FY 2016-17
Combined Behavioral Health Assessment and Plan

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

Louisiana Department of Health and Hospitals
Office of Behavioral Health

September 1, 2015

Bienville Building ▪ 628 N. 4th Street ▪ P.O. Box 629 ▪ Baton Rouge, Louisiana 70821-0629
Phone #: 225/342-9509 ▪ Fax #: 225/342-5568 ▪ WWW.DHH.LA.GOV

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Table of Contents

FY 2016-17
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and
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SECTION I.

STATE INFORMATION

State Information Form

STATE NAME: Louisiana

DUNS#: 809927064

I. STATE AGENCY TO BE THE GRANTEE FOR THE BLOCK GRANT

AGENCY: Louisiana Department of Health and Hospitals
ORGANIZATIONAL UNIT: Office of Behavioral Health
STREET ADDRESS: 628 N. 4th Street, 4th Floor (P.O. Box 4049)
CITY: Baton Rouge **STATE:** LA **ZIP:** 70821-4049
TELEPHONE: (225) 342-2540 **FAX:** (225) 342-5066

II. CONTACT PERSON FOR THE GRANTEE OF THE BLOCK GRANT

NAME: Rochelle Head-Dunham, M.D, FAPA **TITLE:** Assistant Secretary
AGENCY: Office of Behavioral Health
ORGANIZATIONAL UNIT: Department of Health and Hospitals
STREET ADDRESS: 628 N. 4th Street, 4th Floor, (P.O. Box 4049)
CITY: Baton Rouge **STATE:** LA **ZIP:** 70821-4049
TELEPHONE: (225) 342-4760 **FAX:** (225) 342-5066 **EMAIL:** Rochelle.Dunham@la.gov

III. STATE EXPENDITURE PERIOD (most recent expenditure period that is closed out)

FROM: July 1, 2014 **TO:** June 30, 2015

IV. CONTACT PERSON RESPONSIBLE FOR APPLICATION SUBMISSION

NAME: Candace Ricard
TITLE: Director, Quality Management, Division of Health Plan Management
AGENCY: Louisiana Department of Health and Hospitals
ORGANIZATIONAL UNIT: Office of Behavioral Health
STREET ADDRESS: 628 N. 4th Street, 4th Floor, (P.O. Box 4049)
CITY: Baton Rouge **STATE:** LA **ZIP:** 70821-4049
TELEPHONE: (225) 342-2540 **FAX:** (225) 342-1984 **EMAIL:** Candace.Ricard@la.gov

BOBBY JINDAL
GOVERNOR

State of Louisiana

OFFICE OF THE GOVERNOR

Post Office Box 94004
Baton Rouge, LA 70804-9004

July 29, 2015

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857

RE: Designation of Authority to Sign SABG, MHBG, and PATH Grant Application

Dear Ms. Simmons:

As the Governor of the State of Louisiana, for the duration of my tenure, I delegate signatory authority to the Assistant Secretary of the Office of Behavioral Health (OBH), or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG), Mental Health Block Grant (MHBG), and PATH grant.

Thank you for your assistance in this matter.

Sincerely,

Bobby Jindal
Governor

(225) 342-7015 ✣ Fax (225) 342-7099 ✣ www.gov.state.la.us

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Rochelle Head-Dunham, M.D.

Signature of CEO or Designee[1]: 

Title: Assistant Secretary, Louisiana DHH Office Of Behavioral Health

Date Signed: 07/13/15

mm/dd/yyyy

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
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Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Rochelle Head-Dunham, M.D.

Signature of CEO or Designee[1]: Rochelle Head-Dunham MD

Title: Assistant Secretary, Louisiana DHH Office of Behavioral Health

Date Signed: 7/13/15

mm/dd/yyyy

FY 2016-17
Combined Behavioral Health Assessment and Plan

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

SECTION II.

PLANNING STEPS

Step 1: Assess the Strengths and Needs of the Service System to Address the Specific Populations

Overview of the Louisiana Behavioral Health System

The Office of Behavioral Health (OBH) is the state program office within the Department of Health and Hospitals (DHH) responsible for managing and delivering the services and supports necessary to improve the quality of life for citizens with mental illness and addictive disorders. The agency oversees contractors in the provision of specialized behavioral health services provided in both hospital and community-based treatment settings for both Medicaid and non-Medicaid eligible populations.

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

The mission of OBH is to lead the effort to build and provide a comprehensive, integrated, and 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 OBH FY 2014 budget is $272,688,314. The total appropriation for the OBH Community Budget is $115,960,081. The following tables provide additional budgetary information, including a breakdown of federal funding for behavioral health services.

OFFICE OF BEHAVIORAL HEALTH APPROPRIATION FOR FY 13-14		
BUDGET SUB-ITEM	**TOTAL(S)**	**% of TOTAL**
Community Budget		
Central Office	$ 44,015,908	16.1%
Community Behavioral Health Centers	$29,403,179	10.8%
Community Social Service Contracts	$42,540,994	15.6%
Community Total	**$115,960,081**	**42.5%**
Hospital Budget		
Central Louisiana State Hospital	$35,973,405	13.2%
Eastern Louisiana Mental Health System	$113,819,740	41.7%
Hospital Total	**$149,793,145**	**54.9%**

OFFICE OF BEHAVIORAL HEALTH APPROPRIATION FOR FY 13-14 (CONT'D)		
BUDGET SUB-ITEM	**TOTAL(S)**	**% of TOTAL**
State Office		
Administration	$6,915,088	2.5%
State Office Total	**$6,915,088**	**2.5 %**
Auxiliary		
Auxiliary	$20,000	0.00007%
Auxiliary Total	**$20,000**	**0.00007%**
TOTAL	**$272,688,314**	**100%**

HOSPITAL SYSTEM

	FY2014
Total Adult/Child State Hospital Beds (a)	691
State General Funds ($)	88,249,183
Federal Funds ($)	57,289,848

NOTES: (a) Total represents funded beds for adult intermediate care, adult forensic care, adult acute care, transitional forensic care and community homes.

COMMUNITY SYSTEM

	FY2014
Community Behavioral Health Centers	45
State General Funds ($)	15,437,573
Federal Funds ($)	3,906,477
Community Behavioral Health Contract	
State General Funds ($)	21,377,528
Federal Funds ($)	8,182,846

OBH Authorized Table of Organization (T.O.) Personnel Positions

					FY 2014	
Office of Behavioral Health	FY 2013 T.O.	Changes	FY 2014 T.O.		Classified	Unclassified
Administration						
Administration	44	0	44		41	3
TOTAL – Administration	44	0	44		41	3
Community						
Central Office	41	0	41		41	0
Community Behavioral Health Centers	202	-202	0		0	0
TOTAL – Community	243	-202	41		41	0
Hospitals						
Central Louisiana State Hospital	163	123	286		283	3
Eastern Louisiana Mental Health System	1018	3	1021		1014	7
Southeast Louisiana Hospital	563	-563	0		0	0
TOTAL – Hospitals	1744	-437	1307		1297	10
TOTAL – OBH	2031	-639	1392		1379	13

Evolution toward Local Governing Entities

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

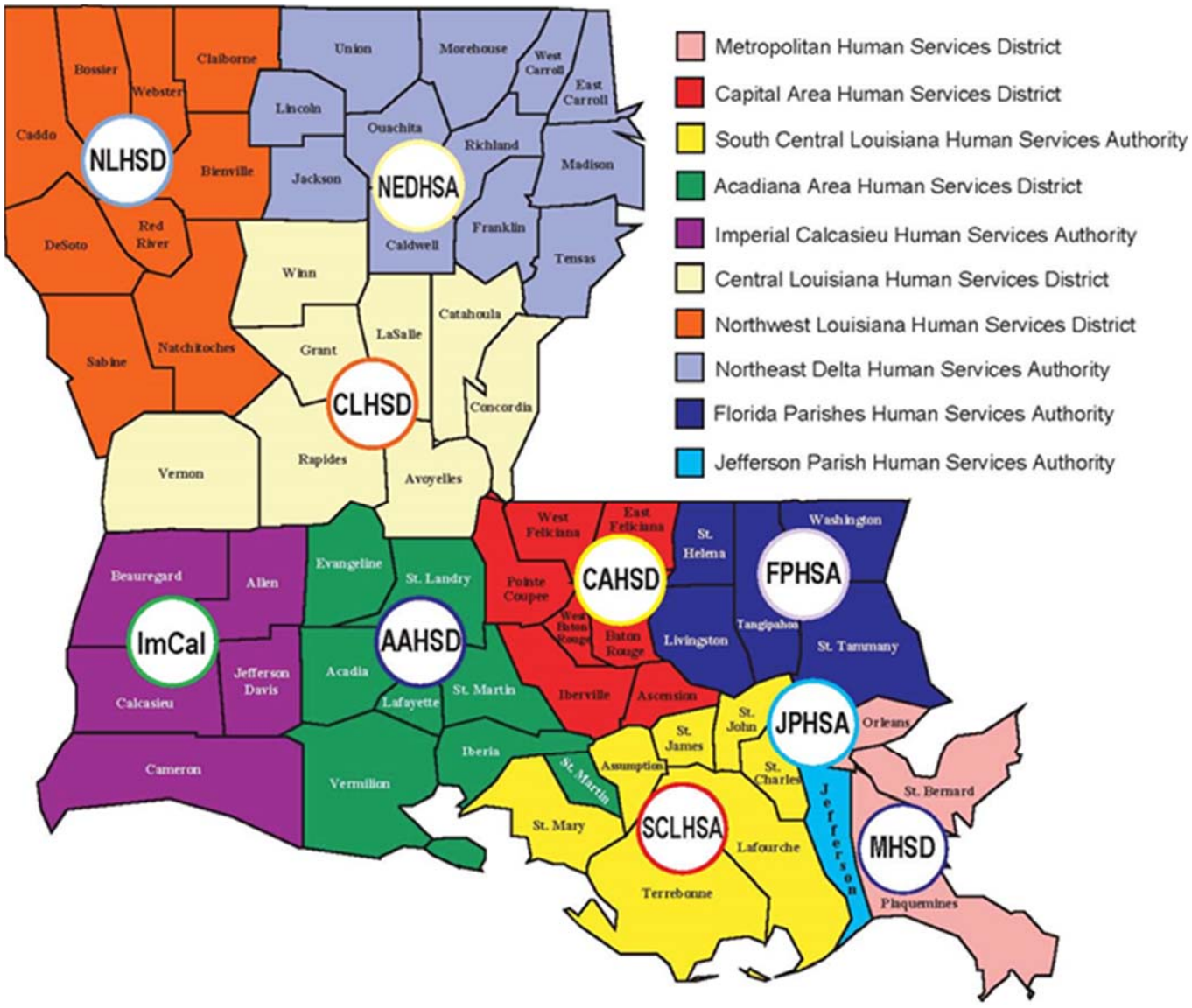
These LGEs, classified as either a district or authority, have a contractual agreement with DHH. The LGEs are local umbrella agencies that administer the state-funded mental health, addictive disorder, and developmental disability services in an integrated system within their localities. Since it is based on local control and authority, the LGE model affords opportunity for greater accountability and responsiveness to local communities. Each LGE is administered by an executive director who reports to a local governing board of directors of community and

consumer volunteers. All LGEs remain part of the DHH departmental organizational structure, but not in a direct reporting line with OBH.

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

Region or District/Authority	Parishes
Metropolitan Human Services District: MHSD (formerly Region 1 - established July 1, 2004) is composed of the New Orleans metropolitan area and two civil parishes to the south of Orleans Parish.	Orleans, Plaquemines, St. Bernard
Capital Area Human Services District: CAHSD (formerly Region 2 - established July 1, 1997) encompasses the Baton Rouge metropolitan area and six surrounding parishes.	Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, West Feliciana
South Central Louisiana Human Services Authority: SCLHSA (formerly Region 3 - established July 1, 2010) includes seven parishes in the bayou country of coastal Louisiana with Houma as the regional hub.	Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne
Acadiana Area Human Services District: AAHSD (formerly Region 4 – established July 1, 2012) is composed of seven parishes in the Acadiana area with Lafayette serving as the regional hub.	Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermillion
Imperial Calcasieu Human Services Authority: ImCal (formerly Region 5 – established July 1, 2014) encompasses five southwestern parishes, including coastal Cameron. Lake Charles is the hub of this region.	Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis
Central Louisiana Human Services District: CLHSD (formerly Region 6 – established July 1, 2014) contains eight central Louisiana parishes that border Mississippi to the east and Texas on the west. With the exception of Rapides, this Region is very rural in nature. Alexandria is the regional hub.	Avoyelles, Concordia, Catahoula, Grant, LaSalle, Rapides, Vernon, Winn
Northwest Louisiana Human Services District: NLHSD (formerly Region 7 – established July 1, 2014) comprises the predominantly rural northwestern area of the state, including nine parishes. Shreveport-Bossier City is the major metropolitan complex. This is an agricultural area but it contains most of the state's heavy manufacturing business.	Bienville, Bossier, Caddo, Claiborne, Desoto, Natchitoches, Red River, Sabine, Webster

Region or District/Authority	Parishes
Northeast Delta Human Services Authority: NEDHSA (formerly Region 8 – established July 1, 2014) comprises the northeastern corner of the state, known as the Delta region. Monroe is the hub of this region, which encompasses 12 parishes, most of which are the poorest in the state in per capita income. This region is dominated by agriculture and light industry.	Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, West Carroll
Florida Parishes Human Services Authority: FPHSA (formerly Region 9 - established July 1, 2004) is composed of the five parishes in the Florida Parishes area. This area borders Mississippi on the north and east, with Lakes Pontchartrain and Borgne to the south.	Livingston, St. Helena, St. Tammany, Tangipahoa, Washington
Jefferson Parish Human Services Authority: JPHSA (formerly Region 10 - established July 1, 1989) is composed of the single parish of Jefferson, with the city of Metairie as its hub. The southernmost part of this parish is costal marsh while the populated area between Lake Pontchartrain and the Mississippi River is highly urban.	Jefferson



Managed Care

The Louisiana Behavioral Health Partnership (LBHP), implemented in March 2012, is the system of care for Medicaid and non-Medicaid adults and children who require specialized behavioral health services in Louisiana, including those children who are at risk for out of home placement. The LBHP is designed to serve the needs of individuals who comprise 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 Louisiana Behavioral Health Partnership 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 LBHP consist of more than 1,800 providers, of which there are 65 state-supported clinics that are operated by the LGEs. Of those 65 clinics, 13 are mental health clinics, 11 are addictive disorders clinics, and 39 are integrated behavioral health clinics providing both mental health and substance use services and two are integrated behavioral health and primary care clinics. While integration remains the goal, not all addictive disorder and mental health clinics are co-located or merged. Physical space, operational needs, rural locations and part-time service delivery are all on-going challenges for complete integration.

The Office of Behavioral Health is currently working with Medicaid to integrate behavioral health care services into the Bayou Health program to improve care coordination for their 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. As OBH and Medicaid work collaboratively to integrate specialized behavioral health services within the Bayou Health program, there are four key principles that serve as important guide posts:

- Behavioral healthcare needs have a significant impact on both an individual's overall well-being healthcare costs and should therefore be integrated into and coordinated by one accountable entity.
- Information should flow smoothly between payers and all provider types to ensure effective and informed clinical decision making by multi-disciplinary care teams.
- Every effort should be taken to reduce unnecessary administrative burdens on providers, allowing them to focus on delivery of services, care coordination, and case management.
- Contracts must promote accountability for delivery of needed care, improving quality and outcomes and lowering overall healthcare costs without restricting needed access.

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

= Mental Health).

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

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

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

LBHP-Bayou Health Integrated Health Care

In November 2014, Louisiana DHH announced a plan to integrate all behavioral health care services into its existing Medicaid managed care system called Bayou Health. Two types of meetings, Integration Advisory Group (IAG) meetings and Public Forums, were held throughout the state to encourage and invite public guidance for the transition.

- The IAG was composed primarily of behavioral health providers, with participation across all LBHP provider types. Also included were other stakeholders including the judiciary, LGEs, behavioral health advocates, the Louisiana Hospital Association, wraparound agencies, state boards, and partner agencies such as the Department of Children and Family Services.
- The public was also invited to attend and participate in the feedback sessions.

- The IAG met on January 30, February 20, March 20, and April 29 of 2015 and was asked to provide recommendations to DHH on specific topics for integration that could be considered for contract implementation with the Bayou Health plans. A consolidation of these recommendations and individual responses from DHH can be found on the integration homepage along with minutes from the meetings.
- On April 29, 2015, DHH presented on the current status of integration decisions at that point in time for a report out to the group. A copy of this presentation can be found on the DHH integration homepage (http://new.dhh.louisiana.gov/index.cfm/subhome/43).

Right-Sizing Inpatient Services

OBH partners 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. Implementation of the current 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 monthly with hospital staff to discuss cases at length, offer guidance, and work as a mediator between the hospital and behavioral health and housing entities. This process, which was established March 1, 2013, and continues to evolve, is in line with OBH's goal of emphasizing community-based treatment.

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

Emergency and Disaster Response

After several years of dealing with both hurricanes and their aftermath, Louisiana has established a core response effort for disasters in the State. Since 2005, the State has been able to activate the core of the Louisiana Department of Health and Hospitals (DHH) disaster infrastructure during emergency events to address the behavioral health needs of survivors, affected communities and DHH responders. The Disaster Preparedness Section, within the OBH, readies the office to respond rapidly and effectively to both natural and man-made disasters, such as hurricanes, oil spills, acts of terrorism or other catastrophic events resulting in significant loss**.** Disaster protocols are reviewed annually, and activities are planned to test effectiveness of established processes. Under the OBH's response plan, employees are alerted in the event of a storm threat or other disaster and are expected to activate and report to their assigned deployment site or job function. Communication needs for response staff are supported by

technology. Response staff members have been issued blackberry devices and have access to 800 MHz two-way radios for use in disasters. Employees also have access to electronic bulletin boards and websites that allow communication between field, supervisory and administrative staff.

Trainings are also offered to emergency service providers as well as behavioral health providers, to support efforts to strengthen the State's emergency response capabilities while reducing the psychological impact of a disaster statewide. Internally, National Incident Management System (NIMS) training has been made a requirement of employment by OBH, and OBH maintains a registry of credentialed behavioral health professionals who are able to provide assistance in disaster behavioral health, stress management, and multiple agency responses to disaster incidents. Emergency preparedness, response, and recovery have become a part of every employee's job function. As such, employees have learned that every disaster is different, often requiring new learning and flexibility. Through ongoing collaboration with the Office of Public Health (OPH), OBH key emergency response personnel are engaged in annual activities and trainings to improve workforce readiness and response operations in Medical Special Needs Shelters and state and local Emergency Operations Centers (EOCs). Trainings are provided in the following areas of focus:

- Hurricane preparedness training, Shelter-in-Place, and evacuation tabletop exercises
- Addressing adverse emotional reactions encountered in hospital or emergency care environments for other professional and para-professional medical staff, as requested;
- Skill-based psychological first aid, skills for psychological recovery, and self-care training to DHH responders and statewide provider networks; and
- Police, fire and EMS training provided to local agencies by OBH, OPH and the Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP) on:
    - Crisis intervention techniques to first responders
    - Dealing with grief and loss
    - Suicide prevention for first responders
    - Compassion fatigue
    - Bio-terrorism preparedness
    - Behavioral health response to mass casualties
    - Coordination of behavioral health resources for first responders
    - Stress management techniques for first responders

OBH works with inpatient facilities and LGEs to examine their capacity to respond in a disaster event throughout the fiscal year through various activities, including through its coordinative participation in the annual Bus Triage tabletop training in 2015. Pre-assigned behavioral health staff participated in functional exercises conducted by the EOC in May and June of 2015. Additional trainings included stress management/debriefing at the EOC and Applied Suicide Intervention Skills Training (ASIST) to the Baton Rouge Fire Department and Lafayette Sheriff's Department. Crisis support and training was also provided to the Lafourche Parish Fire Department and Orleans Parish Sheriff's Department in March and April of 2015. Disaster readiness briefings were conducted with OBH staff during a lunch and learn in 2014 and conducted electronically in May and June of 2015. Crisis Counseling Program readiness briefings

were also conducted with Metropolitan Human Services District (MHSD), Florida Parishes Human Services Authority (FPHSA), Jefferson Parish Human Services Authority (JPHSA), South Central Louisiana Human Services Authority (SCLHSA), Acadiana Area Human Services District (AAHSD) and Imperial Calcasieu Human Services Authority (ImCal).

OBH worked collaboratively with OPH's Center for Community Preparedness to develop the web-based Disaster Behavioral Health Module for the state-wide mandatory ESF-8 annual training. Staff also participated in mandatory EOC sectional trainings in May, web-based training on modules 1-5 of the ESF-8 between February 2015 and April 2015 and the ESF-8 hands-on regional trainings in March and April of 2015.

OBH identified a core behavioral health crisis support cadre in 2014 and developed a peer training model to ready the cadre to respond to statewide crisis situations as required. Training was conducted between February and May 2015 using four modules covering crisis intervention, grief and loss, trauma-informed approaches in crisis intervention and suicide post intervention strategies to increase the capacity of behavioral health staff to provide needed support to survivors and staff in special crisis situations. OBH also conducted training for statewide responders in June 2015 entitled "Using Trauma-Informed Approaches to Mitigate the Impact of Disasters" in Metairie and Baton Rouge with more than 175 participants within the provider community.

Mental Health Service System

Mental Health Clinics

OBH strives to maintain appropriate access to a wide continuum of mental health services. State-supported Community Mental Health Clinics (CMHC) or Behavioral Health Clinics continue to exist as a mainstay of the service system, and are enrolled as providers with the Statewide Management Organization (SMO). The clinics have continued to be the back bone of the public supported mental health service system, providing lower intensities of care. The CMHCs have been fiscally supported in the past through the Medicaid Clinic Option and continue to provide services to a large portion of the mental health population. Estimates for FY 2014 show that 48,828 unique individuals were provided basic mental health care services through the clinic-based delivery system.

Specialized Adult Mental Health Services

Under the 1915(i) Medicaid State Plan authority, eligible adults with Serious Mental Illness (SMI) or Major Depressive Disorder may receive the following specialized home and community-based services:

- Treatment by a Licensed Mental Health Professional
- Community Psychiatric Support and Treatment
- Psychosocial Rehabilitation services
- Crisis Intervention

Specialized Inpatient Facilities

OBH provides for a continuum of care process to facilitate access to acute and intermediate/ long-term hospital placements. In keeping with system of care principles and the need for a comprehensive continuum of care, there is an emphasis on a close liaison among the LGEs, state hospitals, community provider agencies, and consumer and family support and advocacy systems. The community and hospital system of care emphasize continuity of care and treatment in the least restrictive environment appropriate to the person's needs. OBH supports consumer and family involvement in the planning, development, delivery, and evaluation of services.

There are currently two OBH state-operated psychiatric hospitals providing acute, intermediate, and specialized inpatient care, including one forensic division: Eastern Louisiana Mental Health System (ELMHS) in Jackson and Central Louisiana State Hospital (CLSH) in Pineville. Collectively, both hospitals operate 544 intermediate care beds. ELMHS includes a division that is solely designated for the treatment of the forensic population; which has a total of 355 adult (intermediate) forensic beds. Of these 355 forensic beds, approximately 235 of the beds are housed in the specialty forensic division known as Feliciana Forensic Facility (FFF). Across both hospitals, there are 189 civil inpatient beds, most of which are currently at CLSH.

Acute psychiatric inpatient units are short-term (generally less than 14-day) programs utilized to stabilize persons showing emergency needs so as to return them functioning back to their communities as soon as possible. ELMHS operates 48 acute mental health beds. In addition, there are several facilities in the State operated by the Louisiana State University (LSU) medical schools that have acute mental health beds.

OBH previously operated Southeast Louisiana Hospital (SELH), which provided intermediate care for adults, acute care for children and adolescents and a developmental neuropsychology program (DNP) for adolescents. OBH established cooperative endeavor agreements in January 2013 with Meridian Behavioral Health Systems of Louisiana, LLC (MBH) to operate SELH with funding through Medicaid and/or disproportionate share payments for indigent patients. During this process, 94 intermediate beds were transferred to CLSH and ELMHS. The MBH/OBH agreement provides 16 adult acute beds, 22 adolescent beds and 20 flex beds on the former SELH campus, now called Northlake Behavioral Health System. Agreements were also made for eight adult acute beds each with the Washington-St. Tammany Parish Hospital, an LSU facility in Bogalusa, and with Community Care, a privately operated psychiatric hospital in New Orleans. The Washington-St. Tammany Parish Hospital was recently sold and no longer participates in the cooperative endeavor. The distribution of those beds is currently being discussed. In addition, River Oaks Hospital in Harahan agreed to provide services for eight children, aged seven to twelve.

State Psychiatric Facilities Statewide Staffed Beds
(6/30/2014)

Facility			Adult Acute Beds	Adult Civil Intermediate Beds	Adult Forensic Beds	TOTAL
OBH HOSPITALS	Central State Hospital		0	120	0	**120**
	Eastern Louisiana Mental Health System	East Division	48	95	75	**218**
		Forensic Division	0	0	255	**255**
		Total for ELMHS	48	95	330	**473**
TOTAL STAFFED BEDS			**48**	**215**	**330**	**593**

Data from State Psychiatric Inpatient Facilities Daily Census Report

Community Forensic Services

The population of persons with both serious mental health problems and forensic involvement often require specialized services, specific to issues of competency and/or diversion. Within the system of care, the Community Forensic Services (CFS) division operates two distinct programs, Community Forensic Services and Forensic Aftercare Clinic.

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 Conditional Release Program (ConRep) and Assertive Community Services are designed for forensic patients [Not Guilty By Reason of Insanity *(NGRI),* Incompetent to Proceed *(ITP)* or 648B], who are discharged or diverted from DHH inpatient units. Forensic Service Teams are assigned to provide intensive supervision and consultation to forensic patients utilizing existing OBH mental health clinics as a basic delivery model for psychiatric aftercare. These teams also provide assertive crisis intervention services together with monitoring for the court. In New Orleans, where a significant percentage of discharged and potentially dischargeable forensic patients reside, there is a specialized Forensic Aftercare Clinic, administratively and clinically managed by Community Forensic Services (CFS). This program began as a Federal Demonstration Project designed to increase the discharges of forensic clients and to maintain client compliance with ConRep court orders so that threats to public safety (i.e., harm to others) are minimalized.

FORENSIC PROGRAM	PURPOSE	NUMBER SERVED
Community Forensic Services 1 Attorney (Program Director) 17 DHH District Forensic Coordinators (DFCs) 2 Administrative Assistants 2 Administrative Specialists 1 Contract Psychologist	Competency restoration (jail-based and community-based) for pretrial detainees identified as incompetent Intensive supervision and consultation to forensic patients (NGBRI, 648B and ITP) who are discharged or diverted from DHH inpatient units Psychological evaluations to determine competency	Approximately 400 per year on conditional release 200 per year who are ITP in jail/community
Forensic Aftercare Clinic 2 forensic psychiatrists 1 forensic psychologist 1 forensic psychology intern 1 registered nurse 1 social worker/ addictions counselor 1 sex offender therapist 1 case monitor/social services counselor 1 administrative coordinator 1 clinic manager	Multidisciplinary team, intensive supervision, case monitoring, mental health and substance abuse treatment and/or sex offender treatment to forensic patients (NGBRI, 648B, and ITPs) who are discharged or diverted from DHH inpatient units	55-60 clients at any given time – including diversion and conditional release clients (Con Rep)

On April 12, 2010, the Advocacy Center filed an action against DHH, regarding the length of time taken to accept physical custody of an individual determined to be incompetent to proceed to trial. A Federal Consent Decree was entered on April 12, 2011. The Consent Decree requires that all incompetent detainees be assessed within five calendar days of receipt of the court order and a determination be made of whether the person meets criteria for emergency, major mental health needs or other mental health needs. Based upon this determination, admission standards into DHH custody are established and must be followed. DHH finished the three years under the requirements of the consent decree with substantial compliance. OBH continues to employ the method agreed upon during the consent decree and to monitor the length of stay in jail prior to hospitalization. As a result of this legal action and the OBH's general initiative to become less dependent upon more intensive and restrictive levels of care like long-term hospitalization, additional levels of residential care for persons with forensic involvement have been developed. The table below illustrates several of the programs that have been designed and implemented, to provide less restrictive options for this special population and allow for a graduated process of discharge and reintegration into community settings.

FORENSIC PROGRAM	DESCRIPTION	BED/CAPACITY
Secure Forensic Facility (SFF)	Supervised residential placement at a 1:15 ratio for court-ordered, conditionally released, and/or other selected, forensic clients in need of individualized services to develop daily living skills and to prepare for vocational adjustment and reentry into the community	82 male beds
Sex Offender Treatment Program at the Forensic Aftercare Clinic (FAC) in New Orleans	Outpatient sex offender treatment to community based sex offenders receiving services at the FAC	Capacity to serve FAC recipients
Forensic Supervised Transitional Residential and Aftercare Program (FSTRAP) – Baton Rouge	Appropriate, secure and supervised residential housing in the community Services daily living skills instruction, symptoms management, legal rights counseling, medication management and other clinical group services necessitated by the individualized person-centered treatment plan	40 civil beds for individuals determined to be not restorable and who are conditionally released 45 beds for conditionally released clients with an NGBRI status
Forensic Supervised Transitional Residential and Aftercare Program New Orleans (STRAP-NO)	Residential facility for pre-trial ITP clients with mild mental health or substance abuse issues (mental health services and competency restoration to be provided by the FAC)	22 male beds and 6 beds that can be male or female
Group Home for Females	Aftercare services to females discharged from FFF	6 beds contracted through private provider

Children's Services

On March 1, 2012, OBH launched the Coordinated System of Care (CSoC) in conjunction with the Louisiana Behavioral Health Partnership (LBHP), which is a system of care for at-risk children and youth that:

- Provides comprehensive assessment to help assure that services are matched to members' needs

- Enhances access to a broad array of services that can meet the variability of members' and families' needs
- Demonstrates increased coordination and collaboration
- Is inclusive of the members' and families' voices at all levels, including service delivery, planning, and policy development
- Reduces redundant or duplicative services for children and youth
- Reduces the State's reliance on restrictive levels of care such as hospitals and residential settings
- Has enhanced availability of evidence-based practices (EBPs) for assessment, community-based and outpatient treatment, and the establishment of an appropriate range of inpatient/residential options that are aligned with system of care and Building Bridges principles
- Offers an array of specialized services

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

Children who are not eligible for the CSoC program may receive general behavioral health services such as pharmacy, clinic-based individual and family therapeutic services, community-based rehabilitation services, and school-based behavioral health services. Children/youth are also able to access more intense levels of care such as child Therapeutic Group Homes (TGH); Psychiatric Residential Treatment Facilities (PRTFs); and inpatient hospitalization and substance use residential services. All services are being managed with the goal of reducing redundant services for children and reducing the State's reliance on restrictive levels of care.

The following community-based services are allowable and reimbursable through the Louisiana Behavioral Health Partnership (LBHP):

Community Psychiatric Support & Treatment (CPST): CPST provides goal-directed supports and solution-focused interventions to achieve identified objectives on the individualized treatment

plan. CPST uses face-to-face interventions with the individual present; however family or other collateral support may also be involved.

Psychosocial Rehabilitation (PSR): PSR services are designed to assist the individual with compensating for or eliminating functional deficits and/or environment barriers associated with their mental illness. Activities included must be based on an evidence-based model approved by the State and be intended to achieve the identified goals or objectives as set forth in the individualized treatment plan. PSR is a face-to-face intervention with the individual present.

Family Functional Therapy (FFT): FFT teams can serve children with a variety of behavioral health needs, from conduct disorder to substance use. Local FFT teams provide a proven, community-based treatment alternative to out-of-home placement

Multi-Systemic Therapy (MST): MST is an intensive, home-based wraparound model that combines a variety of individual and family interventions within a systemic context. MST has been evaluated with youth at risk for detention/incarceration and at risk for psychiatric or substance use disorder hospitalization, and it has shown significant results in reducing out-of-home placement, externalizing problem behaviors, rates of recidivism and costs of treatment.

The following services are provided to develop a residential treatment network:

Psychiatric Residential Treatment Facility (PRTF): PRTFs are a new (as of 2012) residential option in Louisiana. Currently, there are 158 beds across five different facilities. Twenty-four of these beds are specifically for sexual offenders. The other beds accommodate mental health, substance use disorders, and co-occurring diagnoses. They are defined by Medicaid as a step down from an inpatient hospital for individuals less than 21 years old. PRTFs are required to ensure that all medical, psychological, social, behavioral, and developmental aspects of the youth's situation are assessed and that treatment for these needs is reflected in the plan of care.

Therapeutic Group Home (TGH): TGHs provide a community-based residential service in a home like setting with eight beds or less for individuals less than 21 years old. There are currently four such facilities licensed in Louisiana. This is also a new service for Louisiana.

Addictive Disorder Residential Treatment Facilities for adolescents (12-17 years old) have been part of the continuum of care prior to the implementation of LBHP. Under the LBHP, individuals aged 18 through 21 are now covered by Medicaid for treatment, with OBH or DCFS/OJJ paying for the room and board portion.

Therapeutic Foster Care and Non-Medical Group Homes are part of the residential care options, but are not under the purview of OBH. OBH has increased collaboration with the Department of Children and Families (DCFS) regarding these residential options as part of the continuum of residential care.

The Louisiana Children's Health Insurance Program (LaCHIP) also provides behavioral health services to many children who are eligible for Medicaid. These services include mental health clinic services, psychological tests, and therapy.

In addition, crisis services for youth are available in every region of the state through the LGEs. The community-based Child and Adolescent Response Team (CART) program and other community-based supports and services continue to provide a route to assist in the reduction of inpatient hospitalizations and diversion from out-of-home placements. CART crisis services are available to all children and their families, not just those eligible for state mental health clinics or services. Services include telephone access with additional crisis services and referrals, face-to-face screening and assessment, crisis respite in some areas, clinical case management, consumer care resources, and access to inpatient care when deemed necessary or requested by the caretakers. The infusion of Social Service Block Grant funds supports respite care, in-home crisis stabilization, and family preservation at various locations across the state. The CART program provides daily access to parents/teachers, doctor's offices, emergency room staff or other community persons who identify a child experiencing a crisis. These referrals can begin with any interested party/stakeholder with consent from the guardian. After the maximum seven day period of CART crisis stabilization, youth and their families may still require further in-home intensive services. Intensive in-home services may be provided through any of the available community based services such as FFT, MST, Homebuilders, and CPST or PSR services with child providers.

OBH also has a number of specialty initiatives that have focused on forensically involved youths. OBH has partnered with the other child-serving agencies to develop and provide specific specialized services for children with Serious Emotional Disturbance (SED) in the child welfare, juvenile, or criminal justice systems. Louisiana has participated as one of the states in the juvenile justice reform initiative funded by the John T. and Catherine D. MacArthur Foundation's Models for Change. This initiative focused in part on expansion of treatment alternatives to incarceration. This has been a particularly effective collaboration in the Monroe area, where there is a strong collaborative of child and youth serving agencies that have come together to offer creative and effective community-based options for the children and youth served in this area. This includes an effective District Attorney Diversion program and an enhanced system of managing and diverting the extensive referrals from the local schools. The LSU Health Sciences Center's (LSUHSC) – New Orleans Institute for Public Health and Justice (IPHJ) leads the Louisiana Models for Change Program for Juvenile Justice System Reform and continues to conduct research and make recommendations for juveniles in the juvenile justice system. It is currently involved in proposed legislation to prevent juveniles from automatically being tried as adults. OBH also continues to closely study issues relating to juvenile competency and to review programs in other states. OBH currently has approximately 60 competency restoration providers who can provide restoration services either in the community, in hospitals or in facilities for citizens with developmental disabilities. Annual certification trainings for competency restoration providers are held each year in June when 20 to 30 providers are either certified or re-certified.

Management Systems

Community Based Resources, Staffing, and Training for Mental Health Providers

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

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

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

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

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

Training Topic
Trauma Informed Care Training
Applied Suicide Intervention Skills
Motivational Interviewing Training
CABHI Orientation Training
Adolescent Community Reinforcement Approach (A-CRA)
Global Appraisal of Individual Needs (GAIN)
Gambling Patient Placement
Training to Hospitals on PASRR
Training to Nursing Facilities on Behavioral Health Issues in Older Adults, PASRR, and Discharge Planning

Training Topic
safeTALK Training
Peer Support Specialist Training
Addiction Severity Index (ASI) Training
Wellness Recovery Action Planning (WRAP) Training
Competency Restoration Training
First Episode Psychosis (FEP & related topics trainings)
Training on ATR Policies and Procedures

Housing Programs

There are multiple providers of homeless programs in each area of the state. Each LGE has a Continuum of Care for the homeless that serves as the coordinating body for the development of housing and services to the homeless. These local homeless coalitions were mandated by the U.S. Department of Housing and Urban Development (HUD) to organize and create a continuum of care for the homeless programs that are receiving HUD McKinney Vento funding with the Supportive Housing Program. The regional Continuums of Care incorporate a complete array of assistance for homeless clients from outreach services to placement in permanent housing. Both private and public agencies are members of these organizations. The programs provide outreach and/or shelter and housing services to the homeless, as well as substance use and mental health disorder services.

The State is embracing Permanent Supportive Housing and the evidence-based practice model of Housing First for appropriate chronically homeless individuals and families. Within the homeless continuum, the State is developing One-Stop centers capable of coordinating homeless services and assistance to recover with treatment and locate housing with supports to sustain community living. The Community Development Block Grant along with HOME Investment Partnership Program (HOME) funds are being used to develop affordable housing units in decent, safe, and affordable communities. This type of housing is aimed at those individuals at and below 20 percent of median income.

Efforts to increase available and appropriate housing for persons with mental illness and other disability populations have been paramount, with the State's Housing Finance Agency providing training and recruitment of housing providers and developers to increase the number of affordable housing units. OBH seeks to foster collaboration across departmental agencies like the Department of Children and Family Services (DCFS), the Center for Medicare and Medicaid Services (CMS), the Office of Aging and Adult Services (OAAS), the Office of Public Health (OPH) and state and local housing authorities in order to utilize all available housing funding resources and develop or partner with housing providers to develop a sufficient stock of affordable housing. HUD programs continue to be a focus of development activities with regard to housing. Service providers have pursued Section 811 applications and sought to develop fruitful relationships with local housing authorities, 202 elderly housing programs, and the Louisiana Housing Finance Agency to pursue disability-required rental unit set-asides. In addition, the State was awarded

the Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States) grant through the Substance Abuse and Mental Health Services Administration (SAMHSA) for the period of September 30, 2013 through September 29, 2016. OBH also serves on the Statewide Interagency Council to End Homelessness. It is essential and critical that housing development continue with particular emphasis on strategies to coordinate tax credits, rental vouchers (Section 8 and Shelter Plus Care) and affordable financing.

In addition, Louisiana's Projects for Assistance in Transition from Homelessness (PATH) program provides a significant amount of *outreach* activity as well as other support services targeted to homeless persons with severe mental illness and/or severe mental illness with a co-occurring disorder. The annual reports from Louisiana PATH providers for FY 2014 indicated that 3,170 homeless individuals were served; however, 1,315 were enrolled. The PATH program provides services to eight of the 10 regions demonstrating efforts to provide homeless outreach and housing assistance to individuals with mental health issues and co-occurring disorders. For the federal PATH funding, Louisiana relies on in-kind and contractual contributions as its federal match. For FY 2014, the match amount was $244,333. Virtually all of the PATH service providers are part of the local Continuum of Care systems for the homeless. As a part of the planning process, these coalitions participate in and facilitate public hearings to request comment on the current use of funding to put an end to homelessness, and to provide opportunities for public comment.

Children's Housing Services

Programs and services targeted to homeless children, youth, and their families have generally been limited in the past; however, strides have been made across the State to identify and improve a number of service gaps for children and youth who are homeless. A few examples are listed below:

- At SCLHSA, the Haven (domestic violence shelter), Beautiful Beginning (homeless shelter for families), and Gulf Coast Teaching Family Services provide outreach to homeless youth through their shelters and work with the families.
- At AAHSD, the "Project Matrix" program serves homeless families, including homeless children and youth. These and various other projects are funded through the Department of Housing and Urban Development (HUD) Continuum of Care for the Homeless program.
- At ImCal, the Education Treatment Council's Harbor House and Transitional Living Program (TLP) provides temporary shelter (standard stay is less than 45 days) for homeless youth funded through HUD Continuum of Care. There are staff present 24 hours a day, but it is considered a minimal supervision program. Although TLP is not solely for youth with a mental health diagnosis, it is an option for transitional age youth with a mental health diagnosis as long as they meet their program criteria.

In addition, the Statewide Management Organization (SMO) coordinates services to assist homeless and other youth up to 21 years of age who are in need of health care services.

The issue of education for homeless children and youth is directly addressed in the McKinney-Vento State Plan for the education of homeless children and youth as amended by Title X, Part C of the No Child Left Behind Act of 2001, Public Law 107-110. Specific activities for school districts to address the needs of homeless (and highly mobile) families have been established. These activities include such things as: designating a liaison for the school district to act as a contact person, outreach worker, and advocate for homeless families and youth; identifying local service providers for homeless families, such as shelters, food banks, and community agencies; and informing parents and youth of their right to public education, even if they do not have a permanent address. In Louisiana, expanded definitions have helped local school districts understand who may be in need of assistance. Children and youth living in the following types of situations are eligible for assistance from local homeless educational programs:

- Children and youth in transitional or emergency shelters
- Children and youth living in trailer parks, camp grounds, or vehicles
- Children and youth "doubled-up" in housing
- Children and youth living in motels and weekly-rates apartments
- Foster children and youth
- Incarcerated children and youth
- Migratory children and youth
- Unaccompanied minors, such as: runaways and abandoned youth
- Highly-mobile families and youth

Employment Services

OBH recognizes that employment is a major component in the recovery process and supports consumers who have employment as a goal. Previously, OBH utilized employment specialist training and other related employment training available through the University of North Texas and the Federal Region VI Community Rehabilitation Continuing Education Program to build a cadre of trained employment coordinators in each region. However, most regional employment coordinators now have additional duties and devote on average of less than 25 percent of their time to employment issues. A variety of factors including the transition to managed care and the shifting roles and funding sources of LGEs, have also left the position vacant in some of the LGEs. Each of these issues has served to hamper efforts to increase employment initiatives. Though several LGEs have expressed an interest in hiring full-time employment coordinators and have been working towards doing so, not many have been able to make this a reality to date.

To increase the rate of employment among persons with severe mental illness, OBH has promoted a strategy of actively seeking and accessing opportunities external to OBH at the state and federal level to fund the further development of services that expand employment opportunities. Such external opportunities may include, but are not limited to, monies available for employment, employment services related to housing support, vocational rehabilitation services, and related employment services. Such funds are available through the Social Security Administration, HUD, the Louisiana Workforce Commission (LWC), the Rehabilitation Services Administration, and other federal and state programs. The passage of the Federal Ticket to Work

Program and the Work Incentives Improvement Act of 1999 make a large pool of federal dollars available for development of these employment-related services.

OBH staff coordinates with other programs and program offices, such as the Disability Navigator initiative through the LWC; the Work Incentive Planning and Assistance (WIPA) program through both the Advocacy Center and Louisiana State University; Louisiana Rehabilitation Services; and other employment related work groups, such as the WORK PAY$ committee. The WORK PAY$ committee is comprised of community partners and is intended to further the employment of individuals with disabilities in the state of Louisiana. Additionally, OBH is working diligently to increase the number of certified Peer Support Specialists working within the system of care, effectively enhancing services while enabling individuals with behavioral health conditions to be employed throughout the system. OBH continues to work with Louisiana Rehabilitation Services and other program offices, seeking opportunities for increased collaboration for training and improvements in the Peer Support program design in order to better serve individuals as they transition to work.

The Louisiana Work Incentive Planning and Assistance (LAWIPA) program helps Social Security beneficiaries work through issues relating to social security benefits and employment. The program is a coalition between the Advocacy Center of Louisiana and the LSU Health Sciences Center's Human Development Center. Many individuals with disabilities who receive Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) benefits want to work or increase their level of employment. One barrier for these individuals is the fear of losing health care and other benefits if they work. Valuable work incentive programs can extend benefits, but are often poorly understood and underutilized. The LAWIPA coalition educates clients and assists them in overcoming work barriers, perceived or real; and also focuses on improving community partnerships. Benefit specialists, called Community Work Incentive Coordinators, provide services to all Louisiana SSDI and SSI beneficiaries aged 14 and above who have disabilities. OBH staff and members are able to work with coordinators to help navigate the various work-related resources offered in conjunction with the Ticket to Work program, and identify on an individualized basis the way their benefits will be impacted by going to work. The ultimate goal of the new WIPA coalition is to support the successful employment of beneficiaries with disabilities.

In addition, Act 378 funds for adults can be used in any manner to assist the individual in remaining in the community. Should an individual need any vocational or employment supports, such as job training, assistance in obtaining a job, or the provision of a job coach, these funds can cover those costs. The Access to Recovery (ATR) and CABHI State grant initiative, both of which are managed by OBH Central Office, provide reimbursement for job readiness recovery support services to eligible participants.

The overall goal of OBH's employment initiatives is to create a system within the Office 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. The national economy and lack of resources has made this goal a challenging one at best. Nationwide, a suffering economy can have a spiraling effect as workers are laid off and the need for public assistance increases. However, when resources are not available, the solution-focused alternative is to assist clients in obtaining and maintaining employment through help with resume-writing, job searching, and interview coaching, while ensuring collaborations with community-based partners.

Profile of Persons Served (CMHC)
Adult Mental Health Clients by Employment Status
Louisiana OBH Outpatient Data-Unduplicated Persons Served, FY2014

	Age 18-20			Age 21-64			Age 65+			TOTAL			TOTAL
	Female	Male	Unk.	Female	Male	Unk.	Female	Male	Unk.	Female	Male	Unk.	
Employed: Competitively Employed Full or Part-time (includes Supported Employment)	112	44		2,165	1,135	73	22	8	2	2,299	1,187	75	3,561
Unemployed	35	38		914	629	28	9	1	1	958	668	29	1,655
Not in Labor Force: Retired, Sheltered Employment, Sheltered Workshops, or Other (Homemaker, Student, Volunteer, Disabled, etc.)	513	486	15	11,025	7,413	379	437	198	29	11,975	8,097	423	20,495
Employment Status Not Available	222	211	17	7,338	4,790	525	413	162	27	7,973	5,163	569	13,705
TOTAL	882	779	32	21,442	13,967	1,005	881	369	59	23,205	15,115	1,096	39,416

Employment status at admission. Data from CMHC data: Magellan's Clinical Advisor. Unduplicated across LGE by client.
URS Table 4 Profile of Persons Served CMHC, Adult Clients by Employment Status-Age at Admission

Educational Services

The precursor to the Office of Behavioral Health (OBH), the Office of Mental Health (OMH), initially funded the LSU Supported Education Program for students with serious mental illness (SMI). In 1997 LSU became one of the first four-year universities in the nation to have a supported education program in place and operational. Upon LSU's agreement to independently continue the program, OMH moved its funding to the University of Louisiana at Lafayette (ULL), where a supported education program became operational in the fall of 2000. In 2006, the ULL was also able to sustain its program internally. Both LSU and ULL initially received block grant monies to establish a supported education advisor position within each university's existing services for students with disabilities. Each university historically agreed to contribute in-kind resources for the program and to continue the programs funding once the OBH "seed money" was no longer provided.

Both universities have continued in their efforts to serve this population while utilizing many of the components of the program as they were conceived in original programming, and OBH remains able to provide technical assistance if needed. The supported education advisor serves those students identifying themselves as persons with serious mental illness (SMI), providing assistance with needed accommodations under ADA as well as disability management counseling

and information/referral to on- and off-campus agencies. The supported education advisor serves as a case manager for students with SMI, is a liaison to the student's primary therapist, and serves as an on-campus advocate. The advisor's focus is on attempting to minimize the impact of a student's psychiatric illness by determining what accommodations are needed in order for the student to successfully handle both academics and adaptation to the social milieu of the university. The long-term goal of the program is to see the student with SMI successfully complete a university education and enter into a career field of the student's choice. The program targets students with SMI of all ages, including those who are older and are entering or reentering a secondary educational setting after years of mental health treatment and those who are younger and may be experiencing psychiatric symptomatology for the first time. Thus, the goal of the program is achieved through both funneling individuals back into the educational system as well as maintaining them there as they cope with the onset of their mental illness.

Referrals to the program come from a variety of sources, including clinics, the on-campus mental health services of the universities, Louisiana Rehabilitation Services, and university faculty and staff. The largest referral source, however, continues to be self-referral by SMI students enrolled at each school who have been made aware of the program.

Special Populations

Older Persons

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

Aggregate data for SFY 2014 indicate that more than 10,176 outpatient services have been delivered to Louisiana seniors (those aged 65 and over) with mental health diagnosis throughout the LGEs.

The overwhelming majority of mental health conditions upon admission to community based services for Louisiana's senior population are Major Affective Disorders followed closely by Psychotic Disorders. The following tables represent the distribution of primary admitting diagnoses for seniors.

Primary Diagnosis at Admission	LOCAL GOVERNING ENTITY COUNT OF SERVICES RECEIVED											
	01-MHSD		02-CAHSD		03-SCLHSA		04-AAHSD		05-IMCAL		06-CLHSD	
	N	%	N	%	N	%	N	%	N	%	N	%
Primary DX 1												
Adjustment Disorder	.	.	7	0.6%	17	0.6%	.	.	6	4.6%	.	.
Anxiety Disorder	28	3.4%	51	4.8%	88	3.4%	8	0.7%	3	2.3%	17	3.2%
Attention Deficit	5	0.6%	26	2.4%	20	0.7%	.	.	.	.	.	.

Primary Diagnosis at Admission	LOCAL GOVERNING ENTITY COUNT OF SERVICES RECEIVED											
	01-MHSD		02-CAHSD		03-SCLHSA		04-AAHSD		05-IMCAL		06-CLHSD	
	N	%	N	%	N	%	N	%	N	%	N	%
Conduct Disorder	.	.	.	.	.	.	4	0.3%	.	.	.	.
Dementias	3	0.3%	.	.	12	0.4%	.	.	.	.	.	.
Depressive Disorder	16	1.9%	61	5.7%	26	1.0%	21	2.0%	3	2.3%	15	2.8%
Major Affective Disorder	310	38.5%	473	44.7%	1,190	47.2%	505	50.1%	50	38.7%	197	37.5%
Intellectual Disability	.	.	.	.	6	0.2%	.	.	.	.	.	.
Oppositional Defiant Disorder	.	.	1	0.0%	.	.	.	.	.	.	.	.
Other Disorders	30	3.7%	9	0.8%	93	3.6%	12	1.1%	2	1.5%	4	0.7%
Pervasive Developmental Disorder	.	.	4	0.3%	.	.	.	.	.	.	1	0.1%
Psychotic Disorder	396	49.2%	398	37.6%	725	28.7%	264	26.2%	39	30.2%	272	51.9%
Substance/EtOH Abuse Disorder	3	0.3%	22	2.0%	106	4.2%	68	6.7%	8	6.2%	16	3.0%
Missing/Unknown	13	1.6%	6	0.5%	237	9.4%	124	12.3%	18	13.9%	2	0.3%
Total	804	100.0%	1,058	100.0%	2,520	100.0%	1,006	100.0%	129	100.0%	524	100.0%

PRIMARY DIAGNOSIS AT ADMISSION	LOCAL GOVERNING ENTITY COUNT OF SERVICES RECEIVED								Total	
	07-NLHSD		08-NEDHSA		09-FPHSA		10-JPHSA			
	N	%	N	%	N	%	N	%	N	%
Primary DX 1										
Adjustment Disorder	7	2.0%	.	.	9	0.4%	.	.	46	0.4%
Anxiety Disorder	.	.	18	2.3%	46	2.4%	36	3.0%	295	2.8%
Attention Deficit	4	1.1%	13	1.7%	27	1.4%	27	2.3%	122	1.1%
Conduct Disorder	.	.	.	.	.	.	6	0.5%	10	0.0%
Dementias	.	.	.	.	.	.	.	.	15	0.1%
Depressive Disorder	1	0.2%	20	2.6%	30	1.5%	78	6.7%	271	2.6%
Major Affective Disorder	140	41.5%	295	39.0%	666	35.4%	388	33.3%	4,214	41.4%
Intellectual Disability	.	.	.	.	.	.	.	.	6	0.0%
Oppositional Defiant Disorder	.	.	.	.	.	.	15	1.2%	16	0.1%
Other Disorders	11	3.2%	4	0.5%	276	14.6%	75	6.4%	516	5.0%
Pervasive Developmental Disorder	.	.	.	.	.	.	.	.	5	0.0%
Psychotic Disorder	132	39.1%	376	49.8%	518	27.5%	311	26.7%	3,431	33.7%
Substance/EtOH Abuse Disorder	14	4.1%	22	2.9%	171	9.0%	21	1.8%	451	4.4%

PRIMARY DIAGNOSIS AT ADMISSION	LOCAL GOVERNING ENTITY COUNT OF SERVICES RECEIVED								Total	
	07-NLHSD		08-NEDHSA		09-FPHSA		10-JPHSA			
	N	%	N	%	N	%	N	%	N	%
Missing/Unknown	28	8.3%	7	0.9%	138	7.3%	205	17.6%	778	7.6%
Total	337	100.0%	755	100.0%	1,881	100.0%	1,162	100.0%	10,176	100.0%

OBH is currently working with Office of Aging and Adult Services (OAAS) and Medicaid to ensure delivery of services to older adults through the development and inclusion of behavioral health assessment and services into the Medicaid managed care delivery system targeting elders and adults with physical disabilities.

In addition, OBH works collaboratively with Medicaid, 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. Expert psychiatric consultation is used for cases involving complex clinical presentations, and recommendations for nursing home placement and behavioral health treatment are made based on a comprehensive review of clinical information.

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

PASRR Process FY 2014 Referrals	**2535**	
Types of Referrals		
• Referrals for admission to nursing facilities	1583	62%
• Referrals for resident reviews performed while in the nursing facility after a significant change in status	600	24%
• Referrals for Exempted Hospital Discharges not requiring PASRR process for first 30 days	352	14%
Decisions		
• Approved for Nursing Facility Placement o Temporary Approvals	1241 (382)	49%
• Denied Nursing Facility Placement	290	12%
• Decided not to go to Nursing Facility and withdrew request	61	2%
• Determined not to have a serious mental illness by OBH and determination by OAAS was not required.	943	37%

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 Louisiana Behavioral Health Partnership (LBHP). Individuals may receive services from a psychiatrist, a licensed mental health professional, and providers of addiction services while in the nursing facilities.

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

- Identification of individuals in nursing facilities that no longer meet Level Of Care (LOC)
- Increased collaborations between OBH and the DHH Health Standards Section (HSS)
- Site visits to nursing facilities that have large populations with behavioral health issues
- Continued consultation between OBH and HSS as behavioral health issues arise
- Collaborations to include PASRR in state nursing facility licensing standards
- OBH offers continuous technical assistance and trainings. Trainings offered by OBH include:
    - Training to state surveyors regarding PASRR
    - Trainings to Nursing Facilities (NF)
        - DHH Collaborative Discharge Planning Trainings to NF
        - OBH trainings to Louisiana Nursing Home Association members regarding PASRR and behavioral health issues in older adults
    - Trainings to 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, OCDD and private hospital 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.

Rural Populations

Although OBH has implemented many effective programs in rural areas, residents of rural areas continue to face barriers to service, especially transportation. Transportation in the rural areas of the state has long been problematic, not only for OBH consumers, but for the general public living in many of these areas. The lack of transportation resources not only limits access to mental health services, but also to employment and educational opportunities. The expansion of behavioral health programs and providers and the recruitment of transportation providers in rural areas are ongoing goals. In many cases, community-based services, such as Assertive Community Treatment (ACT) or Intensive Case Management (ICM), have been made available to

serve some of these populations. The ability of the Statewide Management Organization (SMO) 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 SMO has been the development of a more robust provider network, even in the more rural areas of the state.

Service Members, Veterans and their Families

A Louisiana delegation attended the Service Members, Veterans, and their Families (SMVF) Policy Academy. The delegation consisted of members of Louisiana Department of Veterans Affairs, OBH, the Louisiana State University Health Sciences Center (LSUHSC), the Veteran's Administration, and local behavioral health providers. The overall goal of the SMVF Policy Academy was to strengthen statewide behavioral health care systems and services for SMVF through ongoing collaboration at the federal, state and local levels. The result of the policy academy was the formation of a strategic plan for Louisiana and the decision to form a veteran's coalition. The State is currently in the process of developing a memorandum of understanding between agencies serving veterans in order to strengthen collaboration and communication between them.

In addition, SAMHSA selected Louisiana to participate in the Substance Abuse Services Initiative (SASI) with the Louisiana Army National Guard (LAARNG). SASI provides funding for screening, brief intervention, and referral to treatment (SBIRT) services to members of the LAARNG that began on September 6, 2013. Approximately 100 soldiers have received services to date. Most of the soldiers required only brief intervention services. However, some needed a higher level of care, such as intensive outpatient or inpatient services. While soldiers can self-refer to the program, the majority were soldiers that have tested positive for Tetra Hydro Cannabinol (THC) and are referred to SASI by their commanding officer. In an effort to expand the Louisiana SASI project, OBH has collaborated with the Southwest ATTC (Addiction Technology Transfer Center) and IRETA (Institute for Research, Education & Training in Addictions) by making training available to new providers and LGEs on the SBIRT process, the ASSIST Screening Tool, motivational interviewing and military culture.

The Cooperative Agreements to Benefit Homeless Individuals (CABHI) state grant supplement, which was awarded to OBH in 2014, also provides treatment and recovery support services for homeless veterans with serious mental illness, substance use disorders, or co-occurring disorders. The veteran population served through the CABHI state grant includes any person who served in any branch of the military; therefore, persons who served in the military who are not recognized by the Veterans Administration as veterans are eligible for services through the CABHI state grant.

Addictive Disorder Service System

The Office of Behavioral Health (OBH) continues to maintain a full continuum of substance use disorder treatment even though budgetary restraints have forced significant reductions. Programs statewide, in both urban and rural areas, are categorized along the American Society of Addiction Medicine (ASAM) specifications. They include: ASAM I Outpatient, ASAM II.1 Intensive Outpatient, detoxification (ASAM III.2D Clinically Managed Residential Detox and ASAM III.7D Medically Monitored Inpatient Detox), community-based (ASAM III.1 Clinically Managed Low Intensity Residential (Halfway-houses), ASAM III.3 Clinically Managed Medium Intensity Residential Treatment (therapeutic Communities and three quarter homes), ASAM III.5 High Intensity Residential, and ASAM III.7 Medically Monitored Intensive Treatment (Co-Occurring Unit). During SFY 2014, a total of 16,310 individuals were admitted into the substance use disorder treatment continuum, and a total of 370,485 services were provided, including 8,490 services for the Injecting Drug Users (IDUs), inclusive of all levels of care, as per the Louisiana Addictive Disorder Data System (LADDS) and Clinical Advisor (CA) system. Currently, Block Grant funding is used for intensive outpatient, outpatient, social detoxification, halfway-house, and residential/inpatient levels of care. It is also used for services provided to special populations as required by Block Grant guidelines and funds Recovery Home Outreach Workers.

OBH's implementation of process improvement strategies has also increased access to care, helping providers deliver the "right type of service to the right client, at the right time and at the right intensity". By defining target populations and appropriate service mixes, implementing centralized screening and scheduling, and instituting walk-in appointments, OBH has dramatically reduced waitlists for services. In some cases, clinics maintain no wait lists, and in others waitlists have been reduced from months to just weeks or days. These activities have expanded access, improved provider productivity and generally moved the behavioral health clinics toward a higher practice standard. With the implementation of the Louisiana Behavioral Health Partnership (LBHP), OBH no longer utilizes outpatient settings as the single point of entry to access addiction services. Members are able to contact any service provider who is certified and credentialed in the LBHP to be assessed for services, thus reducing wait times and increasing efficiency even further.

The most commonly abused substances reported in Louisiana by individuals admitted in SFY 2014 include alcohol, heroin, opiates, marijuana, cocaine and methamphetamine, as depicted in the table below. SFY 2014 data about the substance use disorder treatment population indicates that, of the individuals engaged in treatment, 15.66 percent were admitted with an alcohol problem only, 45.82 percent were admitted for treatment of a drug addiction only and 15.73 percent were admitted for treatment of both alcohol and drug addiction.

Most Commonly
Abused Substances (SFY 2014)
SUD Admissions for Clients Reporting a Primary Drug

#	Substance	% of Population
1	Alcohol	28.63%
2	Heroin	17.17%
3	Other Opiates and Synthetics	16.37%
4	Marijuana/Hashish	14.47%
5	Cocaine	10.26%
6	Methamphetamines	6.78%
7	Benzodiazepines	2.67%

Data Source: LADDS and Clinical Advisor

In addition to the populations previously mentioned, individuals admitted for the treatment of gambling addiction represented 2 percent of the population. The table below shows the distribution by age group of individuals served in SFY 2014.

SUD Persons Served By Age
(SFY 2014)

Age Group	% Served
18 and Under	5.82%
19 – 30	30.85%
31 – 50	46.25%
51 and Over	17.07%

Data Source: LADDS and Clinical Advisor. Age at end of time period. Unduplicated by client.

OBH provides access to substance use disorder treatment services through a statewide network of providers that work together in a seamless system of recovery-oriented care, with a range of services accessed according to an assessment of the severity of an individual's substance use disorder. Louisiana's continuum of care is modeled on the ASAM levels of care and is designed to place individuals in the least-restrictive level of care appropriate to the need and to progress to less intensive levels of care until recovery can be sustained with minimal help. OBH and treatment providers utilize the Addiction Severity Index (ASI) assessment interview for adults and the Comprehensive Adolescent Severity Inventory (CASI) assessment interview for adolescents. Patient placement decisions and referrals are based on the six dimensional problem areas used by the ASAM.

OBH funds a full continuum of substance use disorder services, from prevention to brief screening and intervention, and from detoxification to residential and outpatient levels of care. 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.

Prevention

The State's goal is to build, operate, and maintain a prevention system that is family-focused, evidence-based, outcome driven, and cost effective. This mission includes reducing high-risk behaviors associated with alcohol, tobacco and other drug (ATOD) use and increasing the availability and effectiveness of a general health promotion and education message. Prevention services are provided across the state of Louisiana to individuals of all ages and their families. Every effort is made to fill gaps and provide services to those populations of the State that data indicate are underserved.

The Office of Behavioral Health (OBH) continues with the vision that prevention is a process that helps create, reinforce, and support healthy behaviors and lifestyles through an individual's lifespan. As part of the merger of mental health and addictive disorders, prevention planning efforts expanded in scope and now consist of educating citizens not only about addiction, but also about mental health issues, specifically about the prevention of suicide. Suicide prevention activities have been rolled into the plan for prevention services statewide and will be delivered through the existing education infrastructure already utilized for substance abuse prevention. The ultimate goal is to create and operate a seamless system of care that includes primary prevention, intervention, and treatment services for both mental health and substance use disorders.

Addressing the Needs of Diverse Populations

The State addresses the needs of Louisiana's diverse populations in a number of ways. Examples of specific planned and completed activities that are targeted to Louisiana's diverse minority populations are:

- Revising the Prevention Management Information System (PMIS) to include additional data elements in order to ensure adherence to the U.S. Department of Health and Human Services' (HHS) final published standards for data collection on race, ethnicity, sex, primary language and disability status
- Reviewing demographic data to better understand who is in need of services and who is being reached through services, identify disparities in access to services, and provide research-based programs that have been approved for use with diverse populations
- Outreaching and sharing information at events targeted to various minority populations, such as:
    - Providing information about substance use and pregnancy to women who are pregnant, perinatal, or of child-bearing age at large events held at local hospitals for women
    - Sharing substance abuse prevention information with students, particularly minority populations, at school rallies and back-to-school, prom, or graduation events
    - Conducting door-to-door outreach to distribute prevention education literature to high-risk (based on crime and drug use) zip code areas that have high minority populations

    - Providing information at health fairs, parades, and other events to address the needs of the disabled, aging, and LGBTQ populations
    - Providing school-based trainings and programs
- Sharing information and messaging through various media outlets targeted toward various audiences
- Preparing prevention-related materials and offering services in multiple languages for individuals whose primary language is not English
- Establishing relationships with members of the community who can serve as key cultural informants and cultural brokers with minority populations
- Utilizing training and policies related to diversity to raise awareness of the importance of understanding and addressing needs of minority populations among staff
- Partnering with and educating local agencies, governmental entities, and members of workforces in order to address the needs of minority populations, including those with disabilities, those who identify as LGBTQ, and racial minority populations
- Providing trainings to heighten awareness and understanding of cultural differences and sensitivity towards them
- Establishing and maintaining a Cultural Competency Committee in order to identify areas in need of improvement to increase awareness of cultural issues in the community and regarding prevention and treatment service delivery

Prevention services are provided across the state of Louisiana to individuals of all ages and their families. However, the State has acknowledged the need to further expand prevention services across an individual's lifespan, particularly by providing services geared toward adults beyond student populations located at institutions of higher education.

In addition to national data sources, Louisiana currently collects and has access to state/parish level data in the State Epidemiology Workgroup (SEW) Online Data System on adults over 25 years of age from the Office of Public Health (mortality, Hepatitis, HIV/AIDS), Office of Behavioral Health (treatment admissions), Highway Safety Research Group (crash report data) and the CORE Alcohol and Drug Survey. The SEW has identified two additional state/parish data sources that currently exist and collect data on adults over 25 years of age: Louisiana Early Event Detection System (LEEDS) and the Prescription Drug Monitoring Program (PDMP). LEEDS is a web-based reporting system that automatically processes hospital emergency department data to identify visits indicative of specific syndromes, which are linked to symptoms in chief complaint data. PDMP is an electronic system for the monitoring of controlled substances and drugs of concern which are dispensed in the state or dispensed to an address within the state.

Examples of prevention services targeted toward adults include:

- Programming geared toward parents and families
- SafeTALK suicide prevention training
- ASIST suicide prevention training
- Prevention training for the Louisiana Behavioral Health Advisory Council (LBHAC)

- Prevention training for each Regional Advisory Council (RAC)
- Participation in health fairs, community rallies, and festivals (such as alcohol and drug free zones during Mardi Gras parades)
- Employee Assistance Program (EAP) referrals for state employees
- Efforts through the Louisiana Higher Education Coalition to Reduce Alcohol, Tobacco, and Other Drugs, including continued administration of the CORE Survey, which serves as a higher education needs assessment and is used to assist higher education institutions in the development and implementation of action plans to address identified needs specific to their student populations
- The Alcohol Information School, which is a court-approved program for DWI offenders that is available in English and Spanish
- Media and marketing efforts through which prevention staff provides informational materials related to substance use prevention and treatment resources, such as the following:
    - Media campaigns, including billboards, theater ads, newspaper articles/newsletters, and public service announcements
    - Referral guides that include information about regional resources
    - Websites that include treatment resources and educational publications
    - Outreach to the public at health fairs, sorority and fraternities' events, and coalition events

Examples of prevention services targeted toward children and youth include:

- The Strengthening Families Program, which is an evidence-based, family-focused curriculum for children ages six to 12 and their caregivers that is implemented in the community in order to enhance the parent-child relationships by strengthening problem-solving, decision-making, and communication skills
- Summer youth programs sponsored through partnerships with local agencies such as YMCAs and Arts Councils
- Youth groups using environmental strategies to reduce tobacco and alcohol use among youth
- The Families in Focus program, which is an in-home family life skills program that addresses seven life coping skills and allows families to gain control of their lives by working with facilitators in a non-therapeutic environment
- The Parent Education Program, which is a program designed for parents of children of all ages to assist them in developing new ideas and practicing new techniques to improve relationships with their children by addressing behavior problems, discipline, communication, and conflict resolution
- SafeTALK suicide prevention trainings

Strategies addressing the prevention of substance abuse and the promotion of mental health are implemented in Louisiana through a variety of funding mechanisms. In order to share resources and build capacity to more efficiently address these behavioral health issues, OBH provides opportunities for networking across funding streams, i.e., Drug Free Communities (DFC),

Louisiana Partnership for Success (LAPFS), Tobacco Free Living (TFL), Louisiana Traffic Safety Coalitions, Office of Behavioral Health Local Governing Entities and Louisiana Higher Education Coalitions (LaHEC). Collaboration among regional, parish, and local coalitions can more effectively achieve the long-term outcome of reducing substance use and promoting mental health across the state of Louisiana.

Prevention Strategies
During SFY 2015, 55 Community-Based Prevention Providers and 10 Community Synar Projects were funded. They provided services in the areas of the six CSAP (Center for Substance Abuse Prevention) prevention strategies to include: Information Dissemination, Education, Alternative Activities, Problem Identification and Referral, Community-Based Process, and Environment. The Community-Based Prevention Providers implemented 15 evidence-based programs.

Information Dissemination: All OBH contract providers provide information specific to their program and ATOD to the communities in which they reside. OBH also maintains at least one Regional Alcohol and Drug Awareness Resource (RADAR) Associate Network in each of the ten Local Governing Entities (LGEs). OBH, through its Prevention Management Information System (PMIS), confirms that this information dissemination strategy impacted 2,469,741 citizens during SFY 2015. Provider and agency staff provided the following services: 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.

Education: OBH contract providers provide on-going prevention education from evidence-based curriculums to enrollees in their respective program(s). During SFY 2015, OBH confirmed through its Prevention Management Information System (PMIS) that evidence-based services were provided to 89,191 enrollees, exceeding the 76,238 target. The following table lists the 15 Evidence-Based Educational Programs that were funded during SFY 2015 designated by Universal, Selective, or Indicated.

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

Selective Evidence-Based Program
Strengthening Families
Selective Program Total: 1

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

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 provided 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.

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

OBH Prevention Services maintains the EAP, which is available to all state employees and identifies those experiencing problems that interfere with the normal performance of work duties. OBH maintains the EAP contact information on their website for all regions of the state, and provides technical assistance to agency staff regarding tracking EAP referrals in the Prevention Management Information System (PMIS) database.

Less than one percent of the total Block Grant Primary Prevention funds support Problem Identification and Referral Strategies. These funds support additional services beyond those offered through the existing Employee Assistance Program (EAP). Through memorandums of understanding with the schools, staff can identify students who may be experiencing emotional or personal issues and report them to the classroom teachers. Teachers and principals can then refer to the list of resources. Additionally, the Insight Class Training Program is implemented to help teens overcome problems with alcohol, marijuana, and other drugs and referrals are made from the schools associated with the program. Lastly, community support staff may assist with community resource referrals. Technical assistance is provided to contract facilitators to assist and encourage them in identifying and referring youth to appropriate services. Training relative to identification and referral for issues such as child abuse or bullying is made available to the facilitators as well.

Community Based Process: The 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 and resources assessment; 2) assessment and 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.

Environmental: OBH continues to fund 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 actively scan their respective communities and regions to identify and collaborate with other agencies and organizations (e.g. the Coalition for Tobacco-Free Living, Students Against Destructive Decisions, the American Lung Association, 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, community mobilizing for change on alcohol, 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.

Louisiana Caring Communities Survey

OBH co-sponsored the 2014 Louisiana Caring Communities Survey (CCYS) for sixth, eighth, 10th, and 12th graders with the Louisiana Department of Education (DOE). The 2014 survey was successful, with a total of 92,605 participating students. Results of the survey are outlined in state, regional and parish reports, which are posted on the OBH website for review and use by the general public. School-level reports are available only to the superintendents of each school district. OBH will provide a community tool for reviewing CCYS reports. PowerPoint templates for state-, regional- and parish-level data are being distributed by OBH to the LGEs and Community Partners to ensure consistency and accuracy of presentations. Technical assistance will be provided as needed to the LGEs as they present the data to their Local Education Authority (LEA). The 2016 Louisiana Caring Communities Survey will be coordinated and administered in fall 2016, with results released in early spring 2017.

Task Force to Prevent Underage and High Risk Drinking

The Task Force to Prevent Underage and High Risk Drinking was disbanded and returned under the umbrella of the Prevention Services Committee, which is a subcommittee of the State Drug Policy Board, late in the first quarter of 2011. This is the body from which the Task Force was originally formed. The Task Force was formed under Goal 3 of the State's first Strategic Plan developed under the Strategic Prevention Framework State Incentive Grant (SPF-SIG).

In SFY 2012, the State received the Strategic Prevention Enhancement (SPE) Grant and spent SFY 2012 updating the State's five-year strategic plan. As part of the data prioritization process, indicators for youth 30-day alcohol use and youth binge drinking were considered to determine areas of greatest need of resources to address underage alcohol use and high-risk drinking. The data in regards to underage alcohol use showed that alcohol is clearly the number-one substance of choice by Louisiana youth. Therefore, a special section specific to underage drinking was

included in the State's five-year strategic plan to raise awareness around this serious problem. The State has begun implementation of the five-year strategic plan and will work in collaboration with partners to develop action plans that identify strategies to reduce underage and high risk drinking.

Louisiana Higher Education Coalition to Reduce Alcohol, Tobacco, and Other Drugs
OBH funded the Louisiana Higher Education Coalition to Reduce Alcohol, Tobacco, and Other Drugs (LaHEC) during SFY 2015. LaHEC stimulated vision and commitment for the LaHEC mission within and among all institutions through collaboration among higher education staff and faculty as well as key community and state stakeholders. LaHEC facilitated communication within and among all member institutions through monthly emails and telephone communication with liaisons at the 35 institutions of higher education. OBH also sponsors the administration of the biennial CORE Alcohol and Drug survey for institutions of higher education across the state of Louisiana. The CORE survey was conducted in spring 2015.

LaHEC organized and implemented a professional development culture between/among LaHEC institutions of higher education in the state for the purpose of establishing campus-community coalitions throughout Louisiana that address environmental problems related to substance use through policy education, development, enhancement, and enforcement using a public health model.

OBH also sponsors an annual LaHEC summit to assess and address high-risk behaviors and plan interventions for institutions of higher education. The SFY 2015 LaHEC Professional Development Summit was held on June 11 and 12, 2015 with the overall goal of mobilizing institutions of higher education and community stakeholders to address the issue of ATOD in collegiate populations by utilizing empirical data to inform interventions, programs, and policy change. A total of seven different presentations were made during the summit. The titles included: 2015 Core Survey Results, Alcohol and other Drug Individualized Management Group (A.I.M), Motivational Interviewing in Counseling, Establishing a Collegiate Recovery Community at LSU, Synthetic Drug Use, Sexual Violence 101, and Future Funding for Prevention in Higher Education. All of the Summit presentations, educational documents and website links were made available through the LaHEC website. All Summit participants completed an evaluation of the Summit, and an analysis and report on these evaluations were prepared by LaHEC staff.

Prevention Workforce Development
The strengths of Louisiana's prevention service system to address training to providers, sub-recipients, and/or coalitions are demonstrated through the following:

- Diverse training environments that include school- and community-based settings in both rural and urban areas
- A professional group of trained, dedicated, experienced, and credentialed trainers
- Regularly provided training opportunities
- Diversity among participants in training events

- The ability to adjust programs to meet individual needs without compromising program fidelity
- Efforts undertaken to ensure that there is little to no duplication of training services
- The utilization of federal, state, and local data within trainings and to assess need and make decisions about training needs
- The ability to be flexible and change or evolve as needed
- The sustainability of partnerships among the Louisiana prevention service system and providers, sub-recipients, and coalitions
- Demonstration of excellent communication
- Provision of cost effective and fiscally sound training efforts

A few examples are summarized below:

- OBH Prevention Services, through a contractual agreement with Southern University Baton Rouge, offers one online prevention professional seminar and five face-to-face courses/trainings to meet the educational requirements for employees, contractors, and other interested persons to become certified or licensed prevention professionals and to further develop the prevention workforce in Louisiana. During SFY 2015, 228 individuals participated in these courses/trainings.
- OBH funds a contract with Dr. Murelle Harrison to develop and deliver specialized prevention professional workforce development training for employees, contractors and other persons referred by OBH. During SFY 2014, a total of 1,717 individuals participated in these courses/trainings.
- OBH hosted and participated in the Eighth Annual Children's Behavioral Health Summit, *The Well Child: An Integrated Approach* on June 30, 2015. Approximately 450 family members, social workers, licensed professional counselors, licensed addiction counselors and other human service professionals were in attendance. State and national speakers presented on such topics as behavioral health integration and children's services, pediatric integrated care, marijuana, building bridges, preventing mental, emotional, and behavioral disorders in children, engaging military families in community prevention, and safety-focused practice.

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

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

- Dissemination of a variety of evidence-based prevention programs/environmental prevention strategies.

Tobacco Regulation and Youth Access Control

Louisiana utilizes environmental, legal, and community-based strategies to reduce the access of tobacco products to minors as required by the Synar Amendment to the Public Health Service Act (PL 102-321). Louisiana law prohibits any manufacturer, retailer, or distributor of tobacco to sell tobacco to persons less than 18 years of age. The State enforces this law by conducting random, annual, and unannounced inspections of tobacco distribution outlets and must achieve an inspection failure rate that is no more than 20 percent. The reported non-compliance rate for FFY 2015 is 17.9 percent (FFY 2014 was 15.9). This increase in the non-compliance rate is related to a reduction of Office of Alcohol and Tobacco Control (ATC) staff. As there are fewer ATC agents available, there are also fewer on-going compliance checks, which influences the overall compliance rate. There are also fewer enforcement checks due to reduced staff.

OBH funds 10 regional Synar contractors to provide merchant education through unconsummated compliance checks of tobacco retailers. OBH also contracts with the ATC to conduct the random, unannounced inspections necessary to complete the required Annual Synar Report. The OBH Synar Coordinator is responsible for monitoring contract deliverables as outlined in the contract between OBH and the Louisiana ATC. ATC is expected to conduct 2,400 random, unannounced compliance checks of tobacco retailers annually. Of these 2,400 compliance checks, 1,000 are conducted for the Annual Synar Report and 1,400 are conducted routinely throughout the year.

During the Annual Synar Survey, referred to in Louisiana as the Annual Synar Report, three layers of monitoring are employed to ensure accuracy of the data. Agents, employed by the ATC, review the tobacco retailers' compliance check forms before submitting the forms to his/her supervisor. Then, the supervisor reviews the forms before sending the form to ATC headquarters. Finally, the State Synar Coordinator reviews each form before sending them to the Synar Principal Investigator. Synar contractors are monitored programmatically on a monthly basis by OBH Regional Prevention Coordinators (RPCs) who conduct monthly statements of work compliance and quarterly facility, staff, and policy reviews. Synar contractors submit tobacco retailer unconsummated compliance check forms to OBH through the PMIS web-based computer system.

Substance Use Disorder Treatment for Adults

Screening and Referral for Military Personnel

The Substance Abuse and Mental Health Services Administration (SAMHSA) selected Louisiana to participate in the Substance Abuse Services Initiative (SASI) with the Louisiana Army National Guard (LAARNG). The SASI program provides funding for screening, brief intervention and referral to treatment (SBIRT) services to members of the LAARNG by utilizing the SBIRT model. There are approximately 11,500 Soldiers serving in LAARNG, with 74 separate units located in 44 parishes (56 Unit Armory/Drilling Facilities). Soldiers serving in the Army National Guard (ARNG)

that have alcohol and substance abuse problems have to pay for substance abuse services through private insurance or personal funds, making it inaccessible for many. The ARNG considers this lack of access to substance abuse care to be a readiness issue. In FY 2012, approximately 4,640 Soldiers tested positive for illicit drugs and needed a mandatory substance abuse assessment. Historically, the ARNG has had limited substance abuse treatment options for any substance abuse cases. The ARNG has the highest illicit drug positive rate in the comparison to the regular Army and the Army Reserves. The ARNG has experienced the highest increase in drug positives than any component. In FY 2012, the percentage of illicit drug positives for the ARNG was 2.23 percent. In FY 2012, the LAARNG percentage of illicit drug positives was 3.82 percent, which was the highest in the nation. Access to Recovery (ATR) providers who choose to participate in the SASI will provide screening, brief intervention, and referral to treatment to LAARNG soldiers who are referred for services. OBH staff will provide suicide prevention trainings to LAARNG units.

The Louisiana SASI project began on September 6, 2013. Approximately 100 soldiers have received services to date. Most of the soldiers required only brief intervention services, however, some needed a higher level of care, such as intensive outpatient or inpatient care. While soldiers can self-refer to the program, the majority of soldiers have tested positive for THC and are referred to SASI by their commanding officer. In an effort to expand the Louisiana SASI project, OBH has collaborated with the Southwest Addiction Technology Transfer Center (ATTC) and Institute for Research, Education & training (IRETA) by making training available to new providers/LGEs on the SBIRT process, the ASSIST Screening Tool, motivational interviewing and military culture.

Detoxification Services

A range of detoxification treatments are available at varying levels of intensity. Care can be provided in outpatient, inpatient or even residential settings if the individual's biomedical conditions or complications are severe and acute enough to warrant primary medical and psychiatric care on a 24-hour basis. Treatment at the residential setting assures a safe withdrawal and stabilizes the individual. Specific services provided depend on the acuity and severity of the individual's problem and are described below:

- *Level II-D Ambulatory Detoxification with Extended On-Site Monitoring:* Ambulatory detoxification provides care to patients whose withdrawal signs and symptoms are of moderate intensity but are sufficiently stable enough physically and mentally to permit participation in outpatient treatment. Organized outpatient services are delivered in an office, health care, or addiction treatment facility by trained clinicians, who provide medically supervised evaluations, detoxification, and referrals. Ambulatory detoxification is provided in conjunction with intensive outpatient treatment services (Level II.1).
- *Level III.2-D Clinically Managed Residential Detoxification*: Clinically Managed Residential programs provide care to patients whose withdrawal signs and symptoms are non-severe but require 24-hour inpatient care to address biomedical and recovery environment conditions/complications. In this organized, residential, non-medical setting,

appropriately trained staff provide safe, 24-hour medication monitoring, observation, and support in a supervised environment to help patients achieve initial recovery from the effects of alcohol and/or other drugs.

- *Level III.7-D Medically Monitored Residential Detoxification – Adult:* Medically monitored residential detoxification provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. Medical and nursing professionals deliver 24-hour medically supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols.
- *Level IV-D Medically Managed Intensive Inpatient Detoxification:* Intensive inpatient detoxification delivers the highest level of care in a full-service hospital setting with 24-hour availability of nursing and physician care for medication dispensation and monitoring of all medical and withdrawal symptoms. This level of care is available statewide and funded via Medicaid.

During SFY 2014, the service delivery system for detoxification services consisted of two Clinically Managed Residential and seven Medically Monitored Residential programs provided through state-operated and contract facilities. According to the Louisiana Addictive Disorders Data System (LADDS) and Clinical Advisor (CA), there were 2,272 client admissions (unduplicated by client within an LGE) during SFY 2014 to detoxification programs statewide, including - 110 to Clinically Managed Residential facilities, and 2,162 to Medically Monitored Residential facilities. OBH continues to work on expansion of programs in Louisiana's network of providers through the Louisiana Behavioral Health Partnership (LBHP), which expands services for individuals in need of detoxification services.

Outpatient Treatment

Outpatient services represent the least intense and restrictive options for care and are intended for those individuals who need some treatment, but whose problems have a low severity rating. Services are provided as needed, typically once a week, and for fewer than nine hours a week for adults and fewer than six hours a week for adolescents. As part of the continuum of care, outpatient treatment can also be a "step down" from more intense levels of care, for those individuals who have progressed and no longer need more intense services. Services can include education and individual, family, or group counseling. Counselors/clinicians in state treatment programs provided services as clinically indicated and assumed the responsibility of providing case management/care coordination services. These services included, but were not limited to, referral, discharge planning, and aftercare treatment.

Some LGEs utilize a combined access unit that screens for both mental and addictive disorders and refers to addiction, mental health or co-occurring services. Others have designated an access point, such as particular clinic, which completes all admissions. Many LGEs have implemented an open access model that allows for walk-in screening and assessments on the same day. Screening, assessment and referral protocols continue to improve, making LGEs more efficient and maximizing resource utilization. With participation in the LBHP, OBH and its partners no longer have to utilize outpatient settings as the single point of entry to access addiction services.

Members are able to contact any service provider who is certified and credentialed in the LBHP to be assessed for services, thus reducing wait times and increasing efficiency even further.

Intensive Outpatient Treatment
Intensive outpatient services are offered to individuals who need more intense treatment than is offered in outpatient services, but do not require the constancy and intensity of residential or inpatient treatment. Services offered in this level of care are the same as those in outpatient (including compulsive gambling counseling), except that they are offered more frequently. Typically, intensive outpatient services are provided to the individual three or four times a week for a total of at least nine hours per week for adults, and at least six hours per week for adolescents.

Residential Treatment
Residential programs provide community-based care and treatment. Individuals are provided with transitional arrangements, support, counseling, room and board, social and recreational activities, and vocational opportunities in a moderately structured, substance-free environment. Community-based residential treatment focuses on re-socialization and encourages individuals to resume independent living and functioning in the community.

The residential level of care provides services for those individuals who need relatively moderate-to-high intensity treatment in a structured environment. There are four subcategories of intensity within this level of care: Clinically Managed Low Intensity (Level III.1), Clinically Managed Medium Intensity (Level III.3), Clinically Managed High Intensity (Level III.5), and Medically Monitored Intensive Residential (Level III.7). Services provided in these levels of care are dependent on the medical necessity and severity of the individual's disorder, and are available 24 hours a day, seven days a week. OBH funds residential programs across the state. OBH also funds one residential program for compulsive gambling treatment that provides services for the entire state.

Population Served	# Programs	# Beds
Adult	33	581
Adolescent	3	48
Women and Dependent Children	7	109
Total	**43**	**738**

These residential facilities utilize standardized treatment services which include screening, assessments, drug testing, individual therapy, group therapy, family therapy, primary educational services, medical services, and STD/TB/HIV services. Services also include treatment for co-occurring disorders as well as recreational therapy and social/life skills training.

In SFY 2014, OBH maintained thirty-three adult residential programs, seven women with dependent children programs and three adolescent programs within the 10 Local Governing Entities (LGEs) throughout the state, having a total bed capacity of 738 beds. There were a total

of 6,223 admissions to residential adult programs and 130 admissions to residential adolescent programs.

Below is a description of Louisiana's residential levels of care:

- *Level III.1 Clinically Managed Low Intensity Residential Treatment – Adult*: Residential programs offer at least five hours of a combination of low-intensity clinical and recovery-focused services per week. Treatment is directed toward applying recovery skills; preventing relapse; improving emotional functioning; promoting personal responsibility; and reintegrating the individual into the worlds of work, education, and family life. Services provided may include individual, group, and family therapy; medication management; and medication education. Mutual/self-help meetings usually are available on site. This does not include sober houses, boarding houses or group homes where treatment services are not provided.
- *Level III.3 Clinically Managed Medium Intensity Residential Treatment – Adult:* Residential programs offer at least 20 hours of a combination of medium-intensity clinical and recovery-focused services per week. Frequently referred to as extended or long-term care, Level III.3 programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery from substance disorders.
- *Level III.5 Clinically Managed High Intensity Residential Treatment – Adolescent*: These programs treat persons who have significant social and psychological problems and are characterized by their reliance on the treatment community as a therapeutic agent. Treatment goals are to promote abstinence from substance use and antisocial behavior and to effect a global change in participants' lifestyles, attitudes and values. Individuals typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values (example: therapeutic community or residential treatment center). The program must include an in-house education/vocational component if serving adolescents.
- *Level III.7 Medically Monitored Intensive Residential Treatment – Adult*: These facilities provide 24 hours of structured treatment activities per week including, but not limited to, psychiatric and substance use assessments, diagnosis treatment, habilitative services, and rehabilitation services to individuals with co-occurring psychiatric and substance disorders (ICOPSD), whose disorders are of sufficient severity to require a residential level of care. It also provides a planned regiment of 24-hour professionally directed evaluation, observation, and medical monitoring of addiction and mental health treatment in a residential setting. They feature permanent facilities, including residential beds, and function under a defined set of policies, procedures, and clinical protocols. Appropriate for patients whose subacute biomedical and emotional, behavioral, or cognitive problems are so severe that they require co-occurring capable or enhanced residential treatment, but who do not need the full resources of an acute care general hospital. In addition to meeting integrated service criteria, Co-Occurring Disorder (COD) treatment providers must have experience, and licensure and/or certification in both AD and MH is preferred.

Recovery Support Services

Services to support the recovery of an individual are a vital part of successful treatment. Such services help an individual to sustain the positive behavioral and lifestyle changes made during their treatment, and foster relapse prevention. Examples of recovery support services are housing, job readiness, transportation, and child care.

The Access to Recovery (ATR) program is a resource available throughout the State's local communities to persons with substance abuse disorders. Unlike any other substance abuse treatment program available, ATR provides both clinical treatment and recovery support services to persons with addictive disorders. ATR's treatment model impacts the addictive disorders population that does not typically engage in traditional treatment models, offers a service system of faith- and community-based providers who are accustomed to the cultural needs of the populations within their local communities and provides additional recovery support services that help ATR clients to maintain abstinence and lead a recovery-oriented lifestyle.

SAMHSA's Center for Substance Abuse Treatment (CSAT) awarded Louisiana its first ATR grant (ATR-I) in 2004. ATR was created as a presidential initiative to provide client choice among clinical substance abuse and recovery support providers, expanding access to a comprehensive array of clinical treatment and recovery support options, including faith- and community-based organizations.

The Louisiana ATR-I program targeted all residents of the State, with special emphasis on women and adolescents with substance abuse disorders. In 2007, Louisiana was one of 19 states and five tribal organizations out of 40 applicants who were awarded a second Access to Recovery (ATR-II) grant. This grant provided $13.4 million over a three-year period to assist in closing identified gaps in substance abuse treatment and recovery support services for adults and adolescents involved in the criminal justice system as well as methamphetamine users.

Currently, the ATR program is entirely financed with state general funds. The maximum lifetime of a client's voucher is six months, with the average cost per voucher, including administrative costs, being approximately $1,284 for SFY 2014. The administration of the program involves remote on-line and on-site monitoring by a highly skilled team of OBH staff who ensure compliance with policies and procedures and monitor to prevent and detect fraud, waste, and abuse.

ATR is a performance-based program, and ongoing participation as an ATR provider is determined by each agency's individual performance and outcomes when compared to similar provider agencies in the state. ATR vendors were included in the dialogue regarding plans to pursue and achieve accreditation standards in order to serve the Medicaid population.

There are 32 ATR providers in Louisiana. The ATR provider network currently includes community-based agencies, which consists of agencies from the private, public, non-profit, for-profit, and faith-based sectors in all 10 Local Governing Entities (LGEs) service areas throughout the state:

Access to Recovery (ATR) Providers	
LGE	**ATR Vendors**
MHSD	2
CAHSD	9
SCLHSA	4
AAHSD	4
ImCal	0
CLHSD	0
NLHSD	1
NEDHSA	5
FPHSA	1
JPHSA	6
Total – June 30, 2015	**32**

The ATR program provides services beyond the traditional addiction treatment services offered through state clinics, other providers, or the LBHP to include recovery support services such as those listed below:

- *Alcohol and Drug Free Social Activities* – ATR provides activities that foster healthy relationships, involve little stress, and encourage clients to engage in new and constructive activities. Events may involve an array of activities such as ball games, picnics, holiday meals, and community service projects and are encouraged to take place during weekend nights and holidays, as these are the times that clients are most susceptible to relapse.
- *Childcare* – Daycare can be provided for the children of ATR clients in treatment.
- *Job Readiness* – Educational and employment supports are provided for clients who are employable and in need of guidance or direction with the process of securing and maintaining employment.
- *Life Skills* – ATR provides individual or group sessions with clients discussing such topics as parenting, recreational therapy by a certified therapeutic recreational therapist, anger management, healthy relationships, and HIV/AIDS education.
- *Spiritual Support* – These ATR services are designed to assist the client in developing their spirituality as an integral part of their recovery and may cover practices and principles such as establishing a relationship with a higher power; identifying a sense of purpose and mission in one's life; achieving serenity and peace of mind; balancing one's body, mind and spirit; and utilizing spiritual practices such as prayer or meditation. Spiritual support is based on universal spiritual practices and principles and not on specific religious convictions and beliefs.
- *Transitional Housing* – Board and care is provided to residents in licensed facilities.
- *Transportation* – ATR can provide round-trip transportation for clients to and from treatment.

ATR will continue to provide payment to providers for clinical services not reimbursable under the LBHP, including drug screening and Government Performance and Results Act (GPRA) discharge.

During the SFY 2014, a total of 1,943 persons were in the ATR program, of which 67 percent completed treatment. As of June 30, 2015, the ATR budget was $3.2 million for SFY 2014 and is financed by state general funds.

The remote monitoring capability of the web-based system supports a smaller workforce to administer and monitor the program in an efficient manner with a low administrative overhead of only 10%. The greater part of the ATR budget is dedicated solely to providing direct services to persons with addictive disorders via the ATR provider network.

Services and resources available through the ATR program result in reduced recidivism into higher cost levels of care or services, such as inpatient/residential treatment, emergency rooms, and incarceration. The efficiency of the ATR program allows additional treatment and recovery support services to individuals at a lesser cost, utilizing community-based service providers, with improved outcomes.

The ATR program has continued to be an investment in communities and community programs by DHH/OBH, by investing nearly the entire ATR budget in community-based agencies as the service providers for the voucher program. The ATR voucher program and web-based voucher management system has served as a prototype for the knowledge and movement of OBH into a managed care environment, and the ATR staff continues to work in collaboration with the LBHP to build strategies for rebalancing funding to include Medicaid and State General Funds.

Oxford Houses

OBH no longer participates in the SAPT Block Grant option to maintain a revolving loan fund process for the development of recovery group homes. Historically, home loans were made available by the State for the development of Oxford homes – which are democratically run, self-supporting, and drug free homes that follow the Oxford House, Inc. model. All of these home loans have been paid in full, and Oxford chapters now make home loans directly through the home office, Oxford House, Inc. During FY 2014, OBH and Oxford House, Inc. maintained a contractual agreement to monitor and promote the development of Oxford homes throughout Louisiana. OBH continues to make referrals to Oxford homes on a statewide basis, and Oxford outreach workers and LGE administrators continue collaborations to locate and lease housing to serve recovering individuals. Oxford homes are currently in all Louisiana LGEs (except SCLHSA) with 93 operational homes and a total of 681 beds. Of these homes, 59 are for men with 438 beds, 20 are for women with 142 beds, and 14 are for women and children with 101 beds. The Oxford House Inc. contract provides for two outreach workers, one male and one female. The female homes are monitored by the female outreach worker, and the male homes are monitored by both outreach workers. An OBH program manager conducts quarterly teleconferences with regional administrators/LGE executive directors and Oxford outreach workers. The bed utilization rates, home status reports, new home openings, home closures or moves, Oxford

Model presentations, and future goals are discussed during these teleconferences. Vacancies as well as any problematic issues are also discussed.

Evolution of Co-occurring Disorder Integrated Treatment

In 2003, the state of Louisiana was part of the first cohort of states awarded the Co-Occurring State Infrastructure Grant (CoSIG), creating an integrative project between the Office of Mental Health (OMH) and the Office for Addictive Disorders (OAD), which are now consolidated into OBH. The goal of this initiative was to address infrastructure changes required within the two program offices to better meet the needs of the co-occurring populations, which provided much of the framework for building an integrated outpatient behavioral health system. The initiative addressed ease of access to needed services, and required systematic changes to collaboratively improve treatment outcomes for persons with both mental illness and addictive disorders. The grant funded statewide trainings for all service providers within OMH and OAD to better screen, assess, engage and treat individuals with co-occurring disorders.

As a result of the CoSIG grant, the Louisiana Integrated Treatment Services Initiative (LITS) was created. LITS was also a joint effort between the Office of Mental Health and the Office for Addictive Disorders. The mission of LITS was to develop a system in which all mental health and addiction treatment programs are expected to be Co-Occurring Diagnosis Capable (CODC). Standards include screening all adults for the presence of co-occurring disorders, assessing the level of severity, and treating co-occurring disorders in a coordinated manner that is both seamless and person-centered. At the completion of the CoSIG initiative, the primary clinics in every Local Governing Entity (LGE) were able to reach at least a status of Co-occurring Capability as defined by the Dual Diagnosis Capability Assessment Tool (DDCAT). Many of the COSIG supported clinics reached beyond this level and moved toward integrated care and the development of clinic operations that reached a status of Enhanced Co-occurring Capability.

In an effort to provide distinction for those counselors who have achieved a specified level of expertise in the treatment of this population, the Louisiana Association of Substance Abuse Counselors and Trainers Certification and Examiners Board now offers the Certified Co-Occurring Disorders Professional (CCDP) credential and the Certified Co-Occurring Disorders Professional Diplomat (CCDP-D) credential. An increase in properly trained and certified personnel helps ensure better treatment for individuals with co-occurring disorders.

Execution of needed programmatic changes to integrate mental health and substance use disorder treatment clinically and administratively continues to be a priority of the Office of Behavioral Health (OBH). During SFY 2013, the Center for Substance Abuse Treatment (CSAT) State Systems Technical Assistance Project (SSTAP) allowed for onsite technical assistance through two separate projects that assisted OBH with co-occurring efforts. Specifically, the two projects were focused on the development of integrated substance abuse and mental health program licensing standards (“LA-7” Project) and the expansion of co-occurring certification credentialing of licensed practitioners (“LA-10” Project).

A consultant was assigned to provide technical assistance off-site for the LA-7 Project. The objectives of this technical assistance project were to explore options for integrated licensing standards and to develop integrated substance abuse and mental health program licensing standards. The consultant reviewed draft standards created by DHH staff, conducted a comparative review of the draft standards with those of other states and other relevant resources, and provided feedback to the State. The consultant offered various recommendations to help refine and complete the standards document and suggested that a training program be developed and implemented. The State has since completed the standards and has presented them to stakeholders. Enacting legislation for the adoption of the new standards was presented to the Louisiana Legislature during the 2013 legislative session and was passed. The final rule implementing the Behavioral Health License will be published in August 2015.

Two consultants were assigned to provide technical assistance both off-site and on-site for the LA-10 Project. The objective of this project was to explore expansion of the co-occurring certification credential for licensed practitioners. The consultants facilitated a series of conference calls and an on-site meeting with representatives from each professional discipline, which involved discussion and examination of professional competency standards with a goal of reaching agreement on a trans-disciplinary framework that the State could use to measure professional competency associated with assessing and treating co-occurring mental illness and addictive disorders. The consultants prepared for the State a series of documents to help in the State's efforts to design a co-occurring disorder certification process by providing a practical framework for subsequent discussions between the State and licensing boards.

Substance Use Disorder Treatment for Adolescents

The Office of Behavioral Health (OBH) offers ASAM III.5 Clinically Managed High-Intensity Residential, ASAM III.1 Clinically Managed Low-Intensity Residential, ASAM I Outpatient and ASAM II.1 Intensive Outpatient services to adolescents. The 24 hour facilities accept statewide admission. Outpatient programs are also available statewide.

- *Gateway Adolescent Treatment Center* provides residential treatment services for sixteen adolescents, aged 12 through 17. Ten of these beds were allocated as male beds and six beds were allocated as female beds. Bed capacity was previously reduced from 26 to 16 beds in order to meet Centers for Medicare & Medicaid Services (CMS) IMD requirements. Treatment was provided utilizing the psychosocial service model, with a strong cognitive behavioral approach. The facility utilized community resources to address the needs of the co-occurring population.
- *Cavanaugh Center* provides residential treatment services for sixteen adolescent beds, for ages 12 through 17. Designated beds were utilized for either males or females, dependent on necessity. Cavanaugh utilized the Twelve Step Minnesota Model for Recovery as their primary therapeutic approach. The facility also maintained fourteen halfway house beds for adolescents who were in need of a longer length of stay.
- *Odyssey House* provides residential treatment services for adolescents ages 12 through 17, with a sixteen bed capacity. Odyssey House utilizes a cognitive behavioral model

based on the Living in Balance Curriculum. The program operates on a Points and Level System, in which clients earn points that enable them to progress in curriculum levels. There are four levels to complete before a client may graduate, with each level lasting approximately two weeks. Clients can move up or down in levels depending on what goals are completed according to their treatment plans. While the program is structured to last eight weeks, the length of stay varies based on the need for each client.

Treatment Models Utilized for Adolescent Substance Use Disorder Treatment
LGEs have the opportunity to use one or more of the following EBP/curriculums dependent on needs of adolescents and families in their specific area:

- *Adolescent Community Reinforcement Approach (ACRA)* was developed to promote abstinence from marijuana, drugs, and alcohol in the intensive outpatient level of care. This program emphasizes improved family relationships, positive peer relationships, and improved functioning within the environment. It is designed for a minimum of twelve weeks with treatment extended as necessary.
- *Seven Challenges Model* targets adolescents with co-occurring disorders. It is an individualized program that incorporates a cognitive/emotional decision-making model. Participation is a minimum of 12 weeks. Treatment Improvement Protocol (TIP 32) by the Substance Abuse and Mental Health Services Administration (SAMHSA) is a comprehensive review of best treatment practices and has specific information on assessment, placement factors, and special considerations for the adolescent population.
- *Cannabis Youth Treatment Series (CYT)* was designed to target marijuana use among youth 12 to 18 years old. It is geared for individuals who may benefit from one to 14 weeks of outpatient treatment. It is available through SAMHSA.
- *The Matrix Model* is an intensive 16 week outpatient mode for stimulant abuse and dependence. The intervention consists of relapse-prevention groups, education groups, social support groups, individual counseling, and urine and breath testing. The program also addresses education for family members affected by the addiction.
- *Motivational Enhancement Therapy and Cognitive Behavioral Treatment Model (CBT/MET 5 and CBT/MET 7)* utilizes motivational enhancement and cognitive behavioral therapy. The program starts with two individual sessions of MET with emphasis on change and three or 10 supplemental group sessions of CBT. The focus of the CBT sessions is on learning to meet needs in ways that do not result in turning to marijuana and alcohol, as well as the development of better coping skills. It is available through the Addiction Technology Transfer Centers with some cost associated.
- *Contingency Management (CM)/Motivational Incentives* is the systematic reinforcement of desired behaviors and the withholding of reinforcement or punishment of undesired behaviors. This program uses low cost reinforcement (prizes, vouchers, clinic privileges, etc.), delivered in conjunction with onsite urine screening. It promotes higher rates of treatment retention and abstinence from drug abuse and is an effective strategy in the treatment of alcohol and other drug (AOD) use disorders.

- *Multi-systemic Therapy (MST) for Juvenile Offenders and Multi-systemic Therapy with Psychiatric Supports (MST-Psychiatric*) are designed to treat youth who are at risk of out of home placement due to serious behavioral problems and co-occurring mental health disorders such as thought disorder, bipolar affective disorder, depression, anxiety and impulsivity. They address the multidimensional nature of behavioral problems in troubled children (ages 6-12) and adolescents (ages 13-17) in an intensive outpatient, home based model. MST addresses risk factors in an individualized, comprehensive and integrated fashion, allowing families to enhance protective factors. The primary goals of MST programs are to decrease anti-social behaviors and other clinical problems, and to improve functioning in family relations and school performance.

ATR (Access to Recovery) Recovery Support Services (RSS) for Adolescents

Through the Access to Recovery (ATR) program, the Office of Behavioral Health has provided Recovery Support Services (RSS) to children and adolescents. Needs for services are identified during the screening and assessment process and are included as part of the treatment plan. In Louisiana, the following RSS are made available to children and adolescents:

- *Alcohol and Drug Free Social Activities* - Activities that foster healthy relationships, involve little stress, and encourage clients to engage in new and constructive activities. Events may involve an array of activities such as ball games, picnics, holiday meals, and community service projects and are encouraged to take place during weekend nights and holidays, as these are the times that clients are most susceptible to relapse.
- *Childcare* - Daycare provided for the children of ATR clients in treatment.
- *Job Readiness* – Educational and employment supports for clients who are employable and in need of guidance/direction with the process of securing and maintaining employment.
- *Life Skills* - Individual or group sessions with clients discussing such topics as parenting, recreational therapy by a certified recreational therapist, anger management, healthy relationships, and HIV/AIDS education.
- *Spiritual Support* - Designed to assist the client in developing their spirituality as an integral part of their recovery and may cover practices and principles such as establishing a relationship with a higher power; identifying a sense of purpose and mission in one's life; achieving serenity and peace of mind; balancing one's body, mind, and spirit; and utilizing spiritual practices such as prayer or meditation. Spiritual support is based on universal spiritual practices and principles and not on specific religious convictions and beliefs.
- *Transitional Housing* – Board and care is provided to residents in licensed facilities.
- *Transportation* - Providing round-trip transportation for clients to and from treatment.

Adolescent Treatment Enhancement and Dissemination Program

The Louisiana State Adolescent Treatment Enhancement and Dissemination Program (LA-SAT-ED) serves adolescents ages 12 to 18 with substance abuse/co-occurring disorders and their families. The program developed a blueprint for policies and procedures and financing structures that can be used to widen the use of evidence-based substance abuse practices in Louisiana.

Through the development of two learning laboratories with collaborating local community-based treatment provider sites during year one and four additional sites during year two, Louisiana was able to not only improve substance abuse assessment and treatment services for adolescents and their families, but also to identify barriers to access to treatment and test solutions that can be applied throughout the state. These address the treatment of adolescents with substance use and co-occurring substance use and mental disorders, and their need for recovery support through improved integration and efficiency of services. As a result, the program expects: 1) decreased juvenile justice involvement for adolescents; 2) increased rates of abstinence; 3) increased enrollment in education, vocational training, and/or employment; 4) increased positive social linkages; and 5) increased access, service use, and outcomes among adolescents most vulnerable to health disparities. The project goals include the provision of evidence-based assessment, treatment and recovery services to a minimum of 360 adolescents and their families by the end of year three. Participants of the program receive evidence-based treatments that include Adolescent Community Reinforcement Approach (A-CRA) augmented by Assertive Continuing Care (ACC) and evidence-based assessment using the Global Appraisal of Individual Needs (GAIN). LA SAT-ED collaborated with providers of substance use and co-occurring disorders and state child-serving agencies to develop and provide training and continuing education events throughout Louisiana.

Collaboration/Coordination with Other Agencies

Central to the operational activities of OBH is the coordination of services with other agencies and additional collaboration between agencies to enhance internal resources and afford clients a wider scope of services. OBH continues to work collaboratively with the Office of Public Health, Office for Citizens with Developmental Disabilities, Department of Children and Family Services, Department of Education, Office of Juvenile Justice, and other agencies/stakeholders, via cooperative agreements, contracts, task forces, training events, and pilot projects to take full advantage of treatment resources and maximize service delivery to individuals. This collaboration allows OBH to be more actively involved in the community and to enhance the Office's input and knowledge of issues critical to client welfare.

Prevention Partners

OBH continues to work with the Louisiana Department of Education (DOE) to conduct the Louisiana Caring Communities Youth Survey (CCYS) for Louisiana School students in the 6th, 8th, 10th, and 12th grades. Prevention Services also coordinates and collaborates with other agencies by serving as members of state, regional, and local organizations to include, but not limited to, Louisiana Campaign for Tobacco Free Living, Children's Coalition, Office of Alcohol and Tobacco Control, Louisiana Department of Education, Southwest Prevention Center, Addictive Disorders Regulatory Authority, Office of the Attorney General, Office of Youth Development, Drug Enforcement Administration, Office of Public Health, University of Louisiana system, Louisiana State University system, Southern University system, Louisiana National Guard, Highway Safety Commission, Louisiana Supreme Court, and the Louisiana Governor's Office.

Faith-Based Providers

OBH continues to work with faith-based and other recovery support providers to expand service capacity via the Access to Recovery (ATR) program and CABHI state grant. ATR utilizes an electronic voucher system that provides clients with freedom of choice for clinical and recovery support services. The ATR initiative is currently sustained by state general funds. ATR clinical and recovery support services are offered by private providers (including faith-based providers). Recovery support services offered through ATR include alcohol and drug free social activities, childcare, job readiness, life skills, spiritual support, transitional housing, and transportation.

Office of Public Health

OBH and the Office of Public Health (OPH) continue to collaborate on training for HIV Rapid Testing, staff cross training, and counseling of HIV positive clients. In addition, OBH and OPH's Maternal and Child Health Division coordinate efforts to improve statewide birth outcomes via ongoing implementation of the SBIRT/Birth Outcomes Initiative, which is aimed at enhancing statewide education and screening of pregnant women for addictions, depression, and domestic violence. In SFY 2011, the SBIRT project in Louisiana assumed a new name and an expanded focus. It is now called the Louisiana Health Assessment Referral and Treatment (LaHART) system. In 2011, under the DHH Birth Outcomes Initiative, the project was elevated to a health care priority under the DHH Office of the Secretary.

OBH maintains a Memorandum of Understanding with the Office of Public Health (OPH), Division of Maternal and Child Health, to offer voluntary pregnancy testing to women entering, or re-entering, treatment for addiction services on a statewide basis. This collaboration affords the Office of Public Health (OPH) the opportunity to reach one of their target populations (women with addictions), and OBH is able to provide more comprehensive care to women seeking addiction treatment. Women are encouraged to test at all levels of care and are educated on the harm of alcohol, tobacco, and drug use during pregnancy.

The Office of Behavioral Health (OBH) developed a partnership with the Office of Public Health (OPH) and other stakeholders to address the needs of individuals with behavioral health conditions and tobacco/nicotine dependency. This team participated in the *Smoking Cessation Leadership Academy,* and as a part of their participation developed a strategic plan targeting a 5% reduction in smoking prevalence among those diagnosed with behavioral health conditions by 2020.

Department of Children and Family Services

OBH and the Department of Children and Family Services (DCFS) have joined forces for policy development regarding substance exposed newborns, and on the Temporary Assistance for Needy Families (TANF) Initiative, to expand services for TANF eligible women and children in need of addiction treatment. Despite mid-year budget reductions during SFY 2013, OBH maintained the women and dependent children's residential treatment program. This program supports 88 beds for seven residential facilities for women, pregnant women, and women with dependent children through TANF funding. Six of these facilities housed children on-site with their mothers and provided a drug free environment, thus preserving family unity and providing therapeutic

services for the entire family. However, the screening, assessment, and referral programs at child welfare sites and Family Independence Temporary Assistance Program (FITAP) sites, located in each of the ten LGEs throughout the state, were eliminated during SFY 2013. These services were absorbed by the DCFS site program staff through re-implementation of screening the TANF population by utilization of the DAST 20 instrument. In addition, two TANF women's gender-specific intensive outpatient treatment programs were eliminated due to this reduction.

Department of Corrections

During SFY 2011, OBH collaborated with the Department of Corrections (DOC) to submit a grant proposal for wrap around services for incarcerated women before they leave prison, and made recommendations for improvement of substance use treatment programs at the Louisiana Correctional Institute for Women. In addition, OBH has an MOU with DOC for a process to communicate with one another and to provide an appointment within two weeks of release for those inmates on psychotropic medications in order to ensure they continue their medication which should improve mental health and decrease recidivism. OBH also has an agreement with DOC to allow the DOC physician to do the medical clearance of individuals due for full-term release and needing hospitalization in an acute unit in order to expedite services and to avoid clogging up the emergency departments with those who need medical clearance prior to admit to the acute unit. OBH has recently facilitated a plan for DOC attorneys to file Judicial Commitments for those about to receive full-term releases who need longer term care. In this way, the individual is placed on the waiting list for long-term hospitalization prior to release. Juvenile judges often order youth to DHH/OBH custody as a diversion which requires OBH to place the youth in the hospital or to work with the managed care organization to find more appropriate placement such as a psychiatric residential treatment facility and then to find appropriate community resources upon discharge.

DHH Health Standards Section

OBH continues to work collaboratively with the Louisiana Department of Health and Hospitals (DHH) Health Standards Section, and the LGEs within the State to refine a proposed draft of licensing regulations, standards, and guidelines. Specifically, the Medical Director of OBH requested that staffing patterns congruent with ASAM recommendations be included in the licensing standards. These revised standards were reviewed by the Bureau of Health Standards. In addition to this process, the OBH proposed to collate the Addiction and Mental Health Standards to create one Behavioral Health Minimum Standards.

Medicaid

Louisiana is one of seven (7) states participating in the Innovation Accelerator Program for Substance Use Disorders (IAP-SUD) with CMS' Center for Medicaid and CHIP Services (CMCS) and the Center for Medicare and Medicaid Innovation. With its kick off in January 2015, the Medicaid Innovation Accelerator Program for Substance Use Disorders (IAP-SUD) represented a new collaboration from CMS' CMCS and the Center for Medicare and Medicaid Innovation. The IAP-SUD is a state technical assistance project that focuses on substance use disorder issues. The IAP-SUD intends to develop strategically targeted functions to advance delivery system and

associated payment reforms, and to align with transformation efforts underway in Medicare and the commercial market.

Provider Policy

Priority Admissions

Current agency policy states that all funded programs give priority admission and preference to treatment in the following order: pregnant injecting drug users, other pregnant substance abusers, other injecting drug users, and all others. This approved policy has been posted on the agency SharePoint site whereby LGE staff can access and review current policies as well as other resource documents. Priority admissions are included in the peer review process and on the peer review form documents. This has helped to confirm that priority admissions are handled in a timely manner and according to Block Grant mandates.

LGE-operated and contract programs are required to provide interim services to these priority populations within 48 hours, if comprehensive care cannot be made available upon initial contact with a waiting period of no longer than 120 days. Regional Administrators report an average waiting list period of seven to fourteen days for outpatient clients. 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 in each LGE.

The Louisiana Addictive Disorder Data System (LADDS) generates a waiting list (as a component of the admissions and utilization report). All residential facilities report census information online, including waiting list data and the occupancy percentage, on a daily basis utilizing a database program on the OBH web page. This database produces a daily bed availability report which can be accessed on the web page for immediate review. The utilization report data is distributed to designated staff monthly for review and monitoring of facilities that have reached 90 percent capacity.

Disclosure of Patient Records

OBH maintains its policy to ensure adherence to all confidentiality, privacy, and security guidelines, including HIPAA requirements, state licensing standards, and federal regulations.

OBH includes a confidentiality requirement (HIPAA Business Associate Addendum) in all contracts with providers and the Statewide Management Organization (SMO). The SMO must require all of its contracted providers to adhere to the same guidelines, requirements, standards, and regulations. As part of licensure, OBH requires training of all staff to ensure adherence to confidentiality regulations in CFR42 Part 2, HIPAA requirements, state licensing standards, and federal regulations.

DHH Policy Number: 7008-79 covers rules on disclosures of medical information as per CFR42 Part 2. This policy is available on the Louisiana Department of Health and Hospitals (DHH) Intranet and accessible by all DHH employees. Also, according to licensing guidelines, in order for a facility

to be licensed, the facility must document that training on confidentially is conducted at the time of employment and annually thereafter. Each OBH LGE has a coordinator to ensure that training on confidentiality/HIPAA is conducted. OBH ensures that HIPAA training is provided to new employees in a timely fashion by keeping track of this on the new employee training checklist. Facilities make sure new employees are aware of HIPAA and confidentiality by educating them during employee orientation. OBH uses an online, web-based Learning Management system to enroll, deliver, monitor, and report on HIPAA compliance.

Charitable Choice

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

Agency policy has been created to ensure that providers adhere to Charitable Choice in all treatment facilities at all levels of care throughout the State. OBH has a non-discriminatory policy regarding faith based organizations. OBH accepts proposals from and awards contracts to faith based organizations, provided they are currently licensed by Health Standards, the state agency responsible for approving licensure for treatment agencies. Charitable Choice mandates are included in the Standard Provisions of all contracts, and Charitable Choice policy is documented on the agency policy website.

Hypodermic Needle Program

OBH enforces a statewide policy, inclusive of LGE-operated and contract provider programs, to prohibit the use of SAPT Block Grant funds to provide individuals with hypodermic needles and syringes. The standard provisions for provider contracts includes the stipulation that Block Grant funds may not be used for the purchase and distribution of sterile needs for injection of any illegal drugs, or bleach for the purpose of cleaning the needles. Adherence to this mandate is monitored as part of the contract monitoring and independent peer review processes. OBH continues to adopt the policy of terminating a contract with any provider that violates this stipulation.

Special Populations

Pregnant Women and Women with Dependent Children

OBH ensures that pregnant women are given preference in admission to treatment facilities; and, when the facility has insufficient capacity, ensures that the State Office is notified to assist in placement. If no such placement is available, it is OBH's policy to make interim services available within 48 hours, including a referral to prenatal care. OBH continues to maximize access to treatment for pregnant women by maintaining priority admission status for this client population.

According to the EHR system, during SFY 2014, there were at total of 202 pregnant women admissions and 249 pregnant women served. OBH provided approximately 8,406 services to this client population. According to the Block Grant Set Aside Reports, OBH provided 491 interim services to pregnant women during SFY 2014. Interim services are provided until such time as the appropriate level of care becomes available for women needing services. Interim services include education or counseling concerning Fetal Alcohol Spectrum Disorders (FASD), HIV, STDs, the danger of sharing needles, and the advantages of/need for prenatal care. Tuberculosis, STD and HIV screenings are also included in interim services, as well as referral for emergency medical services and prenatal care.

OBH also collaborates with the Office of Public Health to provide voluntary pregnancy testing and Fetal Alcohol Spectrum Disorder (FASD) education for all women entering the system. In urban areas, OBH may have more than one residential facility providing services in an area, such as in the New Orleans area.

OBH monitors pregnant women and women with dependent children services, using admission data generated by the LADDS Data System. LGE monitors review cases and admission patterns at facility levels to ensure adherence to OBH priority admission policy for pregnant women. Priority admission guidelines are also addressed during the annual peer review process. LGEs and OBH staff also monitor the adequacy of efforts to meet the specific needs of women by reviewing admission data and census data (Utilization Reports), which include waiting list reports.

OBH coordinates services with statewide Opiate Replacement Clinics to provide services to pregnant opiate dependent females. OBH promotes Buprenorphine and/or Suboxone treatment services to facilitate appropriate detoxification protocols, post-delivery. Pregnant women requiring services are assessed and, pending community based resources, referred to opioid treatment clinics or SAMHSA approved Buprenorphine and/or Suboxone physicians.

The following residential programs served pregnant women and women with dependent children during SFY 2014.

Pregnant Women and Women with Dependent Children:

- *CENLA Chemical Dependency Council, Pineville La. (CLHSD), ASAM Level III.3* - maintained a bed capacity of 21 beds for women and children under the age of 12. This program provided a community-based rehabilitation program in a residential house setting.
- *Grace House, New Orleans La. (MHSD), ASAM Level III.3* - maintained 10 beds for women only. The average length of stay at this facility is between three to six months.
- *Rays of Sonshine, Monroe La. (NEDHSA), ASAM Level III.3* - maintained 8 beds at this facility reserved for women with dependent children, including pregnant women. This facility utilizes a therapeutic community model with some emphasis on the 12 Step Model.
- *Reality House, Baton Rouge (CAHSD), ASAM Level III.3* - provides services for 19 women and pregnant women and/or women with dependent children in a residential setting, to

foster emotional growth, encourage sobriety, and teach problem solving skills that are linked to positive lifestyle changes.

Women and Pregnant Women:

- *The Alcohol and Drug Unit, Mandeville (FPHSA), ASAM Level III.5* - maintained a 12-bed capacity and prioritized admissions for pregnant women, located on the campus of Northlake Behavioral Health (formerly Southeast Louisiana State Hospital). This facility is under the jurisdiction of the Florida Parishes Human Services Authority (FPHSA). Treatment services included group/individual counseling, gender specific groups, educational lectures, family sessions, and relapse prevention programming.
- *Fairview Treatment Center, Houma (SCLHSA), ASAM Level III.5* - maintained a 24-bed capacity and prioritized admissions for pregnant women. This facility uses motivational interviewing to meet the client at her level of need and integrates the Minnesota 12-Step Recovery Model in its therapeutic approach.

Injecting Drug Users

Injecting drug users (IDU's) are defined as individuals who, within the last year, have used drugs and presented themselves for treatment, and who used needles for injection of those drugs irrespective of the site or route of injection. This definition has been incorporated into the Louisiana Addictive Disorders Data System (LADDS) glossary of terms, the Block Grant Set Aside Reports submitted by each LGE, and contract special provisions. OBH requires that state-operated and contracted programs providing services to drug users will give priority for admission and treatment to injecting drug users (IDU's) and that preference is given to clients in the following order:

1. Pregnant injecting drug users
2. Other pregnant substance abusers
3. Other injecting drug users
4. All other individuals

OBH has established a policy to ensure that priority admission is granted to IDU's. OBH state-operated and contract programs admit IDU clients to treatment programs within 14 days of the request for admission and provide interim services to IDU clients, within 48 hours, if comprehensive care cannot be made available upon initial contact. The waiting period is not to exceed 120 days. OBH contract stipulations outline this policy requirement, and LGE contract monitors review this stipulation for compliance on a quarterly basis.

During SFY 2014, there were a total of 1,808 IDU client admissions and 2,317 IDU clients served across all levels of care. This population received approximately 8,490 services. The Block Grant Set Aside Reports for SFY 2014 submitted by the LGEs recorded 2,017 interim services and 1,901 outreach services provided to this population.

IDU Outreach

All programs and treatment modalities (e.g., outpatient, detoxification, residential treatment, and halfway houses) are available to injecting drug users. OBH policy provides for priority

admission to this population in both contract and LGE-operated facilities throughout the state. To comply with 42 U.S.C.300x23 (b) of the PHS Act, OBH continues to offer outreach services statewide using the Indigenous, Behavioral, and/or other outreach models.

OBH provides and solicits training for staff on topics that pertain to IDU outreach that include preventing the transmission of HIV, confidentiality requirements (42 CFR, Part 2), and the relationship between injecting drug use and transmittable diseases. OBH providers educate staff, clients/patients, agencies, and the general public on infectious diseases such as HIV/AIDS, Tuberculosis (TB), and sexually transmitted diseases (STDs). OBH networks and collaborates with contractors, state agencies, and community-based organizations to provide outreach services in local communities. Outreach activities include education, prevention, condom distribution, clean needle demonstrations (no cleaning supplies or needles provided), medical evaluations, and referrals for treatment. Information and pamphlets are distributed and referrals are made in a variety of community and/or organizational settings, including United Way, AA/NA groups, businesses, mental health clinics, health clinics, charity hospitals, barber shops, nail salons, correctional facilities, and jails. Community health fairs as well as public and educational forums also provide opportunities for the provision of outreach services.

Primary Health Screening and Testing in Addictive Disorder Programs

Tuberculosis

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

TB services are made available by the administration of a Sign and Symptom Screen (developed by the Office of Public Health) or by administration of the Purified Protein Derivative (PPD) Tuberculin Skin Test by a clinic nurse. The tuberculosis skin test or PPD test is used to determine if the individual has developed an immune response to the bacterium that causes tuberculosis (TB). This response can occur if someone currently has TB, if they were exposed to it in the past, or if they received the BCG vaccine against TB (which is not performed in the United States). When a client tests positive, the client is referred to the Office of Public Health and the Regional TB Nurse for ongoing evaluation and treatment, or to the client's private physician, when requested by the client. Clients with positive test results, or those with any number of signs and symptoms from a previous positive PPD, are not admitted for treatment until they have been cleared by the treatment facility's medical director and by the Office of Public Health. Protocol dictates that the medical director or the clinic physician clears the patient for admission.

During SFY 2014, OBH provided tuberculosis testing to 4,806 clients admitted to treatment programs, and 70 yielded positive results. According to the Block Grant Set Aside Reports, OBH

provided a total of 9,072 TB related services, with 2,544 of these services offered to TB positive clients.

TB educational groups are offered to clients and in-service trainings are offered to staff. Each LGE has established an infectious disease control protocol or committee to track and record positives, as well as to create local policy.

HIV Protocol

The Office of Behavioral Health provides treatment for persons with substance use disorders with an emphasis on making available, within existing programs, early intervention services for HIV in areas of the State that have the greatest need for such services and monitors such delivery.

At least 5 percent of Block Grant allocations are spent on HIV services. All clients are screened for risk behaviors and offered an HIV test. In SFY 2014, OBH tested 4,277 clients for HIV. Of those tested, 25 were positive for HIV. OBH provided 11,698 HIV services to this population. Of those services, 15,065 were rendered to HIV positive clients.

Clients that are tested for HIV receive pre-test and post-test counseling services. If results are inconclusive, clients are re-tested with referrals and additional services provided as applicable. For those who test positive, clients receive on-going counseling and educational groups and are referred to local community based health clinics or Office of Public Health (OPH) outpatient clinics for any additional services that are deemed appropriate. Clients previously tested that report high risk behaviors are assessed for re-testing as needed. Partners of HIV positive clients are also provided counseling. Client education is chiefly conducted during group sessions and/or individual sessions in OBH clinics and facilities. LGE-operated and contract providers offered 4,290 pre-test counseling services and 4,236 post-test counseling services across all levels of care during SFY 2014.

Health clinics in all parishes also offer HIV testing capability. The Louisiana Department of Health and Hospitals, Office of Public Health HIV/AIDS Program (HAP) assures through their programs, community based organizations, and contractors that treatment services are available for HIV/AIDS. OBH utilizes referral resources to access additional services for substance use disorder clients diagnosed with HIV/AIDS. OBH has established a working relationship with the referral entities and is able to monitor the needs of clients that have been referred. These referral resources include State and private hospitals, community based health clinics, and HIV community based grantees. Protocols for monitoring the needs of clients that have been referred vary from program to program. In some instances, staff may make the appointment, verify an appointment has been scheduled, or utilize a continuity of care form (name may vary) to document activities.

OBH and the Office of Public Health (OPH) continue to collaborate on training for HIV Rapid Testing, HIV/AIDS, prevention counseling, and other health issues of common concern to both agencies. OPH provides all OBH staff and contract staff training on pre-test and post-test counseling as well as HIV Rapid Testing administration. Trainings are scheduled through the *LA*

HIV 411 website, which allows for quick and easy registration. This website also allows all providers to obtain current information and other resources on HIV/AIDS. The website address is www.hiv411.org.

OBH monitored the implementation and delivery of HIV Rapid Testing and services statewide, via the Block Grant Set Aside Report. This report is one of the resources that OBH Central Office monitors to ensure that the LGEs are providing Rapid Testing and completing pre-test and post-test counseling.

Each LGE has established an infectious disease control protocol and/or committee to track and record positive test results, as well as to create policy. OBH adheres to 42 CFR and all department confidentiality policies in providing HIV services. Programs are monitored through quarterly reports, chart documentation and contract monitoring by OBH Central Office to ensure that they are in compliance with contractual agreements. Programs are monitored to ensure compliance of guidelines and requirements. During compliance checks, if programs are cited, they must develop and submit corrective action plans to correct noted findings. All Block Grant requirements are indicated in contractual agreements with language that address details related to termination of agreement due to lack of compliance.

At the local level, Local Governing Entities (LGEs) capture data elements such as the number of tests, number of services, and number tested positive and report them to OBH Central Office. In addition, Quality Assurance and Contract Monitoring reports are completed every quarter in each LGE.

Addictive Disorder Service Provider Independent Peer Review

OBH implements an independent peer review process to assess and improve the quality and appropriateness of treatment services delivered by providers that receive funds from the SAPT Block Grant.

OBH utilizes the peer review process to ensure and enhance the quality of treatment services in its state-operated and contracted programs. The peer review program is intended to share programmatic and clinical expertise across Local Governing Entity (LGE) administrations, programs, and professional disciplines, and to identify strengths and weaknesses in the service delivery system. Peer review is a comprehensive process designed to enhance and improve administrative and treatment services, utilizing a multi-disciplinary approach. The goals of the independent peer review process are to: 1) increase the quality of care and services; 2) make the service delivery system responsive to the needs of clients; 3) provide effective treatment services; and 4) deliver services in an efficient manner.

The treatment peer review process is an opportunity to share professional expertise (both administrative and clinical) and is conducted with the overarching goal of quality improvement as well as sharing programmatic and clinical ideas. Key elements of the review process are:

- OBH requires a minimum of one program per LGE (total of 10 treatment programs reviewed annually). This represents approximately 21 percent of the total number of substance use disorder treatment programs and exceeds the 5 percent requirement for Peer Review.
- The composition of the peer review team is dependent on the organization to be reviewed, but consists of a minimum of three persons, including administrative and treatment staff, and a staff person or representative from OBH Central Office.
- Facilities provide the review team with their Policy and Procedure Manual and description of the program being reviewed.
- After the peer review, an exit interview summarizes findings and recommendations to enhance programming.

The Louisiana Peer Review model varies from the prototype provided by CSAT. The present theoretical framework used provides an exchange of information and processes regarding performance, without the burden of contracting with another agency. CSAT accepted this method since the technical requirements of the peer review guidelines are met. This process also includes a review of findings with written recommendations and corrective action plans to be implemented.

Peer review assignments are governed by the federal fiscal year. A new peer review process begins October 1 and ends September 30 of each year. OBH selects the LGEs and the OBH Central Office staff representative; LGE management selects the local reviewers. The objectivity of the reviewer is accomplished by having cross-regional members, with OBH Central Office staff being a non-critical observer.

LGEs are paired to review continuum of care components (outpatient, detoxification, residential), including administrative services. Assessment tools are utilized for treatment and administrative services. LGEs assigned are rotated. Each continuum of care is reviewed before rotation. An OBH Central Office staff person, the LGE Administrator and/or designee, staff or administrators of the program being reviewed, and persons deemed necessary and appropriate attend and participate in the review.

Workforce Development

OBH continues to develop and implement training specific to the needs of addictive disorder service providers and prevention staff in order to ensure the use of best practices for state operated and contract providers. The OBH Louisiana Behavioral Health Partnership (LBHP) certification process also requires that addictive disorder service providers ensure that continuing education in prevention and treatment services is made available to staff who provide these services.

OBH continues to make use of a web-based learning management system (Louisiana Employee Online Training) to provide training at the state, LGE, parish, and community levels. OBH also provides “live” training events as topics, presenters, and identified needs are made known.

Participants for most of the "live" trainings are selected individually by LGE leadership, and must possess the leadership and communication skills required to transfer information and provide trainings to colleagues and other providers within their respective LGE. Transfer of learning remains a key objective for all training provided, whether online or "live" and supervisory follow up is encouraged as a basic requirement for all training offered.

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

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

Training Topic
Trauma Informed Care Training
Applied Suicide Intervention Skills
Motivational Interviewing Training
CABHI Orientation Training
Adolescent Community Reinforcement Approach (A-CRA)
Global Appraisal of Individual Needs (GAIN)
Gambling Patient Placement
Training to Hospitals on PASRR
Training to Nursing Facilities on Behavioral Health Issues in Older Adults, PASRR, and Discharge Planning
safeTALK Training
Peer Support Specialist Training
Addiction Severity Index (ASI) Training
Wellness Recovery Action Planning (WRAP) Training
Competency Restoration Training
First Episode Psychosis (FEP & related topics trainings)
Training on ATR Policies and Procedures

Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System

Older Adults, Adults and Youth

Per the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI), the State Mental Health Agency (SMHA) mental health services expenditures in Louisiana was $55.50 per capita, which was less than half of the national average of $119.62 during SFY 2013. Based on data from the Centers for Disease Control, Louisiana ranked 37th among the states in its rate of suicides during 2013. The State's rate of suicides per 100,000 population (12.6) was slightly lower than the national rate (13.0).

Per the Center for Behavioral Health Statistics and Quality at SAMHSA, National Survey on Drug Use and Health (NSDUH) 2012 and 2013, Louisiana is among the top ten states with the highest rates of the following:

- 2nd: Past Month Use of Illicit Drugs Other than Marijuana among those 12 to 17 (4.35%)
- 6th: Past Month Binge Alcohol Use among those 26 and older (25.81)
- 7th: Past Month Cigarette Use among those 12 to 17 (8.1%)
- 7th: Past Year Serious Thoughts of Suicide among those 26 and older (3.86%). 9th in the same indicator for those 18 and older (4.35%).
- 8th: Needing but not Receiving Treatment for Illicit Drug Use among those 18 and older (2.57%). 10th in the same indicator for those 12 and older (2.66%), and also 26 and older (2.29%).
- 9th: Past Year Cocaine Use among those 26 and older (1.61%)
- 9th: Past Month Tobacco Product Use among those 12 to 17 (10.75%)
- 9th: Past Year Any Mental Illness among those ages 18 and older (20.08%) and also among those age 26 and older (20.45%)

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

- 13th: Past Year Nonmedical Pain Reliever Use among those 12 to 17 (5.58%)
- 14th: Past Month Alcohol Use among those ages 12 to 17 (13.03%)

According to the Behavioral Health Barometer for Louisiana (2014), which includes the data from the NSDUH (2009-2013), the following differences are statistically significant at the .05 level:

- Louisiana's percentage of cigarette use (8.1%) among adolescents was higher than the national percentage (6.1%) in 2012-13.
- The percentage of Louisiana adolescents (70.1%) perceiving no great risk from marijuana use once a month was lower than the national percentage (74.7%) in 2012-13.

Additional data from the Behavioral Health Barometer for Louisiana and the US (2012-13) can be found in the table below:

Indicators	Louisiana	US
Past-Month Illicit Drug Use Among Adolescents Aged 12–17	8.4%	9.2%
Past-Month Binge Alcohol Use Among People Aged 12–20	14.4%	14.7%
Adolescents aged 12-17 perceiving no great risk from smoking one or more packs of Cigarettes a day	37.1%	35.0%
Past-Year Major Depressive Episode (MDE) Among Adolescents Aged 12–17	9.3%	9.9%
Past-Year Serious Thoughts of Suicide Among Adults Aged 18 or Older	4.3%	3.9%
Past-Year Alcohol Dependence or Abuse Among Individuals Aged 12 or Older	6.0%	6.7%

Per the Kaiser State Health Facts (2013), approximately 35% of the adult population in Louisiana reported that their mental health was "not good" between one and 30 days in the past 30 days. Services to adults are a critical area of need in the OBH system, as prevalence estimates indicate that only a small proportion of the need is being met by existing OBH services. Of the estimated 91,325 adults with serious mental illness (SMI) in Louisiana, OBH reported a caseload of 37,464 adults at the end of SFY 2014 (as of 6/30/14). Of the estimated 314,312 persons aged twelve and older in need of substance use disorder treatment in Louisiana, OBH reported a total of 24,701* persons served in SFY 2012.

In the Annie E. Casey Foundation Kids Count Data Book (KIDS Count, 2014), Louisiana continued to rank near the bottom of the nation in terms of child health and well-being, ranking 47th in the nation on the index of children's health status and wellbeing. This ranking is a slight deterioration from the 2013 publication, in which Louisiana was ranked 46th. Louisiana ranked poorer than the nation for the following indicators:

Indicators	Louisiana	United States
Economic Well-Being Indicators (Rank = 42nd)		
• Children in poverty: 2013	28%	22%
• Children whose parents lack secure employment: 2013	34%	31%
• Teens(16-19 years) not in school and not working: 2013	12%	8%
Education Indicators (Rank = 45th)		
• Fourth graders not/below proficient in reading: 2013	77%	66%
• Eight graders not/below proficient in math: 2013	79%	66%
• High school students not graduating on time: 2011-12	28%	19%
Health Indicators (Rank = 41st)		
• Low-birth weight babies: 2012	10.8%	8.0%
• Infant mortality per 1,000: 2011	8.2%	6.1%

• Children who have one or more emotional, behavioral, or developmental conditions: 2011-2012	21%	17%
Family and Community Indicators (Rank = 47th)		
• Children in single-parent families: 2013	46%	35%
Indicators	**Louisiana**	**United States**
• Children in families where the household head lacks a high school diploma: 2013	15%	14%
• Children living in high-poverty areas: 2009-2013	19%	14%
• Teen births per 1,000: 2012	43	29

Data source: Indicator percentages from http://datacenter.kidscount.org/. Ranks from 2014 KIDS Count Data Book.

A significant proportion of Louisiana's children and their families suffer the consequences of multiple health, developmental, and social-emotional problems daily. Furthermore, the negative economic impact of the multiple disasters to the state compounds the challenges of building an effective system of care. Of the estimated 100,166 children with serious emotional/ behavioral disorders (SED) or Emotional Behavioral Disorders (EBD) in Louisiana, OBH reported a caseload of 6,591 children and youth at the end of FY 2014 (as of 6/30/14), revealing that 6.6 % of the estimated children with serious emotional disturbances (SED) were being served in LGE clinics.

Data Definitions and Methodology

SMI and EBD Definitions: OBH SMI and EBD population definitions follow the national definition. However, Louisiana uses the designation SMI for what is more usually 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 the CMHS estimation methodology, applying the national prevalence rates for SMI (2.6%) and EBD (9%) directly to current general population counts to arrive at the estimated prevalence of targeted persons to be served. This method has been used since the revised rates were published in 1996.

Addictive Disorders - OBH uses the SAMHSA National Survey on Drug Use and Health (NSDUH) data, applying the most recent estimate for "*Past Year Alcohol or Illicit Drug Dependence or Abuse*" prevalence for Louisiana to current general population counts to arrive at the estimated prevalence of targeted persons to be served.

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

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

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

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

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

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

Assessment of Need: Services and System Infrastructure
Louisiana Population and Prevalence Estimates

Based on the estimates published in June 2014 by the Population Division of the US Census Bureau, there were estimated to be 4,625,470 individuals in Louisiana (3,512,513 adults, and 1,112,957 children/youth).

POPULATION BY AGE

State's Population By Age Range*		
Age Range	**Number of Persons**	**Percentage of State's Population**
0-17	1,112,957	24%
18+	3,512,513	76%
TOTAL	4,625,470	100%

*Based on Annual Estimates of the Resident Population 7/1/2013 Annual State Population Estimates by Demographic. Estimates Source: Population Estimates Division, US Census Bureau. Release Date: June 2014.

Mental Health: Population and Prevalence Estimates

According to the *2013 Annual Estimates of the Resident Population 7/1/2013 State Characteristics, Population Estimates Division, U.S. Census Bureau (released June, 2014)*, the total number of adults in Louisiana is **4,625,470**. Of these, according to national benchmarks, **2.6%** are expected to have Serious Mental Illness (SMI). That translates into a total of **91,325** adults with serious mental illness (SMI) in Louisiana based on national prevalence rates. According to the same Census report, the total number of children and youth in Louisiana is **1,112,957**. Of these,

according to national benchmarks, **9%** are expected to have an Emotional or Behavioral Disorder (EBD). That translates into a total of **100,166** children and youth with an EBD in Louisiana based on national prevalence rates.

Statistics show that 20,788 adults with SMI received outpatient services through LGEs in FY 2014 in Community Mental Health Clinics. Of the total number of adults served, both with and without SMI (40,336), 41% met the definition of Seriously Mentally Ill (SMI). Statistics show that 3,527 children and youth with EBD received outpatient services through OBH and the LBHP in Community Mental Health Clinics. Of the total number of children and youth served (7,168), 42% met the definition of EBD.

As the term is used in Louisiana, SMI is a national designation that includes only those individuals suffering from the most severe forms of mental illness. EBD is a national designation for children/youth that includes only those individuals suffering from the most severe forms of mental illness. Those who have any type of mental illness would increase the population figures, but not the numbers of individuals served, since Louisiana's outpatient mental health facilities are designated to serve only those adults with SMI and children/youth with EBD. Therefore, individuals with SMI/EBD are considered to be the target population for these programs. These numbers reflect an unduplicated count within LGEs.

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

LOUISIANA PREVALENCE ESTIMATES*
July 1, 2013 - (Released June 2014)

	Child/Youth = 9%		Adult = 2.6%		Total	
Statewide	Population Count	Prevalence Count	Population Count	Prevalence Count	Population Count	Prevalence Count
	1,112,957	100,166	3,512,513	91,325	4,625,470	191,491

* 2013 Annual Estimates of the Population for Parishes of Louisiana

Estimates Source: Population Division, US Census Bureau. Release Date: June 2014.
http://www.census.gov/popest/datasets.html

Prevalence Count = Estimated Prevalence Count (2.6% Adults*, 9% Children**)
Adult =18 Years of Age and Older Child/Youth = 17 Years of Age and Younger

* Source for Adult prevalence estimate: Kessler, R.C., et al. The 12-Month Prevalence and Correlates of Serious Mental Illness (SMI). Mental Health, United States, 1996. U.S. Department of Health and Human Services pp. 59-70.

** Source for Child prevalence estimate: Friedman, R.M. et al. Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996. U.S. Department of Health and Human Services pp 71-89.

Please note: Louisiana uses the designation SMI for what is more usually referred to as SPMI.
SMI (SPMI) is a national designation that includes only those individuals suffering from the most severe forms of mental illness. Those who have all types of mental illness would increase the population figures, but would not increase the numbers of individuals served since Louisiana's facilities are designated to serve those with SMI (SPMI).

Estimated State Population and Estimated Prevalence of Adults with Serious Mental Illness and Child/Youth with Emotional Behavioral Disorders by LGE and Parish (July 1, 2013 Pop Est.)*

LOCAL GOVERNING ENTITY	PARISH	CHILD/YOUTH (Age 0-17) POPULATION ESTIMATE	CHILD/YOUTH (AGE 0-17) POPULATION ESTIMATE	ADULT (Age 18 +) POPULATION Estimate	ADULT (Age 18 +) PREVALENCE Estimate	TOTAL POPULATION ESTIMATE JULY 1, 2013	TOTAL PREVALENCE ESTIMATE
1-METROPOLITAN HUMAN SERVICE DISTRICT and NOAH Outpatient clinics	Orleans Parish	78,035	**7,023**	300,680	**7,818**	378,715	**14,841**
	Plaquemines Parish	6,296	**567**	17,254	**449**	23,550	**1,015**
	St. Bernard Parish	11,577	**1,042**	31,905	**830**	43,482	**1,871**
Total for 1-MHSD		95,908	**8,632**	**349,839**	**9,096**	**445,747**	**17,728**
2-CAPITOL AREA HUMAN SERVICE DISTRICT	Ascension Parish	31,939	**2,875**	82,454	**2,144**	114,393	**5,018**
	East Baton Rouge Parish	102,149	**9,193**	343,078	**8,920**	445,227	**18,113**
	East Feliciana Parish	3,819	**344**	15,909	**414**	19,728	**757**
	Iberville Parish	7,124	**641**	26,243	**682**	33,367	**1,323**
	Pointe Coupee Parish	5,263	**474**	17,236	**448**	22,499	**922**
	West Baton Rouge Parish	5,930	**534**	18,643	**485**	24,573	**1,018**
	West Feliciana Parish	2,584	**233**	12,860	**334**	15,444	**567**
Total for 2-CAHSD		158,808	**14,293**	516,423	**13,427**	675,231	**27,720**
3-SOUTH CENTRAL LOUISIANA MENTAL HEALTH AUTHORITY	Assumption Parish	5,311	**478**	17,876	**465**	23,187	**943**
	Lafourche Parish	23,077	**2,077**	74,064	**1,926**	97,141	**4,003**
	St. Charles Parish	13,448	**1,210**	39,169	**1,018**	52,617	**2,229**
	St. James Parish	5,267	**474**	16,485	**429**	21,752	**903**
	St. John the Baptist Parish	11,188	**1,007**	32,573	**847**	43,761	**1,854**
	St. Mary Parish	13,199	**1,188**	40,344	**1,049**	53,543	**2,237**
	Terrebonne Parish	28,907	**2,602**	83,842	**2,180**	112,749	**4,782**
Total for 3-SCLMHA		100,397	**9,036**	304,353	**7,913**	404,750	**16,949**
4-ACADIANA AREA HUMAN SERVICES DISTRICT	Acadia Parish	16,747	**1,507**	45,457	**1,182**	62,204	**2,689**
	Evangeline Parish	8,817	**794**	24,761	**644**	33,578	**1,437**
	Iberia Parish	19,677	**1,771**	54,201	**1,409**	73,878	**3,180**
	Lafayette Parish	55,260	**4,973**	175,585	**4,565**	230,845	**9,539**
	St. Landry Parish	22,500	**2,025**	60,954	**1,585**	83,454	**3,610**
	St. Martin Parish	13,383	**1,204**	39,553	**1,028**	52,936	**2,233**
	Vermilion Parish	15,612	**1,405**	43,641	**1,135**	59,253	**2,540**
Total for 4-AAHSD		151,996	**13,680**	444,152	**11,548**	596,148	**25,228**
5-IMPERIAL CALCASIEU HUMAN SERVICES AUTHORITY	Allen Parish	5,767	**519**	19,770	**514**	25,537	**1,033**
	Beauregard Parish	9,102	**819**	27,065	**704**	36,167	**1,523**
	Calcasieu Parish	48,634	**4,377**	146,662	**3,813**	195,296	**8,190**
	Cameron Parish	1,618	**146**	5,126	**133**	6,744	**279**
	Jefferson Davis	8,071	**726**	23,230	**604**	31,301	**1,330**
Total for 5-IMCAL		73,192	**6,587**	221,853	**5,768**	295,045	**12,355**
6-CENTRAL LOUISIANA HUMAN SERVICES DISTRICT	Avoyelles Parish	9,819	**884**	31,480	**818**	41,299	**1,702**
	Catahoula Parish	2,260	**203**	7,978	**207**	10,238	**411**
	Concordia Parish	4,951	**446**	15,491	**403**	20,442	**848**
	Grant Parish	4,800	**432**	17,230	**448**	22,030	**880**
	La Salle Parish	3,360	**302**	11,417	**297**	14,777	**599**
	Rapides Parish	33,797	**3,042**	98,926	**2,572**	132,723	**5,614**
	Vernon Parish	14,065	**1,266**	38,541	**1,002**	52,606	**2,268**
	Winn Parish	3,273	**295**	11,540	**300**	14,813	**595**
Total for 6-CLHSD		76,325	**6,869**	232,603	**6,048**	308,928	**12,917**

LOCAL GOVERNING ENTITY	PARISH	CHILD/YOUTH (Age 0-17) POPULATION ESTIMATE	CHILD/YOUTH (AGE 0-17) POPULATION ESTIMATE	ADULT (Age 18 +) POPULATION Estimate	ADULT (Age 18 +) PREVALENCE Estimate	TOTAL POPULATION ESTIMATE JULY 1, 2013	TOTAL PREVALENCE ESTIMATE
LOCAL GOVERNING ENTITY	**PARISH**	**CHILD/YOUTH (Age 0-17) POPULATION ESTIMATE**	**CHILD/YOUTH (AGE 0-17) POPULATION ESTIMATE**	**ADULT (Age 18 +) POPULATION Estimate**	**ADULT (Age 18 +) PREVALENCE Estimate**	**TOTAL POPULATION ESTIMATE JULY 1, 2013**	**TOTAL PREVALENCE ESTIMATE**
7-NORTHWEST LOUISIANA HUMAN SERVICES DISTRICT	Bienville Parish	3,263	**294**	10,718	**279**	13,981	**572**
	Bossier Parish	31,317	**2,819**	92,506	**2,405**	123,823	**5,224**
	Caddo Parish	62,190	**5,597**	192,697	**5,010**	254,887	**10,607**
	Claiborne Parish	3,097	**279**	13,553	**352**	16,650	**631**
	De Soto Parish	6,650	**599**	20,433	**531**	27,083	**1,130**
	Natchitoches Parish	9,378	**844**	29,760	**774**	39,138	**1,618**
	Red River Parish	2,216	**199**	6,678	**174**	8,894	**373**
	Sabine Parish	5,832	**525**	18,403	**478**	24,235	**1,003**
	Webster Parish	9,455	**851**	31,223	**812**	40,678	**1,663**
Total for 7-NLHSD		133,398	**12,006**	415,971	**10,815**	549,369	**22,821**
8-NORTHEAST ELTA HUMAN SERVICES AUTHORITY	Caldwell Parish	2,294	**206**	7,695	**200**	9,989	**407**
	East Carroll Parish	1,858	**167**	5,671	**147**	7,529	**315**
	Franklin Parish	5,359	**482**	15,212	**396**	20,571	**878**
	Jackson Parish	3,627	**326**	12,485	**325**	16,112	**651**
	Lincoln Parish	9,657	**869**	37,757	**982**	47,414	**1,851**
	Madison Parish	2,961	**266**	8,966	**233**	11,927	**500**
	Morehouse Parish	6,554	**590**	20,503	**533**	27,057	**1,123**
	Ouachita Parish	40,308	**3,628**	115,912	**3,014**	156,220	**6,641**
	Richland Parish	5,233	**471**	15,624	**406**	20,857	**877**
	Tensas Parish	1,219	**110**	3,689	**96**	4,908	**206**
	Union Parish	5,020	**452**	17,324	**450**	22,344	**902**
	West Carroll Parish	2,768	**249**	8,697	**226**	11,465	**475**
Total for 8-NEDHSA		86,858	**7,817**	269,535	**7,008**	356,393	**14,825**
9-FLORIDA PARISHES HUMAN SERVICE AREA	Livingston Parish	35,595	**3,204**	98,458	**2,560**	134,053	**5,763**
	St. Helena Parish	2,480	**223**	8,395	**218**	10,875	**441**
	St. Tammany Parish	60,081	**5,407**	182,252	**4,739**	242,333	**10,146**
	Tangipahoa Parish	31,158	**2,804**	94,254	**2,451**	125,412	**5,255**
	Washington Parish	11,297	**1,017**	35,122	**913**	46,419	**1,930**
Total for 9-FPHSA		140,611	**12,655**	418,481	**10,881**	559,092	**23,535**
10-JEFFERSON PARISH HUMAN SERVICE AREA	Jefferson Parish	95,464	**8,592**	339,303	**8,822**	434,767	**17,414**
STATE TOTAL		**1,112,957**	**100,166**	**3,512,513**	**91,325**	**4,625,470**	**191,491**

Suggested Citation:
Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2013. Source: Population Division, U.S. Census Bureau. Release Date: June 2014. http://www.census.gov/popest/data/index.html .

Adult =18 Years of Age and Older. Child/Youth =17 Years of Age and Younger.

** Source for Adult prevalence estimate: Kessler, R.C., et al. The 12-Month Prevalence and Correlates of Serious Mental Illness (SMI). Mental Health, United States, 1996. U.S. Department of Health and Human Services pp. 59-70. ** Source for Child prevalence estimate: Friedman, R.M. et al. Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996. U.S. Department of Health and Human Services pp 71-89.* http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

LOUISIANA COMMUNITY MENTAL HEALTH CLINICS DATA
UNDUPLICATED COUNT OF PERSONS SERVED
FROM JULY 1, 2013 TO JUNE 30, 2014

LOCAL GOVERNING ENTITY	UNDUPLICATED WITHIN LGE PERSONS SERVED			TOTAL
	CHILD (0-17)	ADULT (18+)	Missing Age	
1-MHSD	808	6,427	66	7,301
2-CAHSD	1,294	4,261	103	5,658
3-SCLHSA	1,322	6,939	74	8,335
4-AAHSD	522	4,184	15	4,721
5-IMCAL	237	1,705	11	1,953
6-CLHSD	313	2,615	19	2,947
7-NWLHSD	285	2,409	22	2,716
8-NEDHSA	186	2,918	9	3,113
9-FPHSA	519	3,745	35	4,299
10-JPHSA	1,680	5,133	84	6,897
TOTAL	**7,166**	**40,336**	**438**	**47,940**

Data Source: Magellan's Clinical Advisor Age at end of time period. Unduplicated within LGE.
Persons receiving services count is the number of clients who received at least one service at a CMHC during the time period. **This includes CONTACTS who are seen but not admitted**. *CAHSD data includes School-based Services.

MENTAL HEALTH INPATIENT & OUTPATIENT CASELOAD ON JUNE 30, 2014 WITH SMI/EBD; PERCENTAGE OF SMI/EBD

CASELOAD ON June 30, 2014 for Inpatient and Outpatient Facilities	ADULT: SMI/CHILD: SED		NOT SMI/EBD		Missing		TOTAL
	COUNT	Percent	COUNT	Percent	COUNT	Percent	
Child/Youth (Age 0-17)	2,659	40.34%	88	1.34%	3,844	58.32%	6,591
Adult (Age 18+)	14,591	38.34%	1,198	3.15%	22,270	58.51%	38,059
Missing Age	192	50.66%	10	2.64%	177	46.70%	379
TOTAL	**17,442**	**38.74%**	**1,296**	**2.88%**	**26,291**	**58.4%**	**45,029**

Data from CMHC data: Clinical Advisor and PIP data. Age at end of time period. Count of open cases at the end of the time period.

Louisiana Community Mental Health Clinics
ADULTS – CMHC PERSONS SERVED
UNDUPLICATED within LGE FY13-14

LGE	Adults with SMI Served (persons served)	Total Adults Served	% SMI
1-MHSD	4,371	6,427	68%
2-CAHSD	3,276	4,262	77%
3-SCLHSA	3,353	6,937	48%
4-AAHSD	1,051	4,184	25%
5-IMCAL	1,125	1,705	66%
6-CLHSD	754	2,616	29%
7-NWLHSD	1,649	2,409	68%
8-NEDHSA	951	2,919	33%
9-FPHSA	1,758	3,745	47%
10-JPHSA	2,500	5,132	49%
TOTAL	**20,788**	**40,336**	**52%**

Data Source: Magellan's Clinical Advisor. Age at end of time period. Unduplicated by client within LGE.
SMI based on most recent Special Population SMI available from admission to end of time period.

Louisiana Community Mental Health Clinics
CHILD/YOUTH – CMHC PERSONS SERVED
UNDUPLICATED within LGE FY13-14

LGE	Children/Youth with EBD Served (persons served)	Total Children/Youth Served	% EBD
1-MHSD	185	811	23%
2-CAHSD	1,110	1,293	86%
3-SCLHSA	834	1,322	63%
4-AAHSD	53	522	10%
5-IMCAL	111	237	47%
6-CLHSD	87	312	28%
7-NWLHSD	175	285	61%
8-NEDHSA	74	185	40%
9-FPHSA	276	519	53%
10-JPHSA	622	1,682	37%
TOTAL	**3,527**	**7,168**	**49%**

Data Source: Magellan's Clinical Advisor Age at end of time period. Unduplicated by client within LGE.
SMI based on most recent Special Population SMI available from admission to end of time period.

CMHC ADULT MENTAL HEALTH CASELOAD SIZE
ON LAST DAY OF FY2013 & FY2014

LGE	FY12-13			FY13-14		
	Age 18-64	Age 65+	TOTAL 18+	Age 18-64	Age 65+	TOTAL 18+
1-MHSD	5,631	226	5,857	5,568	260	5,828
2-CAHSD	4,943	304	5,247	2,809	198	3,007
3-SCLHSA	6,868	345	7,213	6,384	374	6,758
4-AAHSD	3,743	196	3,939	4,037	244	4,281
5-IMCAL	1,974	50	2,024	1,305	41	1,346
6-CLHSD	2,094	77	2,171	2,492	94	2,586
7-NWLHSD	2,226	42	2,268	2,220	62	2,282
8-NEDHSA	2,584	89	2,673	2,764	86	2,850
9-FPHSA	3,094	158	3,252	3,530	178	3,708
10-JPHSA	4,494	119	4,613	4,651	167	4,818
TOTAL	**37,651**	**1,606**	**39,257**	**35,760**	**1,704**	**37,464**

Data from CMHC data: Magellan Clinical Advisor: Age at end of time period. Count of open cases at the end of the time period.

CMHC CHILD/ YOUTH MENTAL HEALTH CASELOAD SIZE
ON LAST DAY OF FY2013 & FY2014

LGE	FY12-13			FY13-14		
	Age 0-11	Age 12-17	TOTAL 0-17	Age 0-11	Age 12-17	TOTAL 0-17
1-MHSD	439	448	887	358	440	798
2-CAHSD	814	923	1737	451	557	1,008
3-SCLHSA	578	769	1347	515	752	1,267
4-AAHSD	203	243	446	211	279	490
5-IMCAL	142	206	348	74	113	187
6-CLHSD	100	106	206	127	170	297
7-NWLHSD	154	179	333	105	152	257
8-NEDHSA	57	70	127	78	96	174
9-FPHSA	153	230	383	200	294	494
10-JPHSA	795	940	1,735	677	942	1,619
TOTAL	**3,435**	**4,114**	**7,549**	**2,796**	**3,795**	**6,591**

Data from CMHC data: Magellan Clinical Advisor: Age at end of time period. Count of open cases at the end of the time period.

CASELOAD SERVED COMPARED TO
PREVALENCE ESTIMATES AND CENSUS DATA
FY 2013

Age Range	LA Population Estimated*	National Prevalence Rate	Est. Number of persons in LA Population with SMI/EBD
Child/ Youth* 0-17	1,112,957	9%	1,112,957 X .09 = **100,166**
Adult 18+**	3,512,513	2.6%	3,512,513 X .026 = **91,325**
Total	**4,625,470**	-----	**191,491**

*Based on Annual Estimates of the Population for Parishes of Louisiana. Estimates Source: Population Estimates Division, US Census Bureau. Release Date: June, 2014.

Age Range	Estimated Number of persons in LA population with SMI/EBD	Number of Persons with SMI/EBD in OBH and LGE Caseload*	Louisiana Percent of Prevalence Served*
Child/ Youth 0-17	100,166	2,659	2,659 / 100,166 = **2.7%**
Adult 18+	91,325	14,591	14,591/ 91,325 = **16%**
Total	**191,491**	**17,442**	17,442 / 191,491 = **9.1%**

PLEASE NOTE: These figures do not include persons seen in the offices of private practitioners.
These figures do not include all persons seen in the Mental Health Rehab programs.

Prevalence Count = Estimated Prevalence Count (2.6% Adults*, 9% Children**)
Adult =18 Years of Age and Older Child/Youth = 17 Years of Age and Younger

* Source for Adult prevalence estimate: Kessler, R.C., et al. The 12-Month Prevalence and Correlates of Serious Mental Illness (SMI). Mental Health, United States, 1996. U.S. Department of Health and Human Services pp. 59-70.

** Source for Child prevalence estimate: Friedman, R.M. et al. Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996. U.S. Department of Health and Human Services pp 71-89.

The goal to increase access to mental health services to persons with Serious Mental Illness/ Emotional Behavioral Disorder (National Outcome Measure (NOMS) Performance Indicator "Increased Access to Services") has historically been reported by the State as the percentage of prevalence of individuals who have SMI/EBD who receive mental health services from the OBH during the fiscal year. The measure of this NOMS is now requested to be reported as simply the number of persons who have a mental illness and receive services.

The historical figures detailed below for this quantitative target should be interpreted with caution due to fluctuations and inaccuracies in population figures following the hurricanes of 2005. It also should be noted that the data collected are more accurate than in prior reporting. In the past, the caseload figures were inflated by cases that had not been "officially" closed, making it appear that more individuals were being seen than actually were. A process implemented in the clinics automatically cleaned out information relating to clients who had not been seen for nine months.

- The OBH reported information presented below is conservatively estimated. It should be noted that Louisiana experienced a reduction in reporting for FYs 2014 and 2015. This reduction was attributed to data transmission challenges and does not represent a decrease in service provision. The Louisiana OBH has recognized and taken steps to address the reduction in reporting. A number of LGEs have transitioned from the SMO data system, Magellan's Clinical Advisor, and adopted to purchase and use their own data systems/electronic health records (EHR). Challenges were experienced as the LGEs worked to transfer the data collected through the EHRs into the OBH data warehouse. OBH has been and is collaborating with the LGEs as these issues are corrected. Action steps taken by OBH include increased communication with the LGEs regarding data transmission, review of LGE data test submissions by the OBH analytics team, and test submission feedback meetings with the LGEs. Progress has been made and upon receipt of the data, OBH will focus on quality testing of the data and will update affected reports.
- Barriers to data collection and reporting include, but are not limited to information systems concerns, costs to providers, cost to the state, training individuals on data collection methods, electronic health record (EHR) modification, and time required to implement change. Louisiana estimates a period of at least 12 months to modify the current information system. In addition, coordination with the LGEs and their EHR vendors will be necessary.

ADULT POPULATION

- Numerator: unduplicated count of adults who have serious mental illness and who receive mental health services during the state fiscal year through OBH or the LGEs in a community or inpatient setting.
- Denominator: estimated prevalence of adults in Louisiana with serious mental illness during a twelve month period.

These figures for the Adult population for each of the preceding years were:

FY 2005 25,297 / 84,475 X 100 = 29.95%
FY 2006 24,667 / 71,294 X 100 = 34.6%
FY 2007 25,604 / 71,294 X 100 = 35.9%
FY 2008 27,619 / 83,555 X 100 = 33.05%
FY 2009 29,189 / 85,873 X 100 = 33.9%
FY 2010 24,368 / 87,586 X 100 = 27.8%
FY 2011 26,916 / 88,799 X 100 = 30.3%
FY 2012 22,488 / 89,873 X 100 = 25.0%
FY 2013 14,591 / 91,325 X 100 = 16%

CHILD/YOUTH POPULATION

- Numerator: unduplicated count of children/youth who have emotional behavioral disorder and who receive mental health services during the state fiscal year through OBH in a community or inpatient setting.
- Denominator: prevalence of children/youth in Louisiana with emotional behavioral disorder during a twelve month period.

These figures for the C/Y population for each of the preceding years were:

FY 2005 3,765/ 109,975 X 100 = 3.43%
FY 2006 3,552/ 85,223 X 100 = 4.17%
FY 2007 3,818/ 85,223 X 100 = 4.5%
FY 2008 4,286/ 97,160 X 100 = 4.4%
FY 2009 4,317 / 99,718 X 100 = 4.3 %
FY 2010 3,966 / 101,105 X 100 = 3.9 %
FY 2011 4,641 / 100,621 X 100 = 4.6 %
FY 2012 3,579 / 100,638 X 100 = 3.6%
FY 2013 2,659 / 100,166 X 100 = 2.7%

Addictive Disorders: Population and Prevalence Estimates

The OBH agrees to submit an assessment of the need for both treatment and prevention in the State for authorized activities both by localities and the State in general.

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

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

- The NSDUH data used in calculating the number of people that are in need of treatment services and that would seek treatment does not include estimates for the population under 12 years of age; therefore, that segment of the population was excluded from the reported estimates.
- The NSDUH data estimates used for the calculations are only representative of the state as a whole (or U.S. geographic region as used for the injecting drug user calculations), and not necessarily specific to the parishes that comprise the Sub-state Planning Areas.

- The NSDUH data estimates are not specific to gender, race or ethnicity.
- The estimates for Drug Related Arrests and Hepatitis B were calculated by applying a statewide total to the parish percentage of the total state population estimate, which results in figures that may not accurately reflect the parishes comprising the Sub-State Planning Areas.
- The OBH reported information presented below is conservatively estimated. It should be noted that Louisiana experienced a reduction in reporting for FYs 2014 and 2015. This reduction was attributed to data transmission challenges and does not represent a decrease in service provision. The Louisiana OBH has recognized and taken steps to address the reduction in reporting. A number of LGEs have transitioned from the SMO data system, Magellan's Clinical Advisor, and adopted to purchase and use their own data systems/electronic health records (EHR). Challenges were experienced as the LGEs worked to transfer the data collected through the EHRs into the OBH data warehouse. OBH has been and is collaborating with the LGEs as these issues are corrected. Action steps taken by OBH include increased communication with the LGEs regarding data transmission, review of LGE data test submissions by the OBH analytics team, and test submission feedback meetings with the LGEs. Progress has been made and upon receipt of the data, OBH will focus on quality testing of the data and will update affected reports.
- Barriers to data collection and reporting include, but are not limited to information systems concerns, costs to providers, cost to the state, training individuals on data collection methods, electronic health record (EHR) modification, and time required to implement change. Louisiana estimates a period of at least 12 months to modify the current information system. In addition, coordination with the LGEs and their EHR vendors will be necessary.

Treatment Needs Assessment Summary Matrix

				TOTAL POPULATION		INJECTING DRUG USERS		WOMEN		PREVALENCE OF SUBSTANCE-RELATED CRIMINAL ACTIVITY		INCIDENCE OF COMMUNICABLE DISEASE (per 100,000)		
Sub-state Planning Area	Population by area[1]	12+ Population by area[1]	Female 12+ Population by area[6]	Needing Treatment Services[2]	That would seek treatment[3]	Needing Treatment Services[4]	That would seek treatment[5]	Needing Treatment Services[7]	That would seek treatment[8]	Number of DWI Arrests[9]	Number of Drug Related Arrests[10]	Hepatitis B[11]	AIDS[12]	TB[13]
MHSD	446,006	377,109	197,442	30,772	3,385	1,169	129	16,111	1,772	1,760	3,101	8	161	26
CAHSD	675,320	564,846	290,620	46,091	5,070	1,751	193	23,715	2,609	2,877	4,645	12	186	13
SCLHSA	404,633	335,309	171,508	27,361	3,010	1,039	114	13,995	1,539	1,697	2,758	7	40	12
AAHSD	596,981	490,725	253,456	40,043	4,405	1,521	167	20,682	2,275	1,961	4,036	11	65	10
ImCal	295,640	244,660	123,567	19,964	2,196	758	83	10,083	1,109	1,538	2,012	5	28	9
CLHSD	309,406	255,847	126,842	20,877	2,296	793	87	10,350	1,139	1,271	2,104	6	29	4
NLHSD	549,790	455,956	237,235	37,206	4,093	1,413	155	19,358	2,129	2,269	3,750	10	66	17
NEDHSA	356,525	296,177	153,417	24,168	2,658	918	101	12,519	1,377	1,523	2,436	6	46	18
FPHSA	559,459	463,121	238,812	37,791	4,157	1,436	158	19,487	2,144	2,748	3,809	10	43	7
JPHSA	435,524	368,114	190,842	30,038	3,304	1,141	126	15,573	1,713	1,366	3,027	8	67	23
TOTAL	**4,629,284**	**3,851,864**	**1,983,741**	**314,311**	**34,574**	**11,939**	**1,313**	**161,873**	**17,806**	**19,010**	**31,678**	**83**	**731**	**139**

[1] The estimates for Total Population by Sub-state Planning Area (SPA) for 2013 were obtained from the US Census Bureau's 2014 Population Estimates dataset for Louisiana Parishes. To estimate the 12+ Population by SPA from the same dataset: the *Under 5 Years*, *5 to 9 Years,* and one-half of *10 to 14 Years* categories were excluded. http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

[2] Information from the 2012 and 2013 National Survey on Drug Use and Health (NSDUH) was used to estimate the Total Population Needing Treatment Services by SPA. According to the 2012 and 2013 State Estimates for Louisiana, the prevalence estimate for "Past Year Alcohol or Illicit Drug Dependence or Abuse" for the age group 12 and older is **8.16%.** The 12+ Population for each SPA was multiplied by **8.16%** to estimate the number of people needing treatment services. *Table 48 – Selected Drug Use, Perceptions of Great Risk, Average Annual Rates of First Use of Marijuana, Past Year Substance Dependence or Abuse, Needing But Not Receiving Treatment, and Past Year Mental Health Measures in Louisiana, by Age Group: Percentages, Annual Averages Based on 2012-2013 NSDUHs.*
http://www.samhsa.gov/data/sites/default/files/NSDUHsaeSpecificStates2013/NSDUHsaeLouisiana2013.pdf

[3] According to SAMHSA-Center for Substance Abuse Treatment, the proportion of those needing treatment for addictions or abuse of multiple drugs and alcohol who either get treatment or attempt to get it is approximately **11%** in any given year. (Source: SAMHSA-Center for Substance Abuse Treatment; Hal Krause, Public Health Analyst - (240) 276-2897 - hal.krause@samhsa.hhs.gov). **11%** was used as the estimate to determine the Total Population that Would Seek Treatment by SPA.

[4] Information from the *NSDUH Report: Demographic and Geographic Variations in Injection Drug Use (July 19, 2007*) was used to estimate the Number of IDU's Needing Treatment Services by SPA. According to this report, the estimated rate for injection drug use in the South is .0031 (*Table 1.Past Year Injection Drug Use among Persons Aged 12 or Older, by Geographic Characteristics: Percentages, 2002-2005.* http://www.oas.samhsa.gov/2k7/idu/idu.pdf).

[5] The 12+ Population for each SPA was multiplied by .0031 to estimate the number of IVDU's needing treatment services. The estimate of **11%** that was used to calculate the number of people that would seek treatment was also used to determine the Number of IVDU's that Would Seek Treatment.

[6] An estimate for the Female Population by SPA was obtained from the US Census Bureau's 2013 Population Estimates dataset for Louisiana Parishes by Gender. The Female Population was estimated to include only those 12 years and older.

[7] Information from the 2012 and 2013 National Survey on Drug Use and Health (NSDUH) was used to estimate the Total Number of Women Needing Treatment Services by SPA. The prevalence estimate of **8.16%** used to calculate the number of people needing treatment was used to estimate the number of women in need of treatment.

[8] The estimate of **11%** that was used to calculate the number of people that would seek treatment was also used to determine the Number of Women that Would Seek Treatment.

[9] The estimates for Number of DWI Arrests for 2014 were obtained from the Louisiana State University, Highway Safety Research Group's *2014 Number of Arrests and DWI by Parish* Report. http://datareports.lsu.edu/report4DWI.aspx?p=dwi&yr=2013&rpt=parish

[10] Information from the Federal Bureau of Investigations, Crime in the United States, 2013 Report was used to estimate the Number of Drug Related Arrests for Calendar Year 2013. According to this report, there were 31,677 drug related arrests in Louisiana in 2013 (20,727 Drug Abuse Violations + 6,182 Driving Under the Influence + 1,650 Liquor Law Violations + 3,118 Drunkenness = 31,677). Parish estimates for the Number of Drug Related Arrests were calculated by multiplying this figure (31,677) by the Parish percentage of the total state 12 years and older population estimate. United States Department of Justice, Federal Bureau of Investigation. *Crime in the United States, 2013*: https://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2013/crime-in-the-u.s.-2013/tables/table-69/table_69_arrest_by_state_2013.xls. Table 69 Arrests by State, 2013.

[11] According to the CDC, Louisiana's incidence rate for Hepatitis B in 2013 was 1.8/100,000 (Viral Hepatitis Surveillance – United States, 2013; Table 3.1: Reported cases of acute hepatitis B, nationally and by state — United States, 2009 – 2013 http://www.cdc.gov/hepatitis/statistics/2013surveillance/index.htm#tabs-801937-1). This estimates 83 cases (.000018*4,629,284) for the total population. Parish estimates for Incidence of Hepatitis B/100,000 were calculated by multiplying this figure (83) by the Parish percentage of the total state population estimate.

[12] According to the CDC, Louisiana's incidence rate for AIDS in 2013 was 16.9/100,000 (HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2013; Vol 25; February 2015 http://www.cdc.gov/hiv/pdf/g-l/hiv_surveillance_report_vol_25.pdf). This estimates 783 cases for the total population. The 2013 HIV/AIDS Program Report published by the Louisiana Department of Health and Hospitals-Office of Public Health details the Geographic Distribution of AIDS Diagnoses in each Parish for 2013, which are provided in the estimates table. http://new.dhh.louisiana.gov/assets/oph/HIVSTD/hiv-aids/2015/2013_STD_HIV_Surveillance_Report.pdf

[13] According to the Louisiana Department of Health and Hospitals Tuberculosis Control Program, Louisiana's incidence rate for Tuberculosis in 2013 was 3.0/100,000 (Louisiana TB Morbidity Report – 2013: Louisiana Tuberculosis (TB) Cases/Rates http://dhh.louisiana.gov/assets/oph/Center-PHCH/Center-PH/tuber/2013TBMorbidityTable.pdf). This estimates 139 cases for the total population. The distribution of cases by Parish as published by the Tuberculosis Control Program are provided in the estimates table.

TREATMENT NEEDS BY AGE, SEX, AND RACE/ETHNICITY

Age	Total in Need	White		Black or African American		Native Hawaiian /Other Pacific Islander		Asian		American Indian /Alaska Native		More than One Race Reported		Unknown		Not Hispanic or Latino		Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
17 & Under	**19,793** (7%)	6,588	5,861	3,362	2,991	5	4	168	149	63	56	189	168	100	89	9,995	8,892	479	427
18-24	**78,319** (27%)	24,500	24,762	12,503	12,637	17	17	623	630	234	236	701	709	373	377	37,168	37,566	1,783	1,802
25-44	**78,500** (27%)	26,464	22,912	13,505	11,693	18	16	673	583	252	219	757	656	403	349	40,147	34,760	1,926	1,667
45-64	**77,448** (27%)	25,435	23,280	12,980	11,880	17	16	647	592	243	222	728	666	387	354	38,586	35,317	1,851	1,694
65 & Over	**37,906** (13%)	11,153	12,690	5,692	6,476	8	9	284	323	106	121	319	363	170	193	16,919	19,251	812	923
Total	**291,965** (100%)	**94,140**	**89,506**	**48,043**	**45,678**	**65**	**61**	**2,395**	**2,277**	**898**	**854**	**2,694**	**2,561**	**1,432**	**1,362**	**142,816**	**135,785**	**6,850**	**6,513**
		62.9%		**32.1%**		**0.04%**		**1.6%**		**0.6%**		**1.8%**		**1.0%**		**95.4%**		**4.6%**	

The estimates for Age categories were obtained from the US Census Bureau's 2013 Population Estimates dataset for Louisiana – tables used include Sex by Age, Race, and Hispanic or Latino by Race. The 17 and under category estimates include only those 12 years and older. Information from the 2012-2013 National Survey on Drug Use and Health (NSDUH) was used to estimate the Total in Need of Treatment for the Age categories.

According to the 2012 and 2013 State Estimates for Louisiana, the prevalence estimate for Past Year Alcohol or Illicit Drug Dependence or Abuse is **6.07%** for the age group 12-17, **16.27%** for the age group 18-25, and **6.95%** for the age group 26 and older. (*Table 48 – Selected Drug Use, Perceptions of Great Risk, Average Annual Rates of First Use of Marijuana, Past Year Substance Dependence or Abuse, Needing But Not Receiving Treatment, and Past Year Mental Health Measures in Louisiana, by Age Group: Percentages, Annual Averages Based on 2010-2011 NSDUHs.* http://www.samhsa.gov/data/sites/default/files/NSDUHsaeSpecificStates2013/NSDUHsaeLouisiana2013.pdf)

TREATMENT ADMISSIONS AND PERSONS SERVED
COMPARED TO PREVALENCE ESTIMATES AND CENSUS DATA
SFY 2014

The tables below provide a comparison of the number of admissions and persons served to the prevalence estimates determined in the *Treatment Needs Assessment Summary Matrix* and the *Treatment Needs by Age, Sex, and Race/Ethnicity Matrix* for the state Total Population, Injecting Drug Users (IDU), and Women. The current National Survey on Drug Use and Health (NSDUH) prevalence estimate for "*Past Year Alcohol or Illicit Drug Dependence or Abuse*" for the age group 12 and older in Louisiana of 8.16% was used to determine the number of persons in each LGE *needing treatment services* for the tables representing the Total Population and Women. The NSDUH estimated rate for injection drug use in the South of .0031 was used to determine the number of persons *needing treatment services* in the Injecting Drug Users (IDU) table.

It is estimated that approximately 11% of persons needing treatment services *would seek treatment*, according to SAMHSA - Center for Substance Abuse Treatment. Data collected from the Louisiana Addictive Disorders Data System (LADDS) and Clinical Advisor (CA) for the total number of persons served during SFY2014 is compared to the total estimated number needing treatment services to determine the *percent of prevalence served* in Louisiana.

TREATMENT ADMISSIONS AND PERSONS SERVED
COMPARED TO PREVALENCE ESTIMATES AND CENSUS DATA
SFY 2014

TOTAL SUD POPULATION ADMITS and SERVED

LGE	***Needing Treatment Services***	**That would seek treatment**	**Admissions***	***Total Served****	**Percent of Prevalence Served**
1-MHSD	30,772	3,385	2,927	*3,879*	3,879 / 30,772 = 12.61%
2-CAHSD	46,091	5,070	920	*2,048*	2,048 /46,091 = 4.44%
3-SCLHSA	27,361	3,010	2,108	*3,303*	3,303 /27,361 = 12.07%
4-AAHSD	40,043	4,405	858	*1,542*	1,542 /40,043 = 3.85%
5-IMCAL	19,964	2,196	986	*1,378*	1,378 /19,964 = 6.90%
6-CLHSD	20,877	2,296	2,222	*2,766*	2,766 /20,877 = 13.25%
7-NLHSD	37,206	4,093	1,441	*2,286*	2,286 /37,206 = 6.14%
8-NEDHSA	24,168	2,658	2,636	*3,586*	3,586 /24,168 = 14.84%
9-FPHSA	37,791	4,157	1,383	*2,050*	2,050 /37,791 = 5.42%
10-JPHSA	30,038	3,304	829	*1,863*	1,863 /30,038 = 6.2%
TOTAL	***314,311***	**34,574**	**16,310**	***24,701***	24,701 /314,311 = **7.86%**

*Unduplicated by Client within LGE; Source: Louisiana Addictive Disorders Data System (LADDS) and Clinical Advisor (CA).
Total served figures do not include clients engaged in ATR services in SFY 2014.

INJECTING DRUG USERS (IDU)
SUD POPULATION ADMITS and SERVED

LGE	*Needing Treatment Services*	That would seek treatment	Admissions*	*Total Served**	Percent of Prevalence Served
1-MHSD	1,169	129	606	*657*	657 /1,169 = 56.2%
2-CAHSD	1,751	193	43	*103*	103 /1,751 = 5.88%
3-SCLHSA	1,039	114	144	*191*	191 /1,039 = 18.38%
4-AAHSD	1,521	167	73	*104*	104 /1,521 = 6.84%
5-IMCAL	758	83	93	*112*	112 /758 = 14.78%
6-CLHSD	793	87	289	*324*	324 /793 = 40.86%
7-NLHSD	1,413	155	103	*162*	162 /1,413 = 11.46%
8-NEDHSA	918	101	353	*505*	505 /918 = 55.01%
9-FPHSA	1,436	158	67	*95*	95 /1,436 = 6.62%
10-JPHSA	1,141	126	37	*64*	64 /1,141 = 5.61%
TOTAL	**11,939**	**1,313**	**1,808**	***2,317***	2,317 /11,939 = **19.4%**

*Unduplicated by Client within LGE; Source: Louisiana Addictive Disorders Data System (LADDS) and Clinical Advisor (CA); Drug route at admission. Total served figures do not include IDU clients engaged in ATR services in SFY 2014.

SUD WOMEN (Female Age 18+) ADMITS and SERVED

LGE	*Needing Treatment Services*	That would seek treatment	Admissions*	*Total Served**	Percent of Prevalence Served
1-MHSD	16,111	1,772	986	*1,365*	1,365 /16,111 = 8.47%
2-CAHSD	23,715	2,609	242	*650*	650 /23,715 = 2.74%
3-SCLHSA	13,995	1,539	729	*1,230*	1,230 /13,995 = 8.79%
4-AAHSD	20,682	2,275	377	*693*	693 /20,682 = 3.35%
5-IMCAL	10,083	1,109	357	*549*	549 /10,083 = 5.44%
6-CLHSD	10,350	1,139	870	*1,076*	1,076 /10,350 = 10.4%
7-NLHSD	19,358	2,129	577	*947*	947 /19,358 = 4.89%
8-NEDHSA	12,519	1,377	961	*1,256*	1,256 /12,519 = 10.03%
9-FPHSA	19,487	2,144	556	*825*	825 /19,487 = 4.23%
10-JPHSA	15,573	1,713	323	*809*	809 /15,573 = 5.19%
TOTAL	**161,873**	**17,806**	**5,978**	***9,400***	9,400 /161,873 = **5.81%**

*Unduplicated by Client within LGE; Source: Louisiana Addictive Disorders Data System (LADDS) and Clinical Advisor (CA); Persons served age at end of time period; Admissions age at admit. Total served figures do not include women engaged in ATR services in SFY 2014.

Race/Ethnicity and Age Compared to SFY2014 Population Profile

Race/Ethnicity	Needing Treatment Services	SUD Population Served Profile
American Indian /Alaska Native	0.6%	0.76%
Asian	1.6%	0.3%
Black/African American	32.1%	35.48%
Native Hawaiian /Other Pacific Islander	0.04%	0.16%
White	62.9%	61.62%
More than One Race Reported	1.8%	0.44%
Unknown - Other	1.0%	1.23%
Hispanic or Latino	4.6%	1.69%
Not Hispanic or Latino	95.4%	89.7%
Unknown	-	8.6%

Age	Needing Treatment Services	SUD Population Served Profile
18-24	25%	12.85%
25-44	28%	53.59%
45-64	27%	27.68%
65 & Over	41,218	1.12%

Gender	Needing Treatment Services	SUD Population Served Profile
Male	48.5%	39.39%
Female	51.5%	60.61%

Source: Louisiana Addictive Disorders Data System (LADDS); Clinical Advisor (CA). Unduplicated by client across all LGES

State Epidemiology Workgroup

The State Epidemiology Workgroup (SEW) is a subcommittee of the Louisiana Drug Policy Board. The SEW is tasked with identifying, collecting, analyzing and disseminating consumption and consequence data related to substance use and related mental, emotional and behavioral disorders that is available from state and national data sources, as well as prioritizing available data for substance abuse prevention needs. The SEW maintains an online data system, which includes consumption indicators and long- and short-term consequence indicators at the state and community level. The SEW makes recommendations regarding improvements in data collection, and continuously works to fill data gaps to improve the quality and integrity of the data at all levels, while supporting regional and community epidemiological efforts. The work of the SEW is guided by formalized bylaws and Cooperative Involvement Agreements that detail member roles and responsibilities.

The SEW, which is currently funded by the Strategic Prevention Framework Partnerships for Success Grant (LaPFS), was created in 2005 by the Strategic Prevention Framework State Incentive Grant. OBH is a standing member of the SEW and provides prevention and treatment

data to the workgroup 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.

LaPFS staff are currently working with SEW to select, implement, and evaluate evidence-based prevention programs, policies, and practices that best address the selected prevention priorities. 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. Finally, there are plans to augment the SEW online system to ensure that the website provides a user interface to encourage use of data for decision-making.

The online system can be viewed at http://www.bach-harrison.com/lasocialindicators/Default.aspx

Below is a list of current SEW members and agencies that are represented.

State Epidemiology Workgroup (SEW) Membership

Agency	Member
Governor's Office, Drug Policy Board	Missy Graves
Department of Health and Hospitals (DHH), Office of Behavioral Health (OBH), Prevention	Leslie Freeman
DHH, OBH, Prevention Louisiana Partnerships for Success Epidemiologist	Ashanti Corey
DCFS, Office of Family Assistance Program Policy Section	Allana Thomas
Louisiana Commission on Law Enforcement	Opal West
Louisiana Highway Safety Commission	Cathy Childers
DHH, Office of Public Health (OPH), State Epidemiologist, Infectious Disease Epidemiology Section, SEW Chair	Dr. Gary Balsamo
DHH, OPH, Epidemiologist, Infectious Disease Epidemiology	Jenna Iberg-Johnson
DHH, OPH, Center for Health Statistics - Public Health Epidemiologist	Melissa McNeil
Southern University, Department of Psychology	Dr. Murelle Harrison
Capital Area Human Services District, Project Manager, FASD Prevention Collaborative	Vivian Gettys
Governor's Office of Elderly Affairs	vacant
LSU School of Public Health, Associate Professor, Epidemiology	Susanne Straif-Bourgeois
DHH, OBH, Treatment	Ivory Wilson
Louisiana Center Addressing Substance Use (LaCASU)	Shelley Lee

Veteran Affairs	vacant
DHH, OBH Business Intelligence & Analytics, Division of Health Plan Management	Kashunda Williams
Department of Education	Lillie Burns
LSU Health Science Center / DHH Tobacco Control Program	vacant
State Police	Rebecca Nugent
Coroner's Office	vacant
Drug Enforcement Administration	vacant
DHH/OPH	Mary Johnson
Xtreme Cleaners	Larry Douglas
DHH, Office of the Secretary	Dr. Bhaskar Toodi
	Angel Norwood
Department of Transportation and Development	Dortha Cummins
DHH, OBH, Mental Health	Annette Giroir
OPH	Tyler Carrutth
Addiction Doctor	Dr. Howard Wetsman
LSU School of Public Health	Dr. Katherine Theall
LSU Information Systems and Decision Sciences (ISDS) Research for Highway Safety	Dr. Helmut Schneider
LA Supreme Court	Chris Andrieu
LA Sheriff's Association	Danny Jackson
DHH, OBH, Prevention	Felecia Johnson
Governor's Office	Dawn Diez

Prevention

Problem Assessment (Epidemiological Profile)

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

The rationale for prioritizing primary prevention programs in Louisiana is to address the fundamental substance abuse-related issues in the state. The basis for judging the most pressing needs in Louisiana are found in the data. For instance, LifeSkills Training, Project Northland and Second Step account for 60 percent of all enrollees in SFY 2014. The proven outcomes for these programs are centered around alcohol, tobacco, family relationships, drugs, social functioning, crime and violence as indicated on NREPP. These programs have outcomes that address substance-abuse related problems in the State as revealed by data. Three of these data sources are the 2012 Caring Communities Youth Survey (CCYS) and, the 2013 CORE Alcohol and Drug

Survey, which are both funded by OBH, as well as the 2013 State Epidemiology Workgroup (SEW) report.

Using alcohol as an example of what the data reveals; the CCYS 2012 indicated that 18.8% of 6th grade, 40.7% of 8th grade, 61.4% of 10th grade and 70.7% of 12th grade students used alcohol in their lifetime. Additionally in CCYS 2012, 6.8% of 6th grade, 18.5% of 8th grade, 35% of 10th grade and 45.8% of 12th grade students reported using alcohol in the past 30 days. The SEW report sites data from the Louisiana Department of Education (DOE) that states there were 410 suspension and expulsions in schools for alcohol-related violations. Alcohol and drug consumption patterns tend to increase when students enter college. The CORE survey, a survey distributed to all two and four year Institutions/Universities in Louisiana, reported 78.3% of college students consumed alcohol in the past year and 62.6% of students consumed alcohol in the past 30 days. OBH focuses prevention efforts on school age children based on the CCYS 2012 finding that the average age of first use of is lowest with cigarettes at 12.45 years. A period of one and a one half years separates the age of first sip of alcohol and the first regular alcohol use, with the first sip occurring at 12.68 years, and the first regular use of alcohol at 14.18 years. Of the youth who had used marijuana, the average age of first use was 13.73 years – nearly a half year before youth indicated that they had begun drinking regularly.

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 Planning Framework. OBH continues to move toward the goal of fully implementing the SPF process throughout the agency for making data-driven prevention decisions.

Prevention System Assessment (Capacity and Infrastructure)

OBH Prevention infrastructure includes Central Office staff, field staff, and community–based providers through contractual agreements. The State is divided into 10 geographic service areas. SAPT Block Grant funds are distributed to each of these 10 areas to fund programs, policies, and practices that are needed.

Statewide contracts are managed by Central Office staff and monitored monthly. Statewide contracts include the sponsorship and co-sponsorship of the Louisiana Caring Communities Youth Survey, CORE Survey for Higher Education, and Annual Synar Report. These statewide contracts provide necessary needs assessment data for OBH and other state partners through the State Epidemiological Outcomes Workgroup. Other statewide contracts provide workforce development and outcome evaluation services.

LGEs enter into contractual agreements with community-based providers. These providers implement individual-direct services through evidence-based programs or population-based

services through community Synar Providers. In addition to Synar Providers, evidence-based program providers and OBH staff provide population-based services. It is the goal of OBH to fund at least 60 prevention programs annually through contractual agreement to include the following: 50 evidence-based program providers and 10 community Synar providers. Louisiana plans to use a minimum of 20% of its SAPT Block Grant funds for primary prevention activities, including funding the 6 primary prevention strategies with block grant funds.

All LGE contracts are monitored monthly. Each provider is required to collect process data and enter it into the OBH Prevention Management Information System (PMIS). A report is generated each quarter by the state analyzing services for each geographic service area, provider, and program. This report is followed by a quarterly site visit by Central Office prevention staff to analyze and review findings in the report. A technical assistance assessment is completed at the end of each site visit. State and regional staff create a plan to fill existing needs using internal and external resources during the service delivery period.

Each provider of an evidence-based prevention program administers the pre- and post-test that was developed and validated by the developer of that particular evidence-based program. During the first quarter site visit, state and LGE staff and providers analyze annual outcome reports. Outcome reports and process data are used to make an informed decision as to whether a particular program will be continued. Resources are monitored and reallocated during the year as indicated.

OBH Prevention Services has developed and remains involved in an extensive network of multi-sector state, regional and community partnerships. Statewide partnerships include the Governor's Office of Safe and Drug Free Schools and Communities, the Office of Public Health, the Department of Education, the Department of Social Services, Office of Alcohol and Tobacco Control, Louisiana Highway Safety Commission, and Institutions of Higher Education.

More specifically, OBH Central Office staff serves on several formal committees and workgroups to include the Prevention Systems Committee, State Epidemiological Workgroup, Louisiana Drug Policy Board, and Coordinated Systems of Care workgroups.

OBH Central Office and field staff actively participate in and provide needs assessment data, technical assistance and resources to support a variety of broad-based community coalitions, including SPF-SIG Coalitions. Membership includes representation from state and local law enforcement, district attorneys, the Department of Education, the Office of Public Health, local media outlets, universities, citizens, youth, the recovery community, elected officials, the alcohol and tobacco industries, and community leaders.

Prevention System Capacity Development

The primary needs assessment sources used by OBH are the Caring Communities Youth Survey (CCYS) and, the CORE Alcohol and Drug Survey, both of which are funded by OBH, as well as the State Epidemiology Workgroup (SEW) report. OBH, in partnership with the Department of Education (DOE) and Louisiana Higher Education Coalition (LaHEC), will research and work toward

increasing participation in the CCYS and the CORE survey. OBH will actively support the SEW in the development of information systems that will collect data and identify data gaps where changes and enhancements are needed.

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

Mobilizing the existing infrastructure via partnership growth and expansion of the SPF planning process is the focus of change. Mobilizing the state and community partners around the SPF training will increase community awareness and support around the consequences of substance use, abuse and addiction.

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

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

OBH has required evidence-based strategies for several years and is cognizant of the benefits. By requiring contract providers to offer only evidence-based programs, OBH has implemented a cost band, which allows for cost savings and waste reduction. OBH continues to monitor evidence-based programs' cost to develop a more fiscally responsible contract process.

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. 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.

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, perception of harm and positive attitudes toward substance abuse for youth aged 12 and above are measured.

OBH faces numerous challenges in the coming year. The biggest challenge is the pending reduction in resources, staff, and funding by OBH and partnering agencies. For example, the braiding of OBH and DOE resources will be drastically reduced due the Safe Schools Grant ending. This will impact DOE staffing patterns and increases the workload of OBH staff and providers to continue to meet statewide needs and provide necessary school-based services. The key resources that will be utilized to address resources, staff, and funding shortfalls will be the reliance on relationships that have been established and lessons learned through the previous Prevention streamlining efforts.

Another challenge is moving from the Risk and Protective Factor model to the Public Health Model. Delays in curriculum development and reduction in travel and training costs have impacted the formal rollout of the SPF planning process and training of OBH field and provider staff. The forthcoming statewide rollout of the SPF curriculum and subsequent onsite SPF training and technical assistance visits by Southern University and OBH Central Office staff will permit the state to progress towards the goal of implementation of the Public Health Model.

There are several key contextual and cultural conditions that impact the State's prevention capacity and function. Louisiana's 4.5 million population is racially, culturally, and economically diverse. English is the dominant language, though Spanish is increasingly used as well; however, significant minorities of Louisianans continue to speak Cajun-French and Louisiana Creole French. Culturally competent and sensitive prevention services are offered with this cultural diversity in mind. Rural areas in Louisiana are much underserved and have higher than average poverty rates.

In Louisiana there is a *"Laissez les bon temps rouler"* or "*Let the good times roll*" attitude. The state culture promotes and is accepting of alcohol use by youth. There is an overwhelming belief that fairs, festivals, football games, and parades cannot be enjoyable without the sale and

consumption of alcoholic beverages. Although the legal drinking age in Louisiana is 21 years, there is a loophole in the State's law allowing 18 year olds to enter bars and lounges where social availability of alcohol is common. In addition there are drive-thru daiquiri shops where only the driver is asked for identification for age verification. OBH is cognizant of these conditions and strives to meet the unique needs of the state through innovative and proven interventions.

Implementation of a Data-Driven Prevention System

The Office of Behavioral Health (OBH) Prevention Services implements a data-driven planning process to identify and implement appropriate primary prevention services. Annually, the 10 geographic service areas of the state review their funding of prevention services. The mechanisms by which 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 is reviewed, along with the current resources available to the service area, including partnerships that braid funding, such as the local Department of Education.

At the sub-recipient level, allocation of resources and sub-recipient deliverables are strategically planned. Resources are reallocated as needed, and a new action plan and a Statement of Work (SOW) is written. The action plan includes information on the provider, the provider's mission, goals, objectives, evidence-based program strategies, target population, performance indicators, and process and outcome evaluation. OBH State Office provides guidance and technical assistance during this process to ensure that action plans are appropriate. LGEs monitor the deliverables of Block Grant sub-recipients on a monthly basis and OBH State staff review sub-recipient reports and documentation of deliverables during quarterly site visits.

OBH Prevention Services has been involved in the development of multiple strategic plans, including the SPF-SIG Strategic Plan, but does not yet have a formal Prevention Strategic Plan. OBH recognizes the need for a formal Strategic Plan for prevention services. For this reason, OBH, in partnership with the Governor's Office, has devoted the last four years to developing an innovative, state-specific SPF curriculum that incorporates lessons learned by SPF-SIG sub-recipients. In preparation for the SPF curriculum, OBH has been committed to building its internal infrastructure capacity in the areas of needs assessment, development of action plans, implementation, monitoring, and process and outcome evaluation.

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

program. This report is followed by a quarterly site visit by a state office Prevention staff member to provide technical assistance during the service delivery period. Resources are monitored and reallocated during the year as needed.

Evaluation of Primary Prevention Outcomes

Surveillance of new data, trends, and evidence-based programs, policies, and practices are researched by Central Office staff and disseminated to the field on an on-going basis. In addition, surveillance of Prevention staff activities and contractor deliverables is conducted through quarterly site visits by Central Office staff and on-going assessment of PMIS data to ensure integrity and validity.

OBH Prevention staff monitors contract providers on a monthly basis. Contract monitoring tools are specific to each evidence-based program funded to ensure fidelity of the program as outlined in the contract statement of work. The monitoring tool also includes a standardized program improvement plan and evaluation checklist.

Process evaluation is conducted at the state, regional, and provider level. Prevention staff and contract providers input information about direct and indirect individual services into PMIS. PMIS is available to all on a daily basis. Data on Population-based services are also collected, including information about Synar unconsummated retail compliance checks; merchant education, identification, and referral services provided through the OBH employee assistance program; and resource assessments at the community level. Specific data elements collected by PMIS include demographic data, such as age, race, and ethnicity, and data on specific services that includes the number served, target population and services provided within the six CSAP prevention strategies.

Real-time rollup reports are available at the state, regional or provider level. These reports allow OBH to assess current capacity and determine areas where additional progress is needed. These reports indicate whether performance targets have been achieved and allow staff to intervene and take corrective action in a timely manner.

In addition to monthly monitoring, a quarterly Prevention Service Report is published outlining direct, indirect, individual-based, and population-based services. These reports are distributed to executive leadership and field staff. Through Central Office staff meetings and quarterly site visits to each of the 10 geographic service areas, these evaluation results along with monthly monitoring reports are used in the decision-making process. Review of these important documents is the driving force used to modify the implementation of direct contract deliverables, resource allocations, and performance targets.

Another outcome of the quarterly report and site visit is a summary report and the development of a technical assistance plan to include workforce development, PMIS, contract negotiation, development, monitoring, and evaluation. Each technical assistance plan is tailored to each geographic service area.

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 aged 12 and older.

These supplemental GPRA questions include: 1) How frequently have you smoked cigarettes during the past 30 days?; 2) How frequently have you used smokeless tobacco during the past 30 days?; 3) On how many occasions (if any) have you had beer, wine or hard liquor to drink during the past 30 days?; 4) Think back over the last two weeks. How many times have you had five or more alcoholic drinks in a row?; 5) On how many occasions during the past 30 days have you: A. sniffed glue, breathed the contents of an aerosol spray can, or inhaled other gases or sprays, in order to get high? B. used marijuana during the past 30 days? C. used LSD, cocaine, methamphetamines, or heroin? D. used MDMA (X, E, or ecstasy)? E. used prescription drugs (Stimulants: Ritalin, Dexedrine) without a doctor telling you to take them? F. used prescription drugs (Sedatives: Valium, Xanax, barbiturates or sleeping pills) without a doctor telling you to take them? E. used prescription drugs (Narcotics: OxyContin, methadone, morphine, codeine, Demerol, Vicodin, Percocet) without a doctor telling you to take them?; 6) How much do you think people risk harming themselves (physically or in other ways) if they have five or more drinks of an alcoholic beverage once or twice each weekend?; 7) How much do you think people risk harming themselves (physically or in other ways) if they smoke one or more packs of cigarettes per day?; 8) How much do you think people risk harming themselves (physically or in other ways) if they smoke marijuana regularly?; 9) How wrong do you think it is for someone your age to drink beer, wine or hard liquor?; 10) How wrong do you think it is for someone your age to smoke cigarettes?; 11) How wrong do you think it is for someone your age to smoke marijuana?; and 12) How old were you when you first had more than a sip or two of beer, wine or hard liquor?; 13) How old were you when you first smoke a cigarette, even just a puff?; and 14) How old were you when you first smoked marijuana?

Prevention Needs Assessment

Louisiana Census data places the total population according to the 2010 Census at 4,533,572. There was a modest 1.4% (64,396) increase in the state population from the prior year estimates. To further describe the population you must first take into consideration the following statistics and tables.

Race	Number	Percent
White	2,836,192	62.6
African American	1,452,396	32.0
Asian	70,132	1.5
Pacific Islander	1,963	-
Other	69,227	1.5
Two or More Races	72,883	1.6
Total population	**4,533,372**	**100**
Ethnicity	**Number**	**Percent**
Hispanic or Latino	192,560	4.2

Sex and Age	Number	Percent
Total population	**4,533,372**	**100**
Male population	2,219,292	49
Female population	2,314,080	51
Under 5 years	314,260	6.9
5 to 9 years	306,362	6.8
10 to 14 years	306,836	6.8
15 to 19 years	326,779	7.2
20 to 24 years	338,309	7.5
25 to 29 years	332,925	7.3
30 to 34 years	295,508	6.5
35 to 39 years	276,479	6.1
40 to 44 years	288,120	6.4
45 to 49 years	325,046	7.2
50 to 54 years	329,329	7.3
55 to 59 years	292,567	6.5
60 to 64 years	242,995	5.4
65 to 69 years	178,365	3.9
70 to 74 years	133,629	2.9
75 to 79 years	102,876	2.3
80 to 84 years	77,301	1.7
85 years and over	65,686	1.4

The use and abuse of alcohol, tobacco, and illicit drugs constitute a major public health threat to the state of Louisiana. Recent estimates suggest that approximately 8.1% of adults (195,409) drank heavily within the past month, 3% have used illicit drugs within the past month (102,649) and 10.2% (349,007) of adults aged 18 and over in Louisiana need treatment to address problems related to compulsive or out-of-control substance use (Herman-Stahl et al., 1999, Kroutil et al., 1999). Substance abuse is widespread, affecting males and females of all ages from both upper and lower socioeconomic classes and living in both urban and rural areas. In the state of Louisiana, the annual economic cost of substance abuse is approximately $4 billion, which translates into a cost of $943 per every man, woman, and child. Included in this cost is medical, criminal, property damage, accidents, lost wages, lost productivity, and death of citizens.

Experimentation and often regular use of alcohol, tobacco and other drugs often begins during youth. A statewide youth survey conducted during 2012 reflects lifetime and 30 day use among Louisiana youth in the following tables.

Caring Communities Youth Survey

Table 3. Percentage of Students Who Used ATODs during Their Lifetime

	Grade 6			Grade 8			Grade 10			Grade 12		
Drug Used	2008	2010	2012	2008	2010	2012	2008	2010	2012	2008	2010	2012
Alcohol	25.7	22.8	18.8	4934	46.5	40.7	67.6	64.9	61.4	73.9	73.5	70.7
Cigarettes	12.6	10.6	8.8	27.7	24.6	21.3	38.4	34.9	31.7	44.3	41.9	38.3
Chewing Tobacco	5.6	4.7	3.9	10.8	10.9	9.2	15.6	15.3	14.4	15.7	17.6	16.1
Marijuana	2.0	1.8	1.7	9.6	10.2	9.8	20.2	22.0	22.9	27.5	30.3	31.7
Inhalants	8.9	7.6	6.7	12.1	11.7	9.7	10.3	9.0	7.5	6.8	6.9	5.4

(Formerly the Communities That Care Survey)

Caring Communities Youth Survey

Table 3. Percentage of Students Who Used ATODs during Past 30 Days

	Grade 6			Grade 8			Grade 10			Grade 12		
Drug Used	2008	2010	2012	2008	2010	2012	2008	2010	2012	2008	2010	2012
Alcohol	9.5	8.1	6.8	23.9	21.8	18.5	37.8	35.3	35	46.9	45.7	45.8
Cigarettes	3.0	2.3	2.0	9.0	7.8	6.1	15.3	13.1	12.0	20.7	19.7	17.5
Chewing Tobacco	2.0	1.7	1.4	5.0	4.9	4.2	7.7	7.5	7.7	7.7	8.8	8.8
Marijuana	0.8	0.7	0.7	4.2	5.1	4.6	8.9	10.6	11.3	11.2	14.6	15.4
Inhalants	3.7	2.8	2.8	4.4	4.4	3.8	2.5	2.2	2.0	1.2	1.2	1.0

(Formerly the Communities That Care Survey)

There is an approach which may help ease the burden of substance abuse 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
- *Selected 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 abuse disorders
- *Indicated interventions* – focuses exclusively on those individuals already displaying mild symptoms indicative of a problem that is not yet severe enough to be classified as a full-blown disorder (i.e., sub-clinical)

Although it is important to recognize that not all use is necessarily problematic, for some, experimental use will inevitably escalate to regular or heavy use. In fact, a study of Louisiana youth focusing on problem substance use found that approximately 13.5% of adolescents (57,503) may need some form of intervention to address high frequency or risky alcohol or drug

use (Farrelly et al., 1998). In the 2010 CCYS survey, 13.3% of Louisiana students met the criteria for substance abuse or addiction. Both prevention and treatment are necessary tools within the full range of service provision for attacking substance abuse problems.

Stakeholder Input

In order to assess consumer needs, as well as to establish a common ground for providing information to the community about behavioral health services and receiving input from stakeholders, an annual Public Forum is conducted in each of the ten Local Governing Entities (LGEs).

During the FY 2014-2015 Public Forums, the primary discussion topic was the preparation from carve-out to the carve-in of the Bayou Health Managed Care Organizations (MCOs). Discussions also focused on the transition of the non-Medicaid population. At each Public Forum, OBH presented the budget allocation for that particular LGE – state general funds, block grant funds and other federal funding sources. Stakeholders expressed concerns for the non-Medicaid population and how they will be served, after Magellan no longer provides oversight, how services will be effected during the transition period and the worry of substance use services being lost in the transition. Additional concerns were noted regarding treatment services, including—better education for family members on intervention techniques, incarcerated population needing services during sentence and following release, job training for the substance use population, lack of intensive outpatient treatment for adolescents and lack of services for relapse prevention following a treatment.

OBH Priorities to Address Unmet Service Needs and Critical Gaps

Due to the assessed strengths and needs of Louisiana's service system, OBH has established the following priorities for this FY:

- Increase and/or maintain access to and capacity of the state-supported behavioral health system.
- Reduce reliance on and length of stay at the state-managed intermediate care psychiatric facilities.
- Improve access to behavioral health services and engagement with physical health providers through the integration of all behavioral health care services into the existing Medicaid managed care system.
- To increase and/or maintain the quality of behavioral health services based on measurement using Healthcare Effectiveness Data and Information Set (HEDIS) specifications.

Quality and Data Collection Readiness

The Office of Behavioral Health (OBH) continues to make great strides in upgrading information technology and data systems to address the growing and changing business intelligence needs of the agency as the behavioral health service delivery system adjusts to significant transformations. On March 1, 2012, OBH entered into the Louisiana Behavioral Health Partnership (LBHP) with Magellan Health. Magellan is the Statewide Management Organization (SMO) that is responsible for implementation and management of the LBHP. The LBHP was designed to better coordinate care provided to individuals in need of specialized behavioral health services. Often mental health needs and addictive disorder needs are co-occurring, meaning individuals with one need also often have the other. The LBHP expanded access to providers by more than double, growing to approximately 1,700 providers from 800. There has also been an 87 percent increase in available adult inpatient beds since the LBHP was implemented.

Rather than accept a bid for a new three-year LBHP contract with Magellan, DHH has negotiated a shorter-term contract ending November 30, 2015. DHH announced a plan to fully integrate all behavioral health care services into its existing Medicaid managed care system (MCO) called Bayou Health. DHH is working with families, stakeholders, health care providers and legislators on this integration, which is scheduled for implementation on December 1, 2015.

OBH recognizes that the best possible outcomes are achieved when the care of the whole patient is effectively managed. By coordinating primary care and behavioral healthcare, providers will be able to look at the whole person, identifying behavioral health issues that need treatment and helping to prevent problems before they occur. Behavioral health services include treatment and prevention for both mental health and substance abuse disorders.

The OBH Business Intelligence (BI) Section serves to provide: information management and data standards development; decision support and support performance improvement initiatives; and computer/network technical support and assistance. The BI Section strives to transform data into actionable information for purposes of behavioral health service planning, quality improvement, and performance accountability. The OBH BI collects and reports on client-level data. The BI team regularly provides information, training, and technical assistance to Local Governing Entities (LGE), clinic, facility, state office, and private provider staff/personnel on how to access and utilize program data. Currently, the OBH BI takes part in the SA-TEDS and MH-TEDS reporting.

In regards to the collecting and reporting on the newly drafted client level measures, Louisiana is currently not able to collect and/or report on these measures. Barriers to data collection and reporting include, but are not limited to information systems concerns, costs to providers, cost to the state, training individuals on data collection methods, electronic health record (EHR) modification, and time required to implement change. Louisiana estimates a period of at least 12 months to modify the current information system to collect the drafted measures. In addition, coordination with the LGEs and their EHR vendors will be necessary.

Electronic Health Record System

The primary means of capturing and reporting the number and characteristics of persons served through behavioral health programs and services statewide is Magellan's proprietary Electronic Heath Record (EHR), Clinical Advisor (CA). CA is scheduled to be decommissioned on December 1, 2015. Through its integration initiative, DHH and Bayou Health support the development of EHRs; however, the state will not be providing an EHR via Bayou Health. Providers are encouraged to explore individual options for electronic records or maintain paper records. At this time, the majority of LGEs have contracted with EHR vendors (i.e., ICANotes, CareLogic-Qualifacts, SuccessEHS, and E-Clinical Works) with the remaining engaging in efforts to secure a contract.

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

OBH Data Warehouse/Business Intelligence System

Our Mental Health and Substance Use Disorder IT systems are integrated into one database/data system. OBH operates a comprehensive data warehouse/business intelligence system to provide access to and use of integrated statewide data and performance measures to managers and staff. The data warehouse is the main source of data for the URS/NOMS tables and for all statewide *ad hoc* reporting. All program data for community mental health centers, substance use disorder services/clients, state psychiatric hospitals, regional acute units, and regional pharmacies are regularly uploaded into the data warehouse and are stored in a standardized format (SAS) for integrated access, analysis, and reporting. Managers and staff have access to performance reports via a web-based interface called Decision-Support (DS) Online, which provides a suite of tools for statewide reports and downloads for local analysis and reporting. This resource significantly enhances local planning, monitoring, and evaluation. The DS Online suite includes DataQuest, an easy to use (point-&-click) *ad hoc* reporting tool, which provides virtually unlimited views of the wide range of mental health performance data, displayed in easy-to-read, comparative (relative percentage) tables, with drill-down capability from the regional to facility and service provider levels. DS Online provides access to performance score cards and reports of consumer quality of care surveys by LGE and community mental health centers. DS Online also includes DataBooks, a section of electronic spreadsheets and reports, including the latest population statistics organized by parish and LGE, and access to the annual URS Table reports which show Louisiana in comparison to other states across a wide range of important performance dimensions. OBH is in the process of upgrading the data warehouse and business intelligence system by integrating the current data from legacy systems prior to LBHP implementation to the data collected in Magellan's Clinical Advisor system.

Data Definitions and Methodology

SMI and EBD Definitions: OBH SMI and EBD population definitions follow the national definition. However, Louisiana uses the designation SMI for what is

more usually 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 the CMHS estimation methodology, applying the national prevalence rates for SMI (2.6%) and EBD (9%) directly to current general population counts to arrive at the estimated prevalence of targeted persons to be served. This method has been used since the revised rates were published in 1996.

Addictive Disorders - OBH uses the SAMHSA National Survey on Drug Use and Health (NSDUH) data, applying the most recent estimate for "*Past Year Alcohol or Illicit Drug Dependence or Abuse*" prevalence for Louisiana to current general population counts to arrive at the estimated prevalence of targeted persons to be served.

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

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

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

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

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

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

Target Populations

Mental Health Clients: Adult

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

Age: 18 years of age or older.

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

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

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

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

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

Mental Health Clients: Child/Youth

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

Age: Under age 18

Diagnosis: Must meet one of the following:

1) Exhibit seriously impaired contact with reality and severely impaired social, academic, and self-care functioning; thinking is frequently confused; behavior

may be grossly inappropriate and bizarre; emotional reactions are frequently inappropriate to the situation; or,

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

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

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

Duration: Must meet at least one of the following:

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

Addictive Disorder Clients: Adult and Adolescent

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

- Pregnant women who use drugs by injection;
- Pregnant women who use substances;
- Other persons who use drugs by injection;
- Substance using women with dependent children and their families, including females

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

Prevention Management Information System

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

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

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FY 2016-17
Combined Behavioral Health Assessment and Plan

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

SECTION III.

PLANNING TABLES

States should describe specific performance indicators that will be used to determine if the goals for that priority area were achieved. For each performance indicator, the state must describe the data and data source that has been used to develop the baseline for FY 2016 and how the state proposes to measure the change in FY 2017. States must use the template (Plan Table 1: Priority Areas by Goal, Strategy, and Performance Indicators) below.

Plan Table #1. Priority Area and Annual Performance Indicators

States should follow the guidelines presented above in Framework for Planning – Mental Health and Substance Abuse Prevention and Treatment and Planning Steps to complete Plan Table 1. States are to complete a separate table for each state priority area to be included in the MHBG and SABG. Please include the following information:

1) *Priority area* (based on an unmet service need or critical gap). After this information is completed for the first priority area, another table will appear so additional priorities can be added.

2) *Priority type*. From the drop-down menu, select **SAP –** substance abuse prevention, **SAT –** substance abuse treatment, or **MHS --** mental health service.

3) *Targeted/required populations*. Indicate the population(s) required in statute for each block grant as well as those populations encouraged, as described in IIIA *Framework for Planning—Mental Health and Substance Abuse Prevention and Treatment*. From the drop-down menu select:
SMI–Adults with SMI,
SED–Children with an SED,
PWWDC–Pregnant women and women with dependent children,
IVDUs–Intravenous drug users,
HIV EIS–Persons with or at risk of HIV/AIDS, who are in treatment for substance abuse, **TB**–Persons with or at risk of TB who are in treatment for substance abuse, and/or **Other**: Specify (Refer to section IIIA of the Assessment and Plan).

4) *Goal of the priority area*. Provide a general description of what the state hopes to accomplish.

5) *Strategies to attain the goal*. Indicate state program strategies or means to reach the stated goal.

6) *Annual Performance Indicators* to measure success on a yearly basis. For the SABG, each indicator must reflect progress on a measure that is impacted by the block grant. After this is completed with the information for the first indicator below, the table will expand to enter additional indicators. For each performance indicator, specify the following components:

(a) Baseline measurement;

(b) First-year target/outcome measurement (Progress to end of State FY (SFY) 2016);

(c) Second-year target/outcome measurement (Final to end of SFY 2017),
(d) Data source;
(e) Description of data;, and
(f) Data issues/caveats that affect outcome measures.

Plan Table 1: Priority Area and Annual Performance Indicators

Priority Area	**Behavioral Health System Transformation**
Priority Type	SAT, MHS
Population(s)	SMI, SED, PWWDC, IVDUs, HIV EIS, TB
Goal of the Priority Area	Monitor and influence access to and capacity of the state-supported behavioral health system.
Objective	Increase and/or maintain access to and capacity of the state-supported behavioral health system.
Strategies to attain the objective	Continue to implement a Medicaid managed care structure to manage all behavioral health services and effectively leverage federal dollars through a CMS 1915b waiver. The program is called the Louisiana Behavioral Health Partnership (LBHP) and is managed by Managed Care Organizations (MCOs). Continue to implement a Coordinated System of Care (CSoC) model that better coordinates and manages the behavioral health system for multi-agency involved children and youth through a CMS 1915c waiver.
Indicator #1	Continue to refine and support the Louisiana Behavioral Health Partnership (LBHP) through the Managed Care Organizations (MCOs). The MCOs enroll and reimburse for services for an increased number of mental health recipients in SFY 16 and SFY 17 as compared to those served in SFY 15.
Baseline Measurement	The number of persons receiving mental health services through the Louisiana Behavioral Health Partnership (LBHP) in SFY 15.
First Year Target/Outcome Measurement	The number of persons receiving mental health services through the Louisiana Behavioral Health Partnership (LBHP) in SFY 16.
Second Year Target/Outcome Measurement	The number of persons receiving mental health services through the Louisiana Behavioral Health Partnership (LBHP) in SFY 17.
Data Source	This data will be collected from electronic health records (EHR).
Description of Data	The unduplicated number of persons diagnosed with a mental health disorder receiving services through the Louisiana Behavioral Health Partnership (LBHP) during the SFY (July 1 – June 30).
Data Issues/Caveats	As a result of the steep implementation schedule, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with EHR vendors. This will allow OBH to better analyze data of interest to use in planning efforts.

Indicator #2	Continue to refine and support the Louisiana Behavioral Health Partnership (LBHP) through the MCOs. The MCOs enroll and reimburse for services for an increased or maintained number of substance use disorder recipients in SFY 16 and SFY 17 as compared to those served in SFY 15.
Baseline Measurement	The number of persons receiving substance use disorder services through the Louisiana Behavioral Health Partnership (LBHP) in SFY 15.
First Year Target/Outcome Measurement	The number of persons receiving substance use disorder services through the Louisiana Behavioral Health Partnership (LBHP) in SFY 16.
Second Year Target/Outcome Measurement	The number of persons receiving substance use disorder services through the Louisiana Behavioral Health Partnership (LBHP) in SFY 17.
Data Source	This data will be collected from electronic health records (EHR).
Description of Data	The unduplicated number of persons diagnosed with a substance use disorder receiving services through the Louisiana Behavioral Health Partnership (LBHP) during the SFY (July 1 – June 30).
Data Issues/Caveats	As a result of the steep implementation schedule, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with EHR vendors. This will allow OBH to better analyze data of interest to use in planning efforts.
Indicator #3	Ensure the maintenance of service delivery related to SAPT and CMHS Block Grant populations of focus. There is an increased number of persons served in each of the SAPT and CMHS Block Grant populations of focus during SFY 16 and SFY 17 as compared to those served in SFY 15.
Baseline Measurement	The number of persons served in each of the SAPT and CMHS Block Grant populations of focus during SFY 15.
First Year Target/Outcome Measurement	The number of persons served in each of the SAPT and CMHS Block Grant populations of focus during SFY 16.
Second Year Target/Outcome Measurement	The number of persons served in each of the SAPT and CMHS Block Grant populations of focus during SFY 17.
Data Source	This data will be collected from electronic health records (EHR).
Description of Data	The unduplicated number of persons with a substance use diagnosis, the unduplicated number of persons with a Serious Mental Illness (SMI), and the unduplicated number of persons with a Serious Emotional Disturbance (SED) receiving services through the management of the Statewide Management Organization (SMO) during the SFY (July 1 – June 30).
Data Issues/Caveats	As a result of the steep implementation schedule, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with EHR vendors. This will allow OBH to better analyze data of interest to use in planning efforts.

Indicator #4	Maintain statewide Coordinated System of Care (CSoC) operations in the nine regions. The MCO will serve up to 2400 children/youth statewide simultaneously during SFY 16.
Baseline Measurement	The number of children enrolled in the CSoC and receiving CSoC waiver services at the end of SFY 15.
First Year Target/Outcome Measurement	The number of children enrolled in the CSoC and receiving CSoC waiver services at the end of SFY 16.
Second Year Target/Outcome Measurement	The number of children enrolled in the CSoC and receiving CSoC waiver services at the end of SFY 17.
Data Source	This data will be collected from electronic health records (EHR).
Description of Data	The number of children who were enrolled in the CSoC and received CSoC waiver services by the end of the SFY (as of June 30).
Data Issues/Caveats	The enrollment of 2,400 children and youth statewide is based on the phase-in schedule as initially laid out by Louisiana, but the state experienced delays in statewide expansion while waiting for CMS to approve waiver amendments adding additional parishes to the program. Full statewide implementation has been in place since November 2014. There has been a steady increase in the number of children/youth enrolled in CSoC since this final expansion occurred.

Priority Area	Utilization of Inpatient Levels of Care
Priority Type	MHS
Population(s)	SMI, SED
Goal of the Priority Area	Monitor and influence utilization of inpatient levels of care.
Objective	Reduce reliance on and length of stay at the state-managed intermediate care psychiatric facilities.
Strategies to attain the objective	Employ a comprehensive discharge process to build collaborative discharges and utilize system of care approaches that leverage community-based resources. Enhance the network of community-based providers and services.
Indicator #1	The length of stay for intermediate care civil psychiatric patients admitted to OBH-managed intermediate care psychiatric facilities in the fiscal year demonstrates a decrease.
Baseline Measurement	The number of persons whose continuous length of stay is greater than 6 months for civil patients admitted to intermediate care psychiatric facilities during SFY 15.
First Year Target/Outcome Measurement	The number of persons whose continuous length of stay is greater than 6 months for civil patients admitted to intermediate care psychiatric facilities during SFY 16.
Second Year Target/Outcome Measurement	The number of persons whose continuous length of stay is greater than 6 months for civil patients admitted to intermediate care psychiatric facilities during SFY 17.
Data Source	This data will be collected from the Inpatient Hospital Database System (PIP).
Description of Data	The number of persons who were admitted to a state-managed intermediate care psychiatric facility during the SFY (July 1 – June 30) whose continuous length of stay based on the date of admission and the date of discharge from the facility is greater than 6 months.
Data Issues/Caveats	None anticipated.

Priority Area	**Primary Healthcare**
Priority Type	SAT, MHS
Population(s)	SMI, SED, PWWDC, IVDUs, HIV EIS, TB
Goal of the Priority Area	Monitor and influence engagement with physical health provider for individuals receiving behavioral health services.
Objective	Improve access to behavioral health services and engagement with physical health providers through the integration of all behavioral health care services into the existing Medicaid managed care system.
Strategies to attain the objective	The Louisiana Behavioral Health Partnership (LBHP) and the Medicaid Bayou Health plans will engage regularly in order to coordinate care for enrollees and to ensure that the systems are working together. Establish an effective linkage/referral system between the Louisiana Behavioral Health Partnership (LBHP) and the Medicaid Bayou Health plans.
Indicator #1	Percentage of Medicaid Bayou Health plan enrollees who are also enrolled in the Louisiana Behavioral Health Partnership (LBHP) during SFY 16 and SFY 17 as compared to SFY 15.
Baseline Measurement	The percentage of Medicaid Bayou Health plan enrollees who are also enrolled in the Louisiana Behavioral Health Partnership (LBHP) during SFY 15.
First Year Target/Outcome Measurement	The percentage of Medicaid Bayou Health plan enrollees who are also enrolled in the Louisiana Behavioral Health Partnership (LBHP) during SFY 16.
Second Year Target/Outcome Measurement	Not Reported. Applicable only to FY2015 and FY2016.
Data Source	This data will be collected from electronic health records (EHR).
Description of Data	The percentage of Medicaid Bayou Health plan enrollees who are also enrolled in the Louisiana Behavioral Health Partnership (LBHP) at the end of the fiscal year (as of June 30).
Data Issues/Caveats	As a result of the steep implementation schedule, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with EHR vendors. This will allow OBH to better analyze data of interest to use in planning efforts.

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

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

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

	HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #5	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD).
Baseline Measurement	For CY16, percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
First Year Target/Outcome Measurement	For CY17, percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application
Data Source	This data will be collected from the MCO databases.
Description of Data	**Denominator Description** Medicaid members 18 to 64 years of age as of December 31 of the measurement year with schizophrenia and diabetes. **Numerator Description** A hemoglobin A1c (HbA1c) test and a low-density lipoprotein cholesterol (LDL-C) test performed during the measurement year.
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #6	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC).
Baseline Measurement	For CY16, percentage of members 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.
First Year Target/Outcome Measurement	For CY17, percentage of members 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application.
Data Source	This data will be collected from the MCO databases.
Description of Data	**Denominator Description** Medicaid members age 18 to 64 years as of December 31 of the measurement year with schizophrenia and cardiovascular disease. **Numerator Description** A low-density lipoprotein cholesterol (LDL-C) test performed during the measurement year.
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of

	quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #7	Adherence to Antipsychotic medications for Individuals with Schizophrenia (SAA).
Baseline Measurement	For CY16, the percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.
First Year Target/Outcome Measurement	For CY17, the percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application.
Data Source	This data will be collected from the MCO databases.
Description of Data	**Denominator Description** Medicaid members 19 to 64 years of age as of December 31 of the measurement year with schizophrenia. **Numerator Description** The number of members who achieved a proportion of days covered (PDC) of at least 80 percent for their antipsychotic medications during the measurement year.
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #8	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC).
Baseline Measurement	For CY16, the percentage of children and adolescents 1 to 17 years of age who were on two or more concurrent antipsychotic medications.
First Year Target/Outcome Measurement	For CY17, the percentage of children and adolescents 1 to 17 years of age who were on two or more concurrent antipsychotic medications.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application.
Data Source	This data will be collected from the MCO databases.
Description of Data	**Denominator Description** Children and adolescents age 1 to 17 years as of December 31 of the measurement year with 90 days of continuous antipsychotic medication treatment during the measurement year.

	Numerator Description Members on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #9	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM).
Baseline Measurement	For CY16, percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.
First Year Target/Outcome Measurement	For CY17, percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application.
Data Source	This data will be collected from the MCO databases.
Description of Data	**Denominator Description** Children and adolescents age 1 to 17 years as of December 31 of the measurement year with at least two antipsychotic medication dispensing events of the same or different medications, on different dates of service during the measurement year. **Numerator Description** Both of the following during the measurement year: • At least one test for blood glucose or hemoglobin A1c (HbA1c). • At least one test for low-density lipoprotein-cholesterol (LDL-C) or cholesterol.
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #10	Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET).
Baseline Measurement	For CY16, the percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

	• Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
First Year Target/Outcome Measurement	For CY17, the percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Second Year Target/Outcome Measurement	Applicable to the FY2018-19 Block Grant Application.
Data Source	This data will be collected from the MCO databases.
Description of Data	**Denominator Description** Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15). **Numerator Description** Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis. --- Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).
Data Issues/Caveats	Primary care and behavioral health integration is scheduled for implementation on December 1, 2015, and maintenance/improvement of quality behavioral health services is a primary goal. Data collection for the HEDIS measures will begin December 1, 2015. This measure will be collected using calendar year (CY).
Indicators #11	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP).
Baseline Measurement	For CY16, the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

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

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

Description of Data	A standardized survey administered by designated prevention program staff at the start and completion of program. Questions specific to past 30-day use of alcohol, tobacco, and marijuana have been added to pre- and post-tests for middle and high school programs (ages 12-17). Collection is daily, monthly, and/or quarterly. Pre- and Post-Tests are administered by Scantron, matched, and scored. Reporting is annual.
Data Issues/Caveats	The survey respondent's ability to comprehend subject matter and motivation; qualification and experience of teachers and presenters; method and quality of instruction can all impact the data. The success of this indicator is measured by maintenance of abstinence or a decrease in reported past 30-day use of alcohol, tobacco, or marijuana. This indicator is contingent on funding being maintained, as well as on continued partnership with the Louisiana Department of Education (DOE).

Priority Area	**Preventing Access of Tobacco Products to Minors**
Priority Type	SAP
Populations(s)	SMI, SED, PWWDC, IVDUs, HIV EIS, TB, Other
Goal of the Priority Area	Monitor and influence the access of tobacco products to individuals under the age of 18.
Objective	Reduce the access of tobacco products to individuals under the age of 18.
Strategies to attain the objective	Oversee random, unannounced compliance inspections of tobacco retailers to determine Louisiana's non-compliance rate as required under the federally mandated SYNAR Amendment.
Indicator (1)	Maintain a non-compliance rate of no more than 20%.
Baseline Measurement	Annual SYNAR Retailer Violation Rate (RVR), as reported in 2015 Annual SYNAR Report.
First Year Target/Outcome Measurement	Annual SYNAR Retailer Violation Rate (RVR), as reported in 2016 Annual SYNAR Report.
Second Year Target/Outcome Measurement	Annual SYNAR Retailer Violation Rate (RVR), as reported in 2017Annual SYNAR Report.
Data Source	SAMHSA's required Annual Synar Report for the state of Louisiana.
Description of Data	Completed random, unannounced compliance checks conducted by the Office of Alcohol and Tobacco Control are submitted to OBH for review of accuracy. Once they are confirmed to be valid, accurate, and reliable, the results of the checks are run through statistical software to generate the state's non-compliance rate.
Data Issues/Caveats	This indicator is contingent on continued partnership with the Louisiana Office of Alcohol and Tobacco Control (OATC) and enforcement of laws and regulations specific to retail availability of tobacco products to minors.

Plan Table 2: State Agency Planned Expenditure (Substance Abuse)

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period. All expenditures should be documented for activities, services, and or persons not otherwise able to be funded by Medicaid, Medicare, other government programs (e.g., VA or TriCare) or private insurance.

Activity	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	$17,518,502		$0	$14,576,686	$81,363,576	$0	$11,570,068
a. Pregnant Women and Women with Dependent Children*	$4,031,850		$0	$0	$0	$0	$0
b. All Other	$13,486,652		$0	$14,576,686	$81,363,576	$0	$11,570,068
2. Substance Abuse Primary Prevention	$5,005,286		$0	$0	$0	$0	$0
3. Tuberculosis Services	$0		$0	$0	$0	$0	$0
4. HIV Early Intervention Services	$1,251,322		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$1,251,321		$0	$0	$0	$0	$0
13. Total	**$25,026,431**	**$0**	**$0**	**$14,576,686**	**$81,363,576**	**$0**	**$11,570,068**

* Prevention other than primary prevention ** It is important to note that 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.

Plan Table 2: State Agency Planned Expenditure (Mental Health)

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period. All expenditures should be documented for activities, services, and or persons not otherwise able to be funded by Medicaid, Medicare, other government programs (e.g., VA or TriCare) or private insurance.

Activity	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$0	$0	$0	$0	$0
6. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$11,129,686	$1,925,044	$1,466,000	$203,954,502	$0	$16,787,744
8. Mental Health Primary Prevention**		$0	$0	$0	$0	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$1,236,632	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$0	$0	$0	$0	$0	$0
13. Total	**$0**	**$12,366,318**	**$1,925,044**	**$1,466,000**	**$203,954,502**	**$0**	**$16,787,744**

* Prevention other than primary prevention ** It is important to note that 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.

Plan Table 4: SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

States must project how they will use SABG funds to provide authorized services as required by the SABG regulations. Plan Table 4 must be completed for the FY 2016 and FY 2017 SABG awards.

Expenditure Category	FY 2016 SA Block Grant Award
1. Substance Abuse Prevention* and Treatment	$17,518,502
2. Substance Abuse Primary Prevention	$5,005,286
3. Tuberculosis Services	
4. HIV Early Intervention Services**	$1,251,322
5. Administration (SSA Level Only)	$1,251,321
6. Total	**$25,026,431**

* Prevention other than primary prevention

** 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 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 CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. 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 would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Primary Prevention Planned Expenditures

Tables 5a, 5b, and 5c of the FY2016 Block Grant Application

In implementing a comprehensive primary prevention program under the Substance Abuse Block Grant, Louisiana has used a variety of strategies including but not limited to the six strategies listed below:

1) ***Information Dissemination***: This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco and drug use, abuse and addiction and their effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.
2) ***Education***: This strategy involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages) and systematic judgment abilities.
3) ***Alternatives***: This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco and other drug use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco and other drugs and therefore, minimize or obviate resort to the latter.
4) ***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.
5) ***Community-Based Process***: This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, inter-agency collaboration, coalition building and networking.
6) ***Environmental***: This strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.

In addition, prevention strategies may be classified using the Institute of Medicine (IOM) Classification Model of ***Universal***, ***Selective*** and ***Indicated***, as defined below.

Universal: Activities targeted to the general public or a whole population group that has not been identified on the basis of 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 who are identified as having minimal but detectable signs or symptoms foreshadowing disorder; or having biological markers indicating predisposition for disorder but who are not yet meeting diagnostic levels.

As a component of its responsibilities, Prevention Services also ensures that Louisiana complies with Synar legislation which requires States to: 1) enact laws prohibiting the sale and distribution of tobacco products to minors; 2) enforce such laws in a manner that can reasonably be expected to reduce the availability of tobacco products to youth under the age of 18; 3) conduct random, unannounced inspections of tobacco outlets; and 4) report these annual findings to the Secretary of the U.S. Department of Health and Human Services. The Tobacco Regulation for the SAPT Block Grant prohibits the use of Block Grant funds to enforce tobacco laws; however, funds from the 20% primary prevention set-aside allotment may be used for carrying out the administrative aspects of the requirements, such as conducting the random, unannounced inspections. The table below details the planned expenditures under the FY2016 SAPT Block Grant Award for Primary Prevention activities.

Plan Table 5a: SABG Primary Prevention Planned Expenditures

States must project how they will use SABG funds to conduct and/or fund primary prevention and §1926 related activities. Primary prevention activities are those directed at individuals who do not require treatment for substance abuse. In implementing a comprehensive primary prevention program, the state shall use a variety of strategies including but not limited to the six strategies listed on Plan Table 5a. If a state employs strategies not covered by these six strategies, they should be reported under 'Other' in a separate row for each strategy; alternatively, the state may choose to report those activities using the IOM model of universal, selective, and indicated. Note that the row entitled 'Section 1926 Tobacco" on Plan Table 5a must be completed by states reporting expenditures by the six strategies and for those reporting by IOM category. Plan Table 5a must be completed for the FY 2016 and FY 2017 SABG awards. The total amounts should equal amount reported on Plan Table 4, Row 2, and Primary Prevention.

Strategy	IOM Target	FY 2016 SA BG Award	FY 2017 SABG Award
1. Information Dissemination	Universal	$ 323,250.00	$ 323,250.00
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
2. Education	Universal	$ 3,365,116.00	$ 3,365,116.00
	Selected	$ 180,000.00	$ 180,000.00
	Indicated	$ 60,000.00	$ 60,000.00
	Unspecified	$	$
3. Alternatives	Universal	$ 49,730.00	$ 49,730.00
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
4. Problem Identification and Referral	Universal	$ 49,730.00	$ 49,730.00
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
5. Community-Based Processes	Universal	$ 630,000.00	$ 630,000.00
	Selected	$	$
	Indicated	$	$
	Unspecified	$	
6. Environmental	Universal	$ 99,460.00	$ 99,460.00

Strategy	IOM Target	FY 2016 SA BG Award	FY 2017 SABG Award
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
7. Section 1926-Tobacco	Universal	$ 248,000.00	$ 248,000.00
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
8. Other	Universal	$	$
	Selected	$	$
	Indicated	$	$
	Unspecified	$	$
9. Total Prevention Expenditures		$ 5,005,286.00	$ 5,005,286.00
Total SABG Award		$ 25,026,431.00	$ 25,026,431.00
Planned Primary Prevention Percentage		20 %	20 %

Plan Table 5b: SABG Primary Prevention Planned *Expenditures*

States must project how they will use SABG funds to conduct and/or fund primary prevention and §1926-related activities. Plan Table 5b must be completed for the FY 2016 and FY 2017 SABG awards. The total amounts for each award should equal amount reported on Plan Table 4, Row 2, and Primary Prevention.

Plan Table 5b: SABG Primary Prevention Planned Expenditures by IOM Category		
Activity	**FY 2016 SABG Award**	**FY 2017 SABG Award**
Universal Direct	$ 4,565,826.00	$ 4,565,826.00
Universal Indirect	$ 199,460.00	$ 199,460.00
Selective	$ 180,000.00	$ 180,000.00
Indicated	$ 60,000.00	$ 60,000.00
Column Total	$ 5,005,286.00	$ 5,005,286.00
Total SABG Award	$ 25,026,431.00	$ 25,026,431.00
Planned Primary Prevention Percentage	20%	20%

Plan Table 5c: SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the State BG Plans to target with primary prevention set-aside dollars from the FY 2016 and FY 2017 SABG awards.

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

Instructions: In the table below, identify the special population categories the State BG Plans to targets with primary prevention set-aside dollars.

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

Substance Abuse Block Grant Resource Development Activities Planned Expenditures

Table 6a of the FY2016 Block Grant Application

A State may plan to spend its Block Grant funds on resource development activities. Expenditures on resource development activities may involve the time of State or sub-State personnel, or other State or sub-State resources. These activities may also be funded through contracts, grants, or agreements with other entities. Resource development activities are categorized as follows:

Planning, Coordination, and Needs Assessment: This includes personnel salaries prorated for time spent in planning meetings, data collection, analysis, writing, and travel. It also includes operating costs such as printing, advertising, and conducting meetings. Any contracts with community-based organizations or local governments for planning and coordination 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.

Quality assurance: This includes activities to assure conformity to acceptable professional standards and to identify problems that need to be remedied. These activities may occur at the State, sub-State, or program level. Contracts to monitor service providers fall in this category, as do independent peer review activities.

Training (post-employment): This includes staff development and continuing education for personnel employed in local programs as well as support and coordination agencies, as long as the training relates to service delivery. Typical costs include course fees, tuition and expense reimbursements to employees, trainer(s) and support staff salaries, and certification expenditures.

Education (pre-employment): This includes support for students and fellows in vocational, undergraduate, graduate, or postgraduate programs who have not yet begun working in programs. Costs might include scholarship and fellowship stipends, instructor(s) and support staff salaries, and operating expenses.

Program development: This includes consultation, technical assistance, and materials support to local providers and planning groups.

Research and evaluation: This includes program performance measurement, evaluation, and research, such as clinical trials and demonstration projects to test feasibility and effectiveness of a new approach. These activities may have been carried out by the principal agency of the State or an independent contractor.

Information systems: This includes collecting and analyzing treatment and prevention data to monitor performance and outcomes. These activities might be carried out by the principal agency of the State or an independent contractor.

Plan Table 6a: SABG Resource Development Activities Planned Expenditures

States must project how they will use SABG funds to conduct and/or fund resource development activities. Plan Table 6a should be completed for the FY 2016 and FY 2017 SABG awards.

SABG Resource Development Activities Planned Expenditures								
State Identifier:								
	FY 2016 SA Block Grant Award				**FY 2017 SA Block Grant Award**			
	Prevention	**Treatment**	**Combined**	**Total**	**Prevention**	**Treatment**	**Combined**	**Total**
1.Planning, Coordination, and Needs Assessment	**$ 420,847.00**	**$**	**$**	**$**	**$ 420,847.00**	**$**	**$**	**$**
2. Quality Assurance	**$**	**$**	**$**	**$**	**$**	**$**	**$**	**$**
3. Training (postemployment)	**$ 255,950.00**	**$**	**$**	**$**	**$ 255,950.00**	**$**	**$**	**$**
4. Education (pre-employment)	**$**	**$**	**$**	**$**	**$**	**$**	**$**	**$**
5. Program Development	**$**	**$**	**$**	**$**	**$**	**$**	**$**	**$**
6. Research and Evaluation	**$ 156,768.00**	**$**	**$**	**$**	**$ 156,768.00**	**$**	**$**	**$**
7. Information Systems	**$ 15,000.00**	**$**	**$**	**$**	**$ 15,000.00**	**$**	**$**	**$**
8. Total	**$ 848,565.00**	**$**	**$**	**$**	**$ 848,565.00**	**$**	**$**	**$**

Plan Table 6b: MHBG Non-Direct Service Activities Planned Expenditures

States must project how they will use MHBG funds to conduct and/or fund non-direct service activities. Plan Table 6b must be completed for the planning period. States should only report the planned expenditures of the MHBG by the SMHA or programs with which they are in direct contract. States should not report on planned expenditures by programs more than one-level down from the state in funding. For example, if a state provides MHBG funds to county mental health authorities that in turn contract with private, not-for-profit mental health providers, only the planned expenditures by the SMHA and the county mental health authorities should be reported in this table.

MHBG Non-Direct Service Activities Planned Expenditures State Identifier **Planning Period - From: 07/01/2015 To: 06/30/2017**	
Service	**MH Block Grant**
MHA Technical Assistance Activities	$673,447
MHA Planning Council Activities	$179,606
MHA Administration	
MHA Data Collection/Reporting	$140,500
MHA Activities Other Than Those Above	$1,000
Total Non-Direct Services	$994,553

Comments: Figures are based on CMHS Block Grant Intended Use Plan Allocations for FY 2016. Technical Assistance Activities include Staff Development (training and technical assistance).
Data Collection/Reporting includes Consumer Monitoring and Evaluation.
Other includes Block Grant printing.

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FY 2016-17
Combined Behavioral Health Assessment and Plan

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

SECTION IV.

ENVIRONMENTAL FACTORS AND PLAN

1. The Health Care System and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions. Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease. It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions. Overall, America has reduced its heart disease risk based on lessons from a 50year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders. Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral and physical health. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care. In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions. Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges. Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs. In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the

National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care. Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes and ACOs may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

Implementation by SMHAs, SSAs and their partners of the Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. In a recent report, the Congressional Budget Office estimates that by 2018, 25 million persons will have enrolled in the Affordable Care Act Marketplace and 12 million in Medicaid and the Children's Health Insurance Program (CHIP). The Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE) estimates that more than 60 million individuals will have new or expanded access to coverage because of the Affordable Care Act, including both previously uninsured persons and those enrolled in plans that lacked adequate coverage. In 2014, non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

One key population of concern is persons who are dually eligible for Medicare and Medicaid. Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible. SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health

coverage eligibility changes due to shifts in income and employment. Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider. SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices. It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices. The Affordable Care Act provides for workforce development and training grants that may be helpful in staff retention, recruitment, and training efforts.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers. SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

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

1. *Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?*
2. *Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?*
3. *Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.*
4. *Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?*
5. *What specific changes will the state make in consideration of the coverage offered in the state's EHB package?*
6. *Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?*
7. *Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?*
8. *Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?*
9. *What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?*
10. *Indicate tools and strategies used that support efforts to address nicotine cessation.*
    - *Regular screening with a carbon monoxide (CO) monitor*
    - *Smoking cessation classes*
    - *Quit Helplines/Peer supports*
    - *Others_____*
11. *The behavioral health providers screen and refer for:*
    - *Prevention and wellness education;*
    - *Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,*
    - *Recovery supports.*

Integration

The Department of Health and Hospitals (DHH) currently provides physical health services to Medicaid and Louisiana Children's Health Insurance (LaCHIP) enrollees through a Medicaid managed care delivery system, called Bayou Health, and specialized behavioral health services to Medicaid and non-Medicaid enrollees through the Louisiana Behavioral Health Partnership (LBHP), which operates as a carve-out managed care delivery system administered by a Statewide Management Organization.

In November 2014, DHH announced a plan to integrate behavioral health care services into Bayou Health to improve care coordination for Medicaid 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. Through integration, the Department will be able to build upon the successes realized over the last three years through the LBHP, such as enrolling an

entirely new behavioral health provider network and expanding Medicaid-allowable services to include addiction treatment and services for high-risk populations.

As the Department works collaboratively to integrate specialized behavioral health services (including both mental and substance use services) within the Bayou Health program, there are four key principles, listed below, that serve as important guide posts.

- Behavioral healthcare needs have a significant impact on both an individual's overall well-being and healthcare costs and should therefore be integrated into and coordinated by one accountable entity.
- Information should flow smoothly between payers and all provider types to ensure effective and informed clinical decision making by multi-disciplinary care teams.
- Every effort should be taken to reduce unnecessary administrative burdens on providers, allowing them to focus on delivery of services, care coordination, and case management.
- Contracts must promote accountability for delivery of needed care, improving quality and outcomes and lowering overall healthcare costs without restricting needed access.

In addition, the Department will carry forward safeguards for patients and providers into the integrated system, including but not limited to network adequacy requirements; requirements to make good faith effort to contract with significant, traditional providers from legacy Medicaid; robust appeals and grievance processes; prompt pay standards for clean claims; medical loss ratios; outcomes and performance reporting; financial transparency requirements; transition of care requirements; and standards for timely submission of encounter data.

Furthermore, the Department is also developing additional patient protections that are more specific to behavioral health including, but not limited to:

- Increased and specific monitoring to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA)
- Fidelity monitoring of evidence-based practices
- Behavioral-health focused staffing additions to the health plans

In addition, the Office of Behavioral Health plans to contract with an Administrative Service Organization (ASO) that is capable of implementing a system of service management inspired by the Health Home Model for the non-Medicaid population in need of behavioral health services in outpatient, residential, and acute care settings for both mental health and substance use disorders. The ASO would be responsible for ensuring that the non-Medicaid population receives services that are comparable, given available funding sources, to those received by the Medicaid population

Nicotine Dependence/Smoking Cessation

The Office of Behavioral Health (OBH) developed a partnership with the Office of Public Health (OPH) and other stakeholders to address the needs of individuals with behavioral health

conditions and tobacco/nicotine dependency. This team participated in the *Smoking Cessation Leadership Academy,* and as a part of their participation developed a strategic plan targeting a 5% reduction in smoking prevalence among those diagnosed with behavioral health conditions by 2020. Initiatives included but are not limited to:

- Enhancement of data collection capability to identify smokers with behavioral health conditions and/or complications through various methods (i.e., electronic health records, Louisiana Quit Line, and Fax to Quit demographic/screening tool),
- Increasing assessment and treatment through the Ask, Advise, Refer (AAR) model, evidenced based screenings, assessments, individual counseling, group therapies, nicotine replacement therapy and referrals,
- Increasing outreach and awareness of tobacco cessation resources, and
- Special attention to the nicotine dependence assessment/treatment through the Statewide Management Organization contract/RFP, Memorandums of Understanding with the Local Governing Entities, and monitoring through the Accountability Implementation Plan (AIP).

Smoking Cessation Protocol for Hospitals

In March 2013, Louisiana mental health hospitals developed policies and procedures to address nicotine usage among behavioral health patients. The procedures below are used to address nicotine usage:

- All patients are asked questions concerning about their tobacco use as a part of their intake interview.
- Patients who have not used tobacco in the past two weeks are provided informational material relative to tobacco policy and treatment options.
- Patients who have smoked tobacco in the past two weeks are administered the Fagerstrom Test for Nicotine Dependence (FTND).
- Patients who are smokeless tobacco users are administered the Fagerstrom Test for Nicotine Dependence – Smokeless Tobacco (FTND-ST).
- FTND or FTND-ST scores determine if additional assessment and treatment options are offered.

Since Louisiana has adopted 100 percent tobacco-free hospital facilities, only newly admitted individuals are assessed for current use using the steps identified above. Current patients are screened upon admission and then screened every 30 days for depression and/or anxiety that may be related to tobacco cessation. Since these individuals are in an inpatient setting, they do not have access to tobacco; carbon monoxide monitoring is therefore not necessary.

Prevention and Wellness Education

The OBH has promoted and organized events related to behavioral health and substance use. Historically, attendees include LGE staff, central office staff, citizens, and stakeholders. Topics, include but are not limited to:

- National Problem Gambling Awareness Month,
- Alcohol Awareness Month,
- Mental Health Month and Child Mental Health Week,
- National Prevention Week,
- Post-Traumatic Stress Disorder Awareness Week,
- National Recovery Month,
- National Suicide Prevention Week, and
- Domestic Violence Awareness Month

2. Health Disparities

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

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

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

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states are routinely asked to define the population 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 being served or 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 be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

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

1. *Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?*
2. *Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.*
3. *Are linguistic disparities/language barriers identified, monitored, and addressed?*
4. *Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.*
5. *Is there state support for cultural and linguistic competency training for providers?*

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

In an effort to identify any unmet service needs in the service delivery system, the Department requires the Statewide Management Organization (SMO) to collect and report on current and desired utilization trends, including prevalent diagnoses, age, gender, and race/ethnicity characteristics of the enrolled population by region. Further, the Department requires the SMO to take affirmative action to ensure that members are provided covered services without regard to race, color, creed, gender, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program members, or disability. Examples of prohibited practices include, but are not limited to the following:

- Denying or not providing to a member any covered service or availability of a facility.
- Providing to a member any covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large.
- Discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay members.

In addition, the Department requires the SMO to assess and the cultural and linguistic needs of members and deliver services that address these needs to the extent resources are available. This is accomplished by the Statewide Management Organization through:

- Assessing the cultural competence of network providers at least annually.
- Assessing member satisfaction of the services provided as it pertains to cultural competency at least annually.
- Assessing provider satisfaction of the services provided by the SMO at least annually.
- Requiring and providing training on cultural competency, including tribal awareness, to staff and providers for a minimum of three hours per year.
- Providing a language line translation system for callers whose primary language is not English and a TDD and/or relay system, which must be available 24/7/365.
- Providing written member material in alternate formats and languages.

The SMO's Race and Equity Committee, which includes DHH representatives, also reviews and analyzes program data to evaluate racial and ethnic disparities in utilization patterns, outcomes, satisfaction, and provider cultural competency.

3. Use of Evidence in Purchasing Decisions

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse 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 Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

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

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (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 substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[70] was developed to help move the latest information available on effective behavioral health practices into community-based

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

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

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

The OBH utilizes programmatic staff to track and disseminate information regarding evidence-based or promising practices. In order to ensure that assessments and treatment practices utilized statewide are evidence based and approved by the Office of Behavioral Health, a workgroup was convened to review nationally recognized interventions and make appropriate recommendations. An outcome of the workgroup's effort is an OBH-developed document titled "Evidence Based Practice Guidance." This document is disseminated to LGEs as required by the Memorandum of Understanding. The OBH also collaborates with other agencies, foundations, and/or grant funding sources to ensure monitoring of EBPs through contract monitoring and the AIP.

It is the practice of the OBH to ensure utilization of evidence-based or promising practices in service delivery. As such, during purchasing and/or policy decision-making, OBH takes efforts to identify evidence-based or promising practices for use throughout the State considering access to services, client outcomes, and cost allocations. One such example is the implementation of the Coordinated System of Care (CSoC) program that is based upon research-based standards from the National Wraparound Initiative. As with this program and others, the SMA and other purchasers were consulted to discuss fiscal impact and client outcomes. The value-based purchasing strategies listed below have been adopted by Louisiana and will be realized even more through the integration of physical and behavioral health services:

- Leadership support
- Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions
- Use of financial incentives to drive quality
- Provider involvement in planning value-based purchasing
- Gained consensus on the use of accurate and reliable measures of quality
- Quality measures focus on consumer outcomes rather than care processes
- Development of strategies to educate consumers and empower them to select quality services
- Creation of a corporate culture that makes quality a priority across the entire state infrastructure

4. Prevention for Serious Mental Illness

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood. The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up. In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent. The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques. This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

It is important to note that 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.

Please indicate areas of technical assistance needed related to this section

In addition to First Episode Psychosis programming being implemented using the 5 percent set aside, Louisiana has addressed the needs of young people at high clinical risk or in the early stages

of mental disorders with psychosis through training of providers. Namely, the SMO, in conjunction with two Louisiana-based universities (Tulane and Louisiana State University), has financed the training of a workforce of licensed therapists on two evidence-based therapies for children under age 6 years old. The current network of trained providers consists of approximately 130 licensed therapists (LPC, LMSW/LCSW, PhD) available statewide. These therapies include:

Parent-Child Interaction Therapy (PCIT) is a treatment program developed for children aged two to seven years with externalizing behavior disorders. In PCIT, parents are taught specific skills to establish or strengthen a nurturing and secure relationship with their child while encouraging prosocial behavior and discouraging negative behavior. This treatment has two phases, each focusing on a different parent-child interaction: child-directed interaction (CDI) and parent-directed interaction (PDI). In each phase, parents attend one didactic session to learn interaction skills and then attend a series of coaching sessions with the child in which they apply these skills. During the CDI phase, parents learn nondirective play skills similar to those used in play therapy and engage their child in a play situation with the goal of strengthening the parent-child relationship. During the PDI phase, parents learn to direct the child's behavior with clear, age-appropriate instructions and consistent consequences with the aim of increasing child compliance. Ideally, during coaching sessions, the therapist observes the interaction from behind a one-way mirror and provides guidance to the parent through a "bug-in-the-ear" hearing device. PCIT is generally administered in 15 weekly, one-hour sessions in an outpatient clinic by a licensed mental health professional with experience working with children and families.

Positive outcomes include: improved child behavior and decreased externalizing symptoms. SAMSHA review of CPP on the NREPP registry can be accessed at: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=23

Parent Management Training (PMT) is a locally-adapted version of PCIT, delivered by Tulane faculty who themselves have direct training from the developers of PCIT.

Child-Parent Psychotherapy (CPP) is an empirically supported intervention and treatment for children from birth through age 5 who have experienced at least one traumatic event and, as a result, are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) in order to restore the child's sense of safety, attachment, and appropriate affect and improve the child's cognitive, behavioral, and social functioning. CPP makes specific use of a trauma lens that needs specialized treatment because of cumulative trauma experienced by the dyad.

Positive outcomes include: decreased child PTSD symptoms and decreased child behavior problems. SAMSHA review of CPP on the NREPP registry can be accessed at http://nrepp.samhsa.gov/ViewIntervention.aspx?id=194

5. Evidence-Based Practices for First Episode Psychosis

The Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress through its FY 2016 Omnibus bill, Public Law 114-113, to set aside 10 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based programs that provide treatment for those with early serious mental illness (SMI) and a first episode psychosis (FEP) – an increase from the previous 5% set aside. This additional 5 percent increase to the set-aside is over the FY 2015 level. The appropriation bill specifically requires the 10 percent set-aside to fund only those evidence-based programs that target FEP. The law specifically stated:

> *"…..the funds from set-aside are only used for programs showing strong evidence of effectiveness and targets the first episode psychosis. SAMHSA shall not expand the use of the set-aside to programs outside of those that address first episode psychosis."*

Previous appropriation language (P.L. 113-76 and P.L. 113-235) allowed the use of set aside funds for individuals with early SMI, including those without psychosis. However, the new language specifically requires states to focus their efforts only on FEP.

States that are currently utilizing FY 2016 set-aside funds for early SMI other than psychosis must now refocus their efforts to service only those with FEP. SAMHSA will allow states that already signed a contract or allocated money to their providers using the FY 2016 funds to complete these initiatives through the end of their contract or by the end of September 30, 2016, whichever comes first. States may continue to support these efforts using the general MHBG funds; however, the set-aside allocation must be used for efforts that address FEP. Nothing precludes states from utilizing its non-set-aside MHBG funds for services for individuals with early SMI.

If states have other investments for people at high risk of SMI, they are encouraged to coordinate those programs with early intervention programs supported by the MHBG. This coordination will help ensure high risk individuals are swiftly identified and engaged in evidence-based services should they develop into diagnosable SMI. Please note that the MHBG funds cannot be used for primary prevention or preventive intervention for those at high risk of SMI.

States can implement models which 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, every state should be able to begin to move their system toward earlier intervention, or enhance the early intervention services already being implemented.

SAMHSA and NIMH in conjunction with National Association of State Mental Health Program Directors (NASMHPD) will continue to ensure that technical assistance and technical resources are available to states as they develop and implement their plan.

SAMHSA proposes to implement this 10 percent set-aside through a "request for revision of the 2016-17 MHBG plan." States will be required to revise their two-year plan to propose how they will utilize the 10 percent set-aside funding to support appropriate evidence-based programs for individuals with FEP. Upon submission, SAMHSA will review the revised proposals and consult with NIMH to make sure they are

complete and responsive. If a state chooses to submit a plan to utilize the set-aside for evidence-based services other than the services/principles components of Coordinated Specialty Care (CSC) approach developed via the RAISE initiative, SAMHSA will review the plan with the state to assure that the proposed approach is evidence-based. With consultation from NIMH as needed, the proposals will be either accepted, or requests for modifications to the plan will be discussed and negotiated with the State. SAMHSA will notify each State once the revised proposals are approved.

This initiative also includes a plan for program evaluation and data collection related to demonstrating program effectiveness. SAMHSA is also required within six months of the appropriations statute enactment to provide a detailed table showing at a minimum each State's allotment, name of the program being implemented, and a short term description of the program. Additional technical assistance and guidance on the expectations for evaluation, data collection and reporting will follow.

States must submit their proposal into the FY 2016-2017 Block Grant Application under Section III. Behavioral Health Assessment and Plan, C. Environmental Factors and Plan, #5. Evidence-Based Practices for First Episode Psychosis. The state must revise the following for the 10 percent set-aside for first episode psychosis:

1. *An updated description of the states chosen evidence-based practice for the 10 percent set-aside initiative.*
2. *The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.*
3. *A budget showing how the set-aside and additional state or other funds, if any, will be utilized for this purpose.*
4. *The states provision for collecting and reporting data, demonstrating the impact of this initiative.*
5. *Any foreseen challenges.*

Louisiana Plan for FEP Implementation and Current Status

Adolescence and early adulthood can be considered a developmentally vulnerable time. During this time, as youth may move from the safety net of home, they strive toward more independence and self-identity and to create social relationships. Developmental research indicates that adolescents and young adults focus on the external world and friends, as the immediate family serves a valuable, but less central role. The onset of psychotic disorders typically occurs during adolescence and early adulthood. According to the National Alliance on Mental Illness (NAMI), young adults, or those within the 15 to 30 age range, are the most common age group to be at risk for their first episode of psychosis. Experiencing the onset of this serious mental illness further complicates this already vulnerable and challenging time.

In 2014, Louisiana developed a proposal to establish a program capable of addressing the needs of adolescents or young adults experiencing their first episode of psychosis. This approved plan incorporated a two-pronged approach that included: 1) the integration of Peer Support Specialists working as members of clinical teams operating within a Local Governing Entity (LGE)-operated or contracted behavioral health clinic within each of the 10 LGEs of the state and 2) outreach and training. Subsequent to approval and implementation, the plan was expanded to include the completion of a readiness needs assessment, which analyzed the LGEs' existing

service system and their capacity to integrate a program design with full fidelity to the RAISE program.

Funding was originally provided to each of the LGEs to hire and train Peer Support Specialists who were capable of working with the target population. The integration of PSS, as an evidence-based practice, into the existing clinical treatment infrastructure was considered the first phase in developing and enhancing the service delivery system, moving those LGEs with the capacity to do so, toward a model more consistent with RAISE. Though the majority of LGEs within the state have been able to identify Peers for this program, others have utilized existing staff in this initiative.

For the first phase of implementation, Louisiana enlisted Rutgers University for training and consultation. Through an initial needs assessment of each LGE, conducted by Rutgers University staff, the state was better able to identify each LGE's readiness to implement an FEP program and training needs. Subsequent to the completion of the needs assessment, a training series was developed and implemented through which participants were provided information about FEP, tenants of the RAISE model were explored, and best practices regarding the provision of services were reviewed. The trainings included a series of two (2) face-to-face trainings, each held in three areas of the state, and a series of webinars. Training participants included PSS, LGE staff, and Assertive Community Treatment (ACT) providers. ACT providers were included to further the system's capacity to serve this population. Through this training series, 232 individuals from throughout the state have been trained. Additionally, the webinars were recorded and have subsequently been shared for future viewing by staff not able to participate in the live trainings. The PowerPoint presentations from the trainings have also been shared with staff. The schedule of completed trainings is as follows:

- Understanding RAISE: Services for Young People Experiencing FEP (face-to-face)
- FEP - Engaging Youth (webinar)
- FEP - Understanding Change (webinar)
- FEP - Goal Setting (webinar)
- FEP - Facilitating Change (webinar)
- Assessing and Facilitating Change While Utilizing the Psychiatric Rehabilitation Readiness Determination Profile (PRRDP) Process (face-to-face)

Thus far, two (2) LGEs have been identified to implement a FEP program utilizing the RA1SE/Navigate model. In addition, OBH is in discussions with two (2) other LGEs regarding implementing a RA1SE/Navigate program within their catchment areas. All other locations in the state have chosen a public health model for program implementation. Through the public health model, the LGEs will utilize their peers to act as a bridge between clinicians, individuals experiencing FEP, and collaborative partners within the community. The intention is to improve the capacity to effectively serve the population by existing staff without modifications to clinical structures, while outreach and education efforts will provide increased identification and referral into treatment services.

As the Louisiana FEP program continues, activities will include additional training and support for LGEs to establish their capacity to serve individuals under the model of implementation they have selected.

Planned Activities for 2016 & 2017

The next phase of program implementation will result in the following activities:

- Peer Support - Continued support of PSS in each of the 10 LGEs for this initiative.
- Training - continued training of staff throughout the state. This training schedule will include the following and will be available to those locations implementing the RA1SE/Navigate and the Public Health models of programming:
    - ***RA1SE/Navigate*** - Training of staff within at least two (2) LGEs of the state on the RA1SE/Navigate model. Subsequent to this training, each LGE trained will have at least one (1) team capable of providing services congruent with fidelity to the program.
    - ***Prescriber*** - Training of prescribers throughout the state regarding best practices as it relates to prescribing and treating the population of focus.
    - ***Public Health*** – Training of staff within those LGEs which are implementing a Public Health approach to FEP implementation. Coordination will occur between RA1SE/Navigate and Public Health trainers to ensure continuity of material taught, with relevant topics offered to all LGEs regardless of the model being implemented. Examples of trainings can include, but are not limited to, Cognitive Remediation, Foundations of Psychiatric Rehabilitation, and Career Development/Supported Education.
- Outreach – Development and distribution of outreach materials for individuals experiencing FEP and their families. Materials will be in line with that which is available through On Track NY and other established evidence-based FEP programs.
- Ongoing Technical Assistance – Through contracts with consultants, provide on-going technical assistance to LGEs throughout the state, supporting them as they implement their selected FEP model:
    - ***RA1SE/Navigate*** – ongoing conference calls with each of the LGEs implementing the RA1SE/Navigate model for 12 months post training.
    - ***Public Health*** – ongoing assistance to each of the LGEs implementing this model to better help them develop programming which will meet their individualized needs.

As indicated previously, the goal of the Louisiana plan for FEP implementation is to increase capacity of the system to effectively serve and identify individuals experiencing First Episode Psychosis throughout the state while identifying and providing training to those locations capable of implementing full RAISE programs. It is the hope that as LGEs learn more about FEP and treatment strategies, additional locations will modify structures to be able to implement programs of their own, expanding the number of EBP programs in state. As the programs evolve, additional considerations in regard to the integration with managed care will need to be

considered and addressed in implementation activities. This includes training Medicaid and Managed Care Organizations (MCOs) on the utilization of FEP as an evidence-based practice and any subsequent considerations regarding the authorization of services.

Budget for 2016 & 2017 Activities

Peer Support Specialist (PSS) Salaries* ($20,000 x 10 PSS)	$200,000
Travel for PSS to participate in training ($1,000 x 10 PSS)	$ 10,000
Support of RA1SE/Navigate programs**	$200,000
Training and Supplies	$208,316
Total	$618,316

*LGEs are encouraged to match or supplement the PSS salaries. With LGE salary supplements, PSS move from 0.5 FTE (20 hours per week) to 1.0 FTE (40 hours per week).
**Costs are estimated based on LGEs interest and ability to accept funds based on their budget authority approved by the state legislature; those dollars not utilized in this capacity will transition to the Training and Supplies category of the budget.

Data Collection and Reporting
The state's provision for collecting and reporting data will occur through program staff with the LGEs working with the FEP initiative in their areas. The below information is sent to OBH bi-monthly and received via the OBH data warehouse.

Additional measures can be added as deemed appropriate with program expansion. Upon implementation of RAISE programming, additional outcome data will be tracked. Specific data components can include Hospitalization Rates, Emergency Room presentation, and Number of Days Absent from School (which is reported during admission, assessment, and discharge).

Analyses will also occur in regard to number and frequency of encounters with the varying types of clinicians within the FEP program on a local level.

Program Outcome	Variables Monitored	Assessment Tool/ Method of Analysis	Frequency of Monitoring
Client Level Data	Gender	OBH Data Warehouse	Baseline Assessment
	Age	OBH Data Warehouse	Baseline Assessment
	Race	OBH Data Warehouse	Baseline Assessment
	Diagnosis	OBH Data Warehouse	Baseline Assessment and Post Program Assessment
	Employment Status	OBH Data Warehouse	Baseline Assessment and Post Program Assessment

	Education Level	OBH Data Warehouse	Baseline Assessment and Post Program Assessment
	Service Use	OBH Data Warehouse	Ongoing Assessment
	Program Satisfaction	Survey Derived from Telesage Outcome Measurement Survey (TOMS) Instrument	Ongoing Assessment
FEP Program Workforce Development	PSS Identified	Frequency Count	Ongoing Assessment
	PSS Certifications Received	Frequency Count	Ongoing Assessment
	RA1SE/Navigate programs Identified	Frequency Count	Ongoing Assessment
	RA1SE/Navigate programs Trained	Frequency Count	Ongoing Assessment
	FEP Trainings Conducted	Frequency Count	Ongoing Assessment
	Number in Attendance at each FEP Training	Frequency Count	Ongoing Assessment
Outreach	Number of Educational Events Held	Frequency Count	Ongoing Assessment
	Number of Outreach Materials Distributed	Frequency Count	Ongoing Assessment
	Number of Individuals referred to the FEP program	Frequency Count	Ongoing Assessment

6. Participant Directed Care

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program.

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

The Access To Recovery (ATR) program offers clinical and recovery support services to persons experiencing substance use disorders. ATR has utilized a voucher system since 2005. Each individual receives a six month voucher upon admission. Those served have freedom of choice upon admission and are informed that they can select another provider at any time during the life of the voucher. In this way the services follow the individual, rather than being attached to a service provider. Vouchers also allow individuals served to elect to receive clinical services with one provider and recovery support services with a different provider, tailoring treatment to individual needs. Likewise, if an individual moves to a different geographic area, they can easily select a provider nearby without an interruption of treatment. Medicaid does not cover recovery support services, only clinical treatment. However persons eligible for Medicaid can receive a voucher for recovery support services only. Providers are able to bill directly using the electronic ATR system by entering service data.

The 2014 GPRA Outcomes Data showed an eighty-seven percent rate of abstinence upon discharge (twenty-seven percent reported at admission) for those in the program. Likewise employment/education status, social connectedness and stable housing increased.

In addition to quarterly programmatic monitoring, ATR monitors provide technical assistance to treatment providers as part of the overall quality improvement efforts of the program. General and issue specific TA has resulted in overall policy compliance of eighty-five percent.

A unique strength of the program is the use of faith-based providers. Faith and spiritual supports are an integral part of the culture of Louisiana. Over sixty percent of residents report strong religious beliefs and forty-six percent attend church weekly. The inclusion of faith-based providers and spiritual support and pastoral counseling as recovery support services is an important part of the ATR program in our state and part of OBH efforts to assure culturally competent assistance.

7. Program Integrity

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 and premium payments, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 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. If a state chooses to allow the use of block grant funds for these purposes, specific policies and procedures for assuring compliance with the funding requirements must be in place. Under 42 USC § 300x–55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management.*

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. 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 mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required 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 consider the following items as a guide when preparing the description of the state's system:

1. ***Does the state have a program integrity plan regarding the SABG and MHBG funds?***

OBH utilizes a number of strategies in order to ensure Block Grant program integrity. The Local Governing Entities (LGEs) collect Block Grant information from local provider organizations and

conduct onsite visits to validate the information provided. OBH staff reviews a sample of clinical records to document clinical practices and compliance with Block Grant requirements. In addition, OBH requires the inclusion of the Standard Provisions Document for all contracts that involve the provision of services funded by the Block Grant. This Standard Provisions Document outlines all contractual requirements, including all Block Grant requirements. To ensure block-grant funds are allocated appropriately, OBH also requires that a Medicaid application be completed on everyone presenting to the clinics. In addition, the billing system is configured to ensure the appropriate payer is billed for services.

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

Yes, the OBH has created and implemented the Standard Provisions Document, which is utilized statewide and assures that federal requirements are conveyed to all Local Governing Entities (LGEs) and LGE/State contracted providers. The document is inclusive of all SABG and MHBG requirements and includes some other related agreements. For applicable OBH/LGE contracts, the Standard Provisions Document is a required addition.

3. ***Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:***
   a. ***Budget review;***
   b. ***Claims/payment adjudication;***
   c. ***Expenditure report analysis;***
   d. ***Compliance reviews;***
   e. ***Client level encounter/use/performance analysis data; and***
   f. ***Audits.***

OBH is considered a "pass-through entity", which means a non-Federal entity that provides a federal award to a sub-recipient to carry out a federal program. Local Governing Entities (LGEs) are the sub-recipients of the Block Grant funds. OBH uses the following program integrity activities to monitor the LGEs' appropriate use of Block Grant funds:

- OBH monitors the LGEs' use of Block Grant funds through reporting, site visits, regular contact, or other means to provide reasonable assurance that the LGE administers the federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.
- OBH ensures that the LGE is responsible for identifying, in its accounts, all Block Grant awards received and expended and for maintaining internal control over the Block Grant funds that provides reasonable assurance that the LGE and its contractors are managing the awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on its programs.
- LGEs' providers that expend more than $100,000 in funding from OBH during the fiscal year must meet DHH audit requirements. In addition, the LGE providers must meet OMB

Circular A-133 audit requirements if expending $500,000 or more in federal awards during the fiscal year. The audits must be completed within nine months of the end of the LGEs audit period. A management decision on audit findings must be submitted within six months after receipt of the audit report. The LGEs must ensure their providers take timely and appropriate corrective action on all audit findings. In cases of continued inability or unwillingness of the LGEs or the providers to have the required audits, the State through the LGEs shall take appropriate action using sanctions.

- OBH reviews all financial and performance reports submitted by the LGEs and their providers.
- OBH performs site visits on LGEs and their providers to review financial and programmatic records and observe operations.
- OBH ensures that the LGEs identify and investigate irregular transactions during the monitoring and audit processes.
- OBH continues implementation of the Human Services' Accountability and Implementation Plan (AIP) which outlines the criteria process, timelines, and guidelines for planning, monitoring, and providing accountability in the delivery of mental health and addictive disorders services. The AIP also sets forth the guidelines for the provision of technical assistance and training in the support of the delivery of services.

Please indicate if the state utilizes any of the following monitoring and oversight practices:

a. Budget review:

The State requires the LGE to submit annual budget plans for funding of cost for services provided. LGEs are required to submit annual Block Grant Intended Use Plans (IUPs) for the projected State Fiscal Year (SFY). Annual budget requests are subject to review and approval. LGEs are expected to operate within their budget allocation by means of financing and reporting budget expenditures.

b. Claims/payment adjudication:

Claims are traced through the applicable systems on a test basis to verify whether claims are properly adjudicated. The state through its Statewide Management Organization has processes in place that identifies adjudicated claims to final disposition and accounts for non-adjudicated and other pending claims.

c. Expenditure report analysis:

LGEs must maintain an accounting system that contains complete and accurate records that will justify and document all expenditures, reflect all accruals, and provide a clear audit trail to the point of origin. Reports are generated monthly, quarterly, and annually and are used to evaluate and monitor program effectiveness and efficiency of cost. The State also utilizes the LGEs' IUPs to compare to actual expenditures. The State will pursue recoupment in the event there is an adverse audit finding or disallowance of expenditures.

d. Compliance reviews:

The State conducts monitoring activities of all behavioral health services provided by the LGE to ensure compliance with federal and state statues, regulations, and funding requirements. A review of the Surveillance and Utilization Review System (SURS), Health Standards and/or fraud investigation is conducted when necessary.

e. Encounter/utilization/performance analysis:

The State ensures that the LGEs monitor the claims process through the testing of encounters and utilization reports. Testing includes verifications of eligibility, claims and other performance indicators.

f. Audits:

The State requests copies of most recent financial statement audit (including single audit) and current audit engagement agreement to monitor the progress and completion of any reported items and follow-up on any findings that may impact the provider's ability to adequately administer Block Grant funds.

4. ***Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.***

The State requires the LGEs and their providers maintain an accounting system that contains complete and accurate records that will justify and document all expenditures, reflect all accruals, and provide a clear audit trail to the point of origin. Reports are generated monthly, quarterly, and annually and are used by the state to evaluate and monitor program effectiveness and efficiency of cost. The State also utilizes the LGEs' Intended Use Plans to compare to actual expenditures. The State will pursue recoupment in the event there is an adverse audit finding or disallowance of expenditures.

5. ***Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?***

The State offers workforce development opportunities to providers that include in-service trainings, instructional forums, online training opportunities through Essential Learning, peer-to-peer reviews, and a set of provisions and requirements that is included with contracts and includes all relevant Block Grant-related requirements. As a result, each provider has a set of safety standards and policies and procedures in place to ensure safety and quality in their operations.

6. ***How does the state ensure block grant funds and state dollars are used for the four purposes?***

The State monitors methodologies of systems and procedures of the Local Government Entity (LGE) and its contractors. The State utilizes a Statewide Management Organization (SMO) to manage behavioral health services for the uninsured. The LGE is responsible for coordinating with

the SMO within the Louisiana Behavioral Health Partnership (LBHP) to manage the uninsured non-Medicaid population. This includes, but is not limited to the following:

- Requesting service authorization from the SMO for all services except for pass through services that do not require service authorization
- Inputting " *shadow"* claim and encounter data into the SMO claims system. A " *shadow"* claim requires the same data and information as the normal Medicaid claims process; however, an actual Medicaid claim is not generated since the member is uninsured. Instead, a " *shadow"* claim is created and submitted to the SMO for the purposes of ensuring appropriate care management by the SMO and confirming Medicaid eligibility/ineligibility
- Coordinating needs assessment activities with the SMO relative to network capacity and expansion, and providing information on or collaborating with the SMO regarding network sufficiency

8. Tribes

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.

*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. In further recognition of strengthening state/tribal relations, tribal governments shall not be required to waive sovereign immunity as a condition of receiving block grant funds or services. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. 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.*

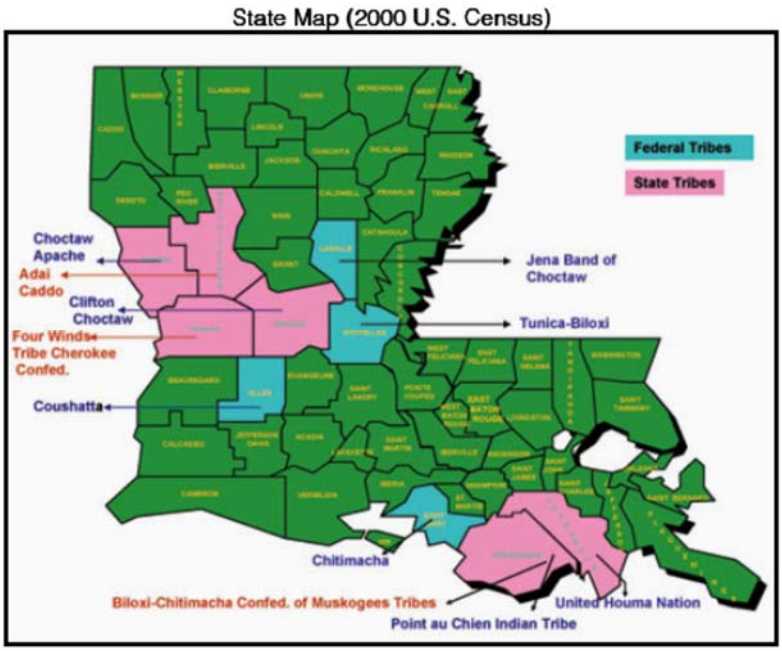
Please consider the following items as a guide when preparing the description of the state's system:

1. *Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.*
2. *Describe current activities between the state, tribes and tribal populations.*

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

In the state of Louisiana, there are four federally recognized Native American tribes that include the Chitimacha Tribe in Charenton, the Tunica-Biloxi Tribe in Marksville, the Coushatta Tribe in Elton, and the Jena Band of Choctaw Indians in Trout. According to the 2013 US Census estimates, the Louisiana population is 0.8 percent Native American.

In addition to the federally recognized tribes, Louisiana also has several state recognized tribes (see figure). The Governor's administration established the Governor's Office of Indian Affairs, which is charged with administering the programs relative to Louisiana Indian tribes and is designated as the official negotiating agent of the State upon which federally recognized tribes in the state of Louisiana may serve notice of any request to negotiate state tribal compacts. In an effort to provide an official voice and gather input from the local tribes to the State government, the Office of Indian Affairs is further charged with collecting facts and statistics as well as conducting special studies of conditions pertaining to the employment, health, education, financial status, recreation, social adjustment, or other conditions affecting the welfare of the Indian people. In addition, the Office submits an annual report to the legislature and to the governor to better inform State government and to establish a mutual exchange of ideas and information with the tribal entities. Further, the Office of Indian Affairs provides supplemental scholarships to American Indian students from Louisiana tribes.



A recent change to the Louisiana Behavioral Health Advisory Council (LBHAC) has been the inclusion of representatives of special populations, including a representative of a federally recognized tribe, in the Council membership composition. The Council, along with several of the local Regional Advisory Councils (RACs) have taken on the responsibility of reaching out to other Native American representatives. An ongoing goal is to recruit additional representatives from tribal communities to participate in the advocacy associated with the Advisory Council activities. Continued community level assessment is needed to determine the best approaches to successfully reaching this population.

In an effort to sustain collaborative relations with local tribes and to comply with the requirements of the Americans Recovery and Reinvestment Act of 2009 (ARRA), the Department of Health and Hospitals notifies Louisiana Indian tribes of major healthcare reforms; current initiatives (e.g., community preparedness response network, EHR, integration of physical and behavioral health); and changes, such as amendments and renewal requests. The Louisiana DHH identified and established key contacts and communications with tribal leaders in the federally recognized tribes. For several of these tribes, there are established collaborative relationships between the tribe and local levels of the state agencies. Specific areas of need and aspects of the service delivery system have been developed to target areas of domestic violence, child abuse

prevention, access to substance abuse rehabilitation, counseling, delinquency, and many other social problems. For each of the federally recognized tribal areas, there is a federally funded health center that provides some essential services. Some of these tribal areas have developed specialty treatment centers to target behavioral health issues.

9. Primary Prevention for Substance Abuse

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG 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 abuse. The program must include, but is not limited to, the following strategies:

- ***Information Dissemination*** *provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.*
- ***Education*** *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 capabilities. There is more interaction between facilitators and participants than there is for information dissemination.*
- ***Alternatives*** *provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.*
- ***Problem Identification and Referral*** *aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does* ***not*** *include any activity designed to determine if a person is in need of treatment.*
- ***Community-based Process*** *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 Strategies*** *establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.*

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- ***Universal:*** *The general public or a whole population group that has not been identified based on individual risk.*
- ***Selective:*** *Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.*
- ***Indicated:*** *Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.*

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1) *Assess prevention needs;*
2) *Build capacity to address prevention needs;*
3) *Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;*
4) *Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and*
5) *Evaluate progress towards goals.*

States also need to be prepared to report on the outcomes of their efforts on substance abuse-related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

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

1. ***Please indicate if the state has an active SEOW. If so, please describe:***
    - *The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);*
    - *The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and*
    - *The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).*

State Epidemiology Workgroup

The State Epidemiology Workgroup (SEW) is a subcommittee of the Louisiana Drug Policy Board. The SEW and 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, and prioritizing available data for substance abuse prevention needs. The SEW maintains an online data system, which includes consumption indicators and long- and short-term consequence indicators at the state and community level. The SEW makes recommendations regarding improvements in data collection, and continuously works to fill data gaps to improve the quality and integrity of the data at all levels, while supporting regional and community epidemiological efforts. The work of the SEW is guided by formalized bylaws and Cooperative Involvement Agreements that detail member roles and responsibilities.

The SEW, which is currently funded by the Strategic Prevention Framework Partnerships for Success Grant (LaPFS), was created in 2005 by the Strategic Prevention Framework State Incentive Grant. OBH is a standing member of the SEW and provides prevention and treatment data to the workgroup 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.

LaPFS staff are currently working with SEW to select, implement, and evaluate evidence-based prevention programs, policies, and practices that best address the selected prevention priorities. 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. Finally, there are plans to augment the SEW online system to ensure that the website provides a user interface to encourage use of data for decision-making.

The online system can be viewed at http://www.bach-harrison.com/lasocialindicators/Default.aspx

The chart below denotes indicators and the source that are currently collected by the SEW and included in the online data system.

Indicator	Source
Adult 30-Day Illicit Drug Use	NSDUH- National Study on Drug Use and Health (NSDUH)
Adult 30-Day Marijuana Use	NSDUH- National Study on Drug Use and Health (NSDUH)
Adult Alcohol Dependence	NSDUH- National Study on Drug Use and Health (NSDUH)
Adult Binge Drinking	BRFSS- Behavioral Risk Factor Surveillance System
Adult Current Cigarette	BRFSS- Behavioral Risk Factor Surveillance System
Adult Current Drinking	BRFSS- Behavioral Risk Factor Surveillance System
Adult Drinking And Driving	BRFSS- Behavioral Risk Factor Surveillance System
Adult Drug Dependence	NSDUH- National Study on Drug Use and Health (NSDUH)
Adult Heavy Alcohol Use	BRFSS- Behavioral Risk Factor Surveillance System
Adult Heavy Cigarette Use	BRFSS- Behavioral Risk Factor Surveillance System
Adult Past Year Rx Pain Reliever Use	NSDUH- National Study on Drug Use and Health (NSDUH)
Adult Any Mental Illness	National Survey on Drug Use and Health (NSDUH)
Adult Major Depressive Episode	National Survey on Drug Use and Health (NSDUH)
Adult Serious Mental Illness	National Survey on Drug Use and Health (NSDUH)
Adult Suicidal Ideation	National Survey on Drug Use and Health (NSDUH)
Alcohol Related Crash Fatalities and Seatbelt Use	HSRG- Highway Safety Research Group
Alcohol Related Fatal Crashes (FARS)	FARS- Fatality Analysis Reporting System
Alcohol Related Motor Vehicle Crashes-Fatal	HSRG- Highway Safety Research Group
Alcohol Related Motor Vehicle Crashes-Fatal By Age	HSRG- Highway Safety Research Group
Alcohol Related Motor Vehicle Crashes-Fatal by Month	HSRG- Highway Safety Research Group
Alcohol Related Motor Vehicle Crashes-Fatal By Time And Day	HSRG- Highway Safety Research Group
Alcohol Related Motor Vehicle Crashes-Fatal Underage Drivers	HSRG- Highway Safety Research Group
Alcohol Related Motor Vehicle Crashes-Injury	HSRG- Highway Safety Research Group
Alcohol Related Motor Vehicle Crashes-Injury By Age	HSRG- Highway Safety Research Group

Indicator	Source
Alcohol Related Motor Vehicle Crashes-Injury by Month	HSRG- Highway Safety Research Group
Alcohol Related Motor Vehicle Crashes-Injury By Time And Day	HSRG- Highway Safety Research Group
Alcohol Related Motor Vehicle Crashes-Injury Underage Drivers	HSRG- Highway Safety Research Group
Alcohol Related School Suspensions And Expulsions	Louisiana Department of Education
Alcoholic Liver Disease Fatalities	NVSS- National Vital Statistics System
Cardiovascular Disease Deaths-All	Louisiana Office of Public Health, Center for Records and Statistics
Chronic Liver Disease Fatalities	Louisiana Office of Public Health, Center for Records and Statistics
Controlled Substances Expulsions And Suspensions	Louisiana Department of Education
Driving While Intoxicated	HSRG- Highway Safety Research Group
Drug Poisoning Fatalities	NVSS- National Vital Statistics System
Gallons Of Alcohol Sold	Alcohol Epidemiological Data System
Higher Ed- Been Arrested For DUI	CORE Survey
Higher Ed- Driven Under The Influence	CORE Survey
Higher Ed-Actual Physical Violence And Substance Use	CORE Survey
Higher Ed-Alcohol Use-30-Day	CORE Survey
Higher Ed-Amphetamine Use-30-Day	CORE Survey
Higher Ed-Argument Or Fight Due To Alcohol/Drugs	CORE Survey
Higher Ed-Average Number Of Drinks Per Week	CORE Survey
Higher Ed-Binge Drinking	CORE Survey
Higher Ed-Campus Atmosphere Promotes Alcohol Use	CORE Survey
Higher Ed-Campus Atmosphere Promotes Drug Use	CORE Survey
Higher Ed-Cocaine Use-30-Day	CORE Survey
Higher Ed-Damaged Property Due To Alcohol/Drugs	CORE Survey
Higher Ed-Designer Drug Use-30-Day	CORE Survey
Higher Ed-Did Something I Regret Due To Alcohol/Drug	CORE Survey

Indicator	Source
Higher Ed-Don't Feel Safe On Campus	CORE Survey
Higher Ed-Ethnic/Racial Harassment & Substance Use	CORE Survey
Higher Ed-Failed Test Or Project Due To Alcohol/Drugs	CORE Survey
Higher Ed-Hallucinogen Use-30-Day	CORE Survey
Higher Ed-Hangover Due To Alcohol/Drugs	CORE Survey
Higher Ed-Heavy Tobacco Use	CORE Survey
Higher Ed-Hurt Or Injured Due To Alcohol/Drugs	CORE Survey
Higher Ed-Inhalant Use-30-Day	CORE Survey
Higher Ed-Marijuana Use-30-Day	CORE Survey
Higher Ed-Memory Loss Due To Alcohol/Drugs	CORE Survey
Higher Ed-Might Have Drinking/Drug Problem	CORE Survey
Higher Ed-Missed A Class Due To Alcohol/Drugs	CORE Survey
Higher Ed-Nausea Or Vomiting Due To Alcohol/Drugs	CORE Survey
Higher Ed-Opiate Use-30-Day	CORE Survey
Higher Ed-Other Illegal Drug Use-30-Day	CORE Survey
Higher Ed-Sedative Use-30-Day	CORE Survey
Higher Ed-Steroid Use-30-Day	CORE Survey
Higher Ed-Suicide Attempt Due To Alcohol/Drugs	CORE Survey
Higher Ed-Theft Due To Force And Substance Use	CORE Survey
Higher Ed-Thought About Suicide Due To Alcohol/Drugs	CORE Survey
Higher Ed-Threats Of Physical Violence And Substance Use	CORE Survey
Higher Ed-Tobacco Use-30-Day	CORE Survey
Higher Ed-Trouble With Police Due To Alcohol/Drugs	CORE Survey
Higher Ed-Underage Alcohol Use-30-Day	CORE Survey
Higher Ed-Unsuccessfully Tried To Stop Using Alcohol/Drugs	CORE Survey

Indicator	Source
Higher Ed-Unwanted Fondling And Substance Use	CORE Survey
Higher Ed-Unwanted Intercourse And Substance Use	CORE Survey
Higher Ed-Unwanted Sex Due To Alcohol/Drugs	CORE Survey
HIV/AIDS Incidence	Louisiana Office of Public Health, Center for Records and Statistics
HIV/AIDS Prevalence	Louisiana Office of Public Health, Center for Records and Statistics
Homicides	Louisiana Office of Public Health, Center for Records and Statistics
Illicit Drug Deaths	Louisiana Office of Public Health, Center for Records and Statistics
Ischemic Cerebrovascular Disease (OPH)	Louisiana Office of Public Health, Center for Records and Statistics
Ischemic Cerebrovascular Disease (SEDS)	NVSS- National Vital Statistics System
Lung Cancer Fatalities	Louisiana Office of Public Health, Center for Records and Statistics
Lung Disease Fatalities	Louisiana Office of Public Health, Center for Records and Statistics
Percent Of Alcohol Related Fatal Vehicle Crashes	FARS- Fatality Analysis Reporting System
Reported Property Crimes	UCR- Uniform Crime Reporting
Reported Violent Crimes	UCR- Uniform Crime Reporting
School Dropouts Grades 7-12	Louisiana Department of Education
School Dropouts Grades 9-12	Louisiana Department of Education
Smoking Related Cardiovascular Disease (OPH)	Louisiana Office of Public Health, Center for Records and Statistics
Smoking Related Cardiovascular Disease (SEDS)	NVSS- National Vital Statistics System
Suicides	Louisiana Office of Public Health, Center for Records and Statistics
Tobacco Or Lighter Expulsions And Suspensions	Louisiana Department of Education
Treatment Admissions (OAD)	OBH- Office for Behavioral Health, Addictive Disorders
Youth Alcohol Use-30-Day	CCYS- Caring Communities Youth Survey
Youth Alcohol Use-Lifetime	CCYS- Caring Communities Youth Survey
Youth Any Gambling In The Past Year	CCYS - Caring Communities Youth Survey
Youth Attacked to Harm	CCYS - Caring Communities Youth Survey

Indicator	Source
Youth Been Arrested	CCYS - Caring Communities Youth Survey
Youth Binge Drinking	CCYS- Caring Communities Youth Survey
Youth Carried A Handgun	CCYS - Caring Communities Youth Survey
Youth Chewing Tobacco Use-30-Day	CCYS- Caring Communities Youth Survey
Youth Chewing Tobacco-Lifetime	CCYS- Caring Communities Youth Survey
Youth Cigarette Use-30-Day	CCYS- Caring Communities Youth Survey
Youth Cigarette Use-Lifetime	CCYS- Caring Communities Youth Survey
Youth Cocaine Use-30-Day	CCYS- Caring Communities Youth Survey
Youth Cocaine Use-Lifetime	CCYS- Caring Communities Youth Survey
Youth Depressive Symptoms	CCYS - Caring Communities Youth Survey
Youth Driving After Drinking	CCYS- Caring Communities Youth Survey
Youth Drunk Or High At School	CCYS - Caring Communities Youth Survey
Youth Ecstasy Use-30-Day	CCYS- Caring Communities Youth Survey
Youth Ecstasy Use-Lifetime	CCYS- Caring Communities Youth Survey
Youth Gang Involvement	CCYS - Caring Communities Youth Survey
Youth Hallucinogen Use-30-Day	CCYS- Caring Communities Youth Survey
Youth Hallucinogen Use-Lifetime	CCYS- Caring Communities Youth Survey
Youth Handgun To School	CCYS - Caring Communities Youth Survey
Youth Heavy Cigarette Use	CCYS- Caring Communities Youth Survey
Youth Heroin Use-30-Day	CCYS- Caring Communities Youth Survey
Youth Heroin Use-Lifetime	CCYS- Caring Communities Youth Survey
Youth Inhalant Use-30-Day	CCYS- Caring Communities Youth Survey
Youth Inhalant Use-Lifetime	CCYS- Caring Communities Youth Survey
Youth Marijuana Use-30-Day	CCYS- Caring Communities Youth Survey
Youth Marijuana Use-Lifetime	CCYS- Caring Communities Youth Survey
Youth Methamphetamine Use-30-Day	CCYS- Caring Communities Youth Survey
Youth Methamphetamine Use-Lifetime	CCYS- Caring Communities Youth Survey
Youth Need For Alcohol Or Drug Treatment	CCYS- Caring Communities Youth Survey
Youth Need For Alcohol Treatment	CCYS- Caring Communities Youth Survey
Youth Need For Drug Treatment	CCYS- Caring Communities Youth Survey
Youth Prescription Narcotics Use-30-Day	CCYS- Caring Communities Youth Survey
Youth Prescription Narcotics Use-Lifetime	CCYS- Caring Communities Youth Survey
Youth Riding With Drinking Driver	CCYS- Caring Communities Youth Survey
Youth Sedative Use-30-Day	CCYS- Caring Communities Youth Survey
Youth Sedative Use-Lifetime	CCYS- Caring Communities Youth Survey
Youth Sold Drugs	CCYS - Caring Communities Youth Survey

Indicator	Source
Youth Stimulant Use-30-Day	CCYS- Caring Communities Youth Survey
Youth Stimulant Use-Lifetime	CCYS- Caring Communities Youth Survey
Youth Stolen A Vehicle	CCYS - Caring Communities Youth Survey
Youth Suicidal Ideation	CCYS- Caring Communities Youth Survey
Youth Suspended From School	CCYS - Caring Communities Youth Survey
Gambling Past Year: Casino	CCYS - Caring Communities Youth Survey
Gambling Past Year: Lottery	CCYS - Caring Communities Youth Survey
Gambling Past Year: Bet on Sports	CCYS - Caring Communities Youth Survey
Gambling Past Year: Bet on Cards	CCYS - Caring Communities Youth Survey
Gambling Past Year: Bet on Horses	CCYS - Caring Communities Youth Survey
Gambling Past Year: Bet on Bingo	CCYS - Caring Communities Youth Survey
Gambling Past Year: Online	CCYS - Caring Communities Youth Survey
Gambling Past Year: Bet on Dice	CCYS - Caring Communities Youth Survey
Gambling Past Year: Game of Skill	CCYS - Caring Communities Youth Survey
Gambling Past Year: Slot Machines	CCYS - Caring Communities Youth Survey
Youth Community Low Neighborhood Attachment	CCYS - Caring Communities Youth Survey
Youth Community Laws and Norms Favorable to Drug Use	CCYS - Caring Communities Youth Survey
Youth Perceived Availability of Drugs	CCYS - Caring Communities Youth Survey
Youth Perceived Availability of Guns	CCYS - Caring Communities Youth Survey
Youth Poor Family Management	CCYS - Caring Communities Youth Survey
Youth Family Conflict	CCYS - Caring Communities Youth Survey
Youth Family History of Antisocial Behavior	CCYS - Caring Communities Youth Survey
Youth Parental Attitudes Favorable Toward Antisocial Behavior	CCYS - Caring Communities Youth Survey
Youth Parental Attitudes Favorable Toward Drug Use	CCYS - Caring Communities Youth Survey
Youth Academic Failure	CCYS - Caring Communities Youth Survey
Youth Low Commitment to School	CCYS - Caring Communities Youth Survey
Youth Rebelliousness	CCYS - Caring Communities Youth Survey
Youth Early Initiation of Antisocial Behavior	CCYS - Caring Communities Youth Survey
Youth Early Initiation of Drug Use	CCYS - Caring Communities Youth Survey
Youth Attitudes Favorable Toward Antisocial Behavior	CCYS - Caring Communities Youth Survey
Youth Favorable Attitudes Toward Drug Use	CCYS - Caring Communities Youth Survey
Youth Intentions to Use Drugs	CCYS - Caring Communities Youth Survey

Indicator	Source
Youth Perceived Risk of Drug Use	CCYS - Caring Communities Youth Survey
Youth Interaction with Antisocial Peers	CCYS - Caring Communities Youth Survey
Youth Friends Use of Drugs	CCYS - Caring Communities Youth Survey
Youth Rewards for Antisocial Behavior	CCYS - Caring Communities Youth Survey
Youth Depressive Symptoms Risk Scale	CCYS - Caring Communities Youth Survey
Youth Total Risk Scale Score	CCYS - Caring Communities Youth Survey
Youth Rewards for Community Prosocial Involvement	CCYS - Caring Communities Youth Survey
Youth Family Attachment	CCYS - Caring Communities Youth Survey
Youth Family Opportunities for Prosocial Involvement	CCYS - Caring Communities Youth Survey
Youth Family Rewards for Prosocial Involvement	CCYS - Caring Communities Youth Survey
Youth School Opportunities for Prosocial Involvement	CCYS - Caring Communities Youth Survey
Youth School Rewards for Prosocial Involvement	CCYS - Caring Communities Youth Survey
Youth Belief in the Moral Order	CCYS - Caring Communities Youth Survey
Youth Religiosity	CCYS - Caring Communities Youth Survey
Youth Interaction with Prosocial Peers	CCYS - Caring Communities Youth Survey
Youth Prosocial Involvement	CCYS - Caring Communities Youth Survey
Youth Rewards for Prosocial Involvement	CCYS - Caring Communities Youth Survey
Youth Total Protection	CCYS - Caring Communities Youth Survey
Youth Obtain Alcohol: Fake ID	CCYS - Caring Communities Youth Survey
Youth Obtain Alcohol: Bought Without ID	CCYS - Caring Communities Youth Survey
Youth Obtain Alcohol: Someone over 21	CCYS - Caring Communities Youth Survey
Youth Obtain Alcohol: Someone under 21	CCYS - Caring Communities Youth Survey
Youth Obtain Alcohol: Home with Parent Permission	CCYS - Caring Communities Youth Survey
Youth Obtain Alcohol: Home without Parent Permission	CCYS - Caring Communities Youth Survey
Youth Obtain Alcohol: Relative (not Parent)	CCYS - Caring Communities Youth Survey
Youth Obtain Alcohol: Stranger	CCYS - Caring Communities Youth Survey

Indicator	Source
Youth Obtain Alcohol: Some Other Way	CCYS - Caring Communities Youth Survey
Youth Places Consume Alcohol: Any Home Without Parent Permission	CCYS - Caring Communities Youth Survey
Youth Places Consume Alcohol: My Home With Parent Permission	CCYS - Caring Communities Youth Survey
Youth Places Consume Alcohol: Someone Else's Home with Permission	CCYS - Caring Communities Youth Survey
Youth Places Consume Alcohol: Open area	CCYS - Caring Communities Youth Survey
Youth Places Consume Alcohol: At an event	CCYS - Caring Communities Youth Survey
Youth Places Consume Alcohol: Restaurant/Bar	CCYS - Caring Communities Youth Survey
Youth Places Consume Alcohol: Empty Building	CCYS - Caring Communities Youth Survey
Youth Places Consume Alcohol: In a car	CCYS - Caring Communities Youth Survey
Youth Places Consume Alcohol: Some Other Place	CCYS - Caring Communities Youth Survey
Youth Attitudes about Adults Drinking Alcohol	CCYS - Caring Communities Youth Survey
Youth Attitudes about Adults Being Drunk	CCYS - Caring Communities Youth Survey
Youth Ease of Underage Alcohol Purchasing	CCYS - Caring Communities Youth Survey
Youth Perceived Risk of Drunk Driving Enforcement	CCYS - Caring Communities Youth Survey
Youth Perceived Risk of Underage Alcohol Penalties	CCYS - Caring Communities Youth Survey
Youth Age First Used Alcohol	CCYS - Caring Communities Youth Survey
Youth Age First Used Cigarettes	CCYS - Caring Communities Youth Survey
Youth Age First Used Marijuana	CCYS - Caring Communities Youth Survey
Youth Feel Unsafe at School	CCYS - Caring Communities Youth Survey
Youth Perception of Disapproval: Violence	CCYS - Caring Communities Youth Survey
Youth School Avoidance Bullying	CCYS - Caring Communities Youth Survey
Youth Bullied at School-Past Year	CCYS - Caring Communities Youth Survey
Youth Perception of Risk: Alcohol	CCYS - Caring Communities Youth Survey
Youth Perception of Risk: Cigarette Use	CCYS - Caring Communities Youth Survey

Indicator	Source
Youth Perception of Risk: Marijuana	CCYS - Caring Communities Youth Survey
Youth Parent Disapproval: Alcohol	CCYS - Caring Communities Youth Survey
Youth Parent Disapproval: Cigarettes	CCYS - Caring Communities Youth Survey
Youth Parent Disapproval: Marijuana	CCYS - Caring Communities Youth Survey
Youth Peer Disapproval: Alcohol	CCYS - Caring Communities Youth Survey
Youth Peer Disapproval: Cigarette Use	CCYS - Caring Communities Youth Survey
Youth Peer Disapproval: Marijuana	CCYS - Caring Communities Youth Survey

Below is a list of current SEW members and agencies that are represented.

State Epidemiology Workgroup (SEW) Membership

Agency	Member
Governor's Office, Drug Policy Board	Missy Graves
Department of Health and Hospitals (DHH), Office of Behavioral Health (OBH), Prevention	Leslie Freeman
DHH, OBH, Prevention Louisiana Partnerships for Success Epidemiologist	Ashanti Corey
DCFS, Office of Family Assistance Program Policy Section	Allana Thomas
Louisiana Commission on Law Enforcement	Opal West
Louisiana Highway Safety Commission	Cathy Childers
DHH, Office of Public Health (OPH), State Epidemiologist, Infectious Disease Epidemiology Section, SEW Chair	Dr. Gary Balsamo
DHH, OPH, Epidemiologist, Infectious Disease Epidemiology	Jenna Iberg-Johnson
DHH, OPH, Center for Health Statistics - Public Health Epidemiologist	Melissa McNeil
Southern University, Department of Psychology	Dr. Murelle Harrison
Capital Area Human Services District, Project Manager, FASD Prevention Collaborative	Vivian Gettys
Governor's Office of Elderly Affairs	Vacant
LSU School of Public Health, Associate Professor, Epidemiology	Susanne Straif-Bourgeois
DHH, OBH, Treatment	Ivory Wilson
Louisiana Center Addressing Substance Use (LaCASU)	Shelley Lee
Veteran Affairs	Vacant
DHH, OBH Business Intelligence & Analytics, Division of Health Plan Management	Kashunda Williams
Department of Education	Lillie Burns

Agency	Member
LSU Health Science Center / DHH Tobacco Control Program	vacant
State Police	Rebecca Nugent
Coroner's Office	Vacant
Drug Enforcement Administration	Vacant
DHH/OPH	Mary Johnson
Xtreme Cleaners	Larry Douglas
DHH, Office of the Secretary	Dr. Bhaskar Toodi
	Angel Norwood
Department of Transportation and Development	Dortha Cummins
DHH, OBH, Mental Health	Dr. Kashunda Williams
OPH	Vacant
Addiction Doctor	Dr. Howard Wetsman
LSU School of Public Health	Dr. Katherine Theall
LSU Information Systems and Decision Sciences (ISDS) Research for Highway Safety	Dr. Helmut Schneider
LA Supreme Court	Chris Andrieu
LA Sheriff's Association	Danny Jackson
DHH, OBH, Prevention	Felecia Johnson
Governor's Office	Dawn Diez

2. ***Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.***

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

The rationale for prioritizing primary prevention programs in Louisiana is to address the fundamental substance abuse-related issues in the State. The basis for judging the most pressing needs in Louisiana are found in the data. For instance, LifeSkills Training, Project Northland and Second Step account for 60 % of all enrollees in SFY 2014. The proven outcomes for these programs are centered around alcohol, tobacco, family relationships, drugs, social functioning, crime and violence as indicated on NREPP. These programs have outcomes that address substance-abuse related problems in the State as revealed by data. Three of these data sources are the 2012 Caring Communities Youth Survey (CCYS), the 2013 CORE Alcohol and Drug Survey, which are both funded by OBH-AD, and the 2013 State Epidemiology Workgroup (SEW) report.

Using alcohol as an example of what the data reveals; the CCYS 2012 indicated that 18.8% of 6th grade, 40.7% of 8th grade, 61.4% of 10th grade and 70.7% of 12th grade students used alcohol

in their lifetime. Additionally in CCYS 2012, 6.8% of 6th grade, 18.5% of 8th grade, 35% of 10th grade and 45.8% of 12th grade students reported using alcohol in the past 30 days. The SEW report sites data from the Louisiana Department of Education (DOE) that states there were 410 suspension and expulsions in schools for alcohol-related violations. Alcohol and drug consumption patterns tend to increase when students enter college. The CORE survey, a survey distributed to all two and four year Institutions/Universities in Louisiana, reported 78.3% of college students consumed alcohol in the past year and 62.6% of students consumed alcohol in the past 30 days. OBH focuses prevention efforts on school age children based on the CCYS 2012 finding that the average age of first use of is lowest with cigarettes at 12.45 years. A period of one and a one half years separates the age of first sip of alcohol and the first regular alcohol use, with the first sip occurring at 12.68 years, and the first regular use of alcohol at 14.18 years. Of the youth who had used marijuana, the average age of first use was 13.73 years – nearly a half year before youth indicated that they had begun drinking regularly.

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 Planning Framework. OBH continues to move toward the goal of fully implementing the SPF process throughout the agency for making data-driven prevention decisions.

3. ***How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?***

OBH intends to build the capacity of its prevention system, including the capacity of its prevention workforce through continuous training and adaptation. Over the past few years, Louisiana's prevention system has changed has changed from the original 10 regions to the formation of Local Governing Entities (LGEs). OBH maintains a functional relationship with both LGEs and Prevention Coordinators (PCs) through regularly scheduled monthly conference calls and Learning Communities. The prevention team also conducts Quarterly site visits. Local Prevention Coordinators are responsible for community mobilization activities, oversight of prevention contract providers, and serve as liaisons to state and local stakeholders. Local PCs are provided technical assistance and resources via OBH's State Prevention Staff and participate in trainings to ensure appropriate delivery of prevention services throughout the State. OBH fully understands the importance of collaborating, braiding resources, and networking to either maintain its existing prevention system or to enhance the system. As prevention broadens its scope to include health promotion and the prevention of mental, emotional and behavioral disorders as well as suicide prevention, trainings are being offered to PCs, providers, and other partners to build prevention workforce capacity.

OBH Prevention Services (through a contractual agreement with Southern University Baton Rouge) offers one online Prevention Professional Seminar and five face-to-face courses/trainings to meet the educational requirements for employees, contractors, and other interested persons to become certified or licensed prevention professionals and to further develop the prevention workforce in Louisiana. During SFY 2014, 228 individuals participated in these courses/trainings.

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

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

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

OBH also funds a contract with Dr. Murelle Harrison to provide to develop and deliver specialized Prevention Professional Workforce Development training for employees, contractors, and other persons referred by OBH. Technical assistance and follow-up are to be provided on an as needed basis. Dr. Harrison provides a minimum of 12 on-site Prevention Professional Exam Preparation workshops to include technical assistance in application preparation. Dr. Harrison monitors the application process for individuals attending the training to ensure accuracy and follow-through

with the Addictive Disorder Regulatory Authority (ADRA). Dr. Harrison is responsible for informing the prevention community of current regulations from International Certification and Reciprocity Consortium (IC&RC) as a Louisiana Delegate. As a part of this contract, Dr. Harrison also serves as the liaison regarding Block Grant and LaPFS with the OBH LGEs and other community coalitions (to include Louisiana Partnerships for Success coalitions) focusing on the prevention of substance use, mental, emotional, and behavioral disorders to provide technical assistance and guidance as they implement the SPF process within their districts Workshops will include the following: Application Preparation Assistance, Prevention Professional Examination Preparation, and SPF technical assistance. During SFY 2014, 1,717 individuals participated in these courses/trainings.

OBH works closely with the Center for the Application of Prevention Technologies (CAPT) and more specifically with the Southwest Regional Expert Team (SWRT). The CAPT is a national substance abuse prevention training and technical assistance (T/TA) system dedicated to strengthening prevention systems and the nation's behavioral health workforce. Each year an annual plan is developed outlining what services/areas will be covered. A summary of T/TA services provided as per Louisiana's CAPT Service Plan for 2014 are listed below:

1) Enhance understanding of the connection between the CLAS standards, data collection, and behavioral health disparities to provide rich epi profile and community profile data to promote culturally competent services in the State and help support PFS 2013 funded communities;
2) Assess the tasks that the SEW must complete based on PFS 2013 requirements and will work with the state to identify and recruit members, define meaningful member roles, and create goals and outcomes in a way that leads to sustainability of the SEW. Services included customized consultation and online meeting technical assistance with the SEW;
3) Provide online training to Louisiana's SEW on the Shared Risk and Protective Factor Tool (SHARP Tool) and the Substance Abuse Prevention Planning and Epidemiology Tool (SAPPET), to include a description on the development of the tools, their purpose and limitations, and the future plans for each tool;
4) Increase the capacity of prevention providers to provide substance abuse prevention services to the military and military families in a culturally competent manner;
5) Provide online course Locating, Hiring, and Managing an Evaluator in order to support their workforce development goals; and
6) Provide peer-sharing calls with 2013 Partnership for Success Grantees.

As part of the Partnerships for Success Grant, there were a series of Learning Communities provided. These Learning Communities were open to PFS sub-grantees, Prevention Coordinators, and other community partners. The Learning Communities were done through "Go To" and face-to-face meetings. The following are topics that were covered: Increasing Caring Communities Youth Survey Response Rate; Health Disparities; Coalition Capacity, Needs Assessment - Steps 1 and 2, Community Readiness Assessments, Logic Models, and Action Planning; Prevention Management Information System – PMIS; and Strategies for Addressing Underage Drinking and Non-Medical Use of Prescription Drugs.

OBH also hosted and participated in the 8th Annual Children's Behavioral Health Summit, *The Well Child: An Integrated Approach* on June 30, 2015. Approximately 450 family members, social workers, licensed professional counselors, licensed addiction counselors and other human service professionals were in attendance. State and national speakers presented on such topics as Behavioral Health Integration and Children's Services, Pediatric Integrated Care, Marijuana, Building Bridges, Preventing Mental, Emotional, and Behavioral Disorders in Children, Engaging Military Families in Community Prevention, and Safety-Focused Practice.

4. Please describe if the state has:

a. A statewide licensing or certification program for the substance abuse prevention workforce;

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

ELIGIBILITY REQUIREMENTS FOR LPP

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

ELIGIBILITY REQUIREMENTS FOR CPP

1) At least 21 years of age and holds a Bachelor's degree from an accredited institution of higher education
2) A legal resident of the United States
3) In not in violation of any ethical standard subscribed to by the ADRA
4) Has not been a substance abuser or compulsive gambler for at least two years prior to the date of the application
5) Has not been convicted of a felony; however the ADRA has the discretion to waive this requirement upon review of the circumstance
6) Has successfully completed 100 total clock hours of education approved by the ADRA. 50 hours of the 100 hours must be specific to substance abuse training, with 6 hours in professional ethics, 30 hours from National Prevention Training with the remaining 14 hours being related. All hours are subject to approval by the ADRA
7) Has successfully completed 4000 hours (2 full-time years) of supervised work experience engaged in providing prevention services. Of the 4000 hours, a 120 hour practicum in the 5 domains must be obtained with at least 10 hours in each domain. The experience must be supervised by a qualified professional
8) Has completed and received approval for testing based on submission of the application prescribed by the ADRA to include a case study
9) Demonstrates competence in addiction counseling by passing the written examination prescribed by the ADRA

ELIGIBILITY REQUIREMENTS FOR RPP

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

b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and

OBH does have a formal mechanism to provide training and technical assistance to the substance abuse prevention workforce. As described in Question #3 above, training and technical assistance are provided by State Staff, contract providers, federal partners, and other stakeholders.

c. A formal mechanism to assess community readiness to implement prevention strategies.

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

5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

The Office of Behavioral Health (OBH) Prevention Services implements a data-driven planning process to identify and implement appropriate primary prevention services. Annually, the ten geographic service areas of the state review their funding of prevention services. The mechanisms by which 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 is reviewed, along with the current resources available to the service area, including partnerships that braid funding, such as the local Department of Education.

At the sub-recipient level, allocation of resources and sub-recipient deliverables are strategically planned. Resources are reallocated as needed and a new action plan and a Statement of Work (SOW), is written. The action plan includes the provider, the provider's mission, goals, objectives, evidence-based program strategies, target population, performance indicators, and process and

outcome evaluation. OBH State Office provides guidance and technical assistance during this process to ensure that action plans are appropriate. LGEs monitor the deliverables of Block Grant sub-recipients on a monthly basis and OBH State staff review sub-recipient reports and documentation of deliverables during quarterly site visits.

6. ***Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.***

Yes. In SFY 2012, the State received the Strategic Prevention Enhancement (SPE) Grant and spent SFY 2012 updating the State's 5-Year Strategic Plan. In order to develop this strategic plan, the current state substance abuse prevention system, accomplishments, gaps in services, and previously submitted Capacity Building / Infrastructure Enhancement plans were reviewed and considered. The explicit goals of the Center for Substance Abuse Prevention (CSAP) for the SPE program were to support states in building capacity and infrastructure with focus on: 1) Data Collection, Analysis and Reporting, 2) Coordination of Prevention Services, 3) Technical Assistance and Training, and 4) Performance and Evaluation. In the action plans, Louisiana outlines steps to further build infrastructure and close gaps in our substance abuse prevention system over the next five years.

The Department of Health and Hospitals' Office of Behavioral Health (OBH) and the Office of the Governor provided management and oversight of the Strategic Prevention Enhancement (SPE) grant with a core team of key advisors from multiple state agencies, including: OBH, Governor's Office, Department of Education (DOE), Louisiana Highway Safety Commission (LHSC), Southern University, and Louisiana Center Addressing Substance Use in Collegiate Communities (LaCASU).

The strategic plan was based on a thorough assessment of available data that provides information about substance abuse consumption and related consequences collected by the State Epidemiology Workgroup (SEW). The assessment included identification of the substances that are most threatening to Louisiana's population across the lifespan and the specific consequences of use and abuse of these substances. The data prioritization process was based on epidemiological findings and was the task of the State Epidemiology Workgroup (SEW). It is a framework used to guide the substance abuse prevention field and sets a focus for future funding.

The data prioritization process began with a review of the consumption and consequence data that is collected and housed within the SEW Online Data System. Prioritization included consideration of consumption and consequence indicators for alcohol, tobacco, and illicit drugs; consideration of data available at the parish level; and application of basic epidemiology principles to determine priorities and areas of highest concern. It was determined that the best data sources for Louisiana include the Caring Communities Youth Survey (CCYS) and the CORE survey, both funded by the OBH.

The data in regards to underage alcohol use showed that alcohol is clearly the number one substance of choice by Louisiana youth. In addition to underage drinking, tobacco and illicit drug use were prioritized. Therefore, a special section specific to underage drinking was included in the State's 5-Year Strategic Plan to raise awareness around this serious problem. The State is still implementing the State's 5-Year Strategic Plan and works in collaboration with partners to implement action plans that identify strategies to reduce underage and high risk drinking, illicit drug use, and tobacco use.

7. ***Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.***

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

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

8. ***Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.***

OBH has required evidence-based programs, practices, and strategies for several years and is cognizant of the benefits. By requiring contract providers to offer only evidence-based programs,

OBH established cost savings and waste reduction. OBH continues to monitor evidence-based program's cost to develop a more fiscally responsible contract process.

Universal, indicated and selective evidence-based programs are funded by the 20% prevention set-aside to include the following school-based programs: Life Skills Training, Project Northland, Positive Action, Kids Don't Gamble…Wanna Bet?, Project Alert, Coping Skills, Too Good for Drugs, Al's Pals, Protecting You – Protecting Me, Project Towards No Tobacco Use, Guided Imagery Program, Second Step, Keep a Clear Mind, Strengthening Families, Leadership and Resiliency, and Insight Class Program. These services are provided through a partnership with the Louisiana Department of Education (DOE). Through this partnership with DOE, OBH is able to avoid duplication of services and promotes the sharing of existing resources. Partnering also ensures that SABG prevention set-aside dollars are used to purchase primary prevention services that are not funded through other means.

OBH is also committed to implementation of each of the six CSAP prevention strategies: education, information dissemination, community-based process, environmental, alternatives, and early identification and referral. Education is provided through evidence-based prevention programs. Information dissemination provides awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. Information dissemination activities include health fairs, RADAR resource centers, materials dissemination, media campaigns, and speaking engagements. Community-based process aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders. Community-based process activities include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking. Environmental strategies establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. Environmental activities include prevention of underage sales of tobacco and alcohol, changing environmental codes, ordinances, regulations and legislation and public policy efforts. Alternatives provide for the participation of the target populations in activities that exclude drug use. Alternative activities include drug-free social and recreational activities, drug-free dances and parties, youth and adult leadership activities, community drop-in centers, community service activities, and mentoring programs. Finally problem identification and referral aims to identify those who have indulged in the illegal use of drugs in order to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if an individual is in need of treatment. Examples of problem identification and referral methods include driving-while-intoxicated education programs, employee assistance programs, student assistance programs, and teen courts.

Implementation of programs, practices, and strategies are tracked through process evaluation, which 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. 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.

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.

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

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

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

10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

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.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention.

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.

These supplemental GPRA questions include:

1) How frequently have you smoked cigarettes during the past 30 days?
2) How frequently have you used smokeless tobacco during the past 30 days?
3) On how many occasions (if any) have you had beer, wine or hard liquor to drink during the past 30 days?
4) Think back over the last two weeks. How many times have you had five or more alcoholic drinks in a row?
5) On how many occasions during the past 30 days have you:
   A. sniffed glue, breathed the contents of an aerosol spray can, or inhaled other gases or sprays, in order to get high?
   B. used marijuana during the past 30 days?
   C. used LSD, cocaine, methamphetamines, or heroin?
   D. used MDMA (X, E, or ecstasy)?
   E. used prescription drugs (Stimulants: Ritalin, Dexedrine) without a doctor telling you to take them?
   F. used prescription drugs (Sedatives: Valium, Xanax, barbiturates or sleeping pills) without a doctor telling you to take them?
   G. used prescription drugs (Narcotics: OxyContin, methadone, morphine, codeine, Demerol, Vicodin, Percocet) without a doctor telling you to take them?
6) How much do you think people risk harming themselves (physically or in other ways) if they have five or more drinks of an alcoholic beverage once or twice each weekend?
7) How much do you think people risk harming themselves (physically or in other ways) if they smoke one or more packs of cigarettes per day?
8) How much do you think people risk harming themselves (physically or in other ways) if they smoke marijuana regularly?
9) How wrong do you think it is for someone your age to drink beer, wine or hard liquor?

10) How wrong do you think it is for someone your age to smoke cigarettes?
11) How wrong do you think it is for someone your age to smoke marijuana?
12) How old were you when you first had more than a sip or two of beer, wine or hard liquor?
13) How old were you when you first smoke a cigarette, even just a puff?
14) How old were you when you first smoked marijuana?

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.

OBH is committed to continuous improvement of evaluation services for programs, policies and practices implemented by the agency and has invested a great deal of effort to developing a strong evaluation infrastructure over the past several years. In 2006/2007 OBH initiated a pilot program to evaluate evidence-based programs funded by the agency in Region 6, serving 8 parishes in the state, with the pilot being expanded in 2007/2008 to include Region 8 serving an additional 12 parishes in the state for a total of 20 out of 64 parishes piloting the initiative.

In fiscal year 2008/2009, OBH initiated the development of a fidelity instrument to measure the fidelity of delivery of programs by facilitators. In 2009/2010 performance indicators were added to all state contracts which required grantees to hire an external evaluation of services. In that same year OBH standardized a pre and post-test for all evidence based programs which led to a statewide template. In 2011, OBH received the first statewide evaluation report which focused primarily on LifeSkills, 60% of program funds, the largest funded program by OBH.

In 2012, OBH received the first regional evaluation report which provided OBH a stronger evaluation measure for the 2011/2012 contract year. New performance indicators were added for the 2012/2013 fiscal year enhancing evaluation consistency and review. The combination of these evaluation efforts gave OBH a solid evaluation infrastructure at the state and regional level.

10. Quality Improvement Plan

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.

In an attachment to this application, states must submit a CQI plan for FY 2016-FY 2017.

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

The Office of Behavioral Health has structured its quality improvement system to address federal and state requirements and to meet the goals of the Medicaid Home and Community-Based Service Quality Framework and the Triple Aim. This structure also ensures stakeholders are active in the quality improvement process and includes several key committees tasked with quality monitoring:

The Coordinated System of Care Governance Board is tasked with overseeing the implementation and administration of the Coordinated System of Care program, which provides specialized behavioral health services to children and youth at-risk of out-of-home placement. This Board is comprised of executives of the Department of Children and Family Services, the Department of Education, the Office of Juvenile Justice, and the Department of Health and Hospitals, a representative from the Governor's Office, and family, youth and advocate representatives who meet at least quarterly. In addition, the Board sets policy for the governance of the Coordinated System of Care program; establishes policy and monitoring adherence; sets standards; directs use of multiple funding sources; directs the implementing agency; and monitors quality, cost, and adherence to standards.

The Board has two standing committees, which are detailed as follows:

1) The Quality Assurance Committee which consists of staff from each agency with expertise in quality improvement and assurance. This committee meets on a quarterly basis and is responsible for:
   - Promoting, coordinating, and facilitating the active exchange of successful programs, practices, procedures, lessons learned, and other pertinent information of common interest to quality assurance
   - Identifying streamlined techniques and benchmarked practices that enable cost-effective implementation of quality assurance processes and programs
   - Formulating recommendations on the Board's position on issues related to quality assurance and quality improvement
   - Monitoring the adequacy of the implementing agency's oversight of the CSoC

2) The Finance and Audit Committee which consist of the Undersecretary/Deputy Superintendent of Finance of each agency. This committee meets on an as needed basis and is responsible for:
   - Identifying and managing financial resources necessary to fund the various components of the CSoC
   - Ensuring the state maximizes available funds
   - Reviewing and making recommendations regarding the funding dedicated to the CSoC
   - Reviewing the financial status and needs of the CSoC and recommending policies for securing resources
   - Facilitating the development of and adherence to the necessary MOUs to support CSoC implementation

In addition, the Interdepartmental Monitoring Team is tasked with analyzing data and information on all delineated performance measures to ensure compliance with state and federal regulations. The Team is comprised of subject matter experts from the Office of Behavioral Health, Bureau of Health Services Financing (Medicaid), Department of Education, Department of Children and Family Supports, and the Office of Juvenile Justice who meet at least quarterly. The Team is also responsible for determining patterns, trends, concerns, and issues in service delivery, providing oversight and monitoring of corrective action plans; and developing, overseeing, and monitoring quality assurance/quality improvement initiatives and activities. The Team currently reviews and analyzes measures inclusive of but not limited to appointment access; member satisfaction; utilization of evidence-based practices and home and community-based services; level of care processes; plan of care development; reported/identified critical incidents; grievances and appeals; juvenile justice involvement; school performance, conduct, and attendance; number of children place in out-of-home or restrictive settings; inpatient admissions and readmissions; and follow-up following discharge.

In anticipation of the integration of physical and behavioral health services under the Bayou Health program, the Department plans to adopt a significant number of national and state developed measures which includes, but are not limited to the measures listed below:

- Screening for Clinical Depression
- Antidepressant Medication Management
- Follow-Up After Hospitalization for Mental Illness
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Diabetes Monitoring for People with Diabetes and Schizophrenia
- Cardiovascular Monitoring for People with Diabetes and Schizophrenia
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Follow-Up Care for Children Prescribed ADHD Medication
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- Metabolic Monitoring for Children and Adolescents on Antipsychotics

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- Identification of Alcohol and Other Drug Services
- Mental Health Utilization
- Psychiatric inpatients with admission screening within the first three days of admission for all of the following: risk of violence to self or others; substance use; psychological trauma history; and patient strengths
- Psychiatric inpatients on two or more routinely scheduled antipsychotic medications with appropriate justification
- Psychiatric inpatients for whom the post discharge continuing care plan is created and contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level recommendations
- Psychiatric inpatients for whom the discharge continuing care plan was transmitted to the next level of care
- Evidence-based practice utilization and availability
- Participant/member outcomes and satisfaction
- Access
- Admissions/readmissions

In addition, the Department has developed a number of measures to determine compliance with the Mental Health Parity and Addiction Equity Act, which are anticipated to be reported on beginning December 2015.

The Louisiana Behavioral Health Advisory Council, in addition to providing guidance for the Block Grant Application/State Behavioral Health Plan, 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.

11. Trauma

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

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach". This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses 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 policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?***

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

Policies and procedures also exist at the community level with the LGE's 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 LGE's and DHH 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, the Statewide Management Organization (SMO), Magellan, has a Clinical Practice Guideline (CPG) Workgroup, through which board-certified practitioners assist Magellan with identifying evidence-based practices to incorporate into treatment best practice recommendations. In addition, the current Department of Children and Family Services (DCFS) and Office of Juvenile Justice (OJJ) format for evaluation contains a section to record trauma issues and history, as well as identifying trauma-related risk factors to be considered in treatment recommendations.

2. ***Describe the state's policies that promote the provision of trauma-informed care.***

OBH does not currently have in place a specific trauma-related policy. Trauma-related training opportunities are offered by the State in order to encourage trauma-informed care. At the present time, Magellan does not include policy guidance in the promotion and provision of trauma-informed care. Guidance is based on evidence-based, clinical best practices for treating specific disorders.

3. ***How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?***

OBH does not offer any evidence-based trauma-specific interventions across the state, although Assertive Community Treatment (ACT) uses trauma-specific CBT approaches, as do many service providers. As residential treatment options are expanded in the state (such as Psychiatric Residential Treatment Facilities and Therapeutic Group Homes), additional training and technical

assistance will be offered to providers on providing trauma-informed care. Each LGE is also required to have a crisis system in their local areas, which may be accomplished through a contract or linkage with another community resource. Within the home and community based services available through the LBHP, the crisis intervention and stabilization services are available to eligible youth and adults.

Behavioral Health Crisis
When experiencing a severe mental health problem or crisis, Magellan has emergency services available 24 hours a day through the Member call center. Crisis counselors are available at all times to help an adult or youth in crisis to connect to the help needed. Crisis counselors will work with the individual, their family, and provider to ensure the individual is linked to services needed. Once linked through the Magellan call center and determined to need crisis services, the Magellan crisis counselor will assist the person with accessing services through one of the following resources:

- A hospital emergency room
- A medical or behavioral health clinic
- Where the person lives, works or goes to school

The use and value of Peers in behavioral health treatment is identified as a best practice, and the State has a history of supporting the use and expansion of Peer Support Specialists Services in all levels of care for behavioral health services. The use of Peers was further expanded in 2014 with the institution of the Louisiana Warmline by Magellan. The Louisiana Warmline is a non-crisis phone line staffed by trained and certified Peer Support Specialists providing confidential and non-judgmental peer support. This service starts with the premise that people have learned to make meaning of their life experiences and relationships, and, as such, want to support others in discovering their strengths. Peer Support Specialist operators provide a message of hope to callers who may feel disabled, abandoned, or isolated. The Warmline is open to all adults who are interested in this service.

The Louisiana Warmline fosters the principles of:
- Personal Responsibility
- Mutuality and Shared Learning
- Respecting others thoughts and beliefs as valid and important
- Growth beyond stigma, shame and limits placed upon those living with mental health barriers

4. ***Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?***

OBH offers access to courses within the learning management system on trauma-informed care. OBH has also made multiple face-to-face trainings on trauma informed care available to service providers throughout the state in 2015. Trauma informed care trainings specific to providers serving the homeless populations with the state's Cooperative Agreements to Benefit Homeless

Individuals (CABHI) State grant, as well as the state's Permanent Housing Program, have also been offered to providers in 2015. Other trauma informed care trainings included four for the Office of Juvenile Justice through the SAT-ED grant in different areas around the state and two Building Capacity in Trauma Informed Care through the Emergency Preparedness section. Specific trauma-related training topics from the learning management system include the following:

- Adapted Trauma Focused CBT for People with Developmental Disabilities
- Diagnosis and Treatment of PTSD and Interpersonal Trauma: The DM/ID Criteria and IBT
- Does Your Organization Measure Up: Are You Really Trauma-informed?
- Evidence-Based Treatment Planning for Posttraumatic Stress Disorder
- Fundamentals of Traumatic Brain Injury
- Introduction to Trauma-Informed Care
- Post-Traumatic Stress Disorder
- PRIDE Module 12: Understanding Preteen and Teen Development 2: Trauma, Loss and Developmental Tasks
- Trauma and People with Intellectual Disabilities
- Trauma Informed Treatment for Children with Challenging Behaviors
- Trauma Recovery and Positive Identity Development

OBH sponsored a free Children's Behavioral Health Summit during the summer of 2015 for parents, providers, and other stakeholders with the theme of "The Well Child: An Integrated Approach." Sessions presented during the summit included topics that impact mental, emotional and behavioral wellness and disorders in children. The Department of Children and Family Services (DCFS) and Tulane University are collaborating on a multi-year, statewide project funded by an Administration for Children and Families (ACF) grant to have DCFS field staff trained in specific trauma-informed screening instruments and to have Tulane provide (voluntary and free) Trauma-Focused Cognitive Behavioral Therapy (CBT) training and follow-up consultation to providers in the Magellan network. OBH is a partner in this project.

12. Criminal and Juvenile Justice

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas. Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

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

1. ***Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?***

The justice system in Louisiana currently attempts to enroll individuals in Medicaid prior to their release to the community so that they can begin receiving services upon release. In addition, individuals involved in the justice system who are in state facilities are assisted in obtaining or reinstating Medicaid to begin upon their release. Utilizing a 1915 (c) Medicaid waiver additional services are available through the Coordinated System of Care (CSoC) for eligible children/youth who are at risk for out of home placement and have has a mental health, substance abuse or co-occurring disorder.

2. ***Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?***

Yes, each parish government has their own method of supporting adjudicated individuals with mental health and/or substance use disorders. Several parish governments have mental health or substance use disorder courts that divert individuals from the jail into treatment. In addition, the OBH has ongoing projects with several regions to provide diversion services for those individuals.

3. ***Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?***

Yes, OBH has a Memorandum of Understanding with the Department of Corrections (DOC) for a process to communicate with one another and to provide an appointment within two weeks of release for those inmates on psychotropic medications in order to ensure they continue their medication. OBH also has an agreement with DOC to allow the DOC physician to do the medical clearance of individuals due for release and needing hospitalization in an acute unit in order to expedite services and to avoid clogging up the emergency departments with those who need medical clearance prior to admit to the acute unit. OBH assists DOC in obtaining judicial commitments for individuals with serious mental illness who are about to full-term out of DOC. These individuals are in the DOC behavioral health unit and are placed on the waiting list for long term psychiatric hospitalization upon their release. Juvenile judges often order youth to DHH/OBH custody as a diversion which requires OBH to either place the youth in the hospital or to work with the managed care organization to find more appropriate placement such as a psychiatric residential treatment facility. Upon discharge the youth are referred for appropriate services in the community.

4. ***Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?***

OBH participates in meetings with juvenile judges and other agencies such as the Office of Juvenile Justice and Department of Child and Family Services where information is shared in regard to obtaining services for juveniles. In particular, there have been on-going efforts to

educate juvenile judges, probation officers, and other stakeholders about CSoC and the referral process. The state CSoC team has a Juvenile Justice liaison as one of its members, along with liaisons from OBH. DCFS and DOE. The three agencies are partners in the Louisiana Behavioral Health Partnership (LBHP), of which OBH is the lead. They work together to ensure that appropriate services are obtained. OBH also works closely with DOC to ensure services are available to adults in the criminal justice system. For example, DOC recently requested assistance from OBH in developing a model outpatient substance use referral, assessment and treatment program. Once developed, DOC contracted with the local behavioral health clinics to provide the services described in the model.

13. State Parity Efforts

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment – and to comply with MHPAEA. Guidance was released for states in January 2013. Further guidance will be released in the winter of 2014-2015.

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.

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

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

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

1. *What fiscal resources are used to develop communication plans to educate and raise awareness about parity?*
2. *Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?*
3. *Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?*

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

Since CMS issued their final rule on mental health parity, the Department has developed a robust set a performance measures to capture both the letter and spirit of the law. It is anticipated these measures will be incorporated into the Bayou Health managed care organization contracts beginning December 1, 2015 when specialized behavioral health services are integration with primary care services. The contract will also require that the managed care organizations comply with the Mental Health Parity and Addiction Equity Act generally in an effort to ensure a broader level of compliance outside performance measure reporting. Proposed measures are listed below:

- Number and percent of out-of-network referrals for behavioral health services compared to primary care services
- The percentage and total number of value added behavioral health services compared to primary care services
- The percent of compliance to access to service standards for behavioral health services compared to primary care services
- The percentage and total number of grievance and appeals related to behavioral health services compared to primary care services
- Number of services requiring prior authorization for behavioral health compared to primary care
- Network requirements for behavioral health providers compared to primary care providers
- Referral requirements for behavioral health services compared to primary care services
- Any pharmacy limits for behavioral health diagnoses as compared to primary health diagnoses
- Provider reimbursement rates for behavioral health care services as compared to primary care services
- Number of rates above Medicaid established rate floor for behavioral health care services as compared to primary care services
- Number and types of provider incentives for behavioral health services compared to primary care services

14. Medication Assisted Treatment

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40, 43, 45, and 49. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have failed abstinence-based treatment in the past and who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

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

1. ***How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?***

Currently the Office of Behavioral Health (OBH) provides programmatic oversight which coincides with licensure of providers who provide Methadone services within Louisiana. OBH has collaborated with the Methadone providers to form the Methadone Educational Initiative to educate healthcare providers, behavioral health providers and the general public on Methadone treatment to dispel myths and stigma associated with treatment. To date, the providers have been meeting monthly and performed in-services to boards and groups within the state. The State Opioid Treatment Authority (SOTA), attends AATOD conference every 15 months along with the SOTAs from all 50 states. Currently, funding is not available for education and awareness.

2. ***What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?***

Pregnant women are a priority population within Louisiana. OBH has participated in the Louisiana Neonatal Abstinence Syndrome workgroup to answer questions regarding treatment available for pregnant women and to resolve specific issues that (Obstetrics/Gynecology and Neonatologist) providers had regarding services rendered to pregnant women. In addition, individual Methadone program administrators have been given the names of specific providers that may be contacted by the Medical Directors within the Methadone provider offices to discuss issues as they occur. Our efforts have been very individualized in nature but remain effective to ensure that services received are made known to providers rendering services to pregnant women.

OBH has also collaborated with Medicaid to have Methadone as a covered formulary with a diagnosis of Substance Use Disorder effective Dec. 1, 2015. Currently, there are 10 privately owned Methadone providers within the state who offer services on a cash basis. This prohibits access by those who cannot afford payment; however, the state has moved to provide coverage to Medicaid eligible participants effective Dec. 1, 2015. This will facilitate services to a broader audience; in addition, the five MCO plans which comprise "Bayou Health", Louisiana's Managed Care administration of Medicaid services, advertise on television, radio and billboards; thereby creating a broad outreach to individuals in need of services.

Louisiana is one of seven states participating in the Innovation Accelerator Program for Substance Use Disorders (IAP-SUD) with CMS' Center for Medicaid and CHIP Services (CMCS) and the Center for Medicare and Medicaid Innovation. With its kick off in January 2015, the Medicaid Innovation Accelerator Program for Substance Use Disorders (IAP-SUD) represented a new collaboration from CMS' CMCS and the Center for Medicare and Medicaid Innovation. The IAP-SUD is a state technical assistance project, which intends to develop strategically targeted functions to advance delivery system and associated payment reforms, and to align with transformation efforts underway in Medicare and the commercial market. The IAP-SUD project includes ongoing CMS-funded consultation and collaboration, working closely with small groups of volunteer states.

LOUISIANA'S CHOSEN AIM: NEONATAL ABSTINENCE SYNDROME (NAS)

- By 12/31/2016, Louisiana Medicaid intends to increase early identification, coordinated referral and treatment engagement by **5%**, when compared to 2013, for at risk Medicaid-enrolled mothers and youth between birth and 12 months of age, who are at risk for NAS in two initial settings: a large metropolitan Women's Hospital and a rural tri-parish area/system of care.
- As IAP-SUD project goals and aims are achieved, work plans will strive to generalize and extend enhancements statewide to other facilities and communities beyond the initial two settings, and will apply lessons learned to additional substance use disorder service enhancements statewide.

3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with 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, advocacy with state payers)?

The providers who provide Medicated Assisted Treatment within Louisiana are licensed within OBH; the language which governs those programs indicates that the provider must maintain CARF accreditation status. Each privately owned provider is chosen by a RFP process which must be approved by a needs assessment conducted by the Department of Health & Hospitals and approved by the Louisiana legislature. Language within licensure was designed to ensure that all persons who receive Methadone must receive counseling (including but not limited to the

patient, family or persons who the patient indicates as significant other); there are also safeguards within the guidelines to address diversion and/or misuse. For instance, Providers must obtain DEA numbers and receive periodic unscheduled DEA visits. In addition, the LA Pharmacy Board also makes unscheduled visits. The SOTA makes unscheduled visits to review the program, the facility, and staff within their roles to provide care. When patient complaints are received, they are investigated in collaboration with Health Standards within DHH.

15. Crisis Services

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

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

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

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

Crisis Prevention and Early Intervention:

- *Wellness Recovery Action Plan (WRAP) Crisis Planning*
- *Psychiatric Advance Directives*
- *Family Engagement*
- *Safety Planning*
- *Peer-Operated Warm Lines*
- *Peer-Run Crisis Respite Programs*
- *Suicide Prevention*

Crisis Intervention/Stabilization:

- *Assessment/Triage (Living Room Model)*
- *Open Dialogue*
- *Crisis Residential/Respite*
- *Crisis Intervention Team/ Law Enforcement*
- *Mobile Crisis Outreach*
- *Collaboration with Hospital Emergency Departments and Urgent Care Systems*

Post Crisis Intervention/Support:

- *WRAP Post-Crisis*
- *Peer Support/Peer Bridgers*

- *Follow-Up Outreach and Support*
- *Family-to-Family engagement*
- *Connection to care coordination and follow-up clinical care for individuals in crisis*
- *Follow-up crisis engagement with families and involved community members*

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

Louisiana's statewide crisis services include crisis prevention, early intervention, crisis intervention and stabilization and post crisis intervention and support. Most activities occur at the LGE level; some suicide prevention and post crisis response also occurs from OBH headquarters. Many crisis response services occur statewide; a few are only offered in some of the LGEs. Crisis services offered are detailed below.

Crisis Prevention and Intervention Services

Warm Lines/Crisis Lines

Magellan currently has a statewide warm line (1-800-730-8375) staffed by peers in recovery that operates 5 p.m. to 10 p.m. seven days a week. In addition, some LGEs provide crisis lines as part of their services. Others (CAHSD, ImCAL, FPHSA) contract with a crisis center to answer their crisis line after hours, weekends and holidays. Some LGEs contract with community providers to provide crisis services that include a crisis phone line. Some use their staff on the crisis lines and/or as back up to the contracted provider.

Psychiatric Advanced Directives and Crisis Planning

Louisiana's Psychiatric Advanced Directives law allows individuals to provide advanced psychiatric directives for their care. The LGEs address Advanced Directives in the admission, assessment and/or orientation process. If an individual does not have one, they are generally provided with the form and assistance with filling it out. If individuals choose to fill this out at a later date, then the Peer Support Specialists work with them. Crisis Planning is also covered during the admission and assessment process and becomes part of the treatment plan record. Crisis planning is generally re-visited for revision after new crises occur.

Peer Support and WRAP

Most of the LGEs utilize Peer Support Specialists (PSS) as part of their crisis prevention, intervention and support functions. Many of the PSS are trained in the WRAP model. In NEDHSA, the Women and Children's clinic specifically offers WRAP services.

Suicide Prevention at the OBH Headquarters level

Act 582 required the Department of Health and Hospitals to post a list of suicide "assessment, intervention, treatment and management" training opportunities for health and behavioral healthcare professionals on its website. The list included free and fee based trainings listed in the Suicide Prevention Resource Center's best practice registry and some that followed the guidelines for training from the registry. Notification of the posting went to all of the LGEs, the professional boards listed in the Act and the professional organizations.

In 2014 and six months of 2015, OBH headquarters staff provided suicide prevention and early intervention trainings for approximately 800 individuals. These included ten of the half day safeTALK presentations (suicide alertness and how to connect to help) and nine ASIST (Applied Suicide Intervention Skills Training) as well as safeTALK upgrades with the local fire department and presentations on "Means Restriction" and "What You can do to Prevent Suicide". These staff members were trained as trainers under the Garrett Lee Smith grant.

Suicide Prevention and Safety Planning – LGE level

The LGEs provide suicide prevention/intervention training for staff. Suicide intervention and stabilization for individuals is included as part of each area's overall crisis response. Some LGEs primarily address safety planning when an individual is identified as high risk; others address it routinely. NLHSD has a specific policy to follow up individuals assessed as high-risk. When high risk individuals miss an appointment, a phone call is made to the individual and/or the family when appropriate to check up on them. A welfare check from law enforcement is utilized if staff are unable to reach the individual. NEDHSA also funds and supports region-wide programs that provide suicide prevention as part of their evidenced based curriculum. NEDHSA also funds coalitions that address issues of depression and suicidal thoughts; they offered the ASIST suicide prevention training to both clinical staff and interested community partners. FPHSA provided three ASIST trainings in their area in the last SFY.

Crisis Intervention and Stabilization Services

Youth Crisis Services

Crisis services for youth are available in every Local Governing Entity (LGE). With the advent of regionally led services in every area of the state, the LGEs have the autonomy to determine how they want to provide Children's Crisis Services. 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. This process should always include client voice and choice. Crisis services for children and youth involved in CART are provided 24 hours a day, seven days a week. There is a crisis line number available in every LGE which should give direct access to crisis services for children and youth. In some areas these services are provided in conjunction with adult services and in other areas it is not. CART crisis services are available to all children and their families, not just those eligible for public mental health clinics or services. Services include telephone access with additional crisis services and referrals, face-to-face screening and assessment, crisis respite in some areas, clinical case management, consumer care resources, and access to inpatient care when deemed necessary or requested by the caretakers. Assistance from the State Management Organization (SMO) can also be obtained if needed. The infusion of Social Service Block Grant funds supports respite care, in-home crisis stabilization, and family preservation at various locations across the state. The CART program provides daily access to parents, teachers, doctor's offices, emergency room staff or other community persons who identify a child experiencing a crisis. These referrals can begin with any interested party/stakeholder with consent from the guardian. After the maximum seven day period of CART crisis stabilization, youth and their

families may still require further in-home intensive services. Evidenced based intensive in-home services may be provided through any of the available community based services such as Functional Family Therapy (FFT), Multi-Systemic Therapy (MST), Homebuilders, and Community Psychiatric Support and Treatment (CPST) or Psycho-Social Rehabilitation (PSR) services with child providers.

Adult Mobile Crisis Teams and Crisis Evaluators/Specialists

Adult mobile crisis teams are part of the crisis line and overall crisis services response in several areas. MHSD, CAHSD, and NLSHD, and JPHSA all have mobile crisis teams that respond to individuals in crisis throughout their areas. In NEDHSA, the Northeast Delta Crisis Intervention Team (CIT), is a collaborative effort of first responders, including police agencies, fire departments and paramedics. In FPHSA, a contractor provides mobile crisis services in St. Tammany parish. In JPHSA's Community Based Crisis Intervention Service (CCIS), the crisis evaluators also respond to community requests for on-site crisis services during the day from the Coroner's Office, Adult and Elderly Protective Services, and the Jefferson Parish School System. Crisis Specialists also provide on-site stabilization for individuals in identified Health Centers who are awaiting transportation to the hospitals. In JPHSA, the CCIS is also the Single Point of Entry (SPOC) for individuals seeking in-patient psychiatric, detoxification or co-occurring disorder treatment. JPHSA also provides crisis-related transportation services.

Law Enforcement/Crisis Intervention Team (CIT) Training

In many areas, the LGEs work collaboratively with law enforcement for crisis response in the community. Five of the LGES provide CIT training to responders in their area. The Memphis CIT model is utilized so that they can more effectively manage community behavioral health crises and decrease unnecessary use of hospital emergency rooms and jails. CAHSD trains law enforcement and 911/EMS dispatchers. ImCAL fully supports and assists with CIT training of law enforcement. NLHSD provides CIT training for law enforcement. NEDHSA trains the responder personnel. FPHSA provides CIT training for law enforcement and emergency medical technicians in collaboration with the local National Association for Mental Illness (NAMI) chapter.

Post Crisis Intervention and Support Services

OBH Behavioral Health Crisis Support Cadre

In the past post crisis intervention and support was provided via the Louisiana Spirit crisis counseling program which is no longer funded. After the hurricanes, crisis support and postvention has continued to be provided by a limited number of OBH headquarters staff in situations such as workplace deaths by suicide, violence or accident. In SFY 2015, headquarters staff were deployed to work places for traumatic events four times.

In recognition of the need for this type of ongoing support, OBH has created the **Behavioral Health Crisis Support Cadre** at the headquarters level to help survivors of sudden loss or individuals impacted by a traumatic event. This support functions offers emotional support to survivors shortly after a traumatic event utilizing trauma-informed interventions to facilitate the grieving and coping process. It is effective in stabilizing the workplace community and to help the

organization return to normalcy and pursue its mission. The process helps individuals and groups understand normal reactions, helps them work through their crises, and connects them with culturally relevant resources in their community.

Thirty clinicians at the OBH headquarters level were provided training in crisis and stress responses, grief and loss, group dynamics, cultural perspectives, trauma informed practices, postvention processes and strategies related to suicide, Psychological First Aid (PFA) and Skills for Psychological Recovery (SPR).

LGE

Post-crisis intervention and support services provided in the LGEs generally include peer support, linkages to care coordination and follow up to clinical care. Most LGEs provide ongoing support that includes transition for follow up for each individual who has received crisis intervention to ensure the immediate crisis situation was resolved and the linkages are being effectively utilized within the community. The ongoing support can utilize individualized safety planning, inclusion of family and natural support systems, individual and group therapy; psychiatric medication management services and contracted case management services.

In those areas with mobile crisis teams, information about crisis services provided to the individual are generally shared with the appropriate behavioral health clinic. NLHSD also has a respite room available for persons who need additional support or monitoring. If clinically appropriate, this can be an alternative to hospitalization. In CASHD, the Adult Mobile Crisis Team provides Community Psychiatric Supports and Treatment (CPST) services to adult clients and families experiencing symptoms and stressors requiring more intense treatment. Clients and families are educated about medications, provided with counseling to achieve goals and connected to community resources. Both NEDHSA and FPHSA utilize a local contractor to provide post crisis services and to assist with linkage into treatment. NEDHSA utilizes the contractor's peer support programs and centers with all sites staffed to manage follow up care and treatment for clients presenting post crisis. Clients are also referred to community support agencies.

In JPHSA, the Community-based Crisis Intervention Services (CCIS) include effective post-crisis follow up methodologies targeting circumstances, situations, and systems that exacerbate crises for the individual and/or family served. Post-crisis services focus on reducing the likelihood that future crises will occur, and strive to ensure that individuals seeking assistance are linked to needed services and resources that are available to Jefferson Parish residents. Additionally, the Hospital Coordination and Transition (HCT) program facilitates linkages to community-based services to meet the individual's current level of need upon discharge from a hospital or emergency room with detailed attention to the conditions that precipitated acute care and in developing a plan to avoid any future crisis. The HCT or CCIS service may also refer individuals enrolled in services at JPHSA to the peer specialist program for WRAP development.

16. Recovery

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

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

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

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist
- Promotoras
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Supported employment
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. 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.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

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

1. ***Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?***

a. Louisiana has adopted the definition of recovery as stated by Recovery Innovations in Arizona. The definition states: "Recovery is remembering who you are and using your strengths to become all you were meant to be." 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.

b. The state has had peers working within leadership positions (Office of Consumer Affairs) in the Office of Behavioral Health since 2004. This has expanded with the implementation of the Louisiana Behavioral Health Partnership through the Statewide Management Organization and the hiring of the Recovery/Resiliency Manager for the Louisiana Operations. These dual positions work together, enhancing peer-run Recovery Initiatives throughout Louisiana.

c. Person-centered planning and self-direction and participant-directed care are all tenets of care as provided through the Louisiana Behavioral Health Partnership.

d. OBH has been instrumental in bringing initiatives such as WRAP and Peer Support Whole Health to Louisiana through which trainers are functioning throughout the state. Additionally, through a SAMHSA CABHI grant, Peer Navigators are assisting those who are chronically homeless to find the supports they need to obtain and maintain housing.

e. Since Louisiana has transitioned to a managed care model for service delivery and relies on contracted services, there is a need for an effective method of evaluation of services from the consumer's perspective. The Office of Behavioral Health (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 Office of Behavioral Health's 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.

2. ***How are treatment and recovery support services coordinated for any individual served by block grant funds?***

Treatment and recovery support services are coordinated within the ten Local Governing Entities (LGEs) to meet the unique needs in each geographic area of the state. OBH works hand-in-hand with each LGE to ensure that uninsured individuals have parity of services.

3. ***Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?***

a. OBH has worked with the VA to train Peer Support Specialists to work with veterans throughout the state.
b. Peer Navigators are assisting those who are chronically homeless to find the supports they need to obtain and maintain housing through a SAMHSA CABHI grant,
c. Family Peers are working with families of at risk youth through our CSoC program

4. ***Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?***

a. Louisiana has a 76 hour training program for Peer Support Specialists, developed by Recovery Innovations of Arizona. At present, a committee has been convened which is in the process of examining national best practices regarding the training and certification of Peers. This work is being completed with the intention of improving the existing training and certification process.
b. Louisiana is also working with Recovery Innovations to develop a training program for service providers and their staff in order to more effectively supervise Peer Support Specialists.

5. ***Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?***

At present the state does not conduct empirical research on these areas. OBH does offer information and workshops to stakeholders, LGEs and private providers on EBPs, best practices and innovative recovery-oriented approaches such as the use of WRAP®, person-centered planning, motivational treatment strategies and prevention/wellness activities that promote health.

6. ***Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning.***

As a part of its ongoing effort to engage youth and parents in every facet of the Coordinated System of Care, OBH makes provision for and actively "recruits" these consumers for engagement in several committees and workgroups (including State Governance Board, Statewide Coordinating Council, Inter-Agency Monitoring Team, and Quality Assurance Committee). Additionally, OBH/CSoC representatives periodically attend regional community meetings, as a way of both updating the community on new developments; but also to gather information/input from the community about outstanding needs and community successes. As a part of the CSoC, OBH issued a satisfaction survey which reached over 350 youth/parents to assess their satisfaction with the quality of the wraparound services they were receiving.

The Louisiana Behavioral Health Advisory Council (LBHAC) has forty members which includes consumers of both mental health and addiction services, family members of adults with serious mental illness and substance abuse disorders, family members of children with emotional/behavioral disorders, behavioral health advocates, representatives from regional advisory councils (RACs), and state agency employees. The Council is designed to have geographical representation of the ten local governing entities in the state, and includes members from diverse backgrounds and ethnicities. In addition, the Council has representatives of special populations, namely representatives of the managed care industry, substance use disorder treatment programs, as well as representatives of the behavioral health needs of the elderly, members of federally recognized tribes, the homeless, transitional youth, and the LGBTQI population. The Council actively recruits individuals to fill all vacant positions.

The LBHAC currently includes five standing committees (Membership, Finance, Advocacy, Programs and Services, and Planning) that oversee each of the functions entrusted to the Council. The committee on planning was recently added as a standing committee. This committee reports and recommends on such matters as they may deem appropriate for council consideration. The committee on planning is composed of the council officers and chairmen of the other standing committees of the council. The chairman of the council serves as the chairman of the committee on planning. The chair of the Council recently established a Prevention subcommittee of the Committee on Programs and Services. 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.

The Planning Council Liaison continues to promote communication between OBH, the state Planning Council, and the RACs. The liaison organizes LBHAC meetings, maintains communication with Council members, and provides training, education, and support to LBHAC members as well as to RAC members, and management of the LGEs. The liaison continues to educate Council and RAC members, as well as regional administrators as to their roles and responsibilities in behavioral health planning. The liaison will provide direct support for securing training and education for both the state Council and the Regional Advisory Councils.

7. ***Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?***

Since the inception of the Coordinated System of Care (CSoC), OBH has provided training in wraparound and family support practice, in addition to ongoing technical assistance to Family Support Organizations (family and peer-run organizations), that serve youth and families within the CSoC. In the three-year history of CSoC, this training has been provided to well over 1,000 parent and youth peers. Additionally, the State has two contracts with organizations to further the reach of family and youth voice and engagement. A contract with Families Helping Families of Greater Baton Rouge supports family and youth involvement in committees, trainings, and other CSoC/OBH initiatives. Additionally, a longstanding contract with the Louisiana Federation of Families for Children's Mental Health provides for in-person and web-based training for parents and youth, makes available a monthly networking/support conference call for parents and youth across the state, as well as supporting family and peer advocacy events and initiatives (as aligns with the Federation's mission).

8. ***Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.***

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

9. ***Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.***

The Office of Behavioral Health recognizes that the best possible outcomes are achieved when the care of the whole patient is effectively managed. By integrating primary care and behavioral health, providers are able to look at the whole person, identifying behavioral health issues that need treatment and helping to prevent problems before they occur. Behavioral health services include treatment and prevention for both mental health and substance abuse disorders.

The Office of Behavioral Health (OBH) has incorporated treatment of the whole person when developing programs or participating in initiatives. In 2012, the OBH implemented the Coordinated System of Care (CSoC), in which a wraparound facilitator organizes a team that includes the youth, family, service providers, and natural supports (i.e. coach, pastor, extended family, etc.) The team addresses the youth and family holistically, developing a plan that coordinates all services. In fiscal years 2014 and 2015, the Office of Behavioral Health facilitated statewide primary care and behavioral health integration summits. The goal of these summits was to establish a commitment to primary care integration, identify key priorities and next steps, and potentiate networking for the development of local programs needed to promote integration of health services across Louisiana.

The Office of Behavioral Health (OBH) developed a partnership with the Office of Public Health (OPH) to address the needs of individuals with Behavioral Health conditions and Tobacco/Nicotine Dependency. The goal of this collaboration is to reduce smoking prevalence among those diagnosed with Mental Health and/or Substance Used Disorders by 5% by 2020. On June 19-20, 2014, representatives from OBH, OPH, Medicaid, and the Smoking Cessation Trust attended the Substance Abuse and Mental Health Services Administration (SAMHSA) 2014 State Policy Academy on Tobacco Control in Behavioral Health in Rockville, MD. The Academy provided an opportunity for the development of a collaborative action plan to address tobacco use by those with mental and substance use disorders. Initiatives in the plan include but are not limited to: the enhancement of data collection capability to identify smokers with behavioral health conditions and/or complications, increasing outreach and awareness of tobacco cessation resources and increasing access to tobacco cessation services. Implementation of the plan began in 2014 and will continue in 2015 and 2016.

Currently, OBH provides Tobacco Cessation treatment services statewide. Providers at a minimum offer the Ask, Advise, Refer (AAR) model, while others provide evidenced based screening, assessment, individual counseling, group, nicotine replacement therapy and referral. OPH brings fourth the outreach, awareness and training component. OPH partnered with OBH to enhance workforce development efforts by providing the Tobacco Specialist Certification training. This effort is to ensure that clinicians provide evidenced based treatment interventions to enhance positive outcomes. In addition, OPH provides webinars, training and technical

assistance to OBH staff, other key stakeholders and the community, in an effort to enhance and heighten awareness about the prevalence and need for Tobacco Cessation among the behavioral health population. OPH also offers the Louisiana Quit Line, which provides for brief coaching calls via phone and the ability to assist with nicotine replacement.

In 2015, the OBH began a concerted effort to share information on behavioral health and substance related awareness events and information with providers. Links to awareness and promotional materials are disseminated to the local provider networks. Examples include awareness events for topics such as: National Problem Gambling Awareness Month; Alcohol Awareness Month, Mental Health Month and Child Mental Health Week. National Prevention Week; Post Traumatic Stress Disorder Awareness Week, National Recovery Month, National Suicide Prevention Week and Domestic Violence Awareness Month.

10. ***Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?***

Louisiana received 3,000 Section 8 housing vouchers after Hurricanes Katrina and Rita devastated New Orleans and the Gulf Coast area of the state. As a result, the State is able to assist homeless low-income and disability populations, including individuals and families with behavioral health needs. The State has embraced the EBP model of Housing First and recognizes the critical need of Supported Housing that facilitates a continuum of care in the community. The goal is to assist individuals with behavioral health needs in securing housing first to address their immediate need of shelter. However, through outreach and assessment, a plan must be developed for placement into appropriate housing with support services for treatment and other mainstream resources to enhance community integration and housing sustainability. The overarching objective is to work with housing providers, including HUD and local housing assistance programs such as Section 8, HOME Public Housing, Section 811 and CDBG housing programs, to ensure that persons with behavioral health needs are included when affordable housing is developed and available. The Low-Income Housing Taxes Credit has already played a significant role with creative financing for developers to construct affordable housing units that are decent and safe. Moreover, by understanding the needs of individuals and how the housing market works, the State is accessing affordable housing while providing home and community-based supports and services with Assertive Community Treatment (ACT), Intensive Case Management (ICM), and the 1915(i) Medicaid state plan amendment. Children and adolescents are provided in-home community-based supports to maintain and strengthen the unification of families. They are also provided with Therapeutic Group Homes and residential psychiatric facilities with more intensive support and services only when there is a need to remove the children/adolescents from their homes for recovery. In addition, the State has managed care services for children, adolescents, and adults with mental health and substance abuse disorders, along with a provision for indigent and low income persons to access services. Finally, housing in combination with the appropriate support services is the way the State plans to address restrictive environments that are not necessary. This will allow individuals and families the opportunity to live in the least restrictive environment possible.

The Housing First model is an evidence-based practice approach embraced by HUD whereby the primary focus is to place the persons served into affordable housing first because it is a basic 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 Behavioral Health Partnership involves a managed care system, administered by Magellan Health Services of Louisiana, to coordinate 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.

The state is also a recipient of a CABHI State grant through SAMHSA. The populations of focus for the CABHI State grant are chronically homeless individuals with serious behavioral health disorders and homeless veterans with serious behavioral health disorders. The CABHI State grant provides funding for clinical treatment and supportive services to assist the population of focus with maintaining housing successfully in the community.

11. Describe how the state is supporting the employment and educational needs of individuals served.

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

OBH incorporates job readiness into programs when appropriate and monitors the progress of these efforts through the National Outcome Measurement System (NOMS). For example, job readiness is a reimbursable service through the state funded voucher program for substance use disorders and through the CABHI State grant awarded to OBH. In accordance with the four

identified SAMHSA dimensions for recovery, Louisiana recognizes proper supports in the community are critical to a healthy recovery oriented lifestyle.

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

17. Community Living and the Implementation of Olmstead

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 substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (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 residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain 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. Please indicate areas of technical assistance needed related to this section.

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

1. ***Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.***

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

- Implementation of the Louisiana Behavioral Health Partnership (LBHP), in March 2012. The LBHP is Louisiana's system of care for Medicaid and non-Medicaid adults and children who require specialized behavioral health services which are managed by a Statewide Managed Care Organization (SMO). Implementation of the SMO was a major system transformation geared towards rebalancing the institutional versus home and community-based behavioral health services. Since its inception, the behavioral health provider network and service array has 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 has been 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. CSoC is a critical component of the LBHP and 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.

- Intensive Community Based Services for Adults. With the implementation of the LBHP in 2012, Louisiana also requested approval from CMS to implement the 1915(i) state plan amendment to provide intensive community based services for adults. Approved for implementation in March 2012, the 1915(i) state plan amendment allows 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. While allowing for the provision of these intensive home and community based services, the 1915(i) provides supports and services in the individual's community in efforts to prevent institutionalization. Home and community based services reimbursable through the 1915(i) in Louisiana include:
    - Community Psychiatric Support and Treatment (CPST)
        - Includes Assertive Community Treatment (ACT)
    - Psychiatric Rehabilitation Services (PSR)
    - Crisis Intervention

DHH has also recognized gaps in services for the coordination of care for individuals in long term services and is currently engaged in a comprehensive system transformation of the long-term care system through the initiatives listed below:

- On Feb. 1, 2012, DHH launched the single largest transformation of the delivery of 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 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 Bayou Health initiative is to encourage enrollees to own their health and the health of their families by making healthier choices. In Bayou Health, Medicaid recipients enroll in one of five Health Plans, each of which offering different provider networks, health management programs, and incentives. Each of these Plans is accountable to the Department of Health and Hospitals (DHH) and the state of Louisiana

- In November 2014, DHH announced a plan to integrate all behavioral health services into its existing Medicaid managed care system called Bayou Health. This integration is expected to be implemented in December 2015.

In addition to the transformative activities listed above, the following activities are ongoing:

- OBH within the Preadmission Screening and Resident Review program continues to partner with other DHH agencies to ensure individuals in nursing facilities are placed in the appropriate setting with the most appropriate services. OBH also works closely with other agencies and programs such as the Money Follows the Person Rebalancing Demonstration (MFP). MFP encourages serving participants in an individualized and holistic manner. The expectation of MFP is that individuals moving from institutions receive transitional services which are intended to help the person be successful in the community. OBH collaborates with other agencies to training opportunities to nursing facilities on discharge planning.

- Louisiana partners with other DHH 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. OBH utilizes block grant funding to aid individuals in transitioning from institutions with "Bridge Funding" support and supports programs which provide transitional housing to individuals who are at risk of institutionalization

- 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.

- OBH collaborates with the Louisiana Rehabilitative Services to provide employment services to individuals with behavioral health conditions. The overall goal of OBH 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 staff has also been participating in Southern Region Olmstead Data Learning Community and other activities as they arise which are intended to ensure individuals are able to reside and receive services in the least restrictive environments.

2. How are <u>individuals</u> transitioned from hospital to community settings?

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 statewide management organization authorizes acute psychiatric hospital stays based on medical necessity. OBH has cooperative endeavor agreements with psychiatric hospitals to ensure safety net beds for the uninsured and oversees these facilities to continue hospitalization for those individuals who are court ordered or who no longer have a payment source but meet necessity for continued hospitalization due to extenuating circumstances. OBH monitors these individuals through a Continued Stay Review process whereby OBH determines the continued stay needs for these individuals before authorizing further payment. In addition, OBH monitors the state run long-term facilities to ensure that discharge planning is on track and to assist in addressing any barriers to discharge. Coordination of services from institutions are further enhanced by the collaborations between some of the local governing entities.

3. ***What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?***

As indicated in the above sections, Louisiana has engaged in many efforts to address the ADA community integration mandated required by the Olmstead Decision of 1999. Efforts have included utilizing mental health block grant funds to assist persons being discharged from mental institutions with critical supports to be successful in the community. Examples of supports funded include rent, utilities, deposits, furniture, clothing, etc. As stated in previous sections, the state has continued to transform the system of care for delivery of behavioral health services to focus on home and community based services and supports. Examples of the transformations include the integration of mental health and substance use disorder services, development and implementation of the LBHP, Medicaid state plan amendments and waivers to support home and community based services to both adults and youth, as well as the upcoming integration of behavioral and primary health care.

4. ***Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?***

There is currently no litigation the state is involved in in regards to children with SED or adults with SMI.

5. ***Is the state involved in a partnership with other state agencies to address community integration?***

Yes, our state is partnering with other agencies and stakeholders to develop and implement. (See above for our current plan).

18. Children and Adolescents Behavioral Health Services

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. 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 mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

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 substance use disorders and co-occurring disorders 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's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care:

- *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 behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes nonresidential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

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

1. ***How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?***

In March 2012, the state of Louisiana implemented Phase One of the Coordinated System of Care (CSoC) for multi-system involved youth with significant behavioral health (mental health and/or co-occurring) disorders who are in or at-risk of out of home placement. Phase One included five of the state's nine regions. The initiative was expanded statewide in November 2014. Through the use of a 1915(c)/b3 waiver combination, youth identified as those with the most complex and severe behavioral health needs receive individualized care planning through regionally-based Wraparound Agencies (WAAs) and have access to a specialized array of services in addition to traditional Medicaid state plan services. Extensive workforce development and technical assistance has been offered statewide to ensure that the values embraced within CSoC (family driven, youth guided, culturally and linguistically competent, community-based, strength-based, individualized, outcomes-oriented) are generalized across all children's services. A cross-system team of representatives from OBH, Department of Children and Family Services (DCFS), Office of Juvenile Justice (OJJ), Department of Education (DOE), and Medicaid has been established with the sole purpose of technical assistance, support, and monitoring of implementation and operationalization of this approach.

2. ***What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance use, and co-occurring disorders?***

Within Louisiana, it is the expectation that individualized plans of care are established for all youth with behavioral health needs. By contract, the Statewide Management Organization (SMO)

is required to ensure that the treatment planning function in both CSoC implementing and non-implementing regions produces a "community-based individualized treatment plan" (http://new.dhh.louisiana.gov/assets/docs/contracts/305PUR-DHHRFP-SMO-OBH_STATEWIDE_MANAGEMENT_ORGANIZATION.pdf).

In CSoC implementing regions, the staff of the Wraparound Agency (WAA) has been trained to the standards and practices established by the National Wraparound Initiative (http://nwi.pdx.edu/) and are expected to adhere to these guidelines in all of their work. The resulting plans of care are reviewed by staff from the SMO Youth who meeting clinical eligibility, and are awaiting referral to a wraparound agency receive individualized care planning provided through the SMO's Recovery and Resiliency Care Management (RCM) program that uses an individualized care planning approach and recovery oriented principles and practices. As part of care and utilization management practices within the SMO, plans of care are routinely reviewed to assess the degree of individualization.

3. ***How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?***

In March 2012, Louisiana established the Louisiana Behavioral Health Partnership (LBHP), statewide Medicaid managed behavioral healthcare, and the Coordinated System of Care (CSoC) for youth with the most significant and complex needs. Both LBHP and CSoC are multi-system collaborative efforts of the Department of Health and Hospitals (Medicaid and OBH), as well as DCFS, OJJ, and DOE. The efforts are overseen by a State Governance Board established by Governor Bobby Jindal in Executive Order (BJ-2011-5) where the Secretaries (or designees) of the state agencies come together with the Governor's Office, family, advocacy, and youth representatives. The agreements are also memorialized in an annual Memorandum of Understanding signed by each state agency. The four child-serving agencies meet quarterly as the CSoC Quality Assurance committee to review seventeen discrete quality assurance performance measures to track and trend achievement, to discuss barriers and discuss systemic solutions when systemic issues are identified. Members of the OBH CSoC team, made up of staff detailed to OBH by the four child-serving agencies, provide training and technical assistance to executive and field staff from their respective agencies to promote a strength and needs based approach to care-planning, inter-agency collaboration, and increased use of home and community-based services.

4. ***How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?***

Below are examples of ways in which Louisiana will provide training in evidence-based services:

- Through the Statewide Management Organization (SMO), evidence-based practice dissemination is a priority for workforce development. The SMO will continue to work with EBP national partners to identify potential providers and also offer the licensing and training.

• The Office of Behavioral Health is a partner with Tulane University, the Louisiana Department of Children and Families (DCFS), and the behavioral health Statewide Management Organization (SMO) in a project funded by the U.S. Department of Health and Human Services (HHS) Administration for Children and Families (ACF). The project is intended to reduce symptoms and improve functioning for children involved in the child welfare system who have experienced trauma by providing training on recognizing and detecting trauma in youth and completing referrals for clinical assessments and treatment, with an emphasis on evidence-based trauma treatment. Trainings and weekly consultation on cognitive behavioral therapy (CBT) for trauma will be provided. OBH is a member of the project Steering Committee, with OBH providing particular input on assessment and treatment providers. OBH and the SMO will use data from the project to inform the delivery of behavioral health services. The Bayou Health Plans will be encouraged to participate in this project as well. The Louisiana State Adolescent Treatment Enhancement and Dissemination Program (LA-SAT-ED) will serve adolescents aged 12 to 18 with substance abuse/co-occurring disorders and their families. The program will develop a blueprint for policies and procedures and financing structures that can be used to widen the use of evidence-based substance abuse practices in Louisiana. LA SAT-ED developed a learning laboratory with two collaborating local community-based treatment provider sites during year one and four additional sites in years two and three. Through these efforts, Louisiana will be able to improve substance use/co-occurring assessment and treatment services for adolescents and their families, identify barriers to access treatment, and test solutions that can be applied throughout the state. This will address the treatment of adolescents with substance use and co-occurring substance use and mental disorders, and their need for recovery support through improved integration and efficiency of services. As a result, the program expects: 1) decreased juvenile justice involvement for adolescents; 2) increased rates of abstinence; 3) increased enrollment in education, vocational training, and/or employment; 4) increased positive social linkages; and 5) increased access, service use, and outcomes among adolescents most vulnerable to health disparities. The project goals include the provision of evidence-based assessment, treatment, and recovery services to a minimum of 360 adolescents and their families by the end of year three. Participants of the program will receive evidence-based treatments that include Adolescent Community Reinforcement Approach (A-CRA) augmented by Assertive Continuing Care (ACC) and evidence-based assessment using the GAIN. Through workforce development activities, LA SAT-ED also collaborated with providers of substance use and co-occurring disorders and state child-serving agencies to develop and provide training and continuing education events throughout Louisiana.

• A 2012 report released by the Association for the Advancement of Evidence-Based Practice (http://www.advancingebp.org/wp-content/uploads/2012/01/AEBP-assessment.pdf) showcases Louisiana as one of the top five states with one of the most significant increases in EBP coverage when looking at the number of family therapy teams (such as FFT and MST) per million population.

• Evidence-based practices, Functional Family Therapy (FFT), Multi-Systemic Therapy (MST) and Homebuilders, have enhanced rates within the LBHP to support training costs. In addition, the Louisiana Department of Children and Family Services (DCFS) continues to provide for all of

the training and quality enhancement (consultation calls, site visits and record reviews) for our Homebuilders providers in Louisiana.

5. ***How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?***

Through the establishment of centralized access to and authorization of behavioral health services through the Statewide Management Organization (SMO), routine reports that address service utilization, costs, and outcomes will be provided. Priority areas identified by the state for tracking and monitoring include school performance, out of home placements, member and provider satisfaction, and service utilization.

6. ***Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?***
7. ***What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.***

19. Pregnant Women and Women with Dependent Children

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.

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

1. *The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.*
2. *Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.*
3. *Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.*
4. *Discuss who within your state is responsible for monitoring the requirements in 1-3.*
5. *How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)*
    a. *How many of the programs offer medication assisted treatment for the pregnant women in their care?*
    b. *Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?*
6. *How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)*
    a. *How many of the programs offer medication assisted treatment for the pregnant women in their care?*
    b. *Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?*

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

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

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

According to the EHR system, during SFY14 there were a total of 4,253 women with dependent children admissions and 4,092 women with dependent children served. OBH provided 91,713 services to this population during SFY 2014. In addition, there were at total of 202 pregnant women admissions and 249 pregnant women served. OBH provided approximately 8,406 services to this client population.

According to the Block Grant Set Aside Reports, OBH provided 491 interim services to pregnant women during SFY 2014. Interim services are provided until such time as the appropriate level of care becomes available for women needing services. Interim services include education or counseling concerning Fetal Alcohol Spectrum Disorders (FASD), HIV, STDs, the danger of sharing needles, and the benefits of prenatal care. Other interim services include but not limited to: screening for Tuberculosis, pregnancy test, STD and HIV, as well as referral for emergency medical services and prenatal care.

OBH establish partnerships with resources within the community to provide some of the above mentioned screenings. For example; the Office of Public Health partners with OBH to provide voluntary pregnancy test and Fetal Alcohol Spectrum Disorder (FASD) education for all women entering the system.

In urban areas like New Orleans, OBH may have more than one residential facility providing services in the area. There are also a couple of LGEs that do not have residential treatment facilities within their service boundaries, such as the Florida Parishes Human Services Authority.

In these situations, clients are referred to facilities within another LGE where services are available.

OBH coordinates services with statewide Opiate Replacement Clinics to provide services to pregnant opiate dependent females. OBH promotes Methadone, Buprenorphine and/or Suboxone treatment services to facilitate appropriate detoxification protocols, during pregnancy and post-delivery. Pregnant women requiring services are assessed and, pending community based resources, referred to opioid treatment clinics or SAMHSA approved Buprenorphine and/or Suboxone physicians.

The residential programs below served pregnant women and women with dependent children during SFY 2014:

Pregnant Women and Women with Dependent Children:

1) *CENLA Chemical Dependency Council, Pineville La. (CLHSD), ASAM Level III.3* - maintained a bed capacity of 21 beds for women and children under the age of 12. This program provided a community-based rehabilitation program in a residential house setting.
2) *Grace House, New Orleans La. (MHSD), ASAM Level III.3* - maintained 10 beds for women only. The average length of stay at this facility is between three to six months.
3) *Rays of Sunshine, Monroe La. (NEDHSA), ASAM Level III.3* - maintained 8 beds at this facility reserved for women with dependent children, including pregnant women. This facility utilizes a therapeutic community model with some emphasis on the 12 Step Model.
4) *Reality House, Baton Rouge (CAHSD), ASAM Level III.3* - provides services for 19 women and pregnant women and/or women with dependent children in a residential setting, to foster emotional growth, encourage sobriety, and teach problem solving skills that are linked to positive lifestyle changes.

Women and Pregnant Women:

5) *The Alcohol and Drug Unit, Mandeville (FPHSA), ASAM Level III.5* - maintained a 12-bed capacity and prioritized admissions for pregnant women, located on the campus of Northlake Behavioral Health (formerly Southeast Louisiana State Hospital). This facility is under the jurisdiction of the Florida Parishes Human Services Authority (FPHSA). Treatment services included group/individual counseling, gender specific groups, educational lectures, family sessions, and relapse prevention programming.
6) *Fairview Treatment Center, Houma (SCLHSA), ASAM Level III.5* - maintained a 24-bed capacity and prioritized admissions for pregnant women. This facility uses motivational interviewing to meet the client at her level of need and integrates the Minnesota 12-Step Recovery Model in its therapeutic approach.

20. Suicide Prevention

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. ***Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).***

In 2001, the State released STAR: The Louisiana Plan for Youth Suicide Prevention. This strategic plan was developed by the Louisiana Task Force for Youth Suicide Prevention following the 1999 U.S. Surgeon General's Call to Action. The plan included four key dimensions reflected in the acronym title – S: Suicide Prevention for all Louisianans; T: Training and Education; a: Awareness and Advocacy; and R-Research and Resources. This plan was modified slightly when the State had the Garrett Lee Smith grants. This most recent version of the STAR plan can be found in the Application Attachment section of the WebBGAS Assessment and Plan.

The State needs to update the Strategic Plan for Suicide Prevention across the lifespan with the input of other stakeholders and partners, including individuals who have survived suicide attempts or the death of loved ones by suicide. The plan will be based on the 2012 National Strategy for Suicide Prevention and the Zero Suicide initiative. A new State Advisory Board will need to be created to provide input into the plan.

The State will update the plan by December 31, 2015.

2. ***Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.***

Approximately 90 percent of the individuals who die by suicide have a mental health or suicide use disorder. The plan will target these individuals and other high risk populations. The plan will offer training and technical assistance on suicide prevention, intervention, treatment and management for the 10 Local Governing Entities that are responsible for providing mental health, substance use disorder and developmental disabilities services. Opportunities for training and technical assistance will be offered to LGE identified partners and stakeholders in their catchment areas that serve high risk populations such as foster care, the elderly, juvenile justice, institutions of higher learning, children and youth in the Coordinated System of Care, the military, and health care providers.

3. ***Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.***

Louisiana's Strategic Plan for Suicide Prevention has not been significantly revised since its creation in 2001 although the state has been following the plan in its suicide prevention efforts as funding has allowed. The state needs to engage in a strategic planning process to develop a new plan and base the plan on the 2012 National Strategic Plan for Suicide Prevention (NSSP). The goals and objectives of the NSSP and some possible strategies and activities Louisiana can

consider in creating our new plan and establishing measurable goals and objectives can be found in the Application Attachment section of the WebBGAS Assessment and Plan. It will be used as a starting point for initiating the strategic planning process with partner and stakeholder input.

As per the Guidance for State Suicide Prevention Leadership and Plans, the new State plan will be clinically informed and based on the public health approach. It will incorporate collaborative efforts by multiple public and private entities. It will focus on a lifespan approach and will utilize research and safety informed communications. It will comprehensively address multiple factors in suicide prevention and set priorities. It will promote accountability and be regularly monitored, updated and revised. It will be data driven to the extent that suicide attempt and death data is available currently and will include strategies to better identify populations with high numbers and rates of suicide and focus on geographic areas and settings in which risks of suicide are high.

21. Support of State Partners

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- *The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;*
- *The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders 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 actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;*
- *The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;*
- *The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and*
- *The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.*

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

1. *Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.*
2. *Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.*

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

OBH is committed to partnering with other community, State, and local governmental agencies

in order to coordinate its service delivery with the provision of other appropriate services. These partnerships aim to enhance internal resources and afford clients a wider scope of services. Formally, the OBH has the following established strategic partnerships which support the service delivery system as well as the priorities identified within the FY 2014 Block Grant State Plan.

Louisiana Coordinated System of Care (CSoC) - Governance Board

The Louisiana Coordinated System of Care (CSoC) is led by the CSoC Governance Board, as established by Executive Order of Governor Bobby Jindal. The Governance Board is comprised of Executives of the Department of Children & Family Services (DCFS), the Department of Education (DOE), the Office of Juvenile Justice (OJJ) and the Department of Health and Hospitals (DHH), a representative from the Governor's Office, and family, youth and advocate representatives.

The Statewide CSoC Governance Board is responsible for establishing policy for the governance of the CSoC, as well as providing the multi-departmental oversight required to ensure adherence to that policy. The Governance Board also oversees the management of funding resources and directs the State Purchaser contracting with the LBHP Statewide Management Organization (SMO). As of December 1, 2015, the contractor will administer CSoC through a PIHP. Quality assurance and improvement is another key role of the Governance Board, who is responsible for monitoring project outcomes including quality and cost.

As the State Purchaser, OBH was delegated the responsibility for procuring, contracting, and managing the Statewide Management Organization (SMO) for the delivery of behavioral health services to children eligible for the CSoC. The OBH assures that the SMO adheres to the goals and principles of the CSoC initiative and provides performance, outcomes, and quality improvement data to the Governance Board.

Louisiana Coordinated System of Care (CSoC) – Partner Agencies

The four child-serving agencies that are partners in the financing of the Louisiana Coordinated System of Care (CSoC) include the Department of Children and Family Services (DCFS), Department of Education (DOE), Office of Juvenile Justice (OJJ), and OBH. A Memorandum of Understanding that outlines the roles, responsibilities, and commitment of each of these agencies has been signed by representatives from each agency.

Prevention

The OBH continues to partner with the Louisiana Department of Education (DOE) to conduct the Louisiana Caring Communities Youth Survey (CCYS) for Louisiana school students in the 6th, 8th, 10th, and 12th grades. This partnership has historically been formalized through an Interagency Agreement process (see attached in Appendix). 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 behaviors. As the substance abuse prevention field has evolved, the CCYS has been modified to measure additional substance abuse and other problem behavior variables to provide prevention professionals in Louisiana with important information for understanding their communities. Some examples of these additional variables include the

percentage of youth who are in need for alcohol or drug treatment, measures of community norms around alcohol use, and bullying.

Office of Public Health, Bureau of Family Health (BFH)

The Bureau of Family Health is the section of the Louisiana Department of Health and Hospitals that administers several programs that work to assure that pregnant women, women of childbearing age, infants, children, and youth in Louisiana have access to high quality primary and preventive healthcare.

Early Childhood

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) is designed to impact and serve children aged 0-8. In Louisiana, the project is currently being implemented in Lafayette, Acadia, and Vermilion parishes.

Project LAUNCH is a national initiative that is being piloted in Louisiana. It is coordinated by the Louisiana Department of Health and Hospitals by the Bureau of Family Health of the Office of Public Health in conjunction with the Office of Behavioral Health, and funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The aim of Project LAUNCH Louisiana is for all children ages 0-8 to reach social, emotional, behavioral, physical, and cognitive milestones. In addition to providing direct care services, Project LAUNCH states and communities increase knowledge about healthy child development through public education campaigns and cross-disciplinary workforce development activities

Maternal, Infant, and Early Childhood Home Visitation

The Maternal, Infant, Early Childhood Home Visiting Program (MIECHV program) of the Bureau of Family Health implements the evidence-based home visitation models of Nurse-Family Partnership (NFP) and Parents as Teachers (PAT) for eligible Louisiana mothers and their families.

The Nurse-Family Partnership (NFP) is an evidence-based home visitation model for Medicaid eligible first-time mothers and their families. The Louisiana NFP model implementation began in 1999, and the program's goals are to improve pregnancy outcomes, improve child health and development, and improve families' economic self-sufficiency.

Parents as Teachers (PAT) is an evidence-based home visitation model for Medicaid eligible pregnant women or families with Medicaid-eligible children up to 12 months of age (priority given to children under 4 months). The Louisiana PAT model implementation began in October 2013. The families enrolled in the program are supported from pregnancy through to kindergarten with the goals to improve parenting practices, provide early detection or developmental delays and health issues, and increase school readiness and success.

Reproductive Health

The Louisiana Department of Health and Hospitals Office of Public Health Bureau of Family Health Reproductive Health Program (RHP) has been the state's Title X grantee for over 40 years. Services are provided to men, women, and adolescents by a staff of Registered Nurses (RN) and

Advanced Practice Registered Nurses (APRN) through Parish Health Units (PHUs) across the state. These clinics play a critical role in ensuring access to affordable, voluntary family planning information and reproductive health services. Clients are charged based on a sliding fee scale and no one is ever denied care for inability to pay.

Contraceptive Services

- Assessment of reproductive life plan (RLP)
- Counseling and method information provided using a model of shared decision-making and motivational interviewing techniques
- Broad range of FDA-approved contraceptive methods
- Same day insertion for long-acting reversible contraceptives (LARC) available during APRN clinics

Pregnancy Testing & Counseling

- Non-directive options counseling, including information on prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination.

Sexually Transmitted Disease Services

- Screening and treatment services for sexually transmitted diseases in accordance with CDC guidelines, including chlamydia, gonorrhea, and syphilis
- Rapid HIV testing
- HIV results counseling and referral
- Vaccination for human papillomavirus (HPV)
- Counseling on sexual behavior risk reduction
- Condom use and negotiation education

Preconception Health Services

- Provided to individuals and couples trying to achieve pregnancy, or who are at high risk of unintended pregnancy
- Discussion of reproductive life plan
- Assessment of medical history
- Counseling on folic acid supplementation
- Screenings for: Intimate partner violence; Alcohol and other drug use; Tobacco use; Immunizations; Depression; Height, weight, BMI; Blood pressure; Diabetes
- Counseling, education, and referrals, as appropriate, based on screenings provide

Referrals

- Primary care
- Specialty gynecological care
- Mammography
- Prenatal care
- Domestic violence and sexual abuse services
- Other social services, where identified

Nicotine Dependence/Smoking Cessation

The Office of Behavioral Health (OBH) developed a partnership with the Office of Public Health (OPH) and other stakeholders to address the needs of individuals with behavioral health conditions and tobacco/nicotine dependency. This team participated in the *Smoking Cessation Leadership Academy,* and as a part of their participation developed a strategic plan targeting a 5% reduction in smoking prevalence among those diagnosed with behavioral health conditions by 2020.

Louisiana Department of Public Safety and Corrections – Adult Re-entry Program

This MOU, effective July 2011, supports collaborative efforts to create an Adult Re-entry program for Department of Corrections (DOC) offenders released on anti-psychotic medications (see attached in Appendix). The goal of the Adult Re-entry Program will be to ensure the safety of the community and the well-being of participants, by providing uninterrupted behavioral healthcare to released offenders. Approximately 150 offenders from state prisons and local jails will meet criteria and be served each year. Anticipated outcomes are the reduction of relapse potential through expedited referral and appropriate referral to addiction services.

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, 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 abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, requires that, 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.

> *For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.*
>
> *For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.*

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 actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).*
2. *What mechanism does the state use to plan and implement substance abuse services?*
3. *Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?*
4. *Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?*
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.*

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

The Louisiana Behavioral Health Advisory Council (LBHAC), formerly the Mental Health Planning Council, has been receptive to the guidance from SAMHSA to move forward in its development of an Integrated Behavioral Health Planning and Advisory Council. In August 2011, the Mental Health Planning Council began the process of integration. Additional funds were allocated to the LBHAC as well as each Regional Advisory Council (RAC) to assist with the integration process. Since that time, the Mental Health Planning Council has changed its name (11/2011), amended its bylaws (5/2012), and revised its membership to include not only members from the addictive disorders community, but members representative of special populations as well (11/2012). The Council continues to express the need to become more fully engaged in planning and advocacy by setting benchmarks and continuing to empower and educate members to review indicators.

In 1996, the Office of Mental Health established a state policy to provide for the development of a Regional Advisory Council in each of the 10 local regions. Since that time, the Office of Mental Health has merged with the Office of Addictive Disorders, to become the Office of Behavioral Health. Independent local governing entities (LGEs) have replaced the centrally managed Regions. As such, there is even more emphasis on the need for the development and sustainability of the statewide Advisory Council and the ten local Regional Advisory Councils (RACs) to address needs for mental health services across the state. After a review of the old policy establishing the RACs, the executive management of OBH suggested that the policy should come from the LBHAC. The LBHAC, with the assistance of the staff parliamentarian began the process of developing a protocol to charter each of the RACs. With the authority to charter each RAC, the LBHAC can ensure consistency among the RACs and better assist with the development of standard operating procedures.

The RACs have always been 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. Each LGE executive director has been directed by the OBH Assistant Secretary (Commissioner) to annually allocate a minimum of $5,000 (to be split between children/youth and adults) of Block Grant funding to their respective RACs to support the functioning of the Regional Advisory Councils. Executive directors have been instructed to work with the RACs to develop an annual budget. RAC membership is reflective of that of the LBHAC, in that it consists of members who are primary consumers, family members, parents of children with emotional/behavioral disorders, advocates, and state agency employees. One accomplishment for the RACs has been an increased communication and involvement with the LGEs. They are currently actively involved with the planning process as demonstrated by their review of LGE block grant funding allocations. RACs are working toward uniform bylaws and are in communication with LGE leadership and contract monitors to support the use of best practices, and funding of programs that reflect the priorities of the LBHAC as well as their local interests. It is through this personalized local partnership that the LBHAC can ensure that consumers are receiving the necessary access to services and best quality of care.

The Louisiana Behavioral Health Advisory Council is instrumental in assisting in the development of priorities and direction for the Block Grant. Input is solicited from consumers, family members,

providers, and state employees who are all members of the Council. Each year, an Intended Use Plan (IUP) that allocates Block Grant funds for the following state fiscal year is prepared by OBH Central Office and each local governing entity (LGE), in partnership with their local Regional Advisory Council (RAC). This is an opportunity for each LGE and the corresponding RAC to decide upon how Block Grant funds should be allocated. The IUPs are discussed during a RAC meeting attended by RAC members and the LGE Executive Director. Once modifications are made and the Executive Director and RAC members have agreed upon a proposed plan for the allocation of Block Grant funds, the IUPs are then submitted to OBH Central Office for review by OBH executive management. The Central Office and LGE IUPs are then submitted to two separate committees within the Louisiana Behavioral Health Advisory Council for review: the Programs and Services Committee and the Finance Committee. These two committees then report findings from the review process to all members of the Advisory Council.

When new members join the Council, they are provided with a copy of the Block Grant application and plan. They also are educated about the Block Grant during orientation/training through the Council's Committee on Membership. Discussions about the Block Grant are a part of all 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.

Louisiana encourages and provides an opportunity for public input and comment on the Block Grant State Plan through a variety of means. The Louisiana Behavioral Health Advisory Council is instrumental in assisting in the development of priorities and direction for the Block Grant State Plan each year. Input is solicited from consumers, family members, providers, and state employees who are all members of the Advisory Council.

In order to assess consumer needs, and to establish an essential opportunity for providing information to the community and to receive input from stakeholders, annual Public Forums are conducted. The Public Forums were held in each of the ten (10) LGEs throughout the State during FY 2014-2015. Six hundred fifty-eight (658) stakeholders/community members attended these Forums (see table).

District / Authority	Date/Time	Location	Coordinator	OBH Representative
SCLHSA **59** **Participants**	Tuesday, February 24, 2015 9:00 a.m. – 12:00 p.m.	Terrebonne Library North Branch 4130 West Park Avenue Gray, LA 70359	Lisa Schilling	Dr. Dunham Dr. Petersen
CAHSD **136** **Participants**	Tuesday, March 10, 2015 9:00 a.m. - 12:00 p.m.	Capital Area Human Services District 4615 Government Street Building 2 - Room 200 Baton Rouge, LA 70806	Charlene Gillard	Dr. Dunham Dr. Petersen Karen Stubbs
FPHSA **51** **Participants**	Thursday, March 12, 2015 9:00 a.m. – 12:00 p.m.	LA Workforce Commission Conference Center 1711 Nashville Avenue Hammond, LA 70401	Sue Kennedy Jaime Bruins	Dr. Dunham
MHSD **40** **Participants**	Thursday, March 26, 2015 9:00 a.m. – 12:00 p.m.	Ashe Cultural Arts Center 1712 Oretha Castle Haley Boulevard New Orleans, LA 70113	Raevondala Ivory	Dr. Dunham Dr. Petersen Karen Stubbs
ImCal **71** **Participants**	Tuesday, March 31, 2015 10:00 a.m. – 1:00 p.m.	Allen P. August Annex Building 2000 Moeling Street Lake Charles, LA 70601	Laurie Beaugh-Hebert Charmaine Landry	Dr. Petersen Karen Stubbs
JPHSA **58** **Participants**	Wednesday, April 1, 2015 1:00 p.m. – 4:00 p.m.	Jane O'Brien Chatelain West Bank Regional Library 2751 Manhattan Boulevard Harvey, LA 70058	Tammy Valenti	Dr. Dunham Dr. Petersen Karen Stubbs
AAHSD **83** **Participants**	Thursday, April 2, 2015 9:00 a.m. – 12:00 p.m.	Clifton Chenier Center 220 B Willow Street Lafayette, LA 70501	Brad Farmer	Dr. Dunham Karen Stubbs
CLHSD **72** **Participants**	Wednesday, April 8, 2015 9:00 a.m. – 12:00 p.m. 8:00 a.m. breakfast	Kees Park Community Center 2450 Hwy. 28 East Pineville, LA 71360	Chauncey Hardy	Dr. Dunham Dr. Petersen
NLHSD **49** **Participants**	Wednesday, April 8, 2015 4:00 p.m. – 7:00 p.m.	Brentwood Hospital Gymnasium 1006 Highland Avenue Shreveport, LA 71101	Wendy Goad	Dr. Dunham Dr. Petersen Karen Stubbs
NEDHSA **39** **Participants**	Tuesday, April 14, 2015 11:00 a.m. – 2:00 p.m.	St. Francis Medical Center – North 3421 Medical Park Drive, Monroe, LA	Dr. Monteic Sizer	Dr. Dunham Dr. Petersen Karen Stubbs

OBH takes several steps to make the Block Grant State Plan available for review and to encourage public comment by emphasizing that feedback and suggestions for improvement are welcomed. The draft Block Grant State Plan is made available via the Office of Behavioral Health (OBH) website, with instructions for submitting comments to the Louisiana OBH Block Grant State Planner, Advisory Council Liaison, and the Advisory Council Chair online or through email. Email notices are sent to the Regional Managers, LGE Executive Directors, and Advisory Council members, with the recommendation to further disseminate to consumers, providers, stakeholders and the community at large. The draft plan is also reviewed and discussed at the Council's third quarter meeting held in August.

Bound hard copies of the submitted plan are printed and given to all Council members and are available at no charge to the public. Copies can either be picked up at the OBH State Office or mailed out by request.

Currently, the LBHAC includes seats for 40 members consisting of consumers of both mental health and substance use disorder 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. 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.

A recent change to the Council has been the inclusion of representatives of special populations, namely the following: representatives of the managed care industry, substance use treatment programs, as well as representatives of the behavioral health needs of the elderly, members of federally recognized tribes, the homeless, transitional youth, and the LGBTQI population. The Council is excited to have finally filled all of the newly created positions for special populations. At this time, however, there are three vacancies on the Council. Two of the positions are for parents of children with serious emotional disturbance or substance use disorders. It is the goal of the council to fill one seat with a parent of a child with an emotional disturbance and the other seat with a parent of a child with a substance use disorder. The third position, previously held by the child state planner, will be recommended to be changed to a position for an addictive disorder advocate.

The Committee on Finance is charged with overseeing Block Grant budget allocations and Intended Use Plans. The *Joint Block Grant Budget Review Subcommittee* was established to serve as an advisory team to the Office of Behavioral Health, which could be called together on short notice to make recommendations regarding allocation of funds such as changes in contract amounts or nonperformance of contracts. In its continuing efforts at fiscal oversight, the Committee on Finance has begun the task of looking more closely at not only expenditures for mental health services, but expenditures for substance use services as well.

More detailed information has been provided relative to the Block Grant expenditures within all of the Regions, which has provided meaningful information that the local RACs and local advocates could more immediately monitor for such things as goals and performance measures for contracts and programs.

The LBHAC currently includes five standing committees (Membership, Finance, Advocacy, Programs and Services, and Planning) that oversee each of the functions entrusted to the Council.

Three Chairman's committees have also been created. These committees include the Regional Advisory Council Committee, State Agency Committee, and Adolescent Substance Use, Co-Occurring, and Addictive Disorders Committee.

The Regional Advisory Council Committee consists of the representatives from the ten RACs across the state. Their purpose is to come together to share ideas and strategies that have been effective for them in their regions. During the past year, this committee has met to provide input on the bylaw template which will be used by each RAC to insure consistency among all RACs. RAC representatives as well as other RAC and LBHAC members were solicited for input into the template. The staff parliamentarian assisted with this process so that each RAC can have a set of bylaws that meets their needs, while maintaining continuity with the LBHAC as well as other RACs. Efforts were made to insure that the new RAC bylaws reflect the integration of mental health and addictive disorders in both the scope of their duties as well as their membership.

The State Agency Committee is composed of all state agency representatives who serve on the LBHAC. This committee has met several times to outline the services that their agencies provide to individuals receiving behavioral health services. This has been beneficial in assisting the Council to determine what services are available and in what parts of the state. The goal is to provide a statewide map to detail available services, and at the same time, areas in which services do not exist. Once identified, the LBHAC can then begin to advocate for areas which are in need.

The Adolescent Substance Use, Co-Occurring, and Addictive Disorders Committee was established to include members of key agencies and stakeholders (including caregivers and youth) across the child-serving system. This committee will work with LA SAT-ED staff in order to identify strategies to assist, support and maintain the development and/or enhancement of a coordinated network that will develop policies, expand workforce capacity, disseminate evidence-based practices, and implement financial mechanisms and other reforms to improve the integration and efficiency of the adolescent substance use, co-occurring substance use and mental health disorders treatment, and an adolescent recovery support system.

The Adolescent Substance Use, Co-Occurring, and Addictive Disorders Committee will report directly to the Louisiana Behavioral Health Council on a quarterly basis and bring to the Council action items to be voted on, requests for assistance in removing barriers that need to be addressed by the larger Council, and requests for assistance with implementation efforts. The committee will also provide data supporting their efforts to the Council and respond to special requests from the Council.

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.

The Council continues to employ an official (professional) parliamentarian to serve as a protocol advisor for business meetings and committee work. The parliamentarian has been integral in improving the structure and productivity of Planning Council meetings, as well as serving as a resource for Regional Advisory Councils (RACs).

The Planning Council Liaison continues to promote communication between OBH, the LBHAC, local administrators, and the RACs. The liaison organizes LBHAC meetings, maintains communication with Council members, and provides training, education, and support to LBHAC members as well as to RAC members, and management of the LGEs. The liaison continues to educate Council and RAC members, as well as regional administrators as to their roles and responsibilities in behavioral health planning.

Louisiana Behavioral Health Advisory Council
Membership Roster –2015

KEY (By Federal Regulation, ALL MEMBERS must be categorized according to these groupings):					
State Employee	Individuals in Recovery (from mental illness and addictions)	Parents or Caregivers of Children or Youth with Behavioral Health Problems	Family Members of Adult with Serious Mental Illness or in Recovery	Others (Not state employees or providers)	Providers

Agency/ Org. Represented	#	Name	Type of Membership	Address, Phone & Fax/ Email
STATE AGENCY MEMBERS INVOLVED IN DEVELOPMENT OF BLOCK GRANT PLAN				
State Planner	1	*Shamim Akhter*	State Employee	Office of Behavioral Health 628 N. 4th Street P.O. Box 4049 Baton Rouge, LA 70821-4049 225-342-7945 225-342-1984 (Fax) Shamim.Akhter@LA.gov
Addictive Disorder Advocate	2	*Vacant*		
STATE AGENCY MEMBERS MANDATED BY FEDERAL REGULATION				
Louisiana Department of Children and Family Services (DCFS)	3	Sam, Rose	State Employee	Office of Community Services 627 N. 4th Street POB 3318 Baton Rouge, LA 70821 225-342-6509 225-342-0963 (Fax) Rose.Sam@LA.Gov
Louisiana Department of Education (LDE)	4	Comeaux, Michael	State Employee	La Department of Education 1201 N. 3rd Street, 4th Floor P.O. Box 9064 Baton Rouge, LA 70804-9064 Michael.Comeaux@LA.Gov

Louisiana Department of Health and Hospitals, Office of Behavioral Health (OBH)	5	Darling, Ann	State Employee	Office of Behavioral Health 628 N. 4th Street P.O. Box 4049 Baton Rouge, LA 70821-4049 225-342-2563 (work) 225-342-1984 (Fax) Ann.Darling@LA.Gov
STATE AGENCY MEMBERS MANDATED BY FEDERAL REGULATION				
Louisiana Department of Public Safety and Corrections, Office of Juvenile Justice (OJJ)	6	Page, Jacqueline	State Employee	Dep't of Public Safety & Corrections 660 N. Foster Drive Baton Rouge, LA 70806 225-922-1300 225-291-9349 (Fax) Jacqueline.Page@LA.Gov
Louisiana Housing Corporation (LHC)	7	Brooks, Barry E.	State Employee	LA Housing Corporation 2415 Quail Drive Baton Rouge, LA 70808 225-763-8773 225-763-8749 (Fax) BBrooks@LHC.LA.Gov
Louisiana Workforce Commission, Louisiana Rehabilitation Services (LRS)	8	Dixon, Verna	State Employee	La Rehabilitation Services 3651 Cedarcrest Baton Rouge, LA 70816 225-295-8952 225-295-8966 (Fax) VDixon-fletcher@LWC.LA.Gov
STATE AGENCY MEMBERS MANDATED IN STANDING RULES				
DHH, Bureau of Health Services Financing (Medicaid)	9	Montgomery, Darrell	State Employee	Bureau of Health Services Financing 628 N. 4th Street, 7th Floor Baton Rouge, LA 70821-9030 225-342-1203 225-342-1972 (Fax) Darrell.Montgomery@LA.Gov

DHH, Office for Citizens with Developmental Disabilities (OCDD)	10	Greer, Dr. Amy	State Employee	Office for Citizens with Developmental Disabilities 628 N. 4th Street POB 3117 Baton Rouge, LA 70821-3117 225-342-0095 225-342-8823 (Fax) Amy.Greer2@LA.Gov
DHH, Office of Behavioral Health (Prevention Specialist)	11	Brougham-Freeman, Dr. Leslie	State Employee	Office of Behavioral Health 628 N. 4th Street P.O. Box 3868 Baton Rouge, LA 70821 Leslie.BroughamFreeman@LA.Gov
STATE AGENCY MEMBERS MANDATED IN STANDING RULES				
DHH, Office of Behavioral Health (Substance Abuse Treatment Specialist)	12	Womack, Quinetta	State Employee	Office of Behavioral Health 628 N. 4th Street P.O. Box 3868 Baton Rouge, LA 70821 Quinetta.Womack@LA.Gov
DHH, Office of Public Health (OPH)	13	Webb, Karen	State Employee	Bureau of Family Health 1450 Poydras St., Rm 2032 New Orleans, LA 70112 504-568-3504 504-568-3503 (Fax) Karen.Webb@LA.Gov
ADVOCACY ORGANIZATIONS MANDATED IN STANDING RULES				
Louisiana Commission on Addictive Disorders	14	Cunningham, Kerri	Other (not state employee or provider	111 Liberty Avenue Lafayette, LA 70508 337-456-9111 337-456-9131 KCunningham@myvictorycenter.com
Louisiana Federation of Families for Children's Mental Health	15	Bell, Maria	Family Member of Child or Youth with Behavioral Health Problems	5627 Superior Dr. Suite A-2 Baton Rouge, LA 70816 225-293-3508 225-293-3510 (Fax) MBell@LAFFCMH.org

Mental Health America of Louisiana	16	Thomas, Mark	Family Members of Adult with Serious Mental Illness or in Recovery	5721 McClelland Drive Baton Rouge, LA 70805 318-582-9627 225- 356-3704 (Fax) MTMHAL@gmail.com
National Alliance on Mental Illness - Louisiana	17	McGee, Nicole	Other (not state employee or provider)	P.O. Box 40517 Baton Rouge, LA 70816 225-291-6262 (phone) 225-291-6244 (Fax) NMcGee@namilouisiana.org
The Extra Mile	18	Boudreaux, Linda	Other (not state employee or provider)	525 S. Buchanan St. Lafayette, LA 70501 337-354-0038 LindaBTEM@Bellsouth.net

REGIONAL ADVISORY COUNCIL REPRESENTATIVES

These individuals are either RAC Chairs or other representatives from the RAC. One person per LGE.

MHSD	19	Valteau, Brenda	Family Member of Child or Youth with Behavioral Health Problems	10200 Seawood St New Orleans, LA 70127 504-512-9501 BrendaValteau@yahoo.com
CAHSD	20	Kauffman, Steve	Individuals in Recovery (from mental illness and/or addictions)	Advocacy Center 8225 Florida Blvd., Ste. A Baton Rouge, LA 70806 225- 925-8884 225-281-6131 (cell) SKauffman@AdvocacyLA.org
SCLHSA	21	Hadley, Joyce	Family Member of Child or Youth with Behavioral Health Problems	521 Legion Avenue Houma, Louisiana 70364 985-876-8822 Phone 985-857-3782 Fax 985-705-7725 Cell *1-800-805-7934* Joyce.Hadley@LA.Gov
AAHSD	22	Hebert, Karen	Family Member of Child or Youth with Behavioral Health Problems	1003 Broussard St. Parks, LA 70582 337-278-8681 Karen@Hebertworld.com

ImCal	23	Armstrong, Anastasia	Family Member of Adult with Serious Mental Illness or in Recovery	715 Ryan St, Suite 203 Lake Charles, LA 70601 337-433-0219 337-433-1860 (fax) aarmstrong@namiswla.org
CLHSD	24	McDaniel, John	Other (not state employee or provider)	1244 Barrister Street Alexandria, LA 71301 318-792-0233 JTMCDSR@gmail.com
NLHSD	25	Bennett, David	Other (not state employee or provider)	725 Jordan Street Shreveport, LA 71101 318-221-1993 (work) 318-453-7630 (cell) 318-221-1995 (fax) DBennett@LaEasterSeals.com
NDHSA	26	Goldsberry, Kristi Council Chair	Individual in Recovery (from mental illness and/or addictions)	108 Roxanna West Monroe, LA 71291 318-388-6088 (work) 318-791-7456 (cell) 318-388-6872 (fax) KristiExtraMile@yahoo.com
REGIONAL ADVISORY COUNCIL REPRESENTATIVES These individuals are either RAC Chairs or other representatives from the RAC. One person per LGE.				
FPHSA	27	Richard, Nicholas	Family Member of Adult with Serious Mental Illness or in Recovery	100 Saint Anne Circle Covington, LA 70433 985-626-6538 (work) 877-361-1631 (fax) NRichard@NamiStTammany.org
JPHSA	28	Chagnard, Sylvia	Family Member of Adult with Serious Mental Illness or in Recovery	4937 Avron Blvd Metairie, LA 70006 504-349-0014 504-349-8714 (fax) sylviagpearson@yahoo.com
INDIVIDUAL REPRESENTATIVES These individuals are involved in advocacy for specific special populations from the state at-large.				
Parents	29	Vacant	Family Member of Child or Youth with Behavioral Health Problems	

Parents	30	Vacant	Family Member of Child or Youth with Behavioral Health Problems	
Family Members	31	Leary, Kathleen	Family Member of Adult with Serious Mental Illness or in Recovery	212 Lake Crescent Circle Houma, LA 70360 985-868-4826 (home) 985-226-5768 (cell) WrLeary@LouisianaLap.com
Family Members	32	McMahon, Linda	Family Member of Adult with Serious Mental Illness or in Recovery	4207 Pecan Drive Alexandria, LA 71302 318-487-4200 LDrewMcM@Suddenlink.net
Managed Care Industry	33	Mitchell, Margaret	Individual in Recovery (from mental illness and/or addictions)	10000 Perkins Rowe, Ste 500 Baton Rouge, LA 70810 225-367-3151 MMitchell@magellanhealth.com
Substance Abuse Treatment	34	Rowan, Tom	Individual in Recovery (from mental illness and/or addictions)	703 Hutchinson Street Mandeville, LA 70448 985-626-6402
Elderly	35	Mitchell, Beryl	Family Member of Adult with Serious Mental Illness or in Recovery	P.O. Box 66038 Baton Rouge, LA 70896 225-287-7414 BMitchell@CapitalAAA.org
INDIVIDUAL REPRESENTATIVES These individuals are involved in advocacy for specific special populations from the state at-large.				
Federally Recognized Indian Tribe	36	Maxwell, Mona	Other (not state employee or provider)	P.O. Box 14 Jena, LA 71342 318-419-8432 MMAXJBC@Yahoo.com
Homeless Population	37	Bourgeois, Kristi	Other (not state employee or provider)	4363 Rougon Road Port Allen, LA 70767 225-336-0000 KBourgeois@upliftd.org
Transitional Youth	38	Horton, Brandon	Individual in Recovery (from mental illness and/or addictions)	8525 Chalmette Drive, Apt R10 Shreveport, LA 71115 318-780-2491 (cell) 318-425-9101 (fax) Brandon.HortonLA@gmail.com

Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI)	39	Stone, Christopher	Individual in Recovery (from mental illness and/or addictions)	111 Alexander Rd., Apt. 16 West Monroe, LA 71291 318-388-6088 (w) 318-366-9888(cell) 318-388-3850 (fax) stn_chrstphr@yahoo.com
AD Advocate	40	Lowery, Anthony	Individual in Recovery (from mental illness and/or addictions)	331 Wright Ave Gretna, LA 70056 Anthony0522@att.net

Planning Council Support Staff
Donna Schaitel, namilads@bellsouth.net
P.O. Box 40517
Baton Rouge, LA 70816
225-291-6262 (phone) - 225-291-6244 (Fax)

Planning Council Liaison
Melanie S. Roberts, M.S. Melanie.Roberts@La.gov
225-892-2329 (phone)

Parliamentarian: C. Alan Jennings, P.R.P

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)	7	
Family Members of Individuals in Recovery * (to include family members of adults with SMI)	7	
Parents of children with SED *	4	
Vacancies (individual & family members)	3	
Others (Advocates who are not State employees or providers)	7	
TOTAL Individuals in Recovery, Family Members and Others	28	
State Employees	12	
Providers	0	
TOTAL State Employees & Providers	12	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBT Populations	8	
Providers from Diverse Racial, Ethnic, and LGBT Populations	0	
TOTAL Individuals and Providers from Diverse Racial, Ethnic, and LGBT Populations	8	
Persons in recovery from or providing treatment for or advocating for substance abuse services	13	
Federally Recognized Tribal Representatives	1	
Youth/adolescent representative (or member from an organization serving young people).	1	

The LBHAC currently has 3 vacancies. Two of the vacancies are for parents of children with SED or substance use disorders. It is the Council's intent to fill one slot with a parent of a child with SED and the other with a parent of a child with a substance use disorder.

The third vacancy is for a child state planner. This is no longer a position with OBH, so it has been recommended that the position will instead be allocated to an advocate for substance abuse services to further the integration of the Council.

LOUISIANA BEHAVIORAL HEALTH ADVISORY COUNCIL

BYLAWS

AMENDED NOVEMBER 3, 2014

ARTICLE I: NAME

The name of this organization shall be: *Louisiana Behavioral Health Advisory Council* (herein: "council")

ARTICLE II: OBJECT

The object of the council shall be to serve the state of Louisiana as the mental health planning council provided for under 42 U.S.C. 300x-3 (State mental health planning council), to advise and consult regarding issues and services for persons with or at-risk of substance use and addictive disorders, and to exercise the following duties in connection therewith:

1. To review plans provided to the council pursuant to 42 U.S.C. 300x-4(a) by the state of Louisiana and to submit to the state any recommendations of the council for modifications to the plans;
2. To serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems;
3. To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state,
4. To monitor, review, and evaluate the adequacy of services for individuals with substance use and addictive disorders within the state; and
5. To serve as an advocate for persons with substance use and addictive disorders in this state.

ARTICLE III: MEMBERSHIP

SECTION 1. STATUTORY REQUIREMENTS.

A. The council shall be composed of residents of the state of Louisiana, including representatives of:

1. The principal state agencies with respect to mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and the state agency responsible for the development of the plan submitted pursuant to title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);
2. Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
3. Adults with serious mental illnesses who are receiving (or have received) mental health services; and
4. The families of such adults or families of children with emotional disturbance.

5. With respect to the membership of the council, the ratio of parents of children with a serious emotional disturbance to other members of the council is sufficient to provide adequate representation of such children in the deliberations of the council.

B. At least 50 percent of the members of the council shall be individuals who are not state employees or providers of mental health services.

SECTION 2. OTHER REQUIREMENTS

The council shall include residents of the state of Louisiana who are in recovery from substance use and addictive disorders and members of families of individuals with substance use and addictive disorders.

SECTION 3. CLASSES OF MEMBERSHIP.

Membership on the council shall be of two classes: Individual and Organizational.

1. Individual members shall be those persons who are not representatives of a state agency or a public or private entity.
2. Organizational members shall be those persons appointed from state agencies or a public or private entity.

SECTION 4. COMPOSITION.

A. The council shall be composed of not more than 40 members.

B. Members shall be those persons whose applications for membership are approved by the council.

SECTION 5. TERM OF SERVICE.

A. Term of service for members shall be four years. A member who has served two consecutive terms shall not be qualified for membership until the lapse of one year. Ex officio members shall not be term limited.

B. In the event of the death, resignation, removal, or loss of qualification for membership, the council shall fill the vacancy thus created with a properly qualified person to serve for the duration of the former member's term.

C. A member may be removed from the council by a majority vote with notice, a two-thirds vote without notice, or a majority of the entire membership.

SECTION 5. DUTIES OF MEMBERS.

All council members shall serve as an active participant on at least one standing committee of the council. The council may waive this requirement for a member when good cause exists.

ARTICLE IV: OFFICERS

SECTION 1. OFFICERS.

Officers shall be a chairman, a vice chairman, and a secretary. The chairman and vice chairman shall be members of the council.

SECTION 2. DUTIES.

Officers shall perform the duties prescribed by these bylaws and by the parliamentary authority adopted by the council.

A. Chairman. The chairman shall preside at meetings of the council. The council, however, may suspend this provision and elect a chairman pro tempore at any meeting. The chairman shall appoint all standing and special committees except that nothing shall prohibit the council from appointing special committees on its own motion. The chairman may appoint persons who are not members of the council to serve on any committee the chairman is authorized to appoint. The chairman shall be ex officio a member of all committees except the nominating committee, and shall have such other powers and duties as the council may prescribe.

B. Vice chairman. The vice chairman shall serve as a member of the committee on membership, shall be responsible for executing the council's membership recruitment and orientation programs and shall perform such other duties as the council may prescribe. In the absence of the chairman from a meeting, the vice chairman shall preside unless the council elects a chairman pro tempore.

C. Secretary. The secretary shall be the custodian of the records of the council and shall keep or cause to be kept a record of the minutes of the meetings of the council. The secretary shall maintain an indexed book containing all standing rules adopted by the council. The secretary shall also be the custodian of the council seal, and shall attest to and affix said seal to such documents as may be required in the course of its business. The secretary may appoint an assistant secretary who shall be authorized to fulfill the duties under the direction and authority of the secretary.

SECTION 3. NOMINATION AND ELECTION.

A. The council shall elect officers at the regular meeting in the last quarter of each even numbered year.

B. At the regular meeting immediately preceding the election meeting, the council shall elect a nominating committee of three members. It shall be the duty of this committee to nominate candidates for the offices to be filled. The nominating committee shall report its nominees at the election meeting. Before the election, additional nominations from the floor shall be permitted.

C. In the event of a tie, the winner may be decided by drawing lots.

SECTION 4. TERM OF OFFICE.

Officers shall serve for two years or until their successors are elected and assume office. Officers shall assume office at the end of the meeting at which they are elected.

SECTION 5. REMOVAL FROM OFFICE.

The council may remove from office any officer at any time.

SECTION 6. VACANCY.

A. In the event of a vacancy in the office of chairman, the vice chairman shall succeed to the office of chairman.

B. In the event of a vacancy in the office of vice chairman or secretary, the chairman may appoint a temporary officer to serve until the council elects a replacement.

ARTICLE V: MEETINGS

SECTION 1. REGULAR MEETINGS.

A. Regular meetings of the council shall be held on the first Monday of the second month of each calendar quarter. The council may reschedule its next regular meeting at any regular or special meeting.

B. The executive committee may reschedule a regular council meeting provided notice is given in accordance with the notice provisions required for regular meetings.

SECTION 2. SPECIAL MEETINGS.

Special meetings may be called by the chairman and shall be called upon the written request of a majority of the members. The purpose of the meeting shall be stated in the call.

SECTION 3. NOTICE OF MEETINGS.

A. Notice of the hour and location of regular meetings, and notice of any change in the date, time, or place of any regular meeting shall be sent in writing to the members at least ten days before the meeting.

B. Notice of special meetings of the council shall be sent at least ten days before the date of the meeting. The notice shall state the purpose of the meeting. In the event the secretary fails to issue, within a reasonable time, a special meeting call on the request of members of the council, the members who petitioned for the call may schedule the special meeting and issue the call and notice at the expense of the council.

SECTION 4. QUORUM.

A quorum shall consist of twelve members.

ARTICLE VI: COMMITTEES

SECTION 1. STANDING COMMITTEES

A. Standing committees of the council shall be

1. Executive Committee.

a. Composition. The chairman of the council shall be the chairman of the executive committee. The vice chairman, the secretary, and a state block grant planner shall be members of the executive committee.

b. Duties and Powers. The executive committee shall, to the extent provided by resolution of the council or these bylaws, have the power to act in the name of the council. The

executive committee shall fix the hour and place of council meetings, make recommendations to the council and perform such other duties as are specified in these bylaws or by resolution of the council. But, notwithstanding the foregoing or any other provision in these bylaws, the executive committee shall not have the authority to act in conflict with or in a manner inconsistent with or to rescind any action taken by the council; to act to remove or elect any officer; to establish or appoint committees or to name persons to committees; to amend the bylaws; to authorize dissolution; or, unless specifically authorized by a resolution of the council, to authorize the sale, lease, exchange or other disposition of any asset of the council, and in no event shall it make such disposition of all or substantially all of the assets of the council.

c. Meetings. The executive committee shall meet on the call of the chairman or the three other members. Notice of at least 24 hours shall be given for any meeting of the executive committee. Executive committee members may at any time waive notice in writing and consent that a meeting be held. The executive committee is authorized to meet via teleconference or videoconference provided that all members in attendance can hear each other. A quorum of the executive committee shall be a majority of its membership.

2. Committee on Planning. The committee on planning shall report and recommend on such matters as they may deem appropriate for council consideration. The committee on planning shall be composed of the council officers, the chairmen of the other standing committees of the council, and the council representative from the Louisiana Commission on Addictive Disorders. The chairman of the council shall be the chairman of the committee on planning.

3. Committee on Advocacy. The committee on advocacy shall report and recommend on matters involving the mental health advocacy program of the council.

4. Committee on Finance. The committee on finance shall report and recommend on matters affecting the behavioral health block grant funds and the council operating budget.

5. Committee on Membership. The committee on membership shall report and recommend on matters involving the membership recruiting and composition of the council. The council chairman shall appoint the chairman of the committee on membership, and the members of the committee shall include the vice chairman of the council and others appointed as appropriate by the council chair.

6. Committee on Programs and Services. The committee on programs and services shall report and recommend on matters related to planning, development, monitoring, and evaluation of behavioral health programs and services in the state.

B. A state block grant planner shall be ex officio a member of each standing committee.

SECTION 2. DUTIES AND POWERS OF STANDING COMMITTEES.

The council shall establish such specific duties and authority for each standing committee as necessary to carry on the work of the council.

SECTION 3. OTHER COMMITTEES.

Such other committees, standing or special, may be appointed by the chairman or by the council as may be necessary to carry on the work of the council.

SECTION 4. MEETINGS BY TELECONFERENCE.

Council committees are authorized to meet via teleconference provided that all members in attendance can hear each other.

ARTICLE VII: PARLIAMENTARY AUTHORITY

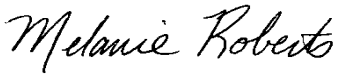
The rules contained in the current edition of *Robert's Rules of Order Newly Revised* shall govern the council in all cases to which they are applicable and in which they are not inconsistent with these bylaws, any special rules of order the council may adopt, and any statutes applicable to the council that do not authorize the provisions of these bylaws to take precedence.

ARTICLE VIII: AMENDMENT

These bylaws may be amended at any council meeting by a two-thirds vote, provided that the amendment has been submitted in writing at the previous regular meeting or written notice of the proposed amendment is sent to the members at least 21 days but no more than 30 days before the meeting at which the proposed amendment is to be considered. Additionally, in the case of a special meeting, notice of the proposed amendment shall be included in the call.

CERTIFICATE

I, Melanie Roberts, Secretary of the Louisiana Behavioral Health Advisory Council, certify that the foregoing bylaws of the council are those as amended on November 3, 2014 at a regular meeting of the council.



Melanie Roberts, Secretary

Louisiana Behavioral Health Advisory Council

STANDING RULES

MEMBERSHIP COMPOSITION

SECTION 1. NUMBER OF MEMBERS

The number of council members shall be 40.

SECTION 2. COMPOSITION OF THE COUNCIL

The membership composition of the council shall be as follows:

A. Organizational members

1. Appointed from state agencies

   a. Two members from OBH responsible for the preparation of the block grant plan.

   b. Six members from state agencies as mandated by federal law, one from each of the following:

      (1) Louisiana Department of Health and Hospitals, Office of Behavioral Health (OBH)

      (2) Louisiana Department of Education (LDE)

      (3) Louisiana Workforce Commission Louisiana Rehabilitation Services (LRS)

      (4) Louisiana Housing Corporation (LHC)

      (5) Louisiana Department of Children and Family Services (DCFS)

      (6) Louisiana Department of Public Safety and Corrections, Office of Juvenile Justice (OJJ)

   c. Five other members from the Louisiana Department of Health and Hospitals (DHH) as follows:

      (1) DHH Bureau of Health Services Financing (Medicaid)

      (2) DHH Office of Behavioral Health Prevention Specialist (OBH)

      (3) DHH Office of Behavioral Health Substance Use Disorder Treatment Specialist (OBH)

      (4) DHH Office for Citizens with Developmental Disabilities (OCDD)

      (5) DHH Office of Public Health (OPH)

2. Appointed from behavioral health advocacy organizations:

   Five members, one from each of the following:

   (1) Louisiana Commission on Addictive Disorders

   (2) Louisiana Federation of Families for Children's Mental Health

   (3) National Alliance on Mental Illness – Louisiana

   (4) Mental Health America of Louisiana

   (5) The Extra Mile

3. Appointed from OBH regional advisory councils (RAC):

   Ten members, one from each RAC.

B. Individual Members

Twelve members, representing specific special populations from the state at-large.

1. Two members who are parents or caregivers of children or youth with behavioral health conditions.
2. Two members who are in recovery from a behavioral health conditions or who are family members of individuals in recovery from behavioral health conditions.
3. Individual representative from the behavioral health managed care industry or an individual involved in the oversight of the behavioral health managed care industry.
4. Individual who is concerned for the behavioral health needs of individuals with substance use disorders.
5. Individual who is concerned for the behavioral health needs of the elderly.
6. Representative of federally recognized Indian tribes.
7. Individual or family member of an individual who is concerned for the behavioral health needs of the homeless population.
8. Individual who is concerned for the behavioral health needs of transitional youth.
9. Individual who is concerned with the behavioral health needs of the Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex Populations.
10. Individual who is an advocate for Addictive Disorders

SECTION 3. QUALIFICATIONS

Council members shall fall into one or more of the following categories in order to be considered qualified for service on the council:

1. Adults with serious mental illness who are receiving or who have received mental health services.
2. Family members of adults with serious mental illness.
3. Adults with substance use disorders.
4. Family members of adults with substance use disorders.
5. Transitional youth, generally between the ages of 14 and 25-inclusive, who are in recovery from serious emotional/behavioral, or substance use disorders who are receiving or have received behavioral health services and related support services.
6. Parents and family members of children/youth with a serious emotional, behavioral, or substance use disorders.
7. Advocates for Individuals with behavioral health care needs.

8. Individuals, including behavioral health care service providers, who are concerned with the need, planning, operation, funding, and use of mental health services and related support services.

SECTION 4. GEOGRAPHIC DIVERSITY

At least 50 percent of the members of the Council shall be drawn from the population at large, outside of the Capital Area.

NON-DISCRIMINATION POLICY

The council shall not discriminate in any regard with respect to race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy and parenthood, custody of a minor child, or physical, mental, or sensory disability.

AUTHORIZED REPRESENTATIONS

1. The council may officially represent itself, but not the office of behavioral health, the state of Louisiana, any state agency, or any individual member in any matter concerning or related to the council.
2. No council member shall make representations on behalf of the council without the authorization of the council.

COUNCIL AGENDA

1. The secretary shall prepare an agenda for each council meeting. Council members may submit motions in advance for placement on the agenda for consideration under the appropriate order of business. Officers and committees reporting recommendations for action by the council shall submit the recommendations to the secretary at least 10 days before the meeting for entry on the agenda. The tentative agenda for all regular meetings will be available to all council members at least five (5) days prior to each council meeting. The secretary shall distribute the tentative agenda in advance to any member who requests it by the method requested by the member.
2. Nothing contained in this rule shall prohibit the council from considering any matter otherwise in order and within its object at any regular meeting.

Revised November 3, 2014

Policies adopted 11/7/2011:

GENERAL DEFINITIONS

COUNCIL CALENDAR AND TIMELINES:

First Quarter: February – March –April

Second Quarter: May–June–July

Third Quarter: August–September–October

Fourth Quarter: November–December–January

Weeks of the quarter:
Commencing with the first week of the regularly scheduled council meeting of the quarter, weeks are designated as Weeks 1—12 (or 13) leading up to the next quarterly council meeting.

MEETINGS

References to "meeting" in policies include any properly called meeting for which proper notice has been given and at which a quorum is present, whether in person, or properly authorized to be conducted by telephone or teleconference.

ALL COMMITTEES

Committee meeting dates

(1) Committees will, at the beginning of each council year, in consultation with the council secretary, establish regular quarterly meeting dates which in the absence of other necessity will occur during weeks 3 to 7 of the council quarter.

(2) The secretary will publish upcoming meeting dates for the quarter in the council meeting notice and on the council meeting agenda.

Committee meeting preparation

Committee chairmen will prepare written meeting agendas [using the annual goals, quarterly expectations and pending issues] for committee meetings

Committee meeting notices

(1) Committee meeting notices will be sent no later than two weeks prior to the scheduled meeting date.

(2) Notices will include the date, time, location (or call-in information), preliminary agenda, and supporting documents and any information relevant to the meeting agenda.

Committee reports

(1) Committees reporting to the council will furnish written reports approved by the committee in advance of the regular quarterly council meeting.

(2) Committee reports may be on a form adopted by the council or by the committee and will include reports of committee actions and recommendations for council action.

COMMITTEE MEETING SUPPORT

Council secretary duties:

(1) Drafts preliminary committee meeting agenda for committee chairman's review at least three weeks before the scheduled meeting;

(2) Distributes the chairman's draft preliminary agenda to committee members no later than three weeks before scheduled meeting date;

(3) Gather and distribute to committee members all materials relevant to the meeting.

(4) Attends regularly scheduled committee meetings

(5) Assists committee chairmen in drafting committee meeting agendas and committee reports

(6) Performs other reminder and support duties as provided by council policy, or as requested.

(7) Sets up conference calls in conjunction with information from the committee chair.

Committee planning responsibilities:

(1) During the fourth quarter of each council year, each committee shall plan its year and set timelines, goals and priorities for its activities.

(2) During the third quarter of each council year, each committee shall assess whether it has met its goals.

COMMITTEE ON ADVOCACY

Ongoing duties

(1) Establish structures for regular communication with state office and other key partners regarding council advocacy priorities.

(2) Monitor pending federal action, both congressional and regulatory (Substance Abuse Mental Health Service Administration [SAMHSA])

(3) Monitor state level initiatives throughout the year, especially those that impact clients

(4) Develop partnerships with state advocacy organizations (with the active involvement of the advocacy organization representatives) decision makers and stakeholders

Specific duties by quarter

First quarter:

(1) Set annual priorities for advocacy – ensuring the block grant application priorities and state and local priorities are considered.

(2) Monitor DHH budget and programmatic initiatives that may lead to state legislative action.

(3) Secure information from statewide organizations on advocacy priorities and initiatives.

Second quarter:

(1) Review pending state legislation affecting behavioral health; inform the council and regional advisory councils (RACs)

(2) Communicate with the regional advisory councils and the public about advocacy priorities – to ensure input is received and state level information is shared

Third quarter:

Ensure information on key Acts of the legislature and budget outcomes is shared with the Louisiana Behavioral Health Advisory Council (LBHAC) and the regional advisory councils (RACs)

Fourth quarter:

(1) In partnership with the committee on programs and services, communicate with regional advisory councils (RACs) to determine regional advocacy issues and needs.

(2) Communicate with state advocacy organizations to secure information on expected advocacy priorities for the coming year.

COMMITTEE ON MEMBERSHIP

Duties

(1) Develop and conduct initial and continuing orientation programs for council members, committee members, and regional advisory council (RAC) members to inform them of their duties and responsibilities as council members and as members of its committees.

(2) Develop and administer membership recruitment and retention policies and programs subject to the approval of the council.

(3) Develop and maintain a council membership application form sufficient to properly qualify prospective council members.

(4) Monitor and encourage council member involvement and consult with members who are not regularly involved.

(5) Develop and administer a program by which newly elected council members will have a member of long-standing available to answer questions for, and further orient the new member on history and purpose of the council and to encourage the new member's involvement in council activities.

(6) Present a regular briefing or training opportunity at each regular council meeting, and to give an overview of the block grant at least once a year.

(7) Plan and coordinate any additional technical assistance training for the Louisiana Behavioral Health Advisory Council (LBHAC)

(8) Support the regular communication with, and orientation of, regional advisory councils (RACs)

COMMITTEE ON PROGRAMS AND SERVICES
Ongoing duties

(1) Assess and report to the council on specific strengths and challenges of the Behavioral Health service delivery system.
(2) Provide a consumer and family voice for communication with state and federal entities
(3) Give input to the state on the development and submittal of the Behavioral Health Block Grant application.
(4) Participate in the *Behavioral Health Needs Assessment* conducted by the state office.

Specific duties by quarter
First Quarter:

(1) Biennially (Every 2 years) review the proposed adult and children's sections of the block grant application and report recommendations to the council Louisiana Mental Health
(2) Through regional outreach and state level partnerships, identify stakeholders and constituents to serve on planning/study groups.

Second Quarter:

(1) Review the regional Intended Use Plans. Assess how the plans support priorities within the block grant.
(2) Review region/district behavioral health services data selected by this committee for analysis and comparisons and report to the council.

Third Quarter:

(1) Review selected data related to block grant performance measures and outcomes and report on this to the council.
(2) Review for the council the effectiveness of behavioral health integration on state and regional levels.

Fourth Quarter:

(1) Review the block grant targets, goals, and indicators, and report recommendations to the council.

GOVERNANCE

Informational reports to the council:

Each organizational member will submit a written report to the secretary at least three weeks before the council meeting, or shall notify the secretary by that date that the organization will not have a report.
Policies adopted 5/07/2012

JOINT BLOCK GRANT BUDGET REVIEW SUBCOMMITTEE

The subcommittee of the Committee on Finance, to be known as the Joint Block Grant Budget Review Subcommittee, was created to advise and recommend to the Office of Behavioral Health on joint block-grant budget allocations, said subcommittee to be composed of the Council chairman, the chairman of the Committee on Finance, the state planner, and one additional member of the Committee on Finance appointed by its chairman.
The subcommittee shall have the following duties:

(1) To review and monitor expenditures of Block Grant funds, and make recommendations for reallocations and management of funds directly to the Assistant Secretary. The subcommittee will report a summary of its recommendations directly to Finance committee to be included in its report.
(2) To identify any contracts that failed to meet measurables and notify council and obtain resolution regarding the contract.
(3) To meet as needed.

COMMITTEE ON FINANCE

Ongoing duties

(1) Review the mental health block grant expenditures spreadsheet from state office (regional and state office contracts) and report highlights to council biennially (twice a year).
(2) Maintain regular communication with state office and other key partners regarding budgets for mental health and substance abuse services at both the state and local levels.
(3) Support regional advisory councils (RACs) in their efforts to review and offer input regarding mental health and substance abuse prevention and treatment expenditures.
(4) Support and assist Commission on Addictive Disorders (CAD) in reviewing expenditures regarding Substance Abuse Prevention and Treatment (SAPT) Block Grant.
(5) Monitor pending federal and state budgetary action, with direct communication with Advocacy committee and Louisiana Behavioral Health Advisory Council (LBHAC) as needed.

Specific duties by quarter

First quarter:

(1) Review fiscally related sections of combined block grant.
(2) Review data from state central office to determine progress made on mental health contract expenditures. Assure measurables are related to outcomes. (Sept & March) Look back to see expenditures and whether measurables were met for preceding year. In March, look at how current fiscal year is going.

Second Quarter:

(1) Discuss with members of Louisiana Commission on Addictive Disorders collaborative efforts between two entities.
(2) Review addictive disorders expenditures (June)

Third Quarter:

(1) Review expenditures on Office of Behavioral Health Central office mental health contracts for previous fiscal year. Assure measurables and performance objectives reflect outcomes.
(2) Review data from state central office to determine progress made on mental health contract expenditures. Assure measurables are related to outcomes. (Sept & March) Look back to see expenditures and whether measurable were met for the preceding year.

Fourth Quarter:

(1) Established activities for Louisiana Behavioral Health Advisory Council, Finance Committee as they relate to Substance Abuse Prevention and Treatment Block Grant.

LOUISIANA MENTAL HEALTH PLANNING COUNCIL

SPECIAL RULES OF ORDER

ADOPTED NOVEMBER 5, 2007

ATTENDANCE

At the first regular council meeting after the second consecutive absence of a council member, the executive committee shall report its recommendation on the question of retention or removal of the member from the council.

PUBLIC COMMENT

1. At any time the council considers a matter on which a member of the public wishes to address the council, the council shall make reasonable efforts to provide the opportunity to a representative number of proponents and opponents on each issue before the council.
2. Each person appearing before the council shall be required to identify himself and the group, organization, or company he represents, if any, and shall notify the chairman no later than the beginning of the meeting by completing a basic information form furnished by the secretary.
3. To be certain that an opportunity is afforded all persons who desire to be heard, the chairman shall inquire at the beginning of any period of public comment on each matter if there are additional persons who wish to be heard other than those who have previously notified the chairman.
4. Subject to such reasonable time limits the council may establish for any public hearing or period of public comment, the chairman shall allot the time available for the hearing in an equitable manner among those persons who are to be heard. In no case, however, shall any person speak more than five minutes without the consent of the council.

COMMENTS ON THE CONTENT OF THIS PLAN ARE WELCOMED AND MAY BE SUBMITTED AT ANY TIME VIA:
https://www.surveymonkey.com/s/publiccomment

OR

LOUISIANA BEHAVIORAL HEALTH ADVISORY COUNCIL LIAISON

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