FY 2018-2019
Combined Behavioral Health Assessment and Plan

Community Mental Health Services
and Substance Abuse
Prevention and Treatment
Block Grants

Louisiana Department of Health

Office of Behavioral Health

September 1, 2017

LOUISIANA DEPARTMENT OF HEALTH

Contents

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<Insert signed agreements.>

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations

Overview of the Louisiana Behavioral Health System

The Office of Behavioral Health (OBH) is the state program office within the Louisiana Department of Health (LDH) responsible for managing the delivery of services and supports necessary to improve the quality of life for citizens with mental illness and substance use or addictive disorders. OBH was created by Act 384 of the 2009 Legislative Session which directed the consolidation of the offices of addictive disorders and mental health into the Office of Behavioral Health effective July 1, 2010, in order to streamline services and better address the needs of people with co-occurring mental illness and addictive disorders. The Department's work in implementing Act 384 was guided by stakeholders and leaders in the behavioral health field from across Louisiana who participated in the Office of Behavioral Health Implementation Advisory Committee.

The mission of OBH is to work collaboratively with partners to develop and implement a comprehensive integrated system of behavioral health and healthcare, social support, and prevention services that promote recovery and resilience for all citizens of Louisiana. OBH assures public behavioral health services are accessible, family-driven, have a positive impact, are culturally and clinically competent, and are delivered in partnership with all stakeholders.

The following tables provide additional budgetary information, including a breakdown of federal funding for behavioral health services.

OFFICE OF BEHAVIORAL HEALTH APPROPRIATION FOR FY 15-16		
BUDGET SUB-ITEM	**TOTAL(S)**	**% of TOTAL**
Community Budget		
Central Office	$30,942,746	13.9%
Community Social Service Contracts	$36,613,756	16.5%
Community Total	**$67,556,502**	**30.4%**
Hospital Budget		
Central Louisiana State Hospital	$33,735,631	15.2%
Eastern Louisiana Mental Health System	$113,848,285	51.2%
Hospital Total	**$147,583,916**	**66.4%**
State Office		
Administration	$7,074,407	3.2%
State Office Total	**$7,074,407**	**3.2 %**
Auxiliary		
Auxiliary	$20,000	0.009%
Auxiliary Total	**$20,000**	**0.009%**
TOTAL	**$272,688,314**	**100%**

Hospital System	FY 2016
Total Adult/Child State Hospital Beds (a)	695
State General Funds ($)	83,976,829
Federal Funds ($)	61,426,541

Community System	FY 2016
State General Funds ($)	15,772,623
Federal Funds ($)	35,300,376
Community Behavioral Health Contract	
State General Funds ($)	7,019,794
Federal Funds ($)	5,596,181

OBH Authorized Table of Organization (T.O.) Personnel Positions						
Office of Behavioral Health	**FY 2015 T.O.**	**Changes**	**FY 2016 T.O.**		**FY 2016**	
					Classified	**Unclassified**
Administration						
Administration	41	0	41		39	2
TOTAL – Administration	41	0	41		39	2
Community						
Central Office	31	10	41		41	0
TOTAL – Community	31	10	41		41	0
Hospitals						
Central Louisiana State Hospital	288	13	275		272	3
Eastern Louisiana Mental Health System	991	18	973		966	7
TOTAL – Hospitals	1,279	-31	1,248		1,238	10
TOTAL – OBH	1,351	-21	1,330		1,379	12

OBH is committed to the efficient and effective use of the state's scarce behavioral health resources to adequately provide for the peace, health, safety, and general welfare of the public, by ensuring:

- Accountability of efficient and effective services through quality and performance measures, statewide standards for monitoring quality of service and performance, and reporting of quality of service and performance information.
- Creation and implementation of minimum service delivery standards.
- Coordination of integration of behavioral health and primary healthcare and continued collaboration with agency contract providers, advocacy groups, Local Governing Entities, regional support networks, and public and private agencies in order to reduce duplication in service

delivery and promote complementary services among all entities that provide behavioral health services to adults and children throughout the state.

- Implementation of a system of reimbursement by the Medical Assistance Program to private hospitals and to state hospitals for covered Medicaid services that, to the extent possible, allocates funding in the areas of the state based on needs, population, and acuity level.
- Performance monitoring and evaluation regarding the effectiveness of services being provided and achievement of outcome measures

The transformational priorities for the agency, which reflect the agency's mission and vision and carry the highest potential impact, are:

Reorganization of Business Operations

OBH has experienced several significant transitions, including a merger of mental health and addictive disorders offices, delivery of services through a managed care model, and integration of behavioral health services into Healthy Louisiana. A review of agency functions is necessary to maximize efficiencies and promote coordination among LDH offices. OBH management, with LDH guidance, will consider reorganization of agency functions and structure to expand services as outlined in the priorities and to accommodate quality monitoring and collaboration with Medicaid integration and expansion.

Access to Behavioral Health Services

OBH will lead efforts to increase access to behavioral health services by promoting early identification of behavioral health concerns, especially through leveraging integration to help physicians and behavioral health specialists collaborate to identify and treat behavioral health concerns (inclusive of trauma exposure) at the earliest opportunity. Strategies may include supporting primary care physicians through behavioral health consultation, as well as increasing access to high-quality evidence-based behavioral therapies for young children.

Additional strategies employed to address the increased volume on the behavioral health system anticipated under Medicaid Expansion will be the integration of Peer Support throughout the system of care. The use of trained, credentialed peers is a critical component to a recovery-oriented system of care and results in improvements in client engagement, treatment outcomes, and recovery. As an enhancement to traditional treatment services, peer support services allow for more effective and targeted interventions resulting in improved care and an increased capacity of the system to serve a broader array of individuals.

To increase access to effective behavioral health supports and services, OBH will work with Medicaid, public and private universities and medical schools, providers, and Healthy Louisiana managed care partners to implement strategies to retain and increase the behavioral health workforce. Workforce development efforts will include training and support for providers of evidence-based therapies addressing issues emerging in early childhood, trauma exposure, and other psychiatric and addictive service needs. OBH will lead efforts to provide training and support for providers of peer recovery supports, including mentoring and coaching opportunities. Expanding the workforce of providers of behavioral healthcare may also include further utilization of provider types such as psychiatric residents, provisionally licensed social workers, licensed professional counselors, licensed marriage and family therapists, certified addiction specialists and licensed prevention professionals.

Outcomes-Based Behavioral Healthcare

OBH will lead efforts to increase the use of outcomes measurement in the provision and decision-making around behavioral health services. Quality assessment and monitoring is necessary to ensure that these services are providing a good value to the state in terms of improving key outcomes and quality of life for Louisianans.

OBH will support PRTF providers to move toward measuring and improving the value of their services, by using data-driven decision making in their daily operations, and embracing best practice models inclusive of trauma-informed care to produce long term, sustainable outcomes for youth and families.

Substance Use Disorder System Enhancements

OBH recognizes the impact of Substance Use Disorders (SUDs) on Louisiana's individuals, families, and communities, and strives to enhance policies, regulations and protocols to reduce the prevalence of SUDs. OBH will focus on several priority areas to achieve this goal. These include enhancement of Medication Assisted Treatment (MAT) services, treatment capacity for pregnant women, reduction of prescription drug/opioid overdose-related deaths, increased use of early Screening, Brief Interventions and Referral to Treatment (SBIRT) including pregnant women, and development of residential treatment programs for pregnant women and children at risk of Neonatal Abstinence Syndrome (NAS).

Inpatient Psychiatric Hospital Needs

An ongoing priority of OBH will be to increase communication with the courts, the Department of Corrections (DOC), and the Office of Juvenile Justice (OJJ) regarding the services provided by OBH and Medicaid managed care. OBH will promote certification in Juvenile Competency Restoration to increase the number of providers across the state and continue oversight of the provision of competency restoration services.

OBH will increase collaboration with the DOC to provide services to reduce recidivism and to monitor compliance of consent decree requirements. This includes determining if patients were evaluated in a timely manner, received twice weekly competency restoration sessions while in jail, and were placed within the established guidelines. Through collaboration with the staff at Eastern Louisiana Mental Health System (ELMHS), compliance with the consent decree rules will be improved.

OBH is committed to providing access to treatment in the least restrictive and least costly setting possible for all clients, and optimizing clients to flow throughout the system, as each moves toward recovery in their own homes and communities, whenever possible. ELMHS and Central Louisiana State Hospital (CLSH) currently maintain 100% utilization of existing bed space; OBH will pursue strategic and financially feasible measures to provide necessary inpatient, jail-based, and community resources in order to accommodate the increasing forensic population. These measures may include partnerships with Cooperative Endeavor Agreement (CEA) hospitals to provide services to civil clients, and increasing resources in order to accommodate jail-based competency restoration in lieu of hospital restoration in the regional areas and parishes that have the highest number of referrals.

Pursuing a culture of wellness for Louisiana citizens

Integrated physical and behavioral healthcare is one strategy in moving toward comprehensive wellness. OBH identifies with the SAMHSA eight dimensions of wellness, described as emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual. OBH will lead efforts to address these elements in designing and implementing wellness activities.

For additional information on the populations and criteria specific to the CMHS and SAPT Block Grants, please refer to the following Environmental Factors and Plan sections:

- Primary Prevention on page 81,
- Community Mental Health Services on page 95, and
- Substance Use Disorder Treatment on page 107.

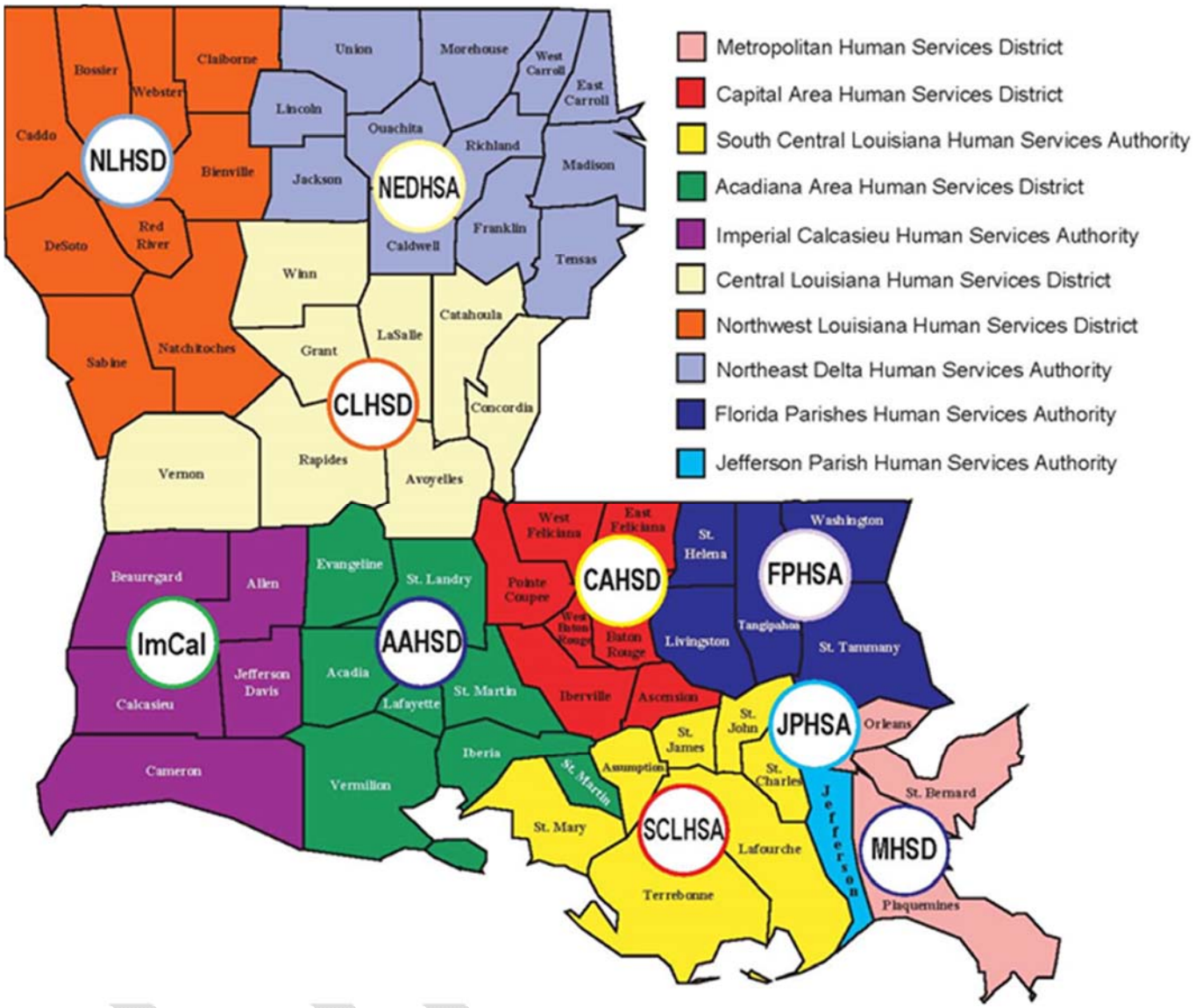
Local Governing Entities

In June of 2014, the Office of Behavioral Health (OBH) completed its portion of a legislative mandate for the Louisiana Department of Health (LDH) to transition Louisiana's mental health, substance-related and addictive disorder, and developmental disability healthcare system from a centrally controlled set of regions to a system of independent healthcare districts or locally controlled authorities. ACT 373, passed during the 2008 Louisiana Legislative Session, required all OBH regions to convert to Local Governing Entities (LGEs). The LGEs were required to complete a readiness criteria process that demonstrated their capability to assume the responsibility for high-quality service delivery and good governance. This process included the establishment of local governing boards that provided ongoing support and advice, while serving as vehicles for community coordination. Members of the governing boards are appointed by the governor, and the bylaws require that membership is reflective of the population of the region.

These LGEs, classified as either a district or authority, have a contractual agreement with LDH. The LGEs are local umbrella agencies that administer the state-funded mental health, substance-related and addictive disorder, and developmental disability services in an integrated system within their localities. Since it is based on local control and authority, the LGE model affords opportunity for greater accountability and responsiveness to local communities. Each LGE is administered by an executive director who reports to a local governing board of directors of community and consumer volunteers. All LGEs remain part of the LDH departmental organizational structure, but not in a direct reporting line with OBH.

With the transition to LGEs and managed care, the role of OBH has changed from direct operational service delivery to one of providing resources and assistance that enable the LGEs to carry out service delivery. OBH is also responsible for providing assistance in setting policy, establishing minimum standards for the operation of the service system, establishing reasonable expectations for service utilization and outcomes, and developing statewide mechanisms for measuring these outcomes. OBH ensures that the LGE service system is well coordinated with those services that continue to be operated by the State (primarily the state-operated psychiatric hospitals). In addition, OBH continues to provide technical assistance and guidance to the LGEs to ensure federal Block Grant requirements are met. LGEs must maintain Regional Advisory Councils (RACs), officially linked to the State Behavioral Health Advisory Council, in order to qualify to receive Block Grant funding. To assist the reader in understanding the state behavioral health care system, the next table includes a description of each LGE and its service area. A map is also provided.

Local Governing Entity	Parishes
Metropolitan Human Services District: MHSD is composed of the New Orleans metropolitan area and two civil parishes to the south of Orleans Parish.	Orleans, Plaquemines, St. Bernard
Capital Area Human Services District: CAHSD encompasses the Baton Rouge metropolitan area and six surrounding parishes.	Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, West Feliciana
South Central Louisiana Human Services Authority: SCLHSA includes seven parishes in the bayou country of coastal Louisiana with Houma as the regional hub.	Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne
Acadiana Area Human Services District: AAHSD is composed of seven parishes in the Acadiana area with Lafayette serving as the regional hub.	Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermillion
Imperial Calcasieu Human Services Authority: ImCal encompasses five southwestern parishes, including coastal Cameron. Lake Charles is the hub of this region.	Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis
Central Louisiana Human Services District: CLHSD contains eight central Louisiana parishes that border Mississippi to the east and Texas on the west. With the exception of Rapides, this Region is very rural in nature. Alexandria is the regional hub.	Avoyelles, Concordia, Catahoula, Grant, LaSalle, Rapides, Vernon, Winn
Northwest Louisiana Human Services District: NLHSD comprises the predominantly rural northwestern area of the state, including nine parishes. Shreveport-Bossier City is the major metropolitan complex. This is an agricultural area but it contains most of the state's heavy manufacturing business.	Bienville, Bossier, Caddo, Claiborne, Desoto, Natchitoches, Red River, Sabine, Webster
Northeast Delta Human Services Authority: NEDHSA comprises the northeastern corner of the state, known as the Delta region. Monroe is the hub of this region, which encompasses 12 parishes, most of which are the poorest in the state in per capita income. This region is dominated by agriculture and light industry.	Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, West Carroll
Florida Parishes Human Services Authority: FPHSA is composed of the five parishes in the Florida Parishes area. This area borders Mississippi on the north and east, with Lakes Pontchartrain and Borgne to the south.	Livingston, St. Helena, St. Tammany, Tangipahoa, Washington
Jefferson Parish Human Services Authority: JPHSA is composed of the single parish of Jefferson, with the city of Metairie as its hub. The southernmost part of this parish is costal marsh while the populated area between Lake Pontchartrain and the Mississippi River is highly urban.	Jefferson



Managed Care for the Medicaid population

LDH transitioned delivery of Medicaid services from a fee-for-service model to a managed care model, previously known as Bayou Health and currently known as Healthy Louisiana, in March 2012, via contracts with five managed care organizations (MCOs) to provide physical health and basic behavioral health services. The Louisiana Behavioral Health Partnership (LBHP), also implemented in March 2012, was a system of care designed to transform the delivery of and payment for specialized behavioral health services for Medicaid and non-Medicaid adults and children who required specialized behavioral health services, including those children who are at risk for out of home placement. LDH contracted with a Statewide Management Organization (SMO) to operate the LBHP with the primary goal of improving coordination of services, quality of care, and outcomes. The LBHP served the needs of individuals who comprised one of the following target populations:

1. Children with extensive behavioral health needs either in or at-risk of out-of-home placement

2. Medicaid-eligible children with medically necessary behavioral health needs who need coordinated care
3. Adults with severe mental illness and/or addictive disorders who are Medicaid eligible
4. Non-Medicaid children and adults who have severe mental illness and/or addictive disorders

Through better coordination of services, the LBHP enhanced the consumer experience, increased access to a more complete and effective array of behavioral health services and supports, improved quality of care and outcomes, and reduced repeat emergency room visits, hospitalizations, out-of-home placements, and other institutionalizations. The LBHP expanded access to providers (increase from 800 to more than 1,800 providers) and there was an 87 percent increase in available inpatient beds. Of the more than 1,800 providers, 65 were state-supported clinics operated by the LGEs. Included in those 65 clinics were 13 are mental health clinics, 11 addictive disorders clinics, and 39 integrated behavioral health clinics providing both mental health and substance use services, and two included integrated behavioral health and primary care clinics.

To continue the significant benefits experienced as a result of development of the managed care delivery system for behavioral health care through the LBHP, LDH developed partnerships with private sector providers to target improved models of care focused on smaller residential settings to deemphasize the role of large, state-run institutions. Residential treatment facilities were developed for adolescents to provide intensive evidence-based treatment in smaller, more homelike settings.

The Office of Behavioral Health and Medicaid worked collaboratively to integrate specialized behavioral health services, previously provided separately by the LBHP, into the benefits coordinated by the Healthy Louisiana plans on December 1, 2015. Children with extensive behavioral health needs either in or at risk of out-of-home placement remain managed by the SMO. Integration of behavioral health care services into the Healthy Louisiana program is designed to improve care coordination for enrollees, provide more opportunities for seamless and real-time case management of health services, and better transitioning and use of all resources provided by the system. Calendar year 2016 established baseline quality indicators of behavioral health services based on Healthcare Effectiveness Data and Information Set (HEDIS) specifications.

Medicaid coverage was expanded under the Affordable Care Act on July 1, 2016, and was made available to more than 400,000 Louisianans ages 19 to 64. Within a year, more than 23,000 adults in the Medicaid expansion group received specialized outpatient mental health services and more than 4,500 received inpatient mental health services at a psychiatric facility. Additionally, more than 4,900 adults received specialized substance use outpatient services and more than 5, 300 adults received specialized substance use residential services.

The following table lists the state-supported clinics and their current capacity to provide mental health services, addictive disorders services or both (BH=Behavioral Health, AD = Addiction, MH = Mental Health).

LGE	Clinic	Type	Address	City
MHSD	Algiers Behavioral Health Center	BH	3100 General DE Gaulle Drive	New Orleans
	Central City Behavioral Health Center	BH	2221 Phillip Street	New Orleans
	Chartres-Pontchartrain Behavioral Health Center	BH	719 Elysian Fields Avenue	New Orleans
	New Orleans East Behavioral Health Center	BH	5640 Read Boulevard, 2nd Floor	New Orleans
	Plaquemines Behavioral Health Center	BH	103 Avenue A, Suite A	Belle Chasse
	St. Bernard Behavioral Health Center	BH	6624 St. Claude Avenue	Arabi
CAHSD	Center for Adult Behavioral Health	BH	4615 Government Street, Bldg. 2	Baton Rouge
	Children's Behavioral Health Services	BH	4615 Government Street, Bldg. 1	Baton Rouge
	Donaldsonville Mental Health Center	MH	901 Catalpa Street	Donaldsonville
	East Feliciana Satellite Clinic	BH	12080 Marston Street	Clinton
	Gonzales Mental Health Center	MH	1112 S.E. Ascension Complex Blvd.	Gonzales
	Iberville Parish Satellite Clinic	MH	24705 Plaza Drive	Plaquemine
	Margaret Dumas Mental Health Center	MH	3843 Harding Boulevard	Baton Rouge
	Pointe Coupee Parish Satellite Clinic	MH	282-A Hospital Road	New Roads
	West Baton Rouge Parish Satellite Clinic	MH	685 Louisiana Avenue	Port Allen
	West Feliciana Satellite Clinic	MH	5154 Burnett Road	St. Francisville
SCLHSA	Lafourche Treatment Center	BH	157 Twin Oaks Drive	Raceland
	River Parishes Treatment Center	BH	1809 West Airline Highway	LaPlace
	River Parishes Assessment/Child & Adolescent Treatment Center	BH	421 Airline Highway, Suite L	LaPlace
	St. Mary Behavioral Health Center	BH	500 Roderick Street, Suite B	Morgan City
	Terrebonne Behavioral Health Center	BH	5599 Highway 311	Houma
AAHSD	Crowley Behavioral Health Clinic	BH	1822 West 2nd Street	Crowley
	Dr. Joseph Henry Tyler, Jr. Behavioral Health Clinic	BH	302 Dulles Drive	Lafayette
	New Iberia Behavioral Health Clinic	BH	611 West Admiral Doyle Drive	New Iberia
	Opelousas Behavioral Health Clinic	BH	220 South Market Street	Opelousas
	Ville Platte Behavioral Health Clinic	BH	312 Court Street	Ville Platte
IMCAL	Allen Parish Behavioral Health Clinic	BH	402 Industrial Drive	Oberlin
	Beauregard Behavioral Health Clinic	BH	106 Port Street	DeRidder
	Jennings Outreach	BH	915 West Shankland	Jennings
	Lake Charles Behavioral Health Clinic	BH	4105 Kirkman Street	Lake Charles
CLHSD	Avoyelles Addictive Disorders Clinic	AD	114 N. Main St	Marksville
	Caring Choices Marksville	MH	694 Government Street	Marksville
	Caring Choices Pineville	BH	242 Shamrock Street	Pineville
	Grant Addictive Disorders Clinic	AD	211 Main Street	Colfax
	Jonesville Addictive Disorders Clinic	AD	308 Nasif Street	Jonesville
	Caring Choices Jonesville	MH	308 Nasif Street	Jonesville
	Leesville Mental Health Clinic	MH	105 Belview Road	Leesville
	Vernon Addictive Disorders Clinic	AD	408 West Fertitta Blvd, Suite E	Leesville
	Winn Addictive Disorders Clinic	AD	301 West Main Street, Suite 202-B	Winnfield
NLHSD	Mansfield Behavioral Health Clinic	BH	501 Louisiana Avenue	Mansfield
	Many Behavioral Health Clinic	BH	265 Highland Drive	Many
	Minden Behavioral Health Clinic	BH	435 Homer Road	Minden
	Natchitoches Behavioral Health Clinic	BH	210 Medical Drive	Natchitoches
	Red River Behavioral Health Clinic	BH	1313 Ringgold Avenue	Coushatta
	Shreveport Behavioral Health Clinic	BH	1310 North Hearne Avenue	Shreveport

LGE	Clinic	Type	Address	City
NEDHSA	Bastrop Behavioral Health Clinic	BH	320 South Franklin	Bastrop
	Columbia Behavioral Health Clinic	BH	5159 Highway 4 East	Columbia
	Jonesboro Behavioral Health Clinic	BH	4134 Highway 4 East	Jonesboro
	Monroe Addictive Disorders Clinic	AD	3200 Concordia Street	Monroe
	Monroe Behavioral Health Clinic	BH	4800 South Grand Street	Monroe
	Northeast Louisiana Substance Abuse/Oak Grove	AD	Oak Grove Courthouse	Oak Grove
	Northeast Louisiana Substance Abuse/Rayville	AD	112 Morgan Street	Rayville
	Northeast Louisiana Substance Abuse/Winnsboro	AD	6564 Main Street	Winnsboro
	Ruston Behavioral Health Clinic	BH	602 East Georgia Avenue	Ruston
	Tallulah Mental Health Center	MH	1012 Johnson Street	Tallulah
	Winnsboro Behavioral Health Clinic	BH	1301 B Landis Street	Winnsboro
FPHSA	Bogalusa Behavioral Health Center	BH	619 Willis Avenue	Bogalusa
	Florida Parishes Human Services Authority Denham Springs	BH	1920 Florida Avenue SW	Denham Springs
	Hammond Addictive Disorders Clinic	AD	835 Pride Drive, Suite B	Hammond
	Lurline Smith Mental Health Center/Northlake Addictive Disorders Clinic	AD	900 Wilkinson Street	Mandeville
	Rosenblum Mental Health Center (Adult Services)	MH	835 Pride Drive, Ste. B	Hammond
	Rosenblum Mental Health Center (Child Services)	MH	15785 Medical Arts Plaza	Hammond
	Slidell Addictive Disorders Clinic	AD	2331 Carey Street	Slidell
	Washington Parish Behavioral Health Clinic	BH	619 Willis Avenue	Bogalusa
JPHSA	JeffCare East Jefferson Health Center	BH/PC	3616 South I-10 Service Road West, Suite 100	Metairie
	JeffCare West Jefferson Health Center	BH/PC	5001 West Bank Expressway, Suite 100	Marrero

OBH retains responsibility for establishing certification requirements for individuals, programs and agencies providing behavioral health services within Louisiana. OBH continues to certify new organizational providers and individual practitioners. OBH also recertifies providers annually in an effort to ensure and maintain clinically competent, qualified providers in the managed care provider network. Providers are required to credential through the managed care entity prior to contracting and are re-credentialed periodically as established by accreditation standards. The managed care entity provides initial and ongoing training to its providers about their infrastructure and operational requirements to assure readiness and success working within a managed care system.

Assessment of Strengths and Needs

During the planning process, OBH identified several items as strengths and needs of the behavioral health system.

Strengths

- High Coverage for Children in Medicaid
- Criminal justice – OBH is working with DOC to provide workshops for reentry on available M/SUD services, including education on opioids.
- Medication Assisted Treatment (MAT) for Pregnant Women Initiative – OBH received technical assistance from SAMHSA and successfully developed a pregnancy toolkit for physicians.
- Statewide survey of evidence-based practices (EBPs) – LSUHSC, School of Public Health is conducting a statewide survey of the current provision of, and additional need for, evidence-based practices (EBPs) in the behavioral health service system. OBH will use the results of this

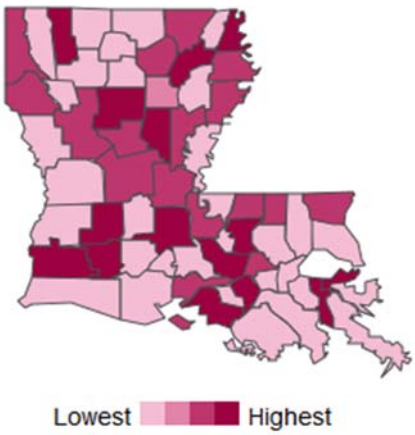
work to plan and prioritize further advancement of and workforce development for the use of evidence-based practices within the behavioral health service system.

- Grants to address the opioid epidemic – OBH applied for and received three grants during FY17 to enhance existing statewide prevention, treatment, and recovery support services.
    - Medication Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA)
    - Strategic Prevention Framework for Prescription Drugs (SPF Rx)
    - State Targeted Response to the Opioid Crisis Grant (Opioid STR)
- Improvements to system delivery and Pre-Admission Screening and Resident Review (PASRR) – See Section 10 on page 95.

Needs

- Loss of funding – Due to economic conditions and reductions in state general funds, OBH has requested a waiver of the State Maintenance of Effort (MOE) requirement for SFY 2017 for the CMHS and SAPT Block Grants. In FY 2017, OBH eliminated two programs:
    - The Access to Recovery (ATR) program served uninsured individuals and provided access to addiction treatment and recovery support services through a "client choice" system with community and faith-based providers. In FY 2016, 2,270 individuals completed ATR treatment, with an average length of treatment of 84 days.
    - The Louisiana Care Authorization Management System (LaCAMS) provided clinical necessity determinations for levels of care for uninsured persons receiving care through the LGEs and their contracted providers, CEA hospitals, and applicable state hospitals. This administrative oversight will be transitioned to the Local Governing Entities (LGEs) with no impact on patient services or care.
- Shortage of licensed providers throughout the state – The Health Resources and Services Administration (HRSA) has designated at least two Mental Health Health Professional Shortage Areas (HPSA)s in each parish. HPSAs may be urban or rural areas, population groups, or medical or other public facilities.
- Access to care, particularly rural areas

HPSAs in Louisiana



Input from the Louisiana Behavioral Health Advisory Council

Beginning in August 2016, the Louisiana Behavioral Health Advisory Council (LBHAC) initiated a strategic planning process to outline its mission, vision, and priorities. As part of this process, LBHAC received on-site TA and scheduled an all-day working meeting to jumpstart its work. Outlined below are the results of the Council's SWOT analysis applicable to the state behavioral health system.

Strengths

- Peer Support
- Collaboration between behavioral health and police efforts statewide (e.g., CIT)
- Expansion of Medicaid

- CSoC
- Collaboration between OBH and OPH for grant applications
- MCO integration of physical health with behavioral health

Weaknesses

- Lack of information for peers regarding services available
- Lack of information regarding array of services provided by MCOs and LGEs, and any variances

Opportunities

- Accountabilities
- Peer Support – measuring efficacy to support growth

Threats

- How do changing laws and access to medications affect recovery?
- Lack of research/use of EBPs
- EBPs are adopted, but training cycles are not continued
- Cuts in services
- Inadequate staffing levels to meet need and perform duties
- Workforce development requirements of advanced degree/certification vs. skill set
- Lack of training for individuals in correction systems

Step 2. Identify the unmet service needs and critical gaps within the current system

The Office of Behavioral Health (OBH) reviewed a variety of data sources to provide a snapshot of the state's behavioral health system. Data collection definitions, methodologies, and barriers are explained on page 31.

National Measures

Per the Center for Behavioral Health Statistics and Quality at SAMHSA, National Survey on Drug Use and Health (NSDUH) 2014 and 2015, Louisiana is among the top ten states with the highest rates of the following:

- 4th: Past Month Cigarette Use among those 12 and older (26.44 %)
- 7th: Alcohol Dependence among those 12 and older (3.57%)
- 7th: Past Month Tobacco Product Use among those 12 and older (31.06%)
- 8th: First Use of Marijuana among those 12 to 17 (4.46%)
- 9th: Alcohol Disorder among those 26 and older (6.42%)

Louisiana is among the top twenty states in the following indicators:

- 14th: Past Year Cocaine Use among those 26 and older (1.57%)
- 16th: Past Year Serious Mental Illness among those 18 and older (4.53%)
- 17th: Alcohol Disorder among those 12 and older (6.59%)
- 18th: Past Month Alcohol Use among those 12 to 20 (23.7%)
- 18th: Past Month Tobacco Product Use among those 12 to 17 (7.92%)

According to the Behavioral Health Barometer for Louisiana (2015), which includes the data from the NSDUH (2013-2014), the following differences are statistically significant at the .05 level:

- Louisiana's percentage of cigarette use (7.1%) among adolescents was higher than the national percentage (5.2%) in 2013-14.
- The percentage of Louisiana adolescents (71.6%) perceiving no great risk from marijuana use once a month was lower than the national percentage (76.5%) in 2013-14.

Additional data from the Behavioral Health Barometer for Louisiana and the US (2013-14) can be found in the table below:

Indicators	Louisiana	US
Past-Month Illicit Drug Use Among Adolescents Aged 12–17	8.5%	9.1%
Past-Month Binge Alcohol Use Among People Aged 12–20	14.5%	14%
Adolescents aged 12-17 perceiving no great risk from smoking one or more packs of Cigarettes a day	36.6%	34.7%
Past-Year Major Depressive Episode (MDE) Among Adolescents Aged 12–17	10.1%	11%
Past-Year Serious Thoughts of Suicide Among Adults Aged 18 or Older	4.2%	3.9%
Past-Year Alcohol Dependence or Abuse Among Individuals Aged 12 or Older	6.0%	6.5%

Per the Kaiser State Health Facts (2015), 34.8% of the adult population in Louisiana reported that their mental health was "not good" between one and 30 days in the past 30 days. This is slightly higher than the United States' adult population, reported at 34.3%. Services to adults are a critical area of need in the OBH system, as prevalence estimates indicate that only a small proportion of the need is being met by existing OBH services. Of the estimated 192,019 adults with serious mental illness (SMI) in Louisiana, OBH reported only 6,220 adults being served at the end of SFY 2016 (as of 6/30/16). Of the estimated 315,478 persons in need of substance use disorder treatment in Louisiana, OBH reported a total of 16,398 persons served in SFY 2016.

Based on data from the Centers for Disease Control, Louisiana ranked 14th among the states in its rate of suicides during 2015. The State's rate of suicides per 100,000 population (12.8) was slightly lower than the national rate (13.0).

In the Annie E. Casey Foundation Kids Count Data Book (KIDS Count, 2017), Louisiana continued to rank near the bottom of the nation in terms of child health and well-being, ranking 48th in the nation on the index of children's health status and wellbeing. This ranking is a slight deterioration from the 2014 publication, in which Louisiana was ranked 47th. Louisiana ranked poorer than the nation for the following indicators:

Indicators	Louisiana	United States
Economic Well-Being Indicators (Rank = 49th)		
• Children in poverty: 2015	28%	21%
• Children whose parents lack secure employment: 2015	34%	29%
• Teens(16-19 years) not in school and not working: 2015	11%	7%
Education Indicators (Rank = 47th)		
• Fourth graders not/below proficient in reading: 2015	71%	65%
• Eight graders not/below proficient in math: 2015	82%	68%
• High school students not graduating on time: 2014-15	23%	17%
Health Indicators (Rank = 49th)		
• Low-birth weight babies: 2015	10.6%	8.1%
• Child and teen deaths per 100,000: 2015	40	25
• Teens who abuse alcohol or drugs: 2013-14	6%	5%
Family and Community Indicators (Rank = 48th)		
• Children in single-parent families: 2015	45%	35%
• Children living in high-poverty areas: 2011-15	13%	14%
• Teen births per 1,000: 2015	34	22

Data source: Indicator percentages from http://datacenter.kidscount.org/. Ranks from 2017 KIDS Count Data Book.

Prevalence Estimates and Person Served

According to the *2015 Annual Estimates of the Resident Population 7/1/2015 State Characteristics, Population Estimates Division, U.S. Census Bureau (released July, 2015)*, there were estimated to be 4,670,724 individuals in Louisiana. This includes 1,114,813 children and youth (ages 0-17) and 3,555,911 adults (ages 18+).

<Insert demographic estimates table>

Population estimates for each LGE service area was used to determine prevalence estimates. These totals can be found in the following sections.

Mental Health

Adults with Serious Mental Illness (SMI) and children/youth with Serious Emotional Disturbance (SED) are national designations that include only those individuals suffering from the most severe forms of mental illness or diagnosable behavioral, mental, or emotional condition/issue. OBH used SAMHSA's methodology and rates for calculating prevalence estimates. According to *SMI/SED Prevalence Estimates 2015, URS Table 1*, 5.4% of adults (ages 18+) are expected to have SMI and 7% of children and youth (ages 9- 17) are expected to have SED. The methodology used in calculating the number of children and youth does not include estimates for the population under 9 years of age; therefore, that segment of the population was excluded from the reported estimates.

Please note that due to a change in the methodology that OBH uses for prevalence estimates, historical trend data is not shown at this time.

Estimates of the prevalence of mental illness for adults and children/youth within the state and LGEs are shown in the following tables. Caution should be used when utilizing these figures, as they are estimates.

LOUISIANA PREVALENCE ESTIMATES (July 1, 2015)						
LGE	Child/Youth = 7%*		Adult = 5.4%		Total	
	Population	Prevalence	Population	Prevalence	Population	Prevalence
MHSD	46,762	3,273	360,524	19,468	407,286	22,741
CAHSD	78,946	5,526	522,809	28,232	601,755	33,758
SCLHSA	50,393	3,528	306,043	16,526	356,436	20,054
AAHSD	76,408	5,349	453,600	24,494	530,008	29,843
IMCAL	37,061	2,594	225,225	12,162	262,286	14,756
CLHSD	37,010	2,591	231,504	12,501	268,514	15,092
NLHSD	64,764	4,533	414,169	22,365	478,933	26,898
NEDHSA	43,093	3,017	269,418	14,549	312,511	17,566
FPHSA	73,740	5,162	431,306	23,291	505,046	28,453
JPHSA	46,140	3,230	341,313	18,431	387,453	21,661
TOTAL	554,317	38,803	3,555,911	192,019	4,110,228	230,822

SAMHSA Drug & Alcohol Services Information System (https://wwwdasis.samhsa.gov/dasis2/urs.htm), SMI/SED Prevalence Estimates 2015 (URS Table 1: Number of adults with serious mental illness, age 18 and older, and Number of children with serious emotional disturbances, age 9 to 17, by state, 2015) SMI Prevalence= 5.4%; SED Prevalence= 7%

*Due to the missing age group of 9-17 population estimates with the Census Bureau, *CDC Wonder* was used as the source to determine the specific population of 9-17 year old youth by region. This age group was necessary to match the age range used for the URS Table 1. https://wonder.cdc.gov/ *The Bridged- Race Population, Single Age Group, July 2015*

Individuals with SMI/SED are considered to be the target population for these programs. The following tables show the total numbers of persons served receiving mental health services and the percentage of persons with SMI/SED. These numbers reflect an unduplicated count within LGEs. Please note that the

overall count of SMI and SED population is under reported due to missing values in the special population SMI/SED variable.

Community Behavioral Health Clinics Mental Health Persons Served – FY 2016				
LGE	PERSONS SERVED			TOTAL
	CHILD (0-17)	ADULT (18+)	Missing Age	
MHSD	657	5,400		6,057
CAHSD	1,577	4,519		6,096
SCLHSA	1,185	4,089		5,274
AAHSD	364	3,074	1	3,439
IMCAL	336	1,643		1,979
CLHSD	144	2,701	1	2,846
NWLHSD	432	2,920	10	3,362
NEDHSA	75	1,389		1,464
FPHSA	505	4,464		4,969
JPHSA	692	1,307		1,999
TOTAL	**5,967**	**31,506**	**12**	**37,485**

Data Source: EHR. Age at end of time period. Unduplicated by client within LGE.
Data for NEDHSA EHR available only from July 1, 2015 – November 30, 2015 of state fiscal year.

Community Behavioral Health Clinics Persons with SMI/SED Served – FY 2016						
LGE	**Child/Youth (Ages 9-17)**			**Adults**		
	Child/Youth with SED	Total Served	% SED	Adults with SMI	Total Served	% SMI
MHSD	75	507	15%	2,129	5,400	39%
CAHSD	617	1,283	48%	1,303	4,519	29%
SCLHSA	124	972	13%	701	4,089	17%
AAHSD		286		158	3,074	5.1%
IMCAL	4	255	1.6%	81	1,643	4.9%
CLHSD	5	115	4.3%	59	2,701	2.2%
NWLHSD	146	353	41%	782	2,920	27%
NEDHSA	25	66	38%	260	1,389	19%
FPHSA	87	425	20%	177	4,464	4%
JPHSA	287	519	55%	570	1,307	44%
TOTAL	**1,370**	**4,781**	**29%**	**6,220**	**31,506**	**20%**

Data Source: EHR. Age at end of time period. Unduplicated by client within LGE.
Data for NEDHSA EHR available only from July 1, 2015 – November 30, 2015 of state fiscal year.

SMI/EBD based on most recent Special Population SMI/EBD available from admission to end of time period.

The next table compares the prevalence estimates and the number of person served. OBH data reported 1,370 children and youth with SED were served at the end of FY 2016 (as of 6/30/16), revealing that 3.5 % of the estimated children with SED were being served in LGE clinics. OBH data reported 6,220 adults with SMI were served at the end of FY 2016 (as of 6/30/16), revealing that 3.24 % of the estimated adults with SMI were being served in LGE clinics. These numbers do not reflect those served in private clinics.

Number of Persons Served Compared to Prevalence Estimates – FY 2016

LGE	Child/Youth (Ages 9-17)		Adults		Total SMI/SED Served	Percentage of Prevalence Served
	Child/Youth with SED	Prevalence Estimate	Adults with SMI	Prevalence Estimate		
MHSD	75	3,273	2,129	19,468	2,204	9.69%
CAHSD	617	5,526	1,303	28,232	1,920	5.69%
SCLHSA	124	3,528	701	16,526	825	4.11%
AAHSD		5,349	158	24,494	158	0.53%
IMCAL	4	2,594	81	12,162	85	0.58%
CLHSD	5	2,591	59	12,501	64	0.42%
NWLHSD	146	4,533	782	22,365	928	3.45%
NEDHSA	25	3,017	260	14,549	285	1.62%
FPHSA	87	5,162	177	23,291	264	0.93%
JPHSA	287	3,230	570	18,431	857	3.96%
TOTAL	**1,370**	**38,803**	**6,220**	**192,019**	**7,590**	**3.29%**

Data Source: EHR. Age at end of time period. Unduplicated by client within LGE.
Data for NEDHSA EHR available only from July 1, 2015 – November 30, 2015 of state fiscal year.
SMI/EBD based on most recent Special Population SMI/EBD available from admission to end of time period.

Substance-related and Addictive Disorders

In order to determine current estimates of the need for substance use disorder treatment, the prevalence of substance-related criminal activity, and the incidence of communicable diseases among Louisiana citizens, OBH collects and analyzes available national and state data sources. These data sources include but are not limited to: US Census Bureau, SAMHSA National Survey on Drug Use and Health (NSDUH), Centers for Disease Control and Prevention, Office of National Drug Control Policy, Louisiana State University, and Louisiana Department of Health. Distributions of the data collected by the EHR are also analyzed to estimate the percentage of people who receive services and the percentage of people who are in need of treatment but not receiving services.

Estimates of the need for substance use disorder treatment, the prevalence of substance-related criminal activity, and the incidence of communicable diseases among Louisiana citizens within the Local Governing Entity (LGE) service areas are detailed in the following tables. Caution should be used when utilizing these figures, as they are estimates. There are also several limitations in the methodology used for the estimate calculations for the Treatment Needs Assessment Summary Matrix and Treatment Needs by Age, Sex, and Race/Ethnicity:

- The NSDUH data used in calculating the number of people that are in need of treatment services and that would seek treatment does not include estimates for the population under 12 years of age; therefore, that segment of the population was excluded from the reported estimates.
- The NSDUH data estimates used for the calculations are representative of the state as a whole, and not necessarily specific to the parishes that comprise the LGE service areas.
- The estimates for Drug Related Arrests and Hepatitis B were calculated by applying a statewide total to the parish percentage of the total state population estimate, which results in figures that may not accurately reflect the parishes comprising the LGE service areas.

Treatment Needs Assessment Summary Matrix

				TOTAL POPULATION		INJECTING DRUG USERS		WOMEN		PREVALENCE OF SUBSTANCE-RELATED CRIMINAL ACTIVITY		INCIDENCE OF COMMUNICABLE DISEASE (per 100,000)		
LGE	**Population[1]**	**12+ Population[1]**	**Female 12+ Population[6]**	**Needing Treatment Services[2]**	**That would seek treatment[3]**	**Needing Treatment Services[4]**	**That would seek treatment[5]**	**Needing Treatment Services[7]**	**That would seek treatment[8]**	**Number of DWI Arrests[9]**	**Number of Drug Related Arrests[10]**	**Hepatitis B[11]**	**AIDS[12]**	**TB[13]**
MHSD	458,520	388,340	204,111	31,456	3,397	1,165	126	16,533	1,786	1,552	2,787	9	51	12
CAHSD	682,125	571,593	294,230	46,299	5,000	1,715	185	23,833	2,574	2,590	4,102	13	76	18
SCLHSA	405,954	336,949	172,300	27,293	2,948	1,011	109	13,956	1,507	1,525	2,218	8	45	12
AAHSD	608,879	500,619	258,162	40,550	4,379	1,502	162	20,911	2,258	1,961	3,593	11	68	13
IMCAL	299,189	248,026	125,388	20,090	2,170	744	80	10,156	1,097	1,468	1,780	5	33	12
CLHSD	306,221	254,126	125,910	20,584	2,223	762	82	10,199	1,101	1,496	1,824	5	34	2
NLHSD	545,747	453,362	235,932	36,722	3,966	1,360	147	19,110	2,064	2,730	3,254	11	61	12
NEDHSA	355,045	295,793	153,077	23,959	2,588	887	96	12,399	1,339	1,506	2,123	7	39	10
FPHSA	573,569	476,577	246,041	38,603	4,169	1,430	154	19,929	2,152	2,473	3,420	10	64	9
JPHSA	436,275	369,401	191,494	29,921	3,232	1,108	120	15,511	1,675	1,224	2,651	8	48	19
TOTAL	**4,670,724**	**3,894,785**	**2,006,643**	**315,478**	**34,072**	**11,684**	**1,262**	**162,538**	**17,554**	**18,525**	**27,952**	**87**	**519**	**119**

[1] The estimates for Total Population by LGE service area were obtained from the US Census Bureau's 2015 Population Estimates dataset for Louisiana Parishes. To estimate the 12+ Population by SPA from the same dataset, the *Under 5 Years*, *5 to 9 Years,* and one-half of *10 to 14 Years* categories were excluded. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

[2] According to NSDUH, 8.1% of the population aged 12 or older needed substance use treatment in the past year. The 12+ population for each SPA was multiplied by 8.1% to estimate the number of people needing treatment services. Source: Figure 1. Need for substance use treatment in the past year among people aged 12 or older, by age group: 2015 *America's need for and receipt of substance use treatment in 2015*. The CBHSQ Report: September 29, 2016. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD. https://www.samhsa.gov/data/sites/default/files/report_2716/ShortReport-2716.html

[3] According to NSDUH, 10.8 % of those who needed substance abuse treatment received treatment at a specialty facility in the past year. Source: (Figure 2. Receipt of substance use treatment at a specialty facility* in the past year among people aged 12 or older who needed substance use treatment in the past year: 2015) *America's need for and receipt of substance use treatment in 2015*. The CBHSQ Report: September 29, 2016. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD. 10.8% was used to estimate the Total Population that Would Seek Treatment by SPA. https://www.samhsa.gov/data/sites/default/files/report_2716/ShortReport-2716.html

**Specialty treatment* refers to substance use treatment at a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or outpatient), or a mental health center. This NSDUH definition historically has not considered emergency rooms, private doctors' offices, prisons or jails, and self-help groups to be specialty substance use treatment facilities. https://www.samhsa.gov/data/sites/default/files/NSDUH-ServiceUseAdult-2015/NSDUH-ServiceUseAdult-2015/NSDUH-ServiceUseAdult-2015.pdf (page 5)

[4] Information from a meta- analysis conducted by the CDC and published in 2014 was used to estimate Number of IDU's Needing Treatment Services by SPA. In Research Article: *Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis to Calculate National Rates of HIV and Hepatitis C Virus Infections* the combined estimated rate for injection drug use in the United Stated is .30% *(Table 3. Estimated proportion of persons who injected drugs (PWID) in the past year, by survey and combined by meta-analysis, United States.)* http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0097596

[5] The 12+ Population for each SPA was multiplied by .003 to estimate the number of IVDU's needing treatment services. The estimate of 10.8% that was used to calculate the number of people that would seek treatment was also used to determine the Number of IVDU's that Would Seek Treatment.

[6] An estimate for the Female Population by SPA was obtained from the US Census Bureau's 2015 Population Estimates dataset for Louisiana Parishes by Gender. The Female Population was estimated to include only those 12 years and older.

[7] Information from the 2016 National Survey on Drug Use and Health (NSDUH) was used to estimate the Total Number of Women Needing Treatment Services by SPA. The prevalence estimate of 8.1% used to calculate the number of people needing treatment was used to estimate the number of women (females 12+) in need of treatment.

[8] The estimate of 10.8% that was used to calculate the number of people that would seek treatment was also used to determine the Number of Women that Would Seek Treatment.

[9] The estimates for Number of DWI Arrests for 2015 were obtained from the Louisiana State University, Highway Safety Research Group's *2015 Number of Arrests and DWI by Parish Report*. http://datareports.lsu.edu/cobradashboardParish.aspx

[10] Information from the *Federal Bureau of Investigations, Crime in the United States, 2015 Report* was used to estimate the Number of Drug Related Arrests for Calendar Year 2015. According to this report, there were 27,952 drug related arrests in Louisiana in 2015 (17,686 Drug Abuse Violations + 5,339 Driving Under the Influence + 2,723 Liquor Law Violations + 2,204 Drunkenness = 27,952). Parish estimates for the Number of Drug Related Arrests were calculated by multiplying this figure (27,952) by the Parish percentage of the total state 12 years and older population estimate. United States Department of Justice, Federal Bureau of Investigation. *Crime in the United States, 2015*: https://ucr.fbi.gov/crime-in-the-u.s/2015/crime-in-the-u.s.-2015/tables/table-69 Table 69 *Table 69, Arrests by State, 2015.*

[11] According to the CDC, Louisiana's incidence rate for Hepatitis B in 2015 was 1.9/100,000 (Viral Hepatitis Surveillance – United States, 2015; Table 3.1: Reported cases of acute hepatitis B, nationally and by state — United States, 2011 – 2015 https://www.cdc.gov/hepatitis/statistics/2015surveillance/index.htm. This estimates 87 cases (.000019*4,670,724) for the total population. LGE estimates for Incidence of Hepatitis B/100,000 were calculated by multiplying this figure (87) by the LGE percentage of the total state population estimate.

[12] As stated in the *2015 HIV/AIDS Surveillance Report published by the Louisiana Department of Health and Hospitals-Office of Public Health*, according to the *CDC HIV Surveillance Report, 2015; vol. 27,* Louisiana's incidence rate for AIDS in 2015 was 11.2/100,000. This estimates 519 cases for the total population. The population for each SPA was multiplied by .00012 to estimate the incidence of AIDS. http://new.dhh.louisiana.gov/assets/oph/HIVSTD/2015_STDHIV_SurveillanceReport.pdf

[13] According to the Louisiana Department of Health and Hospitals Tuberculosis Control Program, Louisiana's incidence rate for Tuberculosis in 2015 was 2.5/100,000 (Louisiana TB Morbidity Report – 2015: Louisiana Tuberculosis (TB) Cases/Rates http://dhh.louisiana.gov/assets/oph/Center-PHCH/Center-PH/tuber/2015TBMorbidityTable.PDF). This estimates 119 cases for the total population. The distribution of cases by Parish as published by the Tuberculosis Control Program are provided in the estimates table and broken down by LGE.

The following tables provide a comparison of the number of admissions and persons served to the prevalence estimates determined in the Treatment Needs Assessment Summary Matrix. Data collected from EHRs for the total number of persons served during FY 2016 is compared to the total estimated number needing treatment services to determine the percent of prevalence served in Louisiana. These numbers reflect an unduplicated count within LGEs and do not reflect those served in private clinics.

Substance Use Disorder Treatment – FY 2016					
LGE	Needing Treatment Services	That would seek treatment	Admissions	Total Served	Percent of Prevalence Served
MHSD	31,456	3,397	1,360	1,623	5.16%
CAHSD	46,299	5,000	1,936	2,448	5.29%
SCLHSA	27,293	2,948	1,006	1,617	5.92%
AAHSD	40,550	4,379	652	758	1.87%
IMCAL	20,090	2,170	1,012	1,412	7.03%
CLHSD	20,584	2,223	1,792	2,055	9.98%
NLHSD	36,722	3,966	1,635	2,149	5.85%
NEDHSA	23,959	2,588	1,666	2,054	8.57%
FPHSA	38,603	4,169	1,503	1,686	4.37%
JPHSA	29,921	3,232	369	596	1.99%
TOTAL	**315,477**	**34,072**	**12,931**	**16,398**	**5.2%**

Data Source: LADDS and EHR.
Data for NEDHSA EHR available only from July 1, 2015 – November 30, 2015 of state fiscal year.

Substance Use Disorder Treatment for Women (Females ages 12+) – FY 2016					
LGE	Needing Treatment Services	That would seek treatment	Admissions	Total Served	Percent of Prevalence Served
MHSD	16,533	1,786	501	605	3.66%
CAHSD	23,833	2,574	622	844	3.54%
SCLHSA	13,956	1,507	404	650	4.66%
AAHSD	20,911	2,258	316	361	1.73%
IMCAL	10,156	1,097	427	604	5.95%
CLHSD	10,199	1,101	735	846	8.29%
NLHSD	19,110	2,064	646	899	4.7%
NEDHSA	12,399	1,339	559	697	5.62%
FPHSA	19,929	2,152	523	597	3%
JPHSA	15,511	1,675	140	255	1.64%
TOTAL	**162,538**	**17,554**	**4,873**	**6,358**	**3.91%**

Data Source: LADDS and EHR.
Data for NEDHSA EHR available only from July 1, 2015 – November 30, 2015 of state fiscal year.

Persons Who Inject Drugs – FY 2016					
LGE	Needing Treatment Services	That would seek treatment	Admissions	Total Served	Percent of Prevalence Served
MHSD	1,165	126	557	646	55.45%
CAHSD	1,715	185	41	50	2.92%
SCLHSA	1,011	109	9	16	1.58%
AAHSD	1,502	162	6	7	47%
IMCAL	744	80	27	62	8.33%
CLHSD	762	82	239	278	36.48%
NLHSD	1,360	147	243	259	19.04%
NEDHSA	887	96	436	482	54.34%
FPHSA	1,430	154	151	164	11.47%
JPHSA	1,108	120	56	57	5.14%
TOTAL	**11,684**	**1,262**	**1,765**	**2,021**	**17.3%**

Data Source: LADDS and EHR.
Data for NEDHSA EHR available only from July 1, 2015 – November 30, 2015 of state fiscal year.

Demographics Profile of SUD Population Served

Race/Ethnicity	% Served
Alaska Native	0.04%
American Indian	0.68%
Asian	0.20%
Black/African American	32.83%
Native Hawaiian/Other Pacific Islander	0.14%
White	60.46%
More than One Race Reported	0.24%
Unknown - Other	4.27%
Hispanic or Latino	2.28%
Not Hispanic or Latino	94.79%
Unknown	2.93%

Age	% Served
0-17	5.62%
18-24	13.11%
25-44	56.95%
45-64	23.19%
65 & Over	1.13%

Gender	% Served
Male	60.54%
Female	39.46%

Data Source: LADDS and EHR.
Data for NEDHSA EHR available only from July 1, 2015 – November 30, 2015 of state fiscal year.

Primary Prevention

State Epidemiology Workgroup

The State Epidemiology Workgroup (SEW), a subcommittee of the Louisiana Drug Policy Board, is tasked with identifying, collecting, analyzing and disseminating consumption and consequence data related to substance use and related mental, emotional and behavioral disorders that is available from state and national data sources, as well as prioritizing available data for substance abuse prevention needs. The SEW maintains an online data system, which includes consumption indicators and long- and short-term consequence indicators at the state and community level. The SEW makes recommendations regarding improvements in data collection, and continuously works to fill data gaps to improve the quality and

integrity of the data at all levels, while supporting regional and community epidemiological efforts. The work of the SEW is guided by formalized bylaws and Cooperative Involvement Agreements that detail member roles and responsibilities. Membership is composed of data experts and epidemiologists from various state agencies.

OBH is a standing member of the SEW and provides prevention and treatment data for inclusion in the online data system and other SEW related reports. Through the DPB, the SEW has been successful in the creation and propagation of formal data sharing agreements among Louisiana's government agencies. The collaboration of DBP and SEW has reduced the burden on the SEW for data acquisition and allowed the SEW to focus more on providing analysis and guidance on the understanding and use of the data.

In addition, the SEW continues existing collaborations and institutes new collaborations needed to grow the state data system, disseminate data for decision-making, and monitor and evaluate the accuracy and timeliness of the data system.

Louisiana Caring Communities Youth Survey

The Louisiana Caring Communities Youth Survey (CCYS), a survey of 6th, 8th, 10th, and 12th grade students has been conducted since 1998. The survey is conducted every two years with the most recent survey conducted in the fall of 2016, completed March 2017. The results for the state of Louisiana are presented along with comparisons to 2012 and 2014 CCYS survey results, as applicable.

The Louisiana CCYS was originally designed to assess students' involvement in a specific set of problem behaviors, as well as their exposure to a set of scientifically validated risk and protective factors identified in the Risk and Protective Factor Model of adolescent problem behaviors. These risk and protective factors have been shown to predict the likelihood of academic success, school dropout, substance abuse, violence, and delinquency among youth. As the substance abuse prevention field has evolved, the CCYS has been modified to measure additional substance abuse and other problem behavior variables to provide prevention professionals in Louisiana with important information for understanding their communities. Some examples of these additional variables include the percentage of youth who are in need for alcohol or drug treatment, measures of community norms around alcohol use, and bullying.

Percentage of Students Who Used Gateway Drugs																	
On how many occasions (if any) have you... (One or more occasions)		6th Grade				8th Grade				10th Grade				12th Grade			
		State 2012	State 2014	State 2016	MTF 2016	State 2012	State 2014	State 2016	MTF 2016	State 2012	State 2014	State 2016	MTF 2016	State 2012	State 2014	State 2016	MTF 2016
Lifetime alcohol	had alcoholic beverages (beer, wine, or hard liquor) to drink in your lifetime -- more than just a few sips?	18.8	16.5	16.2	~	40.7	36.4	32.9	22.8	61.4	56.0	51.9	43.4	70.7	66.1	61.2	61.2
Past 30 day alcohol	had beer, wine, or hard liquor to drink during the past 30 days?	6.8	5.7	5.5	~	18.5	16.4	14.1	7.3	35.0	30.7	26.8	19.9	45.8	42.4	36.4	33.2
Binge drinking	How many times have you had 5 or more alcoholic drinks in a row in the past 2 weeks? (One or more times)	3.9	3.2	3.7	~	9.5	8.8	7.8	3.4	18.2	16.8	14.6	9.7	25.9	24.0	21.2	15.5
Lifetime cigarettes	Have you ever smoked cigarettes?	8.8	7.1	6.6	~	21.3	19.2	15.8	9.8	31.7	27.7	24.7	17.5	38.3	34.8	31.6	28.3
Past 30 day cigarettes	How frequently have you smoked cigarettes during the past 30 days?	2.0	1.5	1.2	~	6.1	5.5	3.4	2.6	12.0	9.7	7.3	4.9	17.6	15.8	12.3	10.5
1/2 pack of cigarettes/day	During the past 30 days, how many cigarettes did you smoke per day? (About one-half pack a day or more)	0.2	0.3	0.2	~	1.0	0.9	0.5	0.3	2.3	1.8	1.1	0.6	4.6	4.2	2.6	1.8
Lifetime chewing tobacco	used smokeless tobacco (chew, snuff, plug, dipping tobacco, chewing tobacco) in your lifetime?	3.9	4.0	4.1	~	9.2	9.8	9.0	6.9	14.4	13.7	13.0	10.2	16.1	16.1	14.5	14.2
Past 30 day chewing tobacco	used smokeless tobacco (chew, snuff, plug, dipping tobacco, chewing tobacco) during the past 30 days?	1.4	1.4	1.3	~	4.2	5.1	3.9	2.5	7.7	7.2	5.8	3.5	8.8	8.5	6.9	6.6
Lifetime e-cigarette use*	Have you ever tried electronic cigarettes, e-cigarettes, vape pens, or e-hookahs?	~	~	9.5	~	~	~	22.2	17.5	~	~	33.9	29.0	~	~	40.2	33.8
Past 30 day e-cigarette use*	use electronic cigarettes, e-cigarettes, vape pens, or e-hookahs?	~	~	3.4	~	~	~	8.1	6.2	~	~	11.6	11.0	~	~	12.9	12.5
Lifetime marijuana	used marijuana (grass, pot) or hashish (hash, hash oil) in your lifetime?	1.7	1.5	1.4	~	9.8	8.9	8.0	12.8	22.9	21.4	20.6	29.7	31.7	31.5	30.1	44.5
Past 30 day marijuana	used marijuana (grass, pot) or hashish (hash, hash oil) during the past 30 days?	0.7	0.7	0.6	~	4.6	4.1	3.7	5.4	11.3	10.5	10.2	14.0	15.4	16.4	15.5	22.5
Lifetime inhalants	sniffed glue, breathed the contents of an aerosol spray can, or inhaled other gases or sprays, in order to get high in your lifetime?	6.7	4.9	4.6	~	9.7	9.1	8.5	7.7	7.5	7.1	6.7	6.6	5.4	4.8	4.3	5.0
Past 30 day inhalants	sniffed glue, breathed the contents of an aerosol spray can, or inhaled other gases or sprays, in order to get high during the past 30 days?	2.8	2.1	1.9	~	3.8	3.3	3.0	1.8	2.0	1.8	1.8	1.0	1.0	0.9	0.7	0.8

* Substance categories that were not measured and reported in one or more survey administrations prior to 2016.

* Substance categories that were not measured and reported in one or more survey administrations prior to 2016.

Table 4. Percentage of Students Who Used Other Illicit Drugs <Format>

On how many occasions (if any) have you... (One or more occasions)		6th Grade				8th Grade				10th Grade				12th Grade			
		State 2012	State 2014	State 2016	MTF 2016	State 2012	State 2014	State 2016	MTF 2016	State 2012	State 2014	State 2016	MTF 2016	State 2012	State 2014	State 2016	MTF 2016
Lifetime hallucinogens†	used LSD (acid) or other hallucinogens (like PCP, mescaline, peyote, 'shrooms' or psilocybin) in your lifetime?	0.4	0.4	0.3	~	0.9	0.9	0.9	1.9	2.3	2.3	2.1	4.4	3.3	3.7	3.9	6.7
Past 30 day hallucinogens†	used LSD (acid) or other hallucinogens (like PCP, mescaline, peyote, 'shrooms' or psilocybin) during the past 30 days?	0.2	0.1	0.1	~	0.4	0.4	0.4	0.6	0.7	0.8	0.8	0.9	1.0	1.2	1.3	1.4
Lifetime cocaine	used cocaine or crack in your lifetime?	0.5	0.4	0.4	~	0.9	1.0	0.9	1.4	1.3	1.3	1.0	2.1	2.1	2.2	2.1	3.7
Past 30 day cocaine	used cocaine or crack during the past 30 days?	0.2	0.2	0.1	~	0.4	0.5	0.4	0.3	0.5	0.5	0.3	0.4	0.5	0.7	0.7	0.9
Lifetime methamphetamine	used methamphetamines (meth, speed, crank, crystal meth) in your lifetime?	0.3	0.2	0.3	~	0.6	0.6	0.5	0.6	1.2	1.0	0.7	0.7	1.7	1.3	1.0	1.2
Past 30 day methamphetamine	used methamphetamines (meth, speed, crank, crystal meth) during the past 30 days?	0.1	0.1	0.1	~	0.2	0.3	0.2	0.3	0.4	0.4	0.2	0.2	0.6	0.5	0.3	0.3
Lifetime other stimulants†	used stimulants, other than methamphetamines (such as amphetamines, Adderall, Dexedrine, Ritalin) without a doctor telling you to take them, in your lifetime?	0.6	0.5	0.9	~	1.1	0.9	1.7	5.7	2.6	2.1	4.0	8.8	4.0	3.2	6.6	10.0
Past 30 day other stimulants†	used stimulants, other than methamphetamines (such as amphetamines, Adderall, Dexedrine, Ritalin) without a doctor telling you to take them, during the past 30 days?	0.2	0.2	0.4	~	0.5	0.5	0.8	1.7	1.2	0.9	1.7	2.7	1.5	1.3	2.6	3.0
Lifetime sedatives†	used sedatives (tranquilizers, such as Ativan, Klonopin, Valium, Xanax, barbiturates, or sleeping pills) without a doctor telling you to take them, in your lifetime?	3.2	3.0	2.3	~	5.9	5.0	4.0	3.0	8.7	7.0	6.7	6.1	8.9	8.0	7.9	7.6
Past 30 day sedatives†	used sedatives (tranquilizers, such as Ativan, Klonopin, Valium, Xanax, barbiturates, or sleeping pills) without a doctor telling you to take them, during the past 30 days?	1.3	1.3	1.1	~	2.8	2.3	1.9	0.8	4.1	3.3	3.0	1.5	3.7	3.4	3.1	1.9
Lifetime heroin	used heroin or other opiates in your lifetime?	0.3	0.2	0.3	~	0.5	0.5	0.5	0.5	0.7	0.7	0.6	0.6	1.0	1.0	0.8	0.7
Past 30 day heroin	used heroin or other opiates during the past 30 days?	0.1	0.1	0.1	~	0.2	0.2	0.3	0.2	0.3	0.3	0.3	0.2	0.3	0.4	0.3	0.2
Lifetime prescription narcotics**/†	used narcotic prescription drugs (such as OxyContin, methadone, morphine, codeine, Demerol, Vicodin, Percocet, Suboxone) without a doctor telling you to take them, in your lifetime?	0.5	0.6	0.5	~	1.8	1.8	1.5	~	5.2	4.2	4.0	~	7.2	6.4	5.6	7.8
Past 30 day prescription narcotics**/†	used narcotic prescription drugs (such as OxyContin, methadone, morphine, codeine, Demerol, Vicodin, Percocet, Suboxone) without a doctor telling you to take them, during the past 30 days?	0.2	0.2	0.2	~	0.8	0.8	0.8	~	2.2	1.8	1.6	~	2.8	2.4	1.8	1.7
Lifetime ecstasy†	used MDMA (X,E, 'Molly', or ecstasy) in your lifetime?	0.2	0.2	0.2	~	0.9	0.7	1.0	1.7	2.1	1.7	2.0	2.8	3.3	2.8	2.9	4.9
Past 30 day ecstasy†	used MDMA (X,E, 'Molly', or ecstasy) in the past 30 days?	0.1	0.1	0.1	~	0.4	0.3	0.4	0.3	0.7	0.6	0.7	0.5	0.8	1.0	1.0	0.9
Past 30 day synthetic mariuana use*/**	used synthetic marijuana or herbal incense products (such as K2, Spice, or Gold) in the past 30 days?	~	~	0.4	~	~	~	1.1	~	~	~	1.4	~	~	~	1.3	~
Past 30 day other synthetic drug use*/**	used other synthetic drugs (such as Bath Salts like Ivory Wave or White Lightning) in the past 30 days?	~	~	0.5	~	~	~	0.9	~	~	~	0.5	~	~	~	0.3	~

* Substance categories that were not measured and reported in one or more survey administrations prior to 2016.
** No equivalent MTF data for these substances. Prescription Narcotics are only available for 12th grade.
† The survey questions for these substance categories changed in the 2016 survey administration. Please see the appendix for information on specific changes and comparability to previous survey administrations.

Core Alcohol and Drug Survey

The Core Alcohol and Drug Survey was developed to measure alcohol and other drug usage, attitudes, and perceptions among college students at two and four-year institutions. Development of this survey was funded by the U.S. Department of Education. The survey includes several types of items about drugs and alcohol. One type deals with the students' attitudes, perceptions, and opinions about alcohol and other drugs, and the other deals with the students' own use and consequences of use. There are also several items on students' demographic and background characteristics as well as perception of campus climate issues and policy.

The following table provides details about students' reported use of drugs. Unless otherwise indicated, percentages are based on the total number of students responding validly to a given item.

For comparison purposes, some figures are included from a reference group of 125,371 students from 288 institutions from the 2012 to 2014 National Data.

In general, substantial proportions of students report having used alcohol, tobacco, and marijuana in response to the question, "At what age did you first use?" whereas comparatively few report having used each of the other substances. This question examines "lifetime prevalence" as opposed to annual prevalence and 30-day prevalence.

	Lifetime Prevalence		Annual Prevalence		30-Day Prevalence		3X/Week or more	
Substance	Coll.	Ref.	Coll.	Ref.	Coll.	Ref.	Coll.	Ref.
Tobacco	37.5	42.2	26.7	32.4	18.0	21.1	11.0	10.6
Alcohol	82.7	84.4	77.5	81.5	60.9	68.7	15.3	20.0
Marijuana	42.5	46.1	29.8	33.6	17.3	19.9	8.7	8.2
Cocaine	7.2	7.6	4.5	4.4	1.8	1.8	0.3	0.2
Amphetamines	12.8	9.9	6.9	5.4	3.7	3.0	2.2	1.4
Sedatives	7.4	6.2	3.8	3.1	1.8	1.5	0.5	0.4
Hallucinogens	7.7	7.7	4.9	4.5	1.3	1.3	0.3	0.2
Opiates	2.5	2.4	1.2	1.3	0.7	0.8	0.4	0.3
Inhalants	2.2	2.7	1.0	1.0	0.6	0.5	0.2	0.2
Designer drugs	7.8	8.9	3.7	5.5	0.8	1.7	0.3	0.2
Steroids	1.3	1.0	0.8	0.6	0.5	0.4	0.4	0.2
Other drugs	3.3	3.7	1.4	1.9	0.6	0.7	0.3	0.2

Coll. = Multiple Selection
Ref. = Reference group of 125,371 college students

Quality and Data Collection Readiness

The Office of Behavioral Health (OBH) continues to make great strides in upgrading information technology and data systems to address the growing and changing business intelligence needs of the agency as the behavioral health service delivery system adjusts to significant transformations.

On March 1, 2012, OBH entered into the Louisiana Behavioral Health Partnership (LBHP) with Magellan Health. Magellan was the Statewide Management Organization (SMO) responsible for implementation and management of the LBHP. As of December 1, 2015, specialized behavioral health services were integrated into the physical health services of the five Healthy Louisiana plans (previously called Bayou

Health plans). Magellan is currently responsible for Medicaid specialized behavioral health services for the Coordinated System of Care (CSoC) population (children and youth between 5-20 years).

The OBH Business Intelligence (BI) Section, including the OBH Analytics team, serves to provide: information management and data standards development, decision support and support performance improvement initiatives, and computer/network technical support and assistance. The BI Section strives to transform data into actionable information for purposes of behavioral health service planning, quality improvement, and performance accountability. Information, training, and technical assistance is regularly provided to LGEs, clinics, facilities, the state office, and private provider staff/personnel on how to access and utilize program data. Currently, the BI Section takes part in the Substance Abuse-Treatment Episode Data Set (SA-TEDS), Mental Health (MH)-TEDS, Annual Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) report, and Bi-annual Combined SABG/MHBG Behavioral health Assessment and Plan.

Louisiana has improved statewide client-level data collection from the LGEs and their contracted providers. Currently, nine out of ten LGEs are providing their client-level data through their contracted Electronic Health Record (EHR) vendors. Barriers to data collection and reporting include, but are not limited to, access to data collection systems, costs to providers, cost to the state, training individuals on data collection methods, EHR modification per changes in the Client Level Data Manual, and time required to implement those changes. The OBH Analytics team is focused on improving data quality.

Electronic Health Record System

Since December 1, 2015, Magellan's proprietary Electronic Heath Record (EHR), Clinical Advisor (CA) is decommissioned and replaced by LGE-contracted EHR vendors. Providers are encouraged to explore options for submitting their clinical data through the EHRs procured by their LGE. At this time, all the LGEs have contracted with EHR vendors (i.e., ICANotes, CareLogic-Qualifacts, Greenway health, E-Clinical Works, and Remarkable health).

In addition to EHRs, OBH has continued to operate the legacy system called the Louisiana Addictive Disorders Data System (LADDS) for addictive disorders providers not currently using an LGE EHR.

OBH Data Warehouse/Business Intelligence System

OBH's Mental Health and Substance Use Disorder IT systems are integrated into one database/data system. OBH operates a comprehensive data warehouse/business intelligence system to provide access to and use of integrated statewide data and performance measures to managers and staff. The data warehouse is the main source of data for the URS/NOMS tables and for all statewide ad hoc reporting. All program data for community mental health centers, substance use disorder services/clients, state psychiatric hospitals, regional acute units, and regional pharmacies are regularly uploaded into the data warehouse and are stored in a standardized format (.csv files) for integrated access, analysis, and reporting. Managers and staff have access to performance reports via a web-based interface called Decision-Support (DS) Online, which provides a suite of tools for statewide reports and downloads for local analysis and reporting. This resource significantly enhances local planning, monitoring, and evaluation. The DS Online suite includes DataQuest, an easy to use (point-&-click) ad hoc reporting tool, which provides virtually unlimited views of the wide range of mental health performance data, displayed in easy-to-read, comparative (relative percentage) tables, with drill-down capability from the regional to facility and service provider levels. DS Online provides access to performance score cards and reports of

consumer quality of care surveys by LGE and community mental health centers. DS Online also includes DataBooks, a section of electronic spreadsheets and reports, including the latest population statistics organized by parish and LGE, and access to the annual URS Table reports which show Louisiana in comparison to other states across a wide range of important performance dimensions. OBH is in the process of upgrading the data warehouse and business intelligence system by integrating the current data from legacy systems.

OBH Analytics has also rolled out a new website called OBH Analytics Library to provide a repository for the most up-to-date documentation surrounding reporting requirements between OBH, the ten Local Governing Entities (LGEs) across the state of Louisiana, and Substance Abuse and Mental Health Services Administration (SAMHSA). This site is expected to provide a "one-stop" resource for LGEs and OBH staff seeking information on policies, manuals, and reporting.

Data Definitions and Methodology

SMI and EBD Definitions: OBH SMI and EBD population definitions follow the national definition. However, Louisiana uses the designation SMI for what is more commonly referred to as SPMI. SMI (SPMI) is a national designation that includes only those individuals suffering from the most severe forms of mental illness.

Estimation Methodology:

- Mental Health – OBH uses prevalence rates for SMI (5.4%) and SED (7%) from SAMHSA's Uniform Reporting System (URS) Table 1: Number of adults with serious mental illness, age 18 and older, and Number of children with serious emotional disturbances, age 9 to 17, by state, 2015. Each prevalence rate was applied to Louisiana's current (2015) population counts to arrive at the estimated prevalence of targeted persons to be served
- Substance Use Disorders – According to SAMHSA National Survey on Drug Use and Health (NSDUH) data, the need for substance use treatment in the past year among people aged 12 or older is 8.1%. This national percentage was applied to the current Louisiana population (2015) to arrive at the number of Louisiana citizens needing treatment. NSDUH also reports that 10.8% received treatment at a specialty facility in the past year among people aged 12 or older. This percentage was applied to the number of Louisiana citizens needing treatment, which gives us the estimated number of Louisiana citizens seeking treatment.

Admissions: Number of clients that have been admitted during the time period.

Caseload/Census: Active clients on a specified date. Caseload assumes that when a case is no longer active, it is closed.

Discharges: Number of clients that have been discharged during the time period.

Persons Receiving Services: The number of clients who received at least one treatment service during the time period.

Unduplicated: Counts individual clients only once even if they appear multiple times during the time period.

Duplicated: Duplicated counts episodes of care, where clients are counted multiple times if they appear in the same time period multiple times. Note: The duplicated number must always equal or be larger than the unduplicated number.

Target Populations

Mental Health Clients: Adult

An adult who has a serious and persistent mental illness meets the following criteria for Age, Diagnosis, Disability, and Duration.

Age: 18 years of age or older.

Diagnosis: Severe non-organic mental illnesses including, but not limited to schizophrenia, schizo-affective disorders, mood disorders, and severe personality disorders, that substantially interfere with a person's ability to carry out such primary aspects of daily living as self-care, household management, interpersonal relationships and work or school.

Disability: Impaired role functioning, caused by mental illness, as indicated by at least two of the following functional areas:

1) Unemployed, has markedly limited skills and a poor work history, or if retired, is unable to engage in normal activities to manage income.
2) Employed in a sheltered setting.
3) Requires public financial assistance for out-of-hospital maintenance (i.e., SSI) and/or is unable to procure such without help; does not apply to regular retirement benefits.
4) Severely lacks social support systems in the natural environment (i.e., no close friends or group affiliations, lives alone, or is highly transient).
5) Requires assistance in basic life skills (e.g. must be reminded to take medicine, must have transportation arranged for him/her, needs assistance in household management tasks).
6) Exhibits social behavior which results in demand for intervention by the mental health and/or judicial/legal system.

Duration: Must meet at least one of the following indicators of duration:

1) Psychiatric hospitalizations of at least six months in the last five years (cumulative total).
2) Two or more hospitalizations for mental disorders in the last 12 month period.
3) A single episode of continuous structural supportive residential care other than hospitalization for a duration of at least six months.
4) A previous psychiatric evaluation or psychiatric documentation of treatment indicating a history of severe psychiatric disability of at least six months duration.

Mental Health Clients: Child/Youth

A child or youth who has an emotional/behavioral disorder meets the following criteria for Age, Diagnosis, Disability, and Duration as agreed upon by all Louisiana child serving agencies. Note: For purposes of medical eligibility for Medicaid services, the child/youth must meet the criteria for diagnosis as contained in Item 4 of the Diagnosis Section below; Age and Disability must be met as described below; Duration must be met as follows: Impairment or patterns of inappropriate behavior which have/has persisted for at least three months and will persist for at least a year.

Age: Under age 18

Diagnosis: Must meet one of the following:

1) Exhibit seriously impaired contact with reality and severely impaired social, academic, and self-care functioning; thinking is frequently confused; behavior may be grossly inappropriate and bizarre; emotional reactions are frequently inappropriate to the situation; or,
2) Manifest long-term patterns of inappropriate behaviors, which may include, but are not limited to, aggressiveness, anti-social acts, refusal to accept adult requests or rules, suicidal behavior, developmentally inappropriate inattention, hyperactivity, or impulsiveness; or
3) Experience serious discomfort from anxiety, depression, or irrational fears and concerns symptoms may include but are not limited to serious eating and/or sleeping disturbances, extreme sadness, suicidal ideation, persistent refusal to attend school or excessive avoidance of unfamiliar people, maladaptive dependence on parents, or non-organic failure to thrive; or
4) Have a DSM-IV (or successor) diagnosis indicating a severe mental disorder, such as, but not limited to psychosis, schizophrenia, major affective disorders, reactive attachment disorder of infancy or early childhood (non-organic failure to thrive), or severe conduct disorder; does not include children/youth who are socially maladjusted unless it is determined that they also meet the criteria for emotional/behavior disorder.

Disability: There is evidence of severe, disruptive and/or incapacitating functional limitations of behavior characterized by at least two of the following:

1) Inability to routinely exhibit appropriate behavior under normal circumstances
2) Tendency to develop physical symptoms or fears associated with personal or school problems
3) Inability to learn or work that cannot be explained by intellectual, sensory, or health factors
4) Inability to build or maintain satisfactory interpersonal relationships with peers and adults
5) A general pervasive mood of unhappiness or depression
6) Conduct characterized by lack of behavioral control or adherence to social norms which is secondary to an emotional disorder. If all other criteria are met, then children determined to be "conduct disordered" are eligible.

Duration: Must meet at least one of the following:

1) The impairment or pattern of inappropriate behavior(s) has persisted for at least one year
2) Substantial risk that the impairment or pattern or inappropriate behavior(s) will persist for an extended period
3) Pattern of inappropriate behaviors that are severe and of short duration

Substance-Related and Addictive Disorder Clients: Adult and Adolescent

An adult or adolescent (age 12-17) who has a substance use disorder, including those populations identified as priority or targeted within the SAPT Block Grant provisions:

- Pregnant women who use drugs by injection;
- Pregnant women who use substances;
- Other persons who use drugs by injection;
- Substance using women with dependent children and their families, including females who are attempting to regain custody of their children; and

- Persons with or at risk of contracting communicable diseases; including
    - Individuals with tuberculosis
    - Persons with or at risk for HIV/AIDS and who are in treatment for a substance use disorder

Prevention Management Information System

The state collects process data through OBH's online Prevention Management Information System (PMIS). PMIS is the primary reporting system for the SAPT Block Grant for prevention services. Prevention staff and contract providers input information about direct and indirect individual and population-based services into PMIS. PMIS is available to all on a daily basis and real-time rollup reports are compiled for the state, regional, and provider level. These reports allow OBH Central Office staff to support the field by assessing the state's current capacity and determining whether performance targets have been achieved. This provides a mechanism for staff to develop, intervene and implement corrective action in a timely manner.

Specific data elements collected by PMIS include demographic data (e.g., age, race, and ethnicity) and program deliverables (e.g., target population and number served), as well as services provided within the six CSAP prevention strategies. A PMIS Process Evaluation Report is generated each quarter by OBH state office detailing services and deliverables information for each region, provider, and program. This report is followed by a quarterly site visit by a state office Prevention staff member to provide technical assistance during the service delivery period. Resources are monitored and reallocated during the year as needed.

Step 3. Prioritize state planning activities

Based on the information in Steps 1 and 2, the Office of Behavioral Health has identified the following priorities for the FY18-19 Combined Behavioral Health Block Grant Plan:

1. Increase and/or maintain access to and capacity of the publicly-funded behavioral health system for mental health and substance use disorder services.
2. Increase and/or maintain the quality of behavioral health services based on measurement using Healthcare Effectiveness Data and Information Set (HEDIS) specifications.
3. Prevent the onset and reduce the progression of substance use and other high-risk behaviors.

Strategies and performance indicators for each priority are outlined in the following planning tables.

Planning Tables

Plan Table 1: Priority Area and Annual Performance Indicators <update to reflect correct FY>

States are required to complete a separate table for each state priority area to be included in the MHBG and SABG. Please include the following information:

1. Priority area (based on an unmet service need or critical gap).
2. Priority type (SAP – substance abuse prevention, SAT – substance abuse treatment, or MHS -- mental health service)
3. Targeted/required populations – indicate the population from the following:
    a) SMI–Adults with SMI
    b) SED–Children with an SED
    c) ESMI—Individuals with ESMI including psychosis
    d) PWWDC–Pregnant women and women with dependent children
    e) PP—Persons in need of primary substance use disorder prevention
    f) PWID—Persons who inject drugs, formerly known as intravenous drug users (IVDUs)
    g) EIS/HIV–Persons with or at risk of HIV/AIDS, who are receiving SUD treatment services
    h) TB–Persons with or at risk of tuberculosis who are receiving SUD treatment services
    i) Other: Specify
4. Goal of the priority area. Goal is a broad statement of general intention. Therefore, provide a general description of what the state hopes to accomplish.
5. Objective: Objective should be a concrete, precise, and measurable statement.
6. Strategies to attain the objective. Indicate state program strategies or means to reach the stated goal.
7. Annual Performance Indicators to measure success on a yearly basis. Each indicator must reflect progress on a measure that is impacted by the block grant. For each performance indicator, specify the following components:
    a) Baseline measurement from where the state assesses progress;
    b) First-year target/outcome measurement (Progress to the end of SFY 2018;
    c) Second-year target/outcome measurement (Final to the end of SFY 2019;
    d) Data source;
    e) Description of data; and
    f) Data issues/caveats that affect outcome measures.

Priority Area	**Behavioral Health System**
Priority Type	SAT, MHS
Population(s)	SMI, SED, PWWDC, IVDUs, HIV EIS, TB
Goal of the Priority Area	Monitor and influence access to and capacity of the publicly-funded behavioral health system.
Objective	Increase and/or maintain access to and capacity of the publicly-funded behavioral health system.
Strategies to attain the objective	Continue to implement a publicly-funded behavioral health care structure to manage behavioral health services and effectively leverage federal dollars.

	Continue to implement a Coordinated System of Care (CSoC) model that better coordinates and manages the behavioral health system for multi-agency involved children and youth through a CMS 1915c waiver.
Indicator #1	Continue to refine and support publicly-funded mental health (MH) services through the Local Governing Entities (LGEs) and Managed Care Organizations (MCOs). An increased or maintained number of persons will receive publicly-funded mental health services in SFY 16 and SFY 17 as compared to those served in SFY 15.
Baseline Measurement	The number of unduplicated persons with a mental health diagnosis receiving publicly-funded mental health services in SFY 15.
First Year Target/Outcome Measurement	The number of unduplicated persons with a mental health diagnosis receiving publicly-funded mental health services in SFY 16.
Second Year Target/Outcome Measurement	The number of unduplicated persons with a mental health diagnosis receiving publicly-funded mental health services in SFY 17.
Data Source	This data will be collected from LGE electronic health records (EHR) and Medicaid data warehouse.
Description of Data	The number of unduplicated persons with a mental health diagnosis receiving publicly-funded mental health services from the LGEs or other Medicaid managed care providers during the SFY (July 1 – June 30), excluding emergency department and inpatient services. The number is unduplicated by unique demographic identifiers (i.e., SSN, DOB etc.).
Data Issues/Caveats	The state does not currently receive data from two out of ten LGEs. While the state continues to work with LGEs who are not reporting to the state data warehouse, client/treatment counts are not available for two regions if the person is not receiving services through Medicaid funding. The state has proactively issued Corrective Action Plans to non-reporting entities. In addition, the plan to increase or maintain the number of persons served may depend on budget climates.
Indicator #2	Continue to refine and support publicly-funded substance use disorder (SUD) services through the LGEs and MCOs. An increased or maintained number of persons will receive publicly-funded substance use disorder services in SFY 16 and SFY 17 as compared to those served in SFY 15.
Baseline Measurement	The number of unduplicated persons with a substance use disorder diagnosis receiving publicly-funded SUD services in SFY 15.
First Year Target/Outcome Measurement	The number of unduplicated persons with a substance use disorder diagnosis receiving publicly-funded SUD services in SFY 16.
Second Year Target/Outcome Measurement	The number percentage of unduplicated persons with a substance use disorder diagnosis receiving publicly-funded SUD services in SFY 17.
Data Source	This data will be collected from LGE electronic health records (EHR) and Medicaid data warehouse.
Description of Data	The number of unduplicated persons with an SUD diagnosis receiving publicly-funded substance use disorder services from the LGEs or other Medicaid managed

	care providers during the SFY (July 1 – June 30), excluding emergency department and inpatient services. The number is unduplicated by unique demographic identifiers (i.e., SSN, DOB etc.).
Data Issues/Caveats	The state does not currently receive data from two out of ten LGEs. While the state continues to work with LGEs who are not reporting to the state data warehouse, client/treatment counts are not available for two regions if the person is not receiving services through Medicaid funding. The state has proactively issued Corrective Action Plans to non-reporting entities. In addition, the plan to increase or maintain the number of persons served may depend on budget climates.
Indicator #3	Ensure the maintenance of publicly-funded service delivery to SAPT and CMHS Block Grant populations of focus. There is an increased or maintained number of persons served in each of the SAPT and CMHS Block Grant populations of focus during SFY 16 and SFY 17 as compared to those served in SFY 15.
Baseline Measurement	The number of persons served in each of the SAPT and CMHS Block Grant populations of focus during SFY 15.
First Year Target/Outcome Measurement	The number of persons served in each of the SAPT and CMHS Block Grant populations of focus during SFY 16.
Second Year Target/Outcome Measurement	The number of persons served in each of the SAPT and CMHS Block Grant populations of focus during SFY 17.
Data Source	This data will be collected from LGE electronic health records (EHR).
Description of Data	The unduplicated number of persons with a substance use diagnosis, the unduplicated number of persons with a Serious Mental Illness (SMI), and the unduplicated number of persons with a Serious Emotional Disturbance (SED) receiving behavioral health-related services through an LGE during the SFY (July 1 – June 30).
Data Issues/Caveats	The state does not currently receive data from two out of ten LGEs. While the state continues to work with LGEs who are not reporting to the state data warehouse, client/treatment counts are not available for two regions if the person is not receiving services through Medicaid funding. The state has proactively issued Corrective Action Plans to non-reporting entities.
Indicator #4	Maintain statewide Coordinated System of Care (CSoC) operations in the nine regions. The CSoC Contractor will serve up to 2400 children/youth statewide simultaneously during SFY 16.
Baseline Measurement	The number of children receiving CSoC services at the end of SFY 15.
First Year Target/Outcome Measurement	The number of children receiving CSoC services at the end of SFY 16.
Second Year Target/Outcome Measurement	The number of children receiving CSoC services at the end of SFY 17.
Data Source	This data will be collected from the Medicaid data warehouse.

Description of Data	The number of children who were enrolled in the CSoC and received CSoC services by the end of the SFY (as of June 30).
Data Issues/Caveats	The enrollment of 2,400 children and youth statewide is based on the phase-in schedule as initially laid out by Louisiana, but the state experienced delays in statewide expansion while waiting for CMS to approve waiver amendments adding additional parishes to the program. Full statewide implementation has been in place since November 2014. There has been a steady increase in the number of children/youth enrolled in CSoC since this final expansion occurred.

Priority Area	Clinical Quality Measures
Priority Type	SAT, MHS
Population(s)	SMI, SED, PWWDC, IVDUs, HIV EIS, TB
Goal of the Priority Area	Monitor and influence the quality of behavioral health services.
Objective	To increase and/or maintain the quality of behavioral health services based on measurement using Healthcare Effectiveness Data and Information Set (HEDIS) specifications.
Strategies to attain the objective	Ensure that the MCOs maintain quality of care standards.
Indicators #1	Follow-Up After Hospitalization for Mental Illness (FUH).
Baseline Measurement	For CY16, the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.
First Year Target/Outcome Measurement	For CY17, the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application
Data Source	This data will be collected from the MCO databases.
Description of Data	1. For the CY, the percentage of members who received follow-up within 30 days of discharge. 2. For the CY, the percentage of members who received follow-up within 7 days of discharge. **Denominator Description** Discharges for members age 6 years and older as of the date of discharge who were hospitalized for treatment of selected mental illness diagnoses and who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness on or between January 1 and December 1 of the measurement year **Numerator Description** An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).

Indicators #2	Identification of Alcohol and Other Drug Services (IAD).
Baseline Measurement	For CY16, the number and percentage of members with an alcohol and other drug dependence (AOD) claim who received the following chemical dependency services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and outpatient or emergency department (ED).
First Year Target/Outcome Measurement	For CY17, the number and percentage of members with an alcohol and other drug dependence (AOD) claim who received the following chemical dependency services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and outpatient or emergency department (ED).
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application.
Data Source	This data will be collected from the MCO databases.
Description of Data	This measure provides an overview of members with an alcohol and other drug (AOD) dependence diagnosis and the extent to which the different levels of chemical dependency services are used. **Denominator Description** For commercial, Medicaid, and Medicare product lines, all member months during the measurement year for members with the chemical dependency benefit, stratified by age and sex. **Numerator Description** Members who received inpatient, intensive outpatient, partial hospitalization, outpatient and emergency department (ED) chemical dependency services.
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #3	Mental Health Utilization (MPT).
Baseline Measurement	For CY16, the number and percentage of members receiving the following mental health services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and Outpatient or emergency department (ED).
First Year Target/Outcome Measurement	For CY17, the number and percentage of members receiving the following mental health services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and Outpatient or emergency department (ED).
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application.
Data Source	This data will be collected from the MCO databases.
Description of Data	This measure provides an overview of members with a mental health diagnosis and the extent to which the different levels of services are used. **Denominator Description**

	For commercial, Medicaid, and Medicare product lines, all member months during the measurement year for members with the mental health benefit, stratified by age and sex. **Numerator Description** Members who received inpatient, intensive outpatient, partial hospitalization, outpatient and emergency department (ED) mental health services.
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #4	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).
Baseline Measurement	For CY16, percentage of members 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
First Year Target/Outcome Measurement	For CY17, percentage of members 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application.
Data Source	This data will be collected from the MCO databases.
Description of Data	**Denominator Description** Medicaid members' age 18 to 64 years as of December 31 of the measurement year with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication. **Numerator Description** A glucose test or a hemoglobin A1c (HbA1c) test performed during the measurement year.
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #5	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD).
Baseline Measurement	For CY16, percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
First Year Target/Outcome Measurement	For CY17, percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application
Data Source	This data will be collected from the MCO databases.
Description of Data	**Denominator Description**

	Medicaid members 18 to 64 years of age as of December 31 of the measurement year with schizophrenia and diabetes. **Numerator Description** A hemoglobin A1c (HbA1c) test and a low-density lipoprotein cholesterol (LDL-C) test performed during the measurement year.
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #6	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC).
Baseline Measurement	For CY16, percentage of members 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.
First Year Target/Outcome Measurement	For CY17, percentage of members 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application.
Data Source	This data will be collected from the MCO databases.
Description of Data	**Denominator Description** Medicaid members age 18 to 64 years as of December 31 of the measurement year with schizophrenia and cardiovascular disease. **Numerator Description** A low-density lipoprotein cholesterol (LDL-C) test performed during the measurement year.
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #7	Adherence to Antipsychotic medications for Individuals with Schizophrenia (SAA).
Baseline Measurement	For CY16, the percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.
First Year Target/Outcome Measurement	For CY17, the percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application.
Data Source	This data will be collected from the MCO databases.
Description of Data	**Denominator Description** Medicaid members 19 to 64 years of age as of December 31 of the measurement year with schizophrenia. **Numerator Description**

	The number of members who achieved a proportion of days covered (PDC) of at least 80 percent for their antipsychotic medications during the measurement year.
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #8	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC).
Baseline Measurement	For CY16, the percentage of children and adolescents 1 to 17 years of age who were on two or more concurrent antipsychotic medications.
First Year Target/Outcome Measurement	For CY17, the percentage of children and adolescents 1 to 17 years of age who were on two or more concurrent antipsychotic medications.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application.
Data Source	This data will be collected from the MCO databases.
Description of Data	**Denominator Description** Children and adolescents age 1 to 17 years as of December 31 of the measurement year with 90 days of continuous antipsychotic medication treatment during the measurement year. **Numerator Description** Members on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #9	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM).
Baseline Measurement	For CY16, percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.
First Year Target/Outcome Measurement	For CY17, percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application.
Data Source	This data will be collected from the MCO databases.
Description of Data	**Denominator Description** Children and adolescents age 1 to 17 years as of December 31 of the measurement year with at least two antipsychotic medication dispensing events of the same or different medications, on different dates of service during the measurement year. **Numerator Description** Both of the following during the measurement year: • At least one test for blood glucose or hemoglobin A1c (HbA1c). • At least one test for low-density lipoprotein-cholesterol (LDL-C) or cholesterol.

Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #10	Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET).
Baseline Measurement	For CY16, the percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
First Year Target/Outcome Measurement	For CY17, the percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application.
Data Source	This data will be collected from the MCO databases.
Description of Data	**Denominator Description** Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15). **Numerator Description** Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis. --- Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).

Indicators #11	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP).
Baseline Measurement	For CY16, the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
First Year Target/Outcome Measurement	For CY17, the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application.
Data Source	This data will be collected from the MCO databases.
Description of Data	**Denominator Description** Children and adolescents age 1 to 17 years as of December 31 of the measurement year, with a Negative Medication History, who were dispensed an antipsychotic medication during the Intake Period. **Numerator Description** Documentation of psychosocial care in the 121-day period from 90 days prior to the Index Prescription Start Date (IPSD) through 30 days after the IPSD.
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).

Priority Area	Primary Prevention Services
Priority Type	SAP
Populations(s)	SMI, SED, PWWDC, IVDUs, HIV EIS, TB, Other
Goal of the Priority Area	Monitor and influence the onset and reduce the progression of substance abuse and other high-risk behaviors.
Objective	Prevent the onset and reduce the progression of substance abuse and other high-risk behaviors.
Strategies to attain the objective	Implement evidence-based prevention programs in school-based settings through partnership with the Department of Education and in community-based settings. Oversee random, unannounced compliance inspections of tobacco retailers to determine Louisiana's non-compliance rate as required under the federally mandated SYNAR Amendment.
Indicator (1)	The number of individuals served in evidence-based prevention programs.
Baseline Measurement	The number of persons served in evidence-based prevention programs during SFY 15.
First Year Target/Outcome Measurement	The number of persons served in evidence-based prevention programs during SFY 16.
Second Year Target/Outcome Measurement	The number of persons served in evidence-based prevention programs during SFY 17.
Data Source	This data will be collected from the Prevention Management Information System (PMIS).
Description of Data	Program records are maintained by primary prevention programs. Demographic and service information are maintained on all individuals served in evidence-based prevention programs. Data is entered into OBH's Prevention Management Information System (PMIS) and is monitored on an on-going basis.
Data Issues/Caveats	It is the expectation that data be entered by program providers on a daily basis. If program staff does not enter data on this schedule, data backlog can occur.
Indicator (2)	Percentage of individuals served, ages 12-17, who reported they used alcohol, tobacco, and other drugs during the past 30 days.
Baseline Measurement	Responses to Government Performance and Results Act (GPRA) questions collected from pre-post tests administered to individuals ages 12-17 served by evidence-based programs during SFY 15.
First Year Target/Outcome Measurement	Responses to GPRA questions collected from pre-post tests administered to individuals ages 12-17 served by evidence-based programs during SFY 16.
Second Year Target/Outcome Measurement	Responses to GPRA questions collected from pre-post tests administered to individuals ages 12-17 served by evidence-based programs during SFY 17.
Data Source	Responses to GPRA questions are collected on Scantron pre-post tests administered to those individuals aged 12-17 enrolled in prevention programs.
Description of Data	A standardized survey administered by designated prevention program staff at the start and completion of program. Questions specific to past 30-day use of alcohol,

	tobacco, and marijuana have been added to pre- and post-tests for middle and high school programs (ages 12-17). Collection is daily, monthly, and/or quarterly. Pre- and Post-Tests are administered by Scantron, matched, and scored. Reporting is annual.
Data Issues/Caveats	The survey respondent's ability to comprehend subject matter and motivation; qualification and experience of teachers and presenters; method and quality of instruction can all impact the data. The success of this indicator is measured by maintenance of abstinence or a decrease in reported past 30-day use of alcohol, tobacco, or marijuana. This indicator is contingent on funding being maintained, as well as on continued partnership with the Louisiana Department of Education (DOE).
Indicator (3)	Maintain a non-compliance Retailer Violation Rate (RVR) of less than 20%.
Baseline Measurement	Annual SYNAR Retailer Violation Rate (RVR), as reported in 2015 Annual SYNAR Report.
First Year Target/Outcome Measurement	Annual SYNAR Retailer Violation Rate (RVR), as reported in 2016 Annual SYNAR Report.
Second Year Target/Outcome Measurement	Annual SYNAR Retailer Violation Rate (RVR), as reported in 2017Annual SYNAR Report.
Data Source	SAMHSA's required Annual Synar Report for the state of Louisiana.
Description of Data	Completed random, unannounced compliance checks conducted by the Office of Alcohol and Tobacco Control are submitted to OBH for review of accuracy. Once they are confirmed to be valid, accurate, and reliable, the results of the checks are run through statistical software to generate the state's non-compliance rate.
Data Issues/Caveats	This indicator is contingent on continued partnership with the Louisiana Office of Alcohol and Tobacco Control (OATC) and enforcement of laws and regulations specific to retail availability of tobacco products to minors.

Plan Table 2. State Agency Planned Expenditures (SFY 2018-2019)

State Agency Planned Expenditures Source of Funds							
Activity	**A. SABG**	**B. MHBG**	**C. Medicaid (Federal, State, and Local)**	**D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)**	**E. State Funds**	**F. Local Funds (excluding local Medicaid)**	**G. Other**
1. Substance Abuse Prevention* and Treatment	$34,970,194			$7,359,268	$80,052,106		$10,272,396
a. Pregnant Women and Women with Dependent Children**	$8,048,322						
b. All Other	$26,921,872			$7,359,268	$80,052,106		$10,272,396
2. Primary Prevention	$9,991,484						
a. Substance Abuse Primary Prevention	$9,991,484						
b. Mental Health Primary							
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)		$982,129					
4. Tuberculosis Services							
5. Early Intervention Services for HIV	$2,497,870						
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care		$8,839,161	$1,600,000	$1,466,000	$198,134,546		$7,510,000
9. Administration (Excluding Program and Provider Level)	$2,497,870						
10. SubTotal (1,2,3,4,9)	$39,965,870			$7,359,268	$80,052,106		$10,272,396
11. SubTotal (5,6,7,8)		$9,821,290	$1,600,000	$1,466,000	$198,134,546		$7,510,000
12. Total	$49,957,418	$9,821,290	$1,600,000	$8,825,268	$278,186,652		$17,782,396

Plan Table 3. SABG Persons in need/receipt of SUD Treatment

	Aggregate Number Estimated in Need	Aggregate Number in Treatment
Pregnant Women	44,366	118
Women with Dependent Children	30,000	1603
Individuals with a co-occurring M/SUD	117,345	4753
Persons who inject drugs	66,211	1644
Persons experiencing homelessness	436	767

Plan Table 4. SABG Planned Expenditures

Expenditure Category	FFY 2018 SA Block Grant Award	FFY 2019 SA Block Grant Award
1. Substance Abuse Prevention* and Treatment	$17,485,097	$17,485,097
2. Primary Substance Abuse Prevention	$4,995,742	$4,995,742
3. Early Intervention Services for HIV[1]	$1,248,935	$1,248,935
4. Tuberculosis Services	$	$
5. Administration (SSA level only)	$1,248,935	$1,248,935
6. Total	$24,978,709	$24,978,709

[1] For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120- 137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

Plan Table 5a. Primary Prevention Planned Expenditures

The state's primary prevention program must include, but is not limited to, the six primary prevention strategies defined below. On Table 5a, states should list their FFY 2018 and FFY 2019 SABG planned expenditures for each of the six primary prevention strategies. Expenditures within each of the six strategies should be directly associated with the cost of completing the activity or task; for example, information dissemination should include the cost of developing pamphlets, the time of participating staff or the cost of public service announcements, etc. If a state plans to use strategies not covered by these six categories, please report them under "Other" in Table 5a.

In most cases, the total amounts should equal the amounts reported on Plan Table 4, Row 2, Primary Prevention. The one exception is if the state chooses to use a portion of the primary prevention set-aside to fund Non Direct Services/System Development activities.

Information Dissemination– This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two.

Education - This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental abilities. There is more interaction between facilitators and participants than in the information strategy.

Alternatives - This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities and to discourage the use of alcohol and drugs through these activities.

Problem Identification and Referral - This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

Community-based Process - This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.

Environmental - This strategy establishes or changes written and unwritten community standards, codes, and attitudes; thereby, influencing alcohol and other drug use by the general population.

Other - The six primary prevention strategies have been designed to encompass nearly all of the prevention activities. However, in the unusual case an activity does not fit one of the six strategies, it may be classified in the "Other" category.

Section 1926 – Tobacco - Costs Associated with the Synar Program. Per January 19, 1996, 45 CFR Part 96 Tobacco Regulation for Substance Abuse Prevention and Treatment Block Grants; Final Rule (45 CFR § 96.130), states may not use the Block Grant to fund the enforcement of their statute, except that they

may expend funds from their primary prevention set aside of their Block Grant allotment under 45 CFR § 96.124(b)(1) for carrying out the administrative aspects of the requirements such as the development of the sample design and the conducting of the inspections.

In addition, prevention strategies may be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by the population targeted. Definitions for these categories appear below:

Universal: Activities targeted to the public or a whole population group that has not been identified based on individual risk.

Selective: Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

Indicated: Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not meeting diagnostic levels (Adapted from The Institute of Medicine).

States that are able to report on both the strategy type and the population served (universal, selective, or indicated) should do so. If planned expenditure information is only available by strategy type, then the state should report planned expenditures in the row titled Unspecified (for example, Information Dissemination Unspecified).

Strategy	IOM Target	FFY 2018 SA Block Grant Award	FFY 2019 SA Block Grant Award
1. Information Dissemination	Universal	$57,705	$57,705
	Selected	$6,500	$6,500
	Indicated	$	$
	Unspecified		
2. Education	Universal	$3,311,463	$3,311,463
	Selected	$43,500	$43,500
	Indicated	$16,500	$16,500
	Unspecified		
3. Alternatives	Universal	$16,500	$16,500
	Selected	$28,000	$28,000
	Indicated	$	$
	Unspecified		
4. Problem Identification and Referral	Universal	$71,105	$71,105
	Selected	$6,500	$6,500
	Indicated	$	$
	Unspecified		
5. Community-Based Processes	Universal	$551,245	$551,245
	Selected	$6,500	$6,500
	Indicated	$	$
	Unspecified		

6. Environmental	Universal	$257,363	$257,363
	Selected	$9,750	$9,750
	Indicated	$	$
	Unspecified		
7. Section 1926-Tobacco	Universal	$287,331	$287,331
	Selected	$	$
	Indicated	$	$
	Unspecified		
8. Other	Universal	$29,500	$29,500
	Selected	$	$
	Indicated	$	$
	Unspecified		
9. Total Prevention Expenditures		$4,699,462	$4,699,462
Total SABG Award		$24,978,709	$24,978,709
Planned Primary Prevention Percentage*		18.81%	18.81%

*Does not reflect Non-Direct Services/System Development activities.

Plan Table 5b. SABG Primary Prevention Planned Expenditures by IOM Category

States that plan their primary prevention expenditures using the IOM model of universal, selective, and indicated should use Table 5b to list their FFY 2018 and FFY 2019 SABG planned expenditures in each of these categories. In most cases, the total amount should equal the amounts reported on Plan Table 3, Row 2, Primary Prevention. The one exception is if the state chooses to use a portion of the primary prevention set-aside to fund Non Direct Services/System Development activities.

Activity	FFY 2018 SA Block Grant Award	FFY 2019 SA Block Grant Award
Universal Direct	$4,116,555	$4,116,555
Universal Indirect	$465,657	$465,657
Selective	$100,750	$100,750
Indicated	$16,500	$16,500
Column Total	$4,699,462	$4,699,462
Total SABG Award	$24,978,709	$24,978,709
Planned Primary Prevention Percentage	18.81%	18.81%

*Does not reflect Non-Direct Services/System Development activities.

Plan Table 5c. SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2018 and FFY 2019 SABG awards.

Targeted Substances*	
Alcohol	☒
Tobacco	☒
Marijuana	☒
Prescription Drugs	☒
Cocaine	☒
Heroin	☒
Inhalants	☒
Methamphetamine	☒
Synthetic Drugs (i.e., Bath salts, Spice, K2)	☒

Targeted Populations*	
Students in College	☒
Military Families	☒
LGBT	☒
American Indians/Alaska Natives	☒
African American	☒
Hispanic	☒
Homeless	☒
Native Hawaiian/Other Pacific Islanders	☒
Asian	☒
Rural	☒
Underserved Racial and Ethnic Minorities	☒

*As indicated by the Local Governing Entities, which are sub-recipients of Block Grant funds.

Plan Table 6. Categories for Expenditures for System Development/Non-Direct Service Activities

Expenditures for these activities may be direct expenditures (involving the time of state or sub- state personnel, or other state or sub-state resources) or be through funding mechanisms with independent organizations. Expenditures may come from the administrative funds and/or program funds (but may not include the HIV set-aside funds). These include state, regional, and local personnel salaries prorated for time spent and operating costs such as travel, printing, advertising, and conducting meetings related to the categories below.

Non-direct services/system development activities *exclude* expenditures through funding mechanisms for providing treatment or mental health "direct service" and primary prevention efforts themselves. Instead, these expenditures provide support to those activities.

Please utilize the following categories to describe the types of expenditures your state supports with BG funds, and if the preponderance of the activity fits within a category.

Information systems – This includes collecting and analyzing treatment data as well as prevention data under the SABG in order to monitor performance and outcomes. Costs for EHRs and other health information technology also fall under this category.

Infrastructure Support – This includes activities that provide the infrastructure to support services but for which there are no individual services delivered. Examples include the development and maintenance of a crisis-response capacity, including hotlines, mobile crisis teams, web-based check-in groups (for medication, treatment, and re-entry follow-up), drop-in centers, and respite services.

Partnerships, community outreach, and needs assessment – This includes state, regional, and local personnel salaries prorated for time and materials to support planning meetings, information collection, analysis, and travel. It also includes the support for partnerships across state and local agencies, and tribal governments. Community/network development activities, such as marketing, communication, and public education, and including the planning and coordination of services, fall into this category, as do needs-assessment projects to identify the scope and magnitude of the problem, resources available, gaps in services, and strategies to close those gaps.

Planning Council Activities – This includes those supports for the performance of a Mental Health Planning Council under the MHBG, a combined Behavioral Health Planning Council, or (OPTIONAL) Advisory Council for the SABG.

Quality assurance and improvement - This includes activities to improve the overall quality of services, including those activities to assure conformity to acceptable professional standards, adaptation and review of implementation of evidence-based practices, identification of areas of technical assistance related to quality outcomes, including feedback. Administrative agency contracts to monitor service-provider quality fall into this category, as do independent peer- review activities.

Research and evaluation - This includes performance measurement, evaluation, and research, such as services research and demonstration projects to test feasibility and effectiveness of a new approach as well as the dissemination of such information.

Training and education - This includes skill development and continuing education for personnel employed in local programs as well as partnering agencies, as long as the training relates to either

substance use disorder service delivery (prevention, treatment and recovery) for SABG and services to adults with SMI or children with SED for MHBG. Typical costs include course fees, tuition, and expense reimbursements to employees, trainer(s) and support staff salaries, and certification expenditures.

The planned expenditures indicate non-direct services/system development for the FFY 2018 and FFY 2019 Block Grant awards.

Activity	MHBG	SABG Treatment	SABG Prevention	SABG Combined
1. Information Systems	$247,256	$60,000	$	$369,886
2. Infrastructure Support	$5,200	$78,780	$	$
3. Partnerships, community outreach, and needs assessment	$	$281,772	$1,302,268	$261,260
4. Planning Council activities	$302,600	$	$	$
5. Quality assurance and improvement	$	$277,746	$346,942	$10,000
6. Research and evaluation	$	$	$199,000	$
7. Training and education	$731,656	$12,000	$435,128	$59,224
Total	$1,286,712	$710,298	$2,283,338	$700,370

Environmental Factors

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions. Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease. It has been acknowledged that there is a high rate of co- occurring M/SUD, with appropriate treatment required for both conditions.

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders. SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity. For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co- occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care. Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes and ACOs may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.36 Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

One key population of concern is persons who are dually eligible for Medicare and Medicaid. Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible. SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment. Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider. SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

In November 2014, LDH announced its plan to change the way Medicaid members get behavioral health services (mental health and substance use treatment). Beginning Dec. 1, 2015, LDH integrated behavioral health care into the existing physical health managed care network, then called Bayou Health, now known as Healthy Louisiana. All Louisiana Medicaid members now receive their behavioral health services through integrated managed care in one of the 5 Healthy Louisiana Plans.

The MCO are required to have established policies and to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs.

Principles that guide care integration are as follows:

- Mental illness and addiction are healthcare issues and must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings;
- Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions;
- The system of care will be accessible and comprehensive, and will fully integrate an array of prevention and treatment services for all age groups. It will be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement;
- It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.

Based on this, the MCO must provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity, as well as, cost-effectiveness of care. These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.

Specifically, the following requirements are placed on the Medicaid managed care companies providing both behavioral health and physical health services.

The MCO is required to provide trainings on integrated care including but not limited to the appropriate utilization of basic behavioral health screenings in the primary care setting and basic physical health screenings in the behavioral health setting.

The MCO shall identify available opportunities to provide incentives to clinics to employ Licensed Mental Health Professionals (LMHP) in primary care settings and to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients.

The MCO shall encourage and endorse real time consultation of primary care providers with behavioral health professionals or psychiatrists for behavioral health issues or consultations on medications.

The MCO shall have integrated data, quality and claims systems for both behavioral health and physical health providers and information, including a single or integrated clinical documentation system in order to see the whole health of the member.

The MCO shall provide or arrange for training of providers and MCO staff on identification and screening of behavioral health conditions and referral procedures.

The MCOs must distribute Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use.

The MCO must strongly support the integration of both physical and behavioral health services through:

- Enhanced detection and treatment of behavioral health disorders in primary care settings;
- Coordination of care for members with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for members with co-existing medical-behavioral health disorders;
- Assisting members without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder;
- Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled members with co-existing medical and behavioral health disorders requiring co-management.
- Developing capacity for enhanced rates or incentives for integrated care by providers.

- Educating MCO members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate, and Identifying members who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate SMO-contracted behavioral health specialists;
- Ensuring, continuity and coordination of care for members who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for member(s) requiring behavioral health services.

The MCO must use an integration assessment tool to self-assess annually. The assessment should be inclusive of, but not limited to, such factors as provider locations, integrated or collocated provider numbers, programs focusing on members with both behavioral health and primary care needs, use of multiple treatment plans, and unified systems across behavioral and physical health management. This assessment is reported annually to LDH.

Each MCO conducts annual assessments of practice integration using the publicly available Integrated Practice Assessment Tool (IPAT) on a statistically valid sampling of providers to include but not be limited to behavioral health providers and primary care providers: internists, family practitioners, pediatrics, OB-GYNs and any other providers that are likely to interface with BH populations.

Housing:

The integrated managed care entities also support a housing initiative and employ staff specific to the Permanent Supportive Housing (PSH) program as a liaison to work with LDH PSH program staff to assure effective implementation of PSH program deliverables. LDH partners with the Louisiana Housing Authority (LHA) to co-manage the Louisiana Permanent Supportive Housing (PSH) program. PSH provides deeply affordable, community-integrated housing paired with tenancy supports that assist persons with disabilities to be successful tenants and maintain stable housing. The Louisiana PSH program is a cross-disability program that provides access to over 3,300 affordable housing units with rental subsidies statewide. In Louisiana, PSH services are reimbursed under several Medicaid HCBS programs, and under specialized behavioral health State Plan services where it is billed as a component of CPST and PSR. However, Medicaid members must meet PSH program eligibility criteria, in addition to medical necessity criteria for services in order to participate in PSH. Overall management of the PSH program is centralized within LDH and final approval for members to participate in PSH is made by the LDH PSH program staff. For the Louisiana PSH program, the MCO shall:

- Provide outreach to qualified members with a potential need for PSH;
- Assist members in completing the PSH program application;
- Within one (1) working day of request by designated LDH PSH program staff, provide accurate information about status of eligibility assessment, determination, and recertification;
- Assure timely prior authorization for PSH tenancy and pre-tenancy supports as applicable;
- Assure timely provider referral for members who are approved by LDH for PSH program participation and are authorized for tenancy or pre-tenancy supports;

- Assure PSH tenancy supports are delivered in a timely and effective manner in accordance with an appropriate plan of care;
- Respond to service problems identified by PSH program management, including but not limited to those that place a member's/tenant's housing or PSH services at risk;
- Work with PSH program management to assure an optimal network of qualified service providers trained by the LDH PSH program staff or designee to provide tenancy supports across disability groups and certified to deliver services as defined in the PSH Provider Certification Requirements.
- Develop all written policies and procedures necessary to implement the PSH-related requirements.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

OBH was created by Act 384 of the 2009 Legislative Session which directed the consolidation of the offices of addictive disorders and mental health into the Office of Behavioral Health effective July 1, 2010 in order to streamline services and better address the needs of people with co-occurring mental illness and addictive disorders. LDH's work in implementing Act 384 was guided by stakeholders and leaders in the behavioral health field from across Louisiana who sat on the department's Office of Behavioral Health Implementation Advisory Committee.

Currently, the Office of Behavioral health has an integrated organizational chart and does not distinguish between addictive disorder and mental health staff, resources, or state general fund mechanisms. LGEs as Medicaid and non-Medicaid providers provide services in an integrated manner for both mental health and addictive disorders, as do the Medicaid managed care organizations discussed above.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?

a) ☒ Yes ☐ No

and Medicaid?

b) ☒ Yes ☐ No

4. Who is responsible for monitoring access to M/SUD services by the QHPs?

OBH is responsible. OBH works closely with the state Medicaid agency, BHSF. There is an MOU and operational plan delineating responsibilities for monitoring the managed care companies. The state Medicaid agency acknowledges and appreciates that the Office of Behavioral Health is the subject matter expert for all behavioral health benefits and services.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?

☒ Yes ☐ No

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education

☐ Yes ☒ No

b) Health risks such as

i) heart disease, ☐ Yes ☒ No
ii) hypertension, ☐ Yes ☒ No
iii) high cholesterol ☐ Yes ☒ No
iv) diabetes ☐ Yes ☒ No

c) Recovery supports

☐ Yes ☒ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?

☒ Yes ☐ No

The Office of Behavioral Health is involved in rate development for the comprehensive risk contracts with the Medicaid MCOs for the integrated delivery of physical and behavioral health.

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?

☒ Yes ☐ No

Office of Behavioral Health is lead on the parity compliance activities for Louisiana and is staffed by state Medicaid staff and resources.

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

Louisiana will meet the demonstration of parity by October 2, 2017 despite the tight timeline. The biggest issue is staff resources for analysis of over 5 managed care organizations plus a fee for services delivery system.

10. Does the state have any activities related to this section that you would like to highlight?

With regard to parity work, Louisiana is one of 11 states chosen to participate in the SAMHSA policy academy which gives us access to national consultants, resources, and trainings. The Department also created a website to provide information and additional resources on parity for consumers receiving Medicaid benefits. There is a dedicated email address for consumers to ask further questions. Also, LDH is presenting on parity and the work required of the state to various advocacy groups and public meetings. http://new.dhh.louisiana.gov/index.cfm/page/2809

Please indicate areas of technical assistance needed related to this section:

Ongoing parity monitoring that includes development of tools and training for state employees on how to analyze NQTL and QTL and what to look for in MCO responses.

2. Health Disparities – Requested

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, Healthy People, 2020, National Stakeholder Strategy for Achieving Health Equity, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence- based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults

with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

Please respond to the following items:

1) Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?

a)	race	☒ Yes	☐ No
b)	Ethnicity	☒ Yes	☐ No
c)	gender	☒ Yes	☐ No
d)	sexual orientation	☒ Yes	☐ No
e)	gender identity	☒ Yes	☐ No
f)	Age?	☒ Yes	☐ No

2) Does the state have a data-driven plan to address and reduce disparities in access, service use, and outcomes for the above subpopulation?

☐ Yes ☒ No

3) Does the state have a plan to identify, address, and monitor linguistic disparities/language barriers?

☒ Yes ☐ No

4) Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?

☐ Yes ☒ No

5) If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?

☐ Yes ☒ No

6) Does the state have a budget item allocated to identifying and remediating disparities in behavioral health care?

☐ Yes ☒ No

7) Does the state have any activities related to this section that you would like to highlight?

Though we do not currently address health disparities, there are plans to include this in future contracts. There was an effort to address CLC at the state level. A contract was drafted to an outside company to assist with improving CLC. Unfortunately, due to budget cuts, the contract was never implemented.

Cultural competence is addressed in the current contract. The MCOs require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2). MCOs must ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided.

The MCOs must:

- Collect member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required);
- Assess the cultural competency of the providers on an ongoing basis, at least annually;
- Assess member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.;
- Assess provider satisfaction of the services provided by the MCO at least annually; and
- Require and provide training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.

Please indicate areas of technical assistance needed related to this section.

N/A

3. Innovation in Purchasing Decisions – requested

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, **(V = Q ÷ C)**

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence- based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General, The New Freedom Commission on Mental Health, the IOM, and the NQF. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online." SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (TIPS) are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across

the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT) was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ☒Yes ☐No

2. Which value based purchasing strategies do you use in your state (check all that apply):

   a) ☒ Leadership support, including investment of human and financial resources.
   b) ☒ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c) ☐ Use of financial and non-financial incentives for providers or consumers.
   d) ☒ Provider involvement in planning value-based purchasing.
   e) ☒ Use of accurate and reliable measures of quality in payment arrangements.
   f) ☒ Quality measures focus on consumer outcomes rather than care processes.
   g) ☒ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   h) ☒ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

   N/A

Please indicate areas of technical assistance needed related to this section.

N/A

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – Ten percent set aside - Required MHBG

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention[2] is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

1. Does the state have policies for addressing early serious mental illness (ESMI)?

   ☐ Yes ☒ No

   Though the state has standards regarding the provision of person-centered, recovery oriented treatment, it does not have policies for addressing early serious mental illness. Efforts have been made in the initial years of program implementation to increase awareness of the needs of individuals experiencing first episodes of psychosis and the benefit of early identification and

[2] MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

treatment in order to reduce the duration of untreated psychosis. It is expected that as programming becomes embedded within the system, policies for addressing ESMI will be developed.

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI

☒ Yes ☐ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI

During SFY16, three (3) LGEs made the commitment to implement First Episode Psychosis (FEP) programs utilizing the NAVIGATE model (formerly RAISE) which is an evidence based model of coordinated treatment. These LGEs include Jefferson Parish Human Services Authority (JPHSA), Capital Area Human Services District (CAHSD), and Florida Parishes Human Services Authority (FPHSA). These LGEs participated in the 2-day NAVIGATE training which occurred in June, 2016, and have continued to participate in ongoing consultation activities with the NAVIGATE trainers which are scheduled to continue through September, 2017. The calls are scheduled as follows:

- Director/Family Education Specialists – bi-monthly for the first 6 months switching to monthly the last 6 months.
- IRT Specialists – bi-monthly for the first 6 months, switching to monthly the last 6 months
- SEE Specialists - bi-monthly for the first 6 months, switching to monthly the last 6 months
- Prescriber – monthly for 12 months

In addition to the implementation of FEP programming within 3 of the state's 10 LGEs, OBH has also contracted with an FEP program in New Orleans called EPIC-NOLA. This program is operated through Sinfonia Family Services of Louisiana, a Medicaid-affiliated community behavioral health provider. The FEP program has been implemented in conjunction with Tulane University and is modeled off of the Yale STEP program. This program, which had established itself prior to OBH's support, is fully staffed and operational with OBH support allowing for the provision of services to those who are without a payor source (no Medicaid or private insurance). This contract began in February, 2017.

All other locations in the state have chosen to maintain a public health model for program implementation. Through this public health approach, LGEs will continue to provide peer support services (PSS) to individuals experiencing their first episode of psychosis. The goal of the Louisiana plan for FEP implementation in these areas of the state is to increase capacity of the system to effectively serve individuals experiencing first episode psychosis through trainings while supporting the identification of individuals experiencing FEP and moving them into traditional treatment, thereby shortening the individual's duration of untreated psychosis.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Most of the recruitment for the CSC programs affiliated with the LGEs is done through engagement with individuals seeking traditional clinical treatment. Development of marketing materials is being done in conjunction with the EPIC-NOLA program. Individualized treatment is a

component of programming while integrated physical and mental health services will become standardized in future iterations of the program when the MCOs become more engaged in the provision of services for these programs.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a FEP ESMI?

☒ Yes ☐ No

The CSC programs implemented in Louisiana are comprised of state entities (LGEs) and a private program operated through Sinfonia Family Services, a behavioral health program operating in conjunction with Tulane University. As the programs evolve additional considerations in regard to the integration with managed care will need to be considered and addressed in implementation activities. This includes training Medicaid and Managed Care Organizations (MCOs) on the utilization of FEP as an evidence-based practice and any subsequent considerations regarding the authorization of services.

5. Does the state collect data specifically related to FEP ESMI?

☒ Yes ☐ No

Reporting includes the following measures:

Program Outcome	Variables Monitored	Assessment Tool/ Method of Analysis	Frequency of Monitoring
Client Level Data	Gender	OBH Data Warehouse	Baseline Assessment
	Age	OBH Data Warehouse	Baseline Assessment
	Race	OBH Data Warehouse	Baseline Assessment
	Diagnosis	OBH Data Warehouse	Baseline Assessment and Post Program Assessment
	Employment Status	OBH Data Warehouse	Baseline Assessment and Post Program Assessment
	Education Level	OBH Data Warehouse	Baseline Assessment and Post Program Assessment
	Service Use	OBH Data Warehouse	Ongoing Assessment
	Program Satisfaction	Survey Derived from Telesage Outcome Measurement Survey (TOMS) Instrument	Ongoing Assessment
	PSS Identified	Frequency Count	Ongoing Assessment

FEP Program Workforce Development	PSS Certifications Received	Frequency Count	Ongoing Assessment
	RA1SE/Navigate programs Identified	Frequency Count	Ongoing Assessment
	RA1SE/Navigate programs Trained	Frequency Count	Ongoing Assessment
	FEP Trainings Conducted	Frequency Count	Ongoing Assessment
	Number in Attendance at each FEP Training	Frequency Count	Ongoing Assessment
Outreach	Number of Educational Events Held	Frequency Count	Ongoing Assessment
	Number of Outreach Materials Distributed	Frequency Count	Ongoing Assessment
	Number of Individuals referred to the FEP program	Frequency Count	Ongoing Assessment

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?

☒ Yes ☐ No

Efforts have been made in the initial years of program implementation to increase awareness of the needs of individuals experiencing first episodes of psychosis and the benefit of early identification and treatment in order to reduce the duration of untreated psychosis.

For the first phase of implementation, Louisiana enlisted Rutgers University for training and consultation. Through an initial needs assessment of each LGE, conducted by Rutgers University staff, the state was better able to identify each LGEs readiness to implement an FEP program and training needs. Subsequent to the completion of the needs assessment, a training series was developed and implemented through which participants were provided information about FEP, tenants of the RAISE model were explored, and best practices regarding the provision of services were reviewed. The trainings included a series of two (2) face-to-face trainings, each held in three areas of the state, and a series of webinars. Training participants included PSS, LGE staff, and Assertive Community Treatment (ACT) providers. ACT providers were included to further the system's capacity to serve this population. Through this training series, 468 individuals from throughout the state have been trained. Additionally, the webinars were recorded and have

subsequently been shared for future viewing by staff not able to participate in the live trainings. The PowerPoint presentations from the trainings have also been shared with staff. The schedule of completed trainings is as follows:

- Understanding RAISE: Services for Young People Experiencing FEP (face-to-face)
- FEP - Engaging Youth (webinar)
- FEP - Understanding Change (webinar)
- FEP - Goal Setting (webinar)
- FEP - Facilitating Change (webinar)
- Assessing and Facilitating Change While Utilizing the Psychiatric Rehabilitation Readiness Determination Profile (PRRDP) Process (face-to-face)
- NAVIGATE Team Overview – This webinar provided an overview to individuals throughout the state on the NAVIGATE model of treatment for individuals experiencing FEP; 105 individuals participated in this training including PSS, LGE and hospital clinicians as well as private providers.
- FEP Prescriber Training – This face to face training provided an overview of best prescriptive practices for individuals experiencing FEP. The training was held in 5 areas of the state and attended by a total of 107 behavioral health clinicians from the LGE and hospital systems as well as various private providers.
- 2-day NAVIGATE Training – This training, which occurred June 23 and 24, 2016, was targeted towards those staff members working within an LGE-sponsored NAVIGATE team. Through this process, specific sessions were provided to those individuals functioning as Team Leaders and Family Education Clinicians, Individual Resiliency Trainers, and Supported Employment and Education Specialists. LGE staff, administrators and PSS participated for a total attendance of 24 individuals.

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

The goal of the Louisiana plan for FEP implementation is to increase capacity of the system to effectively serve and identify individuals experiencing FEP throughout the state while identifying and providing training to those locations capable of implementing Coordinated Specialty Care (CSC) programs. Louisiana has implemented the following programs:

NAVIGATE – Three (3) LGEs have decided to implement this evidence based model of coordinated treatment. These LGEs include Jefferson Parish Human Services Authority (JPHSA), Capital Area Human Services District (CAHSD), and Florida Parishes Human Services Authority (FPHSA).

YALE-STEP - OBH has also contracted with an FEP program in New Orleans called EPIC-NOLA. This program is operated through Sinfonia Family Services of Louisiana, a Medicaid-affiliated community behavioral health provider. The FEP program has been implemented in conjunction with Tulane University and is modeled off of the Yale STEP program.

Public Health Model - Through this public health approach, LGEs will continue to provide peer support services (PSS) to individuals experiencing their first episode of psychosis. The goal of the Louisiana plan for FEP implementation in these areas of the state is to increase capacity of the system to effectively serve individuals experiencing first episode psychosis through trainings while

supporting the identification of individuals experiencing FEP and moving them into traditional treatment, thereby shortening the individual's duration of untreated psychosis.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis.

Ongoing activities related to Louisiana's First Episode Psychosis initiative include the following:

- Peer Support - Continued support of PSS in each of the 10 LGEs for this initiative.
- Outreach – Development and distribution of outreach materials for individuals experiencing FEP and their families. Materials will be in line with that which is available through On Track NY and other established evidence-based FEP programs.
- CSC Program Implementation and Support – Continued support of the CSC programs implemented in JPHSA, CAHSD, and FPHSA. These programs began identifying and serving individuals experiencing FEP SFY17, subsequent to the 2-day NAVIGATE training held June 23 and 24, 2016. Also in SFY17, OBH began supporting the EPIC-NOLA CSC program which is operated through Sinfonia Family Services in Louisiana, in conjunction with Tulane University.
- Ongoing Technical Assistance – Through contracts with consultants, provide on-going technical assistance to LGEs throughout the state, supporting them as they implement their selected FEP model:
  - *NAVIGATE* – ongoing conference calls with each of the LGEs implementing the NAVIGATE/NAVIGATE model for 12 months post training.
  - *Public Health* – ongoing assistance to each of the LGEs implementing this model to better help them develop programming which will meet their individualized needs.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

The state's provision for collecting and reporting data will occur through OBH program staff receiving programmatic data from the CSC programs operating through the LGEs and EPIC-NOLA program. Reports are received from each program monthly with OBH program staff participating in staffings with the LGEs. Formal reports are provided by the LGEs quarterly, with the EPIC-NOLA program providing their report monthly with invoicing.

10. Please list the diagnostic categories identified for your state's ESMI programs

NAVIGATE: 15 – 40 y.o. (+/- with approval of treatment team); 1 year or less of treatment; 12 months or less of taking anti-psychotic medications and/or 2 year or less of psychotic symptoms

EPIC-NOLA (modeled off of the YALE-STEP program): 12 – 35 y.o. (+/- with approval of treatment team); Experiencing psychosis for less than 2 years, have received a diagnosis of schizophrenia or other psychotic disorder, have recently been hospitalized for psychosis, are willing to be evaluated and treated by healthcare professionals.

Please indicate area of technical assistance needed related to this section.

Technical assistance in regards to the sustainability of programming would be beneficial, especially in regards to the engagement of Managed Care Organizations and reimbursement of services through Medicaid.

5. Person Centered Planning (PCP) –Required (MHBG)

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning?

☒ Yes ☐ No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

The State requires contracted managed care entities to:

- Initiate welcome calls to all new members to provide a brief explanation of the program, discuss availability of oral and written translation services, and determine if the member has any special health care needs;
- Provide members with a member handbook which includes information on topics such as member rights and responsibilities, freedom of choice, disenrollment rights, procedures for obtaining benefits, policies on advance directives and grievance and appeal procedures; and
- Develop and maintain a member-focused webpage which includes general program information, contact information, member handbook, and provider directory.

Further, the State requires sufficient mechanisms in place to solicit feedback and recommendations from stakeholders and members and use said feedback to improve performance.

4. Describe the person-centered planning process in your state.

For the Coordinated System of Care program, the planning process is guided by System of Care values (family driven, youth guided, culturally and linguistically competent, home and community based, strength-based, individualized, integrated across systems, connected to natural helping networks, data and outcome driven, and unconditional care). The Wraparound Facilitator is responsible for convening the Child and Family Team, which is comprised of the member, his/her caregiver, and other individuals agreed to by the member and family, to develop the person and family-centered service plan. As part of this process, the Wraparound Facilitator provides information to the member and his/her caregiver on available services and providers in order to support member freedom of choice. The member and his/her caregivers have the primary role of identifying appropriate goals, strengths, needs, and the development of a risk assessment (crisis plan). The Wraparound Facilitator documents decisions made by the Child and Family Team, facilitates the overall meeting and assures that all members of the team have an opportunity to participate.

For other Medicaid-funded services including but not limited to mental health rehabilitation, substance use disorder services (all ASAM levels), and inpatient level of care (psychiatric residential treatment facilities and acute inpatient), a treatment plan is required. The outpatient services that do not require a treatment plan are therapeutic services delivered by a licensed mental health practitioner (individual, family, and group therapy) when not part of a mental health rehab agency. Regarding FQHC, the requirement for a treatment plan is in manual not state plan.

6. Self-Direction – Requested

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self- direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States

and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following:

1. Does your state have policies related to self-direction?

   ☐ Yes ☒ No

2. Are there any concretely planned initiatives in your state specific to self-direction?

   ☐ Yes ☒ No

If yes, describe the current or planned initiative. In particular, please answer the following questions:

a. How is the initiative financed?
b. What are the eligibility criteria?
c. How are budgets set, and what is the scope of the budget?
d. What role, if any, do peers with lived experience of the mental health system play in the initiative?
e. What, if any, research and evaluation activities are connected to the initiative?
f. If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

7. Program Integrity – Required

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x- 31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x– 55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG

funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

1) Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

☒ Yes ☐ No

2) Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

☒ Yes ☐ No

3) Does the state have any activities related to this section that you would like to highlight?

N/A

Please indicate areas of technical assistance needed related to this section.

N/A

8. Tribes – Requested

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs, and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall **not** require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please respond to the following items:

1. How many consultation sessions have the state conducted with federally recognized tribes?

   LDH Bureau of Minority Health Access and Promotions consults with state and federally recognized tribes annually, starting with a listening tour to all the tribes that begins in August and then maintaining contact throughout the entire year. The tribes partake in a number of programs sponsored by the Bureau since 1997 up to the present day.

Two LGEs engage tribes within their respective service delivery areas. The Chawasha Tribe in Grand Bayou Indian Village in Plaquemines, LA is included in the coalition "Plaquemanians in Action" in the Metropolitan Human Services District. The South Central LA Human Services District conducts an annual consultation session with the United Houma Nation.

2. What specific concerns were raised during the consultation session(s) noted above?

LDH Bureau of Minority Health Access lists the following as the biggest concerns from both state and federally recognized tribes:

1. Diabetes
2. Obesity
3. High Blood Pressure
4. Hypertension
5. Heart Disease

The next major concern is emergency preparedness, especially if there is a pandemic flu outbreak. Tribes feel they are not adequately prepared in the event of an outbreak.

In SCLHSA, specific concerns included need for collaboration, student worker placements in clinic settings, and community outreach.

Does the state have any activities related to this section that you would like to highlight?

N/A

Please indicate areas of technical assistance needed related to this section.

N/A

9. Primary Prevention-required (SABG only)

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

4. **Problem identification and referral** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

5. **Community-based processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. **Environmental strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following questions:

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?

   a) ☒ Yes ☐ No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):

   a) ☒ Data on consequences of substance-using behaviors
   b) ☒ Substance-using behaviors
   c) ☒ Intervening variables (including risk and protective factors)
   d) ☐ Other (please list :)

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply):

   a) ☒ Children (under age 12)
   b) ☒ Youth (ages 12-17)
   c) ☒ Young adults/college age (ages 18-26)
   d) ☒ Adults (ages 27-54)
   e) ☒ Older adults (age 55 and above)
   f) ☒ Cultural/ethnic minorities
   g) ☒ Sexual/gender minorities
   h) ☒ Rural communities
   i) ☐ Other (please list :)

4. Does your state use data from the following sources in its primary prevention needs assessment? (check all that apply):

a) ☒ Archival indicators (Please list :)

- Alcohol Epidemiologic Data System (AEDS)
- Fatality Analysis Reporting System (FARS)
- National Vital Statistics System (NVSS)
- Uniform Crime Reporting Program (UCR)
- United States Census Bureau Population Projections
- Louisiana Caring Communities Youth Survey
- CORE Alcohol and Drug Survey
- Crash Report Data. Louisiana Highway Safety Commission (LHSC)/Highway Safety Research Group (HSRG)
- Hepatitis Data, Louisiana Office of Public Health (OPH)
- HIV/AIDS Data, Louisiana Office of Public Health (OPH)
- Mortality Data, Louisiana Office of Public Health (OPH)
- Student Information System (Disciplinary Action Data Related to Substance Use), Louisiana Department of Education
- Substance Abuse Treatment Admissions, Office of Behavioral Health (OBH)

b) ☒ National Survey on Drug Use and Health (NSDUH)

c) ☒ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☐ Youth Risk Behavior Surveillance System (YRBS)

e) ☒ Monitoring the Future

f) ☐ Communities that Care

g) ☒ State-developed survey instrument (Louisiana Caring Communities Youth Survey)

h) ☒ Other (please list :)

The SEW maintains an online data system, which includes consumption indicators and long- and short-term consequence indicators at the state and community level. The online data system can be accessed at http://www.bach-harrison.com/lasocialindicators/.

Other National Data Sources:

- Alcohol Epidemiologic Data System (AEDS)
- Fatality Analysis Reporting System (FARS)
- National Vital Statistics System (NVSS)
- Uniform Crime Reporting Program (UCR)
- United States Census Bureau Population Projections

Louisiana Specific Data Sources:

- Louisiana Caring Communities Youth Survey
- CORE Alcohol and Drug Survey
- Crash Report Data. Louisiana Highway Safety Commission (LHSC)/Highway Safety Research Group (HSRG)
- Hepatitis Data, Louisiana Office of Public Health (OPH)
- HIV/AIDS Data, Louisiana Office of Public Health (OPH)
- Mortality Data, Louisiana Office of Public Health (OPH)
- Student Information System (Disciplinary Action Data Related to Substance Use), Louisiana Department of Education
- Substance Abuse Treatment Admissions, OBH

5. Does your state use needs assessment data to make decisions about the allocation of SABG primary prevention funds? ☒ Yes ☐ No

a) If yes, please explain.

The criteria that OBH Prevention Services uses for establishing primary prevention priorities requires that state epidemiological data support the decision to fund a given intervention. Only programs that are evidenced-based and on a federally recognized register, or have been presented in a peer-reviewed journal with good results, are considered. Further, there must be statistically significant outcomes achieved with a sufficient sample in the program research to yield a reliable evaluation.

The rationale for prioritizing primary prevention programs in Louisiana is to address the fundamental substance abuse-related issues in the State. The basis for judging the most pressing needs in Louisiana are found in the data. For instance, LifeSkills Training, Kids Don't Gamble…Wanna Bet?, and Second Step account for 71% of all enrollees in SFY 2016. The proven outcomes for these programs are centered around alcohol, tobacco, family relationships, drugs, social functioning, crime and violence as indicated on NREPP. These programs have outcomes that address substance-abuse related problems in the State as revealed by data. Three of these data sources are the 2014 and 2016 Caring Communities Youth Survey (CCYS), the 2015 and 2017 CORE Alcohol and Drug Survey, which are both funded by OBH, and the State Epidemiology Workgroup (SEW) online data system.

OBH maximizes the positive impact on citizens by funding primarily universal programs based on needs (indicated by data) and partnering with the DOE to deliver these services using a cost-effective school-based model. OBH headquarters staff annually reviews epidemiological data with Local Governing Entity (LGE) staff. It is important to note that the three core reports that provide epidemiological data are collected every two years. In years that new data are available, additional training and technical assistance is provided on how to interpret the new information. OBH has initiated training sub-recipients and staff on SAMHSA's Strategic Prevention Framework (SPF). OBH continues to move toward the goal of fully implementing the SPF process throughout the agency for making data-driven prevention decisions.

b) If no, please explain how SABG funds are allocated.

Capacity Building

6. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?

a) ☒ Yes (if yes, please describe)

b) ☐ No

Louisiana does have a statewide licensing/certification program for the substance abuse prevention workforce. The Addictive Disorder Regulatory Authority is the state licensing and credentialing board for addiction counsellors and prevention professionals. A prevention professional must first register as a Prevention Specialist in Training (PSIT). Based on education and experience, a prevention professional may become a Licensed Prevention Professional (LPP), a Certified Prevention Professional (CPP), and a Registered Prevention Professional (RPP).

ELIGIBILITY REQUIREMENTS FOR LPP

1) At least 21 years of age and holds a Master's or Doctoral degree from an accredited institution of higher education
2) A legal resident of the United States
3) In not in violation of any ethical standard subscribed to by the ADRA
4) Has not been a substance abuser or compulsive gambler for at least two years prior to the date of the application
5) Has not been convicted of a felony; however the ADRA has the discretion to waive this requirement upon review of the circumstance
6) Has successfully completed 100 total clock hours of education approved by the ADRA. 50 hours of the 100 hours must be specific to substance abuse training, with 6 hours in professional ethics, 30 hours from National Prevention Training with the remaining 14 hours being related. All hours are subject to approval by the ADRA
7) Has successfully completed 2000 hours (1 full-time year) of supervised work experience engaged in providing prevention services. Of the 2000 hours, a 120 hour practicum in the 5 domains must be obtained with at least 10 hours in each domain. The experience must be supervised by a qualified professional
8) Has completed and received approval for testing based on submission of the application prescribed by the ADRA to include a case study
9) Demonstrates competence in addiction counseling by passing the written examination prescribed by the ADRA

ELIGIBILITY REQUIREMENTS FOR CPP

1) At least 21 years of age and holds a Bachelor's degree from an accredited institution of higher education
2) A legal resident of the United States
3) In not in violation of any ethical standard subscribed to by the ADRA
4) Has not been a substance abuser or compulsive gambler for at least two years prior to the date of the application
5) Has not been convicted of a felony; however the ADRA has the discretion to waive this requirement upon review of the circumstance

6) Has successfully completed 100 total clock hours of education approved by the ADRA. 50 hours of the 100 hours must be specific to substance abuse training, with 6 hours in professional ethics, 30 hours from National Prevention Training with the remaining 14 hours being related. All hours are subject to approval by the ADRA
7) Has successfully completed 4000 hours (2 full-time years) of supervised work experience engaged in providing prevention services. Of the 4000 hours, a 120 hour practicum in the 5 domains must be obtained with at least 10 hours in each domain. The experience must be supervised by a qualified professional
8) Has completed and received approval for testing based on submission of the application prescribed by the ADRA to include a case study
9) Demonstrates competence in addiction counseling by passing the written examination prescribed by the ADRA

ELIGIBILITY REQUIREMENTS FOR RPP

1) At least 21 years of age and hold a High School Diploma or a high school diploma equivalent (GED).
2) A legal resident of the United States
3) In not in violation of any ethical standard subscribed to by the ADRA
4) Has not been a substance abuser or compulsive gambler for at least two years prior to the date of the application.
5) Has not been convicted of a felony; however the ADRA has the discretion to waive this requirement upon review of the circumstance
6) Has successfully completed 100 total clock hours of education approved by the ADRA. 50 hours of the 100 hours must be specific to substance abuse training, with 6 hours in professional ethics, 30 hours from National Prevention Training with the remaining 14 hours being related. All hours are subject to approval by the ADRA
7) Has successfully completed 6000 hours (3 full-time years) of supervised work experience engaged in providing prevention services. Of the 2000 hours, a 120 hour practicum in the 5 domains must be obtained with at least 10 hours in each domain. The experience must be supervised by a qualified professional
8) Has completed and received approval for testing based on submission of the application prescribed by the ADRA to include a case study
9) Demonstrates competence in addiction counseling by passing the written examination prescribed by the ADRA

7. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?

a) ☒ Yes (if yes, please describe mechanism used)

b) ☐ No

OBH builds the capacity of its prevention system, including the capacity of its prevention workforce through continuous training and adaptation. Over the past few years, Louisiana's prevention system has changed from the original 10 regions to the formation of Local Governing Entities (LGEs). OBH maintains a functional relationship with both LGEs and Prevention

Coordinators (PCs) through regularly scheduled monthly conference calls and Learning Communities. The prevention team also conducts Quarterly site visits. Local Prevention Coordinators are responsible for community mobilization activities, oversight of prevention contract providers, and serve as liaisons to state and local stakeholders. Local PCs are provided technical assistance and resources via OBH's State Prevention Staff and participate in trainings to ensure appropriate delivery of prevention services throughout the State. OBH fully understands the importance of collaborating, braiding resources, and networking to either maintain its existing prevention system or to enhance the system. As prevention broadens its scope to include health promotion and the prevention of mental, emotional and behavioral disorders as well as suicide prevention, trainings are being offered to PCs, providers, and other partners to build prevention workforce capacity.

OBH Prevention Services (through a contractual agreement with Southern University Baton Rouge) offers one online Prevention Professional Seminar and five face-to-face courses/trainings to meet the educational requirements for employees, contractors, and other interested persons to become certified or licensed prevention professionals and to further develop the prevention workforce in Louisiana.

The online Prevention Professional Seminar (worth 45 clock hours) provides the fundamentals of prevention as a science and emphasizes the transition of Louisiana's focus from a risk and protective model to the public health model. The public health model incorporates the Strategic Prevention Framework as the focus is on environmental strategies to make population level changes rather than only individual changes through programs. Participation in OBH’s trainings demonstrate evidence of prevention workforce development.

The five face-to-face courses/trainings include Ethics (6 clock hours); Cultural Competency in Prevention (6 clock hours); Prevention of Mental, Emotional, and Behavioral Disorders Seminar; Suicide Prevention (45 clock hours), and the Substance Abuse Prevention Skills Training (SAPST). Ethics and Cultural Competency in Prevention are each provided four times annually. The Prevention of Mental, Emotional, and Behavioral Disorders Seminar and Suicide Prevention are each provided twice annually. The SAPST is provided three times annually.

Ethics and Cultural Competency in Prevention are both requirements of prevention professionals to acquire and/or maintain licensure/certification. The Prevention of Mental, Emotional, and Behavioral Disorders Seminar highlights progress and possibilities in the prevention of mental, emotional, and behavioral disorders (MEB) among young people. Research evidence underscores the importance of identifying and intervening at early ages to prevent the onset of these disorders that have serious human, societal, and economic impacts. Information presented is applicable for persons working in the fields of criminal justice, substance abuse prevention, education, mental health and other related fields. Suicide Prevention provides the opportunity for participants to first learn about the nature of suicidal communications, what forms these communications take and how they may be used as the stimulus for a Question Persuade and Refer (QPR) intervention. To gain perspective, students are introduced to the history of suicide, suicide prevention and the spectrum of modern day public health suicide prevention education efforts. Finally, SAPTS provides an introduction to the fundamentals of substance abuse prevention based on the current knowledge and practice in the field. This training is designed to prepare practitioners to reduce

the likelihood of substance abuse and promote well-being among individuals, and within families, workplaces, schools and communities.

OBH also funds a contract with Dr. Murelle Harrison to deliver specialized Prevention Professional Workforce Development training for employees, contractors, and other persons referred by OBH. Technical assistance and follow-up are to be provided on an as needed basis. Dr. Harrison provides a minimum of 12 on-site Prevention Professional Exam Preparation workshops to include technical assistance in application preparation. Dr. Harrison monitors the application process for individuals attending the training to ensure accuracy and follow-through with the Addictive Disorder Regulatory Authority (ADRA). Dr. Harrison is responsible for informing the prevention community of current regulations from International Certification and Reciprocity Consortium (IC&RC) as a Louisiana Delegate. As a part of this contract, Dr. Harrison also serves as the liaison regarding Block Grant and LaPFS with the OBH LGEs and other community coalitions (to include Louisiana Partnerships for Success coalitions) focusing on the prevention of substance use, mental, emotional, and behavioral disorders to provide technical assistance and guidance as they implement the SPF process within their districts Workshops will include the following: Application Preparation Assistance, Prevention Professional Examination Preparation, and SPF technical assistance.

OBH works closely with the Center for the Application of Prevention Technologies (CAPT) and more specifically with the Southwest Regional Expert Team (SWRT). The CAPT is a national substance abuse prevention training and technical assistance (T/TA) system dedicated to strengthening prevention systems and the nation's behavioral health workforce.

As part of the Partnerships for Success Grant, there are on-going Learning Communities provided. These Learning Communities are open to PFS sub-grantees, Prevention Coordinators, and other community partners. The Learning Communities are done through "Go To" and face-to-face meetings.

8. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

a) ☒ Yes (if yes, please describe mechanism used :)

b) ☐ No

The state has adopted the Strategic Prevention Framework as the Planning Model for all Prevention services. Much time has been devoted to training and technical assistance around the first and second steps of the SPF, Assessment and Capacity. Specific information is provided on assessing data, readiness and resources. Webinars and face-to-face trainings are held each year with individuals from each Local Governing Entity on these topics with special attention devoted to assessment and capacity. The training begins with a review of the Strategic Prevention Framework. The assessment section of the training includes: an assessment of data from community profiles, review of community resource scans and a power point describing the Tri-Ethnic community readiness model. The capacity section of the training includes an overview and review of action planning templates for developing coalition membership action plans, data enhancement action plans and community readiness action plans. As homework, each LGE must

complete interview questions, look at the information across dimensions, score and develop strategies related to final readiness score.

Planning

9. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?

a) ☒ Yes (If yes, please attach the plan in BGAS)

b) ☐ No

Louisiana's Strategic Plan for Substance Abuse Prevention 2012-2016 was released in July 2016 and is uploaded in BGAS. Louisiana is currently finalizing Louisiana's Strategic Plan for Substance Abuse Prevention 2017-2021. Once finalized, this document will be shared with SAMHSA.

10. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG?

a) ☒ Yes ☐ No

☐ Not applicable (no prevention strategic plan)

11. Does your state's prevention strategic plan include the following components? (check all that apply):

a) ☒ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds (Note: Needs assessment datasets identify the priorities, but there is no specific mention of the SABG primary prevention funds)
b) ☒ Timelines
c) ☒ Roles and responsibilities
d) ☒ Process indicators
e) ☒ Outcome indicators
f) ☒ Cultural competence component
g) ☒ Sustainability component
h) Other (please list:)
i) Not applicable/no prevention strategic plan

12. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?

a) ☒ Yes ☐ No

The Louisiana Behavioral Health Advisory Council (LBHAC) provides guidance for the Block Grant Application/State Behavioral Health Plan and monitors, reviews, and evaluates the allocation and adequacy of behavioral health services within the state. Regional Advisory Councils (RACs) are similar in purpose to the LBHAC, but with interests specifically geared toward activities in their respective areas. The RACs are the lead agencies in advising how Block Grant funds will be allocated locally.

13. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?

a) ☒ Yes ☐ No

b) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

OBH Prevention Services over the past four years has moved from a pattern of historical funding of prevention services to a data-driven planning process. Annually, the 10 geographic service areas of the state review their funding of prevention services. As previously mentioned in Question #5, the mechanisms by which SABG primary prevention funding decisions are made include needs assessments using the Louisiana Caring Communities Youth Survey, the Higher Education Core Survey reports, and the State Epidemiological Workgroup report. These documents are reviewed and serve as a link to intended state outcomes at the local level. These needs assessments are updated every two years. The capacity of the providers available is reviewed, along with the current resources available to the service area, including partnerships that braid funding, such as the local Department of Education.

OBH only funds evidence-based programs and strategies. The State funds programs that meet the following criteria: 1) Inclusion in a federal list or registry of evidence-based interventions, or 2) Being reported (with positive effects) in a peer-reviewed journal. Over the last two years, these action plans have become standardized based upon the evidence-based intervention's developer. The contracts (action plans) are monitored monthly at the regional level. Implementation of deliverables and process data is tracked through data collected in the State's web-based data management system, PMIS. A PMIS report is generated each quarter by the state Prevention Services detailing services and deliverables information for each region, provider, and program. This report is followed by a quarterly site visit by a state office Prevention staff member to provide technical assistance during the service delivery period. Resources are monitored and reallocated during the year as needed.

Implementation

14. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

a) ☐ SSA staff directly implements primary prevention programs and strategies.
b) ☒ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
c) ☒ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
d) ☒ The SSA funds regional entities that provide training and technical assistance.
e) ☒ The SSA funds regional entities to provide prevention services.
f) ☒ The SSA funds county, city, or tribal governments to provide prevention services. (Note: SSA funds parish-level services through regional systems.)
g) ☒ The SSA funds community coalitions to provide prevention services. (Note: Community coalitions are funded by regional system.)

h) ☐ The SSA funds individual programs that are not part of a larger community effort.

i) ☒ The SSA directly funds other state agency prevention programs.

j) ☐ Other (please describe)

15. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

All OBH contract providers provide information specific to their program and ATOD to the communities in which they reside. OBH also maintains at least one Regional Alcohol and Drug Awareness Resource (RADAR) Associate Network in each of the ten Local Governing Entities (LGEs). OBH, through its Prevention Management Information System (PMIS), confirms that this information dissemination. Examples include dissemination of ATOD literature, audiovisual materials, curriculum materials, printed material, resource directory, and telephone information. They also conducted health fairs, health promotion events, media campaigns, public service announcements, and speaking engagements.

b) Education:

OBH contract providers provide on-going prevention education from evidence-based curriculums to enrollees in their respective program(s). OBH confirms through its Prevention Management Information System (PMIS) the number of evidence-based programs provided to enrollees. The following table lists the 15 Evidence-Based Educational Programs that were funded during SFY 2017 designated by Universal, Selective, or Indicated.

Universal Evidence-Based Program
Life Skills Training
Kids Don't Gamble… Wanna Bet?
Second Step
Project Northland
Too Good for Drugs
Guided Imagery Program
Protecting You-Protecting Me
Project Alert
Al's Pal
Positive Action
Project Toward No Tobacco Use
Keep A Clear Mind
Universal Program Total: 13

Selective Evidence-Based Program
Parenting Wisely
Strengthening Families
Selective Program Total: 2

Indicated Evidence-Based Program
Insight Class Program
Indicated Program Total: 1

c) Alternatives:

Prevention contractors have the option of providing alternative strategies through in-kind contributions to their respective target population(s) as may be appropriate. Provider staff

provides alcohol, tobacco and other drug-free events; community drop-in center activities; community services; and youth and adult leadership functions. OBH also implemented the evidence-based Leadership and Resiliency Program.

d) Problem identification and referral

OBH continues to provide problem identification and referral services to all state employees through the existing Employee Assistance Program (EAP). Currently, EAP is a peer-referral program only and does not provide direct services. OBH tracks the number of referral requests, referral sources, and identified problems. Contract providers are responsible for ensuring access to community resources by referring participants and/or their families for services not provided by the contractor. Providers referred customers to services that included DUI/DWI/MIP services, as well as student and employee assistance programs. Providers delivered these services on an individual basis and in venues such as adult education classes, suicide prevention workshops, and teen job fairs.

e) Community-Based Processes:

OBH continues to develop a comprehensive, research-based approach to prevention services. In an effort to mobilize communities, OBH staff and contractors participate in the implementation of the Strategic Prevention Framework. The Framework includes the following steps: 1) needs, readiness, and resource assessment; 2) building capacity; 3) selecting appropriate programs, policies and practices; 4) implementing selected programs, policies and practices; and 5) evaluating outcomes. Agency and provider staff participated in accessing services and funding, assessing community needs, community volunteer services, community needs assessment, community team activities, contract monitoring, formal community teams, professional development, strategic prevention planning, technical assistance, and training.

e) Environmental:

OBH funds a Synar Contractor in each region of the state in an effort to maintain no more than a 10 percent sale rate of tobacco products to minors. OBH staff and contractors identify and collaborate with other agencies and organizations (e.g. the Coalition for Tobacco-Free Living, Students Against Destructive Decisions, the American Lung Association, Highway Safety Coalitions, etc.) that are engaged in environmental strategies that address substance use disorders and related behaviors.

Provider and agency staff participated in alcohol use restrictions in public places, changing environmental laws, social norms campaigns, social marketing campaigns, compliance checks of alcohol and tobacco retailers, environmental consultation to communities, establishing ATOD-free policies, prevention of underage alcoholic beverage sales, public policy efforts, checking age identification for alcohol and tobacco purchase, minimum age of seller requirements, developing policies concerning cigarette vending machines, and alcohol restrictions at community events.

16. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?

a) ☒ Yes (if so, please describe:)

b) ☐ No

Mobilizing the existing infrastructure via partnership growth and expansion of the SPF planning process is the focus of change. Mobilizing the state and community partners around the SPF training will increase community awareness and support around the consequences of substance use, abuse and addiction. OBH has learned that in order to effectively reach the citizens of the state, it cannot operate in isolation. For this reason OBH has cultivated true partnerships with agencies whose focus aligns with the primary mission of prevention; to reduce substance use, abuse and addiction and related consequences. These partnerships allow us to avoid duplication of services and maximize existing resources. This change in the service-delivery model was possible through a partnership with DOE, which allowed OBH to move from funding infrastructure, and use these monies to provide increased service delivery to our citizens.

OBH has an existing strong relationship with the Office of Alcohol and Tobacco Control and Office of Public Health, Tobacco Control Program in the implementation of Synar requirements and tobacco education. In the future, changes are planned to develop partnerships (in addition to tobacco) that target population-based prevention strategies including retail and social availability, enforcement, community norms, and promotion. Implementation of these population-based prevention strategies will involve strengthening existing and creating new partnerships with additional agencies such as Highway Safety, State Police, the Attorney General, the Sheriff's association, institutions of higher education, and elected officials.

Evaluation

17. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?

a) ☐ Yes (If yes, please attach the plan in BGAS)

b) ☒ No

Though not a formal Evaluation plan, OBHS has a process to track process and outcomes of SABG-funded programs.

18. Does your state's prevention evaluation plan include the following components? (check all that apply):

a) ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
b) ☐ Includes evaluation information from sub-recipients
c) ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
d) ☐ Establishes a process for providing timely evaluation information to stakeholders
e) ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
f) ☐ Other (please describe:)
g) ☒ Not applicable/no prevention evaluation plan

The state collects process data through OBH's online Prevention Management Information System (PMIS). PMIS Process evaluation is conducted at the state, regional, and provider level. Prevention staff and contract providers input information about direct and indirect individual and population-based services into PMIS. PMIS is available to all on a daily basis and real-time rollup reports are compiled for the state, regional, or provider level. Specific data elements collected by PMIS include demographic data (age, race, and ethnicity) as well as tracking of specific services to include number served, target population, as well as services provided within the six CSAP prevention strategies.

Real time reports allow OBH Central Office staff to support the field by assessing the State's current capacity and determining whether performance targets have been achieved. This provides a mechanism for staff to develop, intervene and implement corrective action in a timely manner.

In addition to tracking process data, OBH is committed to a statewide system to evaluate outcomes. Each contract provider is required to obtain an external evaluator. Each provider administers the pre- and post-test that was developed and validated by each evidence-based program's developer. Since SFY 2011, a state evaluator compiles regional and state outcome reports based upon each evidence-based program funded by OBH Prevention services. In addition to the developer's pre-and post-test, Government Performance and Results Act (GPRA) supplemental questions are asked of youth age 12 and older.

State and Regional staff review these reports to determine fidelity improvement needs by content area of each program. It also helps strengthen our monitoring process of the evaluation cycle. Quarterly reviews of process and monitoring data ensures a stronger outcome evaluation system.

19. Please check those process measures listed below that your state collects on its SABG funded prevention services:

a) ☒ Numbers served
b) ☒ Implementation fidelity
c) ☐ Participant satisfaction
d) ☒ Number of evidence based programs/practices/policies implemented
e) ☒ Attendance
f) ☒ Demographic information
g) ☐ Other (please describe:)

20. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

a) ☒ 30-day use of alcohol, tobacco, prescription drugs, etc…
b) ☒ Heavy use
   ☒ Binge use
   ☒ Perception of harm
c) ☒ Disapproval of use
d) ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe:)

10. Statutory Criterion for MHBG (Required MHBG)

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Louisiana began its efforts to establish and implement an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders, in 2012 with the implementation of the Louisiana Behavioral Health Partnership (LBHP). The implementation of the LBHP was the beginning of Louisiana's efforts to right-size inpatient services and increase the utilization of community-based services through the managed care.

In November 2014, the Louisiana Department of Health (LDH) announced a plan to integrate all behavioral health care services into its existing Medicaid managed care system. On December 1, 2015, behavioral health services were integrated with primary health care services under Louisiana Medicaid's managed care system, Healthy Louisiana.

OBH continues to partner with both Central Louisiana State Hospital and East Louisiana State Hospital to help facilitate and coordinate the discharge of patients located in the civil intermediate care units. This collaborative process mirrors the State's previous discharge efforts during the Mental Health Redesign and Hospital Discharge Initiative. This discharge initiative has the objective of working with hospital discharge teams to find secure and effective placement settings (such as Permanent Supportive Housing units, group homes, or family homes) that will provide the level of care necessary to help the patient obtain optimal success. OBH staff meets with hospital staff to discuss cases at length, offer guidance, and work as a mediator between the hospital and behavioral health and housing entities. This process, which was established March 1, 2013, and continues to evolve, is in line with OBH's goal of emphasizing community-based treatment.

Additionally, OBH has implemented an acute care Continued Stay Review (CSR) process. The CSR process was put in place in order to appropriately ration disproportionate shares funding to psychiatric acute care facilities. Currently, the State's contracted Statewide Management Organization (SMO) determines medical necessity for both Medicaid and non-Medicaid inpatient services. When this care extends beyond what is deemed as the typical acute care stay (due to a number of capacity issues), disproportionate shares funding is used to cover the remainder of the stay. The OBH CSR unit helps to manage this support to assure that funds are appropriately spent.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

a) Physical health
☐ Yes ☐ No

b) Mental Health
☒ Yes ☐ No

c) Rehabilitation services
☒ Yes ☐ No

d) Employment services
☒ Yes ☐ No

e) Housing services
☒ Yes ☐ No

f) Educational services
☐ Yes ☒ No

g) Substance misuse prevention and SUD treatment services
☒ Yes ☐ No

h) Medical and dental services
☒ Yes ☐ No

i) Support services
☒ Yes ☐ No

j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)
☒ Yes ☐ No

k) Services for persons with co-occurring M/SUDs
☒ Yes ☐ No

Please describe as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state's case management services

Case management services are available via various programs within the Louisiana behavioral healthcare system.

Within the managed care model for integrated primary and behavioral healthcare services, it is a requirement of the contract that services provided by MCOs includes Case Management services. The MCOs are required to maintain an adequate number of case management staff necessary to support members in need of specialized behavioral health services. These staff persons shall be certified in treatment planning through the completion of specialized training in the Treatment Planning Philosophy. For the population receiving specialized behavioral health services, the MCO shall have integrated care management centers/case management staff that physically co-locate with care management staff. The MCO shall employ care managers to coordinate follow-up to specialty behavioral health providers and follow-up with patients to improve overall health care.

Within the integrated primary and behavioral health care managed care model for Medicaid services, the Special Health Care Needs (SHCN) population is also required to be offered

specialized case management services. The Special Health Care Needs population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. For the behavioral health population, individuals with special health care needs include:

- Individuals with co-occurring mental health and substance use disorders;
- Individuals with intravenous drug use;
- Pregnant women with substance use disorders or co-occurring disorders;
- Substance using women with dependent children;
- Children with behavioral health needs in contact with other child serving systems who are not eligible for CSoC;
- Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination; and
- Adults, 21 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed by the CSoC program contractor and have declined to enter the CSoC program.

The MCO shall identify members with special health care needs and assess those members within the specified timelines. The assessment must be done by appropriate behavioral or primary healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management.

Assertive Community Treatment (ACT) is available in multiple areas of the state. This medical, comprehensive case management and psychosocial intervention program is provided on the basis of the following principles:

- The service is available 24 hours a day, seven days a week.
- An individualized service plan and supports are developed.
- At least 90% of services are delivered as community-based outreach services.
- An array of services are provided based on individual patient medical need.
- The service is consumer-directed.
- The service is recovery-oriented.

4. Describe activities intended to reduce hospitalizations and hospital stays.

A major goal of the efforts to integrate behavioral and primary health care services into Louisiana Medicaid's managed care model, Health Louisiana, is to improve care coordination for their enrollees, provide more opportunities for seamless and real-time case management of health services, and better transition and use of all resources provided by Louisiana's healthcare system. Through better coordination of services, the integrated model enhances the consumer experience, increases access to a more complete and effective array of behavioral health services and supports, improves quality of care and outcomes, and reduces repeat emergency room visits, hospitalizations, out-of-home placements, and other institutionalizations. The managed care model consist of more than 1,800 behavioral health providers statewide.

Competency Restoration/Jail-Based Services are designed for pretrial detainees, who have been identified or adjudicated as incompetent and ordered to be hospitalized or to receive jail-based (community) treatment. District Forensic Coordinators (DFC), working with contract Psychiatrists and Psychologists, go to the jails and perform mental status assessments to determine the timeframe for admission to the hospital which may be 30 days, 10 days or 2 days depending on severity of symptoms. Other individuals may be deemed appropriate for 90-day jail-based competency restoration which allows them to bypass hospitalization, thus diverting the need for lengthy inpatient stays.

Crisis services are available in every region of the state through the LGEs. The community-based Child and Adolescent Response Team (CART) program and other community-based supports and services continue to provide a route to assist in the reduction of inpatient hospitalizations and diversion from out-of-home placements. Assertive Community Treatment (ACT) services, an evidence-based medical, comprehensive case management and psychosocial intervention program, is also available in eight (8) areas of the state, which contributes to the reduction of inpatient hospitalizations and offers intensive supports to allow individuals to remain in the community.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

Estimate of statewide prevalence and incidence rates of individuals with SMI/SED for SFY 2015-16		
Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	192,019	Not Available
2. Children with SED	38,803	Not Available

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Statewide prevalence of adults (age 18 and over) with SMI and children with SED (ages 9 to 17) are calculated by obtaining the estimated Louisiana population count from the federal census website https://www.census.gov/quickfacts and then multiplying the estimated population by civilian population (age 18 and over) SMI rate or midpoint between the upper and lower boundary

of Level of Functioning =50 for child population (age 9-17) rate from 2015 URS table #1 (SAMHSA Drug & Alcohol Services Information System website https://wwwdasis.samhsa.gov/dasis2/urs.htm , SMI/SED Prevalence Estimates 2015 URS Table 1: Number of adults with serious mental illness, age 18 and older, and Number of children with serious emotional disturbances, age 9 to 17, by state, 2015).

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

Does your state integrate the following services into a comprehensive system of care?

a) Social Services
☒ Yes ☐ No

b) Educational services, including services provided under IDE
☒ Yes ☐ No

c) Juvenile justice services
☒ Yes ☐ No

d) Substance misuse prevention and SUD treatment services
☒ Yes ☐ No

e) Health and mental health services
☒ Yes ☐ No

f) Establishes defined geographic area for the provision of the services of such system
☒ Yes ☐ No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community- based services to individuals in rural areas; and community-based services to older adults.

Describe your state's targeted services to rural and homeless populations and to older adults

Community- Based Services to Homeless Population

In 2013, the Louisiana Office of Behavioral Health was awarded the Cooperative Agreement to Benefit Homeless Individuals (CABHI) States Grant through the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS) to fund the Louisiana Chronic Homelessness Assistance and Treatment Services (LaCHATS) project. In September 2014, the Louisiana Office of Behavioral Health was also awarded the CABHI States Grant Supplement. The major goal of the Cooperative Agreement to Benefit Homeless Individuals program is to ensure that the most vulnerable individuals who are chronically homeless with SMI and/or SUD, or Veterans who are homeless with behavioral health disorders, receive access to sustainable permanent housing, treatment, and recovery supports through mainstream funding sources. This has been accomplished by establishing Provider Agreements and Contracts with providers in both Baton Rouge and New Orleans where the highest population of homeless individuals reside. Since the implementation of the CABHI grant, over 420 homeless individuals with behavioral health disorders have been served by the CABHI states grant.

The Projects for Assistance in Transition from Homelessness (PATH) program is a formula grant through which states and territories provide Homeless and Outreach services. Specifically, these services are for individuals with serious mental illnesses and those with co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. PATH services include community-based outreach, mental health, substance use, case management and other support services, as well as a limited set of housing services. States are encouraged to develop a uniform permanent supportive housing resources policy framework, priority population targeting criteria and defined pathways for entry into housing. This approach coupled with street outreach and case management should result in strong linkages and referrals to permanent supportive housing for persons with serious mental illnesses and co-occurring substance use disorders that are homeless or at imminent risk of becoming homeless.

In an effort to carry out this grant, the LGEs identify the appropriate social service contract to allocate PATH funds. LGE staff monitors these contracts for programmatic issues, outcomes, chart documentation and data reporting. The chart below provides information on Louisiana PATH providers.

Louisiana PATH Providers	**LGE**
Unity of Greater New Orleans	MHSD
Volunteers of America - Greater New Orleans	MHSD
Volunteers of America - Greater Baton Rouge	CAHSD
South Central Louisiana Human Service Authority	SCLHSA
Volunteers of America - Greater Baton Rouge	AAHSD
Volunteers of America - North Louisiana	CLHSD
HOPE Connection	NLHSD
Wellspring Alliance for Families	NEDHSA
Responsibility House	JPHSA

In addition, OBH has two contracts using Mental Health Block Grant funding to provide housing supports and services to homeless individuals with serious mental illness. These contracts include the Housing Assistance Program Contract with Mental Health of America of Louisiana (MHAL) and a contract with the National Alliance for the Mentally Ill of St. Tammany (NAMI St. Tammany)

The current contract with NAMI in St. Tammany Parish assists with the funding of (3) separate residential projects to serve thirty (30) adults living with Serious and Persistent Mental Illness (SPMI) who meet HUD's definition of homeless. While these individuals have a primary diagnosis of SPMI, they may also have co-occurring disorders with substance use disorders and/or intellectual/developmental disabilities.

This program allow individuals, who otherwise may be subject to further institutionalization or homelessness, to live in a less restrictive community-based environment while preparing them to move in the direction of recovery and independence. NAMI provides qualified trained staff to ensure supervision of the residents and provision of services to the group home residents ranging from assistance with ADLS. Life Skills, Job Readiness and Case Management needs. NAMI St. Tammany also partners with other community based healthcare providers to ensure the residents behavioral and primary healthcare needs are met.

The purpose of the contract with Mental Health of America of Louisiana (MHAL) is to provide housing assistance for the transition from institutional care facilities, transitional housing programs, and/or substandard community housing for mental health individuals with mental health and/or substance use issues who are served through the Office of Behavioral Health (OBH) system of care. The intent is to be consistent with the Supreme Court Olmstead Decision to provide alternative housing options in least restrictive settings and to inform institutional mental health and substance abuse individuals with treatment options that provide wraparound services in the community. The contract provides an opportunity for stable housing and allow the individuals to participate in treatment and recovery.

Clients discharging from intermediate care facilities often do not have stable housing or support systems that they can return to in the community. Moreover, residing in the institutional care facilities for extended timeframes has resulted in a lack of sufficient household furnishing and basic necessities for community living. In addition, some individuals with mental health disorders residing in substandard housing will require assistance to transition into independent housing.

Community- Based Services to Individuals in Rural Areas

Although OBH has implemented many effective programs in rural areas, residents of rural areas continue to face barriers to service, especially transportation. Transportation in the rural areas of the state has long been problematic, not only for OBH consumers, but for the general public living in many of these areas. The lack of transportation resources not only limits access to mental health services, but also to employment and educational opportunities. The expansion of behavioral health programs and providers and the recruitment of transportation providers in rural areas are ongoing goals. In many cases, community-based services, such as Assertive Community Treatment (ACT) or Intensive Case Management (ICM), have been made available to serve some of these populations. The ability of the five (5) Healthy Louisiana Managed Care Organizations (MCOs) to use mapping technology to monitor services and service providers throughout the State continues to help shape the network of providers and services by identifying gaps in services and locating where additional providers may be needed. One outcome of the transfer of the management of behavioral health services to the MCOs has been the development of a more robust provider network, even in the more rural areas of the state.

Community-based Services to Older Adults

As behavioral health services are largely targeted to all adults, inclusive of older persons, the Office of Behavioral Health (OBH) has no specific treatment programs for this population. Services typically provided to the general adult population with SMI include psychiatric evaluation, bio-psychosocial assessments, individual therapy, specialized group therapy and other evidence-based treatments based on unique individual needs.

Aggregate data for SFY 2016 indicate that 19,928 outpatient services have been delivered to Louisiana seniors (those aged 65 and over) with mental health diagnosis throughout the LGEs.

The overwhelming majority of mental health conditions upon admission to community based services for Louisiana's senior population are Psychotic Disorders followed closely by Depressive Disorders. The following table on page 102 represents the distribution of primary admitting diagnoses for seniors.

FISCAL YEAR 2016 Current Primary Diagnosis	LOCAL GOVERNING ENTITY COUNT OF SERVICES RECEIVED for Mental Health Clients 65 and Over																				TOTAL	
	MHSD		CAHSD		SCLHSA		AAHSD		IMCAL		CLHSD		NWLHSD		NEDHSA		FPHSA		JPHSA			
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
ANXIETY DISORDERS	5	0.5%	197	3.2%	63	1.3%	7	1.3%	.	.	10	0.9%	.	.	24	6.6%	44	1.0%	8	3.9%	358	1.8%
BIPOLAR AND RELATED DISORDERS	104	10.1%	993	16.2%	840	17.3%	114	21.6%	19	9.8%	49	4.4%	199	16.1%	66	18.3%	154	3.6%	13	6.3%	2551	12.8%
DEPRESSIVE DISORDERS	195	18.9%	1486	24.2%	2021	41.5%	216	40.9%	59	30.6%	151	13.5%	438	35.4%	118	32.7%	324	7.6%	55	26.7%	5063	25.4%
DIAGNOSIS DEFERRED	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	285	6.7%	.	.	285	1.4%
INTELLECTUAL DISABILITY	2	0.2%	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	2	0.0%
NEUROCOGNITIVE DISORDERS	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	61	1.4%	4	1.9%	65	0.3%
NEUROGOGNITIVE DISORDERS	5	0.5%	10	0.2%	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	15	0.1%
OCD & RELATED DISORDERS	.	.	.	.	.	.	6	1.1%	.	.	2	0.2%	.	.	.	.	.	.	.	.	8	0.0%
OTHER DISORDERS	.	.	.	.	14	0.3%	.	.	.	.	.	.	.	.	.	.	.	.	.	.	14	0.1%
OTHER/UNSPECIFIED MENTAL DISORDERS	6	0.6%	41	0.7%	.	.	.	.	.	.	.	.	.	.	.	.	508	12.0%	.	.	555	2.8%
PSYCHOTIC DISORDERS	410	39.8%	2507	40.8%	1571	32.3%	167	31.6%	16	8.3%	87	7.8%	364	29.4%	149	41.3%	266	6.3%	53	25.7%	5590	28.1%
SUBSTANCE RELATED AND ADDICTIVE DISORDER	4	0.4%	25	0.4%	.	.	3	0.6%	5	2.6%	.	.	19	1.5%	.	.	.	.	48	23.3%	104	0.5%
TRAUMA & STRESSOR RELATED DISORDERS	8	0.8%	34	0.6%	46	0.9%	.	.	.	.	.	.	.	.	4	1.1%	16	0.4%	4	1.9%	112	0.6%
UNSPECIFIED MENTAL DISORDER	.	.	.	.	.	.	1	0.2%	.	.	.	.	6	0.5%	.	.	1	0.0%	.	.	8	0.0%
Z CODES	.	.	24	0.4%	7	0.1%	.	.	.	.	.	.	.	.	.	.	164	3.9%	.	.	195	1.0%
missing	291	28.3%	830	13.5%	304	6.2%	14	2.7%	94	48.7%	822	73.3%	212	17.1%	.	.	2415	57.0%	21	10.2%	5003	25.1%
TOTAL	1030	100%	6147	100%	4866	100%	528	100%	193	100%	1121	100%	1238	100%	361	100%	4238	100%	206	100%	19928	100%

OBH works collaboratively with Medicaid, the Office of Aging and Adult Services (OAAS), and the Office for Citizens with Developmental Disabilities (OCDD) in identifying and monitoring individuals with behavioral health disorders who are nursing facility (NF) applicants and may require specialized treatment beyond those traditionally offered in a nursing home setting. The collaboration is part of the federally mandated Pre-Admission Screening and Resident Review (PASRR) process created in 1987 through the Omnibus Budget Reconciliation Act and a required part of the Medicaid State Plan. PASRR has three main goals: to ensure that individuals are evaluated for evidence of possible mental illness, to see that they are appropriately placed in the least restrictive setting possible, and to recommend needed services wherever they are placed. Presently, OBH incorporates the use of web-based record filing and faxing to accommodate the transmission, receipt and storage of information obtained from hospitals and nursing facilities throughout the state.

OBH has integrated the PASRR evaluation process into the contracts with the five (5) Managed Care Organizations. The MCOS have Licensed Mental Health Practitioners (LMHPs) conduct face to face evaluations on individuals who are seeking nursing facility placement. The evaluations are completed in compliance with federal PASRR standards and include topics covering the individual's behavioral health history, their physical/medical history, social history, trauma history, living situation, learning/working and functional status including mental status and risk assessment. The evaluations are completed prior to admission to nursing homes as well as when there is a significant change in status (resident review) or an extension to the existing authorization is being made (extension request). Expert psychiatric consultation is also used for cases involving complex clinical behavioral health and medical presentations and when nursing facility placement is not the least restrictive environment for the individual. Recommendations for nursing home placement and behavioral health treatment are made based on a comprehensive review of clinical information.

The table below represents the number of individuals evaluated to date by OBH for nursing home determinations and specialized mental health services:

PASRR Process FY 2016 Referrals	**2887**
Types of Referrals	
• Referrals for admission to nursing facilities	1828
• Referrals for resident reviews performed while in the nursing facility after a significant change in status	622
• Referrals for Exempted Hospital Discharges not requiring PASRR process for first 30 days	435
Decisions	
• Approved for Nursing Facility Placement o Temporary Approvals	1613 (765)
• Denied Nursing Facility Placement	74
• Decided not to go to Nursing Facility and withdrew request	236
• Determined not to have a serious mental illness by OBH and determination by OBH Level II Authority was not required. Final determination made by the PASRR Level I Authority, Office of Aging and Adult Services (OAAS).	713

Number of MCO Evaluations	964
• Aetna	134
• Amerigroup	191
• Amerihealth Caritas of Louisiana	195
• Louisiana Healthcare Connections	233
Number of Evaluations by Medicaid Contract Psychologist	6
Number of Evaluations by OBH Contract Psychiatrist	63

The status of individuals recommended for specialized behavioral health care is tracked and monitored to ensure the delivery of services. Services are provided by an array of mental health care providers managed by the five (5) Healthy Louisiana Managed Care Organizations (MCOs). Individuals may receive services from a psychiatrist, a licensed mental health professional, and providers of addiction services while in the nursing facilities.

OBH worked on several multi-agency initiatives over the past year to enhance the identification of individuals in nursing homes with a mental illness and ensure they have appropriate services. These initiatives include:

- Identification of individuals in nursing facilities that no longer meet Level of Care (LOC)
- Increased collaborations between OBH and the LDH Health Standards Section (HSS)
- Site visits to nursing facilities that have large populations with behavioral health issues
- Continued consultation between OBH and HSS as behavioral health issues arise
- Collaborations to include PASRR in state nursing facility licensing standards
- OBH offers continuous technical assistance and trainings. Trainings offered by OBH include:
  - Training to state surveyors regarding PASRR
  - Trainings to Nursing Facilities (NF)
  - LDH Collaborative Discharge Planning Trainings to NF
  - OBH trainings to Louisiana Nursing Home Association members regarding PASRR and behavioral health issues in older adults
- Trainings to Managed Care Organizations (MCOs)
- Training to OBH PASRR staff
- Trainings to the Office of Aging and Adult Services' (OAAS) staff regarding suicide awareness and behavioral health services provided to older adults

OBH also partners with other agencies on activities and best practices for this population. These activities include Money Follows the Person (MFP), which is a federal initiative to transition people with Medicaid from nursing facilities back into the community with necessary supports and other activities identified through OAAS, Adult Protective Services, OCDD, Health Standards, as well as private hospitals and providers. OBH staff also represents the State as a member of the National Association of State Mental Health Directors' (NASMHPD) Older Persons Division. The purpose of this group is to represent and advocate for state mental health agencies by informing them of emerging policy issues, research findings and best practices, and to provide consultation and collaboration on mental health issues pertaining to older persons.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Describe your state's management systems.

The Louisiana Medicaid and CSoC MCOs offered statewide training to behavioral health providers on the following topics: utilization management, progress note completion, billing, eligibility, website resources and tools, authorization process, billable services, levels of care, care coordination, treatment planning, peer support, effective practices in ADHD treatment, crisis management planning, crisis interventions, and coordination of care with primary care physicians.

The Coordinated System of Care (CSoC) staff has been responsible for ensuring that all wraparound agencies and family support organization staff has the necessary training to successfully implement wraparound in their regions. In addition, the CSoC team at OBH and representatives from the CSoC MCO (Magellan) are responsible for providing additional training and support in the CSoC implementing regions.

OBH continues to make use of a web-based learning management system (Louisiana Employee Online Training) to provide training at the state, LGE, parish, and community level. OBH also provides "live" training events as topics, presenters, and identified needs are made known. Participants for most of the "live" trainings are selected individually by LGE leadership, and must possess the leadership and communication skills required to transfer information and provide trainings to colleagues and other providers within their respective LGE. Transfer of learning remains a key objective for all training provided, whether online or "live" and supervisory follow up is encouraged as a basic requirement for all training offered.

OBH continues to sponsor, co-sponsor, or support with in-kind resources trainings and conferences within the state, such as the annual National Association of Social Workers Louisiana Chapter (NASW-LA) conference and the Louisiana Association of Substance Abuse Counselors and Trainers (LASACT) annual conference, by presenting specified material during workshops as requested. OBH intends to continue to support these efforts for the upcoming fiscal years.

In June 2017, OBH also sponsored a statewide Behavioral Health Symposium, which addressed treatment and prevention topics related to adult, child and family services. The two-day behavioral Health Symposium was co-sponsored by the six (6) MCOs, which included the five LA Medicaid MCOs and the CSoC MCO, as well as the Louisiana Public Health Institute (LPHI) and Louisiana Federation of Families. The mission of the 2017 Behavioral Health Symposium was to present an opportunity for community partners to join the conversation about promising and innovative practices in behavioral health to strengthen our communities. The Behavioral Health Symposium provided training on behavioral health in Louisiana across the lifespan, including prevention, treatment, and recovery support services. Topics of the Symposium included mental health, substance use, and prevention services, as well as a special one-day track on the impact of the opioid epidemic on Louisiana's communities. Capacity of the Symposium was 400

participants from throughout the state, with the target audience identified as an array of partners who played important roles in promoting healthy communities. Partners invited to participate in the 2017 Behavioral Symposium included service providers throughout the private and public behavioral health and primary health systems, preventionists, peer support specialists, other state agencies, as well as service recipients, their families and advocates. Please see list below of training topics included in the 2017 Behavioral Health Symposium:

- SBIRT (Screening, Brief Intervention & Referral to Treatment)
- Opioid Epidemic
- Neonatal Abstinence Syndrome (NAS)
- ACEs (Adverse Childhood Experiences)
- DSM-5 In Action
- Ethics for Behavioral Health Specialists
- NARCAN Education & Demonstration
- Neurobiology of Addiction
- Behavioral Health Disorders in Older Persons
- Cultural Competence
- Gambling: The Invisible Addiction
- Lunch Plenary Speaker Mindfulness: Whole Body Mental Health
- Co-Occurring Disorders with ID/DD
- First Episode Psychosis (FEP)
- Collaboration with Criminal Justice System to Serve Justice Involved Population
- Closing Plenary: Treatment of Explosive, Inflexible, Easily Frustrated Children and Adolescents and their Families
- Serving Homeless Population with Behavioral Health Disorders
- Principles of Pediatric Psycho-pharmacology
- Service Members, Veterans and their Families

Since the combination of the Offices of Mental Health and Addictive Disorders to create the Office of Behavioral Health in 2010, this was the first OBH statewide training event addressing the complete array of behavioral health services to both the adult and youth populations. OBH intends to continue these collaborative partnerships to host similar statewide training opportunities in the future.

Due to the opioid epidemic plaguing Louisiana and with the supports of the State Targeted Response (STR) grant, the 2017 Behavioral Health Symposium included a one-day Opioid Epidemic Track, which included topics such as Opioid Best Practices, Opioids and other Pharmaceuticals – DEA Perspective, Community Response and Leadership to the Opioid Epidemic, as well as the presentation of a newly released documentary on the opioid epidemic, Written Off. During the upcoming fiscal years, OBH intends to utilize block grant funds and STR funds to support ongoing community education and training on the opioid epidemic.

In addition to statewide sponsored, supported, or directly provided training, the following table is an example of continuous and ongoing training within the State and LGE levels:

Training Topic
Trauma Informed Care Training
Applied Suicide Intervention Skills
Motivational Interviewing Training
CABHI Training
Permanent Supportive Housing 101
Adolescent Community Reinforcement Approach (A-CRA)
Global Appraisal of Individual Needs (GAIN)
Gambling Patient Placement
Training to Hospitals on PASRR
Training to Nursing Facilities on Behavioral Health Issues in Older Adults, PASRR, and Discharge Planning
safeTALK Training
Peer Support Specialist Training
Peer Support Specialist (PSS) Supervisor Training
Wellness Recovery Action Planning (WRAP) Training
Competency Restoration Training
First Episode Psychosis (FEP & related topics trainings)
Training on ATR Policies and Procedures
SSI/SSDI Outreach, Access, and Recovery (SOAR)

11. Substance Use Disorder Treatment - Required SABG

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs.

Improving access to treatment services

1. Does your state provide:
   a) A full continuum of services:
      i) Screening
      ☒ Yes ☐ No
      ii) Education
      ☒ Yes ☐ No
      iii) Brief intervention
      ☒ Yes ☐ No
      iv) Assessment
      ☒ Yes ☐ No
      v) Detox (inpatient/social)
      ☒ Yes ☐ No
      vi) Outpatient
      ☒ Yes ☐ No
      vii) Intensive outpatient
      ☒ Yes ☐ No

viii) Inpatient/residential
☒ Yes ☐ No

ix) Aftercare; recovery support
☒ Yes ☐ No

b) Are you considering any of the following:

Targeted services for veterans
☒ Yes ☐ No

c) Expansion of services for:

(1) Adolescents
☒ Yes ☐ No

(2) Older adults
☐ Yes ☒ No

(3) Medication-Assisted Treatment (MAT)
☒ Yes ☐ No

Criterion2: Improving Access and Addressing Primary Prevention – see Section 9 (page 81)

Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability?

   a) ☒ Yes ☐ No

2. Either directly or through an arrangement with public or private nonprofit entities make prenatal care available to PWWDC receiving services?

   a) ☒ Yes ☐ No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?

   a) ☒ Yes ☐ No

4. Does your state have an arrangement for ensuring the provision of required supportive services?

   a) ☒ Yes ☐ No

5. Are you considering any of the following:

   a) Open assessment and intake scheduling
   ☒ Yes ☐ No

   b) Establishment of an electronic system to identify available treatment slots
   ☒ Yes ☐ No

   c) Expanded community network for supportive services and healthcare
   ☒ Yes ☐ No

d) Inclusion of recovery support services
☒ Yes ☐ No

e) Health navigators to assist clients with community linkages
☒ Yes ☐ No

f) Expanded capability for family services, relationship restoration, custody issue
☒ Yes ☐ No

g) Providing employment assistance
☒ Yes ☐ No

h) Providing transportation to and from services
☒ Yes ☐ No

i) Educational assistance
☒ Yes ☐ No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

OBH ensures that pregnant women are given preference at admission to treatment facilities and, when the facility has insufficient capacity, ensures that the State Office is notified to assist in placement. If no such placement is available, it is OBH's policy to make interim services available within 48 hours, including a referral to prenatal care. OBH continues to maximize access to treatment for pregnant women by maintaining priority admission status for this client population. To ensure adherence to these requirements, language is written into OBH RFPs, MOUs, Contracts, Accountability Implementation Plan (AIP), and Special Provisions requirements. OBH conducts desk top and on-site monitoring visits within each Local Governing Entity (LGE) within the state. In addition, OBH monitors pregnant women and women with dependent children services, using admission data generated by the State Management Organizations Electronic Health Record (EHR) Data System. Surveillance also occurs at the local level by each LGE. The LGE is required to monitor local level provider compliance with state and federal regulations.

LGE monitors review cases and admission patterns at facility levels to ensure adherence to OBH priority admission policy for pregnant women. Priority admission guidelines are also addressed during the annual Independent Peer Review process. LGEs and OBH Central Office staff also monitor the adequacy of efforts to meet the specific needs of women by reviewing admission data and census data (Monthly Production and Utilization Reports), which include waiting list reports and field surveys.

OBH ensures that interim services are provided until such time as the appropriate level of care becomes available for women needing services. Interim services include education or counseling concerning Fetal Alcohol Spectrum Disorders (FASD), HIV, STDs, the danger of sharing needles, and the benefits of prenatal care. Other interim services include but not limited to: screening for Tuberculosis, pregnancy test, STD and HIV, as well as referral for emergency medical services and prenatal care.

OBH establish partnerships with resources within the community to provide some of the above mentioned screenings. For example; the Office of Public Health partners with OBH to provide

voluntary pregnancy test and Fetal Alcohol Spectrum Disorder (FASD) education for all women entering the system.

Based upon the outcomes and results of monitoring activities, when indicated or requested, LGEs are provided technical assistance and trainings on areas that are challenged or needs improvement/enhancements to meet or exceed established state and federal guidelines or regulations.

Criterion 4, 5 and 6: Persons Who Inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the

   a) 90 percent capacity reporting requirement
   ☒ Yes ☐ No
   b) 14-120 day performance requirement with provision of interim services
   ☒ Yes ☐ No
   c) Outreach activities
   ☒ Yes ☐ No
   d) Syringe services programs
   ☐ Yes ☒ No
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation
   ☒ Yes ☐ No

2. Are you considering any of the following:

   a) Electronic system with alert when 90 percent capacity is reached
   ☐ Yes ☒ No
   b) Automatic reminder system associated with 14-120 day performance requirement
   ☐ Yes ☒ No
   c) Use of peer recovery supports to maintain contact and support
   ☒ Yes ☐ No
   d) Service expansion to specific populations (military families, veterans, adolescents, older adults)
   ☒ Yes ☐ No

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   Current agency policy states that all funded programs give priority admission and preference to treatment in the following order: pregnant injecting drug users, other pregnant substance abusers, other injecting drug users, and all others. This approved policy has been posted on the agency SharePoint site whereby LGE staff can access and review current policies as well as other resource documents. Priority admissions monitoring practices are reviewed during the mandated independent peer review process and during the Annual Accountability Implementation Plan (AIP) on-site visits. This has helped to confirm that priority admissions are handled in a timely manner and according to Block Grant mandates.

LGE-operated and contract programs are required to provide interim services to these priority populations within 48 hours, if comprehensive care cannot be made available upon initial contact with a waiting period of no longer than 120 days. Interim services are made available through individual sessions, phone contact, and referral or linkage to self-help groups and activities. Documentation of interim services and waiting period are discussed during annual peer reviews and (AIP) visits within each LGE.

All Block Grant requirements related to the OBH system of care are communicated through contractual agreements, with language that addresses the details related to termination of the agreement due to lack of compliance.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?

   a) ☒ Yes ☐ No

2. Are you considering any of the following:

   a) Business agreement/MOU with primary healthcare providers
      ☒ Yes ☐ No
   b) Cooperative agreement/MOU with public health entity for testing and treatment
      ☒ Yes ☐ No
   c) Established co-located SUD professionals within FQHCs
      ☒ Yes ☐ No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   OBH ensures that LGEs routinely makes available tuberculosis (TB) services to each individual receiving substance use treatment and monitors availability of TB treatment service delivery either directly, or through arrangements with other public or private entities. A Memorandum of Understanding (MOU) between OBH and the Office of Public Health has established a system to provide the necessary supplies for TB and STD services by the Office of Public Health. However, due to budgetary cuts, supplies are not always available from OPH, which has resulted in some LGEs purchasing supplies out of their budgets.

   TB services are made available by the administration of a Sign and Symptom Screen (developed by the Office of Public Health) or by administration of the Purified Protein Derivative (PPD) Tuberculin Skin Test by a clinic nurse. The tuberculosis skin test or PPD test is used to determine if the individual has developed an immune response to the bacterium that causes tuberculosis (TB). This response can occur if someone currently has TB, if they were exposed to it in the past, or if they received the BCG vaccine against TB (which is not performed in the United States). When a client tests positive, the client is referred to the Office of Public Health and the Regional TB Nurse for ongoing evaluation and treatment, or to the client's private physician, when requested

by the client. Clients with positive test results, or those with any number of signs and symptoms from a previous positive PPD, are not admitted for treatment until they have been cleared by the treatment facility's medical director and by the Office of Public Health. Protocol dictates that the medical director or the clinic physician clears the patient for admission.

Based upon the outcomes and results of monitoring activities, when indicated or requested, LGEs are provided technical assistance and trainings on areas that are challenged or needs improvement/enhancements to meet or exceed established state and federal guidelines or regulations.

Early Intervention Services for HIV (For "Designated States" Only)

1. Does your state current have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery?

   ☒ Yes ☐ No

2. Are you considering any of the following:

   a) Establishment of EIS-HIV service hubs in rural areas
      ☒ Yes ☐ No
   b) Establishment or expansion of tele-health and social media support services
      ☐ Yes ☒ No
   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS
      ☒ Yes ☐ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes (42 U.S.C.§ 300x-31(a)(1)F)?
   ☒ Yes ☐ No
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program
   ☐ Yes ☒ No
3. Do any of your programs use SABG funds to support elements of a Syringe Services Program

   a) ☐ Yes ☒ No
   b) If yes, please provide a brief description of the elements and the arrangement

Criterion 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement?
   ☒ Yes ☐ No
2. Are you considering any of the following:

a) Workforce development efforts to expand service access
☒ Yes ☐ No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services
☒ Yes ☐ No

c) Establish a peer recovery support network to assist in filling the gaps
☒ Yes ☐ No

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)
☒ Yes ☐ No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations
☒ Yes ☐ No

f) Explore expansion of services for:

i) MAT
☒ Yes ☐ No

ii) Tele-health
☒ Yes ☐ No

iii) Social media outreach
☒ Yes ☐ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?
☒ Yes ☐ No
2. Are you considering any of the following:

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
☒ Yes ☐ No

b) Establish a program to provide trauma-informed care
☒ Yes ☐ No

c) Identify current and perspective partners to be included in building a system of care, e.g., FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education
☒ Yes ☐ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)
☒ Yes ☐ No
2. Are you considering any of the following:

a) Notice to Program Beneficiaries
☒ Yes ☐ No

b) Develop an organized referral system to identify alternative providers
☒ Yes ☐ No

c) Develop a system to maintain a list of referrals made by religious organizations
☐ Yes ☒ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs
☒ Yes ☐ No
2. Are you considering any of the following:

a) Review and update of screening and assessment instruments
☒ Yes ☐ No

b) Review of current levels of care to determine changes or additions
☒ Yes ☐ No

c) Identify workforce needs to expand service capabilities
☒ Yes ☐ No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background
☒ Yes ☐ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records
☒ Yes ☐ No
2. Are you considering any of the following:

a) Training staff and community partners on confidentiality requirements
☒ Yes ☐ No

b) Training on responding to requests asking for acknowledgement of the presence of clients
☒ Yes ☐ No

c) Updating written procedures which regulate and control access to records
☒ Yes ☐ No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure
☒ Yes ☐ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers

a) ☒ Yes ☐ No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

There are 10 LGEs in the state and within each respective area, two providers will participate in the independent peer review, which is a total of twenty providers.

3. Are you considering any of the following:

a) Development of a quality improvement plan
☒ Yes ☐ No

b) Establishment of policies and procedures related to independent peer review
☒ Yes ☐ No

c) Develop long-term planning for service revision and expansion to meet the needs of specific populations
☒ Yes ☐ No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?

a) ☒ Yes ☐ No

b) If Yes, please identify the accreditation organization(s)

i) ☒ Commission on the Accreditation of Rehabilitation Facilities

ii) ☒ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7 and 11: Group Homes for Persons In Recovery and Professional Development

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?
☐ Yes ☒ No

2. Are you considering any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service
☐ Yes ☒ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing
☒ Yes ☐ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state
☒ Yes ☐ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services
☒ Yes ☐ No

c) Performance-based accountability
☒ Yes ☐ No

d) Data collection and reporting requirements
☒ Yes ☐ No

2. Are you considering any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs
☒ Yes ☐ No

b) Addition of training sessions designed to increase employee understanding of recovery support services
☒ Yes ☐ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services
☒ Yes ☐ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort
☒ Yes ☐ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924 and 1928 (42 U.S.C. § 300x-32(f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations Regarding Women
☐ Yes ☒ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus

a) Tuberculosis
☐ Yes ☒ No

b) Early Intervention Services Regarding HIV
☐ Yes ☒ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment
☒ Yes ☐ No

b) Professional Development
☒ Yes ☐ No

c) Coordination of Various Activities and Services
☒ Yes ☐ No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

LAC 48:I.Chapter 56. Behavioral Health Services Providers (page 293)
http://www.doa.la.gov/osr/LAC/48v1/48v01.doc

12. Quality Improvement Plan- Requested

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?

a) ☐ Yes ☒ No

The State is in the process of updating the quality improvement strategy.

Please indicate areas of technical assistance needed related to this section.

N/A

13. Trauma –Requested

Trauma is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma- informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma paper.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?

   ☒ Yes ☐ No

   OBH does not have a specific trauma-related policy. However, policies and procedures exist at the community level with the LGEs to address client issues related to trauma. Providers are required to complete a comprehensive assessment with all clients presenting for services. A personal history of trauma is collected during this assessment process. If a need for trauma informed care is identified, then it is the responsibility of the provider to link the client to the appropriate resources. The contract with the LGEs and LDH also requires each LGE to have a crisis system in their local area that ensures the ability to handle and respond to crises. This service may be provided by the LGE or the LGE may partner with another resource in the local community to provide this resource.

In addition, each of the five (5) Managed Care Organizations have Behavioral Health Medical Director's meetings and Clinical Practice Guideline (CPG) Workgroups, through which board-certified practitioners assist the MCOs with identifying evidence-based practices to incorporate into treatment best practice recommendations. Also, the MCOs shall work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs).

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?

   ☒ Yes ☐ No

   Multiple trauma-related training opportunities are offered by the State annually in order to encourage trauma-informed care. The Office of Behavioral Health headquarters established a crisis support / incidence response behavioral health cadre comprised of professionals who could respond to events in the community or statewide where individuals may have been traumatized or are in need of behavioral health supports. Examples of traumatic events would include suicide or domestic violence events within a state agency, as well as disasters, such as hurricanes or oil spills.

   Trauma-related training opportunities are offered by the State in order to encourage trauma-informed care. Guidance is based on evidence-based, clinical best practices for treating specific disorders.

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?

   ☒ Yes ☐ No

   The MCOs work with behavioral health providers to ensure behavioral health services are offered to address the needs of youth with serious emotional disorders, adults with Serious Mental Illness (SMI), members with substance use disorders, members with co-occurring including mental health and substance use disorders and other developmental disorders. This includes ensuring the provider networks offer an appropriate range of preventive and specialized behavioral health services inclusive of trauma-informed programming.

   Additionally, OBH has been involved with the Adverse Childhood Experiences (ACEs) project. There is a tremendous amount of evidence that trauma experiences in children have an impact on their mental, emotional and physical health as adults. Individuals have been trained to deliver ACE presentations and they have been educating people around the state to understand the impact of trauma on future health and to establish the need for trauma informed care in organizations.

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?

   ☒ Yes ☐ No

Since 2008, Louisiana has trained Peer Support Specialists to work within the behavioral health system of care. A large part of the training of peers involves trauma informed care. In addition, the Office of Behavioral Health has worked with RI International of Arizona to develop a training for the supervisors of Peer Support Specialists, helping them to learn about the unique role of Peer Support and how to utilize the lived experience of Peer Support Specialists to engage with and enhance the care of consumers. Supervisors are encouraged to not only utilize peers in the care of consumers, but also to utilize their lived experience to better understand consumers and to develop better plans of care with that understanding.

5. Does the state have any activities related to this section that you would like to highlight.

In response to the increasing statewide demand for education regarding ACE concepts, OBH has collaborated with the Office of Public Health, Bureau of Family Health and the Tulane Institute of Infant and Early Childhood Mental Health as they have partnered to support the Louisiana ACE Initiative to create the Louisiana ACE Educator Program in the spring of 2015. The LA ACE Educator Program is part of an effort to incorporate an understanding of the impact of childhood adversity and trauma into policy and practice by building community awareness about ACEs, trauma, and resilience science across the state. Louisiana is the 7th state to adopt the ACE Interface model. OBH has provided various ACE training opportunities to clinical staff as well as prevention professionals and community coalitions.

Please indicate areas of technical assistance needed related to this section.

N/A

14. Criminal and Juvenile Justice – Requested

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Please respond to the following items:

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services?

   ☒ Yes ☐ No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?

   ☒ Yes ☐ No

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

   ☒ Yes ☐ No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances?

   ☒ Yes ☐ No

5. Does the state have any activities related to this section that you would like to highlight?

   LDH has collaborated with the Department of Corrections regarding the release of adults from incarceration. This effort has focused on ensuring that inmates are enrolled in a health plan prior to release and are instructed in how to access care; including behavioral health care. Additionally, efforts are being made to ensure that typical barriers to thriving upon release are addressed; including housing, employment and medical services.

   The leadership of OBH recently attended a SAMHSA funded Best Practices Implementation Meeting on training Law Enforcement Officers to recognize signs and symptoms of mental illness. Crisis interventions techniques and de-escalation process are a part of this practice. Louisiana has already implemented this process in St. Tammany Parish and will begin soon in Livingston Parish. The goal is to achieve statewide implementation within the next three years.

Motivational Interviewing and other evidence based practices are offered to mental health practitioners in all areas of care giving in Louisiana. Juvenile Justice and Adult Corrections staff are invited to participate and often do.

There are a number of collaborative committees that meet to discuss issues that cross traditional agency boundaries, including a multi-agency board that advises the leadership of the Coordinated System of Care program.

Please indicate areas of technical assistance needed related to this section.

The state is contemplating the operation of a center of excellence that would examine the continuum of care and make recommendations for evidence based practices that would improve the services to youth and families. Technical assistance in this area would be most helpful.

15. Medication Assisted Treatment – Requested

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA- approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?

   ☒ Yes ☐ No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?

   ☒ Yes ☐ No

3. Does the state purchase any of the following medication with block grant funds?

a) ☐ Methadone
b) ☐ Buprenorphine; Buprenorphine/naloxone
c) ☐ Disulfiram
d) ☐ Acamprosate
e) ☐ Naltrexone (oral, IM)
f) ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance use disorders are used appropriately[3]?

   ☒ Yes ☐ No

5. Does the state have any activities related to this section that you would like to highlight?

   In an effort to increase access to medicated assisted treatment the Louisiana Department of Health, Office of Behavioral Health (OBH) received the Medication Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA) Grant to expand and enhance capacity for medication-assisted treatment (MAT), wraparound services and recovery support services for individuals with opioid use disorders. The Greater New Orleans area was identified as the region in the state with the most opioid overdose deaths. Funding to Metropolitan Human Services District (MHSD) for administration will allow a network of programs in the three-parish (Orleans, St. Bernard, and Plaquemine) catchment to increase the total number of individuals receiving MAT services and integrated care. The ultimate goal is to decrease illicit substance use and behavioral health access disparities among the population of focus. The lessons learned will be translated and shared with other LGEs statewide.

   The Louisiana Department of Health, Office of Behavioral Health (OBH) received the Strategic Prevention Framework for Prescription Drugs (La SPF Rx) for the purpose of raising awareness about the dangers of sharing medication; to work with pharmaceutical and medical communities on the risks of overprescribing to young adults; to raise community awareness; and to increase prescription drug abuse education to schools, communities, parents, prescribers and patients. The goals of the La SPF Rx project include:

   1. Prevent and reduce prescription drug and opioid misuse and abuse in the target population;
   2. Raise awareness about prescription drugs and illicit opioid misuse and abuse; and
   3. Develop a system to use existing data sources in program planning and evaluation in a proactive/preventive manner in the targeted parish. *Note: The SPF Rx differs from previous and existing prevention grants because of its specific focus on illicit opioid misuse and abuse.* A coalition, as identified by Jefferson Parish Human Services

[3] Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychosocial treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Authority, will be the conduit for prescriber education and community awareness activities.

The La SPF Rx project will utilize the existing SPF-based infrastructure as a basis to prevent prescription drug misuse and abuse in the 12 – 17 year old and 18+ age groups. The initial target or pilot area will be Jefferson Parish. Note: Jefferson Parish was identified as the pilot parish by reviewing data from the following sources: Opioid Death Records; Louisiana Hospital Inpatient Discharge Data (LaHIDD) – Opioid Hospitalizations; Louisiana Early Event Detection System (LEEDS) – Total Emergency Room Visits, Total Prescription Drug Related Emergency Room Visits, and Percentage of Emergency Room Visits Related to Prescription Drug Use; and the 2014 Louisiana Caring Communities Youth Survey – Percentage of Students who used Prescription Drugs and Heroin.

The Louisiana Department of Health, Office of Behavioral Health (OBH) applied for the State Targeted Response to the Opioid Crisis Grant (Opioid STR) to enhance existing statewide prevention, treatment, and recovery support services offered for individuals experiencing or at risk for opioid use disorder (OUD). Through this grant, OBH will:

1. Utilize the existing Strategic Prevention Framework (SPF)-based infrastructure as a basis to prevent prescription drug misuse and abuse through a media campaign, provider training, and an intervention strategy of Naloxone education and distribution to target populations.
2. Build the capacity of the local Opioid Treatment Programs (OTP) and other behavioral health provider networks to provide access to evidence-based treatments, particularly Medication Assisted Treatment (MAT), and education and training on non-opioid alternatives.
3. Work with the Department of Corrections to provide treatment services for offenders participating in re-entry-programs at two designated facilities
4. Increase recovery support services for OUD clients by building capacity for the 10 LGEs to have staff to serve as Behavioral Health Recovery Support Specialists to provide local visibility and coordination with local resources for referral and access to services for the OUD population.

16. Crisis Services – Requested

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful. SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de- escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow- up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
   - a) ☒ Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) ☒ Psychiatric Advance Directives
   - c) ☒ Family Engagement
   - d) ☒ Safety Planning
   - e) ☒ Peer-Operated Warm Lines
   - f) ☐ Peer-Run Crisis Respite Programs
   - g) ☒ Suicide Prevention

2. Crisis Intervention/Stabilization:
   - a) ☒ Assessment/Triage (Living Room Model)
   - b) ☒ Open Dialogue
   - c) ☒ Crisis Residential/Respite
   - d) ☒ Crisis Intervention Team/ Law Enforcement
   - e) ☒ Mobile Crisis Outreach
   - f) ☒ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support:
   - a) ☒ WRAP Post-Crisis
   - b) ☒ Peer Support/Peer Bridgers
   - c) ☒ Follow-Up Outreach and Support
   - d) ☒ Family-to-Family engagement
   - e) ☒ Connection to care coordination and follow-up clinical care for individuals in crisis
   - f) ☒ Follow-up crisis engagement with families and involved community members
   - g) ☒ Recovery community coaches/peer recovery coaches
   - h) ☒ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

MHSD operates a Crisis Response Team, which is a contracted, dedicated team of clinicians who work in conjunction with NOPD CIT.

SCLHSA has hosted several educational events region-wide concerning crisis intervention response and is working on creating a Crisis Continuum for the seven parish catchment area. Additionally, SCLHSA is working with the Lafourche Parish Sheriff's Office to help with the formation of a Volunteer Counseling Corp.

SCLHSA has also expanded its Mobile Crisis Services to include 1 full-time staff to work exclusively in the school system assisting students experiencing a behavioral health crisis-related situation. In addition, services such as consultation, telephone, and on-site support and education are extended to school personnel in their efforts to mitigate crisis situations within the school.

JPHSA's Hospital Coordination and Transition (HCT) Program has successfully managed to link and assist individuals with maintaining the treatment needed to decrease repeated hospitalizations, which are costly and limited in long term effectiveness.

Please indicate areas of technical assistance needed related to this section.

N/A

17. Recovery – Required

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: *health* (access to quality health and behavioral health treatment); *home* (housing with needed supports), *purpose* (education, employment, and other pursuits); and *community* (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

> Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;

- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer-run respite services
- Peer-run crisis diversion services
- Whole Health Action Management (WHAM)
- Shared decision making
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?
   ☒ Yes ☐ No

   Louisiana has a 76-hour training program for Peer Support Specialists (PSS), developed by RI International of Arizona. For sustainability, Louisiana has had four (4) Associate Facilitators trained by RI International. These facilitators conduct PSS trainings throughout the State. The curriculum developed through RI International is widely used throughout the United States and beyond. The training begins with an overview of recovery and the power of peer support. Additionally, tenants of recovery are embedded within the other modules of the training which include: self-esteem, community culture and environment, meaning and purpose, emotional intelligence, telling your personal story, employment as a path to recovery, ethics and boundaries, communication skills, conflict resolution, recovery from trauma, substance use challenges and co-occurring recovery, integrated health, being with people in challenging situations, and partnering with other professionals.

   Louisiana has also worked with RI International to develop a training program for service providers and their staff in order to more effectively supervise Peer Support Specialists. This supervisor training has been offered throughout the state with great success. The focus of the training is the provision of supervision in a recovery oriented environment. RI International has partnered with OBH to train four (4) facilitators – 2 peers and 2 supervisors – who co-facilitate trainings together.

   b) Required peer accreditation or certification?
   ☒ Yes ☐ No

   The Office of Behavioral Health has established a statewide training for the credentialing of Peer Support Specialists. This training was developed by RI International of Arizona. This is a two (2) week, 76-hour training. There are eight (8) hours of class work and several hours of homework daily. There is also a written midterm and a written and practical final exam. All applicants must meet all of the following qualifications:

      a) Lived Experience – Peer Support Specialists must have lived experience with a behavioral health diagnosis. A behavioral health diagnosis can include a diagnosis with mental health challenges, addiction challenges, or co-occurring disorders.
      b) Educational Standards – Peer Support Specialists must have a minimum of a High School diploma or a GED.
      c) Age Requirements – Peer Support Specialists must be at least 18 years of age.
      d) Time in Recovery – Peer Support Specialists must have at least twelve (12) months of continuous demonstrated recovery.
      e) Obtain a minimum score of 24 on the application for training.

   Applications for training are scored by committee. The committee is made up of a minimum of three (3) individuals including OBH identified staff, a representative of an advocacy or peer support organization, and one other at-large person. Applications are scored according to a specified rubric, assigning points to the topics of understanding of peer support, personal

responsibility, community activity, literacy, employability, support system, and recovery maintenance.

Once credentialed, Peer Support Specialists must complete a minimum of ten (10) continuing education units (CEUs) per calendar year to maintain their active status. Three (3) of these CEUs must be in the area of Ethics. The other seven (7) will be in the competencies related to tenets of peer support.

c) Block grant funding of recovery support services.
☒ Yes ☐ No

Treatment and recovery support services are coordinated within the ten LGEs to meet the unique needs in each geographic area of the state. OBH works hand-in-hand with each LGE to ensure the implementation of recovery-oriented practices.

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?
☒ Yes ☐ No

As a part of its ongoing effort to engage youth and parents in every facet of the Coordinated System of Care, OBH makes provision for and actively "recruits" these consumers for engagement in several committees and workgroups (including State Governance Board, Statewide Coordinating Council, Inter-Agency Monitoring Team, and Quality Assurance Committee). Additionally, OBH/CSoC representatives periodically attend regional community meetings, as a way of updating the community on new developments; and to gather information/input from the community about outstanding needs and community successes. CSoC utilizes a nationally recognized fidelity monitoring tool which includes measures of satisfaction. The survey assesses a random sample of CSoC members. This fiscal year the survey received 489 responses (60% response rate) from parents/caregivers and 343 responses (79% response rate) from youth. Louisiana's results were above the national mean for satisfaction levels with parent/caregiver ratings between 77.9% and 88.8% on the items scored and youth ratings between 78.5% and 88.8%.

The Louisiana Behavioral Health Advisory Council (LBHAC) has forty members which includes consumers of both mental health and substance-related or addiction services, family members of adults with serious mental illness and substance use disorders, family members of children with emotional/behavioral disorders, behavioral health advocates, representatives from regional advisory councils (RACs), and state agency employees. More information regarding the LBHAC can be found in Section 22 on page 146.

2. Does the state measure the impact of your consumer and recovery community outreach activity?

☐ Yes ☒ No

Consumer outreach is done by the LGEs, where data is collected. OBH will continue to coordinate with the LGEs to ensure data is analyzed and coordinate technical assistance where needed.

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Louisiana has adopted the definition of recovery as stated by SAMHSA. The definition states: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The recovery principles are simply to allow those with behavioral health challenges to guide their own recovery. These principles were developed by key stakeholders, especially those in recovery.

The state has had peers working within leadership positions (Office of Consumer Affairs) in the Office of Behavioral Health since 2004. This has expanded through the Managed Care Organizations (MCOs) through Healthy Louisiana.

OBH utilizes the C'est Bon program for continuous quality improvement of both services and facilities, as well as to provide accountability to the public. The C'est Bon program, which is Cajun French for "That's Good," uses a consumer satisfaction team-model for consumer-to-consumer monitoring and evaluation. The consumer-to-consumer interviews foster more open and honest feedback from the consumers and assures that the consumer respondents fully understand the purpose and use of the survey. Because the C'est Bon program process relies on consumers as the core of this initiative by having direct involvement in monitoring and evaluating the services they receive, consumers and family members have a greater voice and a more meaningful role in influencing the design and quality of public behavioral health services. Consumer satisfaction teams also offer opportunities for fostering consumer empowerment, leadership development and paid employment experiences.

Peer Support services are offered by all ten (10) LGEs and all State run psychiatric hospitals as well as being imbedded into Assertive Community Treatment (ACT) and Permanent Supported Housing (PSH). Peer Support Specialists (PSS) are assisting consumers with services such as:

a) Integrated Health Care – OBH recognizes that the best possible outcomes are achieved when the care of the whole consumer is effectively managed. By integrating primary care and behavioral health, providers are able to look at the whole person, identifying behavioral health issues that need treatment and helping to prevent problems before they occur. Behavioral health services include treatment and prevention for both mental health and substance abuse disorders. PSS are assisting consumers with navigating the integrated health care system.
b) Employment – PSS are assisting consumers with job readiness and in searching for employment. PSS are conducting groups within the LGEs to assist consumers to develop WRAP plans to help them to maintain wellness so that they can become and remain employable. PSS are also assisting consumers with resume building and skills building including the development of computer skills and job search skills.
c) Wellness Recovery Action Plan (WRAP) – OBH has been instrumental in bringing WRAP to Louisiana, training two (2) Advanced Level WRAP facilitators to train PSS in becoming WRAP facilitators. These facilitators are functioning throughout the state, helping consumers to develop their own WRAP plans.
d) PSS are working within treatment teams to assist with identifying goals, treatment planning, life skills coaching, resource referral, conducting recovery groups, and assisting with discharge planning.

e) In Louisiana, PSS work in a variety of capacities throughout the behavioral health service system. While PSS provide vital roles in peer to peer programs which are not funded by Medicaid, there are several rehabilitation services outlined within the Behavioral Health Manual in which PSS are identified as a qualified provider type. These services include:
    1) Community Psychiatric Support and Treatment
    2) Psychosocial Rehabilitation
    3) Crisis Intervention
    4) Assertive Community Treatment
    5) Permanent Supported Housing
    6) Addiction Services

The Coordinated System of Care (CSoC) is a joint effort of the Office of Behavioral Health, Medicaid, the Office of Juvenile Justice (OJJ), The Department of Children and Family Services (DCFS), and Department of Education (DOE). The CSoC is conceptualized upon the national standards of the system of care and is expanding practices that support family involvement as a core component. Through the CSoC, children who are at-risk for out-of-home placement are able to access wraparound services through a Wraparound Agency (WAA) that coordinates comprehensive children's behavioral health services and supports, inclusive of wraparound facilitation/child and family teams (CFTs). Children and youth enrolled in CSoC are eligible for all LBHP services, including four (4) services not available to other members. These specialized services are independent living/skills building, youth support and training, parent support and training, and crisis stabilization. A commendable innovation within the Louisiana CSoc model is the partnership with the family Support Organization (FSO), which provides the services and support of youth and family mentors within the child and family teams through youth support and training and parent support and training.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Louisiana has long been a supporter of Oxford House. Oxford Houses are democratically run, self-supporting, drug free houses established for the purpose of providing a sober living environment for those seeking to live a sober, drug free life. OBH contracts with Oxford House to provide for two (2) outreach workers and one (1) re-entry worker to assist those leaving incarceration. The regional manager of Oxford House Louisiana is a credentialed Peer Support Specialist. Currently there are 110 Oxford Houses within Louisiana with over 1000 beds.

The Temporary Assistance for Needy Families (TANF) program addresses the needs of women, including pregnant women with dependent children, through residential treatment services. The program provides addiction services to women eighteen (18) years of age and older. Minor children up to age twelve (12) are allowed to accompany their mother/guardian to treatment, thus preserving the family unity. Women will receive gender specific treatment which may include education on such topics as parenting, healing from trauma, spousal or partner abuse, overcoming depression and post-traumatic stress disorder, etc. Educational or employment assistance, in conjunction with transportation services as well as linkages to housing and other community resources are also provided.

The Neonatal Abstinence Restoration Program, through the creation of specialty beds within an existing TANF residential program, will provide Medication Assisted Treatment (MAT) to pregnant and postpartum women, and women with dependent children who have been diagnosed with Opioid Use Disorders. This NAS program provides specialized intensive residential treatment for pregnant and postpartum women, to include screening, comprehensive assessment, medication assisted treatment, individual, family, and group counseling, care-coordination, parenting skills, and trauma informed care.

Louisiana Association for Substance Abuse Counselors and Trainers (LASACT) has adopted the Peer Recovery Support Specialist (PRSS) certification developed by IC&RC. As a result, many of the substance use treatment facilities in the state now employ PRSS to assist their treatment teams in engaging with consumers.

5. Does the state have any activities that it would like to highlight?

FEP – Beginning in FFY2014, the Office of Behavioral Health dedicated the federally mandated portion of Mental Health Block Grant funds to develop programs to assist those experiencing their First Episode Psychosis (FEP). These programs target youth ages 15-30 who are first entering into behavioral health services. These programs include wraparound services and peer support in order to engage individuals into treatment and to assist them with navigating the behavioral health system so that they can remain engaged.

CABHI – In 2013, Louisiana received a grant for the Cooperative Agreement to Benefit Homeless Individuals (CABHI). This program utilized case management and peer support services to assist chronically homeless individuals' mental health and substance use challenges to receive the treatment needed to end their homelessness. Since the inception of this program, over 420 individuals who were chronically homeless have received services to enable them to obtain and maintain housing.

STR – In 2017, Louisiana was awarded the State Targeted Response (STR) grant to target and reduce opioid abuse across the state. The grant will be used to enhance existing statewide prevention, treatment and recovery services that are available to individuals who are addicted to opioids or who are at risk for opioid addiction or opioid abuse or misuse. Supports will include the addition of Peer Support Specialists in each of the 10 LGEs to provide recovery support and prevention services.

Please indicate areas of technical assistance needed related to this section.

N/A

18. Community Living and the Implementation of Olmstead- Requested

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most

integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include :

housing services provided	☒ Yes	☐ No
home and community based services	☒ Yes	☐ No
peer support services	☒ Yes	☐ No
employment services.	☒ Yes	☐ No

Housing Services

Louisiana partners with other LDH Agencies and housing authorities in 811 and Permanent Supportive Housing (PSH) opportunities, both of which offer priority housing assistance to those individuals who had been institutionalized or are at risk of institutionalization. Additionally, OBH utilizes block grant funding to aid individuals in transitioning from institutions with Housing Assistance Program support and supports programs which provide transitional housing to individuals who are at risk of institutionalization

The State has embraced the model of Housing First which is an evidence-based practice approach whereby the primary focus is to place the persons served into affordable housing first because it is a necessity. However, while developing the appropriate plan of care for community living, an assessment is completed to determine the necessary support services for a healthy transition. Experience and research has demonstrated that supportive services and affordable housing is a combination that works. A critical component of the plan of care is ensuring that mainstream resources and services are secured along with employment and a comfortable support system.

The State has Permanent Housing with home and community-based services to sustain persons with behavioral health needs in the community. The Louisiana system of managed care, administered by the five (5) Managed Care Organizations affiliated with Healthy Louisiana, coordinates treatment services for behavioral health in the community and treatment facilities. The plan is to continue working across state, federal, and local community agencies to coordinate enrollment into services and assistance that are essential for community living. The State has worked with the Louisiana Housing Corporation, previously called the Louisiana Housing Finance Agency, to include persons with behavioral health disorders. Finding ways to supplement low-income with supported employment and increasing the affordable housing stock is critical to sustaining community living. The State is advocating for additional subsidized housing and has recently developed Project Base Vouchers (PBV) units through the Low-Income Housing Tax Credit and CDBG housing funding, along with other creative financing options, to reduce developing cost and attract developers to build more affordable units.

In addition to the Permanent Supportive Housing program, the state also participates in other housing initiatives. In particular, OBH utilizes Mental Health Block Grant dollars to support individuals as they transition into the community. This Housing Assistance Program allows for the temporary funding for rent and associated utilities until social security or more sustainable funding is available. Also, in 2013, the state was awarded a CABHI State grant through SAMHSA. The populations of focus for the CABHI State grant are chronically homeless individuals with serious behavioral health disorders and homeless veterans with serious behavioral health disorders. The CABHI State grant provides funding for clinical treatment and supportive services to assist the population of focus with maintaining housing successfully in the community.

Home and Community Based Services

Louisiana has made significant strides in re-balancing the system from an institutional focus to a community integrated approach. This has been achieved through major transformations to the behavioral health system in Louisiana which occurred through the activities listed below:

- On Feb. 1, 2012, the Department of Health and Hospitals, now the Louisiana Department of Health (LDH), launched the single largest transformation of the delivery of primary health care services in Louisiana Medicaid history with the transition of nearly 900,000 Medicaid and LaCHIP recipients from the state's 45-year-old legacy, fee-for-service program to a managed health care delivery system, known as Bayou Health. Enrolling members in a Bayou Health Plan (now Healthy Louisiana) was the primary focus for the first four months of the program with the statewide rollout completed on June 1, 2012. The overriding goal of the Healthy Louisiana initiative is to encourage enrollees to own their health and the health of their families by making healthier choices. Through this program, Medicaid recipients enroll in one of five Health Plans, each of which offering different provider networks, health management programs, and incentives. Each of these Plans is accountable to the LDH and the state of Louisiana

- Implementation of the Louisiana Behavioral Health Partnership (LBHP) occurred in March 2012. The LBHP was Louisiana's first iteration of managed care for behavioral health services. This system managed services for Medicaid and non-Medicaid adults and children who require specialized behavioral health services. Implementation of the SMO

was a major system transformation geared towards rebalancing the institutional versus home and community-based behavioral health services. Since the inception of the LBHP, the behavioral health provider network and service array expanded for individuals with behavioral health issues with outcomes focusing on reducing repeat ER visits, hospitalizations, out-of-home placements, and institutionalizations, enhancing the consumer experience, and improving quality of care. Achievement of these outcomes were possible through better coordination of services within the behavioral health system and through linkages with Bayou Health and Medicare.

- Implementation of the Coordinated System of Care (CSoC) in March, 2012 was a critical component of the LBHP. CSoC ensures the provision of individualized, recovery-oriented, wrap around services to children and youth with extensive behavioral health needs either in or at risk of out of home placement. Through the implementation of a coordinated network of services and supports for children and youth with behavioral health challenges and their families, data has demonstrated the following outcomes: increased attendance in school, improvement in grades, fewer arrests, reduction in disciplinary problems, improved emotional health, fewer suicide attempts, reduction in inpatient and residential care. At any given point in time, CSOC has the capacity to serve 2400 youth. Since the implementation of the program, 5125 children have received services through CSoC.

- In 2015, this system of Managed Care was further enhanced through the integration of behavioral health into the Bayou Health (now Healthy Louisiana) system of care. This merger occurred due to the belief that integrated services, incorporating physical and behavioral healthcare, was critical to ensuring an individual's whole health was accounted for.

- Intensive Community Based Services for Adults. With the implementation of the LBHP in 2012, Louisiana also expanded its community based service array, implementing a variety of intensive community based services for adults. These services allow for the provision of home and community based services to persons with serious mental illness, major mental disorders, acute stabilization needs, and/or an adult who has previously met the above criteria and needs subsequent medically necessary services for stabilization and maintenance. Through the provision of these intensive home and community based services within the individual's community, the goal is to prevent institutionalization. Home and community based services in Louisiana include:

    - Community Psychiatric Support and Treatment (CPST) including Assertive Community Treatment (ACT)
    - Psychiatric Rehabilitation Services (PSR)
    - Crisis Intervention

Peer Support Services

Louisiana has a robust peer support training program through which Peer Support Specialists are trained and certified to work throughout the system of care in both hospital and community based settings. The role of the peers is intended to support clinical treatment and foster recovery in

individuals with behavioral health conditions, thereby improving outcomes related to increased community tenure and deinstitutionalization.

Employment Services

OBH collaborates with the Louisiana Rehabilitative Services to provide employment services to individuals with behavioral health conditions. The overall goal of OBH's employment initiatives is to create a system within the Office of Behavioral Health that will encourage and facilitate consumers of mental health services to become employed, thereby achieving greater self-determination and a higher quality of life, while helping consumers transition from being dependent on taxpayer supported programs, to being independent, taxpaying citizens contributing to the economic growth of the state and society.

OBH requires all providers to complete a comprehensive assessment that includes evaluating the educational and employment needs of all consumers requesting services. When assistance with employment and/or education needs is identified through the intake assessment process, the individual presenting for services, clinical team, and any other identified support systems for the individual work collectively to develop a treatment plan that addresses these domains.

OBH incorporates job readiness into programs when appropriate and monitors the progress of these efforts through the National Outcome Measurement System (NOMS). For example, job readiness is a reimbursable service through the CABHI State grant awarded to OBH. In accordance with the four identified SAMHSA dimensions for recovery, Louisiana recognizes proper supports in the community are critical to a healthy recovery oriented lifestyle.

In addition, understanding that peers play an important role in the recovery process and that the utilization of trained peers contributes to more positive and successful outcomes for persons in treatment for mental health, substance use, or co-occurring disorders, OBH has developed a Peer Support Specialist (PSS) training program in which individuals with lived experience work throughout our system of care. OBH has invested in having staff certified as PSS trainings and to providing quarterly peer support specialists trainings throughout the state.

2. Does the state have a plan to transition individuals from hospital to community settings?

☒ Yes ☐ No

Individuals in psychiatric hospitals are continuously monitored for discharge potential keeping in mind length of stays. Hospital discharge planners coordinate community supports based on the needs of the individuals upon discharge.

The managed care organizations through Healthy Louisiana authorizes acute psychiatric hospital stays based on medical necessity. OBH has cooperative endeavor agreements with psychiatric hospitals to ensure safety net beds for the uninsured and oversees these facilities to continue hospitalization for those individuals who are court ordered or who no longer have a payment source but meet necessity for continued hospitalization due to extenuating circumstances. OBH monitors these individuals through a Continued Stay Review process whereby OBH determines the continued stay needs for these individuals before authorizing further payment. In addition, OBH monitors the state run long-term facilities to ensure that discharge planning is on track and

to assist in addressing any barriers to discharge. Coordination of services from institutions are further enhanced by the collaborations between some of the local governing entities.

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

As indicated in the above sections, Louisiana has engaged in many efforts to address the ADA community integration mandated required by the Olmstead Decision of 1999. Efforts have included utilizing mental health block grant funds to assist persons being discharged from mental institutions with critical supports to be successful in the community. Examples of supports funded include rent, utilities, deposits, furniture, clothing, etc. As stated in previous sections, the state has continued to transform the system of care for delivery of behavioral health services to focus on home and community based services and supports. Examples of the transformations include the integration of mental health and substance use disorder services, development and implementation of the LBHP, Medicaid state plan amendments and waivers to support home and community based services to both adults and youth, as well as the upcoming integration of behavioral and primary health care.

Please indicate areas of technical assistance needed related to this section.

N/A

19. Children and Adolescents Behavioral Health Services

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children

are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence- based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.

According to data from the 2015 Report to Congress on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

Please respond to the following:

1. Does the state utilize a system of care approach to support:

   a) The recovery and resilience of children and youth with SED?
   ☒ Yes ☐ No

   b) The recovery and resilience of children and youth with SUD?
   ☒ Yes ☐ No

2. Does the state have an established collaboration plan to work with other child- and youth- serving agencies in the state to address behavioral health needs

   a) Child welfare?
   ☒ Yes ☐ No

   b) Juvenile justice?
   ☒ Yes ☐ No

   c) Education?
   ☒ Yes ☐ No

3. Does the state monitor its progress and effectiveness around:

   a) Service utilization?
   ☒ Yes ☐ No

   b) Costs?
   ☒ Yes ☐ No

   c) Outcomes for children and youth services?
   ☒ Yes ☐ No

4. Does the state provide training in evidence-based:

   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?
   ☒ Yes ☐ No

   b) Mental health treatment and recovery services for children/adolescents and their families?
   ☒ Yes ☐ No

5. Does the state have plans for transitioning children and youth receiving services:

   a) to the adult behavioral health system?
   ☒ Yes ☐ No

   b) for youth in foster care?
   ☒ Yes ☐ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

   FY 2017 was the second full year of statewide implementation of CSoC which began in 2012 as the result of a Centers for Medicare and Medicaid Services (CMS) waiver. Throughout the course of the fiscal year, enrollment numbers continued to increase. As of June 30, 2017, 2,174 children and youth were enrolled in CSoC, with a maximum enrollment of 2,400 children and youth at any given time. A total of 10,248 children, youth and their families have been served in CSoC from implementation in March of 2012 to the end of FY 2017.

   CSoC serves children and youth aged 0 through 21 with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out-of-home placement. Children and youth with complex behavioral health challenges and their families benefit from a coordinated approach to care. New behavioral health services that were previously not part of the service array in Louisiana are now available as part of the Medicaid State Plan Amendments and Waivers that support CSoC. These new services include an organized planning process for young people with significant emotional and behavioral challenges, called Wraparound, which helps to ensure that individual and family needs are identified and addressed with an array of specialized services and natural supports. These efforts are proven to result in a reduced need for more costly out-of-home placement options. Families and young people also benefit from other specialized services which include: Parent Support and Training, Youth Support and Training, Independent Living/Skills Building and Short-term Respite.

7. Does the state have any activities related to this section that you would like to highlight?

   As of June 30, 2017 CSoC has served 10,248 youth and children, with the fiscal year end enrollment of 2,174 children/youth. Fiscal year end enrollment ranges from 126 to 389 per region as follows: Greater New Orleans (389), Baton Rouge (220) Covington (245), Thibodaux (277), Lafayette (126), Lake Charles (177), Alexandria (162), Shreveport (191), and Monroe (387).

   The CSoC team is composed of a CSoC Director with over thirteen years of experience leading system of care efforts, a Family Lead and two additional team members who provided guidance and technical assistance to the Wraparound Agencies (WAAs) and Family Support Organization (FSO) in each region in order to ensure that the appropriate certification and training requirements were completed. The CSoC team was also responsible for the oversight and monitoring of quality measures and waiver performance measures.

   Quarterly meetings of the CSoC Governance Board were held to review progress, provide guidance, and establish policy as needed. Governor John Bel Edwards continued the CSoC Governance Board with signing of a new Executive Order JBE 16-31 on June 28, 2016. The Statewide Coordinating Council (SCC) provided community level input to the CSoC Governance Board.

   WAAs in each region ensured that youth with complex needs benefited from a coordinated care planning process that produced a single plan of care that was created with the youth, their family, natural supports and all agencies and providers involved with the youth and family.

During FY16 and FY17, the CSoC Team contracted with two national wraparound trainers to support the on-going skill development of the WAA supervisors/coaches and facilitators. The goal of these trainings is to assure these WAA staff have the knowledge, skills and experience needed to deliver high fidelity wraparound to the children, youth and families of Louisiana.

Outcomes data reflects positive trends for the children, youth and families enrolled in CSoC. An analysis of the global Child and Adolescent Needs and Strengths (CANS) Assessment scores beginning at initial intake and then at discharge for 570 children/youth discharged in the third quarter of FY17 revealed that 78.6% of children and youth demonstrated improved functioning in their homes and communities.

The CANS school module which evaluates school functioning showed the following results:

- 76.48% showed improved school function
- 67.68% showed improved school attendance
- 73.81% showed improved school behavior

The use of Home and Community Based Services, one of the factors that contributes to children and youth being able to stay successfully in their homes and communities, has shown a steady increase since implementation of CSoC. In addition, the number of children, youth and families connecting to natural supports evidenced by their participation on child and family (CFT) teams continues to grow. In the third quarter of FY 17, the WAAs report that 87.3% of their Child and Family Teams had a natural and/or informal member (this number excludes family members living with the child).

One of the primary goals of CSoC is to maintain children and youth safely in their homes and communities. In the last quarter of FY 17, the living situation at discharge from CSoC for 91.98% of children and youth was to a home and community based setting.

Another goal of CSoC is to decrease the use of inpatient psychiatric hospitalization. Data from Medicaid claims during the period of January 1, 2017 – March 31, 2017 revealed a decrease in utilization of inpatient psychiatric hospitalization for CSoC youth who were enrolled in CSoC for more than 90 days. Review included use of inpatient psychiatric hospitalization 90 days before enrollment in CSoC and 90 days post discharge from CSoC. The data reveals a 75% decrease in the use of inpatient psychiatric hospitalization in the 90 days post discharge from CSoC.

Please indicate areas of technical assistance needed related to this section.

N/A

20. Suicide Prevention

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern.

SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years?

   ☒ Yes ☐ No

2. Describe activities intended to reduce incidents of suicide in your state.

   OBH staff provided suicide prevention and early intervention trainings to approximately 482 individuals n SFY 2016. These included: three Applied Suicide Intervention Skills Trainings (ASIST), seven safeTALK suicide alertness trainings, two sessions of Suicide Safety Planning Intervention, two sessions of Means Restriction in Suicide Prevention, one session of What We Know about Suicide and Bullying, and three sessions of Suicide Scope, Awareness & What We Can Do. Presentations were done at the NASW State Social Work Conference and the Shreveport Suicide Coalition Conference as well as two different Army National Guard units and in a variety of workplace settings. Participants included professional clinicians, care managers, school personnel, individuals who work with vulnerable populations as well as lay audiences from a variety of backgrounds.

   OBH is represented on the State level Child Death Review Panel and provides information and technical assistance on youth suicide prevention. Youth suicide prevention resources and best practices are shared with panel members for further dissemination through their member networks.

   OBH worked with the Louisiana Department of Education(LDOE) to develop and implement a youth suicide prevention training plan for LA schools during the FY2016 school year. Major components of this plan include policy development and skills-building training for adults and youth. District and school administrators and staff received training and technical assistance with developing comprehensive suicide prevention, intervention and postvention policies.

   The focus of policy development training was to ensure that Local Education Authorities (LEAs) have clear policies and procedures in place concerning how to respond effectively to a student who may be expressing suicidal behaviors or threats, how to respond in the aftermath of a suicide attempt or death, and the various roles school personnel may play in preventing, intervening, and helping to keep a student who may be suicidal safe. The training was designed to complement state lay requirements and to help schools ensure that students in crisis are referred to supportive resources and services.

   The emphasis of the skills-building training was on teaching those who have regular contact with young people to recognize behavioral patterns and other warning signs that may indicate that a

young person may be at risk of suicide; to actively intervene in ways that explore the level of risk without increasing it and to ensure that young people at risk receive necessary services.

As a result of LDOE's implementation of this plan, two suicide prevention modules were developed, 12 trainers were trained as the PBIS Consortium Suicide Prevention Trainers, 253 participants from 66 parish, city and charter school districts received youth suicide prevention training & 28 participants received certifications to teach the evidence based Signs of Suicide program to middle and high school students.

3. Have you incorporated any strategies supportive of Zero Suicide?

   ☒ Yes ☐ No

   OBH has been conducting trainings in Suicide Safety Planning and Means Restriction with clinicians around the state. In addition, information on accessing free online trainings continues to be disseminated via the Act 582 list of suicide "assessment, intervention, treatment and management of suicide" which is posted on the LDH website at: http://new.dhh.louisiana.gov/index.cfm/page/2092. Safety Planning and Means Restriction are two strategies with a strong evidence base for reducing suicide deaths with individuals at risk of suicide and can also be found on the Act 582 list. The interventions are included in the Zero Suicide initiative.

   OBH has also been working with the Eastern Louisiana Mental Health System (ELMHS) psychiatric facilities to begin implementing Zero Suicide in their organization. OBH and ELMHS are participating in a Community of Practice Learning Collaborative focused on implementation of Zero Suicide at the state and organizational levels. ELMHS has created an implementation team and completed the organizational assessment available on the Zero Suicide website. In 2016, ELMHS also began training their psychiatric aides and guards in the suicide alertness program safeTALK; a new protocol was created for the staff who spend the most time with patients to notify clinical and medical staff about patients who are suicidal.

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?

   ☐ Yes ☒ No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted?

   ☒ Yes ☐ No

   If so, please describe the population targeted:

   In the absence of a current suicide prevention grant targeted to a specific age group, OBH has been providing suicide prevention and intervention programs across the lifespan. OBH conducted an analysis of the statewide trainer network for the LivingWorks programs ASIST and safeTALK to ascertain where there were no trainers. Both programs were initiated in LA with the Garrett Lee Smith youth suicide prevention grants, but the number of individuals who maintain their certifications to train has declined and there were areas with no trainers remaining.

Based on that analysis, 11 individuals were trained to deliver safeTALK trainings; these individuals were selected by the LGEs and came from the areas of the state that had no trainers remaining. Two of those individuals were from ELMHS so that they can continue to train their staff in safeTALK.

In addition, 23 individuals were trained to deliver the two day ASIST trainings. Three of those individuals were from ELMHS so that they can train their clinical and nursing staff in ASIST. Two individuals from nine of the LGEs were trained so that they can deliver ASIST trainings in their local areas.

Please indicate areas of technical assistance needed related to this section.

N/A

21. Support of State Partners - Required MHBG

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in

behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?

   ☒ Yes ☐ No

   As part of its transformation goals, OBH has enhanced its partnership with the Department of Corrections (DOC). Efforts are being made to ensure that typical barriers to thriving upon release are addressed, including housing, employment and medical services. OBH is also working with DOC to provide treatment services for offenders participating in re-entry-programs.

   OBH collaborated with the Louisiana Commission on Law Enforcement (LCLE) on the Comprehensive Opioid Abuse Program (COAP) grant and the Juvenile Detention Alternatives Initiative which they oversee. OBH is also involved with the Best Practices Implementation Academy (BPIA) initiative, which involves training Law Enforcement Officers (LEOs) in recognizing signs and symptoms of mental illness.

   OBH also established a memorandum of understanding with the Louisiana Workforce Commission regarding referrals, trainings, and other services.

2. Has your state identified the need to develop new partnerships that you did not have in place?

   ☒ Yes ☐ No

   If yes, with whom?

   During discussion of the drafted block grant plan, the LBHAC identified the need to enhance partnership with DCFS for training of their social workers and field staff.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

   Central to the operational activities of OBH is the coordination of services with other agencies and additional collaboration between agencies to enhance internal resources and afford clients a wider scope of services. OBH continues to work collaboratively with the Office of Public Health, Office for Citizens with Developmental Disabilities, Department of Children and Family Services, Department of Education, Office of Juvenile Justice, and other agencies/stakeholders, via cooperative agreements, contracts, task forces, training events, and pilot projects to take full advantage of treatment resources and maximize service delivery to individuals. This collaboration

allows OBH to be more actively involved in the community and to enhance the Office's input and knowledge of issues critical to client welfare.

Please indicate areas of technical assistance needed related to this section.

N/A

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.)

    a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment, and recovery services?

    The Louisiana Behavioral Health Advisory Council is instrumental in assisting in the development of priorities and direction for the Block Grant. Input is solicited from consumers, family members, providers, and state employees who are all members of the Council. Each year, an Intended Use Plan (IUP) that allocates Block Grant funds for the following state fiscal year is prepared by OBH Central Office and each Local Governing Entity (LGE), in partnership with their local Regional Advisory Council (RAC). This is an opportunity for each LGE and the corresponding RAC to decide upon how Block Grant funds should be allocated. The IUPs are discussed during a RAC meeting

attended by RAC members and the LGE Executive Director. Once modifications are made and the Executive Director and RAC members have agreed upon a proposed plan for the allocation of Block Grant funds, the IUPs are then submitted to OBH Central Office for review by OBH executive management. The Central Office and LGE IUPs are then submitted to two separate committees within the Louisiana Behavioral Health Advisory Council for review: The Programs and Services Committee and the Finance Committee. These two committees then report findings from the review process to all members of the Advisory Council.

Discussions about the Block Grant are a part of all quarterly Council meetings, with an overview and updates about the current status, issues, etc. occurring during each meeting. The Assistant Secretary of the Office of Behavioral Health as well as representatives from the executive management team attend all quarterly meetings of the LBHAC. At the local level, local executive directors and/or administrators attend all RAC meetings. Their presence at these meetings provides ample opportunity for open dialogue between the administration and the LBHAC members. It is during this time that information is shared, questions are asked and answered, and recommendations and suggestions are made.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

☒ Yes ☐ No

2. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

☒ Yes ☐ No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

In addition to providing guidance for the Block Grant Application/State Behavioral Health Plan, the LBHAC also monitors, reviews, and evaluates the allocation and adequacy of behavioral health services within the state. The LBHAC serves as an advocate for adults with serious mental illness, children with serious emotional disturbance, other individuals with mental illness or emotional problems, and persons with substance use and addictive disorders. This includes continued efforts toward public education, education of its members, and endeavors to reduce the stigma of mental illness and addictive disorders throughout the state. Council members are given opportunity to review the block grant application and implementation reports online and make comments prior to their submission.

Currently, the LBHAC includes seats for 40 members consisting of consumers of both mental health and addiction services, family members of adults with serious mental illness and substance abuse disorders, family members of children with emotional/behavioral disorders and substance abuse disorders, behavioral health advocates, representatives from regional advisory councils (RACs), and state agency employees. Additionally, the council has representatives of special populations, namely the following: representatives of the behavioral health needs of the elderly,

members of a federally recognized tribe, the homeless, transitional youth, and the LGBTQI population.

The Council has been designed to have geographical representation of the ten local governing entities in the state, and includes members from diverse backgrounds and ethnicities. A representative from each RAC serves on the LBHAC. Improved communication has been a continuing initiative, and each RAC representative reports on regional activities at quarterly LBHAC meetings.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.

<Membership Table to be included for final printing.>

Behavioral Health Advisory Council Composition by Member Type

Type of Membership	Number	Percentage of Total Membership
Total Membership	40	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	8	
Family Members of Individuals in Recovery * (to include family members of adults with SMI)	2	
Parents of children with SED/SUD *	3	
Vacancies (individual & family members)	3	
Others (Advocates who are not State employees or providers)	10	
Total Individuals in Recovery, Family Members, and Others	20	50%
State Employees	12	
Providers	1	
Vacancies	3	
TOTAL State Employees & Providers	13	32.5%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBT Populations	11	
Providers from Diverse Racial, Ethnic, and LGBT Populations	0	
TOTAL Individuals and Providers from Diverse Racial, Ethnic, and LGBT Populations	11	
Persons in recovery from or providing treatment for or advocating for SUD services	12	

Federally Recognized Tribal Representatives	1	
Youth/adolescent representative (or member from an organization serving young people).	0	

*States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

23. Public Comment on the State Plan

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

   a) Public meetings or hearings?

   ☒ Yes ☐ No

   b) Posting of the plan on the web for public comment?

   ☒ Yes ☐ No

   If yes, provide URL: http://ldh.louisiana.gov/index.cfm/page/100

   c) Other (e.g. public service announcements, print media)

   ☐ Yes ☒ No

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