likelihood of an accurate self-report of evidence-based or promising. Specifically, respondents were asked, "Does the intervention/service/practice being described include any of the following?" (select all that apply). The answer options were:

- Externally acquired treatment manual (i.e., replication of an existing model)
- Internally developed treatment manual
- Outcome monitoring
- Process monitoring method and/or fidelity tracking procedures
- Quality improvement process
- External licensing from parent company

- Routine structured supervision
- Standardized service delivery documentation procedures
- Specific training for practice supervisors
- Structured staff training on specific service/intervention methods
- Written/Standardized training curriculum

Chart 4: % Providers Self-Reporting Quality Components

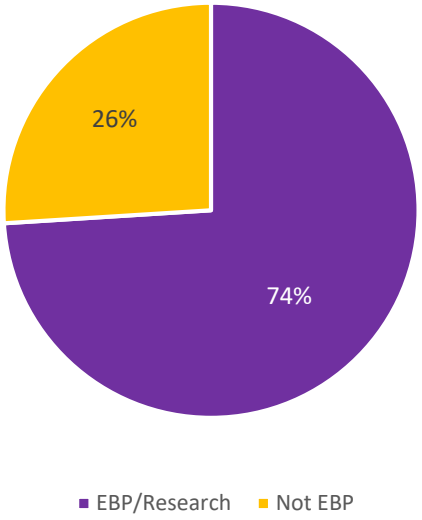


The proportion of providers (n=702) reporting using an externally acquired treatment manual (36%); practice specific training for staff (56%); fidelity monitoring processes (30%), etc. suggests that the number self-reporting to be an evidence-based or promising practice is inflated. (See **Chart 4.**)

Clinicians Trained and Delivering Services

Survey respondents were asked to report the number of staff/practitioners trained to deliver the intervention/service they were describing. Specifically, the survey asked, "What are the number of staff/practitioners trained to deliver the interventions/services?" (n=773)

Chart 5: % of Clinical Staff Using EBPs or Promising Practices



Of the 8,196 staff who were described as trained to provide the 782 services reported, **74%** (n=6,037) **staff were described to be delivering an evidence-based or research-driven or promising practice**. Additionally, providers were asked to identify the number of staff/practitioners providing service, but not yet fully-trained or certified to deliver the service/practice. **Providers reported 1297 (14% of the entire workforce described) staff/practitioners not fully-trained and providing services, and 1097 of those were associated with EBPs or research driven services (13% of the reported EBP workforce)**. See **Chart 5,** illustrating that **just over 1 in 4 staff may be delivering a service other than an EBP or promising practice**.

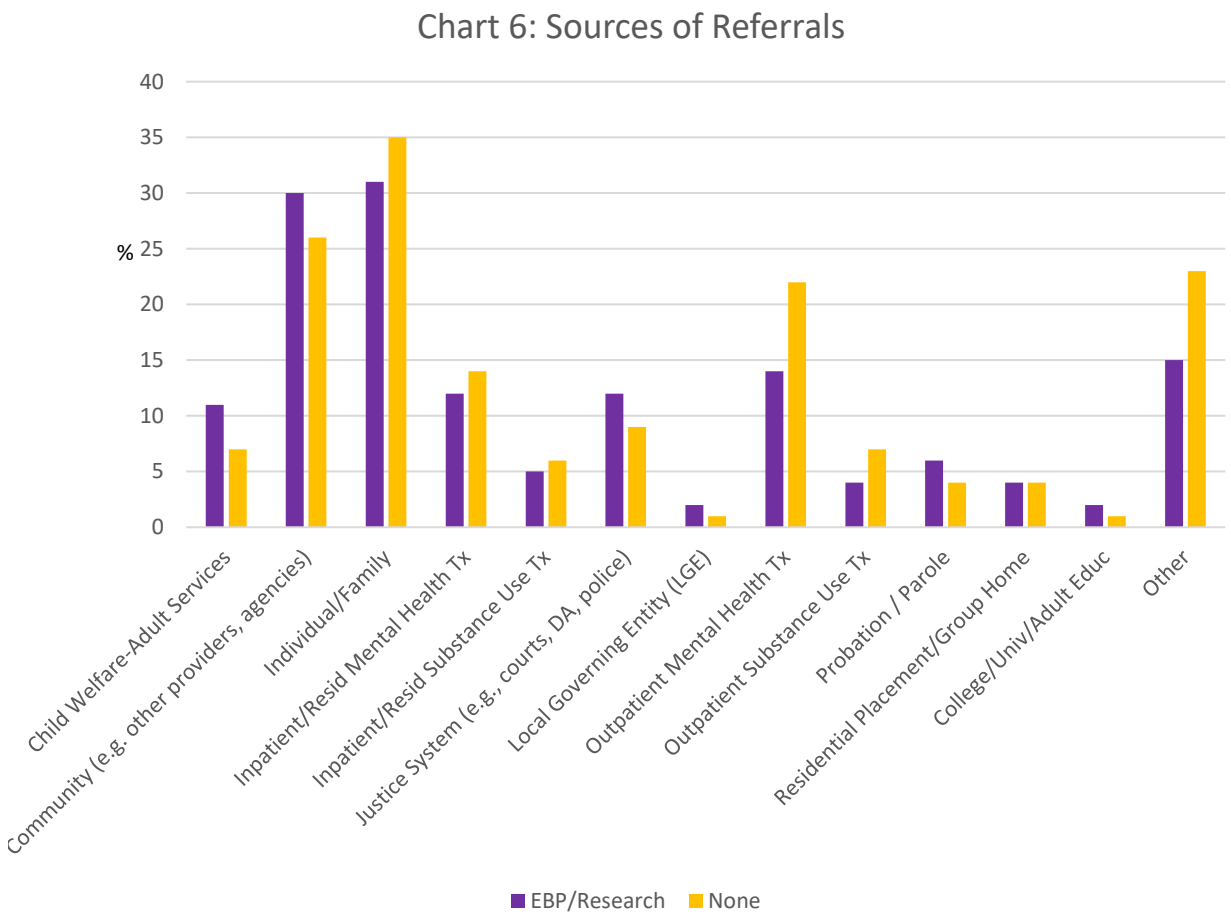
Organizations ranged in size from one to one-thousand and fifty-nine providers delivering these self-reported services. The **average team size was 8 providers**. Required education and/or training credentials of the providers delivering services was reported (n=604) as follows (providers could select all that applied):

Bachelor's Degree: 49%
Master's Degree: 86%
PhD/MD/Other Doctoral Degree: 34%
Specialty License: 53%
Certificate: 20%
No Degree or Specialty Required: 13%

Referral Sources

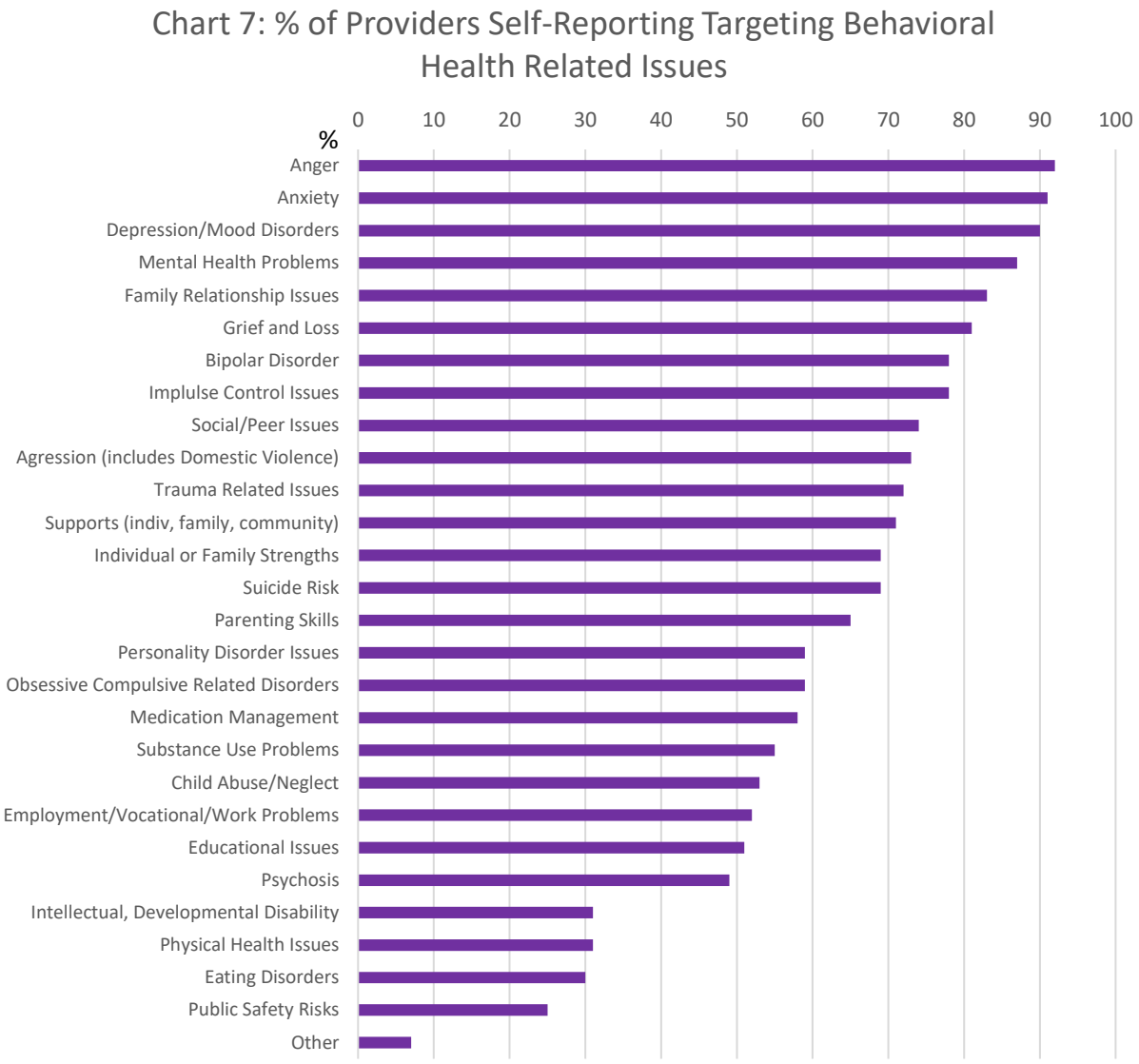
The survey asked providers to describe, "From what source do these services/interventions get their referrals? (select all that apply)" (n=773). The highest proportion of referrals reported by providers were from individuals/families (self-referrals), the community (e.g., other providers, churches, etc.), and outpatient mental health treatment centers. Other was also often clarified as doctors office or primary care physician, general hospital, colleagues, internet/website, insurance or MCO, wraparound, emergency room. When divided by whether the receiving service was an

evidence-based/research-based practice or not, **referrals from outpatient mental health treatment agencies and "other" were the least likely to receive an evidence-based or research-based practice. Most other referrals had almost an even likelihood of being referred to an evidence-based or research-based practice as compared to not**. (See **Chart 6**.)

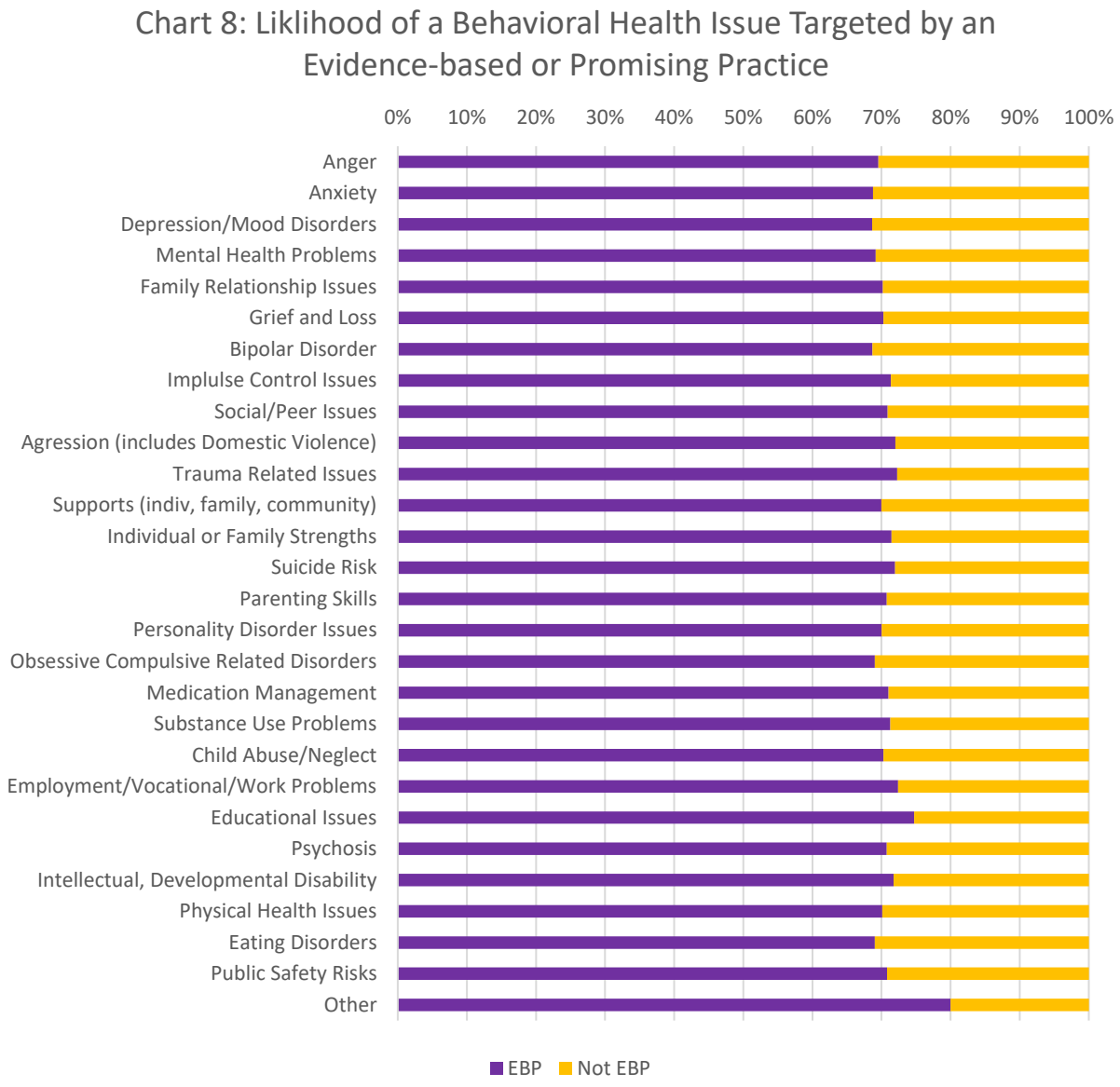


Interventions Targets / Populations of Focus

Providers were asked to describe the population their interventions serve. The first of several survey items was, "Describe what behavioral health related issues the service / intervention targets (check all that apply)." (n=146) As described in **Chart 7**, **anger, anxiety, depression, mental health problems, and family relationship issues were the most commonly targeted issues of providers' interventions**. Physical health, eating disorders, and public safety risk were the least targeted by the sample.



Further analysis of those same data against providers self-reporting as an evidence-based practice vs. those not describing themselves as evidence-based was completed. Chart 8 suggests that there was **about a two-thirds chance of most issues being targeted by interventions describing themselves as an evidence-based practice**. The number of EBPs was discussed earlier as over-reported, so it would be expected that **more than 1 out of every 3 clients would not have access to an EBP**. (See **Chart 8**)



Another survey question asked about the age of the population the programs/services were addressing. The survey asked providers to, "Describe the age range of those served (check all that apply)." (n=527) As described in **Chart 9**, on average, **providers were most likely to serve adults between the ages of 25 and 44 years of age. Thirty-nine percent also indicated serving these adult's children below the age of eighteen**. They were **least likely to report serving the 65 and older population**.

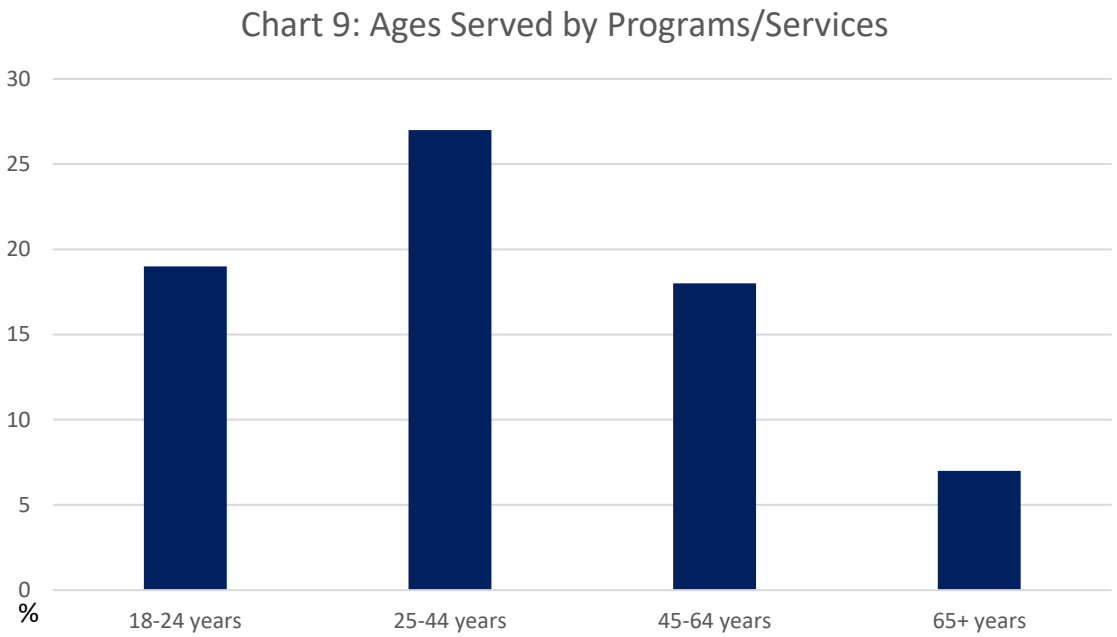
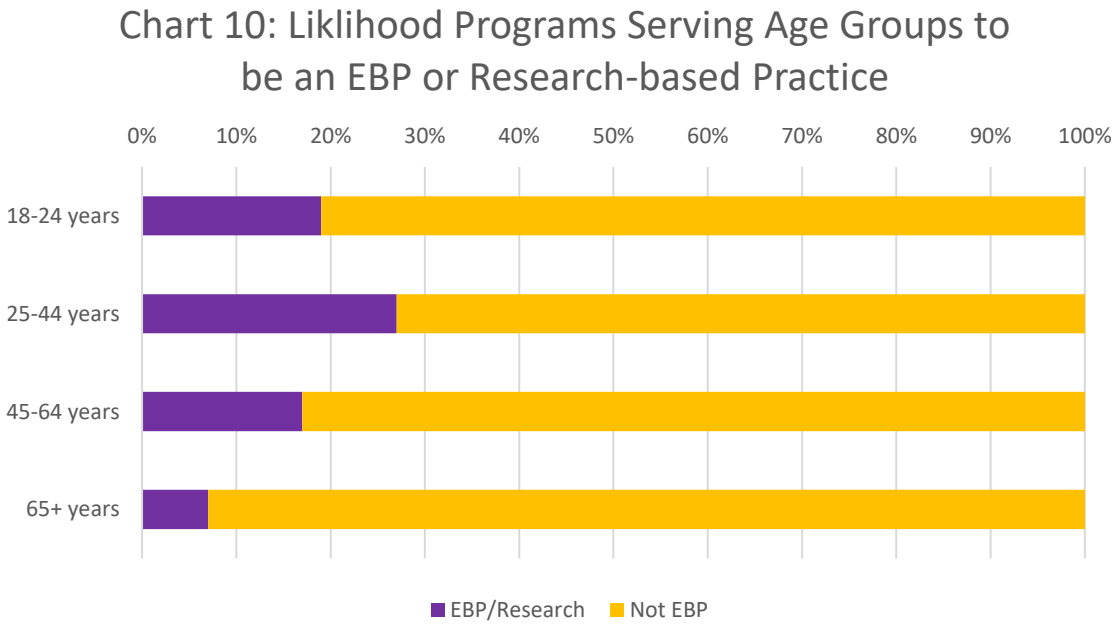
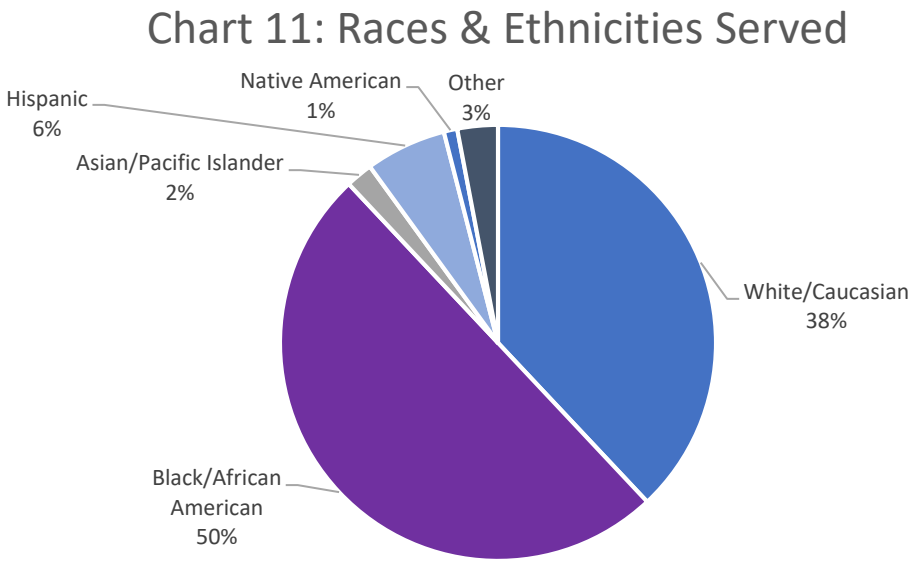


Chart 10 describes the **likelihood of the program or service being an evidence-based or research-based practice is highest for adults ages 25 to 44** and **least likely for those over 65.**

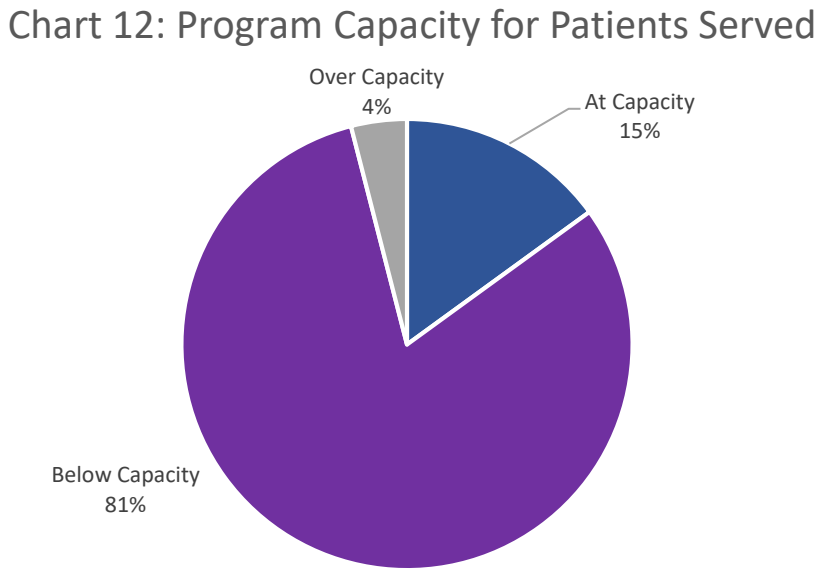


The Survey also asked about gender served by programs and services. There were slightly more women served than men. **Programs and services self-reported (n=517) serving about 55% female and 45% male populations**. Of those that described races/ethnicities served (n=508), providers reported serving **predominantly Black/African-American and White/Caucasian**

clients. **Chart 11** below gives a breakdown of the races/ethnicities providers described being served by their programs and services. Providers were also asked if they offered their program/service in a language other than English. One-hundred and forty-four (19%) providers, of the 773 survey respondents, reported yes, with Spanish being the other language by the vast majority.



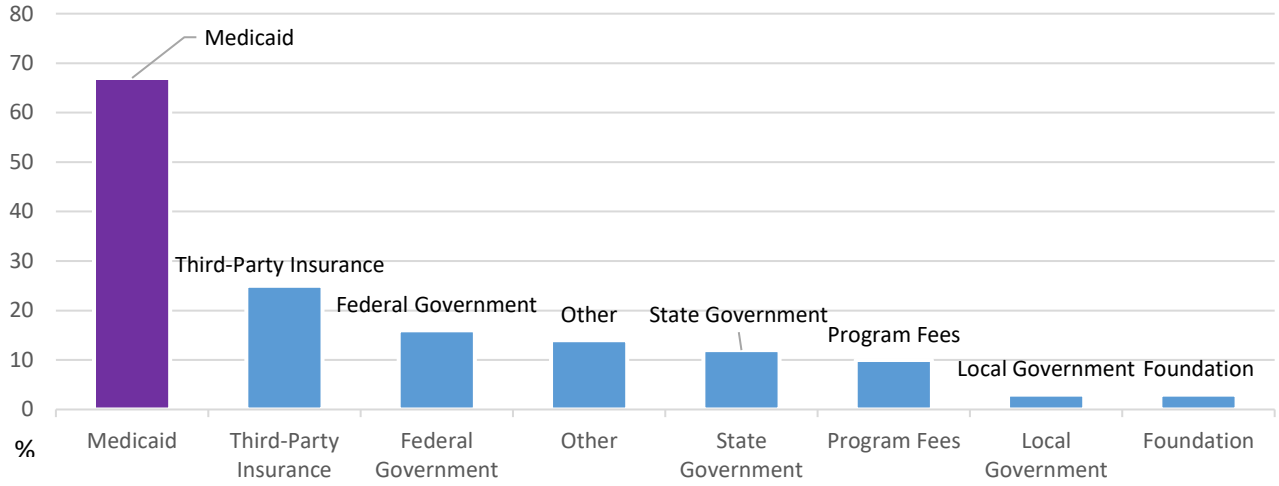
When asked about capacity (n=515), 15% of providers reported at that they were at capacity, **81% said they were operating below capacity**, and 4% believed they were over capacity. See Chart 12.



Program Funding

Survey respondents (n=456) were asked to describe the funding sources for their programs and services. **Chart 13** shows **programs rely on Medicaid for the majority of their funding**. Other, lesser, funding sources included third-party private insurance, as well as, federal and state government contracts and grants.

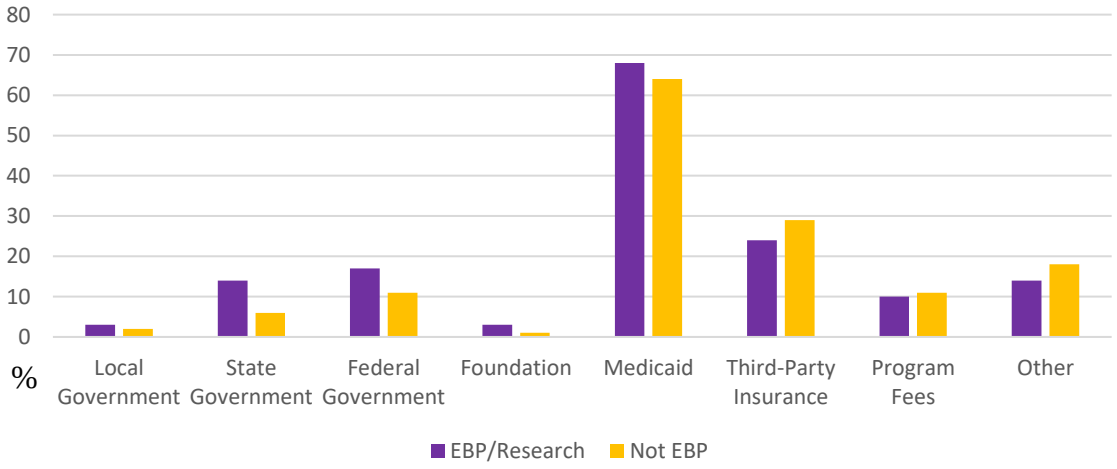
Chart 13: Program/Service Funding Sources



The **estimated average annual agency budget** self-reported (n=487) to provide the services and interventions described **was $984,387**.

The **likelihood of the service or intervention being an evidence-based or research-based practices did not appear to be impacted significantly by the funding source**. **The one exception being State Government contracts** that were proportionately more than twice as likely to be evidence- or research-based. (See **Chart 14**.)

Chart 14: Liklihood of EBP/Research-Based Practice by Funding Sources



Qualitative Findings

Providers were asked to give their perceptions in three areas. These included behavioral health priorities, policy issues, and service gaps.

The first question was **to rank order/prioritize gaps they perceive in services given a list of twenty behavioral health areas/issues**. They could also write in "other" suggestions. With three-hundred and thirty-five (n=342) providers responding to this survey question, **the following are the highest perceived gaps in order from highest to lowest**.

1. **Anger management**
2. **Family focused behavioral health services**
3. **Aggression (including domestic violence) prevention and intervention**
4. **Mental health wellness programming**
5. **Crisis interventions (including suicidal behaviors)**

Respondents were then asked, "**what state policies benefit your organizations ability to provide behavioral health services the most**?" (n=214) These open-ended responses were coded and categorized. The **top three response** areas were as follows:

1. **Medicaid expansion/ability to offer behavioral health services (n= 65)**
2. **Licensing (standards)/Uniform Regulations (including LDH, CARF, etc.) (n=37)**
3. **Increased community services/service types & policies (examples mentioned: Motivational Interviewing, peer support, crisis intervention, opioid treatment, Community Psychiatric Supports & Treatment (CPST), Psychosocial Rehab (PSR); school/home services) (n=34)**

Other responses included none/nothing (n=16); funding maintenance (n=6); all/everything (n=4); improved payment models (n=4); care coordination policies (n=2); rural health supportive policies (n=2); justice reinvestment program (n=2); Health Service Districts- noting access for indigent populations that would otherwise not be served (n=2); Erin's Law & Louisiana Children's Code (n=1); Federal government assistance (n=1); having only one MCO (n=1); allowing us to provide service, but getting credentialed and maintaining credentialing is an extensive, often horrible process. Same has been experience with state licensure and communication from the state. Providers are suffering which means clients suffer (n=1); Louisiana insurance mandate for ABA services for Autism (n=1); Louisiana Psychological Association (n=1); LSBME authorizing telepsychiatry; NOW waivers (n=1); Physician Emergency Commitment / PEC (n=1); supporting insurance carriers (n=1)

Next, the survey asked providers, "**If you could implement any behavioral health service to address what you perceive as the top need in your community, what would it be**?" (n=224) These open-ended responses were coded and categorized. The **top were**:

1. **Funding, including higher Medicaid reimbursement (n=37)**
2. **Only one MCO or Return to State Management (n=19)**
3. **Offer more services and maintain access (n=19)**

Other responses included state and MCOs need consistent rules (n=15)**;** clarify/streamline administrative policies (n=13); increase in the number of individual sessions and/or length of stay for out- and in-patient treatment (n=11); extending insurance coverage (n=10); improve social services (n=10); change limitations on clinical care staff/allow wider ability to contract (n=10); more community based family services (n=8); improve substance use (e.g., opioid) treatment support/reduce restrictions (n=7); include policies/regulations that include underserved communities (n=5); include provider input in policy making (n=4); improve crisis intervention services/supports (n=3); allow LPCs to bill Medicare (n=2); bill and receive payment for preventive and risk assessment services allowing early identification (n=1); allocate more DCFS workers to better respond to child abuse reports and provide more services for those families (n=1); allow same day billing for behavioral health services in RHCs and FQHCs (n=1); better access for all to receive benefits in mental health and medical health programs (n=1); better mental health education for all to decrease stigma for people with mental health issues, allowing for preventive measures, and better information for primary care providers to increase importance of getting assistance or preventing mental health issues (n=1); collaboration with the Department of Education for in-school services provided by non-licenses staff persons (n=1); eliminating the 60-day OTR requirement for clients receiving CPST/PSR services (n=1); enrollment process for MCOs needs to be quarterly instead of annually (n=1); expand healthcare payment assistance (n=1); have an LMHP on site 35 hrs per week (n=1); state should require all MCOs to credential newly licensed providers (n=1); always keep agencies abreast of new policies and procedures (n=1); knowledge of mental health (n=1); managed care (n=1); understanding of the importance of mental health assistance (n=1); reporting treatment compliance to the Social Security Administration for those who have mental health disabilities and receive SSI (n=1); stope insurance programs from interfering with treatment/medication decisions and availability of meds (prior authorizations) and other med denials (n=1)

The survey then asked providers, "**If you could implement any behavioral health service or practice to address what you perceive as a top need in your community, what would it be**?" (n=234) These open-ended responses were coded and categorized. The **top responses were**:

1. **Specific issue/condition treatment support (n=47)**
    a. Addiction / Substance use treatment (31)
    b. Anger management (5)
    c. Chronic mental illness support (4)
    d. Eating disorder support (3)
    e. Family violence resources (3)
    f. Autism services (1)
2. **Improved access (e.g., more providers, community programs, centers) (n=33)**
3. **Family focused/parenting support (n=27)**
4. **Social services (e.g., housing, life skill education) (n=23)**
5. **Trauma Prevention/Support (including homicide reduction) (n=18)**

Other responses included intensive youth services (n=13); better integration with somatic disease care (n=12); case management (n=7); dual diagnosis/co-occurring specific programming (n=3); group homes (n=3); medication management (n=3); mental health education (n=3); MCOs not

providing/covering services providers want (n=3); Cognitive Behavioral Therapy (n=2); Dialectical Behavioral Therapy (n=2); increased number of sessions (n=2); EMDR (n=1); increased funds for mental health services (n=1); CA service that is more culturally focused on populations we serve (n=1); adults ages 18-21 with mental disorders (n=1); enforce stricter regulations for delivery of behavioral health services, such as provider qualifications and fraud prevention (n=1); PTSD care (n=1); mandating the Medicaid insurance companies to authorize CPST and PSR units for outpatient care based on clinicians assessment and a doctor out of state who never met the member (n=1); intensive outpatient (n=1); mental health rapid entry (n=1); mental health services for adults (n=1); MHR (n=1); mobile crisis intervention (n=1); provision of outreach services (n=1); MST (n=1); overall mental health (n=1); prevention (n=1); psychological reports for Medicaid clients (n=1); requirement to attend treatment (n=1); change back to Magellan or a similar managed care agency for Medicaid (n=1).

Finally, the survey asked providers, "**If you could receive training in a specific practice to offer Medicaid clients, what would you like more training in?"** (n=205) These open-ended responses were coded and categorized. The **top responses were**:

1. **Trauma (including suicide risk/prevention, PTSD, and Crisis) (n=49)**
2. **Evidence-/Research-based practices (including ACT, MI, CBT, DBT, EMDR) (n=27)**
3. **Substance use (including MAT) (n=22)**
4. **Billing/Interaction with Medicaid (n=14)**
5. **Family and parent oriented therapies (n=10)**

Other responses included available resources for patients (n=9); job interviewing/training/skills (n=8); sexual perpetrator and victimization training (n=4); eating disorders (n=3); any type of training (n=3); mediation management (n=3); skills building (n=2); therapeutic relationship (n=2); don't want any more training/ adequately trained (n=3); play therapy (n=2); Trust-based Relational Intervention (TBRI) (n=1); wholistic approaches to care (n=1); anger management (n=1); stepping outside the box and learning the onset and triggers not only in families or individuals but as a whole community (n=1); chemical imbalances in the brain that offset triggers and are related to individuals acting out (n=1); autism (n=1); behavioral health (n=1); case management (n=1); co-occurring disorders (n=1); domestic violence (n=1); healthy relationships (n=1); influencing persons decisions to seek needed help (n=1); hypnosis (n=1); psychotherapy (n=1); independent living skills for adults (n=1); LGBT community (n=1); mental health(n=1); MHS and MHP need more hands on training available from the state (n=1); mindfulness curriculum (n=1); in-depth training for the clinicians who provide treatment for community members with mental health diagnoses (n=1); peer support (n=1); reaching more families through the use of technology (n=1); state required outpatient training for all administrators, owners, and licensed staff persons (n=1); stress and anxiety management specific to their stressors (community and financial problems) (n=1); transition care (n=1)

CONCLUSIONS

This survey of the adult behavioral health service providers of Louisiana was both successful and challenging. The largest challenges were acquiring and cleaning provider lists in order to establish an efficient way to contact providers (i.e., via email). Based on the final list of providers, it is apparent that several areas of Louisiana may be underserved, particularly rural areas. There are areas of central and south Louisiana that appear to have few reported service providers within an accessible fifteen or thirty mile radius (see Graphs A & B). Thirty-four percent of Louisiana's identified adult providers successfully responded to the survey. Several lessons were learned, conclusions drawn, and recommendations made for future behavioral health practices. These are summarized below.

Available Medicaid mental health diagnosis data for adults served in Louisiana in 2017 were coupled with regional U.S. census data to provide a view of the mental health burden throughout the state. For instance, according to the DSM-5 and the National Institute of Mental Health, the prevalence of Schizophrenia and other Psychotic Disorders nationally, is as high as 0.7%. Louisiana Medicaid diagnosis data reflects a higher prevalence for this category of diagnoses, with a median of 1.54% (see Table 1). Conversely, Louisiana's prevalence rates for all other categories are lower when compared to U.S. population prevalence. Prevalence varies by regions with some regions much more impacted than others. As for the overall prevalence being lower than national averages for most categories, this could be interpreted several ways. Medicaid may not be effectively reaching certain mentally ill populations, diagnoses may not be accurately assessed, and/or some diagnoses, like personality disorders, might rarely meet criteria for a primary diagnosis to warrant coverage. These possibilities would need to be further researched for clearer answers.

Providers responding to this survey were primarily from outpatient mental health and outpatient substance use treatment centers throughout Louisiana (see Charts 1 & 2). Over two-thirds of providers self-reported using an evidence-based or researched-based practice with external, nationally published research supporting utilization (see Chart 3). However, this is likely to be an inflated self-assessment as many of the programs (ranging from 13% to 58% depending on item) failed to describe using key components of research driven practices (see Chart 4). This may suggest quality improvement areas for Louisiana's behavioral health service providers. Areas of improvement that could be targeted include external licensing, training, supervision, documentation, fidelity monitoring, outcome monitoring, and using or developing treatment manuals.

In regards to the workforce delivering services, just over a quarter could be targeted to change their service provisions to those that are more research driven (see Chart 5). Given that the majority of the staff are reported to possess Master's degrees, and most frequently report working in teams of eight providers, several adult and family EBPs could be implemented. These EBPs could target the areas with the least likelihood of a referral receiving an EBP, such as outpatient mental health agencies (see Chart 6). Also, given the national prevalence of substance use disorders (8.5%), the low clinical identification (3.3% to 4.6%) among Louisiana adults accessing Medicaid services, and the number of providers indicating they are providing substance use treatment, this could be an area for workforce capacity development. Finally, providers were also least likely to report

serving adults 45 and over with quality behavioral health services (see Charts 9 & 10), thus developing the workforce to address this older population's needs could address a gap in Louisiana services.

Given both the quantitative and qualitative responses to the survey, providers appear to be heavily reliant on Medicaid funding (see Chart 13). Many agencies are reporting relying on Medicaid for 100% of their behavioral health service funding. These programs were equally as likely to self-reported as an evidence-based or research-based practice as they were to be neither (see Chart 14). This offers a targeted group of providers that may have the capacity to further develop EBPs, as well as a group that may benefit from assistance developing the business practices necessary to sustain EBPs under Medicaid funding. Several key informant discussions with providers also suggests that further development is needed to merge EBP and Medicaid business models. Many EBPs are short-term, intense interventions, while traditional Medicaid approaches rely on frequent, long-term contact with the populations served. Finding ways to incentivize the use of EBPs without needing to transition to longer term Medicaid supported care may be key to improving the likelihood of positive outcomes for many populations while also lowering overall system cost.