FY 2024-2025
Combined Behavioral Health Assessment and Plan

Community Mental Health Services
and Substance Use Prevention, Treatment and Recovery Services
Block Grants

Louisiana Department of Health

Office of Behavioral Health

September 1, 2023

LOUISIANA DEPARTMENT OF HEALTH

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State Information and Funding Agreements

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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 substance use and related addictive disorders by providing oversight and guidance of behavioral health services in the Medicaid Healthy Louisiana plans and Local Governing Entities (LGEs).
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, to include harm reduction models and approaches.
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) 2023, OBH was comprised of three distinct programs: Behavioral Health Administration and Community Oversight, Hospital Based Treatment, and Auxiliary. The SFY23 year-end budgets and notable budget items are shown, below:

Agency Programs	SFY23 Year-end Budget
BH Administration	$124,456,628
Hospital Based Treatment	$236,639,811
Auxiliary	$20,000
Total	**$361,116,439**

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

Notable Areas within SFY23 Budget[1]	SFY23 Year-end Budget
Social and Client Services Contracts	$52,097,076
Allocations to the LGEs	$67,659,765
Hospital Patient-related Budget	$200,191,243

[1]Some 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 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 Substance

Related and Addictive Disorders 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.

Substance Use Disorder System Enhancements

OBH recognizes the impact of Substance Related and Addictive Disorders 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 Medications for Substance Use Disorder (MSUD) 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 Opioid Withdrawal Syndrome (NOWS).

Inpatient Psychiatric Hospital Needs

An ongoing priority of OBH will be to increase communication with the courts, the Department of Public Safety and Corrections (DPSC), 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 DPSC 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. OBH partners with the Department Well

Ahead initiative to ensure coordination with addressing health, mental health and addiction, and health disparities.

Criteria for Mental Health and Substance Use Prevention, Treatment and Recovery

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[1] sections:

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

Local Governing Entities

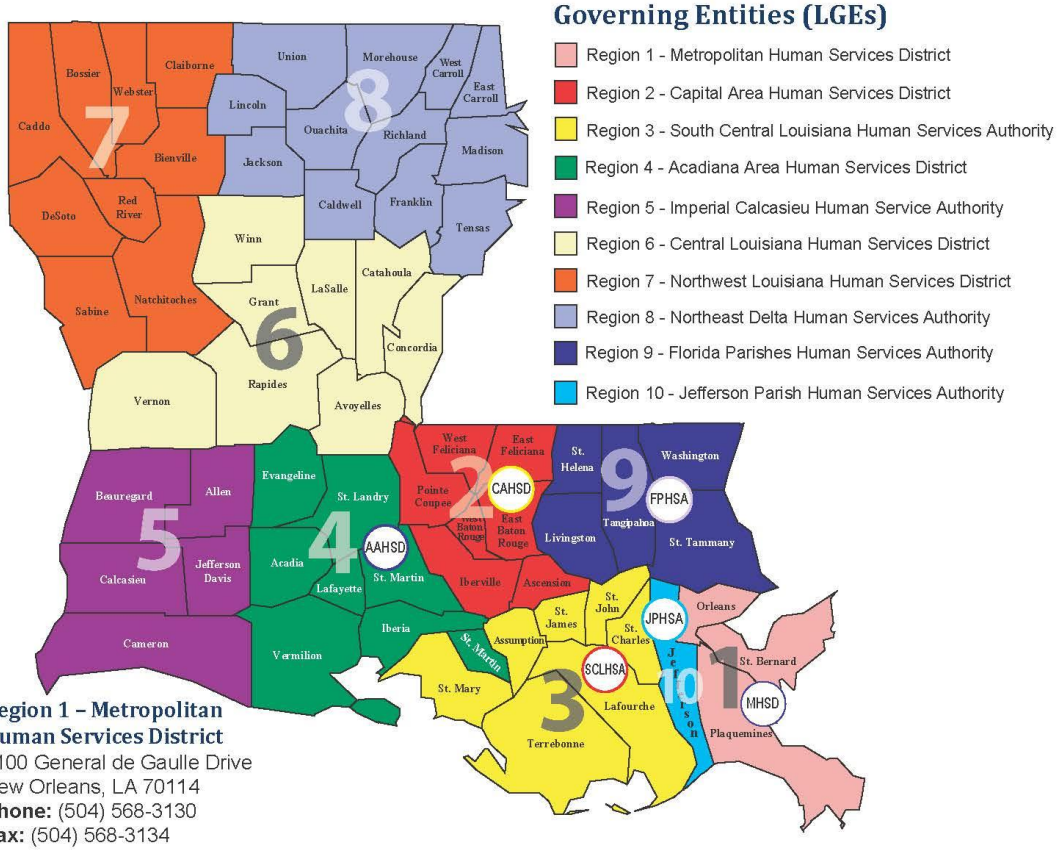
The Local Governing Entities (LGEs), classified as a human services district or authority, have a contractual agreement with the Louisiana Department of Health (LDH). Considered as the local umbrella agencies, the LGEs administer the state-funded behavioral health and developmental disability services 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, training 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.

[1] For information regarding populations and criteria specific to the CMHS and SAPT Block Grants, please refer to the Environmental Factors section beginning on page 110.

LOUISIANA DEPARTMENT OF HEALTH

Office of Behavioral Health Local Governing Entities (LGEs)



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New Orleans, LA 70114
Phone: (504) 568-3130
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Region 3 – South Central Louisiana Human Services Authority
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Region 4 – Acadiana Area Human Services District
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Region 5 – Imperial Calcasieu Human Service Authority
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Phone: (337) 475-3100
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Region 6 – Central Louisiana Human Services District
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Phone: (318) 487-5191
Fax: (318) 487-5184

Region 7 – Northwest Louisiana Human Services District
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Shreveport, LA 71107
Phone: (318) 676-5111
Fax: (318) 676-5021

Region 8 – Northeast Delta Human Services Authority
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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
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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	Baton Rouge Behavioral Health	BH	2751 Wooddale Blvd.	Baton Rouge
	Children's Behavioral Health	BH	422 Colonial Dr.	Baton Rouge
	Donaldsonville Mental Health	MH	901 Catalpa Street	Donaldsonville
	Ascension Behavioral Health	MH	1056 E. Worthey Street Suite B	Gonzales
	Iberville Behavioral Health	MH	24705 Plaza Drive	Plaquemine
	North Baton Rouge Behavioral Health	MH	7855 Howell Blvd. Suite 200	Baton Rouge
	Pointe Coupee Behavioral Health	MH	282-A Hospital Road	New Roads
	West Baton Rouge Behavioral Health	MH	685 Louisiana Avenue	Port Allen
	West Feliciana Behavioral Health	MH	5266 Commerce Street	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	437 North Market Street	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 Alexandria	BH	5411 Coliseum Blvd.	Alexandria
	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
	Many Behavioral Health Clinic	BH	265 Highland Drive	Many
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

LGE	Clinic	Type	Address	City
FPHSA	Bogalusa Behavioral Health Clinic	BH	400 Georgia Avenue	Bogalusa
	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 substance use 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. In addition, residential treatment for adolescents is available 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, enabling more than 785,000 Louisianans ages 19 to 64 to enroll in Medicaid. This momentous expansion of healthcare coverage has dramatically changed the landscape for vulnerable communities and the healthcare sector for the better, and it has provided a critical safety net during the ongoing global COVID-19 pandemic. As of July 2023, more than 200,000 adults in the Medicaid expansion group received specialized outpatient mental health services and more than 58,000 received inpatient mental health services at a psychiatric

facility. Additionally, more than 39,000 adults received specialized substance use outpatient services and more than 45,000 adults received specialized substance use residential services. Over 42,500 adults received medication-assisted treatment for opioid use disorder.

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. 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. LDH plans to submit an extension application for renewal of the 1115 waiver. On December 2, 2022, CMS approved Louisiana's request to extend the 1115 Demonstration Waiver through December 31, 2027.

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. The managed care entities monitor the specialized behavioral health provider network to assess compliance of these qualifications and requirements on an ongoing basis, which includes sampling provider records through desk and onsite reviews. Medicaid providers are required to credential through the managed care entity and re-credential periodically as established by accreditation standards and contract requirements. Medicaid continues to move 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 credentialing and re-credentialing of all Network Providers. 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 local communities to promote services that are reflective of the needs of 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, to ensure Diversity, Equity and Inclusion (DEI). 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, Regional Advisory Councils, Coalition of Louisiana Addiction Services and Prevention Providers (CLASPP), the Louisiana affiliates of NAMI and Mental Health America, statewide providers, other state and community partner agencies and stakeholders in assessing the needs of these populations. These community entities also provide feedback and recommendations to OBH as a framework to guide ongoing development, enhancement and implementation of the behavioral health service system and to ensure 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.

OBH facilitates numerous presentations and workgroups with various stakeholders to obtain feedback on how to further develop the behavioral health services system to better serve individuals in the community. Through ongoing behavioral health system development, training, community partnerships, presentations, and workgroups 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.

The state implements Culturally and Linguistically Appropriate Services (CLAS) that facilitates equitable organizational governance, leadership and workforce that are responsive to the population and promotes policy, practices and trainings to ensure services are responsive to diverse cultures. The state also integrates the National CLAS Standards into the assessment step. The standards support in the identification of disparities and risk factors. The standards also allow for better selection of strategies that are most appropriate to address the substance use challenges within the identified population. Qualitative and quantitative data is used in the assessment process to ensure services are equitable and meets the needs of the communities in which we serve. The state does integrate the National CLAS Standards into capacity building efforts. In capacity building, we develop a strong infrastructure and team to support implementation of efforts. Representation of disparate populations are often part of the team to better understand challenges and identify reasonable, equitable, and appropriate solutions. In addition CLAS is also integrated into the planning step. It is a critical step in our process as we strive to identify high risk populations and limitation in resources. As stated previously, including representation of disparate populations in the planning process allows for the ability to provide more appropriate, effective and equitable services.

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

OBH facilitated several opportunities to engage community, providers, and other stakeholders on best practices in the behavioral health system. This included Advisory Council quarterly meetings, ongoing

dialogues with mental health and SUD treatment providers, associations, and with LGEs. The OBH also participates in South Southwest Addiction/Prevention Technology Transfer Center forums to stay abreast of evidence and promising practices. OBH compiled these items as strengths and needs during the planning process.

Strengths

Grants:

- Louisiana Partnerships for Success II (LaPFS II) - focuses exclusively on addressing underage drinking behaviors, consequences, and risk factors among 9-20 year olds. This grant supports 9 Parishes within 7 of Office of Behavioral Health's Local Governing Entities (LGEs) across Louisiana. LaPFS II is a 5 year grant that began October 1, 2018 and will end on September 29, 2023. OBH will submit a 1 year no cost extension for a period of Sept. 30, 2023 to Sept. 29, 2024. OBH has submitted the application for the 2023 Louisiana Partnerships for success III.
- Zero Suicide Grant – The purpose of the Zero Suicide Initiative is to improve care and outcomes for individuals aged 25 years and older who are at risk for suicide within state behavioral healthcare systems by implementing the Zero Suicide Framework. The Louisiana Department of Health (LDH) Office of Behavioral Health (OBH) implemented the Zero Suicide Initiative in six health systems: four state operated regional behavioral health systems, referred to as Local Governing Entities (LGEs) and two state operated psychiatric hospitals. Four LGEs were chosen to participate in the Zero Suicide Initiative based on the prevalence of suicide deaths in their catchment areas: Florida Parishes Human Services Authority (FPHSA), South Central Louisiana Human Services Authority (SCLHSA), Acadiana Area Human Services District (AAHSD), and Northeast Delta Human Services Authority (NEDHSA). In addition, OBH implemented the Zero Suicide Initiative at the Eastern Louisiana Mental Health System (ELMHS) and the Central Louisiana State Hospital (CLSH), which are state hospitals in OBH's psychiatric system that receive patients from across the state. The Zero Suicide framework includes: leadership development, healthcare provider training, identification of suicide risk factors, patient engagement, access to treatment, health system transition, and health system quality improvement. Training will be provided through a Zero Suicide Academy for the workforce of professionals who are addressing suicide prevention in local communities. The Zero Suicide Academy occurred on June 13th and 14th, 2023. There were 12 teams that participated.
- COVID-19 Emergency Response for Suicide Prevention Grant – This grant supports the state and communities during the COVID-19 pandemic in advancing efforts to prevent suicide and suicide attempts, including an overall reduction in suicide rates. The grant focuses on reducing suicide for individuals who have attempted suicide or had a suicidal crisis. Therefore, the Fisher Project was developed for individuals aged 25 and older who are at increased risk for suicide, after a suicide attempt, after discharge from a psychiatric facility, after a suicide crisis and/or someone struggling with chronic suicide ideations. The program is designed to raise awareness of suicide, establish referral processes and improve care and outcomes for such individuals who are at risk for suicide.
- Emergency COVID-19 Grant and American Rescue Plan Mitigation Supplement Grant – Through these funding sources, the state implemented the Just Breathe stress management program implemented to provide support to health care professionals within the workforce of the Office of Behavioral Health responding to the COVID pandemic. Healthcare professionals all face the challenge of not only being first responders as a civil servant duty, but also coping with the COVID

pandemic within their own families. Two part-time stress managers with knowledge and experience in stress management were hired at OBH to implement the program. This year, two additional stress managers were hired to expand the program to the Office of Public Health (OPH). Featured services of Just Breathe include:

- Just Breathe Website – JustBreatheOBH.com
  The hub for all stress management content. Managers monitor and curate all content posted, to include blogposts as needed

- Consultation Services
  Mental health and organizational stress management consultation services for leadership team (EMT), supervisors and other staff by request.

- 30/30 Sessions
  Live, synchronous presentations that cover important topics related to health and well-being in the workplace. Thirty minutes are devoted to the presentation of a topic or specific content area and thirty minutes remain reserved for questions and/or discussion.

- Weekly All-Staff Emails
  Newsletter style, weekly emails go out to all staff featuring current events and all website content updates.

- Micro-services
  Brief <5 minute video clips featuring tips on stress management. Micro-services feature topics on self-care, mindfulness and a healthy mindset.

- Recommendation & Resource Library
  Recommendations every Monday on how to find relevant materials to help personal growth and coping in various forms: books, documentaries, podcasts, videos and more.

- The Breakroom
  The Breakroom offers an unstructured, virtual space for staff to connect and unwind together.

- Daily Pick-Me-Up
  Daily reminders, light and fun in nature, to go to the Just Breathe blog section.

- Just Breathe Resource Guide
  Organized by SAMHSA wellness dimension, the Just Breathe Resource Guide provides options at the national, state and local level for individuals to get support and assistance.

- 988 Implementation Grant – This technical assistance grant supports the transition from the previous National Suicide Prevention Lifeline number to the new 3-digit 988 number which was launched in July 2022. The grant promotes a shift from a law enforcement and justice system response to one of immediately connecting to care for individuals in suicidal, mental health and substance use crises. The grant provides technical assistance for the implementation of 988.
  - *The 988 Cooperative Agreement Grant*- The purpose of these cooperative agreements is to improve state and territory response to 988 contacts (including calls, chats, and texts) originating in the state/territory by: (1) recruiting, hiring and training behavioral health workforce to staff local 988/Lifeline centers to respond, intervene, and provide follow-up

to individuals experiencing a behavioral health crisis; (2) engaging Lifeline crisis centers to unify 988 response across states/territories; and (3) expanding the crisis center staffing and response structure needed for the successful implementation of 988.

- *The 988 Supplemental Grant*- The supplemental grant works to improve coordination with 911 Public Safety Answering Points (PSAPS) and Marketing and Communications efforts. This grant also supports hiring and workforce development to the local crisis call centers.

- 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 or a substance use disorder who have co-occurring physical health conditions or chronic diseases. OBH will submit a no cost extension to extend the grant period from Sept. 30, 2023 to Sept. 29, 2024. OBH has submitted an application for the 2023 PIPBHC II.
- The Louisiana State Opioid Response (LaSOR) program aims to address the opioid crisis by increasing access to medication- for opioid use disorder (MOUD) using the three FDA-approved medications for the treatment of OUD and through the provision of prevention, treatment, and recovery activities for OUD. In addition, the LaSOR program supports evidence-based prevention, treatment, and recovery support services to address stimulant use and misuse disorders, including cocaine and methamphetamine. The LaSOR 2.0 grant no cost extension ends Sept. 29, 2023. The current LaSOR 3.0 grant ends Sept. 29, 2024

Cross Sector Collaborative Opportunities:

- Heroin and Opioid Prevention and Education (HOPE) Council- Thirteen (13) agency heads, with LDH as the Chair, addresses prevention and education of heroin and opioids.
- The Governor's DWI Taskforce, a sub-committee under the Louisiana Drug Policy Board was reestablished through Executive Order in March 2018. The purpose of the Task Force is to address the high incidence of driving while intoxicated or under the influence of drugs; address data collection and analysis on DWI conviction rates; address the prevalence of drivers refusing to submit to tests as directed by law enforcement and strategies to reduce such incidences; and identify and implement effective DWI countermeasures.
- Project AWARE- In partnership with the Louisiana Department of Education, a comprehensive Louisiana School Mental Health Support Program has been 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.
- OBH collaborates with Local Governing Entities (LGEs), the Department of Public Safety and Corrections (DPSC), and the Orleans Day Reporting Center to provide a comprehensive array of services to justice-involved individuals with opioid use disorder (OUD), including peer support services, outpatient treatment services, and other recovery support services. This collaboration is instrumental in engaging and retaining justice-involved individuals with OUD in treatment and recovery services, increasing the use of diversion and/or alternatives to incarceration, and reducing the incidence of overdose deaths.
- Louisiana Center for Prevention Resources (LCPR) established at Southern University and A&M College and the Office of Behavioral Health (OBH) developed a partnership aimed at improving

implementation and delivery of effective substance use prevention interventions. This Center also offers training and technical assistance services to the Substance Use Prevention Workforce. This partnership provides specific courses and trainings necessary to become a certified/licensed prevention professionals, at no cost to participants. Additional trainings are available to youth, communities, professionals, and others in the prevention community, to increase capacity, skills and expertise to ensure and/or enhance delivery of effective substance use prevention interventions, trainings and other prevention activities. In addition to the above initiative, OBH partnered to:

  - Support mental health training needs specifically related to suicide prevention. Trainings under this partnership enables participants to assist someone in a crisis mode by being trained to recognize the warning signs of suicide ideation. These trainings will provide the skills needed to individuals for outreach and initial support to someone who may be in crisis or developing a mental health or substance use problem.
  - Developed a Statewide Media Alcohol Awareness Campaign. The purpose of this campaign is to increase awareness of alcohol use and misuse and the associated consequences. This campaign will be used to address risk factors and educate community members on the increase in substance use. In addition LCPR will provide trainings and awareness campaigns for Service Members, Veterans and their Families (SMVF) with targeted messages that focus on behavioral health prevention and trainings related to substance use.

- OBH collaborates with the Office of Public Health (OPH) to enhance services provided by Syringe Service Programs (SSPs). This collaboration supports the planning and implementation of HIV early intervention services to prevent HIV from sexual interaction and/or drug use. It also supports outreach campaigns to increase testing and PrEP services. Furthermore, it supports the distribution of harm reduction materials and a health coordinator to connect individuals with treatment and other community resources and supports, along with linkages to care.

New Initiatives:

- Crisis System funding- Funding was approved during the 2021 state legislative session for the implementation of three (3) new Medicaid-funded crisis services to be implemented statewide for individuals 21 years and older. Implementation will be phased in by service beginning in January, 2022 and will include the following:
  - Mobile Crisis Intervention (MCI), a community-based, mobile crisis response service.
  - Community Brief Crisis Support (CBCS), an ongoing crisis intervention response rendered for up to fifteen (15) days for those in need.
  - Behavioral Health Crisis care (BHCC) clinics, a time-limited and facility based walk in clinic for individuals in crisis.
  - Crisis Stabilization (CS), short-term bed-based crisis treatment and support services for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization.
- Funding was approved during the 2023 state legislative session to expand MCR and CBCS to children, with implementation of these services projected to begin in April 2024.
- SSI/SSDI Outreach, Access and Recovery (SOAR) is a SAMHSA initiative that provides technical assistance and a training program that identifies and removes barriers faced by persons who are homeless, at risk of becoming homeless, and who have difficulties accessing benefits. A contract

with Louisiana Housing Corporation was established to employ this initiative within each Region (9) of the State. The goal is to assist individuals not connected to a program that provides assistance with applying for SSI/SSDI benefits and obtaining documents (birth certificates, Identifications and Social Security cards) required to receive other mainstream benefits they may be entitled to.

- Expansion of Medications for Opioid Use Disorder (MOUD) - The Department seeks to enhance Louisiana's substance use and opioid response efforts by increasing access to evidence-based behavioral health treatment services. OBH seeks to expand the number of Opioid Treatment Providers (OTPs) by opening additional clinics within the state of Louisiana. In addition, OBH will increase access to MOUD by expanding hours of operations at four OTPs.
- Expansion of Residential Programs for Women, Pregnant Women and Women with Children -OBH is enhancing the network of residential SUD treatment programs for women, pregnant women and women with dependent children, through infrastructure enhancements of the three existing facilities and the opening of additional new facilities. These efforts will help to increase access to residential treatment services for this vulnerable population.
- Collegiate Recovery Programs (CRP) – OBH partnered with Florida Parishes Human Services Authority (FPHSA), Southeastern University and the Board of Regents (BoRs) to expand the Collegiate Recovery Program statewide. The expansion will support the two existing CRP efforts along with the development of five additional CRPs. CRPs will provide a safe environment for students on college campuses to help deter and support them from returning to drugs and alcohol. The CRPs will build student achievement by offering specialized and strategic supportive services to help students achieve growth and success with their recovery and academic journeys. The students identified as being in recovery will have a facility designed with them in mind and staff will be onsite to assist as needed. The facility and staff will provide support and resources that play a critical role in relapse prevention. The CRPs have the potential to directly impact student success, engagement, resiliency, and retention. Implementation of this initiative began July 1, 2023. The selected higher education institutions include the following: Southeastern University, Tulane University, Southern University Law Center, Grambling University, Louisiana State University and River Parishes Community College.
- Campus Peers in Higher Education Settings – In 2023, OBH established contract partnerships with three (3) NAMI affiliates throughout the state to support students with behavioral health and/or emotional challenges on campus. Through this partnership, trained Campus Peers will be available to a maximum of 12 universities throughout the state. Trained Campus Peers will provide support, guidance and referrals to students who are experiencing behavioral health and/or emotional challenges as they transition to this next phase in their early adulthood.
- Harm Reduction Portal - OBH partnered with the Office of Public Health to develop a new Narcan/Harm Reduction Hub and Spoke Model. With this model, the state created a centralized distribution site (Hub), which performs as an electronic mechanism (website portal) to request Narcan and other harm reduction products, report data, and obtain education and training. Organizations across the state will register as local distribution sites (Spokes). Spokes will request harm reduction products, including Narcan, safe storage and disposal products, fentanyl testing strips (FTS), nalox-boxes, Narcan vending machines, and more, to distribute these essential items to identified areas in need. All requesting organizations are required to complete training as part

of the agreement to distribute Narcan on behalf of the project. This Hub and Spoke Model is instrumental in maximizing Narcan distribution and other harm reduction/prevention materials within Louisiana per the state's naloxone saturation plan.

Data:

- 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 as fortunate and do not have continuity of activities or membership.
- 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, to include online data access to public and private providers and the community.
- The Core Alcohol and Drug Survey has been administered since 2007. The survey was developed to measure alcohol and other drug usage, attitudes, and perceptions among college students at two and four-year institutions. The survey includes several types of items about drugs and alcohol. One component deals with student attitudes, perceptions, and opinions about alcohol and other drugs, and the other deals with students own use and consequences of use.
- The Louisiana Caring Communities Youth Survey (CCYS) is designed to assess student involvement in a specific set of problem behaviors, as well as their exposure to a set of scientifically validated risk and protective factors. These risk and protective factors have been shown to indicate the likelihood of academic success, school dropout, substance use, violence, and delinquency among youth. The survey, which has been implemented since 1998, is administered every two years to Louisiana students in grades 6, 8, 10, and 12. Reports are compiled and generated for the state, regional, school-level (only available to the Department of Education), and parish level.
- The University of Louisiana at Lafayette, Picard Center will conduct a study to determine the prevalence of problem and pathological gambling behaviors, attitudes about gambling, knowledge of gambling interventions and resources for those who need assistance, and gambling infrastructure throughout the state. This study will allow OBH to obtain current rates, assess the distribution of problem gambling across the state, and conduct a trend analysis of gambling rates over time.
- Tulane University Department of Psychiatry and Behavioral Health will conduct a needs assessment to analyze the current capacity and unmet needs of substance use disorder (SUD) treatment in the state of Louisiana for adults, adolescents, and youth. The needs assessment will consist of a review of existing epidemiological data, interviews with key stakeholders, and surveys of individuals with knowledge of and interest in opioid-related issues and SUD. Through this assessment, Tulane will identify gaps in service delivery for SUD treatment, propose means to provide access to a full continuum of SUD services across the state, and delineate a strategy for enhancing SUD provider treatment capacity statewide.

Ongoing:

- Louisiana has statewide coverage through the Compulsive and Problem Gaming Fund that provides free gambling treatment to Louisiana residents. Louisiana offers outpatient and residential treatment for individuals with gambling disorder. All residents that seek treatment for behavioral health issues within the OBH provider network are screened for problem

gambling. Those individuals that screen positive for problem gambling are offered an opportunity to meet with a Certified Compulsive Gambling Counselor (CCGC). The Compulsive and Problem Gaming Fund also provides funding for the Louisiana Problem Gambling Helpline, which is used to assist individuals, whether it be someone with a gambling problem, or others seeking help for someone with a gambling problem. The Louisiana Problem Gambling Helpline links individuals to the appropriate gambling treatment services throughout the state. In addition, the Compulsive and Problem Gaming Fund supports training for Gambling Treatment Coordinators statewide so they can receive the latest standards and best practices to treat a gambling disorder.

- The Tobacco Tax Health Care Fund provides tobacco cessation treatment to Louisiana residents, free of charge. This includes access to nicotine replacement therapy (NRT) including nicotine patches, lozenges and gum. All those that seek treatment for any behavioral health condition are screened for tobacco usage. Those that screen positive are offered the opportunity to participate in Tobacco Cessation Treatment. The Tobacco Tax Health Care fund also supports Tobacco Quitline Services, by providing telephone and web-based tobacco cessation coaching to individuals who are considering quitting tobacco products. To further support workforce development, the Tobacco Tax Health Care fund supports Tobacco Cessation Specialist training statewide. In addition, this fund supports a partnership with the Office of Alcohol and Tobacco Control to conduct consummated tobacco compliance checks, to ensure that underage youth are unable to purchase tobacco products.
- The C'est Bon program is a peer-to-peer process of surveying recipients of state funded 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. Once the data from the surveys is analyzed, a report is prepared and posted in the clinics for service recipients to view the program's performance. This supports total transparency in consumer satisfaction surveys and ongoing improvements. The C'est Bon program was suspended in FY 21 due to the pandemic. In March 2022 the program resumed operations and has conducted surveys with all 10 local governing entities (LGEs).
- 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. In March 2021, the initial phase of Medicaid reimbursement for Peer Support Services was implemented, with LGEs being the first provider type allowed to bill Medicaid for these services. As the initial phase of implementation has been closely monitored, OBH has worked with Medicaid and other stakeholders to plan future phases of implementation for Peer Services within SFY24. In SFY24, LDH/OBH is planning to expand Medicaid reimbursement for Peer Support Services to the Permanent Supportive Housing (PSH) providers throughout the state. This expansion would continue to support some of the most vulnerable populations needing behavioral health services and the DOJ Agreement target population. During SFY21, OBH also obtained approval to hire nine (9) additional Peer Support Specialists [called Peer In Reach Specialists (PIRS)] to support the My Choice LA (MCL) initiative to provide additional supports to individuals with serious mental illness (SMI) who are transitioning from a nursing facility or diversion from nursing facility placements. Through these efforts, PIRS meet with individuals affiliated with the MCL program,

inquiring about their interest in moving into the community, linking them to a transition coordinator, and supporting the transition process. These activities remain ongoing and will continue throughout SF24 and beyond.

- The Addiction Treatment Locator, Assessment, and Standards Platform (ATLAS) is Louisiana's free online SUD treatment locator, launched in July 2020. ATLAS is the product of a two-year, six-state pilot with the national nonprofit Shatterproof and has since increased to being available in 14 states. Louisiana ATLAS-related efforts include:
    - refining and expanding the information available on the website
    - increasing awareness of ATLAS as a treatment locator resource for the public and providers
    - distributing over 250,000 resource cards of vital statewide behavioral health and resource contact information
    - increasing SUD provider participation in ATLAS. Currently 64% of facilities are participating.
- Single Preferred Drug List (PDL) - Opioid antagonist and partial agonist medications are now available without prior authorization to all Medicaid recipients and providers.
- 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.
- Increased professional and workforce development trainings.
- Increased access to MOUD – All residential providers enrolled in the Medicaid managed care program are required to provide MOUD onsite or facilitate access to MOUD offsite which includes coordinating with the member's health plan for referring to available MOUD 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 enrollees ages 18 and older diagnosed with opioid use disorder.
- Supported Employment - In an effort to enhance integrated day activities and improve employment outcomes for individuals with behavioral health conditions, OBH developed a Medicaid-reimbursable supported employment service, Individual Placement and Support (IPS), which is an evidence-based supported employment model designed for individuals with serious mental illness. In 2022, IPS became Medicaid reimbursable for the My Choice Louisiana target population. IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing. To support OBH's ongoing efforts to grow the IPS model statewide, OBH participates in the IPS Learning Community with dozens of other states that have implemented this evidence-based model. In 2022, OBH also applied for and was selected as an Advancing State Policy Integration for Recovery and Employment (ASPIRE) grant participant to be provided with technical assistance from national experts to support further growth of the IPS model in Louisiana.
- Created opportunities and collaborations between Emergency Departments (ED) and the LGEs across the state, to place Peer Support Specialist within EDs. This model will assist in the identification, engagement and referral to treatment for persons that experienced an overdose.

Needs

- Accessible housing for individuals with behavioral health diagnoses.
- Integrated services for patients with intellectual disabilities, mental health issues and substance use disorders, particularly at residential levels of care (inpatient settings, PRTFs, and therapeutic group home settings).
- Data system updates to enhance data collection capacity.
- Expansion of transitional facilities from inpatient to community with a particular focus on housing resources. As individuals with SMI transition from institutional settings to the community, many require added supports and services to be successful in the community. In addition to needing housing supports, many individuals do not have social or family supports to navigate the systems to obtain primary and/or behavioral healthcare, mainstream benefits, job skills or other necessary services and supports. Addressing these areas can decrease re-institutionalization amongst those needing behavioral health services.
- Through its My Choice Louisiana transition coordination initiative, there has been an identified need for in-home Personal Care Assistant (PCA) services for those program participants who do not meet eligibility for existing home and community based service (HCBS) programs.
- While crisis services for adults 21 and older on Medicaid have recently been funded, robust crisis systems are most impactful when they serve the population as a whole. As such, there is the need to expand eligibility to other populations including those without Medicaid. Additionally, it is critical to ensure the availability of a robust 24/7 crisis call center which has the ability to triage and dispatch calls to the newly developed crisis services.
- Enhanced integration initiatives are needed, as studies show coordinating and integrating primary and behavioral healthcare can improve quality and length of life, especially for individuals suffering from an SMI or SUD.
- Expansion of providers to offer Medication for Opioid Use Disorder (MOUD).
- Engagement and expansion of the behavioral health workforce.
- Increased transportation opportunities for those without access to public transportation.
- Narcan distribution within Emergency Departments, to include peer navigators.
- Development of a Youth Crisis System
- Expansion of psychiatric Residential Treatment Facility (PRFT).

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 151 measures shared in the National Healthcare Quality Report (NHQR). Of these 151 measures, Louisiana has 33 measures that are considered "far away from benchmark," which means a state's value for a measure has not achieved 50% of the benchmark. 8 of these 33 "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 use who completed treatment course	13.9	65.2	79%
Suicide deaths among persons age 12 and over per 100,000 population	16.6	9.4	77%
Drug overdose deaths involving natural and semisynthetic opioids per 100,000 resident population	5.6	1.9	193%
Hospital inpatient stays involving opioid-related diagnoses per 100,000 population	263.8	102.9	156%
Drug overdose deaths involving any opioid per 100,000 resident population	21.5	4.3	398%
HIV infection deaths per 100,000 population	2.7	8.8	260%
New HIV cases per 100,000 population age 13 and over	22.8	4.2	443%
Drug overdose deaths involving other synthetic opioids (other than methadone) per 100,000 resident population	16.2	0.7	2113%

Data source: State snapshots from 2022 National Healthcare Quality and Disparities Reports through Agency for Healthcare Research and Quality (AHRQ) *https://datatools.ahrq.gov/nhqdr?tab=state&dash=29*

Per the Kaiser State Health Facts (2021)[2], 15.7% of the adult population in Louisiana reported poor mental health 14+ days per month. This is higher than the United States' adult population, reported at 13.4%.

Based on data from the CDC WONDER Online Database[3], the 2022 Annual Report by America's Health Rankings reports Louisiana is ranked as 50th among the states in its High-risk HIV Behaviors (ages 18+)

[2] https://www.kff.org/statedata/;

[3] https://www.americashealthrankings.org/explore/measures/HIVriskbehaviors America's Health Rankings analysis of CDC, Behavioral Risk Factor Surveillance System, United Health Foundation, AmericasHealthRankings.org, accessed 2023.

rate. The definition of the indicator is the percentage of adults who reported any of the following in the past year: injected any drug other than those prescribed for you; treated for a sexually transmitted disease; or given or received money or drugs in exchange for sex. The State's value is 7.3%, while the U.S. values is 5.6%. Value is a sum of weighted, ranking measure z-scores (the number of standard deviations a state value was above or below the U.S. value).

In the Annie E. Casey Foundation Kids Count Data Book (KIDS Count, 2023), Louisiana continued to rank near the bottom of the nation in terms of child health, education, family/community and economic well-being, ranking 49th overall in the nation. This overall ranking is worse than the 2021 publication. Louisiana ranked worse than the nation for the following indicators:

Indicators	Louisiana	United States
Economic Well-Being Indicators (Rank = 50th)		
• Children in poverty: 2021	27%	17%
• Children whose parents lack secure employment: 2021	35%	29%
• Teens (16-19 years) not in school and not working: 2021	11%	7%
Education Indicators (Rank = 43rd)		
• Fourth graders not proficient in reading: 2022	72%	68%
• Eighth graders not proficient in math: 2022	81%	74%
• High school students not graduating on time: 2019-2020	17%	14%
Health Indicators (Rank = 49th)		
• Low-birth weight babies: 2021	11.3%	8.5%
• Child and teen deaths per 100,000: 2021	52	30
• Children and teens (ages 10-17) overweight or obese: 2020-2021	39%	33%
Family and Community Indicators (Rank = 49th)		
• Children in single-parent families: 2021	45%	34%
• Children living in high-poverty areas: 2017-2021	19%	8%
• Teen births per 1,000: 2019	25	14

Data source: Indicator percentages from http://datacenter.kidscount.org/. Ranks from 2023 KIDS Count Data Book.

Prevalence Estimates and Person Served

According to the U.S. Census Bureau (Annual Estimates of the Resident Population for Selected Age Groups by Sex for Louisiana: April 1, 2020 to July 1, 2022 and Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for Louisiana: April 1, 2020 to July 1, 2022), there were estimated 4,627,098 individuals in Louisiana including 1,074,840 children/youth (ages 0-17) and 3,552,258 adults (ages 18+).

2021 Louisiana Demographics Estimates			
Race	**Estimate**	**Age**	**Estimate**
American Indian/Alaska Native	37,740	0-17	1,074,840
Asian	87,747	18-24	436,040
Black/African American	1,519,906	25-44	1,229,188
Native Hawaiian/Other Pacific Islander	3,004	45-64	1,123,689

White	2,893,307
More than One Race Reported	85,394

65 & Over	763,341

Ethnicity	Estimate
Hispanic or Latino	259,802
Not Hispanic or Latino	4,367,296

Gender	Estimate
Female	2,359,235
Male	2,267,863

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 *URS Table 1: Number of Adults with Serious Mental Illness (SMI), age 18 and older, and Number of Children with a Serious Emotional Disturbance (SED), age 9 to 17, by State, 2021*, 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, categorized by LGE regions, are shown in the following tables. Caution should be used when utilizing these figures, as they are estimates.

2021 LOUISIANA SMI & SED PREVALENCE* ESTIMATES						
LGE	SED Child/Youth (9-17[£])		SMI Adult (18+)		Total SMI & SED	
	General Population (9-17)	Estimated Prevalence (7%* of 9-17 Years Population)	General Population (18+)	Estimated Prevalence (5.4%* of 18+ Population)	General Population (9 and Over)	Total Estimated Prevalence
MHSD	43,211	3,025	353,972	19,114	397,183	22,139
CAHSD	75,149	5,260	537,652	29,033	612,801	34,294
SCLHSA	45,278	3,169	297,361	16,057	342,639	19,227
AAHSD	70,871	4,961	447,549	24,168	518,420	29,129
IMCAL	35,467	2,483	227,653	12,293	263,120	14,776
CLHSD	33,528	2,347	223,492	12,069	257,020	14,416
NLHSD	59,101	4,137	396,953	21,435	456,054	25,573
NEDHSA	39,083	2,736	267,399	14,440	306,482	17,175
FPHSA	72,108	5,048	461,824	24,938	533,932	29,986
JPHSA	45,009	3,151	338,403	18,274	383,412	21,424
TOTAL	**518,802**	**36,316**	**3,552,258**	**191,822**	**4,071,060**	**228,138**

[£] census.gov (https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-detail.html): Annual County and Puerto Rico Municipio Resident Population Estimates by Selected Age Groups and Sex: April 1, 2020 to July 1, 2022 (CC-EST2022-AGESEX).

SMI/SED Prevalence Estimates 2021 (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, 2021) listed SMI Prevalence= 5.4%; SED Prevalence= 7% for Louisiana.

Individuals with SMI/SED are considered to be the target population for MH 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 2021			FY 2022		
	YOUTH (9-17)	ADULT (18+)	TOTAL*	YOUTH (9-17)	ADULT (18+)	TOTAL*
MHSD & EPIC-NOLA Program✪	719	4,374	5,253	633	4,072	4,817
CAHSD	942	3,908	5,040	1,136	5,035	6,364
SCLHSA	1,438	8,085	9,790	1,350	7,054	8,657
AAHSD	418	4,839	5,351	566	4,537	5,219
IMCAL	540	2,600	3,277	653	3,078	3,862
CLHSD	198	2,203	2,430	329	2,563	2,946
NWLHSD	230	1,310	1,566	262	1,579	1,879
NEDHSA	37	1,074	1,115	56	1,335	1,394
FPHSA	503	4,349	4,913	497	4,301	4,852
JPHSA	914	4,412	5,450	929	4,246	5,307
TOTAL	**5,939**	**37,154**	**44,185**	**6,411**	**37,800**	**45,297**

Data Source: LGE EHR data sent to OBH. Age at end of reporting time period. Unduplicated by client within LGE.
✪ EPIC-NOLA (program through Sinfonia Family Services of Louisiana in conjunction with Tulane University). Serves Orleans, St. Bernard, Plaquemines Parishes. *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 2021			FY 2022		
	Child/Youth with SED	Total Served	% SED	Child/Youth with SED	Total Served	% SED
MHSD & EPIC-NOLA Program✪	295	719	41%	268	633	42%
CAHSD	381	942	40%	374	1,136	33%
SCLHSA	737	1,438	51%	767	1,350	57%
AAHSD	367	418	88%	453	566	80%
IMCAL	328	540	61%	333	653	51%
CLHSD	130	198	66%	227	329	69%
NWLHSD	156	230	68%	177	262	68%
NEDHSA	8	37	22%	16	56	29%
FPHSA	234	503	47%	231	497	46%
JPHSA	339	914	37%	363	929	39%
TOTAL	**2,975**	**5,939**	**50%**	**3,209**	**6,411**	**50%**

Data Source: LGE EHR data sent to OBH. Age at end of reporting time period. Unduplicated by client within LGE.
✪ EPIC-NOLA (program through Sinfonia Family Services of Louisiana in conjunction with Tulane University). Serves Orleans, St. Bernard, Plaquemines Parishes. 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 2021**			**FY 2022**		
	Adults with SMI	**Total Served**	**% SMI**	**Adults with SMI**	**Total Served**	**% SMI**
MHSD & EPIC-NOLA Program✪	1,562	4,374	36%	1,798	4,072	44%
CAHSD	1,289	3,908	33%	1,386	5,035	28%
SCLHSA	2,943	8,085	36%	2,138	7,054	30%
AAHSD	2,737	4,839	57%	2,566	4,537	57%
IMCAL	836	2,600	32%	1,116	3,078	36%
CLHSD	782	2,203	35%	845	2,563	33%
NWLHSD	654	1,310	50%	859	1,579	54%
NEDHSA	330	1,074	31%	376	1,335	28%
FPHSA	1,063	4,349	24%	1,039	4,301	24%
JPHSA	959	4,412	22%	894	4,246	21%
TOTAL	**13,155**	**37,154**	**35%**	**13,017**	**37,800**	**34%**

Data Source: LGE EHR data sent to OBH. Age at end of reporting time period. Unduplicated by client within LGE.
✪ EPIC-NOLA (program through Sinfonia Family Services of Louisiana in conjunction with Tulane University). Serves Orleans, St. Bernard, Plaquemines Parishes. 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 2,975 children and youth (ages 9-17) with SED were served at the end of FY 2021, revealing that 7.38 % of the estimated children with SED were being served in LGE clinics. OBH data also reported 13,155 adults with SMI were served at the end of FY 2021, revealing that 7.8 % 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 2021						
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 & EPIC-NOLA Program✪	295	3,025	1,562	19,114	1,857	8%
CAHSD	381	5,260	1,289	29,033	1,670	5%
SCLHSA	737	3,169	2,943	16,057	3,680	19%
AAHSD	367	4,961	2,737	24,168	3,104	11%
IMCAL	328	2,483	836	12,293	1,164	8%
CLHSD	130	2,347	782	12,069	912	6%
NWLHSD	156	4,137	654	21,435	810	3%
NEDHSA	8	2,736	330	14,440	338	2%
FPHSA	234	5,048	1,063	24,938	1,297	4%
JPHSA	339	3,151	959	18,274	1,298	6%
TOTAL	**2,975**	**36,316**	**13,155**	**191,822**	**16,130**	**7%**

Data Source: LGE EHR data sent to OBH. Age at end of reporting time period. Unduplicated by client within LGE.
✪ EPIC-NOLA (program through Sinfonia Family Services of Louisiana in conjunction with Tulane University). Serves Orleans, St. Bernard, Plaquemines Parishes. 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), Federal Bureau of Investigations, Louisiana State University, and Louisiana Department of Health. Distributions of the data collected by the Local Governing Entities (LGEs) through their electronic health records (EHRs) and Louisiana Addictive Disorders Data Systems (LADDS), and Inpatient Psychiatric Hospital's Patient Information Program (PIP), were also analyzed to estimate the percentage of people who received 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 LGE's 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

9 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.
- Counts for Depressive Disorder Diagnosis were from mental health diagnoses in each episode of care for each client from LGE Electronic Health Record (EHR) system, Inpatient Psychiatric Hospital's Patient Information Program (PIP) system and Group Homes from ELMHS. One client may have multiple episode of care, with multiple diagnoses. One episode of care may be counted more than one time in different diagnostic categories (not-unduplicated).
- Counts Cannabis-related Disorder were from substance use disorder diagnoses in each episode of care for each client from LGE Electronic Health Record (E HR) system and Louisiana Addictive Disorders Data Systems (LADDS). One client may have multiple episode of care, with multiple diagnoses. One episode of care may be counted more than one time in different diagnostic categories (not-unduplicated).

Treatment Needs Assessment Summary Matrix

				TOTAL POPULATION		INJECTING DRUG USERS		WOMEN		PREVALENCE OF SUBSTANCE-RELATED CRIMINAL ACTIVITY		TOP BEHAVIORAL HEALTH DISEASE DIAGNOSES		INCIDENCE OF COMMUNICABLE DISEASE
LGE	Population[1]	9+ Population[1]	Female 9+ Population[6]	Needing Treatment Services[2]	That would seek treatment[3]	Needing Treatment Services[4]	That would seek treatment[5]	Needing Treatment Services[7]	That would seek treatment[8]	Number of DWI Arrests[9] (Age>=21, BAC >=0.08)	Number of Alcohol-related Driving Deaths[10]	MENTAL HEALTH (DEPRESSIVE DISORDER)[11]	SUBSTANCE USE (Cannabis Related Disorder)[12]	# Chlamydia Cases[13]
MHSD	444,677	397,183	209,770	61,960	4,213	1,192	81	32,724	2,225	13,046	83	1,255	560	5,457
CAHSD	694,796	612,801	314,458	95,597	6,501	1,838	125	49,055	3,336	25,459	214	581	336	5,458
SCLHSA	389,680	342,639	174,484	53,452	3,635	1,028	70	27,219	1,851	21,853	126	738	271	3,000
AAHSD	594,382	518,420	265,522	80,873	5,499	1,555	106	41,421	2,817	19,620	169	1,596	498	3,710
IMCAL	301,830	263,120	131,843	41,047	2,791	789	54	20,567	1,399	14,632	93	1,535	584	1,837
CLHSD	293,666	257,020	126,687	40,095	2,726	771	52	19,763	1,344	16,044	85	771	281	2,245
NLHSD	518,474	456,054	236,206	71,144	4,838	1,368	93	36,848	2,506	24,866	133	494	468	4,818
NEDHSA	347,742	306,482	156,994	47,811	3,251	919	63	24,491	1,665	16,370	87	211	76	3,389
FPHSA	607,922	533,932	272,708	83,293	5,664	1,602	109	42,542	2,893	26,614	179	1,392	630	3,187
JPHSA	433,929	383,412	198,281	59,812	4,067	1,150	78	30,932	2,103	13,723	51	664	207	3,146
TOTAL	**4,627,098**	**4,071,060**	**2,086,950**	**635,085**	**43,186**	**12,213**	**830**	**325,564**	**22,138**	**192,227**	**1,220**	**9,237**	**3,911**	**36,247**

[1] The estimates for Population and 9+ Population by LGE service area were obtained from *U.S. Census Bureau* (*Annual Estimates of the Resident Population for Selected Age Groups by Sex for Louisiana: April 1, 2020 to July 1, 2022).*

[2] According to NSDUH (https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect5pe2021.htm) , 15.6% of the population aged 12 or older needed substance use treatment in the past year. The 12+ population for each SPA was multiplied by 15.6% to estimate the number of people *needing treatment* services. Source: ***Table 5.39B*** – *Classified as Needing Substance Use Treatment: Among People Aged 12 or Older; Receipt of Substance Use Treatment at a Specialty Facility in Past Year: Among People Aged 12 or Older Classified as Needing Substance Use Treatment; by Demographic Characteristics, Percentages, 2021*.

[3] According to NSDUH, 6.8% of those who needed substance abuse treatment, *received* treatment at a specialty facility in the past year. Source: ***Table 5.39B*** – Classified as Needing Substance Use Treatment: Among People Aged 12 or Older; Receipt of Substance Use Treatment at a Specialty Facility in Past Year: Among People Aged 12 or Older Classified as Needing Substance Use Treatment; by Demographic Characteristics, Percentages, 2021. This 6.8% was used to estimate the Total Population that Would *Receive* 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 Stated is .30% *(Table 3. Estimated proportion of persons who injected drugs (PWID) in the past year, by survey and combined by meta-analysis, United States.)* http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0097596 . The 12+ Population for each SPA was multiplied by .003 to estimate the number of IVDU's needing treatment services.

[5] The estimate of 6.8% that was used to calculate the number of people that would need treatment in total population was also used to determine the *Number of IDU's that Would Seek Treatment*. The number of *IDUs* that will seek treatment was obtained by multiplying each SPA category of IVDU needing treatment services by 6.8%.

[6] An estimate for the Female 9+ Population by SPA was obtained from https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-detail.html): Annual County and Puerto Rico Municipio Resident Population Estimates by Selected Age Groups and Sex: April 1, 2020 to July 1, 2022 (CC-EST2022-AGESEX).

[7] Information from the 2021 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 15.6% that used to calculate the number of total population needing treatment was also used to estimate the number of women (females 9+) in need of treatment. The number of women needing treatment services for each SPA was obtained by multiplying female 9+ population of each SPA category by 15.6%.

[8] The estimate of 6.8% that was used to calculate the number of people that would seek/received treatment was also used to determine the Number of Women that Would Seek/Received Treatment. The number of women that will seek treatment was obtained by multiplying each SPA category of women needing treatment services for by 6.8%.

[9] The estimates for Number of DWI Arrests for 2021 were obtained from the Louisiana State University, Highway Safety Research Group's *2021 Number of Arrests and DWI by Parish Report* (Age>=21 BAC>=.08*)* at https://carts.lsu.edu/datareports/report/dwi .

[10] Information from the *https://www.countyhealthrankings.org/explore-health-rankings/louisiana/data-and-resources* was used to list the **Alcohol-Impaired Driving Deaths**.

[11] **Mental Health: Count of Depressive Disorder Diagnosis in Episode of Care in CY 2021.** Count of mental health diagnoses in each episode of care for each client from LGE *Electronic Health Record (EHR)* system, Inpatient Psychiatric Hospital's *Patient Information Program (PIP)* system and *Group Homes from ELMHS*. One client may have multiple episode of care, with multiple diagnoses. One episode of care may be counted more than one time in different diagnostic categories (not-unduplicated).

[12] **Substance Use Disorder: Count of Alcohol-related Disorder in Episode of Care in CY2021.** Count of substance use disorder diagnoses in each episode of care for each client from LGE *Electronic Health Record (EHR)* system and *Louisiana Addictive Disorders Data Systems (LADDS)*. One client may have multiple episode of care, with multiple diagnoses. One episode of care may be counted more than one time in different diagnostic categories (not-unduplicated).

[13] **2021 # Chlamydia Cases:** Information from the *https://www.countyhealthrankings.org/explore-health-rankings/louisiana/data-and-resources* was used.

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 2021 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 2021					
LGE	**Needing Treatment Services**	**That would seek treatment**	**Admissions**	**Total Served**	**Percent of Prevalence Served**
MHSD	61,960	4,213	644	853	1.4%
CAHSD	95,597	6,501	1,029	1,269	1.3%
SCLHSA	53,452	3,635	2,666	3,561	6.7%
AAHSD	80,873	5,499	1,652	2,476	3.1%
IMCAL	41,047	2,791	760	861	2.1%
CLHSD	40,095	2,726	833	1,041	2.6%
NLHSD	71,144	4,838	1,265	1,441	2.0%
NEDHSA	47,811	3,251	2,207	2,516	5.3%
FPHSA	83,293	5,664	1,251	1,617	1.9%
JPHSA	59,812	4,067	632	905	1.5%
TOTAL	**635,085**	**43,186**	**12,939**	**16,540**	**2.6%**

Data Source: Needing and Seeking Treatment: Table 5.39B – Classified as Needing Substance Use Treatment: Among People Aged 12 or Older; Receipt of Substance Use Treatment at a Specialty Facility in Past Year: Among People Aged 12 or Older Classified as Needing Substance Use Treatment; by Demographic Characteristics, Percentages, 2021).
Admissions and Total Served: LADDS and LGE EHR data sent to OBH.

Substance Use Disorder Treatment for Women (Females ages 12+) – FY 2021					
LGE	**Needing Treatment Services**	**That would seek treatment**	**Admissions**	**Total Served**	**Percent of Prevalence Served**
MHSD	32,724	2,225	215	290	0.9%
CAHSD	49,055	3,336	426	533	1.1%
SCLHSA	27,219	1,851	1,159	1,612	5.9%
AAHSD	41,421	2,817	796	1,309	3.2%
IMCAL	20,567	1,399	379	432	2.1%
CLHSD	19,763	1,344	271	350	1.8%
NLHSD	36,848	2,506	467	559	1.5%
NEDHSA	24,491	1,665	662	789	3.2%
FPHSA	42,542	2,893	588	791	1.9%
JPHSA	30,932	2,103	255	396	1.3%

Data Source: Needing and Seeking Treatment: 2021 NSDUH Survey (Table 5.39B).
Admissions and Total Served: LADDS and LGE EHR data sent to OBH.

Persons Who Inject Drugs – FY 2021					
LGE	**Needing Treatment Services**	**That would seek treatment**	**Admissions**	**Total Served**	**Percent of Prevalence Served**
MHSD	1,192	81	92	134	11.2
CAHSD	1,838	125	36	45	2.4
SCLHSA	1,028	70	202	235	22.9
AAHSD	1,555	106	197	237	15.2
IMCAL	789	54	30	36	4.6
CLHSD	771	52	131	147	19.1
NLHSD	1,368	93	226	245	17.9
NEDHSA	919	63	429	500	54.4
FPHSA	1,602	109	49	57	3.6
JPHSA	1,150	78	44	71	6.2
TOTAL	**12,213**	**830**	**1,436**	**1,707**	**14.0**

Data Source:

- Information from a meta- analysis conducted by the CDC and published in 2014 was used to estimate Number of IDU's Needing Treatment Services by SPA. In Research Article: *Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis to Calculate National Rates of HIV and Hepatitis C Virus Infections* the combined estimated rate for injection drug use in the United Stated is .30% *(Table 3. Estimated proportion of persons who injected drugs (PWID) in the past year, by survey and combined by meta-analysis, United States.)* http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0097596 . The 12+ Population for each SPA was multiplied by .003 to estimate the number of IVDU's needing treatment services.
- Seeking Treatment: 2021 NSDUH Survey (Table 5.39B).
- Admissions and Total Served: LADDS and LGE EHR data sent to OBH.

Demographics Profile of SUD Population Served – FY 2021	
Race/Ethnicity	**% Served**
ALASKA NATIVE	0.05%
AMERICAN INDIAN	0.94%
ASIAN	0.32%
BLACK/AFRICAN AMERICAN	35.02%
MORE THAN ONE RACE REPORTED	0.59%
NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER	0.23%
OTHER SINGLE RACE	1.12%
UNKNOWN	1.82%
WHITE	59.90%
Hispanic or Latino	2.38%
Not Hispanic or Latino	95.11%
Unknown	2.52%

Age	% Served
0 - 17	3.43%
18 - 24	9.75%
25 - 44	55.77%
45 - 64	28.37%
65 and over	2.68%

Gender	% Served
Male	57.08%
Female	42.92%

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 use 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.

State Epidemiology Workgroup	
Core Member Agencies	
Governor's Office of Drug Policy	LA Department of Health, Office of Public Health
Center for Analytics and Research in Transportation Safety at LSU	LA Department of Justice, Office of the Attorney General
Historically Black Colleges & Universities Rep	LA Department of Public Safety, Louisiana Highway Safety Commission
LA Center Addressing Substance Use in Collegiate Communities	LA Department of Public Safety, Louisiana State Police
Social Research and Evaluation Center (SREC) at LSU	LA Department of Revenue, Office of Alcohol and Tobacco Control
LA Department of Education	U.S. Drug Enforcement Administration
LA Department of Health, Office of Behavioral Health	University of Louisiana at Lafayette, Picard Center for Child Development
Of-Counsel Member Agencies	
Capital Area Human Services District	Governor's Office of Elderly Affairs
Louisiana Commission on Law Enforcement	LA Department of Veterans Affairs
LA Department of Children & Family Services	

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 2022 into spring 2023. The results for the state of Louisiana are presented along with comparisons to 2018 and 2020 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 use, 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 2022 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

On how many occasions (if any) have you...		6th				8th				10th				12th			
		State	State	State	MTF	State	State	State	MTF	State	State	State	MTF	State	State	State	MTF
(One or more occasions)		2018	2020	2022	2022	2018	2020	2022	2022	2018	2020	2022	2022	2018	2020	2022	2022
Lifetime alcohol	had alcoholic beverages (beer, wine, or hard liquor) to drink in your lifetime -- more than just a few sips?	17.3	16.5	14.7	~	35.5	29.1	23.9	23.1	53.2	40.9	34.6	41.1	60.5	48.4	41.6	61.6
Past 30 day alcohol	had beer, wine, or hard liquor to drink during the past 30 days?	5.9	5.8	5.1	~	14.8	12.3	10.1	6.0	29.1	19.3	17.1	13.6	37.5	26.8	22.7	28.4
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)	3.7	3.5	3.5	~	7.5	6.7	5.7	2.2	16.3	10.8	9.7	5.9	22.1	15.3	13.0	12.6
Lifetime cigarettes	Have you ever smoked cigarettes?	6.2	5.4	4.9	~	14.9	10.5	7.3	6.1	21.9	13.5	9.0	10.2	28.1	15.9	12.9	16.8
Past 30 day cigarettes	How frequently have you smoked cigarettes during the past 30 days?	1.1	1.0	0.8	~	3.1	1.8	1.2	0.8	5.8	2.9	1.7	0.7	9.3	3.4	3.1	4.0
1/2 pack of cigarettes/day	During the past 30 days, how many cigarettes did you smoke per day? (About one-half pack a day or more)	0.2	0.2	0.3	~	0.4	0.2	0.2	0.1	1.0	0.5	0.5	0.3	1.8	0.4	0.8	0.9
Lifetime chewing tobacco	used smokeless tobacco (chew, snuff, plug, dipping tobacco, chewing tobacco) in your lifetime?	4.1	3.5	3.1	~	8.3	6.6	4.5	3.9	12.4	7.6	5.6	5.8	14.1	8.2	7.1	10.3
Past30 day chewing tobacco	used smokeless tobacco (chew, snuff, plug, dipping tobacco, chewing tobacco) during the past 30 days?	1.4	1.3	1.2	~	3.3	2.3	1.6	1.2	5.5	3.1	2.4	2.5	6.2	3.2	3.1	3.2
Lifetime e-cigarette use	Have you ever tried electronic cigarettes, e-cigarettes, vape pens, or e-hookahs?	11.6	10.7	12.3	~	29.1	23.5	22.1	18.1	43.3	32.9	28.5	29.6	47.0	37.2	33.0	40.7
Past 30 day e-cigarette use	use electronic cigarettes, e-cigarettes, vape pens, or e-hookahs?	5.3	4.1	4.8	~	15.7	11.0	9.7	8.9	26.8	15.8	12.8	17.3	29.5	19.6	15.7	25.6
Lifetime marijuana	used marijuana (grass, pot) or hashish (hash, hash oil) in your lifetime?	1.6	1.5	1.4	~	8.7	6.5	5.7	11.0	21.4	14.2	12.0	24.2	30.6	22.3	18.3	38.3
Past30 day marijuana	used marijuana (grass, pot) or hashish (hash, hash oil) during the past 30 days?	0.5	0.6	0.6	~	3.9	3.0	2.9	5.0	10.7	6.9	6.1	12.1	15.9	11.4	9.9	20.2
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?	4.8	6.2	5.6	~	8.6	9.7	6.6	9.8	6.7	6.6	5.7	7.5	4.2	4.8	3.8	5.8
Past30 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?	2.0	2.0	2.1	~	2.9	2.3	1.8	1.9	1.5	1.1	1.1	1.2	0.8	0.7	0.5	0.7

Table 3. Percentage of Students Who Used Gateway Drugs

On how many occasions (if any) have you...		6th				8th				10th				12th			
(One or more occasions)		State 2018	State 2020	State 2022	MTF 2022	State 2018	State 2020	State 2022	MTF 2022	State 2018	State 2020	State 2022	MTF 2022	State 2018	State 2020	State 2022	MTF 2022
Lifetime alcohol	had alcoholic beverages (beer, wine, or hard liquor) to drink in your lifetime -- more than just a few sips?	17.3	16.5	14.7	~	35.5	29.1	23.9	23.1	53.2	40.9	34.6	41.1	60.5	48.4	41.6	61.6
Past 30 day alcohol	had beer, wine, or hard liquor to drink during the past 30days?	5.9	5.8	5.1	~	14.8	12.3	10.1	6.0	29.1	19.3	17.1	13.6	37.5	26.8	22.7	28.4
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)	3.7	3.5	3.5	~	7.5	6.7	5.7	2.2	16.3	10.8	9.7	5.9	22.1	15.3	13.0	12.6
Lifetime cigarettes	Have you ever smoked cigarettes?	6.2	5.4	4.9	~	14.9	10.5	7.3	6.1	21.9	13.5	9.0	10.2	28.1	15.9	12.9	16.8
Past 30 day cigarettes	How frequently have you smoked cigarettes during the past 30 days?	1.1	1.0	0.8	~	3.1	1.8	1.2	0.8	5.8	2.9	1.7	0.7	9.3	3.4	3.1	4.0
1/2 pack of cigarettes/day	During the past 30 days, how many cigarettes did you smoke per day? (About one-half pack a day or more)	0.2	0.2	0.3	~	0.4	0.2	0.2	0.1	1.0	0.5	0.5	0.3	1.8	0.4	0.8	0.9
Lifetime chewing tobacco	used smokeless tobacco (chew, snuff, plug, dipping tobacco, chewing tobacco) in your lifetime?	4.1	3.5	3.1	~	8.3	6.6	4.5	3.9	12.4	7.6	5.6	5.8	14.1	8.2	7.1	10.3
Past30 day chewing tobacco	used smokeless tobacco (chew, snuff, plug, dipping tobacco, chewing tobacco) during the past 30 days?	1.4	1.3	1.2	~	3.3	2.3	1.6	1.2	5.5	3.1	2.4	2.5	6.2	3.2	3.1	3.2
Lifetime e-cigarette use	Have you ever tried electronic cigarettes, e-cigarettes, vape pens, or e-hookahs?	11.6	10.7	12.3	~	29.1	23.5	22.1	18.1	43.3	32.9	28.5	29.6	47.0	37.2	33.0	40.7
Past 30 day e-cigarette use	use electronic cigarettes, e-cigarettes, vape pens, or e-hookahs?	5.3	4.1	4.8	~	15.7	11.0	9.7	8.9	26.8	15.8	12.8	17.3	29.5	19.6	15.7	25.6
Lifetime marijuana	used marijuana (grass, pot) or hashish (hash, hash oil) in your lifetime?	1.6	1.5	1.4	~	8.7	6.5	5.7	11.0	21.4	14.2	12.0	24.2	30.6	22.3	18.3	38.3
Past30 day marijuana	used marijuana (grass, pot) or hashish (hash, hash oil) during the past 30 days?	0.5	0.6	0.6	~	3.9	3.0	2.9	5.0	10.7	6.9	6.1	12.1	15.9	11.4	9.9	20.2
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?	4.8	6.2	5.6	~	8.6	9.7	6.6	9.8	6.7	6.6	5.7	7.5	4.2	4.8	3.8	5.8
Past30 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?	2.0	2.0	2.1	~	2.9	2.3	1.8	1.9	1.5	1.1	1.1	1.2	0.8	0.7	0.5	0.7

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 66,199 students from 221 institutions who completed the Core Alcohol and Drug Survey Long Form in 2016 to 2018 National Data. More detailed analyses can be found by contacting the Core Institute.

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.

Table 2 describes lifetime prevalence, annual prevalence, 30-day prevalence, and high frequency use (3 times a week or more). **Table 2 - Substance Use**

	Lifetime Prevalence		Annual Prevalence		30-Day Prevalence		3X/Week or more	
Substance	Coll.	Ref.	Coll.	Ref.	Coll.	Ref.	Coll.	Ref.
Tobacco	37.3	33.3	26.5	24.6	19.8	14.9	15.1	6.6
Alcohol	78.5	83.1	72.9	80.3	53.6	67.2	11.3	18.1
Marijuana	47.0	47.5	33.0	36.9	20.4	21.3	11.7	8.4
Cocaine	6.9	8.3	3.3	5.8	1.0	2.4	0.2	0.2
Amphetamines	9.2	7.9	4.0	4.6	2.4	2.4	1.7	1.1
Sedatives	6.5	5.1	2.2	2.7	0.9	1.3	0.5	0.3
Hallucinogens	10.0	7.8	4.7	5.0	1.4	1.3	0.1	0.1
Opiates	2.8	2.0	1.1	1.0	0.7	0.6	0.2	0.2
Inhalants	2.5	1.9	1.1	0.8	0.5	0.5	0.1	0.1
Designer drugs	7.0	6.6	2.1	3.5	0.6	0.9	0.1	0.2
Steroids	1.7	1.0	0.8	0.5	0.6	0.4	0.1	0.2
Other drugs	2.7	2.8	1.1	1.3	0.4	0.6	0.1	0.1

Coll. = Multiple Selection
Ref. = Reference group of 66,199 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 the 2022 CCYS survey, 1.3% of 8th graders, 2.9% of 10th graders, and 4.7% 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.

Primary prevention plans to address gaps and needs by providing the following to providers, sub-recipients, and/or coalitions:

- 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.

As of December 1, 2015, specialized behavioral health services were integrated into the physical health services of the five Healthy Louisiana plans (previously called Bayou Health plans). Magellan, which used to be the Statewide Management Organization (SMO) for specialized behavioral health services for Louisiana until November 31, 2015, is currently responsible for Medicaid specialized behavioral health services for the Coordinated System of Care (CSoC) population (children and youth between 5-20 years).

The OBH Business Intelligence (BI) Section, including the OBH Analytics team, 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 E HR 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 Use-Treatment Episode Data Set (SA-TEDS) and Mental Health (MH) TEDS. Other recurring federal (SAMHSA) reports include annual Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS BG) and Mental Health Block Grant (MHBG) report, MH Universal Reporting System (URS) tables, and bi-annual Combined SUPTRS BG/MHBG Behavioral Health Assessment and Plan.

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

Since December 1, 2015, Magellan's proprietary Electronic Heath Record (EHR), Clinical Advisor (CA) is 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-funded 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 all other statewide reporting.

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 federal reporting requirements. This site is expected to provide a "one-stop" resource for LGEs and OBH staff seeking information on 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 more commonly referred to as SPMI. SMI (SPMI) is a national designation that includes only those individuals suffering from the most severe forms of mental illness.

Estimation Methodology:

- Mental Health – OBH uses prevalence rates for **SMI (5.4%)** and **SED (7%)** from SAMHSA's Uniform Reporting System (URS) *Table 1: Number of Adults with Serious Mental Illness (SMI), age 18 and older, and Number of Children with a Serious Emotional Disturbance (SED), age 9 to 17, by State, 2021*. Each prevalence rate was applied to 2021 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 2021 (https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect5pe2021.htm), the need for substance use treatment in the past year among people aged 12 or older was **15.6%** among the total population. This national percentage was applied to the 2021 Louisiana population to estimate the number of Louisiana citizens needing treatment. NSDUH also reported that **6.8%** 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.

- Population Estimate: State of Louisiana is divided in ten Local Governing Entities (LGEs/Regions), each comprising of several parishes (counties). Parish-level population count, categorized by gender and select age groups are necessary to estimate population for each LGE/Region. In census.gov web portal, no parish/county-level table is available for population in 9-17 years, or 12+ age group (https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-total.html). Moreover, SAMHSA URS Table 1 provides State SED estimate for 9-17 years. Considering these facts and limitations, all parish/county-level population estimates were calculated for age group 9-17 years and 18+ categories, throughout this publication.

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 (SMI) meets the following criteria for Age, Diagnosis, Disability, and Duration.

Age: 18 years of age or older.

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

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

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

6) Exhibits social behavior which results in demand for intervention by the mental health and/or judicial/legal system.

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

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

Mental Health Clients: Child/Youth

A child or youth who has a serious emotional/behavioral disorder (SED) meets the following criteria for Age, Diagnosis, Disability, and Duration as agreed upon by all Louisiana children serving agencies.

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 24-25 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 SUPTRS BG. Please include the following information:

1. Priority area (based on an unmet service need or critical gap).
2. Priority type (SUP– substance use primary prevention, SUT– substance use disorder treatment, SUR – substance use disorder recovery support, MHS– mental health service, ESMI – early serious mental illness, or BHCS – behavioral health crisis services.)
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) BHCS- Individuals in need of behavioral health crisis services,
    e) PWWDC- Pregnant women and women with dependent children who are receiving SUD treatment services,
    f) PP—Persons in need of primary substance use disorder prevention
    g) PWID—Persons who inject drugs, formerly known as intravenous drug users (IVDUs)
    h) EIS (Early Intervention Services)/HIV–Persons with or at risk of HIV/AIDS, who are receiving SUD treatment services
    i) TB–Persons with or at risk of tuberculosis who are receiving SUD treatment services
    j) 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 2024;
    c) Second-year target/outcome measurement (Final to the end of SFY 2025;
    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	SUT, SUP, SUR, MHS, ESMI, BHCS
Population(s)	SMI, SED, ESMI, BHCS, 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 and crisis response 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, including mobile and center-based crisis services.
Strategies to attain the objective	1. Increase access to high-quality evidence-based behavioral therapies for young children 2. Integrate Peer Support throughout the system of care 3. 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 5. Develop and implement Medicaid-funded Mobile Crisis services (including Mobile Crisis Team services and Community Brief Crisis Support services, 24 hour crisis walk in centers and crisis stabilization providers).
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 20
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 24
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 25
Data Source	Provider data: Center for Evidence to Practice reporting and MCO data on credentialed providers in MCO provider networks.
Description of Data	Center for Evidence to Practice (OBH/Medicaid funding, housed at LSU) is in place to coordinate and sponsor trainings for providers in EBPs. We will report the number of therapists serving Medicaid youth who are trained and certified in each OBH/Medicaid-recognized EBP model.
Data Issues/Caveats	
Indicator #2	Access to Qualified Peer Support Specialists
Baseline Measurement	Number of peers trained and recognized for SFY 23
First Year Target/Outcome Measurement	Maintain or increase the total number of peers trained and recognized for SFY 24
Second Year Target/Outcome Measurement	Maintain or increase the total number of peers trained and recognized for SFY 25
Data Source	Training Records and Annual Recognition Renewal Records

Description of Data	Number of Peers successfully completing training and maintaining their status as a Recognized Peer Support Specialist (RPSS).
Data Issues/Caveats	
Indicator #3	Behavioral Health Workforce Development
Baseline Measurement	Number of behavioral health professional development opportunities held in SFY 23
First Year Target/Outcome Measurement	Maintain or increase the number of behavioral health professional development opportunities held in SFY 24
Second Year Target/Outcome Measurement	Maintain or increase the number of behavioral health professional development opportunities held in SFY 25
Data Source	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. (MCO, OBH, LaSOR data)
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.
Indicator #4	Behavioral Health Crisis Providers
Baseline Measurement	Number of behavioral health crisis providers for adults and youth (i.e., MCR, CBCS, BHCC and CS providers) enrolled in SFY 22
First Year Target/Outcome Measurement	Sustain or increase the number of behavioral health crisis providers for adults and youth enrolled in SFY 24
Second Year Target/Outcome Measurement	Sustain or increase the number of behavioral health crisis providers adults and youth enrolled in SFY 25
Data Source	Medicaid Data Warehouse; Managed Care Organization (MCO) Provider Enrollment data

Description of Data	The number of behavioral health crisis providers enrolled in the Medicaid program to deliver crisis services for adults and youth. These crisis services include Mobile Crisis Response (MCR), Community Brief Crisis Support (CBCS), Behavioral Health Crisis Centers (BHCC), and Crisis Stabilization (CS).
Data Issues/Caveats	

Priority Area 2	**Substance Use Disorder System Enhancements**
Priority Type	SUT, SUP, SUR
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 for Opioid Use Disorders (MOUD) 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 Opiate Withdrawal Syndrome (NOWs)
Indicator #1	Medication for Opioid Use Disorder (MOUD)
Baseline Measurement	The number of individuals with OUD receiving MOUD in SFY 22
First Year Target/Outcome Measurement	Maintain or increase the number of individuals with OUD receiving MOUD in SFY 24
Second Year Target/Outcome Measurement	Maintain or increase the number of individuals with OUD receiving MOUD in SFY 25
Data Source	Medicaid Claims
Description of Data	The number of individuals with OUD receiving MOUD
Data Issues/Caveats	
Indicator #2	Workforce Development
Baseline Measurement	Number of Extension for Community Health Outcomes (ECHO)/ EBP trainings for FFY 22
First Year Target/Outcome Measurement	Maintain or increase the number of ECHO/ EBP trainings for FFY 24
Second Year Target/Outcome Measurement	Maintain or increase the number of ECHO/ EBP trainings for FFY 25

Data Source	Tulane University, LASOR Grant
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 LaSOR, which are dependent on federal allocations. Outcomes are based on the federal fiscal year. Participation in these trainings are voluntary.
Indicator #3	Medication for Opioid Use Disorder Prescribers
Baseline Measurement	Number of MOUD prescribers for FFY 22 (1,363 prescribers)
First Year Target/Outcome Measurement	Maintain or increase the number of MOUD prescribers FFY 24
Second Year Target/Outcome Measurement	Maintain or increase the number of MOUD prescribers FFY 25
Data Source	Medicaid Claims Data
Description of Data	Number of physicians, APRN, PA and other prescribing clinicians that prescribed any FDA approved medication for OUD.
Data Issues/Caveats	

Priority Area 3	**Pursuing a culture of prevention and wellness for Louisiana citizens**
Priority Type	SUP, MHS, BHCS, ESMI
Population(s)	SMI, SED, ESMI, BHCS, PWWDC, PP, 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	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 23

First Year Target/Outcome Measurement	Maintain or increase the number of individuals receiving EBPs for Primary Prevention in SFY 24
Second Year Target/Outcome Measurement	Maintain or increase the number of individuals receiving EBPs for Primary Prevention in SFY 25
Data Source	Prevention Management Information System (PMIS)
Description of Data	The numbers are reflective of our school based curricula. 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 SUPTRS Block Grant.
Data Issues/Caveats	N/a
Indicator #2	Suicide Prevention and Awareness Trainings
Baseline Measurement	Number of suicide prevention and awareness trainings in SFY 23
First Year Target/Outcome Measurement	Maintain or increase the number of suicide prevention and awareness trainings in SFY 24
Second Year Target/Outcome Measurement	Maintain or increase the number of suicide prevention and awareness trainings in SFY 25
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.

*Suicide prevention and awareness trainings are funded by MHBG dollars.

Plan Table 2. State Agency Planned Expenditures (SFY 2024-2025)

State Agency Planned Expenditures Source of Funds												
Activity	**A. SUPTRS BG**	**B. MHBG**	**C. Medicaid (Federal, State, and Local)**	**D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA)**	**E. State Funds**	**F. Local Funds (excluding local Medicaid)**	**G. Other**	**H. COVID-19 Supplement SUPTRS BG**	**I. COVID-19 Supplement MHBG**	**J. ARPA Supplement SUPTRS BG**	**K. ARPA Supplement MHBG**	**J. BSCA Supplement MHBG**
1. Substance Abuse Prevention* and Treatment	$ 35,521,410		$ 260,695,452	$ 7,913,698	$ 213,636,526		$ 178,730	$ 7,328,495		$ 5,403,379		
a. Pregnant Women and Women with Dependent Children**	$ 10,047,699							$ 135,000		$		
b. Recovery Support Services	$545,122							$ 553,319		$ 2,094,875		
c. All Other	$ 24,928,589		$ 260,695,452	$ 7,913,698	$ 213,636,526		$ 178,730	$ 6,640,176		$ 3,308,504		
2. Primary Prevention	$ 11,733,326			$ 15,526,954				$ 3,068,080		$ 1,625,942		
a. Substance Use Primary Prevention	$ 11,733,326			$ 15,526,954				$ 3,068,080		$ 1,625,942		
b. Mental Health Primary												
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)		$ 2,511,756							$430,789		$1,046,089	$100,000
4. Tuberculosis Services												
5. Early Intervention Services for HIV	$ 2,563,188									$269,127		
6. State Hospital			$ 211,037,663	$ 2,859,234	$ 200,080,488		$ 961,127					
7. Other 24 Hour Care			$ 584,051,416				$ 38,762					
8. Ambulatory/Community Non-24 Hour Care		$ 20,257,074	$ 670,505,561	$ 75,907,118					$1,412,964		$600,000	

9. Administration (Excluding Program and Provider Level)	$ 1,445,844	$1,092,850		$ 9,242,492				$ 56,411	$90,000	$75,731		
10. Crisis Set-aside (5% of total MHBG Award)		$1,255,878							$ 2,942,887		$ 6,404,765	$893,111
12. Total	**$ 51,263,768**	**$ 25,117,558**	**$1,726,290,092**	**$ 111,449,496**	**$ 413,717,014**		**$ 1,178,619**	**$ 10,452,986**	**$ 4,876,640**	**$7,374,179**	**$8,050,854**	**$993,111**

Plan Table 2 for SUPTRS BG:

- The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SUPTRS BG. Per the instructions, the planning period for standard SUPTRS BG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column H.
- The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the planning period for standard SUPTRS BG and MHBG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.
- The 20 percent set aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

Plan Table 2 for MHBG:

- The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. Per the instructions, the standard SUPTRS BG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.
- The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states
- The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from October 17, 2022 thru October 16, 2024 and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.
- Column B should include Early Serious Mental Illness programs funded through MHBG set aside.
- While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.
- Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.
- Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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

	Aggregate Number Estimated in Need	Aggregate Number in Treatment
Pregnant Women	37,000	109
Women with Dependent Children	46,000	1,676
Individuals with a co-occurring M/SUD	123,000	9,339
Persons who inject drugs	67,000	1,440
Persons experiencing homelessness	39,428	1,017

- Aggregate Number Estimated *in Treatment*: All Measures from Louisiana OBH Data Warehouse for FY 2021
- Aggregate Number Estimated ***in Need***:
    - Row # 1-4: National Survey on Drug Use and Health: 2-Year RDAS (2018 to 2019) (https://rdas.samhsa.gov/#/)
    - Row #5 (Homelessness): Estimated Persons Experiencing Homelessness: https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2021.pdf
- Note: In 2021, HUD gave communities the option to cancel or modify the unsheltered survey portion of their counts based on the potential risk of COVID-19 transmission associated with conducting an in -person survey. As a result, HUD has excluded the unsheltered population sub-totals and all unsheltered sub-population data for this reporting period.

Plan Table 4. SUPTRS BG Planned Expenditures

Expenditure Category	FFY 2024 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]	FFY 2025 SA Block Grant Award
1. Substance Use Prevention and Treatment	$ 17,488,144	$ 6,775,176	$ 3,308,504	$
2. Primary Substance Use Prevention	$ 5,866,663	$ 3,068,080	$ 1,625,942	$
3. Early Intervention Services for HIV[4]	$ 1,281,594	$	$ 269,127	$
4. Tuberculosis Services	$	$	$	$
5.Recovery Support Services	$ 272,561	$ 553,319	$ 2,094,875	$
6. Administration (SSA level only)	$ 722,922	$ 56,411	$ 75,731	
7. Total	$ 25,631,884	$ 10,452,986	$ 7,374,179	$

*Amount of primary prevention funds planned for primary prevention programs under standard block grant (this amount matches the total reported in Table 5a and Table 5b) is $5,126,377.
Amount of primary prevention funds in Table 4, line 2 that are planned for prevention SU resource development and non-direct services is $740,286.

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is September 1, 2021 – September 1, 2025, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[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 SUPTRS BG 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 SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG 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 2022 and FFY 2023 SUPTRS BG 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 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 Use Prevention, Treatment and Recovery Services 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 2024 SA Block Grant Award	COVID-19	ARPA	FFY 2025 SA Block Grant Award
1. Information	Universal	$ 333,215	$ 75,000	$ 334,967	$
	Selective	$	$ 35,000	$ 229,600	$
	Indicated	$	$	$	$
	Unspecified				
2. Education	Universal	$ 3,570,828	$	$ 115,000	$
	Selective	$ 112,610	$ 130,000	$	$
	Indicated	$	$	$	$
	Unspecified				
3. Alternatives	Universal	$ 51,264	$	$ 51,157	$
	Selective	$	$	$ 229,600	$
	Indicated	$	$	$	$
	Unspecified				
4. Problem Identification	Universal	$ 51,264	$	$	$
	Selective	$	$	$	$
	Indicated	$	$	$	$
	Unspecified				
5. Community-Based	Universal	$ 630,000	$ 183,257	$ 243,893	$
	Selective	$	$	$	$
	Indicated	$	$	$	$
	Unspecified				
6. Environmental	Universal	$ 102,528	$	$ 251,074	$
	Selective	$	$	$	$
	Indicated	$	$	$	$
	Unspecified				
7. Section 1926-Tobacco	Universal	$ 274,668	$	$ 20,000	$
	Selective	$	$	$	$
	Indicated	$	$	$	$
	Unspecified	$	$	$	$
8. Other	Universal	$	$	$	$
	Selected	$	$	$	$
	Indicated	$	$	$	$
	Unspecified	$	$	$	$
9. Total Prevention		$ 5,126,377	$ 423,257	$ 1,475,291	$
Total SUPTRS BG Award		$ 25,631,884	$ 10,452,986	$ 7,374,179	$
Planned Primary		20.00%	4.05%	20.01%	0.00%

* The Primary Prevention planned expenditures amount on Table 5a does not match the Table 4 amount because the state uses a portion of the primary prevention set-aside to fund Non-Direct Services/System Development activities. Therefore, planned expenditures for Non-Direct Services/Systems Development activities are not included on Table 5a figures.

Plan Table 5b. SUPTRS BG 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 2024 SUPTRS BG 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 2024 SA Block Grant Award	COVID-19	ARPA	FFY 2025 SA Block Grant Award
Universal Direct	$ 3,570,828	$	$ 115,000	$
Universal Indirect	$ 1,442,939	$ 258,257	$ 901,091	$
Selective	$ 112,610	$	$ 459,200	$
Indicated	$	$ 165,000	$	$
Column Total	$5,126,377*	$ 423,257	$ 1,475,291	$
Total SUPTRS BG	$25,631,884	$ 10,452,986	$ 7,374,179	$
Planned Primary Prevention	20.00 %	4.05 %	20.01 %	%

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

Plan Table 5c. SUPTRS BG 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 2024 and FFY 2025 SUPTRS BG awards.

Targeted Substances*			
	SUPTRS BG	**COVID**	**ARPA**
Alcohol	☒	☒	☒
Tobacco	☒	☒	☒
Marijuana	☒	☒	☒
Prescription Drugs	☒	☒	☒
Cocaine	☐	☒	☒
Heroin	☒	☒	☒
Inhalants	☒	☒	☒
Methamphetamine	☐	☒	☒
Fentanyl	☒	☒	☒

Targeted Populations*			
	SUPTRS BG	COVID	ARPA
Students in College	☒	☒	☒
Military Families	☒	☒	☒
LGBTQI+	☒	☐	☐
American Indians/Alaska Natives	☒	☒	☒
African American	☒	☒	☒
Hispanic	☒	☒	☒
Persons Experiencing Homelessness	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☒	☒	☒
Asian	☒	☒	☒
Rural	☒	☒	☒
Underserved Racial and Ethnic Minorities	☒	☒	☒

*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 SUPTRS BG 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 SUPTRS BG.

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 SUPTRS BG 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 2024 Block Grant award.

Activity	MHBG	MHBG COVID	MHBG ARPA	SUPTRS BG Treatment	SUPTRS BG Prevention*	SUPTRS BG Integrated	SUPTRS BG COVID*	SUPTRS BG ARPA
1. Information Systems	$218,592	$202,525	$	$129,764	$0	$ 244,788	$556,500	$
2. Infrastructure Support	$1,848	$	$	$	$0	$	$468,000	$
3. Partnerships, community outreach, needs assessment	$537,957	$75,000	$	$	$435,450	$ 5,000	$2,110,319	$
4. Planning Council activities	$165,000	$	$	$	$0	$ 5,000	$	$
5. Quality assurance and improvement	$333,200	$	$	$357,125	$0	$ 50,000	$87,939	$
6. Research and evaluation	$27,000	$	$	$0	$99,000	$	$	$
7. Training and education	$2,150,991	$471,898	$	$307,514	$205,836	$ 20,000	$564,923	$161,192
Total	$3,434,588	$1,825,203	$ 0	$794,403	$740,286*	$324,788	$3,787,681	$161,192

* $740,286 of the total standard SUPTRS BG Primary Prevention funds are planned to be used for Non-direct Prevention and are not included in the amounts listed in Tables 5a and 5b.
* $2,644,823 of the COVID-19 Supplement are planned to be used for Non-direct Prevention and are not included in the amounts listed in Tables 5a and 5b.

Environmental Factors

1. Access to Care, Integration, and Care Coordination- Required

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001; https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions. Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

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

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness
b) Pregnant women with substance use disorders
c) Women with substance use disorders who have dependent children
d) Persons who inject drugs
e) Persons with substance use disorders who have, or are at risk for, HIV or TB
f) Persons with substance use disorders in the justice system
g) Persons using substances who are at risk for overdose or suicide
h) Other adults with substance use disorders
i) Children and youth with serious emotional disturbances or substance use disorders
j) Individuals with co-occurring mental and substance use disorders

OBH serves as subject matter experts for all specialized behavioral health services in the Medicaid program. OBH works closely with the state Medicaid agency for monitoring of the managed care organizations (MCOs), including provider network requirements and standards for access to care.

The MCOs are engaged in activities to develop the network of the substance use and PRTFs independently and collaboratively by conducting exhaustive searches for providers to enhance the network; comparison of competitor's network especially those with other lines of business; and reaching out to current providers and hospitals within the state to identify existing providers willing to expand services, levels of care or open new locations. Discussions are initiated with out of state providers in which MCOs enter into single case agreement when there are no available providers to discuss opportunities in Louisiana to increase access expand opportunities in Louisiana to increase access. Discussions focus on barriers to providing care, current levels of care provided, expanding levels of care/populations served, and opportunities to open new locations. The MCOs often offer enhanced rates to expand current services and foundational payments to open new locations.

MCOs continue to promote the use of the Providers Clinical Support System (PCSS) free online training that trains health professionals to provide MAT to patients with OUD in primary care, psychiatric care, substance use disorder treatment, and pain management settings. In addition, they are actively coordinating not only with BH Prescribers for MAT services but also PCPs to expand this service. One MCO in particular collaborated with ASAM for the development of a specialized MAT-ED training.

Several new behavioral health services, including peer support services and four new crisis services for adults, have recently been added to the Medicaid array of covered services. Effective in early 2022 via a soft launch, the four new crisis services include Mobile Crisis Response, Community Brief Crisis Support, Behavioral Health Crisis Care, and Crisis Stabilization. OBH is continuing to collaborate with the providers, stakeholders, trainers, and consultants to work toward implementation of statewide coverage and of 24/7 access to services. In FY23, OBH will also begin preparing the landscape to offer crisis services to Medicaid members under the age of 21. OBH will develop the framework for expanding crisis services to adolescents, including drafting authority documents (service definition, provider qualifications, and licensing requirements) for policy changes, and submission to CMS (where applicable) in anticipation of securing funding for these services.

During the 2022 Regular Legislative Session, OBH worked with legislators, providers, and stakeholders to pass and enact Act 503 to renew the integrity and sustainability of the Medicaid Mental Health Rehabilitation (MHR) program by increasing distinction between Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) services and by expanding utilized provider types for CPST services. Both services are designed for Medicaid members with serious mental illness. The CPST definition was amended to focus on clinically-oriented service components (i.e., assessment, treatment planning, and counseling and clinical psycho-education), and the PSR definition was amended to focus exclusively on skills-building components to promote independent functioning. By including counseling in the redesigned CPST service, the eligible provider types expanded to include Certified Social Workers (CSWs), Licensed Master Social Workers (LMSWs), provisionally licensed practitioners, and psychology interns. This opened up a whole new provider pool for delivering counseling and clinical interventions to Medicaid recipients at an attractive reimbursement rate. CPST and PSR rates both increased as a result of the redesigned program.

OBH also works closely with the local human service districts or authorities, or local governing entities (LGEs). The ten LGEs have local accountability and management of behavioral health, intellectual disability, and developmental disability services, as well as any public health or other services contracted to the district or authority by the department. LGEs ensure that behavioral health services are available statewide, regardless of insurance status or payor source. LGE mandates include, but are not limited to, the following:

- Perform the functions which provide community-based services and continuity of care for the prevention, detection, treatment, rehabilitation, and follow-up care of mental and emotional illness;
- Perform community-based functions for the care, diagnosis, training, treatment, and education related to substance-related and addictive disorders, including but not limited to alcohol, drug abuse, or gambling;
- Perform community-based functions which provide services and continuity of care for education, prevention, detection, treatment, rehabilitation, and follow-up care relating to personal health, as determined to be feasible by the department; and
- Provide state-funded services to meet the needs of the individuals in their statutory governance area.

Utilizing surplus state general funds, OBH is enhancing the network of residential SUD treatment programs for women, pregnant women, and women with dependent children, through infrastructure enhancements of the three existing facilities and the opening of three new facilities. These efforts will help to increase access to residential treatment services for this vulnerable population.

OBH also worked to increase the per diem rates for specialty residential Pregnant Women and Women with Dependent Children Programs. These efforts will help to create and/or increase access to residential treatment services for this vulnerable population.

OBH received a technical assistance grant to prepare for Certified Community Behavioral Health Clinics (CCBHCs) implementation in Louisiana. The work plan includes technical assistance to facilitate a learning collaborative for current CCBHC SAMHSA grantees and to prepare the state and its providers on a preferred path for CCBHC sustainability (e.g., CCBHC Medicaid Demonstration, State Plan Amendment, 1115 Medicaid Waiver). CCBHCs ensure access to integrated, evidence-based substance use disorder and

mental health services, including 24/7 crisis response and medication-assisted treatment (MAT), and ensure that no individuals are denied access to services due to an inability to pay.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

The Louisiana Department of Insurance (LDI) performs state regulatory and oversight functions with respect to MHPAEA, and will refer matters to CMS for possible enforcement. LDH performs regulatory and oversight functions for the Medicaid program and services only. Information on Medicaid compliance can be found at https://ldh.la.gov/page/2809.

LDH's most recent comprehensive parity analysis on the Medicaid program was completed and published in 2017. LDH reviewed the MH/SUD and M/S benefits provided through both its FFS and managed care coverage systems to ensure the full scope of services available to all individuals enrolled in Medicaid complies with parity. As described in the analysis report, "[i]f MH/SUD services for beneficiaries are provided through a combination of MCOs, PIHPs and the state, the state has the responsibility of undertaking the parity analysis within the plans and across delivery systems. While the managed care plans were required to provide information about limitations imposed by the health plan for each benefit package and classification as well as complete surveys designed to elicit assurances to ensure parity and compliance with applicable requirements, because of the multiple delivery systems, LDH is ultimately responsible for performing the parity analysis.

OBH is lead on the parity compliance activities for LDH and the Medicaid program. OBH implemented various monitoring procedures to ensure ongoing compliance with parity, including that non-quantitative treatment limitations (NQTLs), such as prior authorization, network admission standards or documentation requirements, for MH/SUD benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers
b) Efforts to improve behavioral health care provided by primary care providers
c) Efforts to integrate primary care into behavioral health settings

LDH integrated behavioral health care into the existing physical health Medicaid 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 shall establish and maintain interdepartmental structures and processes to support the operation and management of the Medicaid program and services in a manner that fosters integration of physical and behavioral health service provisions.

The MCOs are required to have established policies 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; and
- 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 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.

The MCO shall develop and implement specific strategies to promote the integration of physical and behavioral health service delivery and care integration activities and establish policies and procedures to facilitate integration. Specifically, the MCO shall:

- Support PCPs who screen enrollees for behavioral health issues and treat mild to moderate cases, including educating and training practices on how to treat common behavioral health conditions and providing clinical consultations and guidance for issues that do not require specialty referrals;
- Encourage and support providers to co-locate primary care and behavioral health services, whether the co-located service is in a primary care or behavioral health setting;
- Provide incentives to clinics to employ Licensed Mental Health Professionals (LMHP) in primary care settings to monitor the behavioral health of patients 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;
- Allow providers to bill for both primary care and behavioral health services on the same day;
- Develop, in coordination with LDH and other MCOs, a system to provide psychiatric prescribing support to primary care providers. Such support may be provided through consultation with psychiatrists regarding psychiatric prescribing practices;
- Endorse real time consultation of primary care providers with behavioral health professionals or psychiatrists for behavioral health issues or consultations on medications;
- Distribute Release of Information forms as per 42 C.F.R. § 431.306, and provide training to providers on its use;
- Share necessary and integrated data with its network providers to promote clinical integration of physical and behavioral health; and
- Offer provider trainings on integrated care, including, but not limited to, appropriate utilization of basic behavioral health screens in the primary care setting and basic physical health screenings in the behavioral health setting.

The MCO shall work to integrate physical and behavioral health services through:

- Enhanced detection and treatment of behavioral health disorders in primary care settings;
- Coordination of care for enrollees with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for enrollees with co-existing medical-behavioral health disorders;
- Assisting enrollees 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 enrollees with co-existing medical and behavioral health disorders requiring co-management;
- Have enhanced rates or incentives 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;
- Have enhanced rates or incentives for integrated care by providers;
- Distributing Release of Information forms as per 42 C.F.R. § 431.306, and provide training to MCO providers on its use;
- Educating MCO enrollees and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;
- Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists;
- Ensuring continuity and coordination of care for enrollees 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 enrollee(s) requiring behavioral health services;
- Documenting authorized referrals in the MCO's clinical management system;
- Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures;
- Conducting Case management rounds at least monthly with the Behavioral Health Case management team; and
- Participating in regular collaborative meetings at least yearly or as needed, with LDH representatives for the purpose of coordination and communication.

The MCO shall provide guidelines, education and training, and consultation to PCPs to support the provision of basic behavioral health services in the primary care setting.

The MCO shall ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards. The MCO shall work to increase screening in primary care using validated screening instruments for developmental, behavioral, and social-emotional delays, as well as screening for child maltreatment risk factors, trauma, adverse childhood experiences (ACEs), and substance use. The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care.

The MCO 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, adverse

childhood experiences (ACEs), and substance use. The MCO shall work to increase the percentage of children with positive screens who 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and 2) receive specialized assessment or treatment.

Each MCO shall work with LDH to develop a plan for the MCOs to conduct 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 behavioral health populations. The MCO-led workgroup will identify opportunities to coordinate this effort across MCOs to ensure comparability of results across MCOs and minimize burden on providers. The results of the initial survey must be reported to LDH annually.

The MCO must use an integration assessment tool to self-assess annually. Those results shall also be reported annually to LDH. The assessment should be inclusive of, but not limited to, such factors as:

- Assessing enrollee and provider experiences around integrated care annually and make improvements as appropriate.
- Identifying opportunities to strengthen or complement the IPAT by identifying barriers and opportunities in the following functional areas:
    - Knowledge, attitudes and cross-training needs (e.g., assessing provider knowledge of best practices to address non-complicated behavioral health conditions in primary care);
    - Human resource needs (e.g., access to behavioral health providers at primary care clinics and medical providers at mental health clinics);
    - Access to services (e.g., laboratories for behavioral health practices);
    - Existing processes for integration (e.g., joint rounds on complex medical-behavioral cases, joint treatment team meetings, and established procedures for consultations);
    - Existing tools for integration (e.g., brief screening tools, electronic health records);
    - How contractors will use data from the IPAT assessment in their annual report;
        - Number and type of trainings on integration offered by the MCO;
        - The number of forums held with outcomes;
        - What outreach was done to promote integration, especially on the physical health side;
        - How many “hot spot” sources of high emergency department (ED) referrals and/or inpatient psychiatric hospitalization have been identified;
        - Has the identification of these “hotspots” led to pre-emptive coordination;
        - What incentives are being offered to improve integration of providers and are the incentives effective;
        - The status of real time consultation of primary care providers with behavioral health professionals or psychiatrists for behavioral health issues or consultations on medications;
        - The status of a single or integrated clinical documentation system;
        - The status of unified systems across behavioral and physical health management; and
        - How is the MCO addressing integration at the MCO level to include specific actions taken and the timeline to assess integration at this level.

In support of integrated care through Federally Qualified Health Center (FQHC) providers in the Medicaid program, 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. The alternative payment methodology allows access to behavioral health services on the same day patients access primary care within FQHCs to the benefit of patients.

OBH established the Louisiana Promoting Integration of Primary and Behavioral Health Care (LaPIPBHC) Program 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.

In order to achieve these objectives, OBH contracted with four provider organizations, geographically dispersed in the state, to provide integrated primary and behavioral health services. All providers are located in HRSA designated health professional shortage areas.

LaPIPBHC providers are:

- START Corporation, an FQHC in Houma;
- DePaul Community Health Center, an FQHC in New Orleans, collaborating with Metropolitan Human Service Authority;
- Northeast Delta Human Service Authority, an LGE located in Monroe, collaborating with Morehouse Community Medical Center; and
- Capital Area Human Services, an LGE located in Baton Rouge, partnering with Open Health Care Clinic.

PIPBHC is designed to promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental and substance use disorders, and co-occurring physical health conditions and chronic diseases. A continuum of prevention, treatment and recovery support services are offered to consumers within the PIPBHC grant program. Those individuals enrolled in the program are in one of the following categories:

- Adults with a mental illness who have co-occurring physical health conditions or chronic diseases; or
- Adults with a serious mental illness who have co-occurring physical health conditions or chronic diseases; or
- Individuals with a substance use disorder.

PIPBHC enrollees are given an initial assessment via the NOMS, short for National Outcome Measure System. The NOMS is the tool used to help measure a consumer's level of health as they enter the PIPBHC program. It is also used upon reassessment. The data collected is then entered into SPARS, SAMHSA's database for PIPBHC health indicators. In addition, PIPBHC enrollees are administered a variety of physical and behavioral health screenings, provided care management services, and offered the opportunity to participate in wellness groups.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness
b) Adults with substance use disorders
c) Children and youth with serious emotional disturbances or substance use disorders

The MCOs are required to implement a tiered Case Management program that provides for differing levels of Case Management based on an individual enrollee's needs. This includes three (3) levels of Case Management and Transitional Case Management for individuals as they move between care settings.

- Intensive Case Management for High Risk Enrollees (High) (Tier 3)

  Enrollees engaged in intensive Case Management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of identification and shall include assessment of the home environment and priority. Case Management meetings shall occur at least monthly, in person, in the Enrollee's preferred setting, or more as required within the Enrollee's POC, with monthly updates to the POC and formal in person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of monthly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 3 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs.

- Case Management (Medium) (Tier 2)

  Enrollees engaged in the medium level of Case Management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of identification and include assessment of the home environment and priority SDOH. Case Management meetings shall occur at least monthly, with quarterly updates to the POC and formal in-person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of quarterly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 2 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs.

- Case Management (Low) (Tier 1)

  Enrollees engaged in this level of Case Management are of the lowest level of risk within the Case Management program and typically require support in care coordination and in addressing SDOH. A POC shall be completed in person within ninety (90) Calendar Days of identification and include assessment of the home environment and priority SDOH. Case Management meetings shall occur at least quarterly, or more as required within the Enrollee's POC, with annual updates to the POC and formal in-person re-assessment annually. Attestations of annual updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed.

- Transitional Case Management

  The MCO shall implement procedures to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i). The Contractor shall provide Transitional Case Management for Enrollees to support transitions between institutional and community care settings, including, but not limited to, transitions to/from inpatient hospitals, nursing facilities (not including members of the DOJ Agreement Target Population), psychiatric residential treatment facilities (PRTFs), therapeutic group homes (TGHs), ICF/IIDs, residential substance use disorder treatment settings, and incarceration and transitions to permanent supportive housing.

  Transitional Case Management shall include:

  - Development of a transition POC in coordination with the care setting, the Enrollee, and other key members of an Enrollee's multi-disciplinary team prior to the transition which is provided in writing to the Enrollee upon discharge, includes post discharge care appointments and linkages as appropriate, medication reconciliation, patient education and self-management strategies, and addresses Prior Authorization needs. The Enrollee shall be provided the case manager's name and contact information prior to discharge.
  - For Enrollees preparing for discharge from a PRTF, TGH, or ICF/IID, aftercare services shall be in place thirty (30) Calendar Days prior to discharge.
  - Ensuring that the setting from which the Enrollee is transitioning is sharing information with the Enrollee's PCP and behavioral health providers regarding the treatment received and contact information.
  - Follow up with Enrollees within seven (7) Calendar Days following discharge/transition to ensure that services are being provided as detailed within the Enrollee's transition POC. The POC shall identify circumstances in which the follow-up includes a face-to-face visit.
  - Additional follow-up as detailed in the discharge plan.
  - Coordination across the multi-disciplinary team involved in Transitional Case Management for Enrollees.
  - For Enrollees identified as homeless at the time of care transition, the care management team shall include a housing specialist on the multi-disciplinary care team. Housing specialists shall also be used to ensure Enrollees transitioning from facility to community are connected to appropriate housing resources, including, but not limited to, referral of Potential Enrollees to Contractor's Permanent Supportive Housing liaison for application to the Louisiana Permanent Supportive Housing program.

The MCOs shall develop a comprehensive individualized, person-centered Plan of Care (POC) for all enrollees who are found eligible for Case Management. When an enrollee receives services from the MCO only for specialized behavioral health services, the POC shall focus on coordination and integration, as appropriate. Development of the POC shall be a person-centered process led by the enrollee and their case manager with significant input from members of the enrollee's interdisciplinary care team. When an enrollee receives specialized behavioral health services and has treatment plans developed through their behavioral health providers, the MCO shall work with the enrollee's behavioral health providers in order to incorporate the treatment plans into the enrollee's overall POC and to support the enrollee and the provider in their efforts to implement the treatment plan. The POC 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 MCO.

The MCO shall identify a multi-disciplinary care team to serve each enrollee based on individual need for all enrollees in Case Management Tiers 2 and 3 and Transitional Case Management. The MCO shall assign lead case managers based on an enrollee's priority care needs, as identified through the POC. Where behavioral health is an enrollee's primary health issue, the case manager shall be a behavioral health case manager. If the enrollee is under the age of six (6), the lead case manager shall have expertise in early childhood mental health or access to a consultant with expertise in infant and early childhood mental health.

OBH and the MCOs have also developed a specialized community Case Management program consistent with the DOJ Agreement for the target population transitioning or diverted from nursing facility level of care using subcontracted community case managers who meet the qualifications established by OBH. The MCO makes referrals to a community Case Management agency within one (1) business day of receipt of a referral from LDH. The MCO maintains ultimate responsibility for ensuring the Case Management needs of the target population are met by community case managers and community case managers satisfactorily completing required activities.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

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 and substance use 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, OBH has an integrated organizational chart and does not distinguish between addictive and substance use 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 and substance use disorders, as do the Medicaid managed care organizations. Licensing standards and operations of mental health and substance use providers are integrated under one integrated behavioral health services provider license.

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

N/A

2. Health Disparities – Requested

In In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities, Healthy People*, *2020, National Stakeholder Strategy for Achieving Health Equity,* Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)., 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 orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., 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 Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).

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	☒ Yes	☐ No
b)	ethnicity	☒ Yes	☐ No
c)	gender	☒ Yes	☐ No
d)	sexual orientation	☐ Yes	☒ No
e)	gender identity	☐ Yes	☒ No
f)	age	☒ Yes	☐ No

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

☒ Yes ☐ No

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

☒ Yes ☐ No

4. Does the state have a workforce-training plan to build the capacity of 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).

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

N/A

3. Innovation in Purchasing Decisions – requested

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

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

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The National Center of Excellence for Integrated Health Solutions offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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 M/SUD, 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 (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. 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 recommendations 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, the NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).

One activity of the EBPRC was 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 develop a more detailed understanding of for who and in what circumstances they are most effective.

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?

Louisiana has implemented a performance based incentive program through our Coordinated System of Care 1915c waiver program. We also have an incentive program inclusive of retention and recruitment payments for LMHPs and providers of certain Evidence Based Practices. We've funded these through American Rescue Plan funding opportunities.

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 intervention[5] 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). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-

[5] 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.

based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

States 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. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/ EBPs for SMI/FEP	Number of Programs
NAVIGATE	5
YALE-STEP	1
PIER	1 (Initial training scheduled for August 2023)

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY 2024	FY 2025
1,255,878	1,255,878

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

   Currently, insurances including Medicaid are billed first for ESMI/FEP services provided to individuals such as psychotherapy or medication management. Other services such as peer support, which are not covered by insurance including Medicaid, are then paid for by the MHBG and ARPA funding.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

   Several Local Governing Entities (LGEs) provide ESMI/FEP services using Coordinated Specialty Care models:

   - Capital Area Human Services District (CASHD) provides coordinated specialty care for individuals experiencing ESMI/FEP in Region 2 of Louisiana. CASHD provides medication management, community-based therapeutic intervention, peer support services, family

therapy, case management, and a supportive, team approach to care from a dedicated team of licensed professionals in both the home and community setting.

- Florida Parishes Human Services Authority (FPHSA) also provides coordinated specialty care for individuals experiencing ESMI/FEP, out of three clinic locations and the home and community setting, in Region 6 of Louisiana. FPHSA provides medication management with a physician, nurse practitioner, or medical psychologist, psychotherapy, family education and support, employment and education services, and peer support services with a supportive, team approach to care.
- South Central Human Services Authority (SCLHSA) also provides coordinated specialty care for individuals experiencing ESMI/FEP in Region 3 of Louisiana. Similar to the program mentioned above, SCLHSA through a team approach provides medication management, psychotherapy, family education and support, employment and education services, and peer support services by licensed professionals. For FFY24, they are beginning a partnership with the Early Psychosis Intervention Clinic (EPIC-NOLA) to enhance their services to individuals experiencing ESMI/FEP.
- Metropolitan Human Services (MHSD) also provides coordinated specialty care to individuals experiencing ESMI/FEP. This program mainly focus on youth in region 1 of Louisiana. MHSD provides medication management, therapeutic intervention, peer support services, family therapy, case management, and a supportive, team approach to care from a dedicated team of licensed professionals in both the home and community setting. For FFY24, they are beginning a partnership with the EPIC NOLA clinic to provide joint services to individuals experiencing ESMI/FEP.
- Jefferson Parish Human Services Authority (JPHSA) provides coordinated specialty care services following the NAVIGATE Model. This program focuses on Jefferson Parish. JPHSA provides medication management, community-based therapeutic intervention, peer support services, family therapy, case management, and a supportive, team approach to care from a dedicated team of licensed professionals in both the home and community setting.

LDH-OBH supports a certified Peer Support Specialist at the following LGEs, which use the public health model: Imperial Calcasieu Human Services Authority (Region 5 of Louisiana), Northwest Louisiana Human Services District (Region 7), and Central Louisiana Human Services District (Region 6).

Through a contract with Tulane University, LDH-OBH supports EPIC-NOLA in its efforts to continue to expand its own clinic for both youth and adults in New Orleans and its development of a Hub and Spoke Model to create two new FEP spoke clinics in areas of Louisiana with the greatest need that do not currently have FEP treatment programs. The EPIC-NOLA program provides an evidence-based, recovery oriented, and person centered CSC model of FEP care that includes a comprehensive package of services including: family education, social skills training, individual cognitive behavioral therapy, social cognitive based psychotherapy, and personalized pharmacologic management by using a team approach of staff working within their respective roles to provide collaborative services to program participants. Through this contract, OBH also supports the statewide media campaign Clear Answers to Louisiana's Mental Health (CALM) as a hub for psychosis awareness and treatment resources to provide active outreach and engagement strategies into FEP programs. EPIC NOLA is funded by MHBG, ARPA, and BSCA.

LDH-OBH assists the Volunteers of America – North Louisiana through ARPA funding a new EpiCenter for youth and adults with ESMI/FEP in Region 7. This program represents a partnership between VOA of North Louisiana and LSU Health Sciences of Shreveport. This program was implementation in the summer of 2023. The EpiCenter provides clinic provides Coordinated Specialty Care (CSC) services for first-episode psychosis that include psychotherapy, psychiatric medication management/primary care, case management, supported employment and education, peer services, and individual, group, and family education. The multi-disciplinary team works with patients and their families in order to determine goals and navigate the path towards long lasting recovery and wellness.

Using the COVID supplement, several LGEs have enhanced and expanded their programs to included awareness campaigns, trainings, or clinic expansions.

5. Does the state monitor fidelity of the chosen EBP(s)?

☐ Yes ☒ No

Due to staff resignations (April 2022 and February 2023), current program staff needed to be trained to conduct fidelity monitoring. This occurred in March 2023 when Dr. Donald Addington provided a statewide training, including training OBH staff. OBH is planning to do fidelity monitoring in both FFY24 and FFY 25.

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 LGEs readiness to implement an FEP program and training needs. Subsequent to the completion of the needs assessment, a training series was developed and implemented through which participants were provided information about FEP, tenants of the RAISE model were explored, and best practices regarding the provision of services were reviewed. The trainings included a series of two 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 list of completed trainings is as follows:

- Understanding RAISE: Services for Young People Experiencing FEP (face-to-face)
- FEP - Engaging Youth (webinar)
- FEP - Understanding Change (webinar)

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

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) in 2019. 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

Trainings for FEP providers were conducted in 2020 and 2021 included: A review of the FEP-Fidelity Scale was conducted by Dr. Donald Addington, M.B.B.S., Clinical Professor, Department of Psychiatry, University of Calgary, on September 21st and 22nd 2020.

Cognitive Behavioral Therapy for Psychosis-CBTP conducted by Dr. Michael Garrett MD, Vice Chairman of Clinical Services, SUNY Downstate Medical School on December 1st and 2nd 2021.

Multiple trainings were provided by OnTrackNY who is in partnership with the Center for Practice Innovations, Columbia Department of Psychiatry, Columbia University in New York. These trainings included:

a. Engagement Strategies for the Treatment of Clients Experiencing First-Episode Psychosis- April 7th, 2021
b. Working with Minors and Young Adults Experiencing First Episode Psychosis- April 7, 2021
c. Cognitive Behavioral therapy for the Treatment of Clients Experiencing First-Episode Psychosis- April 20, 2021
d. Psychopharmacology for the Treatment of Clients Experiencing First-Episode Psychosis- April 20, 2021
e. Peer Support for the Treatment of Clients Experiencing First Episode Psychosis- May 5th, 2021
f. Motivational Interviewing for the Treatment of Client's Experiencing First-Episode Psychosis- May 5th, 2021
g. Psychoeducation for the Treatment of Young Adults Experiencing First-Episode Psychosis- May 18th, 2021
h. Supported Education and Employment for the Treatment of Client's Experiencing First Episode Psychosis- May 18th, 2021
i. Risk Assessment, Suicide Prevention, and Assessment Screening Tools- June 29th, 2021
j. Supported Education and Employment- Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) Work Incentives- June 29th, 2021
k. Duty to Care versus Dignity of Risk (Shared Decision Making)- July 2st, 2021
l. First Episode Psychosis and Family Work- July 21st, 2021
m. Evaluation and Enrollment in an First Episode Psychosis Program- August 24th, 2021
n. Fidelity to the Coordinated Specialty Care Model- August 24th, 2021
o. Transition and Continuity of Care- October 20, 2021
p. Self-Care for First Episode Psychosis Staff/Team- November 1, 2021

Stanford University School of Medicine, Department of Psychiatry and Behavioral Sciences, provided multiple trainings and workshops as part of the Master Clinician Series for LGE staff to continue with the most current EBP. These include:

a. Foundations of Cognitive Behavioral Therapy for Psychosis – December 10, 2021
b. Delusional & Extreme Beliefs: What are Beliefs and Why are Some of Them Pathological – January 21, 2022
c. Feeling Safe: A New Paradigm for Working with Paranoia – February 18, 2022
d. Addressing cPTSD and Personality Structures in Psychosis – March 18, 2022
e. Acceptance and Commitment Therapy for Early Psychosis – April 15, 2022
f. Culturally Informed Treatment for Schizophrenia – May 27, 2022
g. DBT Skills for Psychosis – June 17, 2022
h. Recovery Oriented Cognitive Therapy – July 15, 2022
i. Voice Dialogue – August 19, 2022
j. An Introduction to the Maastricht Interview – September 16, 2022
k. Attachment and Psychosis: Theory and Clinical Implications – October 21, 2022
l. Formulating Psychosis – November 18, 2022
m. Working with Systematized Delusions – December 16, 2022

n. An Introduction to the Power, Threat, Meaning Framework: An Alternative to Diagnostic Models of Distress – January 20, 2023
o. Treating Sleep Problems in Early Psychosis – February 17, 2023
p. Talking with Voices – March 17, 2023
q. Cross Cultural Counseling: American Muslims as a Case Study – April 21, 2023
r. Foundations of Cognitive Behavioral Therapy for Psychosis – April 24, 2023 (included EPIC NOLA staff members as well)
s. Metacognitive Training (MCT) for Psychosis – May 19, 2023
t. A Culturally-adaptive Approach to Trauma-focused Assessment in People with Psychosis – June 9, 2023
u. Integrating Psychoanalytic Object Relations Theory and CBTp & Working with Nonpsychotic Paranoid Patients – July 21, 2023

Future workshops with Stanford University include:

v. Learning from Open Dialogue - Improving Outcomes in Psychosis Response and Care – August 18, 2023
w. Addressing Cannabis and Psychosis using Motivational Interviewing and CBT – September 15, 2023
x. Social Cognition and Interaction Training – October 20, 2023
y. Internal Family Systems – November 17, 2023
z. Eye Movement Desensitization and Reprocessing and Psychosis – December 15, 2023

A review of the FEP-Fidelity Scale was conducted by Dr. Donald Addington, M.B.B.S., Dept. of Psychiatry, Foothills Hospital on March 6 and 7, 2023.

Starting August 2, 2023, the Volunteers of America – North Louisiana's EpiCenter staff is to be trained in the coordinated specialty care model of the PIER Institute.

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

The goal of Louisiana ESMI/FEP programs is to reduce the duration of untreated psychosis and to increase the likelihood of recovery by introducing these individuals into treatment within the first few years of their illness. Through partnerships with agencies throughout the state including Tulane University and the Volunteers of America – North Louisiana, LDH-OBH is working towards enhancing and expanding FEP Programs and services available statewide to serve this highly vulnerable population with the CSC evidence based model to improve access to care and the prognosis for individuals living with serious mental illness. Several locations have added staff members including a primary care physician at EPIC NOLA to increase access to services.

LDH-OBH also supports the statewide media campaign CALM as a hub for psychosis awareness and treatment resources to provide active outreach and engagement strategies into FEP programs. Several agencies are increasing outreach and educational events to increase knowledge of psychosis and other serious mental illnesses and decrease myths and stigma regarding psychosis and other serious mental illnesses. This improves awareness and access to treatment.

8. Please describe the planned activities in FFY 2024 and FFY 2025 for your state's ESMI/FEP programs.

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

- Peer Support – Continued support of PSS in each of LGEs that are implementing the public health model
- Outreach – Providers will 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 NAVIGATE, OnTrackNY, PIER, and other established evidence-based FEP programs.
- CSC Program Implementation and Support – Continued support of the CSC programs implemented in JPHSA, CAHSD, FPHSA, SCLHSA and MHSD. These programs, except for SCLHSA and MHSD, began identifying and serving individuals experiencing FEP in SFY17, subsequent to the 2-day NAVIGATE training held June 23 and 24, 2016. Also in SFY17, OBH contracted with the EPIC NOLA program to provide monthly case consultation to these LGEs regarding psychotherapeutic approaches and best prescriber practices. After trainings conducted in June 2019 to promote and encourage other LGEs to begin their own FEP programs, both SCLHSA and MHSD opted to expand or develop new CSC clinics. SCLHSA obtained training through a contract with the EPIC NOLA program on the YALE STEP program and MHSD obtained NAVIGATE training within the year. MHSD and SCLHSA are planning on contracting with EPIC NOLA to enhance their FEP services.
- Ongoing Technical Assistance – Through contracts with consultants, providing 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.

OBH continues to provide trainings and workshops for continuing education through the Stanford Master Clinician Series. OBH is planning on contracting with OnTrackNY to provide future trainings and consultations in the spring of 2024 with the interested FEP providers regarding their specific roles within Coordinated Specialty Care Clinic. These include consultations with prescribers, primary clinicians, the outreach and recruitment staff, the supported employment and education staff, the peer support specialist, and a specific consultation for Program Directors on the implementation of a First Episode Psychosis Coordinated Specialty Care Clinic.

- OBH Central Office First Episode Psychosis Coordinator will begin using the First Episode Psychosis-Fidelity Scale when conducting ongoing monitoring of First Episode Psychosis Clinics who receive MHBG funds in the future.
- OBH has contracted with the Volunteers of America – North Louisiana in Shreveport to establish a FEP Clinic, EpiCenter, to serve youth and adults who have begun experiencing symptoms of psychosis within the last three years to serve individuals in north Louisiana using ARPA funding.

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

- NAVIGATE and OnTrackNY: 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.
- EpiCenter (to begin using the PIER model): No age requirement; Experiencing psychosis for less than 3 years, have received a diagnosis of schizophrenia or other psychotic disorder, and are willing to be evaluated and treated by healthcare professionals.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

The estimated incidence of individuals with a first episode psychosis in Louisiana is 4238 persons per year for the 18-25 age group.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

LDH-OBH is working to actively engage those with FEP who use the public mental health system by a statewide outreach campaign, CALM. CALM not only brings awareness to what psychosis is, it seeks to actively engage those with mental illness into treatment and decrease stigma associated with psychosis and mental illness. CALM and several of the LGEs host and participate in community events to bring awareness to psychosis and promote access to treatment.

Through partnerships with various agencies throughout the state, LDH/OBH is working towards enhancing and expanding FEP Programs and services available statewide to serve this highly vulnerable population with the coordinated specialty care, evidence based model to improve access to care and the prognosis for individuals living with serious mental illness.

LDH-OBH, through a contract with Tulane University's EPIC NOLA clinic, is actively expanding with two spoke clinics into underserved regions of the state. Using statewide data, a needs assessment is currently being conducted to identity underserved regions of the state, with high levels of ESMI/FEP. LDH-OBH also continues to work with the LGEs' public mental health system to have five coordinated specialty care clinics throughout the state as well as three additional LGEs who provide the public health model for ESMI/FEP.

12. 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.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems https://ncapps.acl.gov/home.html with a systems assessment at https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf.

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.

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, and is called My Choice Louisiana (MCL). 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. To complement these activities, national consultants developed a Person Centered Planning training during SFY 21, which the Managed Care Organizations are offering to their provider networks. These trainings are ongoing.

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 plans. 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 but not limited to individuals transitioning from nursing homes and members diagnosed with a SED, SMI or substance use disorder

The managed care contract requires the development of a person-centered assessment and plan of care 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. 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.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's A Practical Guide to Psychiatric Advance Directives)?

Louisiana's Mental Health Law encourages the voluntary treatment of mental illness and substance use and requires medically appropriate treatment in the least restrictive setting possible. Individuals, may not be forced to receive treatment or be confined in a hospital unless certain legal criteria are met.

Louisiana law recognizes two types of advance directives: 1) A living will (also known as a declaration); and 2) A health care power of attorney. Advanced Directives for Behavioral Health Treatment are outlined in Louisiana law, R.S. 28:221-237 (Act 755 of 2001). This outlines that a person may use an advance directive to provide authorization for mental health treatment or to appoint a representative to make mental health treatment decisions when the person is incapable. An advanced directive template has been developed and is available online. Information about advanced directives is made available through the MCO and advocacy organizations.

Additionally, a number programs have been developed with the goal of supporting individuals in their recovery/wellness journey. These include:

1. Behavioral Health Forums which are facilitated throughout the state and provide an overview off the service system but also of available to individuals in an effort to help them understand legal commitments and their rights as service recipients.
2. Peer to Peer groups implemented throughout the state, entitled Target Health. This program is led by trained peers who facilitate a 10 week training program which focuses on the development and implementation of a wellness plan. Sessions are comprised of the following topics:
    a. Coping with Traumatic Events
    b. Recognizing and Managing Anxiety
    c. Understanding Self
    d. Developing Healthy Relationships
    e. Social Media
    f. Practicing Self-Care
    g. Recognizing and Managing Depression
    h. Suicide Awareness
    i. Understanding Substance Abuse

As stated in the Louisiana Medicaid Behavioral Health Services Provider Manual, ACT Teams are expected to have a tracking system for services and time rendered for or on behalf of any member, as well as a treatment plan that must consist of various components, to include a crisis/relapse prevention plan, including an advance directive. LDH/OBH contract partner, NAMI Louisiana (NAMI LA), also provides education and resources on psychiatric advance directives (https://namilouisiana.org/resources/advanced-directive-for-mental-health-treatment/).

6. 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG. 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?

The LSU Social Research and Evaluation Center (SREC) contacted leaders from the four federally recognized tribes within Louisiana. SREC contacted Tribal leadership of the four federally recognized Tribes in Louisiana, the Chitimacha Tribe of Louisiana, the Coushatta Tribe of Louisiana, the Jena Band of Choctaw Indians, and the Tunica-Biloxi Tribe of Louisiana to obtain insight into Tribal leaders'

understanding of the available resources for coping with the opioid crisis and their challenges related to substance use disorder (SUD) issues. Subsequently, three of the four Tribes participated in these efforts and Tribal members and leaders shared their understanding of the nature of Opioid Use Disorder (OUD) and Stimulant Use Disorder (SUD), the magnitude of the problem among Tribal members, and access to resources for prevention and treatment.

Two semi-structured interviews were conducted with healthcare providers who served Tribal members, and one semi-structured interview was conducted with Tribal leadership, each via telephone or Zoom. In total, four focus groups were conducted with 20 Tribal members.

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

In total, four focus groups were conducted with 20 Tribal members, of which 9 were men and 11 were women. In addition to the focus groups, individual stakeholder interviews were conducted with Tribal health services and Tribal leadership. All participants were adults.

Analysis of the focus groups and interview yielded six themes:

- **Urgency and Severity of Need -** Despite the recognition that opioid and stimulant use were an urgent concern, participants reported that there was a great deal of shame around SUD which kept individuals from seeking the help that they needed.
- **Knowledge of Substance Use Resources and Treatment –**Each of the Tribes had an organized social or human services department where Tribal Members could seek help for SUD.
- **Availability of Traditional or Culturally Appropriate Practices -** Agreement was universal among those interviewed that treatment options were available and individualized according to need and preference; however, inconsistencies were noted regarding the opportunities for treatment. The presence of services seemed to reflect the prevalence of SUD and the Tribal communities' commitment to treatment and recovery. Participants were minimally aware of the availability of naloxone and other opioid antagonists for reversing overdoses. Those who were familiar with naloxone conveyed limited understanding of ability to administer and indicated that limited availability, as it is stored in a locked container at the police department.
- **Community Connections -** The majority regarded their close community connections as a protective factor in SUD treatment and recovery which was enhanced by Tribal resources.
- **Trust and Distrust -** Trust issues were discussed regarding law enforcement and how information was shared among the community members. Additionally, concerns were discussed regarding the ability to provide enough information to receive appropriate treatment but not so much that it would be brought up at the next community function.
- **Availability vs Scarcity of Resources -** Most participants indicated that treatment services could be found without the typical roadblocks of insurance approval and lack of in-patient services. Both individual and group services were available for adolescents and adults, and that these services included evidence-based practices.

Barriers Observed

- Asking for help with substance use or overdose was thwarted to avoid the criminal justice system; fear of the possibility of arrest for themselves, family members, and friends if an overdose was reported was a universal concern

- There was no knowledge of the use of medication for opioid use disorder (MOUD) for treatment or of any available services for this in any Tribal areas
- Off reservation treatment requires a referral which must be approved by Indian Health Services (HIS) to ensure payment, otherwise, the member is responsible to pay out of pocket or the Tribe is required to provide payment in full (IHS, 2021)
- Treatment and recovery resources differ in the types and amounts among Tribes depending on financial resources available within the Tribe
- Although deeply rooted in their Indian culture, participants appeared to be open to learning about and having more Native American practices for SUD treatment and recovery
- While connectedness and interrelationships was viewed as a strength, it also threatened treatment opportunities due to limited confidentiality
- Limited treatment services relative to time periods allowed through mandated judicial decisions
- No reservation-based treatment centers for Tribal members were available

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

Currently, the Louisiana Department of Health's Community Partnerships in Health Equity (CPHE) Division is leading outreach and engagement with all populations inclusive of the state's native tribes. The Office of Behavioral Health (OBH) is engaged in activities that support these efforts specifically from a behavioral health lens. These activities include identification of areas of potential inequity, as well as promotion and implementation of evidence-based practices and services that assist in increasing accessibility and availability throughout the state.

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

The Director of the Governor's Office of Indian Affairs has attended Region VI Addiction Technology Transfer Center (ATTC) meetings and received resources to address requested needs for technical assistance.

8. Primary Prevention- Required (SUPTRS BG only)

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG 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 SUPTRS BG 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 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 use 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. The classifications are defined as follows:

- A Universal prevention strategy addresses the entire population (national, local community, school, and neighborhood) with messages and programs aimed at preventing or delaying the use of alcohol, tobacco, and other drugs.
- Selective prevention strategies target subsets of the total population that are deemed to be at risk for substance use by virtue of their membership in a particular population segment--for example, children of adult alcoholics, dropouts, or students who are failing academically.
- Indicated prevention strategies are designed to prevent the onset of substance use in individuals who do not meet DSM-IV criteria for addiction, but who are showing early danger signs, such as falling grades and consumption of alcohol and other gateway drugs.

Please respond to the following questions:

Assessment

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

   a) ☒ Yes ☐ No

   Note: The state's group is identified as the State Epidemiology Workgroup (SEW)

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 Use 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 Use Treatment Admissions, OBH

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG 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 use-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 74% of all enrollees in SFY 2021. The proven outcomes for these programs are centered around alcohol, tobacco, family relationships, drugs, social functioning, crime and violence. These programs have outcomes that address substance-use related problems in the State as revealed by data. Three of these data sources are the 2018 and 2020Caring Communities Youth Survey (CCYS), the 2019 and 2021 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 SUPTRS BG funds are allocated:

6. Does your state integrate National CLAS Standards into the assessment step?

a) ☒ Yes ☐ No

i) If yes, please explain
ii) If no, please explain.

The state integrates the National CLAS Standards into the assessment step. The standards support in the identification of disparities and risk factors. The standards also allow for better selection of strategies that are most appropriate to address the substance use challenges within the identified population. Qualitative and quantitative data is used in the assessment process to ensure services are equitable and meets the needs of the communities in which we serve.

7. Does your state integrate sustainability into the assessment step?

a) ☒ Yes ☐ No

iii) If yes, please explain
iv) If no, please explain.

The state does integrate sustainability in every phase of the SPF process. Sustainability in regards to assessment focuses on funding critical data sources that provides information on demographics, disparities, and evidence-based and/or evidenced-informed programs and strategies.

Capacity Planning

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

a) ☒ Yes (if yes, please describe)
b) ☐ No

Louisiana does have a statewide licensing/certification program for the substance use 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 user 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 use 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 user 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 use 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 user 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 use 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

2. 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 contracts with the Louisiana Center for Prevention Resources (LCPR) at Southern University Baton Rouge (within the Nelson Mandela College of Government and Social Sciences in the Psychology Department) to provide training and technical assistance services to the Substance Use Prevention Workforce. The LCPR will increase capacity, skills and expertise to ensure and/or enhance delivery of effective substance abuse prevention interventions, trainings and other prevention activities.

These services will be available to youth, communities, professionals, and others in the prevention community. The LCPR will work directly with the LDH/OBH Prevention Services and other statewide entities aimed at improving implementation and delivery of effective substance abuse prevention interventions. The LCPR will provide prevention skills trainings and technical assistance based on prevention science; use evidence-based and promising practices; and leverage the expertise and resources available through new and existing alliances. The LCPR will offer courses and trainings required for prevention certification and/or licensure. The LCPR serves as a repository for prevention resources.

More specifically, the LCPR offers the educational requirements needed for Prevention Specialists in-training as well as continuing education requirements needed for Prevention Specialists to renew their credentials. Most of these courses and trainings will be offered online and available free of charge to your prevention coordinators and vendors (providers) on a first-come, first served basis.

Additionally, the LCPR offers specialty trainings related to the "latest trends" that provide knowledge and skills to enhance the capabilities of persons in the prevention field. Below is a list of trainings from SFY 2021 that have been sponsored by the LCPR include

- Generation Rx
- Empowered Health Consciousness
- Anxiety, and Healthy Alternatives: Building Comfort in a Time of Epidemic
- CADCA Youth Engagement;
- Cultural Competency in Substance Use Prevention
- Facilitation Skills Training and Substance Use Prevention
- Prevention and Mental Health First Aid
- Preventing Prescription Misuse
- Health Disparities in Prevention
- Suicide Prevention
- Prevention of Mental, Emotional and Behavioral Disorders Prevention
- Prevention Ethics Seminar
- Substance Use Prevention Skills Training
- Building Prevention Services Capacity To Address Substance Use And Misuse And Related Mental Health Problems Facing Communities
- Pills to Heroin Epidemic
- Social Media and Prevention
- High in Plain Sight: Substance Use Prevention Training
- The Role of Prevention, Treatment, Recovery, and Youth in a Time of National Crisis
- Changing the Conversation
- Tall Cop - High in Plain Sight: Substance Use Prevention Training
- Ensuring Prevention Services are Trauma-Informed and Promote Health
- Tall Cop - Drug Trends: Synthetics, Stashes, and More
- Going Upstream and Digging Deeper: The Critical Role Coalitions Play in Addressing the Nation's Opioid and Heroin Crisis
- CADCA (Community Anti-Drug Coalitions of America)- Social Media & Prevention (Part 1)
- CADCA (Community Anti-Drug Coalitions of America)- Social Media & Prevention - Addressing the Pills to Heroin Epidemic (Part 2)
- Environmental Approach to Alcohol and Other Drug Problems

- Media and Literacy - Best Practices for Preventing -Substance Misuse and OUD at the Grassroots Level

OBH also works closely with the South-Southwest Prevention Technology Transfer Center (PTTC) Network to improve implementation and delivery of effective substance use prevention interventions, and provide training and technical assistance services to the substance use prevention field. The PTTC has provided intensive technical assistance and learning resources to prevention professionals in Louisiana.

During early 2021, the OBH prevention and wellness team participated in a Leadership & Resilient Team Development: Workshop Series with Organizational Wellness & Learning Systems (OWLS). The purpose of the workshops was to provide staff with intentional learning opportunities designed to cultivate and sustain skills and strength-based aptitudes. The workshops incorporated social norms and a culture for ongoing leadership growth, resilient team work, and overall greater well-being amongst individuals and the team as a whole.

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.

3. 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.

4. Does your state integrate the National CLAS Standards into the capacity building step?

a) ☒ Yes ☐ No

i) If yes, please explain

ii) If no, please explain.

The state does integrate the National CLAS Standards into capacity building efforts. In capacity building, we develop a strong infrastructure and team to support implementation of efforts. Representation of

disparate populations are often part of the team to better understand challenges and identify reasonable, equitable, and appropriate solutions.

5. Does your state integrate sustainability into the capacity building step?

a) ☒ Yes ☐ No

iii) If yes, please explain

iv) If no, please explain.

The state does integrate sustainability into the capacity building step. The state hosts several learning communities that supports capacity building across populations at the state and community levels. The state's sustainability efforts allows for stronger teams, improved skill-sets and long-term processes that have proven to be more effective.

Planning

1. 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 *2022-2026 Louisiana Substance Use Prevention Strategic Plan* is the third iteration of a statewide strategic plan focused on preventing substance use in Louisiana. As with the two previous five-year plans, this document serves as the roadmap for realizing the vision of Louisiana's substance use prevention system stakeholders. The plan begins with a pictorial and narrative description of Louisiana's statewide prevention infrastructure. Next, we define the foundational elements of Louisiana's prevention system and explain how the adoption and integration of these elements have provided a legacy for the everlasting support and growth of the system. The plan provides an analysis of data and identifies the priority substance use problems to be addressed. Finally, we outline a set of topic-specific goals and objectives that the members of the prevention system are committed to accomplishing in its effort to making measurable improvements in the health and welfare of Louisiana's citizens.
The *2022-2026 Louisiana Substance Use Prevention Strategic Plan* is a fluid document and adjustments will be made as needed throughout the five-year implementation process to respond to emerging priorities or redirect resources as achievements are realized.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

a) ☒ Yes ☐ No

☐ Not applicable (no prevention strategic plan)

3. 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 SUPTRS BG 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:) SAMHSA's Prevention Core Competencies

i) ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG 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.

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG 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 SUPTRS BG 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, the Prevention Management Information 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.

6. Does your state integrate the National CLAS Standards into the planning step?

a) ☒ Yes ☐ No

v) If yes, please explain

vi) If no, please explain.

The state does integrate the National CLAS Standards into the planning step. It is a critical step in our process as we strive to identify high risk populations and limitation in resources. As stated previously, including representation of disparate populations in the planning process allows for the ability to provide more appropriate, effective and equitable services.

7. Does your state integrate sustainability into the planning step?

a) ☒ Yes ☐ No

i) If yes, please explain

ii) If no, please explain.

Yes, the state integrates sustainability into the planning step. Planning for sustainability of the infrastructure, programs and services is a critical part of the process as desired outcomes are not always reached in short timeframes. It is the people and resources that are incorporated in the planning that increases the likelihood of reaching maximum results.

Implementation

1. States distribute SUPTRS BG 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 SUPTRS BG 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 21 Evidence-Based Educational Programs that were funded during SFY 2021 designated by Universal, Selective, or Indicated.

Universal Program(s)		Selective Program(s)
Life Skills Training	Generation Rx Elementary	Parenting Wisely
Kids Don't Gamble Wanna Bet?	Lion's Quest	Strengthening Families
Second Step	Too Good for Violence	Selective Program(s) Total: 2
Too Good for Drugs		
Project Northland	Generation Rx Teen	Indicated Program(s)
Coping Skills	Curriculum-Based Support Group Program	Insight Class Program
Protecting You - Protecting Me	Stacked Deck	Indicated Program(s) Total: 1
Al's Pals	Positive Action	
Project Toward No Tobacco	Keeping It Real	
	Project Alert	
	Universal Program(s) Total: 18	

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.

*Suicide prevention workshops are funded by the Mental Health Block Grant and are made available to prevention and treatment staff, providers, and community partners

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.

3. Does your state have a process in place to ensure that SUPTRS BG 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, use 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 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.

4. Does your state integrate National CLAS Standards into the implementation step?

a) ☒ Yes ☐ No

iii) If yes, please explain
iv) If no, please explain.

The state integrates National CLAS Standards into the implementation step. In the planning process, disparate populations are identified and appropriate strategies are selected to address specific populations. Integration of the CLAS Standards in this step occurs as the selected programs and strategies are implemented with a goal to support the reduction and/or prevention of substance use challenges related challenges in more vulnerable populations.

5. Does your state integrate sustainability into the implementation step?

a) ☒ Yes ☐ No

i) If yes, please explain
ii) If no, please explain.

Sustainability efforts are embedded in the implementation stage. The state understands how sustainability of staff, programs and stakeholder interests is essential in providing long-term care and reaching short and long-term outcomes.

Evaluation

1. 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 SUPTRS BG-funded programs through the state's Prevention Management Information System.

2. 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.

3. Please check those process measures listed below that your state collects on its SUPTRS BG 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:)

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG 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:)

5. Does your state integrate the National CLAS Standards into the evaluation step?

a) ☒ Yes ☐ No

i) If yes, please explain
ii) If no, please explain.

The state integrates the National CLAS Standards into the evaluation step. As vulnerable populations are a focus in every stage of the SPF Process, evaluation of our plans, programs, and implementation allows for the state to make critical decisions on present and future implementation efforts.

6. Does your state integrate sustainability into the evaluation step?

a) ☒ Yes ☐ No

iii) If yes, please explain
iv) If no, please explain.

Yes, sustainability is a very important part of the evaluation step. Any qualitative and/or quantitative data that is collected helps to tell better tell our story. We utilize this data to ensure that services are meaningful and effective.

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 2015, the Louisiana Department of Health (LDH) integrated 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.

Through a number of quality improvement measures, LDH/OBH partners with the six (6) Medicaid MCOs to strive to ensure implementation of an array of specialized behavioral health services to meet the needs of Louisiana citizens. This includes ensuring an adequate number, type, and geographic distribution of behavioral health providers in addition to ensuring the quality provision of services in congruence with state and national standards of operations. The MCOs are also tasked with quality and utilization reviews, to ensure individuals are receiving services in the least restrictive setting to meet their needs.

In 2014, the United States Department of Justice (DOJ) initiated an investigation of the State of Louisiana's mental health service system to assess compliance with Title II of the ADA. Following this investigation, in 2016, DOJ concluded that Louisiana unnecessarily relies on nursing facilities (NFs) to serve people with serious mental illness instead of serving them in the most integrated setting appropriate to their needs as required by the ADA. On June 6, 2018, the State of Louisiana and the Louisiana Department of Health announced an agreement with the U.S. Department of Justice to help ensure that people with serious mental illnesses have the opportunity to live in a community setting. With the DOJ Agreement, LDH welcomed the opportunity to enhance and strengthen programs to serve individuals in the least restrictive setting. In 2018, LDH established the My Choice Louisiana Program in response to the DOJ Agreement. LDH named the program "My Choice Louisiana" to reflect two of the key principles discussed in the Agreement: self-determination and choice. Through My Choice Louisiana, the State provides transition planning and support, as well as screening and evaluations to all Medicaid eligible individuals with serious mental illness who are currently in a nursing facility. The State also looks to improve on diverting individuals with serious mental illness to appropriate community-based services in lieu of nursing facility placement.

OBH works 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 coordinate 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, a number of the LGEs have established Federally Qualified Health Centers (FQHC) to provide comprehensive integrated primary and behavioral healthcare services to individuals. 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 throughout 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.

In 2022, LDH implemented Community Case Management for individuals who were transitioned or diverted from NFs. Community Case Managers (CCMs) are responsible for engaging individuals who are diverted from NFs through the Preadmission Screening and Resident Review (PASRR) Level II process, assessing their needs, developing a community plan, referring individuals to needed services, and tracking individuals for one year post transition. CCMs are to coordinate services including services in the DOJ Agreement and medical and long-term services and supports to address the individual's healthcare and activities of daily living needs. LDH tracks and reports the number of individuals who were diverted and engaged in Community Case Management, as well as what services are utilized by these individuals.

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.

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 all areas of the state, which contributes to the reduction of inpatient hospitalizations and offers intensive supports to allow individuals to remain in the community.

As reported in previous applications, the Louisiana Department of Health (LDH)/Office of Behavioral Health (OBH) has actively worked towards expanding and restructuring the Medicaid service delivery system related to crisis services. LDH/OBH recognizes that a robust crisis system of care encompasses more than just crisis treatment such as psychiatric hospitalizations. A robust crisis system includes a focus on prevention, early and acute intervention, crisis recovery, and reintegration. Louisiana recognizes it had an underdeveloped crisis system. In an effort to restructure the system, OBH envisioned and planned an expansion of the service array to address the entire crisis continuum and to emphasize community-based provision of crisis services and supports. In this model, crisis prevention and early intervention were emphasized in an effort to stave off higher levels of intervention, while care coordination following the crisis events was strengthened as individuals reintegrate into lower levels of care. Ongoing implementation of services across this continuum allow for the provision of individualized interventions intended to maximize voluntary utilization while keeping individuals out of higher levels of care and in the community.

In 2022, LDH implemented the Louisiana Crisis Response System (LA-CRS), a modern, innovative and coordinated approach to crisis services that builds upon the unique and varied strengths, resources and needs of Louisiana's local communities. LDH launched the expansion of services to Louisiana Medicaid adults experiencing a mental health crisis with the phased implementation of a comprehensive crisis system of care, a critical goal identified in LDH's Fiscal Year 2022 Business Plan. These services are directly correlated to LDH's DOJ Agreement and are critical to LDH's compliance with the Agreement. The services implemented include Mobile Crisis Response, Community Brief Crisis Support, Behavioral Health Crisis Care, and Crisis Stabilization.

Individuals experiencing a psychiatric crisis can access these services until the crisis is resolved and/or the person returns to existing services or is linked to other behavioral health supports as needed. OBH is working to expand services to every region during a phased-in rollout, and is also planning efforts and strategies to expand the Crisis Response System in fiscal year 2024 in order to expand access to these services to youth and their families experiencing mental health crises.

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

As implementation of the Crisis Response System continues to progress and expand to the youth population, technical assistance in areas related to expansion may be needed.

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.

Statewide Prevalence (column B) was determined from the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus. Statewide Incidence (column C) indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system, determined by the method described under Incidence of SMI and SED section below.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED (FY 2019)		
Target Population (A)	**Statewide prevalence (B)**	**Statewide incidence (C)**
Adults with SMI	191,822	6,506
Children with SED	36,316	1,774

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 annual estimates from U.S. Census Bureau (Annual Estimates of the Resident Population for Selected Age Groups by Sex for Louisiana: April 1, 2020 to July 1, 2022), and then multiplying the estimated population by the SMI/SED prevalence rate obtained from 2021 URS table #1 [Number of adults with serious mental illness, age 18 and older (5.4%), and Number of children with serious emotional disturbances, age 9 to 17 (7%), by state, 2021].

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 2021 are calculated following Louisiana Office of Behavioral Health methodology (column A). These numbers include both continuing and new clients. Secondly, numbers are determined for all SMI and SED clients who started receiving services *before* FY 2021 (continuing clients, column B). Lastly, the continuing SMI and SED clients are subtracted from SMI/SED persons served during FY 2021 (column A), to obtain the number of *new* clients during FY2021 (incidence, column C).

SMI/SED	**Person Served in FY 2021 (A)**	**SMI and SED Clients Who Started Receiving Services before FY 2021 (Continuing Clients) (B)**	**Incidence (New SMI and SED Clients) Who Received Services during 2021 (C=A-B)**
Adults with SMI	13,155	6,649	6,506
Child/Youth with SED	2,975	1,201	1,774

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. See SAMHSA's Rural Behavioral Health page for program resources (https://www.samhsa.gov/rural-behavioral-health).

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 continues to be 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. Some of the LGEs have chosen to utilize their block grant funds for transportation contracts, whereas the LGEs are contracting with private transportation companies to provide transportation to clinic appointments when necessary. The ongoing 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), have been made available to serve some of these populations. The ability of the six (6) 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 continues to be the development of a more robust provider network, even in the more rural areas of the state. Overall, the expanded option of telehealth services during the COVID pandemic has been helpful with increasing access to services. Many providers have expressed increase in participation rates and decrease in "no show" rates for scheduled appointments. While telehealth has been an added benefit to access to care for the rural

areas, there continues to be an infrastructure challenge in some rural areas of Louisiana with limited internet availability.

b) Describe your state's targeted services to people experiencing homelessness. See SAMHSA's Homeless Programs and Resources for program resources.

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
- Start Corporation	CAHSD
South Central Louisiana Human Service Authority	SCLHSA
Volunteers of America South Central LA - Lafayette	AAHSD
Volunteers of America South Central LA - Alexandria	CLHSD
HOPE Connection	NLHSD
Easter Seals	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 a contract with Start Corporation (Start Corp) to fund eleven beds with a transitional housing/adult residential care program for individuals with serious mental illness (SMI) who are homeless or at risk of homelessness.

The contract with Start Corp, which began in 2018, funds the Wren Way Transitional Housing program. This program allows a length of stay for up to two years for individuals with a primary diagnosis of serious mental illness. The contract for the Wren Way program was previously with NAMI St. Tammany. As evidenced by the historical data with this program, the majority of residents have co-occurring disorders, to include substance use disorders, chronic medical conditions, and/or intellectual developmental disabilities (IDD).

This Wren Way Transitional Housing 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. Start Corp 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. Start Corp also partners with other community based healthcare providers to ensure the residents behavioral and primary healthcare needs are met. Start Corp coordinates linkage to providers for treatment of primary healthcare, behavioral healthcare, and IDD services through either their own agencies, which includes ACT Teams and FQHCs, or any other appropriate provider agency the resident chooses.

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. In the coming fiscal year, the goal of OBH is to create nine (9) regional SOAR Benefits Specialist positions to assist targeted individuals with serious mental illness with their applications for SSI/SSDI and other mainstream resources. This additional support would also assist with reducing institutionalization, increasing community supports, and support successful long-term recovery in the community.

In 2020, OBH also began to have representation on the Louisiana Statewide Independent Living Council (SILC) to provide behavioral health information and support to the Council and individuals it represents from throughout the state. The Louisiana Statewide Independent Living Council (SILC) was established by the Rehabilitation Act of 1973 to support the efforts of our citizens with disabilities to live independently in the community of their choice. SILC works to maximize the leadership, empowerment, independence and productivity of individuals with disabilities, facilitating integration and full inclusion into the mainstream of American society.

In 2019, LDH Leadership began to serve on the Task Force on Human Degradation & Exploitation of Vulnerable Individuals in Community-Based Settings, which was established through legislation to address the needs for appropriate community-based settings for individuals with SMI and IDD. In addition to LDH Leadership, OBH staff also serves as a support to this Task Force, whose goal is to ensure safe community-based and group home settings for individuals with disabilities.

c) Describe your state's targeted services to the older adult population. See SAMHSA's Resources for Older Adults webpage for resources.

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.

CMHC ADULT MENTAL HEALTH CASELOAD SIZE ON LAST DAY OF FY2021 & FY2022

	FY20-21			FY21-22		
	Age 18-64	Age 65+	TOTAL Age 18+	Age 18-64	Age 65+	TOTAL Age 18+
LGE						
01-MHSD	3,351	304	3,655	3,124	313	3,437
02-CAHSD	3,081	386	3,467	3,664	485	4,149
03-SCLHSA	6,522	475	6,997	5,666	454	6,120
04-AAHSD	3,483	301	3,784	3,215	315	3,530
05-IMCAL	2,515	165	2,680	2,632	168	2,800
06-CLHSD	1,893	232	2,125	2,011	228	2,239
07-NLHSD	1,043	65	1,108	1,117	77	1,194
08-NEDHSA	874	69	943	955	90	1,045
09-FPHSA	3,488	302	3,790	3,276	334	3,610
10-JPHSA	3,218	306	3,524	2,950	321	3,271
TOTAL	29,468	2,605	32,073	28,610	2,785	31,395

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

Current Primary Diagnosis	LOCAL GOVERNING ENTITY COUNT OF SERVICES RECEIVED for Mental Health Clients 65 and Over (Fiscal Year 2020)																				TOTAL	
	01-MHSD		02-CAHSD		03-SCLHSA		04-AAHSD		05-IMCAL		06-CLHSD		07-NWLHSD		08-NEDHSA		09-FPHSA		10-JPHSA			
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
ANXIETY DISORDERS	8	0.7%	75	2.3%	8	0.4%	70	3.8%	107	11.5%	54	4.1%	8	1.4%	49	3.3%	144	4.8%	48	3.2%	571	3.4%
ATTENTION DEFICIT	.	.	.	.	.	.	14	0.8%	9	1.0%	.	.	.	.	.	.	.	.	.	.	23	0.1%
AUTISM SPECTRUM	.	.	.	.	.	.	.	.	5	0.5%	.	.	.	.	.	.	.	.	.	.	5	0.0%
BIPOLAR AND RELATED DISORDERS	58	5.1%	211	6.6%	43	2.2%	250	13.7%	102	10.9%	82	6.2%	88	15.8%	196	13.2%	162	5.4%	23	1.5%	1215	7.2%
DEPRESSIVE DISORDERS	82	7.3%	384	11.9%	323	16.7%	633	34.7%	277	29.7%	282	21.3%	162	29.0%	364	24.5%	459	15.3%	283	18.6%	3249	19.2%
DISRUPTIVE, IMPULSE, & CONDUCT DISORDERS	4	0.4%	.	.	1	0.1%	4	0.2%	.	.	.	.	.	.	.	.	2	0.1%	.	.	11	0.1%
ILLNESS, UNSPECIFIED	.	.	.	.	22	1.1%	.	.	.	.	.	.	.	.	.	.	.	.	.	.	22	0.1%
INTELLECTUAL DISABILITY	.	.	1	0.0%	.	.	.	.	10	1.1%	.	.	.	.	.	.	.	.	1	0.1%	12	0.1%
NEUROCOGNITIVE DISORDERS	8	0.7%	.	.	.	.	1	0.1%	.	.	.	.	.	.	.	.	.	.	.	.	9	0.1%
NEUROGOGNITIVE DISORDERS	2	0.2%	.	.	.	.	.	.	.	.	3	0.2%	.	.	.	.	.	.	.	.	5	0.0%
OTHER/UNSPECIFIED MENTAL DISORDERS	.	.	.	.	.	.	7	0.4%	.	.	.	.	.	.	.	.	.	.	.	.	7	0.0%
PERSONALITY DISORDERS	.	.	.	.	.	.	.	.	.	.	.	.	1	0.2%	.	.	36	1.2%	.	.	37	0.2%
PSYCHOTIC DISORDERS	293	25.9%	866	26.9%	298	15.4%	335	18.4%	114	12.2%	230	17.4%	118	21.1%	352	23.7%	416	13.9%	80	5.3%	3102	18.3%
SUBSTANCE RELATED AND ADDICTIVE DISORDER	11	1.0%	34	1.1%	15	0.8%	73	4.0%	22	2.4%	.	.	.	.	.	.	92	3.1%	39	2.6%	286	1.7%
TRAUMA & STRESSOR RELATED DISORDERS	4	0.4%	17	0.5%	35	1.8%	80	4.4%	24	2.6%	22	1.7%	.	.	41	2.8%	47	1.6%	4	0.3%	274	1.6%
Z CODES	7	0.6%	4	0.1%	13	0.7%	4	0.2%	.	.	5	0.4%	.	.	26	1.7%	20	0.7%	3	0.2%	82	0.5%

Missing	654	57.8%	1623	50.5%	1173	60.7%	352	19.3%	263	28.2%	645	48.8%	181	32.4%	458	30.8%	1616	54.0%	1037	68.3%	8002	47.3%
TOTAL	1131	100%	3215	100%	1931	100%	1823	100%	933	100%	1323	100%	558	100%	1486	100%	2994	100%	1518	100%	16912	100%

Current primary diagnosis is most recent available primary diagnosis from admission to end of the time period

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 six (6) 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 by OBH for nursing home during FY23:

Evaluations for Nursing Home by OBH	**FY 2023**
PASRR Process Referrals	**10,384**
Types of Referrals	
• Referrals for admission to nursing facilities (preadmission)	**3703**
• Referrals for resident reviews performed while in the nursing facility after a significant change in status (resident review)	**2620**
• Referrals for Extension Requests through the Continued Stay Request process for individuals already admitted to a nursing facility (continued stay review)	**4061**
Decisions	
• Approved for Nursing Facility Placement	**5877**
• Denied Nursing Facility Placement	**354**
• Decided not to go to Nursing Facility and withdrew request	**998**
• 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).	**2888**

• OCDD in charge of determination	**199**
Number of Level II Evaluations (MCO and Merakey)	**5618**
• Aetna (MCO)	**856**
• AmeriHealth Caritas of Louisiana (MCO)	**906**
• Healthy Blue (MCO)	**1001**
• Humana (MCO)	**134**
• Louisiana Healthcare Connections (MCO)	**1217**
• Merakey	**373**
• United Healthcare (MCO)	**1131**
Number of Evaluations by OBH Psychiatrist	**1314**

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 six (6) 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 statewide 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. OBH has hired ten (10) regional Transition Coordinators with experience in behavioral health programs and services to assist individuals with SMI transitioning from a nursing facility to the community, as well as to assist with diverting individuals with SMI from nursing facility placements when a less restrictive setting in the community would be the most appropriate placement. This program is called My Choice Louisiana (MCL).
- This program has expanded in scope and in addition to transition coordinators working throughout the state, Peer Support Specialists (called Peer In-Reach Specialists) have also been integrated into the transition teams to assist in the transition process.

- 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) as well as collaborations between LDH and the Louisiana Hospital Association (LHA) and the Louisiana Nursing Home Association (LNHA)
- 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
- Improvements to the PASRR tracking systems
- Internal quality improvement processes for the PASRR and MCL programs
- Development of a dementia protocol within the PASRR program
- 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 LNHA members regarding PASRR and behavioral health issues in older adults
    - LDH trainings to the LHA about PASRR and MCL
    - 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.

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

N/a

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.

a. 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. Due to the COVID-19 Pandemic, training programs made the transition from in-person to virtual in 2020. The MCOs have continued to provide web-based training opportunities to providers and partners.

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 systems (i.e. 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 participants 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 Use Counselors and Trainers (LASACT) annual conference, by presenting specified material during workshops as requested. Throughout the pandemic with virtual events and as events transitioned back to in-person or hybrid models, OBH has continued to provide supportive resources to both of these large statewide conferences. OBH intends to continue to support these efforts for the upcoming fiscal years.

In September 2022 OBH also sponsored a statewide Behavioral Health Symposium with a theme of "Reflecting on our Past-Respecting our Present-Renewing our Future." With the added stressors brought on by the pandemic, the 2022 BH Symposium addressed treatment and prevention topics related to the the impacts of the pandemic and how our paths forward were transformed by the pandemic. The three-day behavioral Health Symposium was co-sponsored by the Medicaid MCOs, the Office of Aging and Adult Services (OAAS), Acadiana Area Human Services District (AAHSD), and Woman's Foundation. Over 800 individuals actively participated in the hybrid 2022Behavioral Health Symposium, which included both in-person and live streaming. 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 pre-

conference day that included day-long presentations on updating Louisiana's Response to the Opioid Crisis and the My Choice Louisiana Initiative. Keynote speakers and topics from the 2022 Behavioral Health Symposium included the following:

- Louisiana Governor John Bel Edwards addressing behavioral health needs in response to the COVID-19 Pandemic
- Dr. Courtney Phillips, LDH Secretary addressing the state's response to COVID-19 with public health and behavioral health resources.
- Dr. Dan Schneider, The Pharmacist from the Netflix documentary
- Kristie Brooks, Regional Administrator for SAMHSA (Region 6)
- Marisa Lee – nationally renowned author of "Grief is Love"
- Emma Benoit – Suicide Survivor and Nationally Recognized Youth Suicide Prevention & Awareness Activities

Partners invited to participate in the 2022 Behavioral Symposium included service providers throughout the private and public behavioral health and primary health systems, preventionists, peer support specialists, other state agencies, as well as service recipients, their families and advocates.

Please see list below of training topics included in the 2022 Behavioral Health Symposium:

- Opioid Epidemic
- Human Trafficking: Modern Day Slavery
- Ethics for Behavioral Health Specialists
- Grief and Loss Health Disparities Among Vulnerable Populations
- Peer Support Services
- Serving Homeless Population with Behavioral Health Disorders
- Medication Assisted Treatment
- Suicide Prevention

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 various behavioral health topics. Throughout the coming 2023-2024 fiscal year, OBH is planning to continue the virtual series of webinars. These webinars will be expansions of topics addressed during the 2022 Behavioral Health Symposium. Topics to be addressed will include those that partners have continued to express an interest and need for additional training as communities, families and individuals.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

As indicated in the previous Criterion, the expanded option of telehealth services during the COVID pandemic has been helpful with increasing access to services. Many providers have expressed increase in participation rates and decrease in "no show" rates for scheduled appointments. Feedback from providers have indicated that telehealth has expanded options to provide services and a combined model of both in-person and telehealth visits has proven to be the most effective. In 2023, LDH issued informational

bulletins announcing the telehealth option for behavioral health services would be extended beyond the public health emergency (PHE).

While telehealth has been an added benefit to access to care for the rural areas, there continues to be an infrastructure challenge in some rural areas of Louisiana with limited internet availability. Based on current research studies, Louisiana currently ranks 46th among states in *BroadbandNow's* annual rankings of internet coverage, speed and availability. In 2019, Louisiana's Broadband for Everyone in Louisiana (BEL) Commission with diverse representation of stakeholders was established with a goal to improve both the adoption and availability of broadband service for Louisiana residents by providing universal access to broadband service with minimum committed speed of 25 Megabits per second (Mbps) download and 3 Mbps upload, scalable to up to 100 Mbps download and 100 Mbps upload, for all Louisianans by 2029.

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

At this time, there are no areas of technical assistance identified within this section.

10. Substance Use Disorder Treatment - Required SUPTRS BG

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) Withdrawal Management (inpatient/social)
      ☒ Yes ☐ No
      vi) Outpatient
      ☒ Yes ☐ No
      vii) Intensive outpatient
      ☒ Yes ☐ No
      viii) Inpatient/residential
      ☒ Yes ☐ No
      ix) Aftercare/Continuing Care
      ☒ Yes ☐ No
      x) Recovery Services
      ☒ Yes ☐ No

b) Services for special populations:
   i) Prioritized services for veterans?
   ☐ Yes ☒ No
   ii) Adolescents?
   ☒ Yes ☐ No
   iii) Older adults?
   ☐ 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.

OBH/LGE Accountability Plan Monitoring Procedures include

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 OBH shall conduct two on-site visits to each LGE managed program location each year.
4. The LGE shall conduct two on-site visits to each contracted program location each year.
5. The OBH standardized tool with outcome scores shall be utilized by OBH and LGEs for all programs.
6. OBH shall email the initial report and corrective action form to the contractor within thirty (30) business days of each monitoring visit.
7. LGE shall email the initial report and corrective action form to the contractor within the LGE's established timelines and processes.
8. For OBH conducted reviews, the LGE may seek clarification, dispute any elements of the initial report and/or submit corrective action within thirty (30) business days of receipt of the initial report. The responses to the report shall be sent to the OBH staff who conducted the review.
9. For LGE conducted reviews, the contractor may seek clarification, dispute any elements of the report, and/or submit corrective action within thirty (30) business days of receipt of the initial report. The responses to the report shall be sent to the OBH staff who conducted the review.
10. For LGE conducted reviews, OBH shall respond to the LGE program within thirty (30) business days to any LGE responses added to the initial report.
11. LGE will respond to the contractor within the LGE's established timelines and processes to the initial report.
12. OBH shall issue the final report to the LGE program within 30 days of receipt of the LGE response.
13. The LGE shall require the contractor to submit a corrective action plan to address any deficiencies identified within the LGE's established timelines and procedures.
14. The LGE will email the final monitoring tool and corrective action plan to OBH for review within thirty (30) business days for LGE operated programs and within forty-five (45) business days for contractors following receipt of the final monitoring report.
15. For any program with a score of less than 70%, the OBH/LGE shall offer technical assistance and 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

c) Service expansion to specific populations (military families, veterans, adolescents, LGBTQI+, 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 users, other injecting drug users, and all others. Priority admissions monitoring practices are reviewed during the mandated independent peer review process and during the Annual Accountability Plan (AP) 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 AP 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.

OBH/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 OBH shall conduct two on-site visits to each LGE managed program location each year.
4. The LGE shall conduct two on-site visits to each contracted program location each year.
5. The OBH standardized tool with outcome scores shall be utilized by OBH and LGEs for all programs.
6. OBH shall email the initial report and corrective action form to the contractor within thirty (30) business days of each monitoring visit.
7. LGE shall email the initial report and corrective action form to the contractor within the LGE's established timelines and processes.
8. For OBH conducted reviews, the LGE may seek clarification, dispute any elements of the initial report and/or submit corrective action within thirty (30) business days of receipt of the initial report. The responses to the report shall be sent to the OBH staff who conducted the review.
9. For LGE conducted reviews, the contractor may seek clarification, dispute any elements of the report, and/or submit corrective action within thirty (30) business days of receipt of the initial report. The responses to the report shall be sent to the OBH staff who conducted the review.
10. For LGE conducted reviews, OBH shall respond to the LGE program within thirty (30) business days to any LGE responses added to the initial report.
11. LGE will respond to the contractor within the LGE's established timelines and processes to the initial report.
12. OBH shall issue the final report to the LGE program within 30 days of receipt of the LGE response.
13. The LGE shall require the contractor to submit a corrective action plan to address any deficiencies identified within the LGE's established timelines and procedures.
14. The LGE will email the final monitoring tool and corrective action plan to OBH for review within thirty (30) business days for LGE operated programs and within forty-five (45) business days for contractors following receipt of the final monitoring report.
15. For any program with a score of less than 70%, the OBH/LGE shall offer technical assistance and 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.

OBH/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 OBH shall conduct two on-site visits to each LGE managed program location each year.
4. The LGE shall conduct two on-site visits to each contracted program location each year.
5. The OBH standardized tool with outcome scores shall be utilized by OBH and LGEs for all programs.
6. OBH shall email the initial report and corrective action form to the contractor within thirty (30) business days of each monitoring visit.
7. LGE shall email the initial report and corrective action form to the contractor within the LGE's established timelines and processes.
8. For OBH conducted reviews, the LGE may seek clarification, dispute any elements of the initial report and/or submit corrective action within thirty (30) business days of receipt of the initial report. The responses to the report shall be sent to the OBH staff who conducted the review.
9. For LGE conducted reviews, the contractor may seek clarification, dispute any elements of the report, and/or submit corrective action within thirty (30) business days of receipt of the initial report. The responses to the report shall be sent to the OBH staff who conducted the review.
10. For LGE conducted reviews, OBH shall respond to the LGE program within thirty (30) business days to any LGE responses added to the initial report.
11. LGE will respond to the contractor within the LGE's established timelines and processes to the initial report.
12. OBH shall issue the final report to the LGE program within 30 days of receipt of the LGE response.
13. The LGE shall require the contractor to submit a corrective action plan to address any deficiencies identified within the LGE's established timelines and procedures.
14. The LGE will email the final monitoring tool and corrective action plan to OBH for review within thirty (30) business days for LGE operated programs and within forty-five (45) business days for contractors following receipt of the final monitoring report.
15. For any program with a score of less than 70%, the OBH/LGE shall offer technical assistance and 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 SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances (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 Program?
☒ Yes ☐ No
3. Do any of your programs use SUPTRS BG 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) MOUD
☒ 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.

      - All ten Sub-recipients/LGEs participate in IPR.

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 Opioid Response

☒ 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 (300x-22(b))

☐ Yes ☒ No

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

a) Intravenous substance use (300x-23)

☐ Yes ☒ No

3. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis

☐ Yes ☒ No

b) Early Intervention Services Regarding HIV

☐ Yes ☒ No

4. Additional Agreements (300x-28)

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.ldh.la.gov/assets/medicaid/hss/docs/BHS/LAC_48v01_BHSP.pdf

5. If the answer is No to any of the above, please explain the reason.

OBH intends to serve these priority populations, as required.

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 2022-FFY 2023?

a) ☒ Yes ☐ No

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

N/A

12. Trauma –requested

Trauma is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. 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 and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their 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 how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, 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 with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to 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 six (6) 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 and other emergencies, such as hurricanes, oil spills, and the COVID Pandemic.

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.

OBH and Medicaid fund the work of the Center for Evidence to Practice (the Center) housed at the Louisiana State University- Health Sciences Center (LSUHSC), which trains therapists statewide in evidence-based interventions for children and youth. A strong focus for the Center in its first several years of operation has been training in interventions for trauma. The Center has trained multiple cohorts of therapists in evidence-based interventions treating trauma, for children from infancy (i.e. Child Parent Psychotherapy), into preschool age (i.e. Preschool PTSD Treatment), school-age and adolescence (Trauma-Focused CBT and EMDR Therapy).

3. Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?

   ☒ Yes ☐ No

As indicated above, OBH works through the Center to conduct trainings on trauma specific treatment and interventions. This includes those working in evidence-based interventions treating trauma, for children from infancy (i.e. Child Parent Psychotherapy), into preschool age (i.e. Preschool PTSD Treatment), school-age and adolescence (Trauma-Focused CBT and EMDR Therapy). Additionally, the Center has integrated topics related to trauma in its training associated with the Louisiana Crisis Response System of staff working within this statewide network of crisis services. This includes effects of trauma and the implementation of interventions and techniques intended to mitigate the iatrogenic harm caused by involuntary or coercive treatment.

4. 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 educated people around the state to understand the impact of trauma on future health and to establish the need for trauma informed care in organizations.

5. 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.

6. Does the state use an evidence-based intervention to treat trauma?

   ☒ Yes ☐ No

As indicated previously, through the Center OBH has implemented training for therapists in a number of evidence-based interventions to treat trauma. These include:

- Child Parent Psychotherapy
- Preschool and Youth PTSD Treatment
- Trauma-Focused Cognitive Behavioral Therapy
- Eye Movement Desensitization and Reprocessing Therapy

7. 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 a third of people in prisons and nearly half of people in jail have a history of mental health problems. Almost two thirds of people in prison and jail meet criteria for a substance use disorder. As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem. States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;

- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

Please respond to the following items:

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

   ☒ Coordination across mental health, substance use disorder, criminal justice and other systems

   ☐ Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups

   ☒ Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder

   ☒ Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g., Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)

   ☒ Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;

   ☒ Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community

   ☒ Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)

   ☐ Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)

☒ Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system

☒ Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met

☒ Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges (Oxford Homes)

☒ Partnering with the judicial system to engage in cross-system planning and development at the state and local levels

☒ Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system

☒ Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD

☒ Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe. Yes ☒ No ☐

   The state implements Culturally and Linguistically Appropriate Services (CLAS) that facilitates equitable organizational governance, leadership and workforce that are responsive to the population and promotes policy, practices and trainings to ensure services are responsive to diverse cultures. The state also integrates the National CLAS Standards into the assessment step. The standards support in the identification of disparities and risk factors. The standards also allow for better selection of strategies that are most appropriate to address the substance use challenges within the identified population. Qualitative and quantitative data is used in the assessment process to ensure services are equitable and meets the needs of the communities in which we serve. The state does integrate the National CLAS Standards into capacity building efforts. In capacity building, we develop a strong infrastructure and team to support implementation of efforts. Representation of disparate populations are often part of the team to better understand challenges and identify reasonable, equitable, and appropriate solutions. In addition CLAS is also integrated into the planning step. It is a critical step in our process as we strive to identify high risk populations and limitation in resources. As stated previously, including representation of disparate populations in the planning process allows for the ability to provide more appropriate, effective and equitable services.

3. 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 recidivism rates by 50% for higher risk returning prisoners, beginning with 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 delivery and, comprehensive planning; (4) Create transitional and permanent jobs by working with Louisiana's business community; (5) Build affordable housing opportunities, linked to employment; (6) Create/adapt DPSC policy and 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.

4. Does the state have any activities related to this section that you would like to highlight?
    - The Office for Behavioral Health (OBH) and the Department of Public Safety and Corrections (DPSC) 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 substance use and recidivism. OBH's goal is to improve mental health and substance use outcomes of women and men returning to society. OBH conducts on-site presentations to returning citizens and facility staff at eleven Re-Entry Facilities in Plaquemines, East Baton Rouge, West Baton Rouge, Iberville, Lafayette, St. Tammany, Allen, Rapides, Franklin, Madison and Caddo parishes. OBH also partners with Oxford House, Inc. to bridge gaps by ensuring safe recovery housing for persons transitioning from incarceration. This approach is coordinated with the Oxford Inc. model, which is a community-based approach to substance use treatment that provides an independent, supportive, and sober living environment. Oxford Outreach Liaisons accompany the designated Licensed Mental Health Professional (LMHP) during visits at designated re-entry sites and conducts specific presentations on the Oxford model and the process involved in facilitating referrals to sober living homes.
    - 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.

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

The sequential intercept model, which details how individuals with mental and substance use disorders come into contact with and move through the criminal justice system. It 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, which is a national initiative to reduce the number of people with mental illnesses in jails, has not been as widely distributed as anticipated and perhaps additional technical assistance or local learning collaboratives could spread the initiative to a larger state footprint.

In addition, OBH would benefit from collaborative learning communities or emersion trainings between the department and the Department of Corrections, to bridge gaps for the planning, implementation and

execution in the use of all FDA approved medications for opioid use disorders within the criminal justice system.

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

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 MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

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. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

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 the use of MOUD for substance use disorders?

   ☒ Yes ☐ No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, 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

   Naloxone is purchased with SUPTRS BG supplemental funds.

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs[6]?

   ☒ 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 MOUD by incorporating language into all behavioral health provider contracts, whereas providers must provide MOUD 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 no wrong door approach for persons on MOUD. In addition, the state is currently implementing the 1115 waiver which requires all residential programs to offer MOUD on site or make those services readily available via referral. OBH has implemented a workforce development initiative to provide training and education on MOUD to physicians and clinicians statewide. These trainings are geared towards providing evidence of the effectiveness of the use of medication for Opioid Use Disorders.

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Substance Use and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*

[6] 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.

CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:

- *Crisis call centers*
- *24/7 mobile crisis services*
- *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*

STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.

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-intervention 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, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed Crisis Services: Meeting Needs, Saving Lives, which includes "National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit" as well as an Advisory: Peer Support Services in Crisis Care and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "National Guidelines for Child and Youth Behavioral Health Crisis Care" which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Regional Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Regional Crisis Call Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A regional crisis call center provides an

alternative. Regional crisis call centers should be made available statewide, provide real-time access to a live mental health professional on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 because either they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either the police department's co-responder team (police officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with police officers who have received Mental Health First Aid and Crisis Intervention Training, including de-escalation methods and behavioral health symptoms; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers then refer to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Call Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be de-escalated by phone. In the current system, police are often dispatched to the location of the individual in crisis. But in an effective crisis system, two-person teams, including a clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be transported to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a no-reject policy. Particularly when police or EMS are dropping off an individual, the hand-off should be "warm" (welcoming) and efficient, and these facilities provide assessment and address mental health and substance use crisis issues. A warm hand-off establishes an initial face-to-face contact between the client and the crisis facility worker. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of professionals and volunteers who are trained to utilize best practices in handling distress calls. Local call centers automatically perform a safety check for every call;

if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (P.L. 116-172) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 but the, 1-800-273-TALK is still operational. The 988 transition has supported and expanded to the Lifeline network and will continue utilizing the live-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited crisis services, but a few have an organized system of services that coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

Please check those that are used in your state:

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Historically, Louisiana had in many ways an underdeveloped crisis system. While there had been requirements for behavioral health treatment providers to render core services including crisis mitigation, such as crisis planning and response, and there were a couple of limited areas of the state that had developed mobile crisis response and/or walk-in centers, there was not a cohesive crisis response system operating throughout the state. However, a number of activities have been undertaken within Louisiana to develop a statewide comprehensive crisis system of care. This is called the Louisiana Crisis Response System (LA-CRS).

In addition to the LA-CRS, all behavioral health service (BHS) providers licensed under LAC 48:1.Chapter 56, including Local Governing Entities (LGEs), must provide core services including crisis mitigation. This critical service offers assistance to individuals during a crisis including 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. Also, providers contracted with at least one managed care organization (MCO) to deliver Medicaid funded mental health and substance use services including Mental Health Rehabilitation (MHR), Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST) 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

LDH has developed 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, sought feedback from individuals, advocates, service providers, and MCOs via a Request for Information (RFI) to develop key components of this modern, innovative and coordinated crisis system for adults which operates in congruence with the following::

- Values and incorporates "lived experience" in designing a crisis system and in crisis service delivery;
- Encompasses a continuum of services that includes crisis prevention, acute intervention and post-crisis recovery services and supports;
- Is built on principles of recovery and resiliency, delivering services that are individualized and person-centered;
- Provides interventions to divert individuals from institutional levels of care including inpatient placements, emergency departments utilization, nursing facilities and other out of home settings;
- Provides timely access to a range of acute crisis responses, including locally available home and community-based services and mobile crisis response;
- Provides stabilizing interventions and supports that allow individuals to recover as quickly as possible;
- Delivers resolution-focused interventions and assists individuals in problem-solving and in developing strategies to prevent future crises and enhance their ability to recognize and deal with situations that may otherwise result in crises;
- Supports individuals to increase or improve their network of community and natural supports, as well as their use of these supports for crisis prevention;
- Continuously improves its processes to assure seamless and efficient care;
- Collaborates and innovates with partner systems including healthcare systems, judicial systems, law enforcement, child protective services, educational systems, homeless coalitions, as well as any other system that touches individuals who may experience a behavioral health crisis; and
- Collaborates with the individual's existing behavioral health service providers, or links individuals to new behavioral health service providers for longer-term treatment when appropriate and desired by the recipient.

In order to support the implementation of the LA-CRS, LDH/OBH is utilizing Mental Health Block Grant funds to support a contract with Louisiana State University Health Science Center (LSUHSC) School of Public Health, Center for Evidence to Practice with the main goal being to recruit and develop a network of providers that provide crisis services ultimately in a stable, sustainable, all-encompassing system. It will conduct activities critical to implementation of a crisis system including the following activities, which will have a positive impact on all crisis providers, which render services to both the insured and uninsured populations:

- Collaborate with communities throughout Louisiana, developing a readiness process and measures for communities that demonstrate awareness, resources, key partners and benchmarks for progress, with technical assistance (TA) being provided to aid in the transition to and implementation of this new crisis service system.

- Develop a training curriculum inclusive of a process for ongoing coaching for the crisis response workforce; this process includes developing a model of implementation to include an online learning platform and a cadre of trainers, which will be critical to the sustainability of this project.
- Identify workforce and implement training curriculum and ongoing coaching to ensure appropriate execution of services.
- Conduct ongoing data collection required to inform LDH/OBH of the quality of the process, sustainability and outcomes associated with these efforts.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

a) The ***Exploration*** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.

b) The ***Installation*** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.

c) ***Initial Implementation*** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA guidelines.

d) ***Full Implementation*** stage: occurs once staffing is complete, services are provided, and funding streams are in place.

e) ***Program Sustainability*** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis call Capacity
    a. Number of locally based crisis call Centers in state
        i. In the 988 Suicide and Crisis Lifeline network
        ii. Not in the suicide lifeline network
    b. Number of Crisis Call Centers with follow up Protocols in place
    c. Percent of 911 calls that are coded out as BH related
2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)
    a. Independent of first responder structures (police, paramedic, fire)
    b. Integrated with first responder structures (police, paramedic, fire)
    c. Number that employs peers
3. Safe place to go or to be:
    a. Number of Emergency Departments
    b. Number of Emergency Departments that operate a specialized behavioral health component.
    c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early implementation Less than 25% of people in state	Middle Implementation About 50% of people in state	Majority Implementation At least 75% of people in state	Program Sustainment
Someone to talk to	X	X	X	X	X	X
Someone to respond				X		
Place to go				X		

b. Briefly explain your stages of implementation selections here.

1. Someone to talk to: Call Center Capacity

a. Number of locally based crisis call Centers in state

i. In the 988 Suicide and Crisis Lifeline network – We have 2 certified Lifeline crisis call centers in Louisiana. With these two centers we have statewide primary and back-up coverage to ensure a high in-state answer rate and to provide referrals to local resources. Trained crisis counselors at these centers respond to calls twenty-four (24) hours per day, seven (7) days per week (24/7) providing telephonic access for crisis intervention, suicide prevention, and information and referral services for Louisiana residents. They also respond to texts and chats from 7pm until 1pm 7 days a week. These crisis call centers are available to everyone in Louisiana regardless of insurance status. Primary coverage areas for each center are listed below:

1. VIA LINK has offices in Orleans and St. Tammany Parishes. VIA LINK provides primary coverage for the following area codes/parishes:

   - 225 area code: Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, St. James, West Baton Rouge, West Feliciana
   - 504 area code: Jefferson, Orleans, Plaquemines, St. Bernard
   - 985 area code: Assumption, Lafourche, St. Charles, St. John the Baptist, St. Tammany, Tangipahoa, Terrebonne, Washington

   Additionally, it provides backup coverage to LACG.

2. Louisiana Association on Compulsive Gambling (LACG) has an office in Bossier Parish. LACG provides primary coverage for the following area codes/parishes:
   - 318 area code: Avoyelles, Bienville, Bossier, Caddo, Caldwell, Catahoula, Claiborne, Concordia, DeSoto, East Carroll, Franklin, Grant, Jackson, LaSalle, Lincoln, Madison, Morehouse, Natchitoches, Ouachita, Rapides,

Red River, Richland, Sabine, Tensas, Union, Webster, West Carroll, and Winn

- 337 area code: Acadia, Allen, Beauregard, Calcasieu, Cameron, Evangeline, Iberia, Jefferson Davis, Lafayette, St. Landry, St. Martin, St. Mary, Vermilion, Vernon

Additionally, it provides backup coverage to VIA LINK.

ii. Not in the suicide lifeline network-N/A Several local areas around the state have crisis call numbers initiated through no profit organizations of regional human service districts providing behavioral health services. These lines are available to everyone regardless of insurance type, including the indigent populations. In addition, the Medicaid managed care organizations also have crisis call numbers available to their members.

b. Number of Crisis Call Centers with follow up Protocols in place - 2 (VIA LINK and LACG)

c. Total number of calls statewide and by local crisis call center-

During 2022 there were 30,268 calls routed to centers in Louisiana. 22,525 or 74.42% were answered in-state. The table below shows the number of calls routed and answered by month. There was a notable increase in the in-state answer rate when LACG joined the network in July 2022.

	Metrics		
Month	**Number of Calls Received**	**Number of Calls Answered In-State**	**In-State Answer Rate**
January 2022	2,537	1,597	63%
February 2022	2,401	1,494	62%
March 2022	2,462	1,655	67%
April 2022	2,244	1,481	66%
May 2022	2,531	1,638	65%
June 2022	2,365	1,510	64%
July 2022*	2,640	2,347	89%
August 2022	2,573	2,340	91%
September 2022	2,434	2,060	85%
October 2022	2,475	2,105	85%
November 2022	2,256	1,942	86%
December 2022	2,671	2,356	88%
January 2023	2,685	2,332	87%
February 2023	2,316	1,968	85%
March 2023	2,549	2,210	87%
April 2023	2,355	2,041	87%
May 2023	2,710	2,340	86%
June 2023	2,548	2,155	85%

*LACG was added to the network when 988 launched in July 2022

d. Percent of 911 calls that are identified as MH related –

Each 911 system maintains their own data and there is no centralized data repository. Therefore, the ability to analyze data for the state is limited. There is a database code for suicide related calls utilized statewide. However, there are no codes for other behavioral health emergencies at this time. The Caddo Parish 911 system recently developed a behavioral health code for call takers and dispatchers to use when making their notes. The Ouachita Parish representative expressed interest in utilizing the coding as well. The code will be useful for future data analysis. The following preliminary suicide related data was shared:

- The Calcasieu Parish PSAP took 1,240 suicide related (includes suicide in progress and callers considering suicide) calls in 2020 which was about 0.6% of the overall call volume. Extrapolating that percentage to the statewide call volume indicates that 911 PSAPs across the state receive about 24,000 suicide related calls annually.
- 131 of 105,000 (0.1%) 911 calls were suicide related in Ouachita Parish

2. Someone to respond: mobile behavioral health crisis capacity

a. Number of crisis mobile responder teams that are independent of first responder structures (police, paramedic, fire) – Through the LA-CRS, Louisiana has implemented mobile crisis response teams operating in six (6) of the ten (10) geographically distinct multi-parish catchment areas.

b. Number of crisis mobile responder teams that are integrated with first responder structures (police, paramedic, fire) -The mobile crisis response teams cited above have the ability to operate in collaboration when needed with first responder structures. However, ongoing collaboration in this space is beneficial in order to ensure programs are operating in congruence with best practices related to co-response models.

c. Number of mobile responders that employ peers – Peer support is a critical component of the Mobile Crisis Response model developed in Louisiana. As such, the mobile crisis response teams cited above have peers working within their programs.

d. Number of police responses to mental health crises – Unknown; this information is not tracked by LDH and is unavailable for reporting here.

3. Place to Go: Available resources in the state

a. Number of Emergency Departments- 107 emergency departments across the state

b. Number of Emergency Departments that operate a specialized behavior health component. – A number of independent hospitals may have behavioral health teams that can assess individuals who present with behavioral health conditions. The frequency and location with which this occurs is not currently tracked by LDH and is unavailable for reporting here.

c. Number of Crisis Receiving and Stabilization Centers (short term, 23 hr units that can diagnose and stabilize individuals in crisis) – Through the LA-CRS, Louisiana has

implemented Behavioral Health Crisis Care (BHCC) Centers in six (6) out of the ten (10) geographically distinct multi-parish catchment areas.

d. Number of hours of overtime by law enforcement related to accompaniment of persons with MH conditions in ED or other settings. This information is not tracked by LDH and is unavailable for reporting here.

e. Number of persons boarded in ED (In ED longer than 24 hours and waiting for psychiatric admission.) This information is not tracked by LDH and is currently unavailable for reporting here.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

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.

The LDH has focused the last 36 months on building a comprehensive crisis system of care for adults. In particular improved services to include a mobile crisis response capacity and crisis intervention services for the Medicaid population, and crisis telephone lines, which will benefit everyone in Louisiana regardless of insurance type/status. Implementation of these services are consistent with the principles outlined above. In order to achieve these goals LDH has developed the following services and supports for Medicaid-eligible adults. Though initially focused on the Medicaid population, it is the goal that these services will eventually be a resource for everyone in Louisiana, including the insured and uninsured:

- Mobile Crisis Response (MCR) Services – a mobile crisis response service that is available as an initial intervention for individuals in a self-identified crisis. The service is available twenty-four (24) hours a day, seven (7) days a week and includes maximum one (1) hour urban and two (2) hour rural face-to-face/onsite response times.

- Behavioral Health Crisis Care (BHCC) Clinics – a facility based service that operates twenty-four (24) hours a day, seven (7) days a week as a walk-in center providing short-term behavioral health crisis intervention for up to 23 hours, offering a community based voluntary home-like alternative to more restrictive settings

- Community Brief Crisis Support (CBCS) – a face-to-face intervention available to individuals subsequent to receipt of MCI, BHUC, or CS. This ongoing crisis intervention response is intended

to be rendered for up to fifteen (15) days and are designed to provide relief, resolution and intervention through maintaining the member at home/community, de-escalating behavioral health needs, referring for treatment needs, and coordinating with local providers.

- Crisis Stabilization (CS) - a short-term bed-based crisis treatment and support services for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization, including nursing home placement.
    - This service is currently available for children and we are expanding it for the adult population.

4. Briefly describe the proposed/planned activities utilizing the 5% set aside.

LDH/OBH is utilizing Mental Health Block Grant funds to support a contract with Louisiana State University Health Science Center (LSUHSC) School of Public Health, Center for Evidence to Practice to conduct activities critical to the ongoing implementation of a crisis system of care. This includes the following activities:

- Collaborate with communities throughout Louisiana, implementing a readiness process and measures for communities that demonstrate awareness, resources, key partners and benchmarks for progress, with technical assistance (TA) being provided to aid in the ongoing implementation of this new crisis service system.
- Develop, implement, and update as needed a training curriculum inclusive of a process for ongoing coaching for the crisis response workforce; this process includes developing a model of implementation to include an online learning platform and a cadre of trainers, which will be critical to the sustainability of this project.
- Identify crisis workforce and implement training curriculum and ongoing coaching to ensure appropriate execution of services within this crisis system.
- Conduct ongoing data collection required to inform LDH/OBH of the quality of the process, sustainability and outcomes associated with these efforts related to the crisis system of care.

This project will run multiple fiscal years and will ultimately affect the larger crisis system in Louisiana including those that serve the uninsured populations. Additionally, the project is being expanded to include the future provision of services (MCR and CBCS) to children and their families. The amounts allocated per year are outlined below:

- $853,689 (SFY 2024)
- $859,987 (SFY 2025)
- $871,575 (SFY 2026)

The block grant also supports Louisiana's two 988 Suicide and Crisis Lifeline crisis call centers. With these two centers we have statewide primary and back-up coverage to ensure a high in-state answer rate and to provide referrals to local resources. Trained crisis counselors at these centers respond to calls twenty-four (24) hours per day, seven (7) days per week (24/7) providing telephonic access for crisis intervention,

suicide prevention, and information and referral services for Louisiana residents. They also respond to texts and chats from 7pm until 1pm 7 days a week. These crisis call centers are available to everyone in Louisiana regardless of insurance status. Primary coverage areas for each center are listed below:

VIA LINK has offices in Orleans and St. Tammany Parishes. VIA LINK provides primary coverage for the following area codes/parishes:

- 225 area code: Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, St. James, West Baton Rouge, West Feliciana
- 504 area code: Jefferson, Orleans, Plaquemines, St. Bernard
- 985 area code: Assumption, Lafourche, St. Charles, St. John the Baptist, St. Tammany, Tangipahoa, Terrebonne, Washington
  Provides backup coverage to LACG

Louisiana Association on Compulsive Gambling (LACG) has an office in Bossier Parish. LACG provides primary coverage for the following area codes/parishes:

- 318 area code: Avoyelles, Bienville, Bossier, Caddo, Caldwell, Catahoula, Claiborne, Concordia, DeSoto, East Carroll, Franklin, Grant, Jackson, LaSalle, Lincoln, Madison, Morehouse, Natchitoches, Ouachita, Rapides, Red River, Richland, Sabine, Tensas, Union, Webster, West Carroll, and Winn
- 337 area code: Acadia, Allen, Beauregard, Calcasieu, Cameron, Evangeline, Iberia, Jefferson Davis, Lafayette, St. Landry, St. Martin, St. Mary, Vermilion, Vernon
  Provides backup coverage to VIA LINK

Staff coverage of a crisis call center varies throughout a 24-hour day, by day of the week, time of the day, weekend, holiday, and other factors based on call volume. The scheduled supervisor monitors incoming calls and is able to add specialists as needed to manage call volume. Louisiana began responding to chats and texts in December 2022 between 7pm and 1am daily. Both crisis centers offer 24/7, free and confidential support for people in distress, delivering prevention and crisis resources for individuals throughout Louisiana. This type of access is the first level of supportive intervention for individuals in crisis, helping to stabilize the individual so that services that are more intensive are only utilized when necessary.

- Coverage of calls to the Louisiana Spirit crisis counseling services line (1-866-310-7977) during non-disaster periods. Louisiana Spirit is the name of Louisiana's Crisis Counseling Program (CCP) that is re-instated during federally declared disasters when Louisiana applies for and receives a Crisis Counseling Program grant. This crisis line number has been in use for disasters since 2005; crisis resources and printed material still in circulation have this number. This number is called infrequently during non-disaster periods but needs to be maintained to be able to respond to disasters in a timely fashion. Call volume to this line increases significantly during periods of federally declared disasters when it becomes the access point for crisis counseling services, and payment for this line will need to be adjusted. The decision to scale up services to handle a higher volume of calls during disaster periods will be made by the Office of Behavioral Health.

Via link increases the service capacity to respond to the needs of statewide callers to the National Suicide Prevention Lifeline, adding crisis line coverage required by the DOJ agreement with the LDH and add providing blue sky coverage of the Louisiana Spirit.

16. Recovery – Required

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to; and coverage for, health care drives 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 M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

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:

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

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?
   ☒ Yes ☐ No
   b) Required peer accreditation or certification?
   ☒ Yes ☐ No
   c) Block grant funding of recovery support services?
   ☒ Yes ☐ No
   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?
   ☒ Yes ☐ No

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

   ☐ Yes ☒ No

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

Louisiana has adopted the definition of recovery as stated by SAMHSA. The definition states: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The recovery principles are simply to allow those with behavioral health challenges to guide their own recovery. These principles were developed by key stakeholders, especially those in recovery. The state has had peers working within leadership positions 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 use 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. Peers are also included with the Individual Placement and Support (IPS) evidence base program (EBP) of supported employment that was implemented in Louisiana in 2022 as they may function as the Employment Specialist in this EBP approach.
c) 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.
d) PSS are working within treatment teams to assist with identifying goals, treatment planning, life skills coaching, resource referral, conducting recovery groups, and assisting with discharge planning.
e) In Louisiana, PSS work in a variety of capacities throughout the behavioral health service system. While PSS provide vital roles in peer to peer programs which are not funded by Medicaid, there are several rehabilitation services outlined within the Behavioral Health Manual in which PSS are identified as a qualified provider type. These services include:
    1) Community Psychiatric Support and Treatment
    2) Psychosocial Rehabilitation
    3) Crisis Intervention
    4) Assertive Community Treatment
    5) Permanent Supported Housing
    6) Addiction Services
    7) Individual Placement and Support (IPS) Supported Employment

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' 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 recognition for individuals wanting to be a Peer Support Specialist and conducts multiple Peer Support Specialist Supervisor trainings a year in order to help develop and sustain a peer support workforce.

Louisiana Association for Substance Use 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 175 Oxford Houses within Louisiana with 1,301 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. There are currently 3 programs statewide in the following Local Governing Entity catchment areas: Reality House -- Capital Area Human Service District (CAHSD) - 18 beds, Claire House—Southcentral Louisiana Human Services Authority (SCLHSA) - 21 beds and Meredith's Place – Acadiana Area Human Services District (AAHSD) - 16 beds.

The Neonatal Opioid Withdrawal (NOWS) Program, through the creation of specialty beds within an existing TANF residential program, provides Medication for Opioid Use Disorder (MOUD) to women, pregnant and postpartum women, and women with dependent children who have been diagnosed with Opioid Use Disorder. This program provides specialized intensive residential treatment for women and pregnant women, to include screening, comprehensive assessment, medication assisted treatment,

individual, family, and group counseling, care-coordination, parenting skills, and trauma informed care. The NOWS Program has 8 beds at Reality House (CAHSD).

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

The momentum in Louisiana in support of the enhancement and expansion of Peer Services has continued to be on a remarkable trajectory. In 2021, the initial phase of Medicaid reimbursement for Peer Support Services was implemented in Louisiana with the LGEs being the first provide type allowed to bill Medicaid for the service. During the 2022 Regular Legislative Session, legislation (HB 334) was submitted that would allow for exceptions for limited criminal offenses for Peer Support Specialists employed in behavioral health settings. Peer Support Specialists are non-licensed persons. This legislation was passed by the Louisiana Legislature with full support from the House, Senate and Governor's Office to become Act 151. Governor John Bel Edwards signed Act 151, which became effective on August 1, 2022.

LaSOR – On September 30th 2018, Louisiana was awarded the first Louisiana State Opioid Response (LaSOR) grant to target and reduce opioid usage across the state. OBH is now in the first year of LaSOR 3.0, which ends September 29. 2024. The grant is being 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 use or misuse. The grant is able to provide guidance and technical assistance to treatment providers in an effort to facilitate data entry compliance. The grant also helped expand financial eligibility criteria to include patients with a higher income due in part to Medicaid Expansion which approved coverage for Methadone treatment. Through LaSOR 3.0, OBH has partnered with the Office of Public Health (OPH) to develop a centralized harm reduction hub to be utilized by providers throughout the state. Providers can register as a distribution site through this hub to get harm reduction materials, including fentanyl testing strips and naloxone, to distribute to the public.

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

In 2023, OBH negotiated a contract with a national subject matter expert (SME) to facilitate a statewide research study on the development of a Peer credential/certification and oversight entity. Upon conclusion of the research study, which includes several focus groups with Peer Stakeholders from throughout the state, the SME will present a final report and recommendations for a statewide certification/credential and oversight entity. As part of this deliverable, the SME will also ensure recommendations align with SAMHSA's National Model Standards for Peer Support Certification. In 2024, Louisiana is also preparing to expand crisis services to the youth population and their families, which will include the expansion of the Peer Program to Family/Parent Peers. With this planned expansion, OBH has begun researching and contacting other entities to identify a Family/Parent Peer curriculum that may be modified to be utilized in Louisiana. With these areas of growth for the Peer Profession and Peer Services in Louisiana in the coming years, technical assistance, guidance and support may be helpful with supporting these goals.

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 the now six 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 statewide managed care organization (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, which occurred in tandem to the LBHP, 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. Though carved out of the merger with the Healthy Louisiana program as outlined below, CSoC has continued under the management of a single, separate, management care organization.
- 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. One 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 on the Pre-Admission 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 services. A summary of updates can be found below:
    - Crisis System – OBH began rolling out an array of new crisis services, ensuring options are available to individuals along a crisis continuum. Services began in March 2022 via a soft launch of implementation based on provider and community readiness. Additional information about this continuum of services, collectively called the Louisiana Crisis Response System, is outlined within the Crisis portion of this grant application.

- Assertive Community Treatment (ACT) – regular monitoring of ACT providers occurs, ensuring both an adequate provider network which renders service in accordance with established standards. Additionally, ongoing meetings with Managed Care Organizations and national consultants occur in order to ensure service implementation in congruence with fidelity and adequate tracking of outcome measures. Training and other programmatic improvements occur based on findings.
- Intensive Community Support Services (ICSS) which is defined as CPST, PSR, and CI – regular monitoring of ICSS providers occurs, ensuring both an adequate provider network which renders service in accordance with established standards.
- Integrated Day Activities such as supported employment and other rehabilitation services – OBH has implemented a stand-alone Medicaid-reimbursable supported employment service using the Individualized Placement and Support (IPS) model. Additionally, guidance has been developed for mental health rehabilitation service providers on how they can enhance the focus of employment for individuals receiving services in collaboration with Louisiana Rehabilitation Services (LRS). Finally, OBH has explored options for expanding ACT services to include the IPS model. Activities related to the implementation of these services are listed in greater detail below.
- Peer Support Services (PSS) – OBH has implemented a stand-alone Medicaid-reimbursable Peer Support service and is in the process of refining the training and credentialing process. A more robust description of services related to this initiative are outlined below.
- Housing and Tenancy Supports – A number of activities are underway related to housing programs in Louisiana. These are outlined within the Housing portion of this grant application.
- Behavioral Health Personal Care Services (PCS) have also been developed for those individuals who meet target population criteria for the Department of Justice Agreement and who do not meet level of care for other Medicaid-funded personal care services.
- Community Case Management (CCM) has been developed for those individuals who meet target population criteria for the Department of Justice Agreement and have been diverted or transitioned from Nursing Facilities via the My Choice Louisiana program. These high touch case management services are offered to individuals with the intention of increasing community tenure.

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 continues working with national consultants on activities intended to further improve the peer training process and inclusion in its behavioral health service delivery system. In particular, OBH will ensure Recognized 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. Additionally, Louisiana implemented a stand-alone

Medicaid-reimbursable Peer Support Service in March of 2021. Implementation has phased in by provider type in order to ensure seamless implementation. With the initial phase of implementation, LGEs are the provider type allowed to bill Medicaid for this service. OBH staff continues to have regular meetings within the system in these initial phases of implementation.

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 the Louisiana Core Peer Support Specialist (PSS) training program with consultation from Appalachian Consulting Group (ACG) to support individuals with lived experience working throughout our system of care. OBH has invested in having Recognized Peer Support Specialists (RPSS) trained as facilitators of the curriculum to providing monthly peer support specialist trainings on a monthly basis either virtually or in-person.

Employment Services

OBH partnered with Louisiana Rehabilitation Services (LRS) to develop a Memorandum of Understanding intended to improve collaboration between offices while boosting employment outcomes for individuals with a serious mental illness. 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). 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. The United States Department of Labor's Office of Disability Employment Policy designated Louisiana as a Core and Vision Quest State for Fiscal Year 2019 under its Employment First State Leadership Mentoring Program Provider. The Visionary Opportunities to Increase Competitive Employment (VOICE) grant provides OBH with 100 hours of training and technical assistance. OBH has previously completed the Employment First State Leadership Mentoring Program through the U.S. Department of Labor's Office of Disability Employment Policy. OBH is working with Louisiana Rehabilitation Services, improving efforts to employ individuals with mental illness. Additionally this has included development of employment programming within the Medicaid array of services, both through MHR and a stand-alone service. These programmatic enhancements have been developed in line with the evidence-based practice of IPS, with multiple staff members participating in IPS trainings.

Individual Placement and Support (IPS) is an evidence-based supported employment model designed for individuals with serious mental illness. In 2022, Individual Placement and Support (IPS) became Medicaid

reimbursable for the My Choice Louisiana target population. IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing.

Individual placement and support comprises eight fundamental principles (IPS Employment Center, 2021):

1) Obtaining competitive employment is the goal, with no artificial time limits imposed by the social service agency.

2) Everyone who wants competitive employment is eligible, regardless of readiness, diagnosis, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

3) Services are based on job seeker's preferences and choices rather than the employment specialist's and supervisor's judgments.

4) Rapid job placement is prioritized to help job seekers obtain jobs rather than assessments, training, and counseling. The first face-to-face contact with the employer occurs within 30 days.

5) Mental health treatment teams are integrated to include employment specialists.

6) Personalized benefits counseling is provided, related to the client's Social Security, AmeriHealth Caritas Louisiana, and other government entitlements.

7) Employment specialists develop relationships with employers in the community according to client preferences.

8) Individualized job support continues for as long as each worker wants and needs the support. Employment specialists have face-to-face contact at least monthly. This individualized approach is gaining support for new populations other than those with serious mental illness. A network of 25 states and regions is participating in a learning community across states and regions devoted to sharing ideas for how to fund and expand individual placement and support services.

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 initiative, OBH has implemented the My Choice Louisiana transition coordination initiative. This program includes cadres of Transition Coordinators (TCs) and Peer Support Specialists (called Peer In-Reach Specialists - PIRS) who 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. This program has expanded since its inception, ten (10) TCs and nine (9) PIRS are currently working within OBH with additional management staff tracking outcomes and the quality of program implementation. Additional TCs are also employed throughout the state working with other LDH program offices.

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 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 SUPTRS BG

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG 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 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third 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 substances before the age of 18, one in four will develop an addiction compared to one in 25 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 use, 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 use 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 2017 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 withdrawal management).

Please respond to the following:

1. Does the state utilize a system of care approach to support:

   a) The recovery of children and youth with SED?

      ☒ Yes ☐ No

   b) The resilience of children and youth with SED?

      ☒ Yes ☐ No

   c) The recovery of children and youth with SUD?

      ☒ Yes ☐ No

   d) The 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) Health care?

      ☒ Yes ☐ No

   c) Juvenile justice?

      ☒ Yes ☐ No

   d) 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

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems?

☒ Yes ☐ No

d) Does the state have an established FEP program? A CHRP program?

☒ Yes ☐ No

e) Is the state providing trauma informed 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 2023 was the eleventh 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 30, 2023, 2,461 children and youth were enrolled in CSoC (including presumptively eligible and enrolled). The maximum enrollment is 2,900 children and youth at any given time. A total of 23,581 children, youth and their families have been served in CSoC from implementation in March of 2012 through June 30, 2023.

CSoC serves children and youth aged 5 through 20, statewide, who have significant behavioral health challenges or co-occurring disorders and are in or at imminent risk of out-of-home placement. Children and youth with complex behavioral health challenges and their families benefit from a coordinated approach to care. New behavioral health services that were previously not part of the service array in Louisiana are now available as part of the Medicaid State Plan Amendments and Waivers that support CSoC. These new services include an organized planning process for young people with significant emotional and behavioral challenges, called Wraparound, which helps to ensure that individual and family needs are identified and addressed with an array of specialized services and natural supports. These efforts are proven to result in a reduced need for more costly out-of-home placement options. Families and young people also benefit from other specialized services which include: Parent Support and Training, Youth Support and Training, Independent Living/Skills Building and Short-term Respite.

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

As of June 30, 2023 CSoC has served 23,581 youth and children, with current enrollment of 2,461 children/youth (including presumptively eligible and enrolled). Current enrollment ranges from 137 to 494 per region as follows: Greater New Orleans (339), Baton Rouge (271) Covington (265), Thibodaux (271), Lafayette (357), Lake Charles (137), Alexandria (190), Shreveport (137), and Monroe (494).

The CSoC team is composed of a CSoC Director with ten years of experience as a wraparound facilitator, coach, and leading system of care efforts and three additional team members who provided guidance and technical assistance to the Wraparound Agencies (WAAs) and Family Support Organization (FSO) in each region. 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 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 FY23, 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 377 children/youth discharged in the third quarter of FY23 revealed that 65.5% of children and youth demonstrated improved functioning in their homes and communities.

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

- 62.9% showed improved school functioning,
- 53.6% showed improved school attendance, and
- 58.9% 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 23, the WAAs report that 88.4% 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 23, the living situation at discharge from CSoC for 93.9% 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 a leading cause of death nationally, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, and social isolation. Mental illness and substance use 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 M/SUD 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 using 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 Suicide Prevention Plan has been updated to include statewide suicide initiatives that will guide suicide prevention activities for the State. Act 450 of the 2018 regular legislative session directs the Office of Behavioral Health to create such a plan 'when funding resources become available'. The State Suicide Prevention Plan is meant to guide the suicide prevention efforts in Louisiana with the goal of reducing suicide. The State Suicide Prevention Plan outlines some of the current initiatives surrounding suicide prevention across the state. Stakeholders in suicide prevention will be engaged during implementation of this plan to identify gaps, areas of need, and align strategies and resources to meet the needs of the State. This plan should be viewed as a foundation that can be used by suicide prevention stakeholders statewide to direct efforts in suicide care. The Office of Behavioral Health will collaborate and partner with stakeholders to expand the efforts of suicide initiatives and increase sustainability of these activities.

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. The Office of Behavioral Health (OBH) continues to prepare the annual Youth Report for submission to the legislatures that outlines compliance with Act 93/Jason Flatt Act and provides updates on OBH's suicide preventions efforts. OBH continues to partner with a local crisis center, VIA LINK, to coordinate requests for stickers to be put on student ID badges. OBH coordinates with VIA LINK when OBH receives requests from schools for 988 stickers for the school ID badges. Some schools have new badges with the 988 number, but some schools that still have the 1-800 number have been using the stickers to promote the transition to 988.

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 has begun planning to re-establish 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. OBH is partnering with the Louisiana Center for Prevention Resources (LCPR) to provide Train-the-Trainers and training workshops in ASIST, safeTALK, START, QPR (Question Persuade, and Refer) and Signs of Suicide (SOS) to increase suicide awareness and increase the sustainability of the training network. Offering an array of trainings allowed OBH to reach various populations across life-span and provided for the flexibility in the delivery method (in-person vs. virtual) in light of the pandemic that limited in-person trainings. Offering the trainings will also increase suicide prevention awareness and reduce stigma as OBH

Next steps will include following SPRC's Strategic Planning process for Comprehensive Suicide Prevention to collaborate with entities working towards preventing 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 continues to focus on safe firearm storage as twenty-five (25) children (ages 14 and below) died between 2016-2018 in Louisiana from suicide and more than half of these suicides involved the use of a firearm (52% Firearm, 36% hanging, 12% overdose). Since 63.4% 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. OPH has created some suicide fatality data maps on their Nonfatal Suicide Data Dashboard: https://partnersforfamilyhealth.org/injury-

dashboards/ OBH also collaborates with OPH to pilot their Suicide Community Alert System (SCAN). For ages 10-19, OPH is sending out the OPH SCAN when there is an uptick in suicide related Emergency Department visits. At this time, participation by emergency departments in syndromic surveillance includes 89% of facilities and accounts for 96% of visits statewide. This includes visits related to suicidal ideation and suicide attempt. The SCAN alerts indicate the parishes of the upticks which will provide an opportunity for targeted action strategies to be implemented.

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), Louisiana Mental Health Association (LAMHA), the National Suicidology Training Center (NSTC), Discovery/Renew Family Resource Center, Governor's Challenge for Suicide Prevention and Service Member, Veterans and their Families (SMVF) Collaborative, 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 and two state psychiatric hospitals. In October 2022, the Office of Public Health established a Suicide Prevention Partner workgroup group that is working towards developing a guide for regions that would like to develop a suicide prevention coalition. The Suicide Prevention Partner group is working to establish a community of practice (or shared statewide network of local and regional groups) to share resources, collaborate, and understand what services and resources are available regionally and statewide.

A case management intervention model was developed for individuals at risk for suicide. OBH partnered with the Louisiana Mental Health Association (LAMHA) to provide case management for individuals who have attempted suicide or experienced a suicide crisis. Individuals are at an increased risk of suicide after discharge from emergency departments and inpatient psychiatric facilities. The program offers rapid follow-up of adults who have attempted suicide or experienced a suicidal crisis after discharge from emergency departments and inpatient psychiatric facilities. Follow-up and care transition protocols were developed to ensure safety, especially among high risk adults. Enhanced services are also being provided to domestic violence survivors to reduce the risk of suicide such as case management, support groups and psychoeducation. Relationships have been established with shelters and other domestic violence coalitions and resources to address trauma of domestic violence survivors. The following services were also provided for domestic violence survivors that are at risk for suicide: screening for suicide risk, ongoing assessment, safety planning and means restriction, discharge planning, transition care, and warm hand off(s) to treatment or community organizations.

In addition to case management intervention, suicide prevention, intervention, and postvention trainings have been provided statewide to community members, health and behavioral health providers, first responders/law enforcement, Peer Support Specialists, and service member veterans and their families (SMVF) to increase awareness of suicide and help individuals recognize when someone is struggling with their mental health.

Data & sustainability

The 988 Implementation Planning Grant was awarded to OBH by Vibrant, the National Administrator for the Lifeline, which provides technical assistance to LDH/OBH to plan for the implementation of a new nationwide three-digit number for mental health crisis and suicide response (988). The goal of this plan was to develop and plan to address key coordination, funding, capacity, operational and other key considerations which are necessary to implement 988 by July 16, 2022. This plan focused on a long-term plan to improve in-state answer rates for Lifeline calls, texts and chats. The 988 Implementation plan provided for the planning of LDH/OBH to establish a robust call system in which two (2) certified Lifeline call centers serve as back-up to each other to increase the in-state answer rate for Lifeline calls, texts and chats. The routing structure allows for more calls to be answered in-state by local crisis centers that are more familiar with the local resources.

OBH was awarded a 988 State and Territory Cooperative Agreement to build local 988 Capacity. The grant is funded through SAMHSA and the grant period is April 30, 2022 through April 29, 2024. The Louisiana 988 Cooperative Agreement will focus on the following areas: 1) recruiting, hiring and training behavioral health workforce to staff local 988/Lifeline centers to respond, intervene, and provide follow-up to individuals experiencing a behavioral health crisis; expanding the crisis center staffing and response structure needed for the successful implementation of 988. The purpose of the cooperative agreement is to continue to build infrastructure and expand crisis center capacity to improve state and territory response to 988 contacts (including calls, chats, and texts) originating in Louisiana by: (1) recruiting, hiring and training behavioral health workforce to staff local 988/Lifeline centers to respond, intervene, and provide follow-up to individuals experiencing a behavioral health crisis; (2) engaging Lifeline crisis centers to unify 988 response across the state; and (3) expanding the crisis center staffing and response structure needed for the successful implementation of 988. It is expected that the grant will: (1) ensure all calls originating in Louisiana first route to an in-state Lifeline crisis call center; (2) improve state response rates to meet minimum key performance indicators; and (3) increase state capacity to meet 988 crisis contact demand.

- The newly awarded Cooperative Agreement will continue to build upon the work that was accomplished through the 988 Implementation grant in which a 988 Implementation Plan and routing structure has been established for Louisiana.

- On December 19th 2022, OBH was awarded a 988 supplemental grant to expand and enhance 988 suicide and crisis lifeline activities. The supplemental grant works to improve coordination with 911 Public Safety Answering Points (PSAPS) and Marketing and Communications efforts. This grant also supports hiring and workforce development to the local crisis call centers. The 988 teams continues to work on a public awareness campaign.
    - Since launch, call volume for 988 has increased by 11%, and the in-state answer rate rose from 64% in June 2022 to a rate ranging from 85% to 91% over the last year. The Lifeline offers specialized supports to veterans and their families, Spanish speakers, LGBTQ+ youth, and deaf and hard of hearing people.
    - In December 2022, OBH launched text and chat for those who prefer not to call. Louisiana has responded to an average of 224 texts and 157 chats per month since December 2022. Chat and text is answered in Louisiana between the hours of 7:00pm and 1:00am (Text and Chats are routed to the National Backup Centers outside of those hours).

- In May 2023, as part of the 988 awareness campaign LDH launched an online 988 Dashboard providing transparency on key metrics of crisis call data from Louisiana's two 988 crisis centers. The dashboard, which will be updated monthly, contains metrics on accessibility, referral source, reason for the call, and some outcomes. The 988 Dashboard can be reached at ldh.la.gov/988
- 988 PSAs are being aired on 75 stations across the state to increase Public Awareness of 988.
- OBH is working with the crisis contact centers to collect and report Infrastructure, Prevention, and Promotion (IPP) measures (workforce trained, partnership/collaborations, screening, referral, access).
- OBH and the call centers continue to discuss opportunities to improve how the call centers connect callers with community based Medicaid funded services.

The State Suicide Prevention Coordinator and State Suicide Prevention Specialist attended the CMHS SAMHSA Black Youth Suicide Policy Academy in Baltimore, MD from July 16- 19, 2023. OBH was tasked with assembling a Louisiana Team consisting of a team of 8 people that would help develop the state plan to address Black youth suicide.

The goal of the CMHS Black Youth Suicide Prevention Initiative is to reduce the suicidal thoughts, attempts, and deaths of Black youth and young adults between the ages of 5-24. SAMHSA gathered teams from multiple states, with the help of subject matter experts, to develop a plan to reduce Black youth suicide and attempts.

The Louisiana team of 8 people was assembled to create the action plan to address Black youth suicide. The action plan includes the following goals:

1. Build community network centering Black youth populations.
2. Increase awareness of wellness for Black youth.
3. Analyze suicidal behaviors and deaths among Black youth.

More recently OBH has been tasked with staffing House Concurrent Resolution 84 (HCR 84) and the State Suicide Prevention Coordinator has been identified as a designee for this taskforce. HRC 84 calls for a task force to study suicide among African Americans in Louisiana.

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

☒ Yes ☐ No

LDH/OBH provides leadership to decrease suicide deaths and suicide attempts of adults aged 25 or older within behavioral healthcare systems through the following objectives:

- Implement the seven elements of the Zero Suicide Initiative throughout four (4) Local Governing Entities (LGEs) responsible for providing behavioral healthcare services in their areas and two (2) state psychiatric hospitals.
- The providers completed their Organizational Self-Studies and workforce survey.
- The providers have trained 608ndividuals in the behavioral healthcare workforce in suicide prevention with evidenced-based services related to their position.

- The providers will develop an organizational work plan, strategic training plan, and evaluation plan.

- Individuals receiving care for suicidal thoughts and behaviors through the Zero Suicide providers will enter a care pathway provide safer suicide care and reduce suicide.
- Louisiana Department of Health, Office of Behavioral Health (OBH) is implementing the Louisiana Zero Suicide Project to improve care and outcomes for adults who are at risk for suicide by implementing the Zero Suicide model within selected state behavioral healthcare systems. The overall goal of the Louisiana Zero Suicide Project is to decrease suicide deaths and suicide attempts of adults aged 25 or older within these behavioral healthcare systems. OBH is working collaboratively with the six identified health systems to implement the seven elements of the Zero Suicide model. On June 6th and June 7th, 2022, OBH provided a Zero Suicide Workshop. During the workshop, participants were introduced to the Zero Suicide framework for safer suicide care. On June 13 -14, 2023, OBH provided a two-day Zero Suicide Academy in which provider organizations were required to attend. Through collaboration with the Education Development Center (EDC)/Zero Suicide Institute (ZSI), OBH will provide ongoing support and technical assistance through monthly Community of Practice (COPs) calls for nine months following the academy. The COP will occur in early 2024. The Zero Suicide providers are working to ensure all clients are screened at intake for suicide risk, all clients identified to be at risk for suicide are engaged in the development of a suicide care management plan and are treated using evidence-based approaches that target suicidal thoughts and behaviors directly, and to support successful care transitions. This coordinated, comprehensive approach to suicide prevention and intervention will help to raise awareness of suicide, establish referral processes, and improve care and outcomes for individuals who are at risk for suicide. The Zero Suicide 2-Day Academy was held on June 13th and 14th. In preparation for the 2-Day Academy there was a 1 hour pre-academy held on June 6th and a 1 hour post-Academy held on June 28th. There were 12 implementation teams that attended the Academy. Six of the teams were Zero Suicide providers (recipients of the grant) and the other 6 teams included local behavioral health organizations, a local crisis stabilization center, and Southern University, a local Historically Black College and University (HBCU). There was increased collaboration and Louisiana received positive feedback from the faculty and staff of the Educational Development Center/Zero Suicide Institute.

- LSU Social Research & Evaluation Center conducted a NOMS data entry training on June 20th for the 6 Zero Suicide Providers. LSU SREC created a data collection hub for ease of NOMS entry. Each provider site has an account created. The system is now ready for data entry.
- The 6 designated state behavioral health systems are developing their care pathways and will begin to implement the Zero Suicide framework into their systems. OBH will continue to work with LCPR and the Education Development Center (EDC)/Zero Suicide Institute (ZSI) to plan for the Community of Practice. The Community of Practice is expected to last for 9 months. The contract for the Community of Practice between LCPR and EDC is currently pending. OBH will continue to support the behavioral health systems during the implementation phase.

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? If yes, please describe how barriers are eliminated.

☒ Yes ☐ No

The COVID-19 Emergency Response for Suicide Prevention (Covid-19 ERSP) Grant was awarded to OBH (7/1/2020 - 11/30/2021). Individuals aged 25 and older who are at increased risk for suicide, after a suicide attempt, after discharge from a psychiatric facility, after a suicide crisis and/or someone struggling with chronic suicide ideations benefit from the program. The program implemented suicide prevention and intervention programs for individuals who are 25 years of age or older. The Louisiana Mental Health Association (LAMHA) has employed a case management intervention utilizing Peer Support Specialists as the case managers with supervision provided by Licensed Mental Health Professional (LMHP). The case manager interaction includes the following elements: screening, assessment, safety planning and means restriction, discharge planning, transition care, warm hand off to treatment or community organizations as needed, information sharing and caring contacts. The program is designed to raise awareness of suicide, establish referral processes and improve care and outcomes for such individuals who are at risk for suicide. The program supported the state/communities during the COVID-19 pandemic in advancing efforts to prevent suicide and suicide attempts. This program continues to provide support to communities post covid. This program utilizes Peer Support Specialists to provide case management, follow-up and transitional care to individuals receiving the case management intervention. Peer Support is an evidenced-based practice for individuals with mental health conditions or challenges. Peer support improves quality of life, increases and improves engagement with services and increases whole health and self-management. Peer Support Specialists have been able to work with participants in this program to improve social determinants of health to improve health outcomes. This program also provided statewide suicide prevention, intervention and postvention trainings to prevent suicide by increasing the awareness of suicide and warning signs of someone who may be experiencing a mental health crisis and connecting them to services. The COVID-19 Emergency Response to Suicide Prevention Grant ended May 31, 2022 and final close out of the grant has been completed.

Our Lady of the Lake Regional Medical Center (OLOLRMC) did not sign a Memorandum of Understanding (MOU), but supported the Fisher Project and was a champion and primary referral source. Research shows that individuals are at increased risk of suicide after being discharged from an inpatient psychiatric facility. The partnership established with OLOL through the Collaborative Assessment and Management of Suicidality (CAMs) team decreased this risk by keeping individuals connected and engaged with resources/services after being discharged. The Fisher Project connects individuals with peer support specialists immediately after being discharged, so they are receiving a warm handoff to the next level of care. The referral system from the CAMs team was paramount in providing safer suicide care for individuals at risk for suicide after being discharged from an inpatient psychiatric facility. Although a formal agreement was not established with OLOLRMC, the strong collaboration resulted in an increase in referrals to the Fisher Project, a reduction in risk of suicide and an opportunity to maximize protective factors for the individuals served.

A new 3 year contract with LAMHA (Project Period: 7/1/2023 – 6/30/2025) was approved on 3/10/2023. The Louisiana Department of Health, Office of Behavioral Health (OBH) and Louisiana Mental Health Association (LAMHA) are continuing to support the efforts of the COVID-19 Emergency Response to Suicide Prevention Program by sustaining the Fisher Project and expanding the peer support case management services to include individuals ages 18 and older who struggle with suicidal ideations and are at risk for suicide. Continuation of the Fisher Project serves to support the overall vision of building a broader crisis response system and providing a person-centered approach in the least restricted setting possible.

- The Fisher Project has enrolled a total 62 clients with 44 active clients currently. There were no suicide deaths or suicide attempts among any of the 62 clients served.
- There was an increase in community education/awareness of suicide prevention and access to on-site services and resources. The Fisher Project staff continues outreach efforts to increase and sustain champions and referral sources for the Fisher Project. The Fisher Project staff has produced an informational video which continues to be available for statewide outreach activities.

5. Have you begun any targeted or statewide initiatives since the FFY 2022-FFY 2023 plan was submitted?

   ☒ Yes ☐ No

   If so, please describe the population targeted?

Veterans are a particularly vulnerable population, with the rate among veterans 1.5 times higher than non-veterans in 2018. OBH is participating in the Governor's Challenge to prevent suicide among Service Members, Veterans, and their families (SMVF). OBH is working in collaboration with organizations committed to reducing suicide among veterans. This group is working on actions plans to achieve upstream approaches to address the many factors that contribute to suicide. The group is working on the following objectives:

1. Identify SMVF and screen for suicide risk.
2. Promote Connectedness and improve care transitions
3. Increase lethal means safety and safety planning.

In addition, each of the identified Zero Suicide providers will collaborate with their nearest VA facility to provide information and enhance their awareness of the availability of the Zero Suicide Initiative for the referral of veterans, especially those who are not eligible for VA services. LGEs and hospitals will enhance the knowledge of VA facility staff and the suicide prevention coordinators who follow up on the Lifeline calls on suicide awareness, intervention and treatment by inviting them to attend staff trainings held as part of the Zero Suicide Initiative. Also, LGEs and hospitals with ASIST and safeTALK trainers will offer these trainings to local VA facility staff. OBH will also invite staff from VA facilities to attend the two-day Zero Suicide Academy. OBH will also work with the Service Member, Veterans, and Their Families (SMVF) Collaborative, a newly established team whose membership includes representatives from LGEs, veterans, family members, and other community organizations with the common interest of providing behavioral health services to this disparate population. The SMVF collaborative is identifying resources for SMVF related to housing, transportation, employment, behavioral health, college/universities, benefits and families. OBH has a full time staff person who works as a liaison between OBH and existing veteran and service member organizations, as well as provide support to the SMVF Collaborative. This ensures OBH has a linkage to veterans to serve this important population.

In 2021, in an effort to reduce suicide amongst Veterans, Louisiana accepted the Governor's Challenge (LAGC), becoming one of 35 participating states. The Governor's Challenge is partnering with the Substance Use Mental Health Services Administration (SAMHSA) and the United States Department of Veterans Affairs (VA) with the focus of preventing suicide among service members, Veterans, and their families (SMVF) in communities across the nation.

The Service Members, Veterans, and their Families (SMVF), Governor's Challenge to Prevent Suicide Initiative is managed by the prevention staff in the Office of Behavioral Health (OBH), Louisiana Department of Health. It is an initiative that began in 2020, with technical assistance (TA) from SAMHSA, to provide support and resources to our service members, veterans and their families.

Key Efforts and Focus Points include:

- Preventing suicides among service members, veterans, and their families
- Increasing access to services and support
- Expanding statewide capacity to engage SMVF in public and private services
- Enhancing provider and SMVF peer practices
- Implementing innovative best practices (e.g., Screening and interventions) to prevent suicides.

The goal of the Louisiana Governor's Challenge is to provide Louisiana's Service Members, Veterans, and their families with a single place to find the resources needed to enjoy quality of life and to thank them for the sacrifices made. OBH continues participation with the SMVF Louisiana Governor's Challenge to develop a wallet size card that includes a QR link to behavioral health and crisis resources in the state. Once available, the resource card will be disseminated from the Zero Suicide provider sites and other facilities to individuals served who identify as a service member, veteran or family member. This is a key accomplishment as the SMVF population is a target population in the Zero Suicide grant.

6. Have you conducted any work using the suicide protocol language with your crisis services set-aside?

☒ Yes ☐ No

If so please describe the work.

OBH contracts with two (2) local crisis centers to ensure statewide coverage for Lifeline calls. The crisis centers have participated in training and have implemented strategies to incorporate suicide protocol language. Suicide protocol language is also incorporated in suicide prevention trainings and the 988 Public Awareness Campaign.

7. 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 SUPTRS BG 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 State Medical Authority (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 are 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 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.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.

- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

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. Pharmacy Board to help reach commercial and independent pharmacist to dispense FDA approved medications for Opioid Use Disorder
   2. Emergency Room Departments to incorporate Peer Support Specialist as vital roles to assist with identification and referral resources for person's with SUD/OUD to treatment
   3. Peer Association Boards, Councils or Advocacy groups
   4. Mobile Crisis Teams, Behavioral Health Crisis Centers and Community Brief Crisis Support providers for adults and youth
   5. Early Childhood Support & Services providers
   6. Federally Qualified Health Centers to provide SUD and Medication for Opioid Use Disorders (MOUD) and

7. Office Based Opioid Treatment (OBOT) providers

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 for Opioid Use Disorder (MOUD), 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, including planning for Certified Community Behavioral Health Clinics (CCBHC) etc. OBH uses a multi-faceted, collaborative approach. Below is a brief description of the partners and their roles.

Opioid Treatment Programs (OTP)

OTPs provide direct substance use services by combining use of Medication for Opioid Use Disorder (MOUD), specializing in Methadone Maintenance, to include counseling and behavioral therapies for treatment. OTPs offer medically necessary treatments and services that target newly under/uninsured persons with opioid use disorder (OUD), including services for the general population.

Louisiana State University Social Research & Evaluation Center (LSUSREC)

LSUSREC provides data collection and performance measurement for multiple programs within OBH, including data storage, cleaning and organization, analysis, and reporting. LSUSREC serves as the subject matter data experts for several OBH federal grants, including offering stakeholder trainings and learning communities to heighten awareness about federal reporting regulations for the Government Performance Results Act (GPRA).

Louisiana State University Health Science Center (LSUHSC)

LSUHSC partners with OBH to serve as the administrative service organization to expand the number of Office based Opioid Treatment Providers (OBOTs) throughout the state. In addition, LSUHSC provides outreach and awareness about the impact of opioid use disorder, provides psychiatric consultation to MOUD providers and 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 OBOT provider to offer services, such as screening, brief intervention and referral to treatment (SBIRT), assessments, case coordination, recovery support services, and assistance with GPRA data collection and entry. LSUHSC also provides clinical supervision to the SCTs.

Tulane University

Tulane University provides implementation of Project ECHO (Extension for Community Healthcare Outcomes), Academic Detailing, and a Fellowship in Addiction Medicine program. 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 meet 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 MOUD. 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 FQHCs, pharmacist and jails, which serve populations at the highest risk for overdose and whose healthcare providers will benefit from MOUD training support. Tulane is also supporting the state in the planning, implementation and development of an upcoming SUD needs assessment and is identified as the evaluator for the state's current SUD 1115 Waiver.

Department of Public Safety and Corrections (DPSC) MOUD

OBH partners with the Department of Public Safety and Corrections (DPSC) to provide MOUD services in seven prisons (3 women's facilities and 4 men's facilities) throughout the state. Offenders with a diagnosis of OUD are selected 9 months to 1 year prior to their earliest release date. Treatment is individualized and may include MOUD, if indicated, in addition to Cognitive-Behavioral Therapy. Currently, the primary medication used in these settings is Naltrexone. Other FDA approved meds are not allowable at this time. However, the state is working with DPSC to help provide knowledge on evidence based practices to this vulnerable population.

- Department of Public Safety and Corrections Re-Entry Program - OBH and DPSC 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 substance use and recidivism. An 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 DPSC staff and re-entering citizens to become familiar with SUD/OUD signs and symptoms and to gain knowledge about OBH's array of services offered. In addition, this program helps assists individuals being released from DPSC facilities to connect to vital mental health, substance use and/or recovery housing services in the respective LGE catchment area in which the incarcerated person will be returning. The linkage to these services will help reduce the overall substance use and incarceration recidivism rates statewide.
- Day Reporting Center - Through an interagency agreement with DPSC, OBH supports a Day Reporting Center in New Orleans, La., which promotes strategies for appropriate diversion and alternatives to incarceration. This program offers individuals with OUD who are on probation with screening, treatment and recovery support services at the center and implement transition services for those individuals reentering the community, including efforts to transition individuals in residential substance use treatment or MOUD services as needed.

Oxford Recovery Housing

Oxford Inc. provides safe recovery housing to persons in recovery and guides administrative oversight of the network. Oxford Outreach Liaisons are hired to create new homes and monitor operations of the existing network of 174 Oxford Houses. The state plans to expand homes statewide by adding 24 additional homes during this block grant period (12-homes in FY24/12-homes in FY25). Oxford Inc.

provides ongoing technical assistance and trainings to new and existing homes, while also troubleshooting any incidence that may occur within any homes statewide. This program offer opportunities for staff and residents to participate in the Annual Oxford World and State Conference, to stay abreast of cutting edge models of practices for treatment and recovery. OBH also provides monitoring and oversight of Oxford Inc., to bridge gaps and improve collaboration with the DPSC Re-Entry Program, to ensure offenders being released are connected to vital substance use and mental health services in their respective communities.

Southern University Center for Prevention Resources,

Louisiana Center for Prevention Resources (LCPR), established at Southern University and A&M College, and the Office of Behavioral Health (OBH) developed a partnership aimed at improving implementation and delivery of effective substance use prevention interventions. This Center also offers training and technical assistance services to the Substance Use Prevention Workforce. This partnership provides specific courses and trainings necessary to become a certified/licensed prevention professionals, at no cost to participants. Additional trainings are available to youth, communities, professionals, and others in the prevention community, to increase capacity, skills and expertise to ensure and/or enhance delivery of effective substance use prevention interventions, trainings and other prevention activities. In addition to the above initiative, OBH partnered to:

- Support mental health training needs specifically related to suicide prevention. Trainings under this partnership enables participants to assist someone in a crisis mode by being trained to recognize the warning signs of suicide ideation. These trainings will provide the skills needed to individuals for outreach and initial support to someone who may be in crisis or developing a mental health or substance use problem.
- Develop a Statewide Media Alcohol Awareness Campaign. The purpose of this campaign is to increase awareness of alcohol use and misuse and the associated consequences. This campaign will be used to address risk factors and educate community members on the increase in substance use. In addition LCPR will provide trainings and awareness campaigns for Service Members, Veterans and their Families (SMVF) with targeted messages that focus on behavioral health prevention and trainings related to substance use.

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.

Early Serious Mental Illness (ESMI) / First Episode Psychosis (FEP)

- *Tulane University School of Psychiatry – Early Psychosis Intervention Clinic of New Orleans (EPIC NOLA)*

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. Tulane University continues to provide consultation to any new ESMI/FEP clinics that are developing in other parts of the state as well as existing programs monthly and as needed. Tulane University Department of

Psychiatry provides monthly consultation to the various LGEs operating FEP programs. Beginning in 2022, through the OBH contract, Tulane University has also provided technical assistance and support to Volunteers of America North Louisiana (VOA North La) and Louisiana State University Health Sciences Shreveport as they develop and implement an FEP program through a contract with OBH to serve the northern region of the state.

- *Early Psychosis Intervention Center (EpiCenter)*

Through a new contract with the Volunteers of America (VOA) – North Louisiana, OBH supports the Early Psychosis Intervention Center in Shreveport. The EpiCenter will provide CSC to both youth and adults using a CSC model to provide a comprehensive package of services including: family education, cognitive behavioral therapy for psychosis, supported employment and education services, and personalized pharmacologic management. Staff members will use a team approach to provide collaborative services to program participants. This program represents a partnership between VOA of North Louisiana and LSU Health Sciences of Shreveport. This program is scheduled for implementation in 2023.

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	Unity of Greater New Orleans
CAHSD	Start Corporation
SCLHSA	SCLHSA
AAHSD	Volunteers of America – Greater Baton Rouge
CLHSD	Volunteers of America – North Louisiana
NLHSD	Hope for the Homeless
NDHSA	Easterseals LA
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.

- *START Corporation Transitional Homes*

The Office of Behavioral Health has partnered with START Corporation to support the transitional housing assistance previously on the campus of Northlake Behavioral Health System. The transitional housing

program was relocated to Houma, LA to a newly constructed facility in 2020. The transitional housing program serves individuals with serious and persistent mental illness (SPMI) who are homeless and need assistance with daily living skills. Start Corporation has a long history of partnering with OBH to serve the most vulnerable populations of those with SPMI who are experiencing lack of stable housing.

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. As part of this collaboration effort, MHAGBR also organizes the annual Behavioral Health Day at the State Capitol building.

- *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.

- *Louisiana State University School of Social Work*

OBH negotiated a contract with the Louisiana State University School of Social Work to initiate a *Better Futures* Program in summer of 2023. This program helps youth in foster care and with serious mental health challenges, prepare for postsecondary education. The program will help support young people in exploring their postsecondary interests and opportunities, and in preparing them to participate in postsecondary education, including college and vocational training programs. The purpose of *Better Futures* is to support young people in exploring their postsecondary interests and opportunities, and in preparing them to participate in postsecondary education, including college and vocational training programs. The purpose of *Better Futures* is to support young people in exploring their postsecondary interests and opportunities, and in preparing them to participate in postsecondary education, including college and vocational training programs.

Peer Support Services

- *The Extra Mile, Region IV, Inc.*

The Extra Mile, Region IV, Inc. continues to partner with OBH to provide an LDH-OBH approved Peer Education Training course for individuals with behavioral health challenges, who are successfully in recovery to become employed as a Certified Peer Support Specialist. In 2023-24, the contract with The

Extra Mile includes the development and implementation of a Family Peer Training Program to support the expansion of Louisiana Crisis Response System to serving youth and their families.

- *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 eers to support the treatment and recovery process, NAMI St. Tammany has provided two Peers to work in the Northlake Behavioral Health Hospital and continues to support this service through a contract with OBH.

- *Louisiana Mental Health Association (LA Affiliate of Mental Health America)*

In 2018, OBH collaborated with the Louisiana Mental Health Association (LAMHA) 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. In 2022, LAMHA expanded the Target Health program with the development and implementation of a curriculum focusing on youth.

- *Campus Peers in Higher Education Settings*

In 2023, OBH established contract partnerships with three (3) NAMI affiliates throughout the state to support students with behavioral health and/or emotional challenges on campus. Through this partnership, trained Campus Peers will be available to a maximum of 12 universities throughout the state. Trained Campus Peers will provide support, guidance and referrals to students who are experiencing behavioral health and/or emotional challenges as they transition to this next phase in their early adulthood.

NAMI AFFILIATE	TARGETED UNIVERSITIES
NAMI Acadiana **Marietta Puckett, Executive Director** nami@namiacadiana.org	• University of Louisiana Lafayette (NAMI ON Campus) • McNeese – Lake Charles • LSU – Alexandria • LSU – Eunice
NAMI LA **LaShonda G. Williams, J.D., Executive Director** lderouen@namilouisiana.org www.namilouisiana.org	• Louisiana State University Baton Rouge (NAMI ON Campus) • Southeast Louisiana – Hammond • Tulane – New Orleans (NAMI ON Campus) • Nicholls State University – Thibodeaux • Southern University HBCU – Baton Rouge
NAMI Ruston **Jerrilene Washington, Ph.D., Executive Dir.** washington.jerrilene1922@gmail.com	• Northwestern State University - Natchitoches (MOU signed) • Grambling State University HBCU – Grambling (MOU signed) • Louisiana State University LSU-S – Shreveport (MOU signed)

4. 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 Use Prevention, Treatment and Recovery Services 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 SUPTRS BG, 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.)

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, advocates, 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, or appointed personnel. 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.

The Block Grant application is posted on the LBHAC webpage on the Office of Behavioral Health website prior to its submission. Council members are provided with a direct link to review the application and encouraged to email with questions and/or comments. Additionally, a review of the application is provided via a webinar.

2. What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment, and recovery services?

All quarterly meetings include presentations from the Office of Behavioral Health prevention and substance use treatment specialists. These presentations include new initiatives, programs, and data sharing. Council members have opportunities to ask questions and provide comments at all meetings.

3. Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

   ☒ Yes ☐ No

4. 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

5. 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 use disorders, family members of children with emotional/behavioral disorders and substance use 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. Since the return to face to face meetings, post COVID, the LBHAC as well as the RACs have been actively rebuilding themselves in terms of membership.

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.

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

N/a

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)	5	
Family Members of Individuals in Recovery * (to include family members of adults with SMI)	2	
Parents of children with SED/SUD *	5	
Vacancies (individual & family members)	2	
Others (Advocates who are not State employees or providers)	8	
Total Individuals in Recovery, Family Members, and Others	**22**	**61%**
State Employees	8	
Providers	1	
Vacancies	0	
TOTAL State Employees & Providers	**9**	**25%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	8	
Individuals/Family Members from LGBTQI+ Populations	1	
Youth/adolescent representative (or member from an organization serving young people)	5	
Persons in recovery from or providing treatment for or advocating for SUD services	3	
Federally Recognized Tribe Representatives	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.
*3 members are pending until they can be elected at the next quarterly meeting.

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

Acronyms

ADRA	Addictive Disorders Regulatory Authority
AEDS	Alcohol Epidemiological Data System
AOD	Alcohol & Other Drugs
AR	Alcohol Related
ARMVC	Alcohol Related Motor Vehicle Crash
ASAM	American Society of Addiction Medicine
ASIST	Applied Suicide Intervention Skills Training
ATC	Alcohol and Tobacco Control
ATLAS	Addiction Treatment Locator, Assessment, and Standards Platform (by Shatterproof)
BRFSS	Behavioral Risk Factor Surveillance System
CADCA	Community Anti-Drug Coalitions of America
CDC	Center for Disease Control and Prevention
CEU	Continuing Education Units
CCN	Coordinated Care Network
CIA	Cooperative Involvement Agreement
CCYS	Caring Communities Youth Survey
CLHS	Central Louisiana State Hospital
CSAP	Center for Substance Abuse Prevention
CSoC	Coordinated Systems of Care
DCFS	Department of Children and Families
DFC	Drug Free Communities
DPB	Drug Policy Board
DOC	Department of Corrections
EBP	Evidence Based Practices
EBS	Evidence-Based Strategies
ECHO	(Project) Extension for Community Healthcare Outcomes
ED	Emergency Department
ELMHS	Eastern Louisiana Mental Health System
ER	Emergency Room
ESMI	Early Serious Mental Illness
FARS	Fatality Analysis Reporting System
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Clinics
HARM	Hepatitis, Addiction, and stigma Reduction in Medicine
HCR	House Concurrent Resolution
HCV	Hepatitis C Virus
HEDIS	Healthcare Effectiveness Data Information Set
HSRG	Highway Safety Research Group
LaBOR	Louisiana Board of Regents
LaHEC	Louisiana Higher Education Coalition
LaPFS	Louisiana Partnerships for Success
LaSOR	Louisiana State Opioid Response
LBHP	Louisiana Behavioral Health Partnership
LCSW	Licensed Clinical Social Worker

LDCFS	Louisiana Department of Children & Family Services
LDOE	Louisiana Department of Education
LDH	Louisiana Department of Health
LEEDS	Louisiana Early Event Detection System
LGBTQ	Lesbian, Gay, Bi-sexual, Transgender and Questioning
LGE	Local Governing Entity
LHSC	Louisiana Highway Safety Commission
LODSS	Louisiana Opioid Data & Surveillance System
LSP	Louisiana State Police
LSU	Louisiana State University
MAT-PDOA	Medication Assisted Treatment-Prescription Drug and Opioid Addiction
MCO	Managed Care Organization
MHBG	Mental Health Block Grant
MOU	Memorandum of Understanding
MOUD	Medication for Opioid Use Disorder
M/SUD	Mental Health/Substance Use Disorder
MTF	Monitoring the Future Survey
NREPP	National Registry of Evidence-based Programs and Practices
NSDUH	National Survey on Drug Use and Health
NVSS	National Vital Statistics System
OAD	Office of Addictive Disorders
OBH	Office of Behavioral Health
OJJ	Office of Juvenile Justice
OMB	Office of Management and Budget
OMV	Office of Motor Vehicle
OPH	Office of Public Health
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PMP	Prescription Monitoring Program
PMIS	Prevention Management Information System
PMS	Prevention Management System
PRAMS	Pregnancy Risk Assessment Monitoring System
PRTF	Psychiatric Residential Treatment Facility
PSC	Prevention Systems Committee
SUPTRS BG	Substance Use Prevention, Treatment and Recovery Services Block Grant, formerly the Substance Abuse Block Grant (SAPT BG)
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPST	Substance Abuse Prevention Specialist Training
SAPT	Substance Abuse Prevention and Treatment
SBIRT	Screening, Brief Intervention and Referral to Treatment
SEW	State Epidemiology Workgroup
SHHP	STD/HIV/HEP Program
SIG	State Incentive Grant
SOW	Statement of Work
SPF	Strategic Prevention Framework
SPF-RX	Strategic Prevention Framework for Prescription Drugs

SPF-SIG	Strategic Prevention Framework State Incentive Grant
SPE	Strategic Prevention Enhancement
SSA	Single State Authority
SSP	Syringe Service Provider
STARS	State Technical Assistance and Resource Staff
SUD	Substance Used Disorder
SUN	Substance Use Navigator
SWCAPT	Southwest Center for the Application of Prevention Technologies
TA	Technical Assistance
TGF	Therapeutic Group Home
UCR	Uniform Crime Reporting Program
YRBS	Youth Risk Behavior Survey

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