



Bobby Jindal
GOVERNOR

Louisiana Commission on Addictive Disorders

May 10, 2012

Commission Members

Thomas P. Lief
New Orleans - MHSD

Anthony Wickramasekera
Member-At-Large
New Orleans - MHSD

Shelley Mockler
Baton Rouge - CAHSD

Kathleen Leary
Houma - SCLHSA

Lloyd Hernandez
Lafayette - Region IV

George W. McHugh
Member-At-Large
Vice Chair, Liaison
St. Martinville - Region IV

Lana Bel
Lake Charles - Region V

Vacant
Alexandria - Region VI

Vacant
Shreveport - Region VII

Damon Marsala
Monroe - Region VIII

Jon Lance Nickelson
Monroe - Region VIII

Vacant
Madisonville - FPHSA

Freddie Landry
Chairperson
Jefferson - JPHSA

The Honorable Bobby Jindal
Governor of Louisiana
Office of the Governor
Post Office Box 94004
Baton Rouge, Louisiana 70804

The Honorable David R. Heitmeier
Chairman
Senate Committee on Health and Welfare
Post Office Box 94183
Baton Rouge, Louisiana 70804

The Honorable Scott M. Simon
House Committee on Health and Welfare
Post Office Box 44281
Baton Rouge, Louisiana 70804

The Honorable John A. Alario, President
President
Louisiana State Senate
Post Office Box 94183, State Capitol
Baton Rouge, Louisiana 70804-9183

The Honorable Charles E. Kleckley
Louisiana Speaker of the House
Post Office Box 44281
Baton Rouge, Louisiana 70804

Bruce D. Greenstein
Secretary
Department of Health and Hospitals
Post Office Box 629
Baton Rouge, Louisiana 70804

RE: 2011 ANNUAL REPORT – Louisiana Commission on Addictive Disorders

Dear Sirs and Madam:

The Louisiana Commission on Addictive Disorders is required by Act 899 of the 1984 Regular Session of the Legislature to provide an annual written report to the Governor, the chairpersons of the House and Senate Health and Welfare Committees, and the Secretary of the Department of Health and Hospitals.

Attached is a copy of the Commission's Annual Report and a list of the present Addictive Disorders Commission members.

If you would like further information, please contact me.

Sincerely,

Freddie G. Landry, Chair
Louisiana Commission on Addictive Disorders
(504) 236-0508

Attachment

c Rochelle Head-Dunham, MD

Louisiana Commission on Addictive Disorders

Annual Report

*A report on the activities of the Louisiana Commission
on Addictive Disorders and related initiatives of the
Office of Behavioral Health.*

2011

A Message from the Chairperson

Dear Legislators and Stakeholders,

The purpose of the Louisiana Commission on Addictive Disorders is to assess, evaluate, and recommend programs and/or services provided on a regional/district level; to represent the community needs related to addictive disorders legislatively; and to act as advocates for addictive disorders services and the clients who need them. Each year the Commission submits an Annual Report outlining the state of addictive disorders services and needs throughout the State of Louisiana. The ensuing report outlines the activities of the Commission along with valuable insights into how addictive disorders impacts many areas of government and the burden untreated addiction places on the state's budget.

During 2010, the Office for Addictive Disorders and the Office of Mental Health merged to create the Office of Behavioral Health within the Department of Health and Hospitals. The Commission's leadership has been active in this process, ensuring that the state's addiction treatment infrastructure remains viable and effective and the clients who need these services continue to receive the best treatment possible within the constraints of looming budget cuts.

The 2011 Annual Report delineates the many programs provided along the Office of Behavioral Health's continuum of care: from universal prevention efforts, to inpatient and outpatient treatment, to recovery support services. The addiction staff within the Office of Behavioral Health continues to work diligently to meet the needs of an ever-present waiting list for services, despite the challenges presented by a tough financial climate. With the creation of the Louisiana Behavioral Health Partnership and the contract with Magellan of Louisiana to serve as the State Management Organization, the Commission is thankful for the in-depth inclusion addiction treatment through these services.

One of the major challenges faced by the field of addictive disorders is the need for workforce development. Following Hurricane Katrina, many licensed and certified addiction professionals left the state and the workforce necessary for treating addiction in Louisiana reduced substantially. The need to provide educational opportunities to train new and efficient addiction counselors is of paramount importance. Compounding this need is the prospect of expanding treatment opportunities and supports for those challenged by co-occurring addiction and mental health issues. It is critical – now, more than ever before – that local institutions of higher learning assist in building a qualified and competent workforce to meet these needs, through specialized recruitment and by offering the curricula necessary to prepare future clinicians to enter the field.

The Louisiana Commission on Addictive Disorders is committed to helping meet the challenges of the future and to serving as advocates for the recovery of those suffering from the ravages of addiction. If we can be of assistance in any way, please do not hesitate to call on us.

Warmest regards,

Freddie G. Landry, M.Ed., LPP
Chair, Commission on Addictive Disorders

I. About the Commission

History and Role of the Commission

Act 899 of the 1984 Regular Session of the Louisiana Legislature created the Louisiana Commission on Addictive Disorders⁵. The same Act created the state agency known as the Office for Addictive Disorders⁵. During the 2009 Regular Session of the Louisiana Legislature, Act 384 merged the Office for Addictive Disorders with the Office of Mental Health to create a single Office of Behavioral Health (OBH)⁵. The new OBH is responsible for serving the needs of Louisiana citizens challenged by mental health issues, addictive disorders, and co-occurring disorders⁵.

The statutory duties and responsibilities of the Commission are as follows:

- 1) To advise the Office of Behavioral Health “concerning the policy of the State with respect to addictive disorders;”⁵
- 2) To “recommend an annual State Plan...to the [Office of Behavioral Health]...setting forth proposed policy, program planning initiatives and goals relative to the prevention and treatment of addictive disorders;”⁵
- 3) To submit an annual report to the Governor, the Joint Health and Welfare Committee of the Louisiana Legislature, and the Secretary of the Department of Health and Hospitals as to the activities of the Commission and the Office of Behavioral Health for the previous calendar year, as well as recommendations concerning future program initiatives;⁵ and
- 4) To “serve as liaison among all State and local government entities concerning addictive disorders”⁵

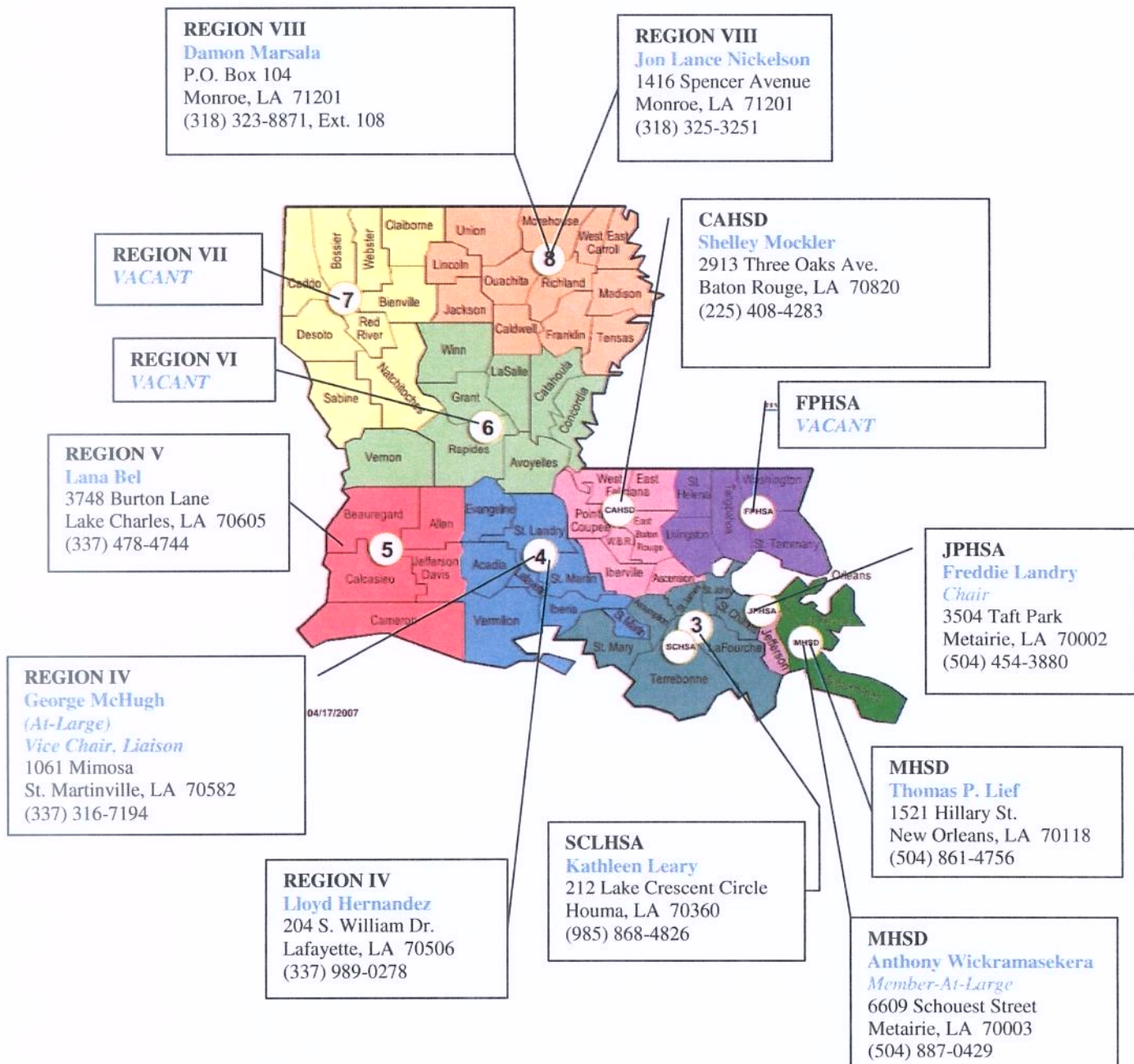
Commission Activities – 2011

The Commission on Addictive Disorders is a viable, active committee, meeting regularly, with activities that have included assisting and supporting the Office for Addictive Disorders and the Office of Behavioral Health with the following initiatives:

- The Commission met 11 times during the 2011 calendar year. The Commission met every month except for the month of July 2011. All of the meetings were held at OBH Headquarters in Baton Rouge.
- Commission members participated in the Public Forums held by the Office of Behavioral Health in 2011. These forums are held annually in the regions/districts around the state as a requirement of the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funding the Office heavily depends upon. Public Forums represent valuable opportunities to obtain input and feedback from consumers, stakeholders, and the public regarding prevention and treatment needs, as well as to demonstrate the accountability of the Office. Interested state legislators also participated in these forums.

Representation

The Commission is comprised of thirteen individuals: the Assistant Secretary of the Office of Behavioral Health, who serves as the Commission's Executive Director in an *ex officio* capacity; ten regular members, who represent the regions and districts of the state; and two "at-large" members. All members are appointed by the Governor and confirmed by the Senate. Currently, the Commission only has eight regular members (not counting the Assistant Secretary) and two "at-large" members, leaving gaps in representation for FPHSA, Region VI, and Region VII. The Commission's membership is detailed on the map below.



Members of the Commission also serve on other boards and committees, including:

- Behavioral Health Planning Advisory Council (*Freddie G. Landry*)
- The Drug Policy Board (*Freddie G. Landry*)
- Greater New Orleans Drug Demand Reduction Coalition (*Freddie G. Landry, Thomas P. Lief, Anthony Wickramasekera*)
- OBH Kitchen Cabinet (*Freddie G. Landry*)
- New Orleans Behavioral Health Coordination Committee (*Freddie G. Landry, Thomas P. Lief, Anthony Wickramasekera*)
- The Prevention System Committee (*Freddie G. Landry*)
- The Association of Problem Gamblers (*Kathleen Leary*)
- Acadiana Area Human Services District Governance Board (*George McHugh*)
- Community Service Center Board of Directors (*Thomas P. Lief*)

II. The State of Addiction

National Trends

During 2010, the Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies) published several reports based on national data that indicate a number of specific areas of concern with regard to addiction's impact on society. One of these concerns was the impact of addiction on hospital emergency department services. A second major area of interest in the reports was trends related to underage drinking and drug use. Other studies point to the relationship between addiction, crime, and recidivism.

Emergency Department Services. Emergency department services are one of the most utilized and expensive categories of health care in the nation. In many cases, hospital emergency departments serve as a point of entry for people seeking substance abuse detoxification or treatment services due to the involvement of alcohol or illicit drugs in an accident, overdose, or suicide attempt³. According to the Drug Abuse Warning Network, approximately 177,879 visits to emergency departments nation-wide in 2008 involved people seeking detoxification or substance use disorders treatment services³.

Underage Drinking and Drug Use. During 2008, adolescents and young adults (ages 12 to 20) made an estimated 188,981 alcohol-related visits to emergency departments⁷. The use of illicit drugs was identified in more than two thirds of those visits, and more than half involved the use or abuse of pharmaceutical drugs⁷. Of those visits, the illicit drug most used in combination with alcohol was marijuana; the next most common was cocaine⁷. The most common pharmaceutical drugs used in combination with alcohol by these patients were those used to treat anxiety or insomnia, followed by narcotic pain relievers and antidepressants or antipsychotics⁷. Alcohol took an especially heavy toll on the adolescent and young adult population during the holidays. During July of 2008, there were an average of 502 emergency department visits per day involving underage drinking⁸; however, during the 3-day Fourth of July weekend, that number increased 87% to an average of 938 per day⁸. An alarming point to note is that of all these patients age 12-20, nearly two thirds did not seek or were not referred to follow-up care or services⁷.

Crime and Recidivism. An expansive body of research documents the relationship between addiction and crime¹. Many of those involved with the criminal justice system have known involvement with alcohol and drugs¹. In addition, a large percentage of persons currently incarcerated or otherwise involved with the criminal justice system (including adolescents) have an addiction or history of addiction, a mental health issue, or both¹⁰. Many of these individuals do not receive effective treatment for their particular situation¹. This has several negative effects on society and its financial stability: emergency room visits, property damages, and costs associated with prosecution and incarceration can all be attributed to a combination of substance abuse and criminal activity¹.

Taken together, the above consequences of untreated addiction (and others) exert a heavy financial toll on a state's budget⁶. Specific information on this topic is provided in the section titled "Impact on State Budget."

Trends in Louisiana

People Served. According to data derived from the Louisiana Addictive Disorders Data System (LADDS), the Office of Behavioral Health provided treatment services to 35,521 people during Fiscal Year 2011⁹. Of these people served, 19,975 (56%) had only one treatment episode; the remaining 15,546 (44%) patients had two or more separate treatment episodes⁹. Of those admitted to treatment during FY 2011, approximately 37% were African American, 61% were Caucasian, and the remaining 2% were composed of Native Americans, Asians, and others⁹. The gender breakdown of people served reveals that 33% were female and 67% were male⁹.

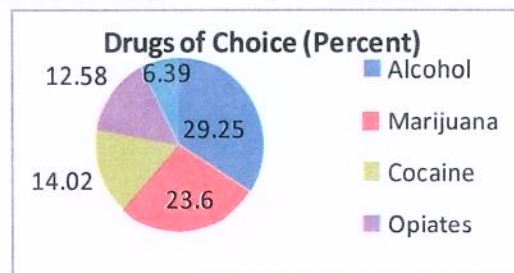
People Served (LADDS):		35,521
Ethnicity:	African American:	37%
	Caucasian:	61%
	Native American, Asian, Other:	2%
Gender:	Male:	67%
	Female:	33%
Source: LADDS		

The Access To Recovery (ATR-I) project provided treatment services to 2,825 people during FY 2011. The ATR-II project provided treatment services to 1,631 people during the same reporting period. In addition to treatment services, the Office of Behavioral Health served 77,171 people with direct, individual-based prevention services and an additional 189,613 people with population-based prevention services during FY 2011. Together, the total number of people served by the Office of Behavioral Health during FY 2011 is 306,761 as demonstrated by the table below.

Prevention		Treatment		Total
Enrollees	77,171	LADDS	35,521	
Participants	189,613	ATR I & II	4,456	
Prevention Subtotal:	266,784	Treatment Subtotal:	39,977	
				306,761

Drugs of Choice. According to the LADDS data described above, the drugs of choice in Louisiana for FY 2011 were (in order of frequency): alcohol (29.25%), marijuana (23.6%), cocaine (14.02%), opiates (12.58%), and heroin (6.39%)⁹. This trend is comparable to those represented by national data on the same topic.

Taken together, the frequency of alcohol and marijuana (commonly used in combination³) represent a majority of the drugs of choice. However, this evidence – in comparison with data from previous years – reveals that the non-medical use and abuse of opiates continues to rise, as does the use of heroin^{3,9}.



Treatment Outcomes. The Office of Behavioral Health collects, tracks, and analyzes data that describes the National Outcome Measures (NOMS) outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA). In addition, the ATR project collects data required by the Government Performance and Results Act (GPRA). Though the GPRA outcome measures are similar to the NOMS, a notable difference is the fact that ATR data reflects lower figures in the “stable living arrangements” category, since the GPRA definition of this outcome does not include dependent living situations, only those considered independent. The NOMS, listed in the table on the next page, include:

- Abstinence from drug and alcohol use;
- Gaining or maintaining either employment or education;
- Reduction in crime or criminal justice involvement;
- Stable living arrangements;
- Social connectedness;
- Access to services and capacity for providing services;
- Retention of patients in treatment;
- The patients’ perception of care;
- The cost-effectiveness of care provided; and
- The use of evidence-based practices.

The table below describes what are considered to be critical or priority patient outcomes for the Office of Behavioral Health during FY 2011.

Outcome Measure		LADDS ¹			ATR-I			ATR-II			National Outcome Measures (NOMS)
		A	D	+/-	A	D	+/-	A	D	+/-	
Arrest Rate		10.8%	3.7%	-7.1%	8%	2%	-6%	7%	2%	-5%	
Abstinence		27.9%	81.6%	+57.3%	29%	88%	+59%	28%	86%	+58%	
Stable Living Arrangement ²		93.6%	95%	+1.4%	61%	51%	-10%	77%	83%	+5%	
Gained or Maintained Employment / Education		28.9%	32.5%	+3.6%	31%	59%	+28%	38%	53%	+22%	
Average Length of Stay	Inpatient	29 Days			87.6 Days			N/A			
	Outpatient	104 Days						101.2 Days			

Source: LADDS, ATR

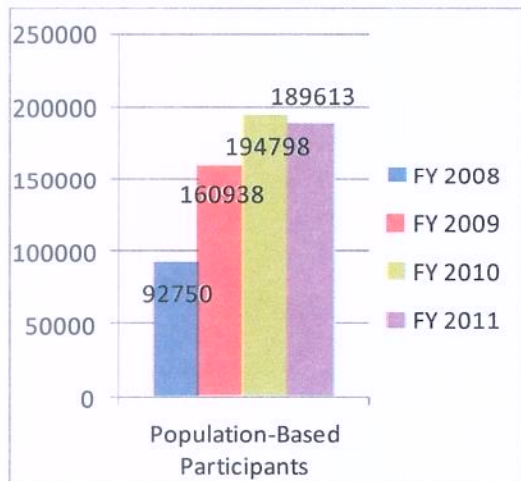
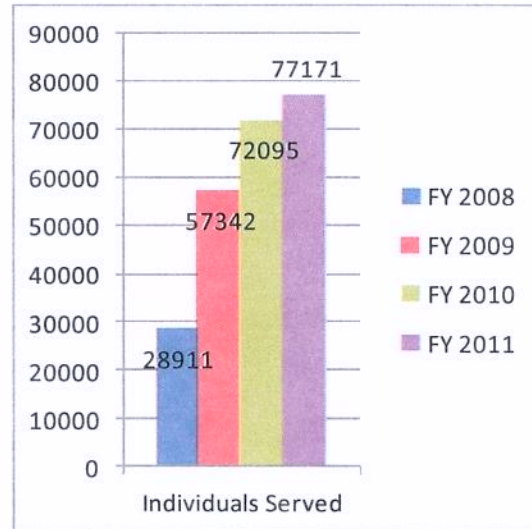
¹ Analyses do not include those who failed to come to treatment after admission or those who dropped out in the first week of treatment.

² ATR reflects lower figures in “Stable Living Arrangement” category due to difference between NOMS and GPRA definitions. GPRA (ATR) definition of Stable Living Arrangement does not include *dependent* living situations, only *independent*.

As indicated by this table, OBH saw improvement in each of these categories. The first category, which describes the arrest rate of patients seen during FY 2011, shows a reduction in arrest rate from admission to discharge for each group of patients admitted to treatment (LADDS, ATR-I, and ATR-II). A significant improvement is also evident in each of these categories for promoting abstinence from drug and alcohol use. In addition, stable living arrangements and employment/education increased in each group of patients (please see footnote 2 regarding decrease in stable living arrangement in ATR-I).

Adolescent Outcomes. In addition to the people served listed above, OBH provided services to 2,321 adolescent patients⁹. This population had a reduction in the arrest rate of 11% (16% at admission to 5% at discharge), a 56% increase in abstinence (28% at admission to 84% at discharge), and a 79% reduction in drug use (or maintained abstinence) from admission to discharge⁹. Of this treatment population, clinicians judged that 76% made some or significant progress⁹.

Prevention Initiatives. Prevention reduces high-risk behaviors associated with alcohol, tobacco, and other drug use by providing evidence-based individual and population-based services and programs. The success of prevention programs is measured by examining the number of individuals enrolled in evidence-based programs, the number of participants positively impacted by one-time prevention services, and the perceived risk/harm of substance abuse as reported by individuals surveyed in schools and other community-based programs. During FY 2011, 77,171 individuals were enrolled in ongoing prevention programs and services,



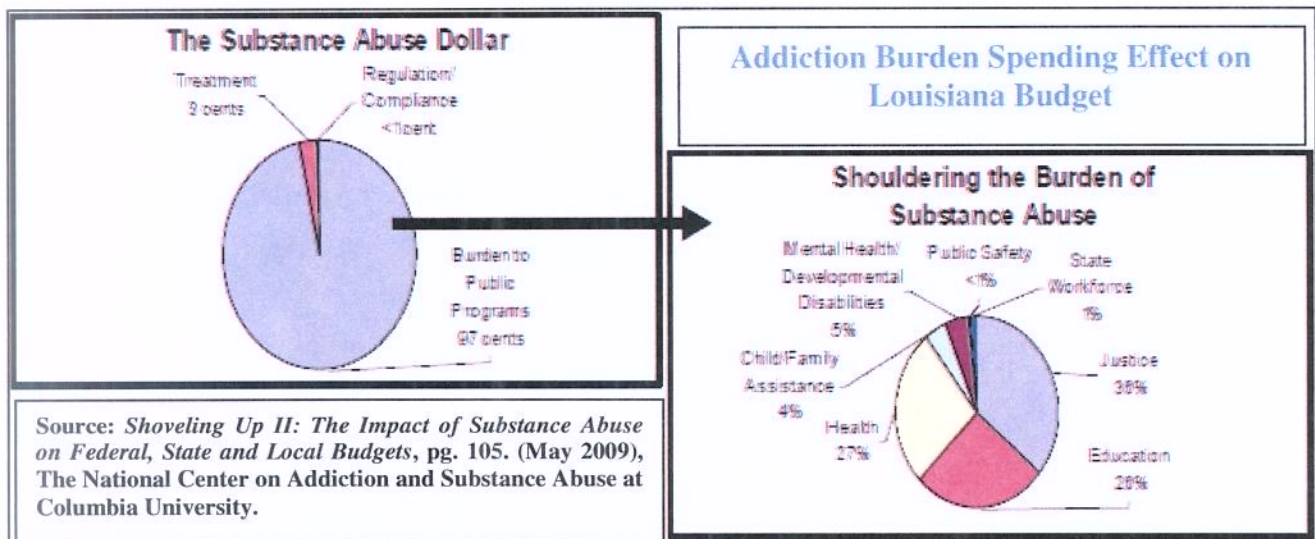
and 189,613 people were positively impacted by one-time population-based services. In total, 266,784 people were served in prevention programs and services during FY 2011. In addition, the perceived risk/harm of substance abuse increased during FY 2011, indicating that prevention efforts are having a positive impact on Louisiana youths' perception of the risks and harms associated with substance abuse.

Prevention services, in addition to the obvious benefits of delaying the age of initiation of substance use and reducing high-risk behaviors that lead to addictive disorders, are also very cost-effective. Since FY 2008, OBH Prevention has ***increased evidence-based prevention services by 167% without additional funding***. This increase has been the result of a cooperative partnership with the Department of Education, the mobilization

of services, and the implementation of cost bands. Prevention services, due to their goals and outcomes, produce a very high return on investment, since they help prevent a younger and significant portion of the population from needing treatment.

Impact on State Budget

Untreated addiction affects every area of the State of Louisiana's budget⁶. The state pays for the consequences of untreated addictive disorders in increased rates of high school dropouts, incarceration, child welfare costs, highway fatalities, and lost workforce productivity⁶. An economic study on addiction titled *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets* states that on average, "States pay over 11 times the total amount spent on prevention, treatment and research coping with the burden of substance abuse and addiction in the health care system"⁶. The same 2009 study, conducted by the National Center on Addiction and Substance Abuse (NCASA) at Columbia University, indicates that as the state invests in addiction treatment programs, society profits from reductions in future criminal justice, medical, and health care expenses⁶. Also, "burden spending" in other areas of state and local government is drastically reduced by funding effective prevention and treatment programs⁶.



According to SAMHSA Administrator Pamela S. Hyde, J.D., "Behavioral health services are critical to health systems and community strategies that improve health status and they lower costs for individuals, families, businesses, and governments. The value of behavioral health services is well documented. Studies have shown that every dollar invested in evidence-based treatments yields \$2.00 to \$10.00 in savings in health costs, criminal & juvenile justice costs, educational costs, and lost productivity. **Yet, too many people don't get needed help for substance abuse or mental health problems and health care costs continue to skyrocket**"¹¹.

Louisiana generally has a higher concentration of population in need of addiction treatment than the national average⁴. In addition, Louisiana has one of the highest incarceration rates in the nation⁴. Given these initial conditions, it is reasonable to assume that investments in the prevention and treatment of substance use disorders for Louisiana residents would produce a return greater than the national average.

The Office of Behavioral Health and the Commission on Addictive Disorders continue to believe in the validity of, and will make all efforts to move toward, the integration of addiction treatment into a primary care/public health model. Leveraging Department of Education partnerships and the existing Public Health Unit infrastructure to increase OBH's preventive impact is a current initiative of the Office.

The Office of Behavioral Health continues to seek and develop additional sources of funding in the interests of expanding the state's service capacity for addiction treatment and ensuring the delivery of quality care to citizens in a timely and effective manner. Addiction is a health care issue, and systems that acknowledge and treat it as such tend to realize significant benefits, as noted above.

Surveys and Studies

Caring Communities Youth Survey (CCYS). OAD co-sponsored with the Louisiana Department of Education, the 2010 Caring Communities Youth Survey (CCYS). The CCYS has been conducted biennially since 1998 among students in grades 6, 8, 10, and 12. The 2010 survey was very successful, with a total of 113,414 participating students. Of all participants, data from 105,814 students were accepted for analysis. The students participating were from 709 schools in 67 LEAs in grades 6, 8, 10 and 12. 62 parishes participated. Results of the survey are outlined in State Regional and Parish reports. School level reports are available only to the superintendents of each parish. The State, Regional and Parish reports are posted on the OBH website for review and use by the general public as follows: <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1790>.

Higher Education Core Survey. The Office for Addictive Disorders provided funding for a Core Survey conducted by Louisiana Institutions of Higher Education Coalition to Reduce Alcohol, Tobacco and Other Drugs (LaHEC) in Spring 2011. Thirty-five institutions of higher education participated in this survey, which produced a sample size of almost 10,000 students. The State and Regional reports are posted at <http://uiswcmsweb.prod.lsu.edu/edco/lacasu/CoreAlcoholandDrugSurvey/CoreData/item30083.html>.

Problem Gambling Study. The 2008 *Louisiana Study on Problem Gambling* measures four areas, divided by region: (1) problem and pathological gambling rates, (2) gaming establishments and video gambling devices per capita rates, (3) calls to the Louisiana Problem Gamblers Helpline, and (4) youth gambling data collected from the *Louisiana Caring Communities Youth Survey*.

The data revealed that 1.7 percent of gamblers in the state are problem gamblers (at-risk for addiction), and 1.4 percent are pathological gamblers (or compulsive gamblers). This represents an estimated 54,360 problem gamblers and 44,767 pathological gamblers statewide. Youth data indicates that almost 50 percent of Louisiana students (6th, 8th, 10th and 12th grades) have engaged in some form of gambling, most of them in the previous year. The numbers were highest in the New Orleans and Houma/Thibodaux areas. Calls to the toll-free problem gambling helpline increased from 2002 to 2007. In the 2006-2007 fiscal years, the Helpline received 53,127 calls. Of the intake calls received in 2007, females represented 53% of the callers and males represented 45%. Most callers identified themselves as either Caucasian (51%) or African American (37%). The study also revealed that the number of gambling sites in the state has decreased since 2002, from 2,890 locations to 2,372. However, the number of gambling devices has increased during this time from 37,864 machines in 2002 to 44,504 machines in 2008. The findings of this study remain consistent with current rates. Over the past few years, though the total number of calls has declined, the percentage of direct calls for assistance has been increasing. During SFY10-11, the Helpline answered 29,582 calls. Of these, 1,739 (5.87%) were calls for direct assistance with a gambling problem.

III. The OBH System of Care for Addiction

Relationship

The Louisiana Behavioral Health Partnership (LBHP) is the partnership between the Louisiana Department of Health and Hospitals - Office of Behavioral Health, the Department of Child and Family Services, the Office of Juvenile Justice, the Department of Education and Magellan Health Services, Inc.

- The LBHP offers expanded services and care for:
 - Eligible adults with a serious mental illness or addiction.
 - Children with a serious emotional disorder or emotional behavioral disorder.
 - Coordinated care, including wraparound services for children and youth with significant behavioral problems.
- Through Magellan Health Services, consumers will be provided 24-hour access to care for themselves and their families, seven days a week.
- Magellan will work closely with behavioral health care providers to ensure consumers are more involved in decisions about their own care.

To be eligible for referrals and reimbursement for covered services rendered to eligible members, each provider must sign a Magellan provider participation contract agreeing to comply with Magellan's policies, procedures, and guidelines.

Providers are contracted as individual practitioners, groups or organizations:

- **Individual Practitioners:** To be a network provider, individual providers must be both *credentialed* and *contracted* by Magellan. Individuals must be enrolled in Medicaid
- **Group Providers:** Magellan *contracts* directly with the group entity. The group must be contracted with Magellan AND the practitioners within the group must be individually credentialed by Magellan in order to be referral eligible
- **Organizations:** To be a network provider, organizations must hold an active license through DHH and be credentialed by Magellan. Organizations must also be enrolled in Medicaid. Practitioners within an organization are not individually credentialed, only the organization itself.

At full implementation, we expect to be able to improve services for:

- About 2,500 of our youth with most significant challenges and those at highest risk through the Coordinated System of Care.
- About another 50,000 children and teens with behavioral health challenges.
- About 100,000 adults with severe and persistent mental illness, major mental disorder, acute stabilization needs and/or addictive disorders.
- Uninsured children and adults who have severe mental illness and/or addictive disorders.

Provider Changes. Under the Louisiana Behavioral Health Partnership, addiction services include an array of individual-centered outpatient, intensive outpatient and residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse symptoms and behaviors.

Services for adolescents must be:

1. Separate from adult services,
2. Developmentally appropriate,
3. Involve the family or caregiver, and
4. Coordinated with other systems (such as child welfare, juvenile justice and the schools).

These services are designed to help individuals achieve changes in their substance abuse behaviors. Services should address an individual's major lifestyle, attitudinal and behavioral problems that have the potential to be barriers to the goals of treatment. Outpatient services may be indicated as an initial modality of service for an individual whose severity of illness warrants this level of treatment or when an individual's progress warrants a less intensive modality of service than they are currently receiving. Intensive outpatient treatment is provided any time during the day or week and provides essential skill restoration and counseling services for individuals needing more intensive treatment. Outpatient, intensive outpatient and residential services are delivered on an individual or group basis in a wide variety of settings, including treatment in residential settings of 16 beds or less, designed to help individuals achieve changes in their substance abuse behaviors.

These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid-eligible individuals with significant functional impairments resulting from an identified addiction diagnosis. Services are subject to prior approval, must be medically necessary and must be recommended by a LMHP or physician who is acting within the scope of his/her professional licensed and applicable State law to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level according to an individualized treatment plan.

Services are provided by licensed and unlicensed professional staff who meets the provider qualifications listed in the LBHP Service Definitions Manual. Anyone who is unlicensed providing addiction services must be registered with the Addictive Disorders Regulatory Authority and demonstrate competency as defined by the Department of Health and Hospitals, state law (ACT 803 of the Regular Legislative Session 2004) and regulations. State regulations require supervision of unlicensed professionals by a Qualified Professional Supervisor (QPS).

The Office of Behavioral Health maintains a dynamic, responsive, and comprehensive system of care for those challenged by mental health and addiction issues. With regard to addiction, that system encompasses a "continuum of care" that begins with prevention and ends with recovery supports for sustained abstinence and re-entry into the community.

How the Continuum Works

The OBH Continuum of Care is comprised of five basic segments, or categories of care: prevention, detoxification, inpatient treatment, outpatient treatment, and recovery support. These five categories represent a logical progression of services for the addiction population. American Society of Addiction Medicine (ASAM) Patient Placement Criteria is utilized in the determination of the appropriate level of care. Although prevention is not typically included in a continuum of care model, it is a vital first step in reducing the incidence and prevalence of addictive disorders, and is therefore included in this description of our service delivery system.

Prevention. OBH prevention services are provided according to two basic categories: individual services, and population-based services. Individual services and programs are administered to enrollees, typically in an educational setting on an ongoing basis. Population-based services are provided to multiple people at once, typically in a one-time event setting such as a health fair. The primary goals of prevention are to delay or prevent initiation to substance abuse, reduce high-risk behaviors that lead to addictive disorders, and divert the state's younger population from entering the treatment system. However, prevention providers are also trained to identify individuals at risk for substance abuse and refer them to necessary services; following this, a determination is made as to whether or not additional services will be necessary to prevent the onset of substance abuse. Combined, these two categories of services positively impacted 266,784 people in Louisiana during state fiscal year 2011.

Detoxification. Detoxification services are provided to those seeking substance use disorders treatment that are at risk for experiencing withdrawal symptoms. There are three types of detoxification services offered by OBH, according to the specific needs of patients. Social detox includes twenty-four hour monitoring, and is available for those who need detox services but have no health risks associated with withdrawal. Medically Supported/Monitored Detox is available for those who may require 24-hour nursing and other medical services as part of their detoxification process provided in a residential setting. Medically Managed Detox is appropriate for those patients who require medication management as part of their detox in a hospital setting. This level of care is appropriate when management of other complex co-occurring medical conditions are present and/or the severity of the withdrawal can be life threatening. Once the period of detoxification is complete coordination of care to the appropriate next lower level of care is recommended.

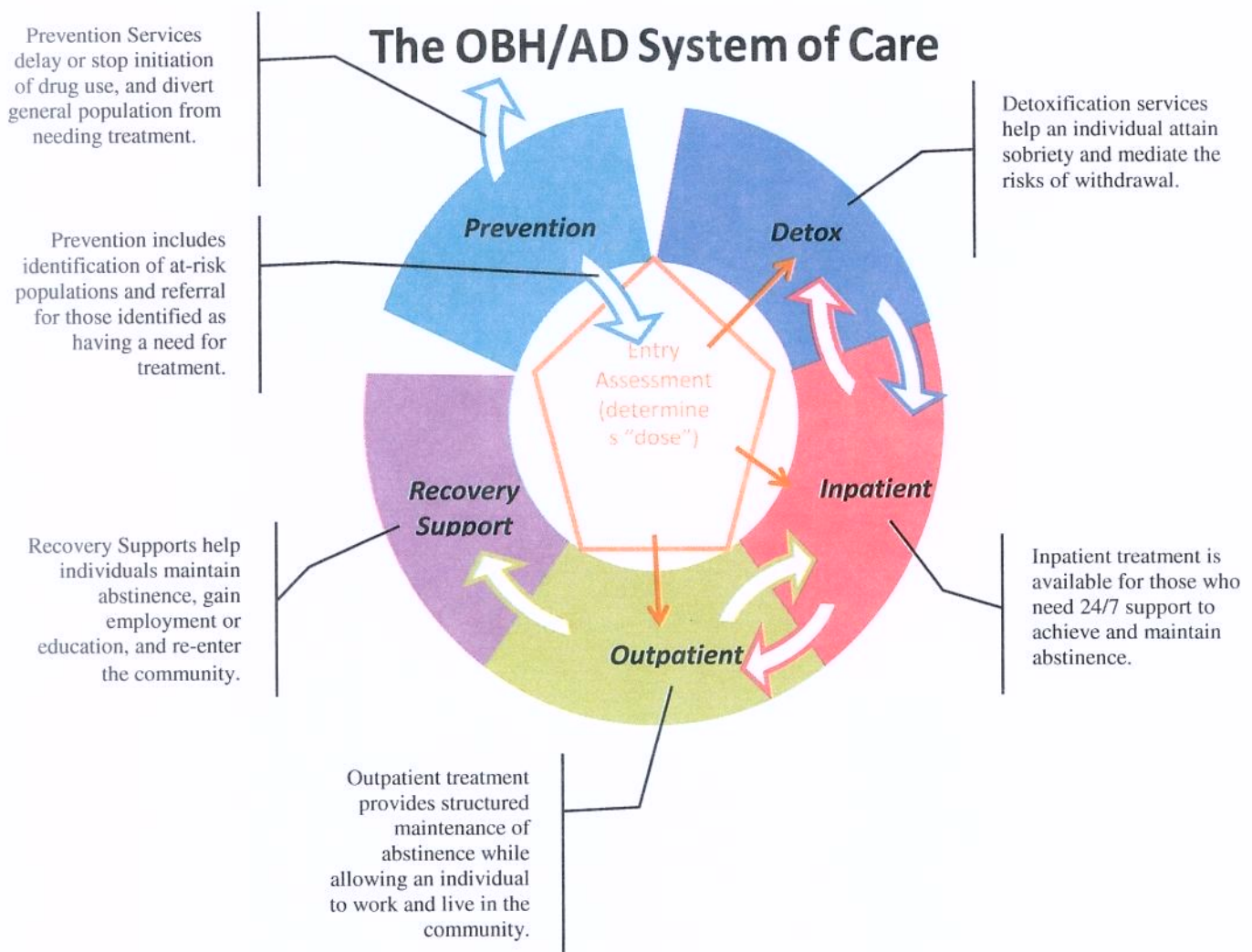
Residential Inpatient Treatment. Residential inpatient treatment is appropriate for many individuals who would benefit from a stable, supervised, and controlled setting. A variety of support services are offered during inpatient treatment, including individual and group therapies, counseling, education, life skills education, and job skills training. Once clinical staff determines that patients would benefit more from a less restrictive setting, they may be stepped down to outpatient treatment options per their specific needs. The option to return to detoxification services is available for those who experience a serious relapse.

Outpatient Treatment. Outpatient treatment comes in two "doses": intensive, and regular. Intensive outpatient treatment (IOP) requires a slightly more rigorous, 9 hours or more, weekly contact schedule of attendance and counseling, and is generally reserved for those patients that would benefit from a greater level of support. Standard outpatient treatment requires less than 9 hours of weekly contact for a less intense attendance and counseling schedule. Each outpatient treatment schedule is determined according to the specific needs and situation of the individual. The option to return to inpatient treatment (and even detoxification) is available for those patients that experience a serious relapse.

Recovery Support. Recovery Support Services (RSS) are ancillary services that help an individual achieve and maintain recovery from substance abuse. These services may include transportation to and from outpatient services, job skills training, and education. Typically, a variety of recovery supports is helpful in achieving sustained recovery. Many recovery support services are provided through the voucher-based Access To Recovery (ATR) program.

Prevention

During SFY 2011, OBH Prevention provided ongoing evidence-based prevention programming to 77,171 enrollees, a significant increase over previous years. Increases in service delivery since SFY 2007 are due to a cooperative partnership with the Department of Education (DOE) and its local education authorities, the mobilization of prevention services, implementation of cost bands for universal, selective and indicated programs, and fee for service contracts. OBH Prevention has worked closely with the DOE to identify gaps in prevention services and has been successful in increasing services by utilizing DOE's infrastructure. By bringing prevention services into school classrooms, OBH Prevention has been able to decrease significantly the necessary personnel, operational, transportation, and capital asset costs, making



these resources available for direct services. It is important to note that increases in services were accomplished utilizing existing SAPT Block Grant funds: no additional monies were received. In addition to the 77,171 enrollees mentioned earlier, population-based prevention services positively

impacted the lives of 189,613 people in Louisiana. The total number of people served by OBH Prevention in FY 2011, including both individual and population-based services, was 266,784.

Strategic Prevention Framework State Incentive Grant. OBH and the Governor's Office of Safe and Drug Free Schools and Communities worked in partnership to apply for the grant. Louisiana was awarded \$11.75 million to implement the SPF State Incentive Grant (SPF-SIG), "The Governor's Initiative to Build a Healthy Louisiana." The Strategic Prevention Framework (SPF) is a data-driven, outcome-based planning process intended to achieve sustainable reductions in the abuse of alcohol, tobacco, and other drugs among targeted populations through evidence-based prevention. The purpose of the SPF is to develop a system that coordinates planning, funding, and evaluation for substance abuse prevention. Through the work of the State Epidemiological Workgroup, twelve (12) parishes were identified as having the highest alcohol-related motor vehicle crashes and violent crime rates. These 12 parishes were offered funding to develop coalitions to address alcohol-related problems in their respective parish with the target population of 12-29 year olds. Of the original twelve (12), ten (10) parishes chose to participate. The 10 parishes are as follows: Cameron, Calcasieu, Jefferson Davis, Lafayette, Orleans, St. James, St. Mary, St. Landry, Tangipahoa, and West Baton Rouge. This grant expired on September 30, 2011. A goal of the SPF-SIG is to identify alternate sources of funding for prevention services and promote the sustainability of the system at the local/community level. SPF-SIG Project Staff did submit a proposal for a competitive grant to continue the work of the SPF-SIG, but were not selected for the grant award. Still, there is concern as to the continuation of the groundwork which has been established.

State Prevention Enhancement Grant. In September 2011, OBH was awarded \$600,000 to implement the State Prevention Enhancement (SPE) Grant. The SPE Grant is a one-year grant intended to strengthen and extend SAMHSA's national implementation of the Strategic Prevention Framework (SPF), in an effort to bring the SPF to scale and support communities of high need nationwide. The SPE Program is designed to support States and Tribes in enhancing their infrastructures to reduce the impact of substance abuse. Through stronger, more strategically aligned substance abuse infrastructures, SPE States and Tribes will be better positioned to apply the SPF process to implement data-driven, evidence-based prevention programs, policies and practices in their communities.

Synar Compliance. OAD has funded a community contractor since 1997 in each of the state's ten regions. Each provides retailer education to 400 tobacco merchants regarding the sale of tobacco products to minors through unconsummated compliance checks. In addition, OAD continues its partnership with the Office of Alcohol and Tobacco Control (OATC) by contracting with OATC to conduct 2,400 random unannounced tobacco compliance checks. This contract ensures that tobacco compliance checks are being conducted statewide on an on-going basis allowing the state to remain in compliance with The Synar Amendment to the Public Health Service Act (PL 102-321).

The Synar Amendment requires that states must implement annual random, unannounced compliance inspections to determine their buy rates of tobacco products sold to youth under the age of 18. If that state's buy rate exceeds 20%, OAD would lose 40% of its Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds, which are used to provide treatment and prevention services. In SFY 2011, the non-compliance rate in Louisiana was 4.3%. This rate is one of the lowest in the nation. The model that Louisiana has utilized is considered as a model program by the Center for Substance Abuse Prevention as it pairs community mobilization and enforcement efforts.

ASAM Levels of Care

The American Society of Addictive Medicine (ASAM) Patient Placement Criteria is the result of a collaborative effort to define one national set of criteria for providing outcome-oriented and results based care in the treatment of addiction. This criterion has become the most widely used and comprehensive set of guidelines for placement, continued stay and discharge of patients with addictive disorders.

Addiction medicine professionals use ASAM Patient Placement Criteria as a resource for describing the continuum of addiction services.

The ASAM Patient Placement Criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided, and the intensity of treatment services provided.

Five Levels of Care Assessed Over Six Dimensions

Level 0.5	Early Intervention
Level I	Outpatient Services
Level II	Intensive outpatient/partial hospitalization services
Level III	Residential/Inpatient services
Level IV	Medically managed intensive inpatient services



1. Acute intoxication and/or withdrawal
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery environment

Through this strength-based multidimensional assessment the ASAM Patient Placement Criteria addresses the patient's needs, obstacles and liabilities, as well as the patient's strengths, assets, resources and support structures.

Detoxification Programs

The State of Louisiana provides for several detoxification programs statewide through contracted providers. Three different levels of intensity are available for those seeking detoxification services:

1. Social Detoxification, for those who require 24/7 monitoring and supervision but who are not at risk for serious withdrawal effects that may adversely affect their health;
2. Medically-Monitored/Supported Detoxification, for those who may need nursing or other 24-hour free-standing residential facility based medical services in addition to the above; and
3. Medically-Managed Detoxification, for those whose detoxification process may be dangerous to their health and may require medication management, close monitoring, nursing, and other 24-hour hospital based medical services.

Residential Inpatient Addiction Treatment

SMO will contract with existing OBH Residential contractors to offer Medically Monitored/Supported treatment options for those seeking treatment who may benefit from a residential environment. Currently, OBH provides for the following number of residential/inpatient treatment programs:

- 19 residential adult programs
- 4 residential adolescent programs
- 7 specialized residential programs for women & dependent children

During 2010, OBH began efforts to privatize its remaining state-operated inpatient facilities. In 2011, all inpatient treatment facilities and programs were then operated under contract with OBH-DHH. However, beginning March 1, 2012, these programs are now under the Louisiana Behavioral Health Partnership and will provide services through Magellan Health of Louisiana.

Compulsive and Problem Gambling. The Office of Behavioral Health contracts with providers to offer compulsive and problem gambling prevention and treatment services to Louisiana citizens. The goal of this program is to raise public awareness of, prevent, and treat problem gambling. The OBH Problem Gambling Services program provides for a 24/7 helpline, a variety of awareness and prevention services, and a full array of treatment services statewide. During FY 2011, a total of 787 people were served by this program. Of those individuals, more than 80% successfully completed the program. Outpatient compulsive gambling treatment services consistently receive very positive feedback.

Services are delivered by local behavioral health clinics or through contracts with local social service agencies and/or behavioral health professionals. These services are provided free of charge to Louisiana citizens, utilizing funds from the Compulsive and Problem Gaming Fund. The total amount of funding provided by the Compulsive and Problem Gaming Fund is \$2.5 million, which covers the entire cost associated with the program. According to the National Council of Problem Gambling, the national social costs of problem gambling in 2010 totaled \$7 billion. Research suggests, however, that for every \$1 invested in problem gambling services, a savings in social costs of \$2 is realized.

Outpatient Addiction Treatment

Access To Recovery I and II (ATR). Admissions for the SAMHSA \$13.4 M Access to Recovery II (LA-ATR II) grant began in January 2008. Substance use disorders treatment and recovery support services were provided to adults and adolescent substance abusers involved with the criminal and juvenile justice system and methamphetamine using clients and others eligible for these services based on their economic levels. This grant provided the opportunity to partner with the Department of Corrections and the Office of Juvenile Justice. The LA-ATR II project served 8,156 clients through a network of 100 service providers, including faith-based, community-based, private and public sector organizations. The LA-ATR II federal grant ended as scheduled on September 29, 2010.

ATR I and II have merged all services into one system as of August 8, 2011. This project continues to be funded with State General Funds.

Emergency Preparedness

The State of Louisiana is vulnerable to a variety of hazards that threaten its citizens, communities, businesses, economy, and environment. It is the responsibility of the Office of Behavioral Health (OBH) to develop and maintain readiness for behavioral health emergency response operations as part of the Department of Health and Hospitals Emergency Support Function (ESF-8) for Public Health and Medical Services within the State of Louisiana Emergency Operations Plan (EOP). In the provision of its mission and essential functions, OBH emergency plans are developed to ensure critical supports and services continue in an all-hazards environment. The following is a general overview of emergency preparedness operations for the Office of Behavioral Health.

- OBH is also the designated lead agency for the development and administration of FEMA and SAMHSA funded emergency crisis counseling programs following a Presidential Declaration of a Major Disaster Incident.
- OBH regional facilities and clinics are responsible for maintaining current emergency response plans which integrate response capacity with other state agencies and local emergency operations.
- In the event of a declared emergency or disaster, the OBH provides support to the Office of Public Health for the department's ESF-8 responsibilities following the National Incident Management Structure (NIMS).
- OBH responsibilities include provision of staff assistance to the Office of Public Health at the designated Medical Special Needs Shelters and to designate behavioral health staff (inclusive of the Office for Citizens with Developmental Disabilities) to staff EOC operations, bus triage, strike teams and other staging areas as assigned.
- Continuity of regular operations as needed for those individuals who are in need of immediate access to outpatient treatment and/or 24 hour care. Each OBH regional office or Local Governmental Entity (LGE) maintains regional protocols for access to emergency psychiatric services, including hospitalization during the preparation, response and recovery phases of the disaster incident
- OBH is also responsible for the health and safety of patients and staff at the psychiatric and detox facilities, all of which are required to have an emergency response plan. These plans address actions for sheltering-in-place and evacuation of staff and psych patients to other host (destination) facilities.
 - During a declared disaster incident OBH makes available excess bed capacity for the temporary sheltering of patients and staff from other public and quasi-public psychiatric facilities within the state (signed Memorandums of Understanding (MOU) required).
 - OBH also serves as the lead state agency for the development, design and implementation of a brief stay medically supported special needs shelter for psychiatric patients through a cooperative endeavor or established contingency contract for emergency psychiatric beds and staff.

Disaster Event Response for 2010/2011. Emergency Preparedness efforts continued to focus on ongoing delivery of disaster response services post Deepwater Horizon Oil Spill event of April 2010. Through ongoing aggressive outreach, residents and workers impacted by the oil spill event received assistance with emotional and psychological support as outreach teams worked to help educate and link individuals to local resources in over 105,084 outreach encounters and 13,750 more in-depth individual and group sessions. Funding for behavioral health services from British Petroleum ended in January 2012 and all related services concluded. OBH Emergency Preparedness Operation was awarded a SAMHSA

Emergency Response Grant to conduct activities related to behavioral health surveillance of individuals in the affected coastal parishes with an extended project end date of November 2012.

OBH Emergency Operations also responded to the Mississippi River Flood Event in May 2011 with coordination of support provided to impacted regions and deployment of the staff and resources as requested.

Hurricane Recovery. Recovery efforts continued during 2010 to repair the damage caused by 2005 Hurricanes Katrina and Rita. Additionally, Hurricanes Gustav and Ike disrupted the service delivery system for prevention and treatment services statewide in 2008. The infrastructure that was in place to provide behavioral health prevention and treatment services has not yet been fully restored, though progress has been made.

Strategic Partnerships

Louisiana Integrated Treatment Services (LITS). The Office of Behavioral Health (OBH) continues to collaborate on the Louisiana Integrated Treatment Services (LITS) initiative, which was originally funded by the Co-Occurring State Incentive Grant (COSIG) through the Substance Abuse and Mental Health Services Administration. The goal of the LITS initiative is to develop and sustain a treatment delivery system within the state of Louisiana in which all publicly-funded mental health and substance abuse programs are Co-Occurring Diagnosis Capable (CODC). At the conclusion of the COSIG Project in 2008, an integrated network was created between state and local mental health and addictive disorders personnel in the areas of Workforce Development/Training, Clinical Protocol Development, Program Evaluation, Information Management, and Funding.

Counselor Education, Licensing & Certification. The Commission maintains a collaborative partnership with both the Louisiana Association of Substance Abuse Counselors & Trainers, Inc. (LASACT), Certification Examining Board (CEB), and the Addictive Disorders Regulatory Authority (ADRA) in the interest of providing a more unified voice in the advocacy for addiction treatment. ADRA's mission is to ensure that the highest quality continuum of care is provided to citizens of Louisiana through the credentialing and regulation of addiction professionals; high standards of education are set by ADRA and required of professionals in the field of addiction treatment and prevention. In addition, LASACT is an Approved Educational Provider (AEP) through ADRA which provides workshops throughout the state year-round on topics such as substance abuse prevention and counseling, compulsive gambling counseling, professional ethics, and clinical supervision. They also sponsor an annual conference which provides continuing education opportunities by presenting in-state experts and nationally and internationally-renowned speakers. A thorough application and testing process are implemented by ADRA and LASACT to ensure only the most qualified specialists in the field of addictions bear ADRA credentials.

Drug Courts. The Drug Court program was transferred to the Supreme Court in 2001. The Office of Behavioral Health continues to collaborate with and support the efforts of drug court programs across the state.

Children and Families. The Office for Behavioral Health continued a contract with the Department of Children and Family Services (DCFS), to address issues among Temporary Assistance for Needy Families (TANF) women and their dependent children. The services in this program provide addictive

disorder treatment for women, including screening, assessment and referral services for women involved with the Child Welfare Section (CWS) and Economic Stability and Self Sufficiency (ES&SS) sections of DCFS, gender specific Intensive Outpatient Treatment services, and residential services for women and their dependent children. All individuals involved in this programming are referred by DCFS staff. This initiative is not funded with Block Grant monies. However, this program greatly impacts OBH's ability to provide services to pregnant females and women with dependent children. OBH was successful in obtaining renewed TANF funding in FY 2012, with continued funding anticipated to continue through FY 2013 and beyond.

OBH continued collaborations with DCFS on the above-listed programs through continued monitoring and implementation of best practices for continued quality outcomes. This process includes quarterly on-site monitoring of all programs, teleconferences with staff, and monthly review of invoices and outcomes which is submitted along with an on-line report. Further, OBH and DCFS staff participates in quarterly teleconferences to address obstacles and barriers to implementation, while developing and/or revising protocols as indicated.

Department of Education. The Office for Addictive Disorders has partnered with the Department of Education (DOE), since 1998, to conduct the bi-annual Louisiana Caring Communities Youth Survey (CCYS). The CCYS is the primary youth needs assessment tool for state, regional, and community prevention planning. In addition, OAD and DOE have partnered to share resources to include funding, staffing and infrastructure to provide school-based prevention programs. This partnership has reduced OAD's infrastructure cost and allowed resources to be moved to direct services.

Future Considerations

As the Office of Behavioral Health transitions out of the role of direct service delivery and moves toward the implementation of a managed care environment, it becomes increasingly important to ensure that services are delivered in an efficient and cost-effective manner. The Louisiana Behavioral Health Partnership Office developed a Coordinated System of Care and contracted with Magellan Health of Louisiana to meet these objectives. As the State Purchasing Agency for these services, one key consideration will be the role of OBH in the preservation of services, professional competency, and provider accountability.

IV. Major Challenges and Triumphs of 2011

The Office of Behavioral Health faced a number of difficult challenges during 2011, but also realized some significant triumphs. Some of those issues or situations constantly challenge the Office since they arise from growth, change, and progress. Others presented new obstacles that stretched the resources of the agency or offered opportunities for expansion and efficiency. Regardless of its origin or nature, each of the following situations is a measure of and tribute to the strength, resolve, and continuing dedication of "those we serve, and those who serve them."

Behavioral Health Merger

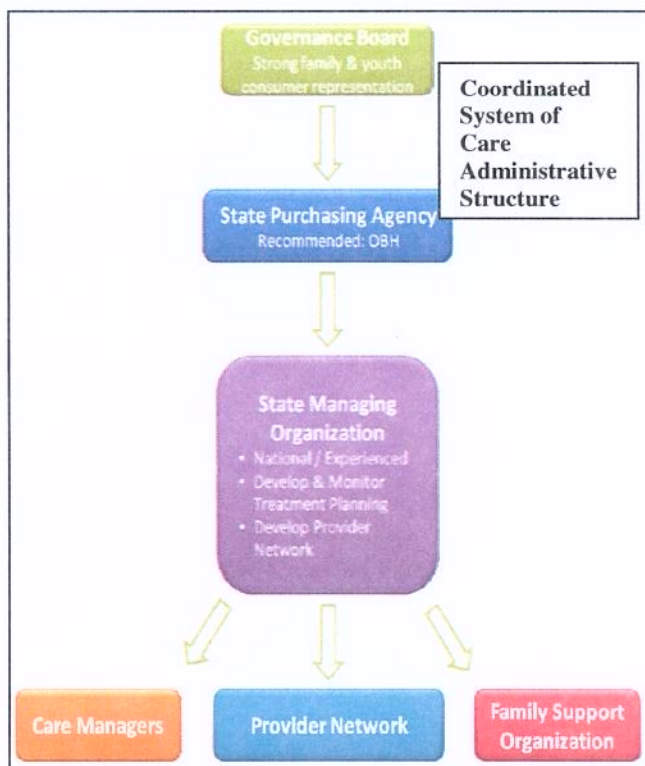
Re-organization. When the merger of the Office of Mental Health and the Office for Addictive Disorders took effect on July 1, 2010, the agency's administration – following the recommendations made in the OBH Implementation Advisory Committee's (IAC) Report – evaluated the appropriateness of its organization structure. Per the recommendations outlined in the IAC report, the administration began the process of re-organizing the Office into a more suitable and effective structure. This re-organization was driven by five key considerations:

- 1) The needs of consumers versus available resources;
- 2) Improving efficiency while maintaining effectiveness;
- 3) The role of OBH in monitoring and supporting the functions of the LGEs;
- 4) The implications of the OBH merger and a more unified service delivery system; and
- 5) The role of OBH in a Coordinated System of Care.

Regional Integration. OBH directly operates behavioral services in five regions of the state, with mental health and addictive disorders regional administrative offices and clinics located in each region. A priority during 2010 (and continuing into 2011) is the integration of these regional offices and clinics without a reduction in service delivery. Aspects of this integration include combining prevention, access to services, treatment, and community supports that allow individuals to function successfully in the community. The next steps in this integration process include:

- 1) The clarification and establishment of performance standards and outcome measures;
- 2) The expansion of a single point of entry process;
- 3) Establishing, through DHH rule-making, revised behavioral health licensing standards; and
- 4) Aligning business operations and workforce development strategies in a manner consistent with maximizing funding resources available at the local, state, and federal level.

Transitioning to Fill New Roles. During the 2006 legislative session, the Department of Health and Hospitals put forward legislation that would convert all remaining Regions to Human Services Districts (Act 90). The transition process began immediately and continues through the present. The legislation outlines that there is to be a Human Services Interagency Council (HSIC) that will be comprised of the Assistant Secretary from each office, the Executive Directors of the Human Services Districts, and the Deputy Secretary of the Department of Health and Hospitals. The HSIC met several times with the goal of formulating a framework document that outlines the expectations of existing and new Districts. The framework



document was promulgated and follows Act 337, which outlines the roles and responsibilities of the Districts and DHH.

Shifting away from the role of direct service delivery, the Office of Behavioral Health investigated the reorganization of its central office. This effort will be finalized during early 2011. The result of the investigation led administration to organize the agency in a manner reflective of its responsibilities. The agency's new organizational structure includes a System of Care Division that includes all personnel involved in the delivery and monitoring of services; a Development Division that includes policy and planning, workforce development, business intelligence, emergency preparedness, and quality management; and an Administration Division that includes executive management and fiscal operations.

The Coordinated System of Care, a new initiative in the State of Louisiana, represents a cooperative partnership across four state agencies: the Department of Health and Hospitals, the Department of Education, the Department of Children and Family Services, and the Office of Juvenile Justice. This new service delivery system is intended to provide more efficient and effective services for those treatment populations who typically receive services from more than one segment of the state system. Specifically, this initiative began as a way to provide "wrap-around" services for youth who are identified as being at-risk for institutionalization or are currently in an institution. As the system was developed, opportunities were discovered to extend services to adults as well as adolescents. The implementation of this new cooperative service delivery system is projected to save Louisiana approximately \$59M.

The Coordinated System of Care model has four basic levels of administration. The top level is a Governance Board that has strong family and youth consumer representation, making the system consumer-driven. The second tier of administration is a State Purchasing Agency. Under the State Purchasing Agency is a State Managing Organization responsible for overseeing the fourth tier (care managers, the provider network, and a family support organization).

As the State Purchasing Agency in this Coordinated System of Care, the Office of Behavioral Health will bear responsibility for coordinating with the other agencies involved, the Governance Board, and the State Managing Organization to develop policy; determining performance-based funding options; and monitoring services for fiscal and quality management.

Maximizing Available Resources

It has been recognized that the previously existing system of care for our citizens with specialized behavioral health needs had not been effective at improving outcomes, increasing quality of care, or improving access for those who are served by the public behavioral health system. In addition, due to significant budget challenges, the behavioral health system has had to streamline its operations to allow it to maintain at least the same level of services while meeting those budget benchmarks. The state saw this as an opportunity to completely reorganize its system of care to achieve improved quality of services, better outcomes, while increasing access to care and experiencing cost savings. The state released an RFP for a statewide management organization (SMO) and in September 2011, Magellan Health Services was recommended as the contractor. Since then, a contract has been approved and signed and implementation operations have led to a successful launch of the system on 3.1.12. Implementation functions continue at present to fully develop the system of care for our target populations that include adults with serious behavioral health needs and/or substance disorders; children and adolescents who have serious emotional disorders; children and adolescents who are or at risk for out of home placements; and special needs

individuals including pregnant females who are using drugs, women who have substance abuse needs with dependent children, individuals with co-occurring mental health and substance disorders. Magellan will manage the care for all of these populations whether or not they are Medicaid eligible.

Magellan is committed to building on existing resources to enhance access to care and where necessary, expanding the resources to increase access. Magellan will do this by taking a multi-year, transformational approach to system development and utilizing a regional approach to build upon existing strengths. They will also bring complementary infrastructure, tools and innovation to advance the foundational system. Magellan is committed to ensuring timely access to care while decreasing reliance on inpatient care and expanding community based evidence base practices. They will continue advancement of the children's coordinated system of care; integrate mental health and substance abuse services; advance recovery and resiliency goals while addressing cultural preferences of members; and assist in the transitioning of services to the LGEs. They will do this by optimizing resources; insuring access to quality services; reducing regional and provider disparities; collaborating with governance and management infrastructure at state and regional levels; integrating accountability, data reporting, and outcome systems; developing a state-based training and technical assistance infrastructure; and insuring sustainability.

Magellan has a three year plan for enhancing resources. Year one objectives include: Contracting with and credential a stable, comprehensive statewide network; implementing an efficient claims system that pays providers accurately and on time; beginning to build out the crisis system and expand the network to include alternatives to inpatient care; developing consensus, establish baseline measures and begin provider profiling. Year two objectives include: Completing the crisis system build out in all regions; assisting providers to ensure all organizations obtain accreditation within 18 months of contract start; expanding Evidence Based Practice (EBP) capacity through learning and technical assistance. Year three objectives include: Moving definitively from provider management to provider oversight and partnership; considering alternative reimbursement models; pay-for-performance initiatives (such as Partners in Care); and creative provider partnerships; reviewing and analyzing program data to identify additional network EBPs, and develop a strategy to implement them in targeted locations.

During 2009, the State of Louisiana announced that it was facing serious budget shortfalls and would need to identify efficiencies within state government. Combined with large cuts at the federal level, the puzzle of continuing funding for prevention and treatment of addictive disorders in Louisiana grew into a large endeavor. The primary challenge for the Office of Behavioral Health lies in identifying and implementing even more evidence-based practices and efficiencies to improve the quantity and quality of services while simultaneously streamlining its administrative functions and service delivery system.

Structure and Location. One opportunity to answer this specific challenge presented itself through the merger of mental health and addictive disorders at both a central office and regional level. The central office began efforts in 2010 to identify and re-organize key personnel into a more suitable and efficient structure. The regional offices for OBH followed the same process, with the added task of determining opportunities for co-location of services. Essentially, this means that where two separate facilities – one for mental health services, and one for addictive disorders – were in relatively close proximity to one another, they could merge into a single facility (as described above) that would offer both types of services.

Waiting Lists. The waiting list for 24-hour care (detox, inpatient/residential and halfway houses) and access to outpatient treatment services remains constant. Progress has been made in the past two years: the average daily waiting list for people waiting to access 24-hour care decreased from an average of 1,450 people per day in 2008 to 1,307 people per day in 2009 and 1,239 in 2010. The waiting lists provide an indicator to determine if OBH's residential treatment service capacity needs to be expanded to meet the needs of Louisiana citizens. In seeking a solution to this problem, the Office of Behavioral Health chose to expand the capacity of its community-based outpatient services and to continue statewide utilization of American Society of Addiction Medicine (ASAM) patient placement criteria. Use of ASAM criteria supports patient placement in the most appropriate level of care, avoiding unnecessary use of more expensive levels of care.

Privatization of Addictive Disorders Services. The Office of Behavioral Health as part of the Department of Health and Hospitals' plan for efficiencies and budget reductions made the decision to privatize the remaining six (6) state operated inpatient /residential programs. RFPs were issued in October 2010 and all programs were awarded to private providers. Implementation of privatized services began with one program on January 27, 2011 and all programs have implemented privatized services with the last program going online March 14, 2011. See table below:

State Facility	Private Organization Operator	Privatized Services Began
Briscoe	Cenikor Foundation, Inc.	February 2, 2011
SOAR	B and B of Marion, LLC	January 27, 2011
Pines	Center Point, Inc	February 13, 2011
Red River Adult Inpatient /Medically Supported Detoxification	Pathways Community Behavioral Healthcare	February 1, 2011
Red River Co-Occurring Unit	Pathways Community Behavioral Healthcare	February 23, 2011
Springs of Recovery Adolescent Inpatient	Pathways Community Behavioral Healthcare	March 14, 2011

Performance Improvement Initiatives. The Office of Behavioral Health is working with the Network for the Improvement of Addiction Treatment (NIATX) and the Treatment Research Institute (TRI) to address performance-based budgeting. This initiative is designed to improve the quality of patient care by addressing patient initiation, engagement, and retention in treatment. The majority of this project is complete, though performance improvement initiatives are ongoing at the clinic level. The outcomes of these projects can be used by other agencies in the state system to improve the use of financial resources and the quality of patient care.

Workforce Development Initiatives. The Office of Behavioral Health continues to seek out technological advances in workforce development in order to improve the level of competency of its workforce. It is still the case that traditional means of training staff (such as face-to-face training sessions) are not cost-effective: they require expenditures for personnel travel reimbursement, costs associated with a venue, and contracting with material experts. Newer technologies and practices allow for more efficient, more effective means of achieving OBH training goals. The use of the Essential Learning online platform for delivery of training has proven to have potential in meeting the ongoing and ever changing demands of training for the OBH workforce and has been most beneficial in meeting compliance requirements. In the interest of ensuring competency development, the Office is looking into

ways to include supervisory processes to follow up and institute a Learning Transfer methodology for targeted training.

Attention to Learning Transfer will allow the Office to achieve a level of integration for training and actual practice that is often overlooked when providing training. Administrators often question whether or not training has actually resulted in improved knowledge, or practice and a focused approach for implementing a Learning Transfer process will address these questions. Coupling Learning Transfer with online training will allow the continued efficiency of distance learning while ensuring that competence is ensured.

The Office will apply these same Learning Transfer principles to its use of electronic seminars called “webinars,” where personnel can attend a “live” training directly from their computer terminal. Thus eliminating the need for travel while providing a high degree of interactivity and presenter functionality (such as the ability to build and present a customized slideshow while speaking to and interacting with the participants). In addition, webinars can be recorded for later viewing by those whose daily work schedules prevent them from attending at a set time.

“Live” training will continue as an important method of delivering content to staff with a renewed focus on how decisions are made and what resources should be allocated to this intensive level of staff development. We can expand the “reach” of our live training by using video conferencing equipment, more interactive learning and overcoming limitations of physical space for training.

Workforce development initiatives will continue to be refined, improved and implementation methodologies structured to allow for the maximum return given the effort and resources allocated. All with the intent and focus of improving the quality of care to those we serve.

Preservation of Critical Infrastructure

Prevention Services. As the only “front line” for deterring the onset of substance abuse, reducing high-risk behaviors that lead to addictive disorders, and diverting the state’s youth population from entering the treatment system, prevention services are a significant and critical portion of the Office of Behavioral Health’s service delivery infrastructure. Since Substance Abuse Prevention and Treatment (SAPT) Block Grant monies (20%) are the sole source of funding for all prevention services, any reduction in this funding stream is likely to impact negatively the prevention service delivery capabilities of OBH, thereby creating a services gap where at-risk youth may not be identified. Such a gap would limit the ability of the office to identify and mitigate high-risk behaviors and increase the youth population’s initiation to drug and alcohol use, creating a larger burden on the state’s treatment system. It is recommended that careful consideration be given to the preservation of funding for prevention services and the critical infrastructure they represent.

Models for Change

Access to Recovery I & II. The Office of Behavioral Health continues to operate the Access to Recovery (ATR-I) initiative, which began in 2004 as a federal grant from the Substance Abuse Mental Health Services Administration (SAMHSA). When the initial ATR-I federal grant ended in 2007, the Louisiana State Legislature and Office of the Governor opted to continue funding the ATR-I prototype

using State General Funds, due to the success of the project. During FY 2010, ATR-I served 3,080 individuals with state appropriated funding.

During the implementation of the ATR-I initiative, OAD recruited a total of 202 service providers for treatment and recovery support services. Of this total, 52% were community- and faith-based providers; 139 were new service providers. The recruitment of faith-based providers was a key component of this grant to ensure freedom of choice for clients. Another unique feature of the grant was the ability to provide recovery support services such as job readiness skills, safe housing, childcare and transportation. Louisiana was required to serve a minimum of 8,928 clients. From March 1, 2005 through August 2, 2008, OAD served more than 24,000 individuals: ***200% of the target required by the federal government.***

In 2007, OAD was awarded an Access to Recovery II (ATR-II) federal grant through SAMHSA. The ATR-II initiative was a \$13.4 million three-year federal grant that targets adult and adolescent methamphetamine using individuals, and individuals involved with the criminal/juvenile justice systems who also have a problem with alcohol or drug use. In 2009, the LA-ATR II project also began to partner with the Louisiana National Guard to serve those returning from deployment to combat in Iraq and Afghanistan. During FY 2010, the ATR-II federal grant initiative served 3,453 individuals. The ATR-II federal grant initiative ended in September of 2010, resulting in a loss of resources and capacity to serve more than 2,200 clients annually.

Both the ATR-I and ATR-II initiatives provide freedom of choice for clients in selecting service providers for clinical treatment and recovery support services through a web-based electronic voucher system. At the close of the 2010 fiscal year, the ATR-II initiative had served more than 3,400 individuals. The ATR-II federal grant initiative ended in September 2010. The loss of federal grant funding presented a challenge to maintenance of the services offered through Access To Recovery providers. \$2.37M in State General Fund dollars was set aside for SFY 2011 to preserve ATR-II services. The \$2.37M noted above was a re-investment of the projected savings generated by the office's privatization efforts. The privatization of inpatient facilities did not occur as early as scheduled; therefore, \$1M was withheld from the \$2.37M to maintain the addictive disorders state-operated inpatient facilities throughout the privatization process. The \$1.37M allocated in state general funds to maintain ATR services allowed the program to serve an additional 760 clients for an additional four (4) months. During 2009, SAMHSA announced the request for grant applications for the Access To Recovery III grant, which focuses on serving military personnel. Despite submitting an application for this grant program and a proven record of accomplishment, the Office of Behavioral Health was not selected to participate in the ATR-III project.

The Louisiana Behavioral Health Partnership (LBHP) was implemented on March 1st, 2012. Effective March 1st, many services currently provided or managed by OBH will be authorized and administered by Magellan Health Services of Louisiana. ATR providers were advised to continue to operate "as is" for the immediate future. OBH will begin discussions with providers regarding how LBHP may impact ATR. Providers were told to begin preparation for the LBHP implementation by enrolling with Magellan as providers for the clinical treatment services they are licensed to provide. The provider enrollment process requires being certified by OBH and credentialed by Magellan to become an approved provider agency for the LBHP.

Some ATR providers have already started the enrollment process and have been approved.

V. References

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