

FY 2020-2021 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, 2019



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State Information and Funding Agreements

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- III. Date Submitted
September 1, 2019
- IV. Contact Person Responsible for Application Submission
Catherine Peay
Block Grant State Planner, Office of Behavioral Health
225.342.7945
Catherine.Peay@la.gov
- V. Third Party Administrators
N/A

Signed Funding Agreements – Certifications and Assurances are submitted online.

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) within the Louisiana Department of Health (LDH) manages and delivers the services and supports necessary to improve the quality of life for citizens with mental illness and substance use disorders. The agency acts as a monitor and subject matter consultant for Medicaid's Coordinated System of Care contract and the Healthy Louisiana plans, which manage specialized behavioral health services. OBH also delivers direct care through grants, state-owned hospitals, and monitoring of behavioral health community-based treatment programs through the human services districts and authorities, also known as local governing entities (LGEs). Services are provided for Medicaid and non-Medicaid eligible populations.

The mission of OBH is to lead the effort to build and provide a comprehensive, integrated, person-centered system of prevention and treatment services that promote recovery and resilience for all citizens of Louisiana. OBH assures public behavioral health services are accessible, have a positive impact, are culturally and clinically competent, and are delivered in partnership with all stakeholders. The goals of the Office of Behavioral Health are:

1. To serve children and adults with extensive behavioral health needs including mental health and/or addictive disorders by providing oversight and guidance of behavioral health services in the Medicaid Healthy Louisiana plans.
2. To assure that all Louisiana citizens with serious behavioral health challenges have access to needed forensic, residential, and other "safety net" services and promote use of contemporary, evidence-informed treatment, support, and prevention services.
3. To support the refinement and enhancement of a comprehensive system and associated service array for children, youth and families that appropriately addresses their behavioral health needs that is based on contemporary, best practice principles of care.

In State Fiscal Year (SFY) 2018, OBH was comprised of four distinct programs: Administration and Support, Behavioral Health Community, Hospital Based Treatment, and Auxiliary. The SFY18 year-end budgets and notable budget items are shown, below:

Agency Programs	SFY18 Year-end Budget
Administration and Support	\$6,948,762
Behavioral Health Community	\$72,223,510
Hospital Based Treatment	\$159,832,066
Auxiliary	\$20,000
Total	\$239,024,338

*Funding sources include State General funds, Interagency Transfers, Fees & Self-Generated revenue, Statutory Dedications and Federal funds

Notable Areas within SFY18 Budget¹	SFY18 Year-end Budget
Social and Client Services Contracts	\$18,863,984
Allocations to the LGEs	\$39,106,618
Hospital Patient-related Budget	\$121,909,227

¹Some budget items within these areas are double-counted

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.
- Performance monitoring and evaluation regarding the effectiveness of services being provided and achievement of outcome measures.

OBH's priorities reflect the agency's mission and vision and carry the highest potential impact. These priorities are:

[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 with 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.

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 Psychiatric Residential Treatment Facility (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 available behavioral health services. 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 reduce recidivism and to monitor compliance of settlement agreement 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 settlement agreement rules will be maintained.

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.

Criteria for Mental Health and Substance Use Prevention and Treatment

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:

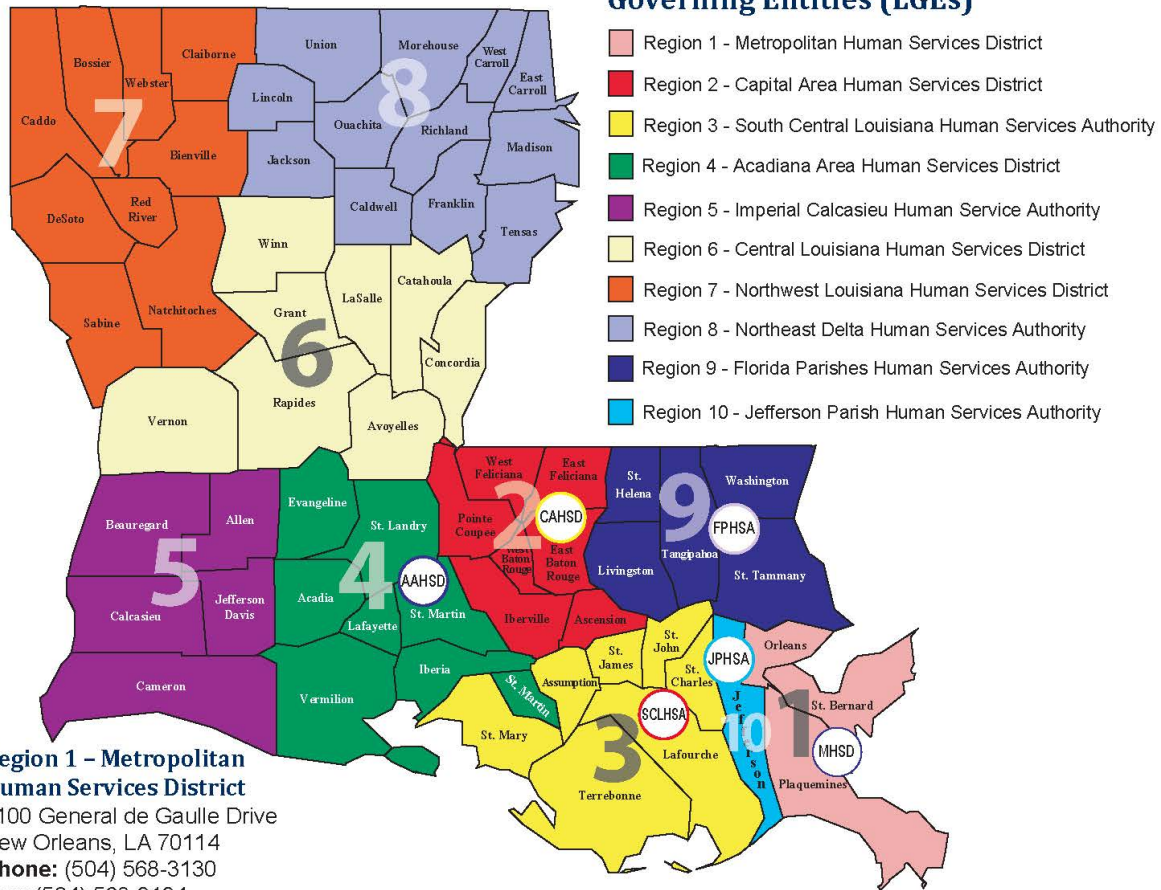
- Primary Prevention,
- Community Mental Health Services, and
- Substance Use Disorder Treatment.

Local Governing Entities

The Local Governing Entities (LGEs), classified as a human services district or authority, have a contractual agreement with the Louisiana Department of Health (LDH). Considered as the local umbrella agencies, the LGEs administer the state-funded behavioral health and developmental disability services in an integrated system within their localities. Because the LGE model increases local control and authority, there is more opportunity for greater accountability and responsiveness to the local communities. Each LGE is administered by an executive director who reports to a local governing board of directors of community and consumer volunteers. In 2017, ACT 73 of the Louisiana Legislature modernized the statutes governing the human service districts and authorities to revise board membership to include professionals and consumers in the fields of mental health, substance-related and addictive disorders, and developmental disabilities. Membership shall also represent professionals in finance, accounting, or auditing; judiciary and law enforcement, school-based healthcare or the coroner's office, depending on the region's needs. All LGEs remain part of the LDH departmental organizational structure, but not in a direct reporting line with OBH.

OBH's responsibilities include surveillance and monitoring of the statewide behavioral health system and the provision of technical assistance and resources that enable the LGEs to carry out service delivery within their catchment area. 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 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, a map is provided, which includes each LGE's service area and its contact information.

Office of Behavioral Health Local Governing Entities (LGEs)



Region 1 – Metropolitan Human Services District

3100 General de Gaulle Drive
New Orleans, LA 70114
Phone: (504) 568-3130
Fax: (504) 568-3134

Region 2 – Capital Area Human Services District

4615 Government Street
Building 2
Baton Rouge, LA 70806
Phone: (225) 922-2700
Fax: (225) 925-1987

Region 3 – South Central Louisiana Human Services Authority

158 Regal Rowe
Houma, LA 70360
Phone: (985) 858-2931
Fax: (985) 858-2934

Region 4 – Acadiana Area Human Services District

302 Dulles Drive, Suite 1
Lafayette, LA 70506
Phone: (337) 262-4190
Fax: (337) 262-4178

Region 5 – Imperial Calcasieu Human Service Authority

One Lakeshore Drive, Suite 2000
Lake Charles, LA 70629
Phone: (337) 475-3100
Fax: (337) 475-3105

Region 6 – Central Louisiana Human Services District

5411 Coliseum Blvd
Alexandria, LA 71303
Phone: (318) 487-5191
Fax: (318) 487-5184

Region 7 – Northwest Louisiana Human Services District

1310 North Hearne Avenue
Shreveport, LA 71107
Phone: (318) 676-5111
Fax: (318) 676-5021

Region 8 – Northeast Delta Human Services Authority

2513 Ferrand Street
Monroe, LA 71201
Phone: (318) 362-3270 or 3020
Fax: (318) 362-5051

Region 9 – Florida Parishes Human Services Authority

835 Pride Drive, Suite B
Hammond, LA 70401
Phone: (985) 543-4333
Fax: (985) 543-4817

Region 10 – Jefferson Parish Human Services Authority

3616 South I-10 Service Road, Suite 200
Metairie, LA 70001
Phone: (504) 838-5215
Fax: (504) 838-5714

The following table lists the LGE clinics with capacity to provide mental health services, substance use disorders services, or both (MH = Mental Health; SUD = Substance Use Disorders; BH=Behavioral 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
	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 Addiction Recovery Services	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 Behavioral Health 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
	Jefferson Davis Behavioral Health Clinic	BH	1211 N. Cutting Avenue	Jennings
	Lake Charles Behavioral Health Clinic	BH	4105 Kirkman Street	Lake Charles
	Sulphur Behavioral Health Clinic	BH	2651 E. Napoleon Street	Sulphur
CLHSD	Caring Choices Marksville	BH	694 Government Street	Marksville
	Caring Choices Pineville	BH	242 Shamrock Street	Pineville
	Caring Choices Jonesville	BH	308 Nasif Street	Jonesville
	Caring Choices Leesville	BH	105 Belview Road	Leesville
NLHSD	Minden Behavioral Health Clinic	BH	502 Nella Street Minden	Minden
	Natchitoches Behavioral Health Clinic	BH	210 Medical Drive	Natchitoches
	Shreveport Behavioral Health Clinic	BH	1310 North Hearne Avenue	Shreveport
NEDHSA	Bastrop Behavioral Health Clinic	BH	451 East Madison Ave	Bastrop
	Columbia Behavioral Health Clinic	BH	5159 Highway 4 East	Columbia
	Monroe Behavioral Health Clinic	BH	4800 South Grand Street	Monroe
	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	2106 Avenue F	Bogalusa

LGE	Clinic	Type	Address	City
	Florida Parishes Human Services Authority Denham Springs	BH	1920 Florida Avenue SW	Denham Springs
	Mandeville Behavioral Health Clinic	BH	900 Wilkinson Street	Mandeville
	Rosenblum Behavioral Health Clinic	BH	835 Pride Drive, Ste. B	Hammond
	Slidell Behavioral Health Clinic	BH	2331 Carey Street	Slidell
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

Managed Care for the Medicaid population

LDH transitioned delivery of Medicaid services from a fee-for-service model to a managed care model 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 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. Residential treatment facilities were developed for adolescents to provide intensive evidence-based treatment.

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 Medicaid managed care plans on December 1, 2015. Children with extensive behavioral health needs either in or at risk of out-of-home placement and enrolled in the Coordinated System of Care (CSoc) program remain managed by a separate managed care entity. Integration of behavioral health care services into the Medicaid managed care program was 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 450,000 Louisianans ages 19 to 64. As of June 2019, more than 85,400 adults in the Medicaid expansion group received specialized outpatient mental health services and more than 21,100 received inpatient mental health services at a psychiatric facility. Additionally, more than 16,600 adults received specialized substance use outpatient services and more than 18,100 adults received specialized substance use residential services. Furthermore, LDH and DOC developed an automated enrollment process that allows the agencies to share information about offenders who are set for release within the next nine

months, and get them enrolled in Medicaid and linked to a health plan pre-release. This enrollment process ensures that the health plan insurance card is mailed to DOC in time for release so that the former offender knows who to contact for access to care after release.

In 2018, to maintain access to care for beneficiaries in need of Opioid Use Disorder and Substance Use Disorder (OUD/SUD) services in residential facilities, Louisiana applied for and received approval of an 1115 Demonstration Waiver, effective February 1, 2018 through December 31, 2022. The waiver is necessary to provide services to beneficiaries residing in Institutions for Mental Disease (IMDs) for stays with durations longer than 15 days. An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases. CMS allowed the traditionally excluded use of IMDs but placed a day limit of 15 days on its usage. This waiver “waived” the cap of 15 days for Louisiana. As a result of waiver approval, Louisiana is able to receive federal financial participation (FFP), i.e. the Medicaid match, for the continuum of services to treat addictions to opioids and other substances.

In the spring of 2019, Louisiana initiated the third procurement cycle for the state’s Medicaid managed care program. Guided by the “Triple Aim”, LDH’s objective is to partner with enrollees, providers, and high-performing health plans to build a Medicaid managed care delivery system that improves the health of populations (better health), enhances the experience of care for individuals (better care), and effectively manages Medicaid per capita care costs (lower costs). With the new Request for Proposals released and anticipated new contract awards to begin in January 2020, the MCO will have increased case management functionalities and improved engagement in care that will assist people in special health care needs populations.

OBH retains the responsibility of establishing guidelines associated with qualifications and requirements for providers rendering specialized behavioral health services, in collaboration with the Louisiana Department of Health, Health Standards Section (healthcare licensing agency) and Medicaid. OBH also monitors the managed care entities to assess compliance of these qualifications and requirements on an ongoing basis, which includes sampling provider records through desk review and onsite audit. Medicaid providers are currently required to credential and re-credential through the managed care entity; however, Medicaid is moving towards the use of a Credentialing Verification Organization (CVO) for enrollment and credentialing. Medicaid providers will credential through the CVO prior to engaging with the managed care entities for the purposes of contracting and will be re-credentialed periodically as established by accreditation standards and contract requirements. 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.

Addressing the Needs of Diverse Populations and Minority Populations

LDH continues its commitment to support all Louisianans in achieving their best, fullest health outcomes. OBH is continuously striving to further develop and enhance the behavioral health services system to implement programs and protocol that are informed by the local communities to promote services that are reflective of the needs of the diverse population of Louisiana. OBH recognizes and respects differences among individuals served in terms of their cultures, values, expectations, and experiences. OBH also recognizes the importance to develop and support service systems that address the needs of diverse racial, ethnic, and sexual gender minorities, as well as the American Indian/Alaskan Native population in the state. These groups encounter barriers to broad-based social, political, and institutional integration.

As such, program efforts are made to ensure that these groups are considered, identified, and appropriately treated in the process of providing services. Louisiana also reaches diverse and minority populations through its primary prevention programs and services, which are implemented universally. Demographic data (to include race, age, and ethnicity) is collected on all individuals served.

The state continues to collaborate with the Louisiana Behavioral Health Advisory Council, statewide providers, other state and community partner agencies and stakeholders in assessing the needs of these populations and in the ongoing development, enhancement and implementation of the behavioral health service system to ensure the cultural and linguistic needs of individuals served are effectively addressed. In addition, the Office of Behavioral Health contracts with the ten LGEs across the state to administer behavioral health services. This model increases local control and authority, in which there is greater accountability and responsiveness to the needs of these populations. These entities also provide annual staff training to ensure competent knowledge, skills and attitudes (KSA) are demonstrated and implemented effectively to serve diverse and minority populations. OBH also utilizes SAMHSA TIP 59: Improving Cultural Competence as a guide in addressing needs of specific populations. TIP 59 is shared with providers as a learning tool/resource.

In 2018, OBH hosted a statewide behavioral health symposium, where topics related to cultural competency and diversity were addressed, to include session topics regarding working effectively with the LGBTQ population, American Indian perspective in behavioral health, ageism and the dangers of stereotyping older adults, as well as other vulnerable populations, such as individuals living with HIV/AIDS or other STDs, veterans, and the homeless. In 2019, OBH conducted a Statewide Listening Tour with sessions in each region of the state. The Listening Tour provided an opportunity for the partners mentioned above, as well as persons who receive services in the local areas, to provide valuable feedback regarding how the behavioral health services system in Louisiana may be further developed to meet the specific needs of the populations in their communities. Through ongoing behavioral health system development, training, community partnerships, and listening tours with all stakeholders, the commitment of OBH is to build a system of care and resources where all Louisianans who struggle with serious mental illness and/or substance use disorders will thrive.

In addition, the Louisiana Department of Health incorporated language within the Behavioral Health Licensing Standards to ensure that all providers adhere to cultural competence. According to section 5651: Treatment Protocols, “providers shall deliver all services according to a written plan that is age and culturally appropriate for the population served.”

Assessment of Strengths and Needs

In 2019, OBH facilitated several opportunities to engage community, providers, and other stakeholders on what works and does not work in the behavioral health system. This includes the Conversation on Behavioral Health Listening Tour, Advisory Council quarterly meetings, ongoing dialogues with mental health and SUD treatment providers, and monthly meetings with the LGEs. OBH has compiled these items as strengths and needs during the planning process.

Strengths

Grants:

- Louisiana Partnerships for Success II (LaPFS II) - focus exclusively on addressing underage drinking behaviors, consequences, and risk factors among 9-20 year olds.
- Comprehensive Opioid Abuse Site-based Program (COAP)- support the development of a coordinated plan between OBH and the Louisiana Commission on Law Enforcement (LCLE) to assist localities in engaging and retaining justice-involved individuals with opioid use disorders in treatment and recovery services, increasing the use of diversion and/or alternatives to incarceration, and/or reducing the incidence of overdose death.
- Promoting Integration of Primary Behavioral Healthcare (PIPBHC)- to promote the integration of primary and behavioral health care services to improve the overall wellness and physical health status of adults with mental illness who have co-occurring physical health conditions or chronic diseases and individuals with a substance use disorder.
- State Targeted Response to Opioid Crisis Grant (STR)- 10,364 total Narcan kits were distributed through this grant.

Cross Sector Collaborative Opportunities:

- Heroin and Opioid Prevention and Education (HOPE) Council- 13 agency heads, with LDH as the Chair, addresses prevention and education of heroin and opioids.
- DWI Taskforce was reinstituted as a subcommittee under the Drug Policy Board.

New Initiatives:

- Shatterproof- In February, 2019, Louisiana announced it is one of 5 pilot states engaging in the development of a substance use disorder treatment quality measurement system. This pilot program will be completed in the summer of 2020.
- Single Preferred Drug List (PDL)- Opioid antagonist and partial agonist are now available without prior authorization to all Medicaid recipients and providers.
- Louisiana Opioid Data & Surveillance System (LODSS) - collects information from LDH and external organizations to analyze health data related to opioid use disorder. LODSS disseminates results through facts sheets, publications, training and educational materials, and the online data and surveillance system.
- Project AWARE- In partnership with the Louisiana Department of Education, a comprehensive Louisiana School Mental Health Support Program will be established to increase awareness of mental health issues among school-aged youth, to provide specialized training to school personnel on how to detect and respond to mental health issues, and to connect students struggling with behavioral or mental health issues and their families to the appropriate services.
- Increased access to MAT– all residential providers enrolled in the Medicaid managed care program are required to provide MAT onsite or facilitate access to MAT offsite which includes coordinating with the member's health plan for referring to available MAT provider and arranging Medicaid non-emergency medical transportation if other transportation is not available for the patient.
- Methadone coverage– LDH received appropriated funding for SFY20 to allow Medicaid coverage of Methadone treatment for Medicaid eligible age 18 and older diagnosed with an opioid addiction.

Ongoing:

- Louisiana has a statewide prevention system, as well as an institutionalized state epidemiology workgroup (SEW). Originally linked to specific grant funds, the SEW is currently

a permanent sub-committee of the Governor's Drug Policy Board, regardless of funding. Many states are not so fortunate and do not have continuity of activities or membership.

- Louisiana has statewide coverage and free access to services for gambling and tobacco cessation.
- The CORE Alcohol and Drug survey has lasted through 7 administrations and the Caring Communities Youth Survey (CCYS) has been ongoing since 1994. Both surveys provide needs assessment data on a continuous basis without any cost to those who participate. Both surveys provide data allowing planning at the state, community and school-level.
- The C'est Bon program is a peer to peer process of surveying recipients of state run behavioral health services regarding satisfaction with services provided. Utilizing a consumer satisfaction team model for consumer-to-consumer monitoring and evaluation, the C'est Bon 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 will have a greater voice and a more meaningful role in influencing the design and quality of public behavioral health 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.
- Open access- When the state moved to Managed Care and with Medicaid expansion, the provider network expanded and gave clients more options and therefore, less waiting for services.
- Louisiana has an Inpatient residential BH treatment facility, while not all states do.

Other:

- All LGEs are now compliant in submitting data.

Needs

- Accessible housing for individuals with behavioral health diagnoses
- More peer services- crisis services, case management, supported employment
- Integrated services for patients with intellectual disabilities and mental health issues, particularly at residential level of care (inpatient settings, PRTFs, and therapeutic group home settings) are a need.
- Education on how to navigate the behavioral health system and access services
- Data system updates, training, and utilization
- Increased professional and work development trainings
- Increased integrated primary care and behavioral health care.

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

The Office of Behavioral Health (OBH) compiled a variety of national measures, prevalence data, and survey indicators as part of a review of the state's behavioral health system. Data collection definitions, methodologies, and barriers are explained in the Quality and Data Collection Readiness section.

National Measures

Per the Agency for Healthcare Research and Quality (AHRQ), Louisiana is lacking in various quality measures when compared to achievable benchmarks, which are derived from the top-performing States. Benchmarks are available for a total of 88 measures shared in the National Healthcare Quality Report (NHQR). Of these 88 measures, Louisiana has 24 measures that are considered “far away from benchmark,” which means a state's value for a measure has not achieved 50% of the benchmark. 5 of these 24 “far away from benchmark” measures are listed in the following table, which also displays the estimate, benchmark, and distance to benchmark:

Measure	Louisiana Estimate	Benchmark	Distance to Benchmark
People Age 12 and Over Treated for Substance Abuse Who Completed Treatment Course	13.9	63.1	78%
Suicide Deaths Among Persons Age 12 and Over per 100,000 Population	18.4	9.38	96%
Hospital Inpatient Stays Involving Opioid-related Diagnoses per 100,000 Population	203.6	99.4	105%
HIV Infection Deaths per 100,000 Population	4.5	.75	500%
New HIV Cases per 100,000 Population Age 13 and Over	31.5	4.3	633%

Data source: State snapshots from 2017 National Healthcare Quality and Disparities Reports through Agency for Healthcare Research and Quality (AHRQ) https://nhqrnet.ahrq.gov/inhqrdr/Louisiana/benchmark/summary/All_Measures/All_Topics

The following table shares statistical differences between Louisiana and the United States, according to the Behavioral Health Barometer for Louisiana (2017), which includes the data from the National Survey on Drug Use and Health (2017):

Indicators	Louisiana	US
Past-Month Alcohol Use Among Adolescents Aged 12–17	12.2%	10.1%
Past month Cigarette Use Among Adolescents Aged 12-17	5.3%	3.9%
Past-Year Serious Mental Illness (SMI) Among Adults Aged 18 or Older	5.0%	4.2%
Past-Year Serious Thoughts of Suicide Among Adults Aged 18 or Older	4.5%	4.1%
Past-Year Alcohol Use Disorder Among Individuals Aged 12 or Older	6.8%	5.8%

Data source: Behavioral Health Barometer for Louisiana (2017) <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Louisiana-BH-BarometerVolume5.pdf>

Per the Kaiser State Health Facts (2017)¹, 39.1% 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 35.6%.

Based on data from the CDC WONDER Online Database², America’s Health Rankings reports Louisiana ranked as 19th among the states in its rate of suicides during 2018. The State’s rate of suicides per 100,000 population (14.6) was slightly higher than the national rate (13.9).

In the Annie E. Casey Foundation Kids Count Data Book (KIDS Count, 2019), Louisiana continued to rank near the bottom of the nation in terms of child health, education, family/community and well-being, ranking 49th overall in the nation. This overall ranking is the same as the 2018 publication. Louisiana ranked worse than the nation for the following indicators:

Indicators	Louisiana	United States
Economic Well-Being Indicators (Rank = 50th)		
• Children in poverty: 2017	28%	18%
• Children whose parents lack secure employment: 2017	33%	27%
• Teens (16-19 years) not in school and not working: 2017	10%	7%
Education Indicators (Rank = 48th)		
• Fourth graders not/below proficient in reading: 2017	74%	65%
• Eighth graders not/below proficient in math: 2017	81%	67%
• High school students not graduating on time: 2016-17	22%	15%
Health Indicators (Rank = 42nd)		
• Low-birth weight babies: 2017	10.7%	8.3%
• Child and teen deaths per 100,000: 2017	39	26
Family and Community Indicators (Rank = 48th)		
• Children in single-parent families: 2017	45%	34%
• Children living in high-poverty areas: 2013-17	20%	12%
• Teen births per 1,000: 2017	29	19

Data source: Indicator percentages from <http://datacenter.kidscount.org/>. Ranks from 2019 KIDS Count Data Book.

Prevalence Estimates and Person Served

According to the *2017 Annual Estimates of the Resident Population 7/1/2017 State Characteristics, Population Estimates Division, U.S. Census Bureau (released July 2017)*, there were estimated 4,684,333 individuals in Louisiana including 1,074,034 children/youth (ages 0-17) and 3,610,299 adults (ages 18+).

2017 Louisiana Demographics Estimates			
Race	Estimate	Age	Estimate
American Indian/Alaska Native	36,526	0-17	1,074,034
Asian	87,305	18-24	469,517
Black/African American	1,528,167	25-44	1,258,135
Native Hawaiian/Other Pacific Islander	2,937	45-64	1,185,265
White	2,951,003	65 & Over	697,383

¹ <https://www.kff.org/statedata/>

² <https://www.americashealthrankings.org/explore/annual/measure/Suicide/state/LA>

More than One Race Reported	78,395
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Ethnicity	Estimate
Hispanic or Latino	243,620
Not Hispanic or Latino	4,440,713

Gender	Estimate
Male	2,289,446
Female	2,394,887

Population estimates for each LGE service area were 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 broken down by LGE region are shown in the following tables. Caution should be used when utilizing these figures, as they are estimates.

2017 LOUISIANA SMI & SED PREVALENCE ESTIMATES						
LGE	Child/Youth [£] = 7%*		Adult = 5.4%*		Total	
	Population	Prevalence	Population	Prevalence	Population	Prevalence
MHSD	47,327	3,313	365,412	19,732	412,739	23,045
CAHSD	78,846	5,519	526,791	28,447	605,637	33,966
SCLHSA	49,502	3,465	303,851	16,408	353,353	19,873
AAHSD	76,043	5,323	455,664	24,606	531,707	29,929
IMCAL	37,589	2,631	228,511	12,340	266,100	14,971
CLHSD	36,376	2,546	231,545	12,503	267,921	15,050
NLHSD	64,451	4,512	412,506	22,275	476,957	26,787
NEDHSA	42,110	2,948	268,572	14,503	310,682	17,451
FPHSA	74,696	5,229	440,233	23,773	514,929	29,001
JPHSA	46,656	3,266	342,845	18,514	389,501	21,780
TOTAL	553,596	38,752	3,575,930	193,100	4,129,526	231,852

[£] As the 9-17 age group is not calculated in the population estimates of Census Bureau, *CDC Wonder* was used as alternative source to determine the estimated population of 9-17 years. 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 2017.

*SAMHSA Drug & Alcohol Services Information System (<https://www.dasis.samhsa.gov/dasis2/urs.htm>), SMI/SED Prevalence Estimates 2017 (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, 2017) SMI Prevalence= 5.4%; SED Prevalence= 7%.

Individuals with SMI/SED are considered to be the target population for mental health block grant funded evidence- based practice (EBP) programs. These EBP programs are provided by the LGE regions and their contracted clinics.

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 Persons Receiving Mental Health Services						
LGE	FY 2017			FY 2018		
	CHILD (0-17)	ADULT (18+)	TOTAL*	CHILD (0-17)	ADULT (18+)	TOTAL*
MHSD	640	5,491	6,131	650	4,462	5,112
CAHSD	1,621	5,503	7,136	1,249	5,871	7,131
SCLHSA	1,685	7,603	9,288	1,687	7,731	9,418
AAHSD	325	1,915	2,240	235	1,665	1,900
IMCAL	386	1,978	2,373	259	1,560	1,824
CLHSD	200	3,521	3,738	129	3,148	3,287
NWLHSD	346	2,188	2,555	282	1,616	1,909
NEDHSA	29	1,490	1,519	37	1,556	1,593
FPHSA	553	4,764	5,385	363	4,057	4,526
JPHSA	547	2,062	2,609	551	2,369	2,920
TOTAL	6,332	36,515	42,974	5,442	34,035	39,620

Data Source: LGE EHR data sent to OBH. Age at end of reporting time period. Unduplicated by client within LGE.

*Total count may include missing ages, resulting in counts greater than direct addition of child and adult counts.

Community Behavioral Health Clinics Child/Youth (Ages 9-17) with SED Served						
LGE	FY 2017			FY 2018		
	Child/Youth with SED	Total Served	% SED	Child/Youth with SED	Total Served	% SED
MHSD	194	519	37%	261	526	50%
CAHSD	760	1,379	55%	457	1,081	42%
SCLHSA	940	1,415	66%	829	1,381	60%
AAHSD	236	253	93%	176	191	92%
IMCAL	87	306	28%	84	218	39%
CLHSD	34	174	20%	24	115	21%
NWLHSD	183	285	64%	154	249	62%
NEDHSA	12	26	46%	27	30	90%
FPHSA	183	486	38%	138	327	42%
JPHSA	194	439	44%	164	456	36%
TOTAL	2,823	5,282	53%	2,314	4,574	51%

Data Source: LGE EHR data sent to OBH. Age at end of reporting time period. Unduplicated by client within LGE.
SMI/SED based on most recent Special Population SMI/SED available from admission to end of reporting time period.

Community Behavioral Health Clinics Adults (Ages 18 and over) with SMI Served						
LGE	FY 2017			FY 2018		
	Adults with SMI	Total Served	% SMI	Adults with SMI	Total Served	% SMI
MHSD	3,074	5,491	56%	2,391	4,462	54%
CAHSD	2,095	5,503	38%	1,550	5,871	26%
SCLHSA	5,780	7,603	76%	4,894	7,731	63%
AAHSD	1,381	1,915	72%	1,161	1,665	70%
IMCAL	192	1,978	9.7%	250	1,560	16%
CLHSD	712	3,521	20%	789	3,148	25%
NWLHSD	797	2,188	36%	608	1,616	38%
NEDHSA	1,194	1,490	80%	1,399	1,556	90%
FPHSA	1,260	4,764	26%	1,125	4,057	28%
JPHSA	691	2,062	34%	695	2,369	29%
TOTAL	17,176	36,515	47%	14,862	34,035	44%

Data Source: LGE EHR data sent to OBH. Age at end of reporting time period. Unduplicated by client within LGE.
SMI/SED based on most recent Special Population SMI/SED available from admission to end of reporting time period.

The next table compares the prevalence estimates and the number of persons served. OBH data reported 2,314 children and youth (ages 9-17) with SED were served at the end of FY 2018, revealing that 5.97 % of the estimated children with SED were being served in LGE clinics. OBH data reported 14,862 adults with SMI were served at the end of FY 2018, revealing that 7.69 % of the estimated adults with SMI were being served in LGE clinics (percentages not shown in the table below). These numbers do not reflect those served in private clinics and/or providers *not* receiving SAMHSA Block Grant money.

Number of SMI/SED Persons Served Compared to Prevalence Estimates – FY 2018						
LGE	Child/Youth (Ages 9-17)		Adults (Ages 18 and over)		Total SMI/SED Served	Percentage of Prevalence Served
	Child/Youth with SED	Prevalence Estimate	Adults with SMI	Prevalence Estimate		
MHSD	261	3,313	2,391	19,732	2,652	11.51%
CAHSD	457	5,519	1,550	28,447	2,007	5.91%
SCLHSA	829	3,465	4,894	16,408	5,723	28.80%
AAHSD	176	5,323	1,161	24,606	1,337	4.47%
IMCAL	84	2,631	250	12,340	334	2.23%
CLHSD	24	2,546	789	12,503	813	5.40%
NWLHSD	154	4,512	608	22,275	762	2.84%
NEDHSA	27	2,948	1,399	14,503	1,426	8.17%
FPHSA	138	5,229	1,125	23,773	1,263	4.35%
JPHSA	164	3,266	695	18,514	859	3.94%
TOTAL	2,314	38,752	14,862	193,100	17,176	7.41%

Data Source: LGE EHR data sent to OBH. Age at end of reporting time period. Unduplicated by client within LGE.
SMI/SED based on most recent Special Population SMI/SED available from admission to end of reporting 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, Federal Bureau of Investigations, Louisiana State University, and Louisiana Department of Health. Distributions of the data collected by the LGEs through their respective electronic health records (EHRs) and sent to OBH 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 demographics of the parishes that comprise the LGE service areas.
- The estimates for Drug Related Arrests 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.
- The estimates for Acute Hepatitis B, Acute Hepatitis C, and HIV were calculated by applying a statewide incidence rate to the parish proportion 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

LGE	Population ¹	12+ Population ¹	Female 12+ Population ⁶	TOTAL POPULATION		INJECTING DRUG USERS		WOMEN		PREVALENCE OF SUBSTANCE-RELATED CRIMINAL ACTIVITY		INCIDENCE OF COMMUNICABLE DISEASE			
				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	Acute Hep B ¹¹	Acute Hep C ¹²	HIV ¹³	TB ¹⁴
MHSD	462,842	393,650	207,722	29,917	3,650	1,181	144	15,787	1,926	1,042	3,177	5	0	102	24
CAHSD	685,568	575,077	295,649	43,706	5,332	1,725	210	22,469	2,741	2,600	4,641	7	4	152	12
SCLHSA	401,568	334,131	171,487	25,394	3,098	1,002	122	13,033	1,590	2,030	2,696	4	0	89	9
AAHSD	608,763	501,901	258,945	38,144	4,654	1,506	184	19,680	2,401	1,986	4,050	6	1	135	11
IMCAL	303,383	251,476	127,048	19,112	2,332	754	92	9,656	1,178	1,381	2,029	3	0	67	11
CLHSD	304,675	253,715	125,196	19,282	2,352	761	93	9,515	1,161	1,568	2,047	3	1	67	4
NLHSD	542,115	451,830	234,954	34,339	4,189	1,355	165	17,857	2,178	2,744	3,646	5	1	120	19
NEDHSA	352,335	294,465	151,951	22,379	2,730	883	108	11,548	1,409	1,434	2,376	4	3	78	14
FPHSA	584,048	488,968	252,270	37,162	4,534	1,467	179	19,173	2,339	2,663	3,946	6	2	129	16
JPHSA	439,036	371,107	192,867	28,204	3,441	1,113	136	14,658	1,788	1,359	2,995	4	0	97	21
TOTAL	4,684,333	3,916,319	2,018,087	297,640	36,312	11,749	1,433	153,375	18,712	18,807	31,604	47	12	1,035	141

¹ The estimates for Population and 12+ Population by LGE service area were obtained from the US Census Bureau's *Annual Estimates of the Resident Population for Selected Age Groups by Sex: April 1, 2010 to July 1, 2017* (<https://www.census.gov/data/datasets/2017/demo/popest/counties-detail.html>). The estimate for the 12+ Population by SPA from the same dataset was obtained by excluding the *Under 5 Years*, *5 to 9 Years*, and one-half of *10 to 14 Years* categories from total population.

² According to NSDUH, 7.6% of the population aged 12 or older needed substance use treatment in the past year. The 12+ population for each SPA was multiplied by 7.6% to estimate the number of people needing treatment services. Source: Table 5.50B – Need for and Receipt of Substance Use Treatment at a Specialty Facility in Past Year among Persons Aged 12 or Older, by Demographic Characteristics: Percentages, 2016 and 2017. <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.htm#tab5-50B>

³ According to NSDUH, 12.2% of those who needed substance abuse treatment received treatment at a specialty facility in the past year. Source: Table 5.50B – Need for and Receipt of Substance Use Treatment at a Specialty Facility in Past Year among Persons Aged 12 or Older, by Demographic Characteristics: Percentages, 2016 and 2017. <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.htm#tab5-50B>. 12.2% was used to estimate the Total Population that Would Seek Treatment by SPA.

**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 States 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> . The 12+ Population for each SPA was multiplied by .003 to estimate the number of IDU's needing treatment services.

⁵ The estimate of 12.2% that was used to calculate the number of people that would seek treatment in total population was also used to determine the *Number of IVDU's that Would Seek Treatment*. The number of IVDUs that will seek treatment was obtained by multiplying each SPA category of IVDU needing treatment services by 12.2%.

⁶ An estimate for the Female 12+ Population by SPA was obtained from the US Census Bureau's *Annual Estimates of the Resident Population for Selected Age Groups by Sex: April 1, 2010 to July 1, 2017* (<https://www.census.gov/data/datasets/2017/demo/popest/counties-detail.html>). The estimate for the Female 12+ Population by SPA from the same dataset was obtained by excluding the *Under 5 Years*, *5 to 9 Years*, and one-half of *10 to 14 Years* categories from total *female* population.

⁷ Information from the 2017 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 7.6% that used to calculate the number of total population needing treatment was also used to estimate the number of women (females 12+) in need of treatment. The number of women needing treatment services for each SPA was obtained by multiplying female 12+ population of each SPA category by 7.6%.

⁸ The estimate of 12.2% 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. The number of women that will seek treatment was obtained by multiplying each SPA category of women needing treatment services for by 12.2%.

⁹ The estimates for Number of DWI Arrests for 2017 were obtained from the Louisiana State University, Highway Safety Research Group's *2017 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, 2017 Report* was used to estimate the Number of Drug Related Arrests for Calendar Year 2017. According to this report, there were 27,952 drug related arrests in Louisiana in 2017 (25,770 Drug Abuse Violations + 2,869 Liquor Law Violations + 2,965 Drunkenness = 31,604). Parish estimates for the Number of Drug Related Arrests were calculated by multiplying this figure (31,604) 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, 2017*: <https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/topic-pages/tables/table-69> Table 69, *Arrests by State, 2017*.

¹¹ **2016** Acute Hep B: According to CDC, Louisiana's incidence rate for Hepatitis B in 2016 was 1.0/100,000 (Viral Hepatitis Surveillance – United States, 2016; Table 3.1: Reported cases of Acute Hepatitis B, nationally and by state or jurisdiction — United States, 2012 – 2016 <https://www.cdc.gov/hepatitis/statistics/2016surveillance/index.htm>). This estimates 47 cases (.00001*4,684,333) for the total population. LGE estimates for Incidence of Acute Hepatitis B/100,000 were calculated by multiplying 0.00001 with the LGE population estimate.

¹² **2017** Acute Hep C: According to the Internal Statewide Registry of STD/HIV/Hepatitis Program, Office of Public Health, Louisiana Department of Health, incidence for Acute Hepatitis C in Louisiana for CY 2017 was 12. The LGE counts for Incidence of Acute Hepatitis C was obtained from the same registry.

¹³ As stated in the *Louisiana HIV, AIDS, and Early Syphilis Surveillance, Quarterly Report, December 31, 2018* (Page#1) (http://ldh.la.gov/assets/oph/HIVSTD/HIV_Syphilis_Quarterly_Reports/2018Reports/Fourth_Quarter_2018_HIV_Syphilis_Report.pdf), Louisiana's incidence rate for HIV in 2017 was 22.1/100,000. There were estimated 1,035 cases for total Louisiana population. The population for each SPA/LGE was multiplied by .000221 to estimate the incidence of HIV.

¹⁴ According to the Louisiana Department of Health and Hospitals Tuberculosis Control Program, Louisiana's incidence rate for Tuberculosis in 2017 was 3.0/100,000 (Louisiana TB Morbidity Report – 2017: Louisiana Tuberculosis (TB) Cases/Rates <http://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/tuber/2017TBMorbidityTable.PDF>). This estimates 141 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 categorized 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 LGEs for the total number of persons served during FY 2018 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 and/or providers *not* receiving SAMHSA Block Grant money.

Substance Use Disorder Treatment – FY 2018					
LGE	Needing Treatment Services	That would seek treatment	Admissions	Total Served	Percent of Prevalence Served
MHSD	29,917	3,650	1,439	1,830	6.12%
CAHSD	43,706	5,332	1,721	2,183	4.99%
SCLHSA	25,394	3,098	2,833	3,600	14.18%
AAHSD	38,144	4,654	893	1,151	3.02%
IMCAL	19,112	2,332	644	898	4.70%
CLHSD	19,282	2,352	1,720	2,013	10.44%
NLHSD	34,339	4,189	1,396	1,713	4.99%
NEDHSA	22,379	2,730	2,913	3,169	14.16%
FPHSA	37,162	4,534	1,023	1,374	3.70%
JPHSA	28,204	3,441	917	917	3.25%
TOTAL	297,640	36,312	15,499	18,848	6.33%

Data Source: Needing and Seeking Treatment: 2017 NSDUH Survey (Table 5.50B).

Admissions and Total Served: LADDS and LGE EHR data sent to OBH.

Substance Use Disorder Treatment for Women (Females ages 12+) – FY 2018					
LGE	Needing Treatment Services	That would seek treatment	Admissions	Total Served	Percent of Prevalence Served
MHSD	15,787	1,926	487	609	3.86%
CAHSD	22,469	2,741	718	925	4.12%
SCLHSA	13,033	1,590	1,237	1,602	12.29%
AAHSD	19,680	2,401	419	558	2.84%
IMCAL	9,656	1,178	296	430	4.45%
CLHSD	9,515	1,161	707	825	8.67%
NLHSD	17,857	2,178	534	686	3.84%
NEDHSA	11,548	1,409	999	1,102	9.54%
FPHSA	19,173	2,339	379	537	2.80%
JPHSA	14,658	1,788	356	356	2.43%
TOTAL	153,375	18,712	6,132	7,630	4.97%

Data Source: Needing and Seeking Treatment: 2017 NSDUH Survey (Table 5.50B).

Admissions and Total Served: LADDS and LGE EHR data sent to OBH.

Persons Who Inject Drugs – FY 2018					
LGE	Needing Treatment Services	That would seek treatment	Admissions	Total Served	Percent of Prevalence Served
MHSD	1,181	144	480	623	52.75%
CAHSD	1,725	210	17	20	1.16%
SCLHSA	1,002	122	138	143	14.27%
AAHSD	1,506	184	202	212	14.08%
IMCAL	754	92	15	22	2.92%
CLHSD	761	93	242	272	35.74%
NLHSD	1,355	165	301	315	23.24%
NEDHSA	883	108	705	755	85.47%
FPHSA	1,467	179	45	57	3.89%
JPHSA	1,113	136	106	106	9.52%
TOTAL	11,749	1,433	2,251	2,525	21.49%

Data Source:

- Needing treatment: 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 States 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>. The 12+ Population for each SPA was multiplied by .003 to estimate the number of IVDU's needing treatment services.
- Seeking Treatment: 2017 NSDUH Survey (Table 5.50B)
- Admissions and Total Served: LADDS and LGE EHR data sent to OBH

Demographics Profile of SUD Population Served – FY 2018			
Race/Ethnicity		% Served	
American Indian		0.81%	
Asian		0.21%	
Black/African American		32.07%	
Native Hawaiian/Other Pacific Islander		0.11%	
White		59.92%	
More than One Race Reported		0.16%	
Unknown - Other		6.72%	
Hispanic or Latino		1.93%	
Not Hispanic or Latino		92.90%	
Unknown		5.17%	
		Age	% Served
		0-17	4.28%
		18-24	10.62%
		25-44	57.47%
		45-64	26.26%
		65 & Over	1.36%
		Gender	% Served
		Male	58.81%
		Female	41.19%

Data Source: LADDS and LGE EHR data sent to OBH.

Primary Prevention

State Epidemiology Workgroup

The State Epidemiology Workgroup (SEW), a subcommittee of the Louisiana Drug Policy Board (DPB), 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 2018, completed March 2019. The results for the state of Louisiana are presented along with comparisons to 2014 and 2016 CCYS survey results, and the Monitoring the Future (MTF) survey results, as applicable. The MTF study is a long-term epidemiological study that surveys trends in drug and alcohol use among American adolescents.

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 use prevention field has evolved, the CCYS has been modified to measure additional substance use 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.

Below are tables from the 2018 CCYS that provide the percentage of students who used gateway drugs (Table 3) and the percentage of students who used other illicit drugs (Table 4).

Table 3. Percentage of Students Who Used Gateway Drugs

		6th				8th				10th				12th			
On how many occasions (if any) have you... (One or more occasions)		State 2014	State 2016	State 2018	MTF 2018	State 2014	State 2016	State 2018	MTF 2018	State 2014	State 2016	State 2018	MTF 2018	State 2014	State 2016	State 2018	MTF 2018
Lifetime alcohol	had alcoholic beverages (beer, wine, or hard liquor) to drink in your lifetime -- more than just a few sips?	16.5	16.2	17.3	~	36.4	32.9	35.5	23.5	56.0	51.9	53.2	43.0	66.1	61.2	60.5	58.5
Past 30 day alcohol	had beer, wine, or hard liquor to drink during the past 30 days?	5.7	5.5	5.9	~	16.4	14.1	14.8	8.2	30.7	26.8	29.1	18.6	42.4	36.4	37.5	30.2
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)	3.2	3.7	3.7	~	8.8	7.8	7.5	3.7	16.8	14.6	16.3	8.7	24.0	21.2	22.1	13.8
Lifetime cigarettes	Have you ever smoked cigarettes?	7.1	6.6	6.2	~	19.2	15.8	14.9	9.1	27.7	24.7	21.9	16.0	34.8	31.6	28.1	23.8
Past 30 day cigarettes	How frequently have you smoked cigarettes during the past 30 days?	1.5	1.2	1.1	~	5.5	3.4	3.1	2.2	9.7	7.3	5.8	4.2	15.8	12.3	9.3	7.6
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)	0.3	0.2	0.2	~	0.9	0.5	0.4	0.3	1.8	1.1	1.0	0.7	4.2	2.6	1.8	1.5
Lifetime chewing tobacco	used smokeless tobacco (chew, snuff, plug, dipping tobacco, chewing tobacco) in your lifetime?	4.0	4.1	4.1	~	9.8	9.0	8.3	6.4	13.7	13.0	12.4	10.0	16.1	14.5	14.1	10.1
Past 30 day chewing tobacco	used smokeless tobacco (chew, snuff, plug, dipping tobacco, chewing tobacco) during the past 30 days?	1.4	1.3	1.4	~	5.1	3.9	3.3	2.1	7.2	5.8	5.5	3.9	8.5	6.9	6.2	4.2
Lifetime e-cigarette use*	Have you ever tried electronic cigarettes, e-cigarettes, vape pens, or e-hookahs?	~	9.5	11.6	~	~	22.2	29.1	21.5	~	33.9	43.3	36.9	~	40.2	47.0	42.5
Past 30 day e-cigarette use*	use electronic cigarettes, e-cigarettes, vape pens, or e-hookahs?	~	3.4	5.3	~	~	8.1	15.7	10.4	~	11.6	26.8	21.7	~	12.9	29.5	26.7
Lifetime marijuana	used marijuana (grass, pot) or hashish (hash, hash oil) in your lifetime?	1.5	1.4	1.6	~	8.9	8.0	8.7	13.9	21.4	20.6	21.4	32.6	31.5	30.1	30.6	43.6
Past 30 day marijuana	used marijuana (grass, pot) or hashish (hash, hash oil) during the past 30 days?	0.7	0.6	0.5	~	4.1	3.7	3.9	5.6	10.5	10.2	10.7	16.7	16.4	15.5	15.9	22.2
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?	4.9	4.6	4.8	~	9.1	8.5	8.6	8.7	7.1	6.7	6.7	6.5	4.8	4.3	4.2	4.4
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?	2.1	1.9	2.0	~	3.3	3.0	2.9	1.8	1.8	1.8	1.5	1.0	0.9	0.7	0.8	0.7

*Substance category not measured in 2014.

Table 4. Percentage of Students Who Used Other Illicit Drugs

		6th				8th				10th				12th			
On how many occasions (if any) have you... (One or more occasions)		State 2014	State 2016	State 2018	MTF 2018	State 2014	State 2016	State 2018	MTF 2018	State 2014	State 2016	State 2018	MTF 2018	State 2014	State 2016	State 2018	MTF 2018
Lifetime hallucinogens†	used LSD (acid, blotter) or other hallucinogens (like PCP, mescaline, peyote, shrooms, or ketamine) in your lifetime?	0.4	0.3	0.3	~	0.9	0.9	1.0	2.2	2.3	2.1	2.3	3.9	3.7	3.9	4.1	6.6
Past 30 day hallucinogens†	used LSD (acid, blotter) or other hallucinogens (like PCP, mescaline, peyote, shrooms, or ketamine) during the past 30 days?	0.1	0.1	0.1	~	0.4	0.4	0.4	0.6	0.8	0.8	0.8	0.8	1.2	1.3	1.5	1.4
Lifetime cocaine	used cocaine or crack in your lifetime?	0.4	0.4	0.4	~	1.0	0.9	0.8	1.4	1.3	1.0	1.1	2.6	2.2	2.1	2.0	3.9
Past 30 day cocaine	used cocaine or crack during the past 30 days?	0.2	0.1	0.2	~	0.5	0.4	0.3	0.3	0.5	0.3	0.4	0.6	0.7	0.7	0.6	1.1
Lifetime methamphetamine	used methamphetamines (meth, speed, crank, crystal meth) in your lifetime?	0.2	0.3	0.3	~	0.6	0.5	0.6	0.7	1.0	0.7	0.8	0.8	1.3	1.0	1.0	0.7
Past 30 day methamphetamine	used methamphetamines (meth, speed, crank, crystal meth) during the past 30 days?	0.1	0.1	0.1	~	0.3	0.2	0.2	0.1	0.4	0.2	0.4	0.1	0.5	0.3	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?	0.5	0.9	1.0	~	0.9	1.7	2.5	5.9	2.1	4.0	4.5	8.6	3.2	6.6	6.3	8.6
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	0.4	0.5	~	0.5	0.8	1.1	1.8	0.9	1.7	1.8	2.4	1.3	2.6	2.1	2.4
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?	3.0	2.3	2.5	~	5.0	4.0	4.9	~	7.0	6.7	6.4	~	8.0	7.9	7.1	4.2
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	1.1	1.1	~	2.3	1.9	2.1	~	3.3	3.0	2.6	~	3.4	3.1	2.6	1.2
Lifetime heroin†	used heroin in your lifetime?	0.2	0.3	0.3	~	0.5	0.5	0.4	0.6	0.7	0.6	0.6	0.4	1.0	0.8	0.4	0.8
Past 30 day heroin†	used heroin during the past 30 days?	0.1	0.1	0.1	~	0.2	0.3	0.2	0.1	0.3	0.3	0.2	0.1	0.4	0.3	0.2	0.2
Lifetime prescription narcotics**/†	used narcotic prescription drugs (such as OxyContin, methadone, morphine, codeine, Demerol, Vicodin, Percocet, Suboxone, fentanyl, carfentanyl, or other opiates) without a doctor telling you to take them, in your lifetime?	0.6	0.5	0.6	~	1.8	1.5	1.8	~	4.2	4.0	3.7	~	6.4	5.6	5.0	6.0
Past 30 day prescription narcotics**/†	used narcotic prescription drugs (such as OxyContin, methadone, morphine, codeine, Demerol, Vicodin, Percocet, Suboxone, fentanyl, carfentanyl, or other opiates) without a doctor telling you to take them, during the past 30 days?	0.2	0.2	0.2	~	0.8	0.8	0.7	~	1.8	1.6	1.2	~	2.4	1.8	1.6	1.1
Lifetime ecstasy	used MDMA (X, E, "Molly", or ecstasy) in your lifetime?	0.2	0.2	0.3	~	0.7	1.0	1.1	1.6	1.7	2.0	1.9	2.4	2.8	2.9	2.6	4.1
Past 30 day ecstasy	used MDMA (X, E, "Molly", or ecstasy) in the past 30 days?	0.1	0.1	0.1	~	0.3	0.4	0.5	0.4	0.6	0.7	0.6	0.4	1.0	1.0	0.8	0.5
Past 30 day synthetic marijuana use*/**	used synthetic marijuana or herbal incense products (such as K2, Spice, or Gold) in the past 30 days?	~	0.4	0.4	~	~	1.1	1.3	~	~	1.4	1.6	~	~	1.3	1.2	~
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	0.6	~	~	0.9	0.8	~	~	0.5	0.6	~	~	0.3	0.4	~

* Substance category not measured in 2014.

** No equivalent MTF data for these substances. Sedative and Prescription Narcotic data are only available for 12th grade.

† The survey questions for these substance categories changed in the 2018 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 Louisiana 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 90,119 students from 233 institutions who completed the Core Alcohol and Drug Survey Long Form in 2013 to 2015 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.

Substance	Lifetime Prevalence		Annual Prevalence		30-Day Prevalence		3X/Week or more	
	Coll.	Ref.	Coll.	Ref.	Coll.	Ref.	Coll.	Ref.
Tobacco	34.8	40.6	24.7	31.2	16.5	19.9	10.5	9.7
Alcohol	80.9	84.3	75.2	81.5	56.3	68.7	11.5	20.0
Marijuana	46.2	46.0	34.2	33.9	20.7	19.8	10.8	8.2
Cocaine	8.0	7.6	4.8	4.7	1.8	2.0	0.3	0.2
Amphetamines	11.5	9.7	6.4	5.4	3.6	3.0	2.2	1.4
Sedatives	7.5	6.0	3.5	3.1	1.6	1.5	0.6	0.4
Hallucinogens	8.4	7.5	5.0	4.5	1.5	1.3	0.2	0.2
Opiates	2.7	2.3	1.5	1.3	0.6	0.7	0.2	0.3
Inhalants	2.6	2.5	1.0	1.0	0.5	0.5	0.1	0.2
Designer drugs	8.0	9.0	3.9	5.4	1.1	1.5	0.2	0.2
Steroids	1.6	1.0	1.0	0.6	0.5	0.4	0.3	0.2
Other drugs	2.9	3.6	1.2	1.8	0.6	0.7	0.2	0.2

Coll. = Multiple Selection

Ref. = Reference group of 90,119 college students

Meeting these Gaps and Needs

There is an approach which may help ease the burden of substance use within Louisiana – that of prevention. The target of prevention activities in the State of Louisiana is conceptualized at three levels based on the presence or absence of symptoms and risk factors:

- Universal prevention - refers to health promotions and disease prevention activities dispersed to the general population with no attempts made to differentiate those at greater risk;

- Selective interventions - targets groups of individuals believed to be at greater risk of developing a problem due to the presence of risk factors which have been identified as precursors to substance use disorders;
- Indicated interventions - focuses exclusively on those individuals already displaying mild symptoms indicative of a problem that is not yet severe enough to be classified as a full-blown disorder (i.e., sub-clinical).

Although it is important to recognize that not all use is necessarily problematic, for some, experimental use will inevitably escalate to regular or heavy use. In fact, a study of Louisiana youth focusing on problem substance use found that approximately 13.5% of adolescents (57,503) may need some form of intervention to address high frequency or risky alcohol or drug use (Farrelly et al., 1998). In the 2018 CCYS survey, 2.2% of 8th graders, 7.2% of 10th graders, and 9.3% of 12th graders in Louisiana were found to be in need of alcohol and/or drug treatment. Both prevention and treatment are necessary tools within the full range of service provision for attacking substance use problems.

The needs of Louisiana's prevention service system to address training to providers, sub-recipients, and/or coalitions include the following:

- Transportation to, and participation in, training events for consumers
- Updates to programs, electronic systems, and/or treatment practices
- Staff development training for providers regarding data analysis (particularly using data to drive programs), increasing community partnering/coalition-building and sustainability strategies, fundraising, identifying and applying for grant funding, understanding grant administration, working with boards, developing policy, acquiring or maintaining certifications and/or licensures, and addressing other issues common among agencies; and
- Dissemination of a variety of evidence-based prevention programs/environmental prevention strategies.

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.

The OBH Business Intelligence (BI) Section, including the OBH Analytics team, is responsible for information management and data standards development, decision support and 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.

Louisiana has improved statewide client-level data collection from the LGEs and their contracted providers. Currently, all ten LGEs are providing client-level data through their contracted Electronic Health Record (EHR) vendors. The OBH Analytics team generates two *Pre-Integration Data Validation Report* each month for each LGE (20 reports per month), analyzing the bi-monthly client-level data files submitted by the LGEs. These reports, which are regularly shared with the LGEs, list the gaps and barriers in the client-level data files. Barriers to data collection and reporting include, but are not limited to, access to data

collection systems, costs to providers, training individuals on data collection methods, needed EHR modifications and data collection modifications per the Client-level Data Manual (CLDM), and time required to implement those changes. The OBH Analytics team conducts data calls with the LGEs and their EHR vendors to provide technical assistance for improving data quality.

The OBH Analytics team regularly uploads MH and SUD client-level admission and discharge records as Substance Abuse-Treatment Episode Data Set (SA-TEDS) and Mental Health (MH) TEDS. Other recurring federal (SAMHSA) reports include annual Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) report, MH Universal Reporting System (URS) tables, and bi-annual Combined SABG/MHBG Behavioral Health Assessment and Plan.

Electronic Health Record Systems for Collection of Statewide MH and SUD Data

As of December 1, 2015, Clinical Advisor (CA), the proprietary Electronic Health Record (EHR) used by the contracted SMO which formerly managed specialized behavioral health services, was decommissioned and replaced by LGE-contracted EHR vendors. LGE contracted providers are encouraged to explore options for submitting their clinical data (MH and/or SUD) through the EHRs procured by their LGE. At this time, all the LGEs have contracted with EHR vendors (i.e. ICANotes, CareLogic-Qualifacts, Success EHS, E-Clinical Works, and Remarkable Health).

In addition to EHRs, OBH has continued to maintain the legacy system called the Louisiana Addictive Disorders Data System (LADDS) for SUD/addictive disorders providers not currently using an LGE EHR. MH Client-level data from the state-funded inpatient psychiatric hospitals are also collected through Patient Information Portal (PIP).

OBH Data Warehouse/Business Intelligence System

Client-level data collected through EHRs, LADDS, and PIP systems from LGE operated/contracted community mental health and substance use disorder service providers, and state-run inpatient psychiatric hospitals, are stored in a standardized format (.csv files) into one integrated database/data system. OBH maintains this 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 MH and SUD-TEDS submission, Uniform Reporting System (URS), federal Block Grant, National Outcomes Measures (NOMS) and other statewide reporting.

Louisiana state office and hospital employees also 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 analysis and reporting. This resource significantly enhances local planning, monitoring, and evaluation. DS Online provides access to performance scorecards and reports of consumer satisfaction surveys conducted at state-run inpatient psychiatric hospitals.

OBH Analytics has also rolled out a new website called LGE Corner/OBH Analytics Library (<http://ldh.la.gov/index.cfm/page/2605>) to provide a repository for the most up-to-date documentation on state and block grant federal reporting requirements. This site is expected to provide a “one-stop” resource for LGEs and OBH staff seeking information on data policies, manuals, and reporting.

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 Center for Substance Abuse Prevention (CSAP) prevention strategies. A PMIS Process Evaluation Report is generated each quarter by OBH central 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.

Data Definitions and Methodology

Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Definitions: OBH SMI and SED population definitions follow the national definitions. However, Louisiana uses the designation SMI for what is commonly referred to as SPMI (Serious Persistent Mental Illness). According to SAMHSA (<https://www.samhsa.gov/find-help/disorders>), SMI and SED are defined as following:

- Serious mental illness is defined by someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.
- or people under the age of 18, the term "Serious Emotional Disturbance" refers to a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

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, 2017 (https://www.dasis.samhsa.gov/dasis2/urs/adult_smi_child_sed_prev_2017.pdf). Each prevalence rate was applied to 2017 Louisiana population to estimate the prevalence of targeted persons to be served.
- Substance Use Disorders – According to SAMHSA National Survey on Drug Use and Health (NSDUH) data in 2017 (<https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.htm#tab5-50B>), the need for substance use treatment in the past year among people aged 12 or older is 7.6%. This national percentage was applied to the 2017 Louisiana population to estimate the number of Louisiana citizens needing treatment. NSDUH also reports that 12.2% received specialty substance use treatment in the past year among people aged 12 or older who needed substance use treatment in the Past Year. This percentage was applied to the number of Louisiana citizens needing treatment, providing the estimated number of Louisiana citizens seeking treatment.

Admissions: Number of clients entering treatment during the time period.

Discharges: Number of clients that have completed treatment 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 (SPMI) 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) Unable to procure appropriate public support services without assistance.
- 5) Severely lacks social support systems in the natural environment (i.e. no close friends or group affiliations, lives alone, or is highly transient).
- 6) 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).
- 7) 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 a serious emotional/behavioral disorder (SED) meets the following criteria for Age, Diagnosis, Disability, and Duration.

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

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 FY 20-21 Combined Behavioral Health Block Grant Plan:

1. Access to behavioral health services
2. Substance Use Disorder system enhancements
3. Pursuing a culture of wellness and prevention for Louisiana citizens

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

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 2020;
 - c) Second-year target/outcome measurement (Final to the end of SFY 2021;
 - d) Data source;
 - e) Description of data; and
 - f) Data issues/caveats that affect outcome measures.

Priority Area 1	Access to Behavioral Health Services
Priority Type	SAT, SAP, MHS
Population(s)	SMI, SED, ESMI, PWWDC, PP, PWID, EIS/HIV, TB
Goal of the Priority Area	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.

Objective	Increase access to behavioral health services
Strategies to attain the objective	<ol style="list-style-type: none"> 1. Increase access to high-quality evidence-based behavioral therapies for young children 2. Integrate Peer Support throughout the system of care 3. Develop plan to expand and enhance Peer Support Services, to include the addition of Peer Support Services as a Medicaid Reimbursable Service 4. Retain and increase the behavioral health workforce
Indicator #1	Access to high-quality evidence-based behavioral therapies for young children
Baseline Measurement	Number of therapists serving Medicaid youth who are trained and certified in each OBH/Medicaid-recognized EBP model in SFY 19
First Year Target/Outcome Measurement	Maintain or increase number of therapists serving Medicaid youth who are trained and certified in each OBH/Medicaid-recognized EBP model for SFY 20
Second Year Target/Outcome Measurement	Maintain or increase number of therapists serving Medicaid youth who are trained and certified in each OBH/Medicaid-recognized EBP model in SFY 21
Data Source	Provider data: Center for Evidence to Practice reporting.
Description of Data	<p>During FY18 and 19, OBH collaborated with MCOs to coordinate MCO-sponsored trainings for Medicaid enrolled therapists in 3 different evidence-based models of therapy for preschool-age children: Child Parent Psychotherapy, Parent-Child Interaction Therapy, and Youth PTSD Treatment.</p> <p>Center for Evidence to Practice (OBH/Medicaid funding, housed at LSU) is now in place to further coordinate and sponsor trainings for providers in EBPs.</p> <p>We will report the number of therapists serving Medicaid youth who are trained and certified in each OBH/Medicaid-recognized EBP model.</p>
Data Issues/Caveats	<p>Members served data: Service Definitions for new EBPs (including credentialing and billing guidance) just published Summer 2019; for this reason EBP tracking codes are not yet being consistently used, and so SFY 19 may not be trackable, and SFY 20 data may be limited at first.</p> <p>.</p>
Indicator #2	Access to Qualified Peer Support Specialists
Baseline Measurement	As of SFY 19, 584 peers have been trained.
First Year Target/Outcome Measurement	Maintain or increase the total number of peers trained and certified for SFY 20
Second Year Target/Outcome Measurement	Maintain or increase the total number of peers trained and certified for SFY 21
Data Source	Training Records and Annual Certification Records
Description of Data	Number of Peers successfully completing training and maintaining their Peer Certification.

Data Issues/Caveats	
Indicator #3	Behavioral Health Workforce Development
Baseline Measurement	Number of behavioral health professional development opportunities held in SFY 19
First Year Target/Outcome Measurement	Maintain or increase the number of behavioral health professional development opportunities held in SFY 20
Second Year Target/Outcome Measurement	Maintain or increase the number of behavioral health professional development opportunities held in SFY 21
Data Source	Centralized document containing Behavioral health professional development opportunities available through sponsored, funded or hosted opportunities by LDH, inclusive of LDH contractors such as the Medicaid Managed Care entities
Description of Data	Professional development opportunities used to educate and instruct the behavioral health workforce to assist them in acquiring, developing and enhancing their knowledge and skill on topics relevant to the behavioral health profession. Behavioral health professional development opportunities include but are not limited to provider trainings, continuing education, seminars, workshops and conferences. The number of behavioral health professional development trainings will be tracked.
Data Issues/Caveats	The number of behavioral health professional development opportunities include peer support, suicide prevention and SUD training counts that may also be reflected in other indicators throughout the priority table. Therefore, there may be duplication in these counts.

Priority Area 2	Substance Use Disorder System Enhancements
Priority Type	SAT, SAP
Population(s)	PWWDC, PWID, EIS/HIV, TB
Goal of the Priority Area	Increase access to quality SUD services
Objective	To improve quality and expand access to SUD care
Strategies to attain the objective	Enhance Medication Assisted Treatment (MAT) services, treatment capacity for pregnant women, 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)
Indicator #1	Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD)

Baseline Measurement	The number of individuals with OUD receiving MAT in SFY 19
First Year Target/Outcome Measurement	Maintain or increase the number of individuals with OUD receiving MAT in SFY 20
Second Year Target/Outcome Measurement	Maintain or increase the number of individuals with OUD receiving MAT in SFY 21
Data Source	Statewide Opioid Treatment Provider (OTP) clinics and Medicaid Claims
Description of Data	The number of individuals with OUD receiving MAT
Data Issues/Caveats	
Indicator #2	Workforce Development
Baseline Measurement	Number of ECHO/ EBP trainings for SFY 19
First Year Target/Outcome Measurement	Maintain or increase the number of ECHO/ EBP trainings for SFY 20
Second Year Target/Outcome Measurement	Maintain or increase the number of ECHO/ EBP trainings for SFY 21
Data Source	Tulane University, LASOR Grant and other Opioid Trainings
Description of Data	The Office of Behavioral Health partners with the Department of Psychiatry and Behavioral Sciences in the Tulane University School of Medicine to implement the Project ECHO Model (Extension for Community Health Outcomes).The ECHO Model is a movement whose mission is to develop the capacity to de-monopolize knowledge and amplify the capacity to provide best practice care of underserved people all over the world. The number of physicians/clinicians participating in ECHO/EBP will be tracked through OBH and Tulane University.
Data Issues/Caveats	Funding for these trainings include MATPDOA, STR, and LaSOR, which are dependent on federal allocations.
Indicator #3	DATA Waivered Prescribers
Baseline Measurement	Number of DATA waived prescribers for SFY 19
First Year Target/Outcome Measurement	Maintain or increase the number of DATA waived prescribers SFY 20
Second Year Target/Outcome Measurement	Maintain or increase the number of DATA waived prescribers SFY 21
Data Source	LASOR Grant and Buprenorphine Physician Locator
Description of Data	Number of physicians, APRN, PA that became a certified data waived prescribers.

Data Issues/Caveats	LaSOR will capture the number of OBOTs registered under LaSOR as a mechanism for tracking. In addition, use of the buprenorphine locator will be used, which may duplicate the numbers from LaSOR grant.
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Priority Area 3	Pursuing a culture of prevention and wellness for Louisiana citizens
Priority Type	SAT, SAP, MHS
Population(s)	SMI, SED, ESMI, PWWDC, PWID, EIS/HIV, TB
Goal of the Priority Area	Ensure that effective and efficient prevention services are provided statewide to promote overall wellness and to delay the initiation and progression of behavioral health disorders by increasing knowledge, awareness, and healthy behaviors
Objective	OBH will continue to provide evidence-based prevention programs in school based settings and suicide prevention awareness trainings.
Strategies to attain the objective	<ol style="list-style-type: none"> 1. Implement evidence-based prevention programs in school-based settings through a partnership with the Department of Education 2. Continue to provide Suicide Prevention education and awareness activities
Indicator #1	Primary Prevention Evidence Based Practices
Baseline Measurement	Number of individuals receiving EBPs for Primary Prevention in SFY 19
First Year Target/Outcome Measurement	Maintain or increase the number of individuals receiving EBPs for Primary Prevention in SFY 20
Second Year Target/Outcome Measurement	Maintain or increase the number of individuals receiving EBPs for Primary Prevention in SFY 21
Data Source	Prevention Management Information System (PMIS)
Description of Data	The numbers are reflective of our school based curriculums. The numbers reported are non-duplicated and represent the total number of students who have been enrolled in an evidence-based prevention program funded by the SAPT Block Grant.
Data Issues/Caveats	
Indicator #2	Suicide Prevention and Awareness Trainings
Baseline Measurement	Number of suicide prevention and awareness trainings in SFY 19
First Year Target/Outcome Measurement	Maintain or increase the number of suicide prevention and awareness trainings in SFY 20
Second Year Target/Outcome Measurement	Maintain or increase the number of suicide prevention and awareness trainings in SFY 21
Data Source	Suicide Prevention and Awareness Training Tracking Form

Description of Data	Number of suicide prevention and awareness trainings
Data Issues/Caveats	It is a voluntary reporting system for all non-OBH employees.

Plan Table 2. State Agency Planned Expenditures (SFY 2020-2021)

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	\$ 35,032,790		\$1,000,284		\$93,464,930		\$15,397,940
a. Pregnant Women and Women with Dependent Children**	\$ 7,603,972				\$93,464,930		\$5,507,024
b. All Other	\$ 27,428,818		\$1,000,284	\$50,916,006			\$9,890,916
2. Primary Prevention	\$ 11,750,004			\$4,620,000			
a. Substance Abuse Primary Prevention							
b. Mental Health Primary							
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)		\$1,955,786					
4. Tuberculosis Services							
5. Early Intervention Services for HIV	\$ 2,502,342						
6. State Hospital			\$176,595,986	\$1,785,704	\$185,685,548		\$1,317,830
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care		\$17,602,078	\$3,412,908	\$1,466,294	\$193,605,714		
9. Administration (Excluding Program and Provider Level)	\$ 761,706						
10. SubTotal (1,2,4,5,9)	\$ 50,046,842		\$1,000,284	\$55,536,006	\$93,464,930		\$15,397,940
11. SubTotal (3,6,7,8)		\$19,557,864	\$180,008,894	\$3,251,998	\$379,301,262		\$1,317,830
12. Total	\$ 50,046,842	\$ 19,557,864	\$ 181,009,178	\$ 58,788,004	\$ 472,766,192		\$ 16,715,770

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

	Aggregate Number Estimated in Need	Aggregate Number in Treatment
Pregnant Women	20,000	193
Women with Dependent Children	67,000	1,757
Individuals with a co-occurring M/SUD	142,000	9,704
Persons who inject drugs	51,000	2,207
Persons experiencing homelessness	444	1,193

- Aggregate Number Estimated *in Need*: NSDUH Data. Different from methodology used in Step 2 Needs Assessment.
- Homelessness: Estimated Persons Experiencing Homelessness: <https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/>
- All other measures: National Survey on Drug Use and Health: 2-Year RDAS (2016 to 2017) (<https://rdas.samhsa.gov/#/>)
- Aggregate Number Estimated *in Treatment*: All Measures from Louisiana OBH Data Warehouse for FY 2018

Plan Table 4. SABG Planned Expenditures

Expenditure Category	FFY 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award
1. Substance Abuse Prevention and Treatment	\$ 17,516,395	\$
2. Primary Substance Abuse Prevention*	\$ 5,875,002	\$
3. Early Intervention Services for HIV ³	\$ 1,251,171	\$
4. Tuberculosis Services	\$	\$
5. Administration (SSA level only)	\$ 380,853	\$
6. Total	\$ 25,023,421	\$

*Amount of primary prevention funds planned for primary prevention programs (this amount matches the total reported in Table 5a and Table 5b) is \$5,134,558.

Amount of primary prevention funds in Table 4, line 2 that are planned for prevention SA resource development and non-direct services (this amount does not include funds reported in Table 5a or Table 5b) is \$740,444.

³ 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 below, Louisiana lists the FFY 2020 and FFY 2021 SABG planned expenditures for each of the six primary prevention strategies plus Synar. 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 the state plans to use strategies not covered by these six categories, they will be reported under "Other" in Table 5a.

In most cases, the total amounts should equal the amount 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. Planned expenditures for Non-Direct Services/System Development activities should not be included in Table 5a.

If the state chooses to report activities utilizing the Institute of Medicine (IOM) Model of Universal, Selective, and Indicated; complete Form 5b. If Form 5b is completed, the state must also complete Section 1926 –Tobacco on Form 5a.

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 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award
1. Information Dissemination	Universal	\$225,110	\$
	Selective	\$8,102	\$
	Indicated	\$	\$
	Unspecified		
2. Education	Universal	\$3,412,699	\$
	Selective	\$127,059	\$
	Indicated	\$16,500	\$
	Unspecified		
3. Alternatives	Universal	\$45,043	\$
	Selective	\$	\$
	Indicated	\$	\$
	Unspecified		
4. Problem Identification and Referral	Universal	\$102,125	\$
	Selective	\$127,702	\$
	Indicated	\$	\$
	Unspecified		
5. Community-Based Processes	Universal	\$490,713	\$
	Selective	\$9,090	\$
	Indicated	\$	\$
	Unspecified		

6. Environmental	Universal	\$250,220	\$
	Selective	\$7,114	\$
	Indicated	\$	\$
	Unspecified		
7. Section 1926-Tobacco	Universal	\$310,081	\$
	Selective	\$	\$
	Indicated	\$	\$
	Unspecified	\$	\$
8. Other	Universal	\$	\$
	Selected	\$	\$
	Indicated	\$	\$
	Unspecified	\$	\$
9. Total Prevention		\$ 5,134,558	\$
Total SABG Award		\$ 25,023,421	\$
Planned Primary Prevention		20.52%	0.00%

*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 Institute of Medicine (IOM) model of universal, selective, and indicated should use Table 5b to list their FY 2020 SABG award planned expenditures in each of these categories. Note that if form 5b is completed instead of Form 5a, the state must also complete Section 1926 – Tobacco on Form 5a. The total amount 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. Planned expenditures for Non-Direct Services/System Development activities should not be included in Table 5b.

Activity	FFY 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award
Universal Direct	\$3,808,702	\$
Universal Indirect	\$1,030,289	\$
Selective	\$279,067	\$
Indicated	\$16,500	\$
Column Total	\$5,134,558*	\$
Total SABG Award	\$25,023,421	\$
Planned Primary Prevention Percentage*	20.52%	20.00%

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

Plan Table 5c. SABG Planned Primary Prevention Targeted Priorities

The following tables identify the categories of substances and populations Louisiana plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Targeted Substances*	
Alcohol	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>
Cocaine	<input type="checkbox"/>
Heroin	<input type="checkbox"/>
Inhalants	<input checked="" type="checkbox"/>
Methamphetamine	<input type="checkbox"/>
Synthetic Drugs (i.e., Bath salts, Spice, K2)	<input checked="" type="checkbox"/>

Targeted Populations*	
Students in College	<input checked="" type="checkbox"/>
Military Families	<input type="checkbox"/>
LGBT	<input checked="" type="checkbox"/>
American Indians/Alaska Natives	<input checked="" type="checkbox"/>
African American	<input checked="" type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>
Homeless	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input checked="" type="checkbox"/>
Asian	<input checked="" type="checkbox"/>
Rural	<input checked="" type="checkbox"/>
Underserved Racial and Ethnic Minorities	<input checked="" type="checkbox"/>

*Louisiana serves all populations in Table 5C through its primary prevention programs and services. While all populations identified in Table 5C are reached, these populations are not intentionally targeted as primary prevention services are implemented universally. Demographic data is collected on all individuals served

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

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.

The following categories are used to describe the types of expenditures supported with Block Grant 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 2020 Block Grant award.

Activity	MHBG	SABG Treatment	SABG Prevention*	SABG Combined
1. Information Systems	\$62,968	\$178,400	\$0	\$186,943
2. Infrastructure Support	\$2,600	\$69,390	\$0	\$0
3. Partnerships, community outreach, and needs assessment	\$508,478	\$209,226	\$435,450	\$114,126
4. Planning Council activities	\$202,396	\$0	\$0	\$0
5. Quality assurance and improvement	\$353,610	\$327,486	\$0	\$155,000
6. Research and evaluation	\$105,603	\$0	\$99,000	\$5,000
7. Training and education	\$391,690	\$25,750	\$205,994	\$101,481
Total	\$1,627,345	\$810,252	\$740,444*	\$562,550

* \$740,444 of the total SA Primary Prevention funds: \$5,875,002 are planned to be used for Non-direct SABG Prevention and are not included in the amounts listed in Tables 5a and 5b.

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 M/SUD 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 M/SUD 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.

LDH integrated behavioral health care into the existing physical health managed care program in 2015. All Louisiana Medicaid members now receive their behavioral health services through integrated managed care with a managed care organization (MCO).

The MCOs 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 organizations 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 colocated 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 must be approved by LDH and results 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.

In support of integrated care through Federally Qualified Health Center (FQHC) providers, LDH created an alternative payment methodology for behavioral health services provided in FQHCs. This allowed a change in the payment for services provided by physicians with a psychiatric specialty; nurse practitioners or clinical nurse specialists with a psychiatric specialty; licensed clinical social workers; or clinical psychologists within an FQHC setting. We recognize that primary care includes a component of behavioral health care. This move allows access to behavioral health services on the same day patients access primary care within FQHCs to the benefit of patients.

OBH is establishing an integration advisory workgroup to assist in developing sustainability plans around integrated care and the great strides LDH has experienced in the area. These activities will focus on developing strategies to preserve integrated services developed through targeted initiatives like the PIPBHC (Promoting Integration of Primary and Behavioral Health Care), an OBH held grant funded by SAMSHA. The workgroup will be comprised of two subgroups, a project team and an advisory team. The project team will take a leadership role in proposing goals and reviewing state policies and contracts as needed to identify and propose solutions to sustainability barriers. The advisory team will support and advise the project team, and will include provider stakeholders with ground level integrated care experience.

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 the 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, the Bureau of Health Services Financing (BHSF). There is an MOU and operational plan delineating responsibilities for monitoring the managed care organizations. 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 M/SUD 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

OBH 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?

N/A

10. 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

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 M/SUD 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 M/SUD 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, sexual orientation, and age?

- | | | |
|-----------------------|---|--|
| a) race | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) ethnicity | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) gender | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) sexual orientation | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| e) gender identity | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| f) age | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> 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 M/SUD 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 M/SUD care?

☐ Yes ☒ No

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

The state has health disparities/cultural competence addressed in the contract with the Healthy Louisiana plans (MCOs).

Per the contract, the MCOs and their providers shall deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity 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. Assurances shall be achieved by:

- Collecting 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);
- Assessing the cultural competency of the providers on an ongoing basis, at least annually;
- Assessing 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.;
- Assessing provider satisfaction of the services provided by the MCO at least annually; and
- Requiring and providing 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.

The Network Development and Management Plan shall state that the MCO's provider network meets requirements with regard to cultural competence and linguistics as follows:

- Cultural competence and linguistic needs, including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206;
- Provides 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.

The MCO shall comply with the Office of Minority Health, Department of Health and Human Services' "Cultural and Linguistically Appropriate Services Guidelines" at the following url: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15> and participate in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees.

The MCO shall incorporate improvement strategies that include, but are not limited to:

- Performance improvement projects;
- Medical record audits;
- Performance measures;
- Plan-Do-Study-Act cycles or continuous quality improvement activities;
- Member and/or provider surveys; and
- Activities that address health disparities identified through data collection.

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:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (V = Q \div C)$$

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 M/SUD 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. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available 43 resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

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 M/SUD 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 M/SUD 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 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)-10 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 intervention⁴ 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.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

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 MHBG 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 specifically 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 treatment in order to reduce the

⁴ 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.

duration of untreated psychosis. OBH continued with additional trainings in 2018-2019 to provide further education to Local Governing Entities (LGEs) and to support them in the development of their own programs to increase the availability of statewide ESMI/FEP services. It is expected that as ESMI programs grow around the state and become more embedded within the system the state's system of care, policies for addressing ESMI will be developed. Currently three of the ten LGEs have implemented an EBP to treat ESMI/FEP within their local programs. Those include Capital Area Human Services District (CAHSD), Jefferson Parish Human Services District (JPHSA), and Florida Parishes Human Services Authority (FPHSA). OBH also contracts with Tulane University School of Psychiatry and Behavioral Sciences to fund the Early Psychosis Intervention Clinic in New Orleans (EPIC-NOLA).

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 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 still continue to implement this program and 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 2016, and continued to participate in ongoing consultation activities with the NAVIGATE trainers which continued through September 2017.

In addition to the implementation of FEP programming within three of the state's ten LGEs, OBH has also contracted with an FEP program in New Orleans called EPIC-NOLA. This program is operated through Tulane University School of Psychiatry and Behavioral Services. This FEP program is modeled from the Yale STEP program that conducted a randomized clinical trial to evaluate the effectiveness of STEP's approach and was funded by the National Institutes of Health and the Donoghue Foundation. The study results were strong, demonstrating that early intervention and well-organized care can have significant benefits for individuals experiencing early psychosis. The EPIC NOLA program, using this model, established itself prior to OBH's support. OBH supports the staffing and operations of this clinic, allowing for the provision of services to those who are without a payer source (no Medicaid or private insurance). This contract began in February 2017 and will continue into the FY 20 budget. Dr. Ashely Weiss, D.O., M.P.H, the Director of the EPIC NOLA clinic as part of the contract services provided to OBH has been providing monthly consultation to the three LGEs that have committed themselves to utilizing evidence based programming. Though the FEP programs operated by the three LGEs continue to use the NAVIGATE Model, they are also able to benefit from the consultation with Dr. Weiss to also incorporate elements of the STEP Program into their practices as well.

All other locations in the state have chosen to maintain a public health model for program implementation. Through this public health approach, LGEs 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.

Three trainings occurred in June 2019 by OBH in partnership with the EPIC NOLA program to educate these LGEs about the importance of implementing ESMI/FEP programming and provide steps to develop an effective program with limited resources. All professions were invited to include Licensed Mental Health Professionals, nurses, psychologists and physicians. OBH will continue to encourage and support these LGEs to build this foundation. Following these trainings were follow up conference calls between Dr. Weiss, OBH and the LGEs who participated one month following the trainings to provide further consultation with the EPIC NOLA clinic. These LGEs as will also be invited to join the monthly consultation calls provided Dr. Weiss on an ongoing basis.

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 Coordinated Specialty Care (CSC) programs affiliated with the LGEs is done through engagement with individuals seeking traditional clinical treatment. THE EPIC NOLA program developed marketing materials and a marketing campaign as part of their contract deliverables with OBH. These activities included

- a comprehensive public education and early detection campaign geared towards the general public, collaborative partners, and referral sources on first episode psychosis entitled CALM (Clear Answers to Louisiana Mental Health)
- Marketing materials were developed to advertise the campaign
- Brochures developed for distribution through the EPIC-NOLA program

Individualized treatment is a component of programming. With integrated physical and mental health services, OBH has engaged the Medicaid MCOs in the provision of services for these programs by inviting to all three ESMI/FEP Treatment trainings conducted statewide in June 2019. Several MCOs participated and sent both behavioral health and medical staff.

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

☒ Yes ☐ No

The CSC programs implemented in Louisiana are comprised of state entities (LGEs) and worked with a private program operated through Sinfonia Family Services, a behavioral health program operating in conjunction with Tulane University. Since that time, Tulane University took over all management of the EPIC NOLA clinic and is now part of Tulane University School of Psychiatry and Behavioral Services.

As the programs evolve, additional considerations in regard to the integration with managed care will need to be considered and addressed in implementation activities. Training with Medicaid Managed Care Organizations (MCOs) on the utilization of FEP as an evidence-based practice was conducted in June 2019 to promote considerations regarding the authorization of services in the future.

5. Does the state collect data specifically related to 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
FEP Program Workforce Development	PSS Identified	Frequency Count	Ongoing Assessment
	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 were 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 LGE's 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 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 (PRRD) 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.

Subsequently in 2018 a needs assessment survey was conducted to determine areas the LGEs wanted addressed in further training. Those need areas identified included more prescriber training, information about the role of peer support staff and information about effective outreach. This information in addition to relevant research supporting the need for early intervention was provided during the statewide trainings June 3rd (Baton Rouge), June 14th (Monroe) and June 29th (Lafayette.,

OBH through contract with the EPIC NOLA program provided the LGEs with additional training and covered the following objectives:

- a. Relevant research supporting the importance of early detection and intervention
- b. The neuroscience foundation for understanding First Episode Psychosis
- c. Understanding the Phases of Schizophrenia-spectrum disorder from a bio-psycho-social framework
- d. Evidenced based approaches to treatment
- e. How to build a case formulation and apply knowledge to build the treatment plan
- f. Building an Early Intervention Service
- g. Procedure and process for referral through treatment phases
- h. Early detection and community education and outreach
- i. Ideas for Expansion throughout the state of Louisiana
- j. Tour of on-line resources for FEP
- k. Best prescriber practices and medication management
- l. The role of the Peer Support Specialist for First Episode Psychosis

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 2020 and FFY 2021 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 – Continue to development and distribute 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 has contracted with the EPIC NOLA program to provide monthly case consultation to these LGEs regarding psychotherapeutic approaches and best prescriber practices.
- 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:
 - LGEs adopting the Public Health Model will be provided with ongoing assistance to each of the LGEs implementing this model to better help them develop programming which will meet their individualized needs through consultation calls with EPIC NOLA regarding the role of the peer support staff within Coordinated Specialty Care
 - *All LGEs who attended the June 2019 trainings will be provided with a month follow up Zoom Conference to further support their efforts to develop their own early intervention clinics.* Those LGEs who continue to grow their programs will be invited to take part in the Monthly consultations calls with the EPIC NOLA programs.

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 teleconferences 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. In addition, more technical assistance to help OBH encourage and support more Local Governing Entities to develop their Early Serious Mental Illness programs in order to expand Coordinated Specialty Care Models throughout the state.

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.

N/A, the state has policies related to person centered planning.

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

The State requires contracted managed care organizations (MCOs) 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, and is interactive and accessible using mobile devices, and has the capability for bidirectional communications, i.e. members can submit questions and comments to the MCO and receive responses.

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

The Louisiana Department of Health (LDH) maintains a website with pages for the Office of Behavioral Health (OBH) and Medicaid. Both sites offer information regarding accessing health coverage, services, and MCOs. Through the website, individuals may contact Medicaid staff who are available to answer questions ranging from Medicaid eligibility to service coverage. The Medicaid member services staff serve as a hub to connect individuals to clinical and program staff throughout LDH.

LDH maintains policies for community based and residential providers related to individual and family engagement. Engagement and information sharing are required training for evidenced based services such as Multi-Systematic Therapy, the Wraparound Model, American Society of Addiction Medicine, and Assertive Community Treatment. Statewide mental health providers that deliver mental health rehabilitation must conduct a full assessment with the participation of individual and family. From that assessment, the provider staff, individual and family, develop a person centered treatment plan. The individual and family agree to services as indicated by their signature on the treatment plan, which is required.

Person Centered Planning is also an integral component of discharge planning activities associated with a Nursing Facility discharge initiative currently underway in Louisiana. The discharge initiative was developed as a result of an Agreement Louisiana has with the Department of Justice related to individuals with serious mental illness in Nursing Homes. Several aspects of the Agreement reiterate the need to utilize person centered planning processes in the development of service/treatment plans and transition activities as individuals move from nursing facilities into the community.

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

Managed Care Organizations

In Louisiana, individuals enrolled in Medicaid receive mental health and substance use disorder services through state contracted managed care. The LDH contracts define person centered planning as the following:

A care planning process driven by the enrollee that identifies supports and services that are necessary to meet the enrollee's needs in the most integrated setting. The enrollee directs the process to the maximum extent possible and is provided sufficient information and support to make informed choices and decisions. The process is timely and occurs at times and locations convenient to the enrollee, reflects the cultural and linguistic considerations of the enrollee, provides information in plain language and in a manner that is accessible to enrollees, and includes strategies for resolving conflict or disagreement that arises in the planning process.

The MCOs are required through contract to offer case management and individual care planning for special populations including individuals transitioning from nursing homes, IV drug users, pregnant drug users, and others who are at high risk as identified by LDH.

The managed care contract states, development of the plan of care shall be a person-centered process led by the enrollee's case manager with significant input from the enrollee as well as members of the enrollee's interdisciplinary care team. The plan of care shall be based on the principles of self-determination and recovery, and shall include all medically necessary services identified by the enrollee's providers as well as the care coordination and other supports to be provided by the Contractor. The plan of care shall be reviewed and revised upon reassessment of functional need.

Behavioral Health Providers

Person centered planning is required for Medicaid funded services delivered by a wide range of providers statewide. Services include community based mental health services including mental health rehabilitation, evidenced based interventions for youth and adults including Multi-Systemic Therapy, Functional Family Therapy, Homebuilders, and Assertive Community Treatment. Person centered planning is also required in the delivery of substance use outpatient treatment and residential treatment. Service delivered by a Federally Qualified Health Center and Rural Health Clinics are required to have a treatment plan that includes goals related to rehabilitation, therapy, and social services.

Louisiana Medicaid has a specialized program, the Coordinated System of Care for youth in or at risk of out of home placement. A critical component of this program is the person centered planning process. This 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 treatment planning team known as the Child and Family Team is facilitated by a Wraparound Facilitator. This is an effective planning process with its primary goal of individual, family, and provider involvement in the treatment planning process.

All behavioral health service (BHS) providers licensed under LAC 48:1.Chapter 56, including Local Governing Entities, must develop treatment plans that meet the following guidelines.

- A. A BHS provider shall deliver all services according to a written plan that:
 - 1. is age and culturally appropriate for the population served;
 - 2. demonstrates effective communication and coordination;
 - 3. provides utilization of services at the appropriate level of care;
 - 4. is an environment that promotes positive well-being and preserves the client's human dignity;
 - 5. utilizes evidence-based counseling techniques and practices.
- B. The provider shall make available a variety of services, including group and/or individual treatment.
 - 1. the strategies and activities to be used to help the client achieve the goals;
 - 2. information specifically related to the mental, physical, and social needs of the client;
 - 3. the identification of staff assigned to carry out the treatment.
- C. The BHS provider shall ensure that the treatment plan is in writing and is:
 - 1. developed in collaboration with the client and when appropriate, the client's family and is signed by the client or the client's family, when appropriate;
 - 2. reviewed and revised as required by this Chapter or more frequently as indicated by the client's needs;
 - 3. consistently implemented by all staff members;
 - 4. signed by the Licensed Mental Health Professional or physician responsible for developing the treatment plan;
 - 5. is in language easily understandable to the client and to the client's family, when applicable.

Nursing Facility Discharge Initiative

Transition Coordinators located throughout the state work with individuals with serious mental illness transitioning from Nursing Facilities utilizing a process, which is driven by the individual that identifies supports and services, which are necessary to meet the individual's needs in the most integrated setting. The individual directs the process to the maximum extent possible and is provided sufficient information and support to make informed choices and decisions. The process is timely and occurs at times and locations convenient to the individual; reflects the cultural and linguistic considerations of the individual; provides information in plain language and in a manner that is accessible to individuals within the Target Population; and includes strategies for resolving conflict or disagreement that arises in the planning process. In order to ensure this occurs, all evaluation tools have been developed in a manner intended to facilitate and support the person centered planning process. Additionally, principles of person centered planning have been integrated in staff training.

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

N/A

6. 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 M/SUD 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 M/SUD 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

7. 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 consulted with three federally recognized tribes and one state recognized tribe 2018-2019 monthly that led to their participation in the Own Your Own Health Physical Activity and Nutrition Challenges, and the Community Preparedness Response Network (CPRN) for emergency preparedness trainings.

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

The biggest concerns still from both state and federally recognized tribes are health related:

- Diabetes
- Obesity
- High Blood Pressure
- Hypertension
- Heart Disease

Emergency preparedness as it relates to natural disasters and potential pan flu outbreaks is still a major concern; however, in the past two years, the tribes have been progressing well and will continue to train, host drills and report its progress directly to the Bureau annually.

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. 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 State Epidemiology Workgroup (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?

a) ☒ Yes ☐ No

i) If yes, (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, Second Step, and Kids Don't Gamble...Wanna Bet? account for 72% of all enrollees in SFY 2018. 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.

ii) 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 (ADRA) is the state licensing and credentialing board for addiction counselors 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. Louisiana's prevention system has changed from the 10 OBH 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 use 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 (SPF) 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 LGE 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

The Louisiana Substance Abuse Prevention Strategic Plan for 2017-2021 was released on October 19, 2017. This is submitted online.

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
- 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 LGEs 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 education agencies.

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.
- g) ☒ The SSA funds community coalitions to provide prevention services.
- 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 alcohol, tobacco, and other drugs (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 LGE. OBH, through its Prevention Management Information System (PMIS), confirms 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 2018 designated by Universal, Selective, or Indicated.

Universal Evidence-Based Program	Selective Evidence-Based Program
Life Skills Training	Parenting Wisely
Kids Don't Gamble... Wanna Bet?	Strengthening Families
Second Step	Selective Program Total: 2
Project Northland	
Too Good for Drugs	Indicated Evidence-Based Program
Guided Imagery Program	Insight Class Program

Protecting You-Protecting Me	Indicated Program Total: 1
Project Alert	
Al's Pal	
Positive Action	
Project Toward No Tobacco Use	
Keep A Clear Mind	
Universal Program Total: 13	

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 statewide. 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.

f) 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 the Louisiana Department of Education, 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, OBH has procedures in place 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:)

9. 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 managed care.

In November 2014, the Louisiana Department of Health (LDH) announced a plan to integrate all behavioral health care services into its existing physical health 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 work 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. When this care extends beyond what is deemed as the typical acute care stay (due to a number of 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 or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Programs and services will vary across the state. For Physical Health and Medical and Dental services, the state is aware of at least one example with the Federally Qualified Health Centers (FQHC) in Jefferson Parish Human Services Authority. Some programs offer supports to individuals for educational services, but not actual Educational Services.

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, Healthy 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 M/SUD system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	193,100	6,940
2. Children with SED	38,752	1,035

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.

Prevalence of SMI and SED

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 the SMI/SED prevalence rate obtained from 2017 URS table #1. (SAMHSA Drug & Alcohol Services Information System, SMI/SED Prevalence Estimates 2017, 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, 2017, https://www.dasis.samhsa.gov/dasis2/urs/adult_smi_child_sed_prev_2017.pdf).

Incidence of SMI and SED

Statewide incidence of adults (age 18 and over) with SMI and children with SED (ages 9 to 17) are calculated in three steps. First, the number of persons (with SMI and SED) served in FY 2018 are calculated following Louisiana Office of Behavioral Health methodology. These numbers are also reported in the Uniform Reporting System (URS) tables, and include both continuing and new clients. Secondly, numbers are determined for all SMI and SED clients who started receiving services before FY 2018 (continuing clients). Lastly, the continuing SMI and SED clients are subtracted from persons served during FY 2018 to obtain the number of new clients (incidence).

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.

- a) Describe your state's targeted services to the rural population.

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.

- b) Describe your state's targeted services to the homeless population.

Community- Based Services to Homeless Population

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 contractor or service delivery method to allocate PATH funds. LGE staff monitors the provision of these services 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 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 National Alliance for the Mentally Ill of Louisiana (NAMI Louisiana) and currently in contract negotiations with a new entity to assume operations of the residential program for individuals with serious mental illness (SMI) in St. Tammany Parish.

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 allows 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 NAMI Louisiana 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. Additionally, this contract includes the implementation of a pilot project to target Transitional Age Youth (TAY) with mental illness and no family or community support.

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 use individuals with treatment options that provide wraparound services in the community. The contract provides an opportunity for stable housing and allows the individuals to participate in treatment and recovery.

Individuals 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.

Successful transition includes stability and income. SSI/SSDI Outreach and Recovery model increase access to the disability income benefit programs administered by the [Social Security Administration \(SSA\)](#) for eligible adults and children who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder. To increase probability of successful transition, Mental Health Block Grant funds are also intended to be used to fund a SOAR Benefit Specialist position to assist participants in NAMI Louisiana housing assistance program.

c) Describe your state's targeted services to the older adult population.

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 2018 indicate that 20,653 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 represents the distribution of primary admitting diagnoses for seniors.

FISCAL YEAR 2018 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	8	0.90%	90	1.40%	66	2.10%	.	.	25	7.40%	77	3.90%	15	1.10%	3	0.80%	192	4.10%	9	0.90%	485	2.30%
BIPOLAR AND RELATED DISORDERS	55	6.20%	554	8.70%	408	12.80%	67	15.80%	2	0.60%	138	7.00%	248	17.60%	83	21.90%	489	10.50%	10	1.00%	2054	9.90%
DEPRESSIVE DISORDERS	98	11.10%	1456	22.80%	1456	45.80%	120	28.40%	21	6.20%	450	22.90%	344	24.40%	106	28.00%	875	18.80%	69	6.60%	4995	24.20%
DISRUPTIVE, IMPULSE, & CONDUCT DISORDERS	9	1.00%	.	.	10	0.30%	.	.	.	.	.	.	.	.	.	.	.	.	.	.	19	0.10%
ILLNESS, UNSPECIFIED	.	.	.	.	53	1.70%	.	.	.	.	.	.	.	.	.	.	.	.	.	.	53	0.30%
INTELLECTUAL DISABILITY	.	.	17	0.30%	1	0.00%	.	.	.	.	21	1.10%	.	.	.	.	4	0.10%	.	.	43	0.20%
NEUROCOGNITIVE DISORDERS	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	5	0.50%	5	0.00%
NEUROGOGNITIVE DISORDERS	3	0.30%	26	0.40%	7	0.20%	.	.	.	.	.	.	.	.	.	.	9	0.20%	.	.	45	0.20%
OCD & RELATED DISORDERS	.	.	82	1.30%	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	82	0.40%
OTHER/UNSPECIFIED MENTAL DISORDERS	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	36	0.80%	.	.	36	0.20%
PSYCHOTIC DISORDERS	366	41.50%	2039	32.00%	1013	31.90%	66	15.60%	13	3.90%	474	24.10%	550	39.00%	136	35.90%	570	12.20%	51	4.90%	5278	25.60%
SUBSTANCE RELATED AND ADDICTIVE DISORDER	.	.	157	2.50%	65	2.00%	108	25.50%	.	.	.	.	33	2.30%	2	0.50%	38	0.80%	63	6.00%	466	2.30%
TRAUMA & STRESSOR RELATED DISORDERS	.	.	9	0.10%	24	0.80%	.	.	19	5.60%	4	0.20%	.	.	1	0.30%	10	0.20%	6	0.60%	73	0.40%
UNSPECIFIED MENTAL DISORDER	.	.	.	.	2	0.10%	.	.	.	.	.	.	.	.	.	.	111	2.40%	.	.	113	0.50%
Z CODES	6	0.70%	.	.	5	0.20%	.	.	.	.	.	.	.	.	.	.	673	14.40%	14	1.30%	698	3.40%
Missing	336	38.10%	1942	30.50%	69	2.20%	62	14.70%	257	76.30%	800	40.70%	219	15.50%	48	12.70%	1655	35.50%	820	78.30%	6208	30.10%
TOTAL	881	100.00%	6372	100.00%	3179	100.00%	423	100.00%	337	100.00%	1964	100.00%	1409	100.00%	379	100.00%	4662	100.00%	1047	100.00%	20653	100.00%

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, when nursing facility placement is not the least restrictive environment for the individual, and/or to verify the presence of Alzheimer's or a dementia-related condition. 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:

	FY 2018
PASRR Process Referrals	3914
Types of Referrals	
• Referrals for admission to nursing facilities	2419
• Referrals for resident reviews performed while in the nursing facility after a significant change in status	1032
• Referrals for Exempted Hospital Discharges not requiring PASRR process for first 30 days	462
Decisions	
• Approved for Nursing Facility Placement <ul style="list-style-type: none"> ○ Temporary Approvals 	1739 (1026)
• Denied Nursing Facility Placement	293
• Decided not to go to Nursing Facility and withdrew request	309
• 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).	1274
Number of MCO Evaluations	1407
• Aetna	201

• Healthy Blue	291
• AmeriHealth Caritas of Louisiana	261
• Louisiana Healthcare Connections	337
• United Healthcare	317
Number of Evaluations by Medicaid Contract Psychologist	0
Number of Evaluations by OBH Contract Psychiatrist	258

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, Assertive Community Treatment team, mental health rehabilitation provider, and providers of addiction services while in the nursing facilities. Of course, they may also utilize inpatient psychiatric treatment as needed.

On June 6, 2018, the Louisiana Department of Health entered into an agreement with the Department of Justice in response to their determination, subsequent to an investigation, that Louisiana has inappropriately institutionalized individuals with serious mental illness in Nursing Facilities throughout the state. OBH has been heavily involved in the implementation of activities developed as a response to the Agreement. These activities include:

- Improvements to the PASRR Level II process as it relates to length and frequency of authorization as well as requirements related to the accurate identification of those individuals who have Alzheimers or other dementia-related conditions. As of June 6, 2018, the effective date of the Agreement with DOJ, PASRR Level II staff has modified processes and all authorizations made by this office are temporary not to exceed 90 – 100 days for initial admits and 365 days for extension requests.
- Development of a cadre of Transition Coordinators who are able to connect with individuals with SMI residing in NF, helping to transition them back into the community in collaboration with Managed Care Organizations, behavioral health service providers, and Office of Aging and Adult Services (OAAS) staff/service providers.
- Evaluation and expansion (as needed) of the behavioral health service system ensuring individuals are able to transition into the community and/or divert from Nursing Facility placement.

Through this DOJ initiative and others, OBH has continued to work on several multi-agency projects 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)
- Trainings to the Behavioral Health provider network
- Trainings to NF referral sources
- Training to OBH/OAAS/OCDD 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 Coordinated System of Care (CSoC) MCOs have continued to offer statewide training to behavioral health providers on various topics, such as: utilization management, 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) team has been responsible for ensuring that all wraparound agencies and family support organization staff have 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.

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 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 September 2018, 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 Healthy Louisiana MCOs and the CSoc MCO, as well as the Louisiana Public Health Institute (LPHI). The mission of the 2018 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 exceeded 500 participants from throughout the state, with the target audience identified as an array of partners who played important roles in promoting healthy communities. Keynote speakers for the 2018 Behavioral Health Symposium included the following:

- Louisiana Governor John Bel Edwards addressing behavioral health needs and statewide system transformations to meet these needs, which included Louisiana's Medicaid Expansion under the Affordable Care Act
- Dr. H. Wesley Clark, former SAMHSA/CSAT Director and national subject matter expert, addressing the Opioid Epidemic and national efforts to overcome the epidemic
- Lt. General Russel Honore, who has been designated by the Federal Government to lead the U.S. Military in multiple national and international disaster recovery efforts including Hurricane Katrina and flooding in Haiti, addressing responses to trauma and disaster.

Partners invited to participate in the 2018 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.

The theme of Louisiana's 2018 Behavioral Health Symposium was, "Changing Practices, Changing Lives." Please see list below of training topics included in the 2018 Behavioral Health Symposium:

- Opioid Epidemic
- ACEs (Adverse Childhood Experiences)
- DSM-5 Diagnostic Skills
- Ethics for Behavioral Health Specialists
- NARCAN Education & Demonstration
- Behavioral Health Disorders in Older Persons
- Cultural Competence
- Gambling: The Invisible Addiction
- Co-Occurring Disorders with ID/DD
- Collaboration with Criminal Justice System to Serve Justice Involved Population

- Serving Homeless Population with Behavioral Health Disorders
- Preparing and Responding to Trauma and Disasters
- Medication Assisted Treatment
- Suicide Prevention
- Native American Perspective in Behavioral Health
- Human Trafficking
- Sustaining Programs Beyond Grant Funding
- Peer Support Services
- Addressing Health Inequities Among Vulnerable Populations

During the upcoming fiscal years, OBH intends to continue to utilize block grant funds and LaSOR funds to support ongoing community education and training on the opioid epidemic. In addition to statewide sponsored, supported, or directly provided training, the following list is an example of continuous and ongoing training within the State and LGE levels:

- Trauma Informed Care Training
- Applied Suicide Intervention Skills
- Motivational Interviewing Training
- Permanent Supportive Housing 101
- 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
- Target Health Training
- First Episode Psychosis (FEP & related topics trainings)
- SSI/SSDI Outreach, Access, and Recovery (SOAR)

10. 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) Services for special populations:
- i) Targeted services for veterans?
☐ Yes ☒ No
 - ii) Adolescents?
☒ Yes ☐ No
 - iii) Older adults?
☐ Yes ☒ No
 - iv) Medication-Assisted Treatment (MAT)?
☒ Yes ☐ No

Criterion 2: Improving Access and Addressing Primary Prevention – see Section 8

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. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?
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. Has your state identified a need for 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.

LGE Accountability Plan Monitoring Procedures

1. Method for monitoring shall include on-site visits.
2. Data types under review may include, but are not limited to assessments, chart audits, policies and procedures, and interviews (staff, clients, secret shoppers, etc.).
3. The LGE shall conduct two on-site visits to each contracted program location each year.
4. The OBH standardized tool with outcome scores shall be utilized at each visit.
5. LGE will email a report and corrective action form to the contractor within thirty (30) business days of each monitoring visit.
6. The contractor may seek clarification, dispute any elements of the report, and/or respond to the report within thirty (30) business days of its issuance. The responses to the report shall be sent to the LGE staff who conducted the review.
7. LGE will respond to the contractor within thirty (30) business days for any responses to the initial report.
8. The LGE shall require the contractor to submit a corrective action plan to address any deficiencies identified.
9. The LGE will email the monitoring tool and corrective action plan (if needed) to OBH for review within forty-five (45) business days after each monitoring visit.
10. For any program with a score of less than 70%, the LGE may conduct a follow-up visit or remote follow-up review.

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. Has your state identified a need for 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 contracted 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.

LGE Accountability Plan Monitoring Procedures

1. Method for monitoring shall include on-site visits.
2. Data types under review may include, but are not limited to assessments, chart audits, policies and procedures, and interviews (staff, clients, secret shoppers, etc.).
3. The LGE shall conduct two on-site visits to each contracted program location each year.
4. The OBH standardized tool with outcome scores shall be utilized at each visit.
5. LGE will email a report and corrective action form to the contractor within thirty (30) business days of each monitoring visit.
6. The contractor may seek clarification, dispute any elements of the report, and/or respond to the report within thirty (30) business days of its issuance. The responses to the report shall be sent to the LGE staff who conducted the review.
7. LGE will respond to the contractor within thirty (30) business days for any responses to the initial report.
8. The LGE shall require the contractor to submit a corrective action plan to address any deficiencies identified.
9. The LGE will email the monitoring tool and corrective action plan (if needed) to OBH for review within forty-five (45) business days after each monitoring visit.
10. For any program with a score of less than 70%, the LGE may conduct a follow-up visit or remote follow-up review.

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. Has your state identified a need for 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.

LGE Accountability Plan Monitoring Procedures

1. Method for monitoring shall include on-site visits.
2. Data types under review may include, but are not limited to assessments, chart audits, policies and procedures, and interviews (staff, clients, secret shoppers, etc.).
3. The LGE shall conduct two on-site visits to each contracted program location each year.
4. The OBH standardized tool with outcome scores shall be utilized at each visit.
5. LGE will email a report and corrective action form to the contractor within thirty (30) business days of each monitoring visit.
6. The contractor may seek clarification, dispute any elements of the report, and/or respond to the report within thirty (30) business days of its issuance. The responses to the report shall be sent to the LGE staff who conducted the review.
7. LGE will respond to the contractor within thirty (30) business days for any responses to the initial report.
8. The LGE shall require the contractor to submit a corrective action plan to address any deficiencies identified.
9. The LGE will email the monitoring tool and corrective action plan (if needed) to OBH for review within forty-five (45) business days after each monitoring visit.
10. For any program with a score of less than 70%, the LGE may conduct a follow-up visit or remote follow-up review.

Early Intervention Services for HIV (For “Designated States” Only)

1. Does your state currently 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. Has your state identified a need for 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. Has your state identified a need for 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. Has your state identified a need for 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. Does your state provide any of the following:
- a) Notice to Program Beneficiaries
☒ Yes ☐ No
- b) An organized referral system to identify alternative providers
☒ Yes ☐ No
- c) 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. Has your state identified a need for 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. Has your state identified a need for 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.
Ten Sub-recipients
3. Has your state identified a need for 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. Has your state identified a need for 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. Has your state identified a need for 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
3. Has your state utilized the Regional Prevention, Treatment, and/or Mental Health Training and Technical Assistance Centers (TTCs)?
 - a) Prevention TTC
☒ Yes ☐ No
 - b) Mental Health TTC
☒ Yes ☐ No

- c) Addiction TTC
☒ Yes ☐ No
- d) State Targeted Response TTC
☒ 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.

http://www.lah.gov/assets/medicaid/hss/docs/BHS/LAC_48v01_BHSP.pdf

11. 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 2018-FFY 2019?

a) ☒ Yes ☐ No

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

N/A

12. 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 M/SUD 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 M/SUD services. 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 M/SUD 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 M/SUD 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 M/SUD 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 M/SUD 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 M/SUD 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

13. 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 M/SUD services?

☒ Yes ☐ No

LDH has collaborated with the Department of Corrections regarding the release of adults from incarceration. Part of this effort has been 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 Office for Behavioral Health (OBH) and the Department of Corrections (DOC) have partnered to provide referrals for treatment services, collaborations and community linkages necessary for men and women with Mental Health and Substance Use Disorders (SUD) to maintain a lifestyle free from the harmful effects of addiction and recidivism. OBH's goal is to improve mental health and substance use outcomes of women and men returning to society. This initiative is providing Louisiana the opportunity to advance its state-specific aims and goals to focus on the rehabilitation women and men with substance use and mental health disorders. The OBH Program Manager conducts on-site presentations at the 11 Re-Entry Facilities in Plaquemines, East Baton Rouge, West Baton Rouge, Iberville, Lafayette, St. Tammany, Allen, Rapides, Franklin, Madison and Caddo parishes. OBH developed an agreement with DOC to provide a re-entry behavioral health educational training program for the offender population. This program educated staff and heightened awareness of offenders about the substance use treatment service array offered within OBH. This program helped address barriers that inmates face to receiving treatment after they are released from prison.

In 2017 OBH and local Louisiana law enforcement attended a learning academy sponsored by SAMHSA regarding the One Mind Campaign. The One Mind Campaign focuses on uniting local communities, public

safety organizations, to reduce the number of persons with mental illness from entering jails. Upon returning to Louisiana, OBH and the Chief Lawrence Callendar of the French Settlement Police Department held a symposium for Louisiana law enforcement leaders. The symposium addressed the growing need to address law enforcement encounters with people suffering from chronic and severe mental illness. Governor John Bel Edwards attended and gave his support to the initiative. Over 100 law enforcement leaders were present and many signed the pledge to join the campaign. The pledge involves certifying 100% of officers in Mental Health First Aid and 20% of the officers in Crisis Intervention Techniques.

In March of 2019 Dr. Janice Petersen, Deputy Assistant Secretary of OBH, presented to the Louisiana Association of Chiefs of Police in Lake Charles, Louisiana. Dr. Petersen covered the work that OBH is doing with justice involved people presenting chronic and severe mental illness. Dr. Petersen also covered the sequential intercept model. Over 200 Chiefs of police attended. Tom Jarlock, OBH, also presented to the chiefs. Mr. Jarlock's presentation was a comparison between the One Mind Campaign and the Stepping Up Initiative. Chief Callendar provided a brief introduction of the One Mind Campaign and the history of the collaboration between OBH and law enforcement.

In October 2017, the Dept. of Justice, Bureau of Justice Assistance awarded OBH the Comprehensive Opioid Abuse Site-Based Program (COAP) Category 4A grant which provided \$100,000 to create a statewide plan to serve engage and retain justice –involved individuals with opioid use disorders in treatment and recovery support services and increase the use of diversion and/or alternatives to incarceration. In October 2018 OBH was awarded a second COAP category 4B implementation grant that provided \$1, 2000 to put this strategic plan into action. Many of the individuals served with OUD also had co-occurring mental health diagnosis. OBH has partnered with Capital Area Human Services District, Metropolitan Human Services District, Florida Parishes Human Services Authority to provide screening, assessment, treatment and recovery support services to justice involved individuals with OUD either incarcerated in the parish jails or receiving services in a Day Reporting Center in New Orleans. These programs connect these individuals with treatment programs in the community upon release

Through the Louisiana Opioid State Targeted Response (STR) Grant, Department of Public Safety and Corrections (DOC) collaborated with OBH to pilot two treatment programs for the releasing offenders in the Greater Baton Rouge area (one for male clients and another for females). Each program was planned to have four part-time clinicians and one supervisor. With the expansion of the STR initiative in year two, DOC was able to provide services to five prisons throughout the state. Releasing offenders with a diagnosis of OUD were selected 9 months to 1 year prior to their earliest release date. Treatment was individualized and included Medication Assisted Therapy, if indicated, in addition to Cognitive-Behavioral Therapy. These participants were enrolled in available entitlement programs (i.e., Medicaid, etc.) prior to release and an intensive and structured discharge planning was done to ensure aftercare services. DOC & OBH collaborated with the Department of Probation & Parole to gather data to estimate the relapse rate, recidivism rate and any other relevant outcome measures. The program also included the proven strategies of using “peer support specialists” and “family therapy.”

OBH will contract to expand recovery homes by funding three Peers/Outreach Workers. Two Outreach Workers will work with the Department of Public Safety and Corrections (DPSC) re-entry population, with a focus on persons with OUD transitioning from incarceration to the community. Re-entry centers will be offered face-to-face workshops on OUD and MAT. One Outreach Worker will serve as a peer trainer to target Recovery Support homes and provide workshops/trainings to Homes statewide on MAT. One

hundred residents statewide will be trained on MAT per year, totaling 200 recovery home residents over the two year grant period. This training will encourage a paradigm shift from abstinence based housing to non-discrimination against persons on MAT. In addition, the Outreach Workers will expand the number of Homes statewide by 10 recovery homes per year, totaling 20 recovery houses over the two year grant. Each home will have at least four residents with OUD each (totaling 80 residents).

OBH administers the Louisiana Coordinated System of Care (CSoC) which is a program designed to serve youth with significant and complex emotional and behavioral health challenges who are in, or at risk of out of home placement. CSoC is a collaboration between the State's four child-serving agencies: Department of Children and Family Services, Department of Education, Department of Health and Hospitals, and Office of Juvenile Justice. The CSoC initiative aims to decrease the number of youth in residential/detention settings, reduce the cost for providing services by leveraging Medicaid and other funding sources, and improve the overall outcomes for these children/youth and their caregivers.

CSoC is an innovative reflection of two powerful movements in health care: coordination of care for individuals with complex needs and family-driven and youth-guided care. CSoC uses a wraparound approach to create and oversee a service delivery system that is better integrated, has enhanced service offerings and achieves improved outcomes by ensuring families who have children with severe behavioral health challenges get the right support and services, at the right level of intensity, at the right time, for the right amount of time, from the right provider, to ultimately keep or return children home or to their home communities. Combining all services into one coordinated plan allows for better communication and collaboration among families, youth, state agencies, providers and others who support the family.

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD 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

The leadership of OBH recently presented information to the Louisiana Chiefs of Police Association. Over 200 Law Enforcement Leaders learned about OBH's work on First Episode Psychosis, Opioid Crisis Response, and the Stepping Up Initiative. Crisis interventions techniques and Mental Health First Aid were promoted to this eager audience. Louisiana has several Stepping Up sites and many jurisdictions pledged to the One Mind Campaign. Additionally, CIT instructors have been in high demand in the last 12 months.

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

☒ Yes ☐ No

OBH developed an agreement with DOC to provide a re-entry behavioral health educational training program for the offender population. This program educated staff and heightened awareness of offenders about the substance use treatment service array offered within OBH and Recovery Homes offered through a contractor. This program helped address barriers that inmates face to receiving treatment after they are released from prison.

The CSOC program (mentioned in question 1) works closely with our State's juvenile justice partners, by providing education about CSOC values and principles, eligibility criteria and referral process, as well as on-going support and technical assistance, as requested.

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 M/SUD and other essential domains such as employment, education, and finances?

☒ Yes ☐ No

OBH serves as a member of the Louisiana Prisoner Reentry Initiative (LA-PRI). The goal of LA-PRI is to cut the recidivism rate by 50% for higher risk returning prisoners, beginning with the parishes that contribute the highest number of prisoners to the system. Objectives: (1) Provide a collaborative process to gain support with state's justice leaders, business leaders, local and state government officials, community human service providers, justice and victim advocates, families of the incarcerated, and law enforcement; (2) Provide process and experimental research evaluations to show impact; (3) Work with communities to demonstrate reduced recidivism through improved case planning and case management, built on actuarial risk/need assessment, good data, enhanced human service delivery³ and, comprehensive planning; (4) Create transitional and permanent jobs by working with Louisiana's business community⁴; (5) Build affordable housing opportunities⁵, linked to employment⁶; (6) Create/adapt DPSC policy procedure in order to ensure sustainability. (6) Link returning citizens to vital mental health and substance use treatment when they return to their respective catchment areas throughout the state.

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

See highlights mentioned below each question.

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

The sequential intercept model has been implemented in one metropolitan region. OBH would like to have additional technical assistance for those areas seeking to learn more about this model as well as assistance in implementation. The Stepping Up initiative has not been as widely distributed as thought possible and perhaps additional technical assistance or local learning collaboratives could spread the initiative to a larger state footprint.

14. 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? No

- 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 appropriately⁵?

☒ Yes ☐ No

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

Currently the state has taken measures to increase access to Medication Assisted Treatment by incorporating language into all behavioral health provider contracts, whereas providers must provide MAT onsite or initiate a referral to such services, when indicated. This method will ensure that providers move from abstinence based models of care to a now wrong door approach for persons on MAT. In addition, the state is currently implementing the 1115 waiver which requires all residential programs to offer MAT

⁵ 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.

on site or make those services readily available via referral. OBH has implemented a workforce development initiative to provide training and education on MAT to physicians and clinicians statewide. These trainings are geared towards providing evidence of the effectiveness of the use of MAT for Opioid Use Disorders.

15. 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 M/SUD 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 M/SUD 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 M/SUD 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
 - g) ☒ Suicide Prevention
2. Crisis Intervention/Stabilization:

- a) ☒ Assessment/Triage (Living Room Model)
- b) ☐ Open Dialogue
- c) ☒ Crisis Residential/Respite (*Covered Medicaid services*)
- 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) ☒ Peer Support/Peer Bridgers (*Peer Support only*)
- b) ☒ Follow-Up Outreach and Support
- c) ☒ Family-to-Family engagement (*Medicaid covered service under CSoC*)
- d) ☒ Connection to care coordination and follow-up clinical care for individuals in crisis
- e) ☐ Follow-up crisis engagement with families and involved community members
- f) ☒ Recovery community coaches/peer recovery coaches
- g) ☐ Recovery community organization

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

The Louisiana Department of Health (LDH) is committed to ensuring that individuals in crisis and their families experience treatment and support that is compassionate, effective and resolution-focused, and delivered by a crisis system that is coordinated, responsive and efficient. By addressing the needs of all populations, including Louisiana's most vulnerable citizens (e.g. children and youth in crisis and their families, and individuals with co-occurring conditions) LDH believes improvements to its crisis system of care will maximize the use of voluntary treatment and reduce the need for law enforcement involvement.

In addition, it will allow people to remain in their communities and reduce the need for restrictive levels of care including nursing homes, residential care centers, out of home placements, jails, intermediate care facilities for individuals with intellectual / developmental disabilities, and hospitals.

All behavioral health service (BHS) providers licensed under LAC 48:1.Chapter 56, including Local Governing Entities, must provide core services including crisis mitigation. This critical service offers assistance to individual during a crisis that provides 24-hour on call telephone assistance to prevent relapse or harm to self or others, to provide referral to other services, and to provide support during related crises. Referral to 911 or a hospital's emergency department alone does not constitute crisis mitigation services. All BHS providers develop a crisis mitigation plan with each individual receiving mental health and/or substance use services.

Providers contracted with at least one managed care organization (MCO) to deliver Medicaid funded mental health and substance use services including mental health rehabilitation, assertive community treatment, multi-systemic therapy and other evidenced based and non-evidenced based interventions must conduct crisis planning and respond to individuals who report a crisis. For providers licensed under LAC 48:1.Chapter 56 the crisis plan and crisis mitigation plan may be the same document.

Expanding Access to Crisis Services

It is LDH's goal to develop a statewide model for crisis response that maintains regional and geographic relevance and builds upon the unique and varied strengths, resources, and needs of Louisiana's individual communities.

To achieve this vision, LDH, in consultation with service users and key system partners, envisions a modern, innovative and coordinated crisis system.

LDH released a Request for Information (RFI) seeking ideas for the design of a behavioral health crisis system of care (inclusive of mental health and/or substance use disorders) as well as ideas for the types of crisis programs, services, and funding models that will best serve the needs of Louisiana and researched other leading states like Washington State.

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

N/A

16. Recovery – Required

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD 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 to the greatest extent possible, 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. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. 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:

- Does the state support recovery through any of the following:
 - Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?
☒ Yes ☐ No
 - Required peer accreditation or certification?
☒ Yes ☐ No
 - Block grant funding of recovery support services?
☒ Yes ☐ No
 - 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
- Does the state measure the impact of your consumer and recovery community outreach activity?
☐ Yes ☒ No
- 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) Target Health - OBH collaborated with the Mental Health Association for Greater Baton Rouge (MHAGBR) to develop a new Peer Support program entitled Target Health. Target Health is a holistic program, based off of the Whole Health Action Management (WHAM) model which will train Peer Support Specialists to assist those they serve to develop and maintain whole health goals.
- e) 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.
- f) 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 OBH, Medicaid, the Office of Juvenile Justice (OJJ), the Department of Children and Family Services (DCFS), and the Louisiana Department of Education (LDOE). 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 Medicaid behavioral health 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 respite. 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.

The Office of Behavioral Health (OBH) subscribes to SAMHSA's definition of "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

OBH encourages and promotes the use of peers within all treatment programs statewide. OBH provides peer support training and certification for individuals wanting to be a Peer Support Specialist and conducts multiple Certified Peer Support Specialist Supervisor trainings a year in order to help develop and sustain a peer support workforce.

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.

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.

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

ESMI/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). This population of focus was later expanded to include anyone experiencing early serious mental illness, regardless of age. 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.

The momentum in Louisiana in support of the enhancement and expansion of Peer Services is remarkable. During the SFY2020 Legislative Session, a resolution was passed in support of the expansion of Peer Services as a Medicaid reimbursable service. This resolution passed with resounding support from the legislature and LDH Executive Leadership.

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.

Within the coming year, LDH intends to move forward with adding Peer Services to the LA Medicaid State Plan as a reimbursable service. With this expansion of Peer Services, technical assistance, guidance and support to ensure compliance with the SAMHSA Core Values for Peer Support Specialist Services may be helpful in supporting this goal.

17. 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 M/SUD 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 M/SUD 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.

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 (currently known as 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 LDH.
- 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
- Agreement with the Department of Justice. On June 6, 2018, the Louisiana Department of Health formally entered into an agreement with the Department of Justice related to individuals with serious mental illness residing in Nursing Facilities. While the agreement is multi-faceted with remediation activities focused the PreAdmission Screening and Resident Review process, diversion activities, and actively transitioning individuals from NF placement, it also involves a series of activities related to the behavioral health service array. In particular, LDH has committed to evaluating its current service delivery system and implementing or enhancing the following:
 - Crisis System
 - Assertive Community Treatment
 - Intensive Community Support Services (ICSS) which is defined as CPST, PSR, and CI
 - Integrated Day Activities such as supported employment and other rehabilitation services
 - Peer Support Services
 - Housing and Tenancy Supports

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.

Through the Agreement with DOJ, OBH is working with national consultants on activities intended to further improve the peer certification process and inclusion in its behavioral health service delivery system. In particular, OBH will ensure certified Peer Support Specialists will continue to be incorporated into its rehabilitation services, CPST, PSR, CI, ACT, Crisis Services, Residential Supports, Integrated Day, SUD Recovery, and Supported Employment systems.

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.

OBH, through the DOJ Agreement, is working with national consultants to improve consumer's access to evidence based supported employment programs. Building on activities currently underway through a Vision Quest (VQ) grant awarded through the Office of Disability Employment Policy (ODEP), OBH is working with Louisiana Rehabilitation Services, improving efforts to employ individuals with mental illness.

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.

In a separate but similar initiative, efforts are currently underway to identify individuals with serious mental illness who have been inappropriately institutionalized in NF throughout the state, transitioning them back into the community. Staff has been hired to work on this initiative developed in response to the Agreement with DOJ. These individuals work with individuals, MCOs, behavioral health service providers, housing providers, as well as those entities providing for the member's physical healthcare needs, ensuring transition occurs utilizing a person centered process.

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 those activities developed in response to the DOJ Agreement, as well as utilizing mental health block grant funds to assist persons being discharged from nursing facilities and 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

18. Children and Adolescents M/SUD Services- Required for MHBG, Requested for SABG

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:

- Reach many children and youth typically underserved by the mental health system;
- Improve emotional and behavioral outcomes for children and youth;
- Enhance family outcomes, such as decreased caregiver stress;
- Decrease suicidal ideation and gestures;
- Expand the availability of effective supports and services; and
- 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 M/SUD 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 M/SUD 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 M/SUD 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 2019 was the seventh year of the implementation of CSoC which began in 2012 as the result of a Centers for Medicare and Medicaid Services (CMS) waiver. As of June 14, 2019, 2,379 children and youth were enrolled in CSoC, with a maximum enrollment of 2,400 children and youth at any given time. A total of 15,058 children, youth and their families have been served in CSoC from implementation in March of 2012 through June 14, 2019.

CSoC serves children and youth aged 5 through 20, statewide, who have 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 14, 2019 CSoC has served 15,058 youth and children, with current enrollment of 2,379 children/youth. Current enrollment ranges from 186 to 390 per region as follows: Greater New Orleans (350), Baton Rouge (229) Covington (323), Thibodaux (290), Lafayette (190), Lake Charles (187), Alexandria (186), Shreveport (234), and Monroe (390).

The CSoC team is composed of a CSoC Director with over fifteen 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.

Wraparound Agencies (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 FY19, the CSoC Team has continued to support the on-going skill development of the WAA supervisors/coaches and facilitators. The goal of this support 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 517 children/youth discharged in the third quarter of FY19 revealed that 76.8% of children and youth demonstrated improved functioning in their homes and communities.

The CANS school module which evaluates school functioning showed the following results:

- 68.8% showed improved school functioning
- 64.9% showed improved school attendance
- 67.4% 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 in child and family (CFT) teams continues to grow. In the third quarter of FY 19, the WAAs report that 89.5% 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 third quarter of FY 19, the living situation at discharge from CSoC for 92.21% of children and youth was to a home and community based setting.

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

N/A

19. 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 M/SUD 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

The State has been laying the groundwork for another State Suicide Prevention Plan with input from multiple sources that will incorporate the strategies of Zero Suicide. Act 450 of the 2018 regular legislative session directs the Office of Behavioral Health to create such a plan 'when funding resources become available'. In addition, the 2019 regular session passed Act 93, which outlines requirements for schools providing youth suicide prevention training for teachers and school staff, including content related to identifying youth suicide risk factors, suicide intervention techniques, and postvention resources. Louisiana Department of Education will designate schools, which meet the requirements of the act as Suicide Prevention Certified when schools have met the requirements of the law.

Office of Behavioral Health has been identifying individuals and entities working to prevent suicide around the state and connecting entities working in the same area to initiate increased collaboration. In addition, OBH began re-establishing a suicide prevention-training network for the Applied Suicide Intervention Skills Training (ASIST) and safeTALK: suicide alertness that existed when LA had the Garrett Lee Smith Grant.

Next steps will include following SPRC's Strategic Planning process for Comprehensive Suicide Prevention with entities working to prevent suicide. The process includes providing data on the scope of the problem and its context, choosing long-term goals, identifying key risk and protective factors in the state, selecting and developing interventions to meet those goals, planning evaluation to track progress to goals and then implementing, evaluating and continuously improving the process.

2. Describe activities intended to reduce incidents of suicide in your state.

OBH is legislatively mandated to be on the State level Child Death Review Panel (CDR) coordinated by the Office of Public Health; the State Suicide Prevention Coordinator 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. The panel will be focusing on safe firearm storage for the next year as firearms are the second leading cause of death in the 10-14

year old population of Louisiana. Since 68% of suicide deaths in LA are completed with firearms, the focus on safe firearm storage is expected to be beneficial across the lifespan. This work has fostered increased collaboration on suicide prevention between the Office of Public Health and the Office of Behavioral health.

The Office of Public Health is working with OBH to examine suicide attempt and death data in more detail and to create a web-based platform to share data on suicide deaths in the Louisiana on the OPH website. Easily accessible data on suicide prevention and attempts will help guide statewide decisions about how to comprehensively address suicide prevention across the lifespan.

OBH's State Suicide Prevention Coordinator has been coordinating and collaborating with multiple entities around suicide prevention. These include but aren't limited to: the Office of Public Health, the American Foundation for Suicide Prevention-LA Chapter (AFSP-LA), suicide prevention specialists with the Veterans Administration in the Alexandria/Lafayette area, suicide prevention specialists with the LA Army National Guard, St. Tammany Outreach for the Prevention of Suicide, SaveCenla, Jacob Crouch Foundation, and some of the LGEs, especially AAHSD and FPHSA.

3. Have you incorporated any strategies supportive of Zero Suicide?

☒ Yes ☐ No

This process is still in initial stages; information about the Zero Suicide initiative and strategies was shared with the state's LGEs when LA applied for the Zero Suicide State Grant in 2017. Two entities, a state psychiatric hospital and an LGE have since embraced the Initiative. I hope these pilot projects help guide the creation of state's suicide prevention plan.

The State Suicide Prevention Coordinator (SPC) has been consulting and collaborating with the Zero Suicide team lead at the East LA Mental Health System in LA. The hospital has now trained all clinical staff in ASIST and all non-clinical staff in safeTALK; these have been integrated into job performance of every employee of the hospital.

The Florida Parishes Human Services Authority is embracing Zero Suicide for their agency. The SPC has provided technical assistance and consultation on this as well. FPHSA had their Zero Suicide Kickoff meeting/training event in April for 165 of their staff. The trainings included the recommended Zero Suicide strategies of 'Suicide Safety Planning Intervention' and "Means Safety" for all clinical staff.*In addition, the SPC has been introducing the idea of Zero Suicide at professional conferences sharing the vision of system change possibilities. Suicide Safety Planning, Means Safety and Zero Suicide trainings with clinical professionals help to advance the initiative.

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?

☒ Yes ☐ No

Again, this is in early stages, the OPH-OBH Collaborative Learning Project on Suicide and Self Harm prevention with technical assistance and support from the Child Safety Network, and the Suicide Prevention Resource Center is developing a pilot project in the Acadiana parish (southwest Louisiana). Two hospitals have been identified to approach about improving care transitions between the emergency department and mental health care and support after discharge. One parish's School Based Health System

has been utilizing the Columbia-Suicide Severity Rating Scale for assessment. One goal of the group is to create a sustainable referral process between the School Based Health System, two of the hospital emergency departments and community behavioral health resources such as Acadiana Area Human Services District and Family Tree. Information about this project will help guide creation of the statewide plan.

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted?

☒ Yes ☐ No

If so, please describe the population targeted?

An informal suicide prevention coalition in southwest Louisiana contacted the SPC about addressing suicide prevention in their community; the group is loosely implementing Suicide Prevention Strategic Planning process. This group has been meeting to identify needs in the area and strategies that could address. The coalition has been working on several levels. The coalition includes OPH, OBH, AAHSD, Family Tree, the 211/crisis line, AFSP, etc. School social workers and counselors in the area are invited to the ASIST trainings and approximately 60 school social workers and counselors in the area have been trained to provide suicide first aid. That area of the state also has two suicide survivor of loss support groups as there are a high number of survivors of loss there. Postvention activities such as these can help to prevent suicide; there are supported by the Acadiana Area Human Services District through Family Tree. The Family Tree is also reaching out to area schools to deliver the gatekeeper suicide prevention program "QPR" (Question, Persuade, Refer) to willing school personnel. The Collaborative Learning Project described above is being implemented in the same area.

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

N/A

20. 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 M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD 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 M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?

☒ Yes ☐ No

2. Has your state identified the need to develop new partnerships that you did not have in place?

☒ Yes ☐ No

If yes, with whom?

1. Birthing Hospitals to screen, identify and refer women with SUD to treatment
 2. Emergency Room Departments to identify and refer person's with OUD to treatment
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.

Through the Louisiana Department of Health (LDH), the Office of Behavioral Health (OBH) implements treatment, prevention and recovery support services statewide for individuals with or at risk for Substance Use Disorders, other related addictions, and mental health diagnoses. In order to accomplish this task several key partners were identified to enhance and expand capacity of treatment providers to provide a full array of comprehensive services, including: screening, assessment, orientation, urine drug screens, methadone management and other forms of Medicated Assisted Treatment (MAT), counseling (individual, group, and/or family), case coordination, home and community based mental health

treatment programs, such as Assertive Community Treatment (ACT) and Mental Health Rehab (MHR) services, and coordinated specialty care (CSC) programs for the ESMI/FEP population of focus, etc. OBH uses a multi-faceted, collaborative approach. Below is a brief description of the Partners and their roles.

Opioid Treatment Programs (OTP)

OTP's provide direct substance use services by combining use of Medication Assisted Treatment (MAT) with counseling and behavioral therapies for treatment. OTP's offer medically necessary treatments and services that target newly under/uninsured persons with opioid use disorder (OUD).

Louisiana State University Social Research & Evaluation Center (LSUSREC)

LSUSREC provides data collection and performance measurement for LaSOR including data collection, storage, cleaning and organization, analysis, and reporting. LSUSREC will also conduct a needs assessment of state-recognized tribes in collaboration with the Governor's Office of Indian Affairs.

Louisiana State University Health Science Center (LSUHSC)

LSUHSC staffs the Spoke Care Teams (SCT), which consist of one Registered Nurse and one Licensed Mental Health Professional (LMHP) per region/LGE catchment area (10 total). These teams provide assistance to the Office Based Opioid Treatment (OBOT) providers, such as screening, brief intervention and referral to treatment (SBIRT), assessments, case coordination, and recovery support services, as well as assistance with GPRA data entry. LSUHSC also provides clinical supervision to the SCTs, psychiatric consultations to MAT providers, and monetary incentives to participating OBOT providers.

Tulane

Tulane University provides academic detailing, implementation of Project ECHO (Extension for Community Healthcare Outcomes), and a Fellowship in Addiction Medicine. Project ECHO uses video-conferencing technology to establish a virtual "knowledge network" between a team of inter-disciplinary specialists located at Tulane Medical Center and OBOT providers for training and mentoring. Academic Detailing uses specially trained clinical educators who meets one-on-one with physicians, nurse practitioners, and physician assistants (at their practice locations), to discuss best practices and corresponding ECHO topics as well as improve their service range in MAT. The Fellowship in Addiction Medicine is a one-year fellowship after which physicians will be eligible to become board certified in the new subspecialty of Addiction Medicine. Tulane expanded academic detailing to focus on jails that are at the highest risk for overdose and whose healthcare providers will benefit from MAT training support.

Department of Corrections (DOC) MAT

DOC will provide services to five prisons (2 women's facilities and 3 men's facilities) throughout the state. Offenders with a diagnosis of OUD will be selected 9 months to 1 year prior to their earliest release date. Treatment will be individualized and may include Medication Assisted Therapy, if indicated, in addition to Cognitive-Behavioral Therapy.

Department of Corrections (DOC) Re-Entry

The Office for Behavioral Health (OBH) and the Department of Corrections (DOC) have partnered to provide referrals for treatment services, collaborations and community linkages necessary for men and women with Mental Health and Substance Use Disorders (SUD) to maintain a lifestyle free from the harmful effects of addiction and recidivism. The OBH Licensed Addiction Counselor conducts on-site presentations at the 11 Re-Entry Facilities in Plaquemines, East Baton Rouge, West Baton Rouge, Iberville,

Lafayette, St. Tammany, Allen, Rapides, Franklin, Madison and Caddo parishes. The goal of the collaboration is for DOC staff and re-entering citizens to become familiar SUD/ODU signs and symptoms and to gain knowledge about OBH's array of services offered. In addition, this program helps assist individuals being released from DOC facilities to connect to vital mental health, substance use and or housing services in the respective LGE catchment area in which they will be returning to. The linkage to these services will help reduce the overall substance use and incarceration recidivism rates statewide.

[Oxford House](#)

Oxford house provides staff to monitor the operation of the existing network of 128 Oxford Houses and expansion of a minimum of eight (8) new homes in the State for each fiscal year during the contract period. The contractor will provide support and oversight necessary to maintain a healthy statewide network of Oxford Houses and participate in the Oxford World and State Conference. Oxford House will also provide monitoring and oversight to enhance OBH's collaboration with the Department of Correction's (DOC) Re-Entry Program and help connect offenders being released to vital substance use and mental health services in their respective communities.

[Southern University Center for Prevention Resources, Louisiana Community and Technical College System and Faith Based Organizations](#)

LDH-OBH intends to partner with Universities, Faith-Based Organizations, and Technical and Community Colleges statewide, to implement four Generation Rx modules: teen, college, adult, seniors. OBH will provide opportunities for service learning and "train the trainer" frameworks to extend this EBP into communities, statewide. These trainings may be offered in-person and/or via live feed, virtually through online learning platforms provided by our partners. In addition, trainings will be offered to the faith-based communities in an effort to heighten awareness of the effectiveness of MAT and to address myths and stigma regarding treatment toward OUD.

[Emergency Preparedness](#)

SMHA/SSA actively partner with the various agencies within the Louisiana Department of Health, regional and local partner agencies to collaborate in 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, recovery) including appropriate engagement of volunteers with expertise and interest in behavioral health.

[Tulane University School of Psychiatry](#)

Through a contract with Tulane University's EPIC NOLA Program, Tulane's existing Coordinated Specialty Care clinic serving individuals experiencing FEP has been able to expand their capacity. Technical Assistance is ongoing amongst the FEP programs, with a consultation contract with the medical director of Tulane's EPIC NOLA Program. The purpose of this is to improve LGEs capacity to serve individual experiencing psychosis with the intention of shortening durations of untreated psychosis. During June 2019, Tulane's EPIC NOLA Medical Director and Clinical Director conducted three (3) trainings in Lafayette, Baton Rouge, and Monroe to provide statewide training and technical assistance on serving this population of focus.

Initiatives to Serve the Homeless Population with SMI

PATH

With the Projects for Assistance in Transition from Homelessness (PATH) grant, outreach services to homeless individuals with SMI are provided by various partners. 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 grant funding supports community-based outreach, mental health, substance use, case management and other support services, as well as a limited set of housing services.

LGE	PATH PROVIDER(S)
MHSD	1) Unity of Greater New Orleans 2) Volunteers of America – Greater New Orleans
CAHSD	Volunteers of America – Greater Baton Rouge
SCLHSA	SCLHSA
AAHSD	Volunteers of America – Greater Baton Rouge
CLHSD	Volunteers of America – North Louisiana
NLHSD	Hope for the Homeless
NDHSA	Wellspring Alliance for Families
JPHSA	Responsibility House

NAMI Louisiana

The Office of Behavioral Health partners with the National Alliance on Mental Illness Louisiana Chapter (NAMI LA) through a contract to support the housing assistance program, which is funded with MHBG funds. Through this contract, eligible individuals with serious mental illness who are homeless/at-risk of homelessness and are exiting an institution, such as a hospital, correctional facility, and/or nursing home, are allowed a specified amount to help with the transition from an institution to the community. This assistance may be temporary rental assistance for an apartment or chosen group home, as well as for incidentals needed to support a successful transition to the community.

NAMI St. Tammany / START Corporation Transitional Homes

The Office of Behavioral Health has partnered with NAMI St. Tammany for the past six years to support the transitional group homes on the campus of Northlake Behavioral Health System. In September 2019, the management of these group homes is scheduled to transition to START Corporation. These transitional homes serve individuals with serious and persistent mental illness (SPMI) who are homeless and need assistance with daily living skills. NAMI St. Tammany and Start have a long history of partnering with OBH to serve the most vulnerable populations of those with SPMI who are homeless.

Mental Health Advocacy and Education

Mental Health Association of Greater Baton Rouge (MHAGBR) / Louisiana Affiliate of Mental Health America

In 2019, MHAGBR was elected by Mental Health America National Office as the Louisiana Affiliate of their organization. In 2019, MHAGBR also began a partnership with OBH, which is an expansion of the already existing partnership, to provide statewide educational forums to families and communities on how to access resources and help when a loved one or member of their community is challenged by mental illness. These forums, Mental Health 911, will occur throughout the state during the coming year.

NAMI St. Tammany

NAMI St. Tammany continues to partner with OBH to provide education and advocacy services to local communities, to include law enforcement agencies and specialty behavioral health courts. This education and advocacy has included training local law enforcement on Crisis Intervention Training (CIT), Mental Health First Aid (MHFA), and the development of an app that includes quick references to resources.

NAMI Louisiana

NAMI Louisiana continues to partner with LDH/OBH to provide advocacy, education and support the Louisiana Behavioral Health Advisory Council (LBHAC). NAMI LA provides statewide training on mental illness and how to work with the legislature to support services and programs for those with mental illness. As part of this collaborative effort, NAMI LA also organizes the annual Behavioral Health Day at the State Capitol.

Peer Support Services

NAMI St. Tammany

NAMI St. Tammany has continued to partner with OBH to provide Peer Support Specialists in one of the mental health hospitals. In support of the evidence based practices of utilizing Peers to support the treatment and recovery process, NAMI St. Tammany has provided two Peers to work in the Northlake Behavioral Health Hospital for the past six years and continues to support this service through a contract with OBH.

Mental Health Association of Greater Baton Rouge (MHAGBR) / LA Affiliate of Mental Health America

In 2018, OBH collaborated with the Mental Health Association for Greater Baton Rouge (MHAGBR) to develop a new Peer Support program entitled Target Health. Target Health is a holistic program, based off of the Whole Health Action Management (WHAM) model which will train Peer Support Specialists to assist those they serve to develop and maintain whole health goals.

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

N/A

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

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 PC, 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 M/SUD 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 in their community. The IUPs are discussed during a RAC meeting attended by RAC members and the LGE Executive Director. Once input has been received from the RAC, 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 the Louisiana Behavioral Health Advisory Council's Committee on Programs and Services for review. The committee then reports 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, veterans, 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.

Strategic planning was conducted in 2017-18 and the following Mission, Vision, and Value statements were adopted and continue to represent the focus of the LBHAC:

Mission Statement

The mission of the Louisiana Behavioral Health Advisory Council is to review and monitor the Behavioral Health system, advise and make recommendations, and serve as advocates for persons with Behavioral Health issues in the state of Louisiana.

Vision Statement

Through advocacy we see Louisiana filled with informed, healthy individuals who have the opportunity to live, work, and play in the community of their choice.

Value Statement

In pursuit of our mission, we believe the following value statements are essential and timeless:

- We trust our colleagues as valuable members of the team and pledge to treat one another with loyalty, respect, and dignity.
- We recognize the value of lived experience and the development of partnerships.
- We believe in prevention and early intervention.

- We promote an atmosphere that is respectful of recovery and wellness and strive for a behavioral healthcare system that is responsive and accountable to the individual's strengths and needs.
- We believe in data driven decisions based on quality measures.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.

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)	6	
Family Members of Individuals in Recovery * (to include family members of adults with SMI)	4	
Parents of children with SED/SUD *	2	
Vacancies (individual & family members)	0	
Others (Advocates who are not State employees or providers)	9	
Persons in recovery from or providing treatment for or advocating for SUD services	5	
Federally Recognized Tribe Representatives	1	
Total Individuals in Recovery, Family Members, and Others	26	65%
State Employees	12	
Providers	0	
Vacancies	2	
TOTAL State Employees & Providers	14	35%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBT Populations	12	
Providers from Diverse Racial, Ethnic, and LGBT Populations	0	
TOTAL Individuals and Providers from Diverse Racial, Ethnic, and LGBT Populations	12	
Youth/adolescent representative (or member from an organization serving young people)	1	

*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.

22. Public Comment on the State Plan- Required

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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