LOUISIANA

FY 2014
Combined Behavioral Health Assessment and Plan

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

September 1, 2013

Office of Behavioral Health
Department of Health and Hospitals

LOUISIANA
FY 2014

Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants
COMBINED BEHAVIORAL HEALTH ASSESSMENT AND PLAN

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LOUISIANA

FY 2014
Combined Behavioral Health Assessment and Plan

Part I
State Information

State Information
FACE SHEET

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: Anthony Speier, Ph.D. **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) 342-2540 **FAX:** (225) 342-5066 **EMAIL:** Anthony.Speier@la.gov

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

FROM: July 1, 2011 **TO:** June 30, 2012

IV. CONTACT PERSON RESPONSIBLE FOR APPLICATION SUBMISSION

NAME: Karen Stubbs, J.D.
TITLE: Deputy Assistant Secretary - 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) 342-5066 **EMAIL:** Karen.Stubbs@la.gov

BOBBY JINDAL
GOVERNOR

State of Louisiana

OFFICE OF THE GOVERNOR

Post Office Box 94004
Baton Rouge, LA 70804-9004

August 27, 2012

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, 7-1109
Rockville, Maryland 20850

RE: Designation of Authority to Sign CMHS and SAPT Block Grant Application

Dear Ms. Simmons:

As Governor of the State of Louisiana, I delegate authority to Anthony H. Speier, Ph.D., Assistant Secretary of the Office of Behavioral Health (OBH), to sign the Community Mental Health Services (CMHS) and the Substance Abuse Prevention and Treatment (SAPT) Block Grant Application on behalf of the Louisiana Department of Health and Hospitals. This letter also serves as recognition of Dr. Speier as the appropriate authority to receive the Louisiana CMHS and SAPT Block Grant funds.

Thank you for your assistance in this matter.

Sincerely,

Bobby Jindal
Governor

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

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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 sub-agreements.

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 Coastal 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

_____ _____

Governor or Governor Designee Date

Anthony Speier, Ph.D.
Assistant Secretary
Office of Behavioral Health
Louisiana Department of Health & Hospitals

For Governor Bobby Jindal

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dis-pensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D Washington, D.C. 20201

3. 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). The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. 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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

_____ _____

Governor or Governor Designee Date

Anthony Speier, Ph.D.
Assistant Secretary
Office of Behavioral Health
Louisiana Department of Health & Hospitals

For Governor Bobby Jindal

Community Mental Health Services
Block Grant Funding Agreements

FISCAL YEAR 2014

I hereby certify that Louisiana agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:
Subject to Section 1916, the State will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:
(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:
(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.

(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:
The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved 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 illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) 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; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:
(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the

Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:
(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:
The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:
(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:
(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the

State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

_____ _____

Governor or Governor Designee Date

Anthony Speier, Ph.D.
Assistant Secretary
Office of Behavioral Health
Louisiana Department of Health & Hospitals

For Governor Bobby Jindal

Substance Abuse Prevention and Treatment
Block Grant Funding Agreements

FISCAL YEAR 2014

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute. SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921
II. Certain Allocations (Prevention Programs utilizing IOM populations; Pregnant women and women with dependent children) Section 1922
III. Intravenous Drug Abuse, Section 1923
IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924
V. Group Homes for Recovering Substance Abusers, Section 1925
VI. State Law Regarding Sale of Tobacco Products to Individuals under Age 18, Section 1926
VII. Treatment Services for Pregnant Women, Section 1927
VIII. Additional Agreements (Improved Referral Process, Continuing Education, Coordination of Activities and Services), Section 1928
IX. Submission to Secretary of Statewide Assessment of Needs, Section 1929
X. Maintenance of Effort Regarding State Expenditures, Section 1930
XI. Restrictions on Expenditure of Grant, Section 1931
XII. Application for Grant; Approval of State Plan, Section 1932
XIII. Opportunity for Public Comment on State Plans, Section 1941
XIV. Requirement of Reports and Audits by States, Section 1942
XV. Additional Requirements, Section1943
XVI. Prohibitions Regarding Receipt of Funds, Section 1946
XVII. Nondiscrimination, Section 1947
XVIII. Continuation of Certain Programs, Section 1953
XIX. Services Provided By Nongovernmental Organizations, Section 1955
XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that Louisiana will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as 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.

_____ _____
Governor or Governor Designee Date

Anthony Speier, Ph.D.
Assistant Secretary
Office of Behavioral Health
Louisiana Department of Health & Hospitals

For Governor Bobby Jindal

LOUISIANA

FY 2014
Combined Behavioral Health Assessment and Plan

Part II
Planning Steps

PLANNING STEP ONE: ASSESS THE STRENGTHS AND NEEDS OF THE SERVICE SYSTEM TO ADDRESS THE SPECIFIC POPULATIONS

Overview of the Louisiana Behavioral Health System

STATE LEVEL

Creation of the Office of Behavioral Health

The Office for Addictive Disorders (OAD) and the Office of Mental Health (OMH) had, until 2010, operated as separate state agencies within DHH, predominantly managing and operating their own separate service delivery systems. Although each parallel mental health and addictive disorders service system had a rich history of service delivery, these services were often times redundant and did not utilize shrinking and limited resources in the most effective manner. This, in turn, affected adequate access and capacity for the target populations. In order to un-encumber these parallel systems and develop an integrated behavioral health care system, Louisiana merged the Offices of Addictive Disorders and Mental Health to form the Office of Behavioral Health (OBH) under the authorization of Act 384 from the 2009 Regular Session. The Office of Behavioral Health began operating as one entity on July 1, 2010.

The Office of Behavioral Health is one of five agencies within the Louisiana Department of Health and Hospitals (DHH). The mission of DHH is to protect and promote health and to ensure access to medical, preventive and rehabilitative services for all citizens of the State of Louisiana. DHH is dedicated to fulfilling its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner. Included under the DHH umbrella with the Office of Behavioral Health (OBH) are the Office of Public Health (OPH); Office of Aging and Adult Services (OAAS); Office of Management and Finance (including the Bureau of Health Services Financing, which is the administrative operation responsible for the Medicaid program); and the Office for Citizens with Developmental Disabilities (OCDD).

The Office of Behavioral Health (OBH) is the state agency responsible for planning, developing, managing, operating, and evaluating treatment and prevention services for the public behavioral health system in order to improve the quality of life for citizens with mental illness and addictive disorders. Within these responsibilities, the OBH is charged with the management and provision of mental health services that target adults with a severe mental illness, children and adolescents with a serious emotional/behavioral disorder, as well as persons experiencing an acute mental illness. Similarly, the OBH is charged with the management and provision of addictive disorders services for people suffering from addictions to drugs, alcohol, or gambling, as well as support for their families, and prevention services. Services are provided for Medicaid and non-Medicaid eligible populations, including those served through the Mental Health and Substance Abuse Block Grants. The OBH oversees the Louisiana Behavioral Health Partnership (LBHP), the statewide management contract for most behavioral health services, and delivers direct care through both hospital and community-based treatment programs. The LBHP is designed to increase access to community-based services, improve quality of care and health outcomes, and reduce utilization of more restrictive and crisis-driven services such as emergency departments, hospitals, out-of-home placements, and institutionalizations. The LBHP consists of a multi-agency partnership, including the Department of Children and Family Services (DCFS), the Department of Education (DOE), the

Office of Juvenile Justice (OJJ), and the Department of Health and Hospitals (DHH). OBH is designated as a lead agency to oversee programmatic, performance, quality, and budget/fiscal aspects of the LBHP.

During its inception, the staff and stakeholders of OBH crafted a new recovery-oriented mission statement and a new vision of the behavioral health system that provided a framework for moving the agency into a period of "Good and Modern" behavioral health service delivery. The mission and vision have since been modified in light of recent changes to the system with the implementation of major Medicaid reform through the Louisiana Behavioral Health Partnership (LBHP).

Mission

The mission of the Office of Behavioral Health (OBH) is to lead the effort to build and provide a comprehensive, integrated, person-centered system of prevention and treatment services that promotes 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.

Vision

People can and do recover from addiction and mental illness. Through the delivery of timely and person-centered, clinically effective treatment, citizens of Louisiana will experience positive behavioral health outcomes and contribute meaningfully to our State's growth and development.

Organizational Restructuring of the Central Office

Act 384 effectively merged the administration and planning functions of the former mental health and addictive disorder offices into one entity on July 1, 2010. In the past, the Offices of Mental Health and Addictive Disorders had been "integrated" and separated in name only by legislative act or directive. However, none of these previous attempts at integration had substantively altered the composition or operations of each distinct office. In accordance with expert consultation, OBH redesigned the Central Office according to functional areas, which eliminated duplication and supported the development of an integrated administrative office that is able to seamlessly support a service delivery system that caters to individual and shared needs of populations with mental health, substance use, or co-occurring disorders.

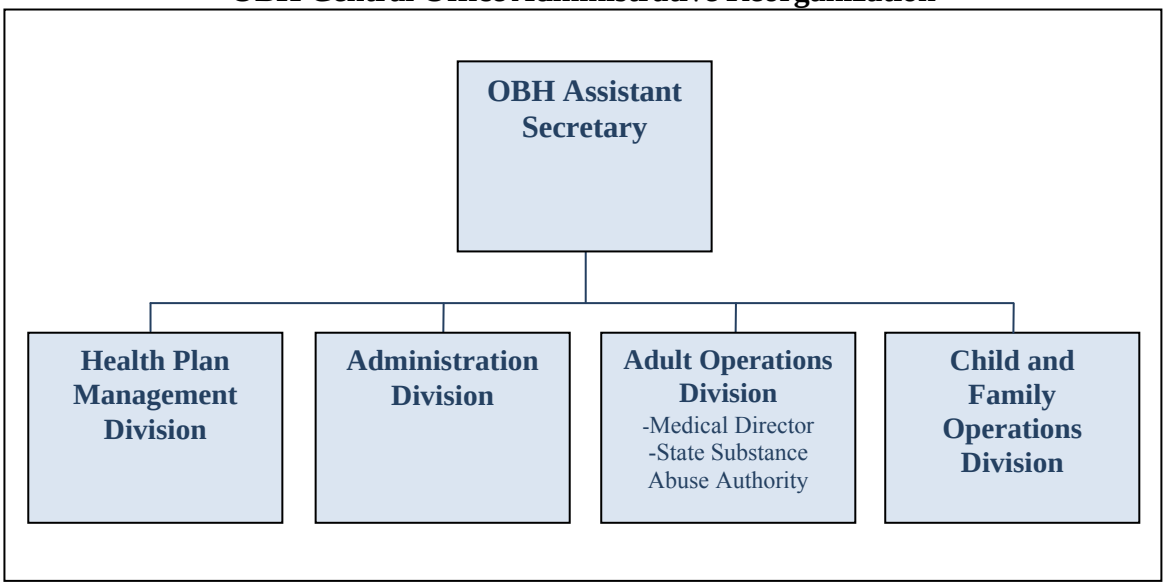
The Office of Behavioral Health (OBH) integrated the infrastructure at the level of the central office operations, inclusive of state agency leadership. Three OBH divisions were created: 1) the Administrative Division; 2) the System of Care Division; and 3) the Development Division. Staff with respective addictive disorders and mental health specializations were re-assigned and redistributed throughout the organization. Previously non-integrated addictive disorder and mental health "siloed" organizational tracks were completely merged within the three primary organizational areas. Redundancy was removed and the organizational table was streamlined. A benefit from this re-organization was the cost savings of 20% of the Office's budget. This included the elimination of eleven positions within the table of organization.

Based on the national trends examined, a mistake that other re-organizing states made was the loss of leadership and the minimization of the needs of the addictive disorders population in the overarching structure of a behavioral health agency. Often times, a State Substance Abuse Authority (SSA) with limited influence was overshadowed by the corresponding mental health authority with

the larger budget, stronger Medicaid ties, and perception of greater authority. In Louisiana, the State Substance Abuse Authority was designated to be the overarching chief Medical Director for the Office. In this capacity, the voice and needs associated with substance use disorders would remain strong and intact.

In light of the major transformations that have occurred since this re-organization with the implementation of the Louisiana Behavioral Health Partnership (LBHP), the Office has undergone another reorganization. The current structure was approved by the Louisiana Department of Civil Service effective February 23, 2013 and OBH operations have been conducted in alignment with this structure since March 4, 2013. The change in the role of OBH to one of purchaser of services and evaluator of outcomes was the driving force for the change in structure. OBH continues to be governed by the Assistant Secretary (Commissioner), who is the appointing authority for the agency and reports to the Secretary of DHH. The current OBH divisions include: 1) the Health Plan Management Division; 2) the Administration Division; 3) the Adult Operations Division; and 4) the Child and Family Operations Division.

OBH Central Office Administrative Reorganization



Office of Behavioral Health Budget

The Office of Behavioral Health FY 2013 budget is $325,287,253. The total appropriation for the OBH Community Budget is $143,668,100. The following tables provide additional budgetary information, including a breakdown of federal funding for behavioral health services.

OFFICE OF BEHAVIORAL HEALTH APPROPRIATION FOR FY 12-13		
BUDGET SUB-ITEM	**TOTAL(S)**	**% of TOTAL**
Community Budget		
Central Office [(a)]	$88,342,548	27%
Community Behavioral Health Centers	$13,979,404	4%
Community Social Service Contracts	$41,346,148	13%
Community Total	**$143,668,100**	**44%**

Hospital Budget		
Central Louisiana State Hospital	$22,064,774	7%
Eastern Louisiana Mental Health System	$101,346,576	31%
Southeast Louisiana Hospital [(b)]	$50,983,130	16%
Hospital Total	**$174,394,480**	**54%**
State Office		
Administration	$7,204,673	2%
State Office Total	**$7,204,673**	**2%**
Auxiliary		
Auxiliary	$20,000	0.0061%
Auxiliary Total	**$20,000**	**0.0061%**
TOTAL	**$325,287,253**	**100%**
(a) FY 12-13 Budget amounts include items related to Region 4.		
(b) Effective January 1, 2013, all beds were transfer to Central LA State Hospital, Eastern LA Mental Health System or private care facilities.		

HOSPITAL SYSTEM

	FY2013 (as of 1/5/13)
Total Adult/Child State Hospital Beds (a)	824
State General Funds ($)	95,781,641
Federal Funds ($)	73,188,501

NOTES: (a) Total represents funded beds for adult intermediate care, adult forensic, adult acute, Transitional Forensic and Community Homes.

COMMUNITY SYSTEM

	FY2013 (as of 1/5/13)
Community Behavioral Health Centers	45
State General Funds ($)	49,354,342
Federal Funds ($)	52,600,169
Community Behavioral Health Contract	
State General Funds ($)	22,502,866
Federal Funds ($)	10,432,789

Office of Behavioral Health
Authorized Table of Organization (T.O.) Personnel Positions

					FY 2013	
Office of Behavioral Health	**FY 2012 T.O.**	**Reductions**	**FY 2013 T.O.**		**Classified**	**Unclassified**
Administration						
Administration	45	-1	44		41	3
TOTAL - Administration	**45**	**-1**	**44**		**41**	**3**

Community						
Central Office	206	-165	41		41	0
Community Behavioral Health Centers	322	-120	202		202	0
TOTAL –Community	**528**	**-285**	**243**		**243**	**0**
Hospitals						
Central Louisiana State Hospital	257	-94	163		160	3
Eastern Louisiana Mental Health System	1,054	-36	1,018		1,011	7
Southeast Louisiana Hospital	579	-16	563		556	7
TOTAL - Hospitals	**1,890**	**-146**	**1,744**		**1,727**	**17**
TOTAL - OBH	**2,463**	**-432**	**2,031**		**2,011**	**20**

LOCAL AUTHORITIES

Evolution toward Local Governing Entities

Legislation has mandated that the administration of the Louisiana mental health, addictive disorder, and developmental disability healthcare system change from a centrally controlled set of regions to a system of independent healthcare districts or locally controlled authorities. These districts and authorities are referred to as Local Governing Entities (LGEs) and are under the administration of OBH. As of March 2013, there are six LGEs in operation and four state-operated regions that are in various stages of the transition to becoming LGEs. 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. The LGE model affords opportunity for greater accountability and responsiveness to local communities since it is based on local control and local authority. Each LGE is administered by an executive director who reports to a local governing board of directors of community and consumer volunteers. All Local Governing Entities remain part of the DHH departmental organizational structure, but not in a direct reporting line with OBH. The Office of Behavioral Health maintains requirements for uniform data reporting through memoranda of agreement arrangements supported by the Department of Health and Hospitals.

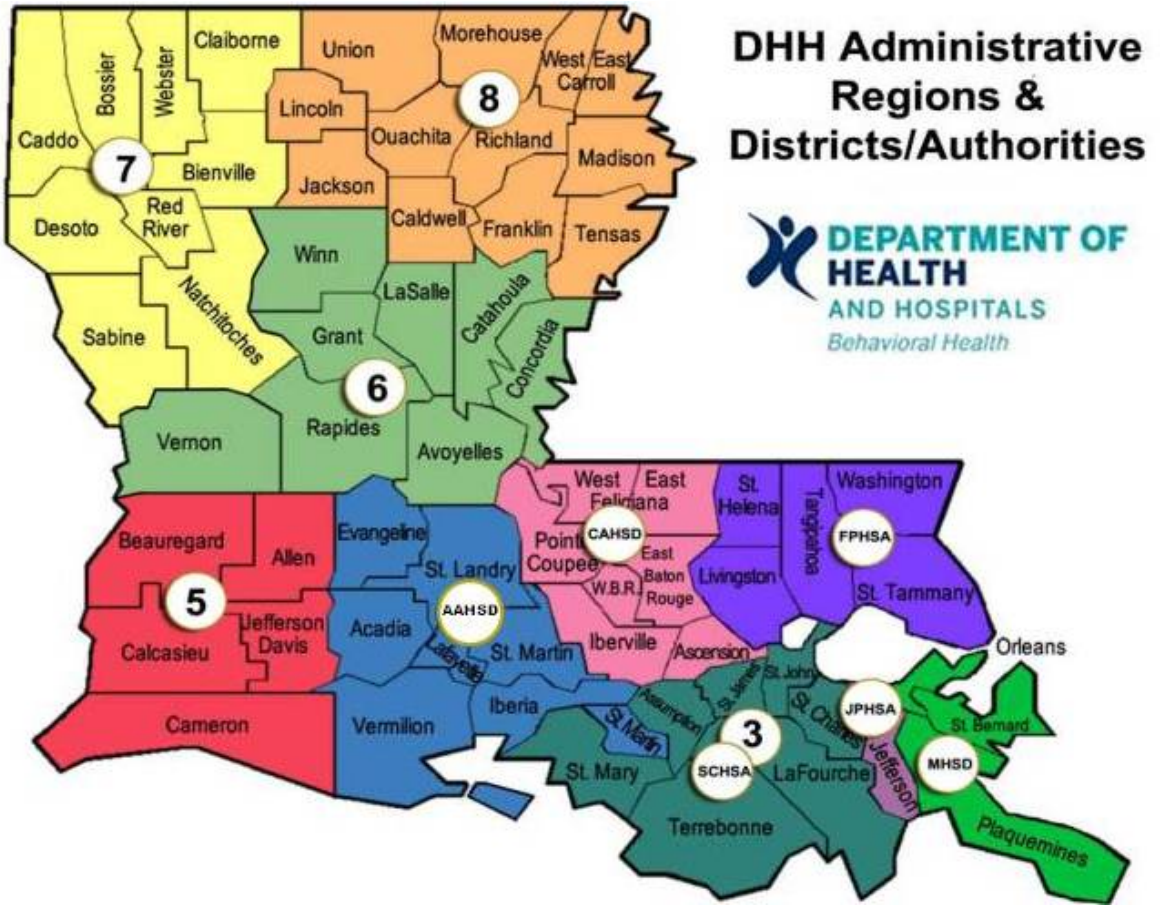
With the emergence of the LGEs and implementation of the Louisiana Behavioral Health Partnership, the role of OBH has begun to transition away from direct operational service delivery to one of providing resources and assistance that enable the LGEs to carry out service delivery. OBH is also responsible 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 mechanisms statewide 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).

The OBH Central Office, under the larger umbrella of DHH, has provided technical assistance and guidance to the remaining state-operated regions as they prepare to transition to Local Governing Entities. Per ACT 373, passed during the 2008 Louisiana Legislative Session, all regions that convert to an LGE must successfully complete a readiness criteria process that demonstrates their capability to assume the responsibility for high quality service delivery and good governance. This process includes the establishment of local governing boards that provide 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.

OBH retains its responsibility as a recipient of federal Block Grant funds to ensure that all regions and LGEs receiving Block Grant funds comply with all federal Block Grant requirements. 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 and map of Louisiana that illustrates the geographic regions or Local Governing Entities (LGEs) and a description of each region and LGE are below.

DHH Administrative Regions and Local Governmental Entities (LGEs)

Region or District/Authority	Parishes
Metropolitan Human Services District: MHSD (formerly Region 1 - established July 1, 2004) is comprised 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 comprised of seven parishes in the Acadiana area with Lafayette serving as the regional hub.	Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermillion
Region 5 encompasses five southwestern parishes, including coastal Cameron. Lake Charles is the hub of this Region *(will become Imperial Calcasieu Human Services Authority).*	Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis
Region 6 contains eight central Louisiana parishes that border Mississippi in the East and Texas on the West. With the exception of Rapides, this Region is very rural in nature. Alexandria is the regional hub *(will become Central Louisiana Human Services District).*	Avoyelles, Concordia, Catahoula, Grant, LaSalle, Rapides, Vernon, Winn
Region 7 comprises the predominantly rural Northwest area of the state, including nine parishes. Shreveport-Bossier City is the major metropolitan complex. This is an agricultural area but contains most of the state's heavy manufacturing business *(will become Northwest Louisiana Human Services District).*	Bienville, Bossier, Caddo, Claiborne, Desoto, Natchitoches, Red River, Sabine, Webster
Region 8 comprises the Northeast 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 *(will become Northeast Delta Human Services Authority).*	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 comprised 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



REGIONAL AND CLINIC LEVEL

Integration of Regional Administration and Clinic Services

Regional Administrative Systems Re-Organization

In 2011, an administrative reorganization similar to that of Central Office also occurred across the administration structures in each of the five regions of the state that were still managed through the OBH Central Office at the time. Prior to the merger of OAD and OMH, both addictive disorders and mental health programs maintained separate regional management, separate budgets, and separate oversight and utilization management functions. A workgroup at the regional and OBH Central Office levels developed an organizational structure for the regions that consisted of one Regional Administrator, one Medical Director/Services, a single Clinical Services department, one Operations section, and one Special Programs section. Re-structuring within the regions resulted in a consolidated management structure with a single Regional Administrator for overall behavioral health operations in that locale. Fiscal, administrative support, and clinical management functions were redesigned to build in efficiencies and eliminate duplications. Efforts to maintain the needed expertise were instituted in an effort to ensure continuity of operations in the midst of massive system changes and to ensure a balance of representation between mental health and addictive disorders. At this time, all regional administrative offices have been consolidated and are co-located.

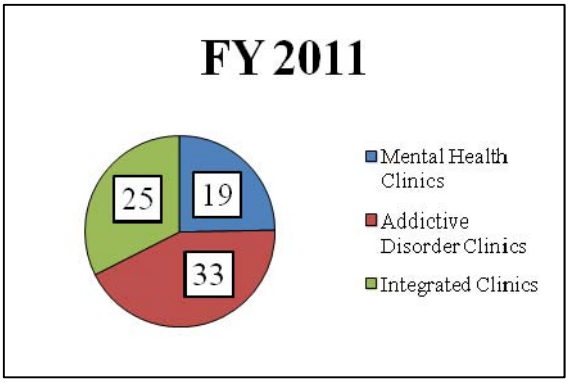
By March 1, 2012, all Regions and LGEs had become certified by OBH and credentialed by the Statewide Management Organization (SMO), Magellan Health Services of Louisiana, to participate in the Louisiana Behavioral Health Partnership (LBHP). The Partnership is the system of care for Medicaid and non-Medicaid 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:

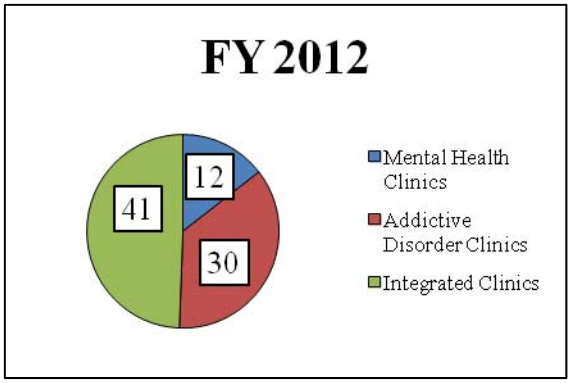
1. Children with extensive behavioral health needs either in or at-risk of out-of-home placement;
2. Medicaid-eligible children with medically necessary behavioral health needs who need coordinated care;
3. Adults with severe mental illness and/or addictive disorders who are Medicaid eligible; and
4. 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.

Clinic Level Systems Re-Organization

Since FY 2011, OBH Central Office executive management and regional managerial staff worked strategically to co-locate and physically integrate the largest mental health and addictive disorders outpatient clinics in each region. In addition, regional administrators assessed staff and facility needs for the purpose of integration of facilities wherever possible. Decisions about integrating physical space were based on several factors, such as bus line proximity for consumers, general accessibility, physical space of the clinics, accommodating increased personnel, operational needs of the clinic, whether the clinic buildings were state owned, distance to other facilities in the region, and cost efficiencies to maintain the physical structures. As of January 2013, there are a total of 83 clinics which are operated by regions or LGEs: 12 are mental health clinics, 30 are addictive disorders clinics, and 41 are integrated clinics providing both mental health and substance use services. There has been an increase of 16 integrated clinics since FY 2011. The graph below illustrates these substantial changes in clinic type across the ten regions and LGEs from FY 2011 to FY 2012. While there has been progress, not all fellow addictive disorder and mental health clinics could be co-located or merged, as not all mental health clinics could accommodate the integration of an addictive disorders clinic in terms of physical space and operational needs. In some instances, leases could not be terminated, or because of their rural location and part-time service delivery, the service system could not merge. The goal is that these logistic barriers to co-location will be resolved and all region and LGE clinic services will ultimately be integrated.





OBH has achieved critical benchmarks in its consolidation and integration of local mental health and addictive disorders clinics, thereby providing the infrastructure to support a service delivery system that is more holistic and comprehensive. As the initial benefits of co-locating mental health and addictive disorder clinics have been realized, OBH clients are better served. Fiscal Year 2012 priorities included institutionalizing the unique features of both mental health and addictive disorder services into an integrated service delivery system that is supported by an integrated and efficient administrative structure. Much of the standards for co-occurring or integrated care are built upon the framework established by the Co-Occurring State Infrastructure Grant (CoSIG) that the state of Louisiana was awarded in 2004. The overarching goal of CoSIG was to move clinic-based services to a "Co-occurring Capable" status. This status was operationalized as being well-coordinated care between mental health and addictive services. The identified fidelity instrument, Dual Diagnosis Capability in Addiction and Mental Health Treatment (DDCAT/DDCMHT) was used to define and measure these practice and programmatic changes that incorporated multiple program dimensions such as program management, milieu, assessment, treatment, staffing patterns, and training. These efforts, along with an expanded service array offered through the Louisiana Behavioral Health Partnership, position the clinics to continue this work and move toward a "Co-Occurring Enhanced" status, which is defined as completely integrated mental health and addictive disorder care that is seamless to the client. OBH is currently pursuing integrated behavioral health licensing standards, integrated behavioral health policies and regulations, and continued behavioral health workforce development.

The table below details the current state-supported operational clinics in the state as well as the clinic's current capacity to provide mental health services, addictive disorders services, or both. This transformational process is anticipated to continue as clinics continue to merge.

Region/LGE	Clinic	Address	City
MHSD	Algiers-Fischer Behavioral Health Center	4422 General Meyer Avenue, St 203	New Orleans
	Central City Behavioral Health Center	2221 Phillip Street	New Orleans
	Chartres-Pontchartrain Behavioral Health Center	719 Elysian Fields Avenue	New Orleans
	New Orleans East Behavioral Health Center	5640 Read Boulevard, Suite 810	New Orleans
	Plaquemines Behavioral Health Center	103 Avenue A, Suite A	Belle Chasse
	St. Bernard Behavioral Health Center	7407 St. Bernard Highway , Suite A	Arabi
CAHSD	Capital Area Center for Adult Behavioral Health Services	4615 Government Street, Bldg. 2	Baton Rouge
	Capital Area Children's Behavioral Health Services Clinic	4615 Government Street, Bldg. 1	Baton Rouge
	Donaldsonville Mental Health Center	901 Catalpa Street	Donaldsonville
	East Feliciana Satellite Clinic	12080 Marston Street	Clinton

	Gonzales Mental Health Center	1112 East Ascension Complex Blvd.	Gonzales
	Iberville Parish Satellite Clinic	24705 Plaza Drive	Plaquemine
	Margaret Dumas Mental Health Center	3843 Harding Boulevard	Baton Rouge
	Pointe Coupee Parish Satellite Clinic	282-A Hospital Road	New Roads
	West Baton Rouge Parish Satellite Clinic	685 Louisiana Avenue	Port Allen
	West Feliciana Satellite Clinic	5154 Burnett Road	St. Francisville
SCLHSA	Lafourche Assessment Center	303 Hickory Street	Thibodaux
	Lafourche Treatment Center	157 Twin Oaks Drive	Raceland
	River Parishes Treatment Center	1809 West Airline Highway	LaPlace
	River Parishes Assessment/Child & Adolescent Treatment Center	421 Airline Highway, Suite L	LaPlace
	St. Mary Assessment Center	521 Roderick Street, Suite 200	Morgan City
	St. Mary Treatment Center	500 Roderick Street, Suite B	Morgan City
	Terrebonne Assessment Center	521 Legion Avenue	Houma
	Terrebonne Treatment Center	5599 Highway 311	Houma
AAHSD	Crowley Behavioral Health Clinic	1822 West 2nd Street	Crowley
	Dr. Joseph Henry Tyler, Jr. Behavioral Health Clinic	302 Dulles Drive	Lafayette
	New Iberia Behavioral Health Clinic	611 West Admiral Doyle Drive	New Iberia
	Opelousas Behavioral Health Clinic	220 South Market Street	Opelousas
	Ville Platte Behavioral Health Clinic	312 Court Street	Ville Platte
Region 5	Allen Parish Behavioral Health Clinic	402 Industrial Drive	Oberlin
	Beauregard Behavioral Health Clinic	106 Port Street	DeRidder
	Jennings Outreach	915 West Shankland	Jennings
	Lake Charles Behavioral Health Clinic	4105 Kirkman Street	Lake Charles
Region 6	Avoyelles Addictive Disorders Clinic	114 N. Main St	Marksville
	Avoyelles Mental Health Center	694 Government Street	Marksville
	Behavioral Health Clinic of Central Louisiana	242 Shamrock Street	Pineville
	Grant Addictive Disorders Clinic	211 Main Street	Colfax
	Jonesville Addictive Disorders Clinic	308 Nasif Street	Jonesville
	Jonesville Mental Health Clinic	2801 Fourth Street , Suite 2	Jonesville
	Leesville Mental Health Clinic	105 Belview Road	Leesville
	Vernon Addictive Disorders Clinic	408 West Fertitta Blvd, Suite E	Leesville
	Winn Addictive Disorders Clinic	301 West Main Street, Suite 202-B	Winnfield
Region 7	Mansfield Behavioral Health Clinic	501 Louisiana Avenue	Mansfield
	Many Behavioral Health Clinic	265 Highland Drive	Many
	Minden Behavioral Health Clinic	435 Homer Road	Minden
	Natchitoches Behavioral Health Clinic	210 Medical Drive	Natchitoches
	Red River Behavioral Health Clinic	1313 Ringgold Avenue	Coushatta
	Shreveport Behavioral Health Clinic	1310 North Hearne Avenue	Shreveport
	Shreveport Behavioral Health Clinic – Child/Adolescent Services	2924 Knight Street, Bdg 3, Suite 350	Shreveport
Region 8	Bastrop Behavioral Health Clinic	320 South Franklin	Bastrop
	Columbia Behavioral Health Clinic	5159 Highway 4 East	Columbia
	Jonesboro Behavioral Health Clinic	4134 Highway 4 East	Jonesboro
	Monroe Addictive Disorders Clinic	3200 Concordia Street	Monroe
	Monroe Behavioral Health Clinic	4800 South Grand Street	Monroe
	Northeast Louisiana Substance Abuse/Oak Grove	Oak Grove Courthouse	Oak Grove
	Northeast Louisiana Substance Abuse/Rayville	112 Morgan Street	Rayville
	Northeast Louisiana Substance Abuse/Winnsboro	6564 Main Street	Winnsboro
	Ruston Behavioral Health Clinic	602 East Georgia Avenue	Ruston
	Tallulah Mental Health Center	1012 Johnson Street	Tallulah

	Winnsboro Behavioral Health Clinic	1301 B Landis Street	Winnsboro
FPHSA	Bogalusa Behavioral Health Center	619 Willis Avenue	Bogalusa
	Florida Parishes Human Services Authority Denham Springs	1920 Florida Avenue SW	Denham Springs
	Hammond Addictive Disorders Clinic	835 Pride Drive, Suite B	Hammond
	Lurline Smith Mental Health Center/Northlake Addictive Disorders Clinic	900 Wilkinson Street	Mandeville
	Rosenblum Mental Health Center (Adult Services)	130 Robin Hood Drive	Hammond
	Rosenblum Mental Health Center (Child Services)	15785 Medical Arts Plaza	Hammond
	Slidell Addictive Disorders Clinic	2331 Carey Street	Slidell
	Washington Parish Behavioral Health Clinic	619 Willis Avenue	Bogalusa
JPHSA	East Jefferson Behavioral Health Center	3616 South I-10 Service Road	Metairie
	West Jefferson Behavioral Health Center	5001 Westbank Expressway	Marrero

Right Sizing Inpatient Care

The OBH continues to "Right Size" inpatient care. Over the last two decades, Louisiana has remained dependent on psychiatric hospital levels of care through the Disproportionate Share Hospital program. While other states were re-organizing their funding approach and moving to a greater proportion of high intensity community based programs, Louisiana continued to have greater fiscal resources directed toward inpatient care. Efforts have been underway to decrease reliance on more restrictive inpatient levels of care. One initiative, implemented during SFY 2010 and SFY 2011, was referred to as the Mental Health Redesign and Hospital Discharge Initiative. The emphasis for this initiative was to reduce the number of adult civil psychiatric beds at East Louisiana State Hospital (ELSH) by 118. In order to accomplish this task and maintain needed capacity in the state psychiatric hospital system, all of the hospitals including Central Louisiana State Hospital (CLSH) and Southeast Louisiana State Hospital (SELH) participated in a structured and coordinated discharge process in collaboration with community providers to prepare appropriate patients for discharge into the community. During this initiative, there were 206 persons discharged into communities from the state psychiatric hospitals, and there were 118 adult civil beds closed as part of the initiative. A comprehensive discharge planning process was utilized to support the discharge of these individuals back into the community. Commensurate with this initiative, reinvestment in the communities was needed to develop and implement the necessary supports and evidence-based practices (EBPs) that were required for successful reintegration into the community. The reinvestment in communities was used primarily for the implementation of Assertive Community Treatment (ACT) and Intensive Case Management (ICM) teams throughout the state. An additional critical component was the expansion of the Permanent Supportive Housing (PSH) program and other creative residential housing approaches to support the housing needs of these individuals. The PSH program was made available to residents along the coastal, hurricane-prone areas of the State. Persons being discharged from institutional care were designated as preferred populations for this program and were provided increased access to the available PSH housing units.

A critical component of the OBH Mental Health Redesign and Hospital Discharge Initiative was the intensive follow-up and tracking system to monitor how persons discharged from the state civil psychiatric hospitals are faring in the community. An OBH team was assembled to conduct at least quarterly contacts with providers who served the discharged SMI patients in order to determine if the person was stable and doing well or to pick up information that would indicate that there was some risk to that stability. The OBH team provided feedback to community providers and OBH local leadership if concerns were detected. It is anticipated that some persons will require additional assistance during the initial period post discharge, and at times acute hospitalizations will

be a part of a person's recovery. But based on information collected during this initiative, the vast majority of persons experiencing acute exacerbations were able to return to a residence in the community. At the last point of contact, 83% of the 206 discharged individuals whose status was being tracked remained in community settings.

Currently, the Office of Behavioral Health is partnering 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 previous discharge efforts by the State during the Mental Health Redesign and Hospital Discharge Initiative. Implementation of the current discharge initiative has the same 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 Central Office staff meets weekly 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 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.

Medicaid Reform for Behavioral Health System

Physical Health/Medicaid Reform: Prior to the development of overall Medicaid transformation within OBH, the Department of Health and Hospitals initiated a sweeping Medicaid reform, moving away from fee-for-service (FFS) and working toward effectively coordinating enrollees' health care. Coordinating primary care is expected to lead to better access, more choices, and improved health for patients, with provider rates no less than those in FFS. The DHH has two types of primary care networks:

1. Prepaid is a traditional, capitated, managed care model in which entities establish networks of providers. Entities receive a monthly fee for each enrollee covered to provide core benefits and services, with prior authorizations and claims payment handled directly through the entity.

2. Shared Savings is an Enhanced Primary Care Case Management Plan, in which the network receives a monthly per member fee to provide enhanced care management services, with opportunities for providers in that network to share in cost savings resulting from coordinating care in this model. Medicaid's fiscal intermediary processes claims.

The amount, duration, and scope of services provided by Medicaid Bayou Health plans cannot be less than the State's Medicaid State Plan. The prepaid model allows the flexibility for plans to provide enhanced benefits (or more than the State Plan required). Dental, pharmacy, hospice, behavioral health, nursing home care, personal care, school-based Individualized Educational Plan

(IEP), and targeted case management were carved out and scheduled to remain Medicaid FFS treatment.

Three contractors were selected for the Prepaid Plan and two contractors for the Shared Savings Plan. Implementation was staggered across three Geographic Service Areas (GSAs). GSA A includes four parishes within the New Orleans region and five parishes within the North Shore region of the state. Implementation for GSA A began in January, 2012, with plans active beginning February 1, 2012. GSA B includes seven parishes within the Baton Rouge region, seven parishes within the Lafayette region, and seven parishes within the Thibodaux region. Implementation for GSA B began in March, 2012, with plans active beginning April 1, 2012. GSA C includes eight parishes within the Alexandria region, five parishes within the Lake Charles region, twelve parishes within the Monroe region, and nine parishes within the Shreveport region. Implementation for GSA C began in May, 2012, with plans active beginning June 1, 2012. Currently, approximately 900,000 people have been enrolled in one of the five Medicaid Bayou Health plans.

Behavioral Health/Medicaid Reform/Louisiana Behavioral Health Partnership*:** On the heels of Medicaid reform for physical health issues, OBH entered into a new era of Medicaid reform that better leverages federal Medicaid funding and positioned Louisiana to expand Medicaid reimbursement for addictive disorders. Entitled the ***Louisiana Behavioral Health Partnership (LBHP), this comprehensive Medicaid reform package maximizes federal funding to support mental health and addictive disorder services, making them more accessible and efficient through the 1915(i), 1915(b), and 1915(c) Medicaid waivers, in addition to expansive State Plan Amendments. Conceptually, the LBHP takes behavioral health services paid for by state general funds and makes these services a substantial part of the Medicaid funded integrated service delivery system. With reduced dollars spent, OBH can maintain, and even expand, to some extent, an integrated service menu and still fund a "safety net" of service delivery not funded by insurance. The overarching goals of the LBHP are to:

- Foster individual, youth, and family-driven behavioral health services.
- Increase access to a broader array of evidence-based home and community-based services that promote hope, recovery, and resilience.
- Improve quality by establishing and measuring outcomes.
- Manage costs through effective utilization of state, federal, and local resources.
- Foster reliance on natural supports that sustain individuals and families in homes and communities.

Under the LBHP umbrella, behavioral health services are effectively managed through an OBH contract with a private health care entity referred to as a Statewide Management Organization (SMO), which provides a robust network of expanded providers in behavioral healthcare statewide. OBH was delegated by the state Medicaid agency to serve as the purchasing agent for the SMO. This helps to assure that the needs of its recipient populations will be met. OBH holds the SMO accountable for improving access to and quality of care, and for managing the care in order to maximize efficiencies in the system and ensure strong coordination of all services. The SMO administers all behavioral health services and implements a Prepaid Inpatient Health Plan (PIHP). Concurrent to the implementation of the PIHP, the following programs are administered through the 1915(b) mandatory enrollment and selective services contracting authority: 1915(c) Children's CSoC Serious Emotional Disturbance (SED), 1915(c) Home and Community-Based Waiver and the

Adult Psychosocial Rehabilitation and Clinic, 1915(i) State Plan Option for Adults with Severe and Persistent Mental Illness (SPMI). The mental health and substance use disorder PIHP is for adult services, including those for at-risk adults with limited mental health and substance use disorder benefits, and is paid on a non-risk basis for children's services and for any individual with retroactive eligibility and spend-down beneficiaries in the month he/she meets the spend-down.

As the transformation of service delivery brought on by Medicaid and the new era of health care reform brings even greater access, OBH's role has changed to one of purchaser of services and evaluator of outcomes.

The LBHP is inclusive of the Coordinated System of Care (CSoC) provided for through the 1915(c) waiver, which provides a model of care for children and youth at risk for out-of-home placement that is guided by the Wraparound model of coordinated care. The CSoC concept in Louisiana involves collaboration and formal agreements from the four critical child-serving agencies: Department of Child and Family Services (DCFS), Office of Juvenile Justice (OJJ), Department of Education (DOE), and the Office of Behavioral Health (OBH). Through the CSoC, each of the child-serving agencies contributes funding that, when summed across all agencies, is used to better leverage federal Medicaid resources. The fiscal resources are managed through the Statewide Management Organization (SMO), which not only better manages the care but prevents the duplication in services that had been a rampant problem when each agency maintained siloed provider systems. The primary focus of care for CSoC through the 1915(c) waiver is children and youth at risk for out-of-home placement. The process of building the local systems of care was planned for implementation in a staged process throughout the state. Five geographic areas of the state were chosen to be initial implementing sites for CSoC implementation. These sites demonstrated a heightened degree of readiness for CSoC, strong commitments from community partners, and the capacity to build Wraparound Agencies and Family Support Organizations.

The Statewide Management Organization (SMO) operates the Prepaid Inpatient Health Plan (PIHP) to provide the following services:

1. Manage behavioral health services for adults with substance use disorders, as well as adults with functional mental health needs, including persons with acute Stabilization Needs, Persons with SMI (Federal definition), persons with major mental disorder (MMD), and adults who have previously met the above criteria and need subsequent medically necessary services for stabilization and maintenance on a risk basis.

2. Manage mental health and substance use care for all eligible children/youth in need of behavioral health care, on a non-risk basis.

3. Implement a CSoC for a subset of children/youth who are in or at risk of out-of-home placements on a non-risk basis. The CSoC will be phased in over the term of the contract through amendments in the State's 1915(c) waiver.

Since the completion of the competitive procurement process for the Statewide Management Organization (SMO), the Office of Behavioral Health successfully contracted with Magellan Health Services of Louisiana on November 17, 2011 as its Statewide Management Organization/PIHP. The contract period began March 1, 2012, and extends to February 28th, 2014. The Office of Behavioral Health has the option to extend the contract for a third year, for a total of 36 months. Once the

contract was signed and approved, preparation for statewide implementation and transformation began. Yearly Transformation Milestones were established, and network development and system transformation began. Implementation plans for all contract deliverables and waiver assurances were developed, reviewed, and approved by the Office of Behavioral Health, and monitored throughout implementation.

Among numerous other implementation activities, Magellan Health Services of Louisiana key staff hiring and network provider education and training began, as provider certification, credentialing, and contracting processes were initiated statewide. Leading up to implementation in an ongoing manner, provider and community forums were conducted across the state, as toll-free telephone access lines, websites, information systems, claims payment systems, and provider and member handbooks were also developed, reviewed, approved, and implemented. Medical Necessity Criteria/Service Authorization Criteria and Clinical Practice Guidelines were developed by Magellan, then reviewed and approved by the Office of Behavioral Health and the DHH Bureau of Health Services Financing (BHSF). Member Services, Care Management, Utilization Management, Quality Management, Information Technology, Provider Network Management, Communication, and Fiscal Management Monitoring Teams (among others) were established. Weekly dashboard updates regarding network, staffing, facilities, community relations, member services, and clinical and quality improvement activities were developed for review by OBH monitoring teams. Processes for assuring that all technical requirements, contract deliverables, and federal and state requirements were met were also developed and monitored.

As the Louisiana Behavioral Health Partnership began its implementation, OBH, Louisiana Medicaid, and Magellan began to work with what would become the five new Bayou Health Plans responsible for management of Medicaid enrollees' physical (non-behavioral) health care, to help assure integration of care and services among all programs and for all eligible members. Numerous collaborative meetings were held with all health plans present, as processes for managing the care of members with co-morbid physical and specialty behavioral health concerns were refined.

As initial implementation dashboards, metrics, and claims data were being developed and communicated to OBH, quality improvement activities continued. OBH worked in partnership with Magellan to further design, develop, and implement Quality Assurance and Performance work plans. OBH monitoring teams and leads for Care Management/Utilization Management, CSoC, Member Services, Provider Services, IT, Fiscal, and Communications were developed and launched, each with specific delegated responsibilities for review and monitoring of RFP deliverables and performance measures related to the CMS-approved Quality Management Strategy.

As the provider network launched and services began initial service gap analysis and ongoing network, geo-access and clinical utilization analysis helped identify opportunities for an expanded offering of services through "In Lieu Of" agreements. Such agreements were submitted and approved by Medicaid/ Bureau of Health Services Financing (BHSF), and included the following: Free Standing Psychiatric Hospitals (effective 3/1/12), Outpatient Psychotherapy by a Licensed Mental Health Practitioner (approved 3/29/12), Residential Substance Abuse Facilities (approved 5/28/12), and Crisis Stabilization Units (approved 6/20/12).

The purpose of the Free Standing Psychiatric Hospitals In Lieu Of agreement is to assist adult Medicaid members including 1915(i) waiver eligible with significant behavioral health challenges.

Without the agreement, this population must be treated in more expensive general hospital psychiatric units. This creates access issues, as beds in this setting are limited. Multiple downstream issues occur as a result. Consumers must remain in emergency departments while waiting for available beds. Costs increase to the healthcare system as members utilize those medical resources while awaiting beds in general hospitals. Use of free standing psychiatric units would reduce emergency department consumption, increase psychiatric bed capacity and provide a less costly alternative to general hospital beds. As implemented, it is expected that psychiatric bed capacity will increase through expansion of the available inpatient facilities in use for the Medicaid population. Reduced consumption of emergency department resources caused by extended wait times due to limited general hospital bed availability is also expected.

The purpose of the Outpatient Psychotherapy by a Licensed Mental Health Practitioner In Lieu Of agreement is to assist adult Medicaid members not eligible for the 1915(i) waiver with significant behavioral health challenges. The members may be at risk for imminent hospitalization, recently discharged from a hospital or may need short-term psychotherapy to deal with an emergent or urgent condition in order to keep the problem from escalating, which may require a higher level of intensity service. Expected outcomes include a reduction in crisis services and admissions and readmissions to higher levels of care, particularly inpatient hospitalization.

The purpose of the Residential Substance Abuse Facilities In Lieu Of agreement is to assist adult Medicaid members including 1915(i) waiver eligible with substance abuse treatment needs. Prior to 3/1/12, this population was treated in residential programs not eligible for Medicaid funding. In traditional Medicaid, these programs are considered Institutions for Mental Disease (IMD) due to the number of beds and the populations served. Without use of these facilities, members will be treated in much more costly acute detox settings and multiple downstream access issues will occur as a result. Consumers will remain in emergency departments while waiting for available beds. Costs increase to the healthcare system as members utilize those medical resources while awaiting beds in general hospitals. Use of residential substance abuse programs would reduce emergency department consumption, increase substance abuse bed capacity and provide a less costly alternative to general hospital beds. Expected outcomes include increased substance abuse residential bed capacity available for use by the Medicaid at risk population and reduced consumption of emergency department resources caused by extended wait times due to limited general hospital bed availability.

Under the Crisis Stabilization Unit In Lieu Of agreement, a plan for crisis beds for respite or stabilization was developed. Felt to be a key component to the crisis continuum, it was determined that this level of care was a significant gap in the continuum of care in Louisiana. Members who have urgent needs but do not require hospitalization would be served by the crisis stabilization units. The units serve both as a diversion and a step down to ER and inpatient hospitalization. The crisis beds are not only appropriate levels of care from a quality of care perspective, but also serve a purpose to improve “flow” both from the “front end”(diversion) and the “back end” (step down). Ultimately, this level of care will reduce hospital and ER admissions rates and average lengths of stay. This is meaningful from both an efficiency and quality perspective and ultimately affects member satisfaction. Additional concerns unique to the State of Louisiana are absence of the services, “plugging of ER’s” and the recent closing of MHERE beds.

In addition to the above services, significant expansions to the available array of services have occurred in the past year through the initiation of the approved State Plan changes and waivers.

Since implementation on March 1, 2012, the ability of qualified licensed mental health professionals, such as psychologists, medical psychologists, Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), Licensed Marriage and Family Therapists (LMFTs), Advanced Practice Registered Nurses (APRNs) with specialty training in behavioral health, and Licensed Addictions Counselors (LACs) to deliver such services as diagnostic interviews; examinations; individual, family and group psychotherapy; Functional Family Therapy; Homebuilders; Multi-systemic Therapy; Assertive Community Treatment; Addiction Services; and Psychiatric Residential Treatment Facility treatment has been expanded. Rehabilitation services including Community Psychiatric Support and Treatment, Psychosocial Rehabilitation, Crisis Intervention, and Therapeutic Group Home services were implemented. The 1915(c) waiver approval and implementation added wraparound care planning in addition to parent support and training, youth support and training, crisis stabilization, respite, and independent living/skills building for those who qualify.

Louisiana Behavioral Health Partnership Workforce Development Initiative: The workforce development process for transitioning Office of Behavioral Health (OBH) behavioral health clinics into competent, qualified Louisiana Behavioral Health Partnership (LBHP) network providers included identifying necessary training, credentialing, and certification standards for providers and provider agencies. OBH providers required orientation and training to these infrastructure and operational requirements in order to assure readiness and a successful transition into the new managed care system as LBHP providers.

As of January 2013, over 2,500 providers have been certified, credentialed, and contracted to provide services within the Louisiana Behavioral Health Partnership based on qualifications documented in the LBHP Service Definitions Manual (http://new.dhh.louisiana.gov/index.cfm/page/538). Of these providers, 1,500 are serving youth. The Office of Behavioral Health providers have received orientation and training as they continue to transition to the requirements and operational procedures necessary to effectively function in the managed care environment. Training has been provided by Magellan and OBH staff throughout the transition. Both continue to provide technical assistance as needs arise and routinely based on ongoing implementation/transition plans.

Active Louisiana Behavioral Health Partnership (LBHP) Providers by Region/LGE As of January, 2013	
MHSD	438
CAHSD	425
SCLHSA	152
AAHSD	324
Region 5	137
Region 6	178
Region 7	243
Region 8	187
FPHSA	282
JPHSA	273
TOTAL	**2,639**

With the implementation of the Coordinated System of Care (CSoC) in March 2012, providing appropriate training to ensure successful program implementation has been a priority. Wraparound facilitation is a key component of the CSoC approach and has resulted in the Office of Behavioral Health offering on-going wraparound training for staff of the regionally based Wraparound Agencies (WAA) and Family Support Organizations (FSO). This comprehensive training program, provided by the University of Maryland, Institute for Innovation and Implementation, is a tiered approach that is based on the roles and responsibilities of the direct care staff in the WAA and FSO. The initial three day core training provides the foundation for wraparound, including the system of care principles and basic wraparound facilitation requirements. Later training sessions focus on strategies to engage families and other stakeholders, coaching practices that support successful implementation, and advanced training and targeted assistance on specific areas of need to ensure fidelity to the wraparound model. Family Support Organization staff also receives specialized training to enable them to build on their strengths and personal experiences in order to support enrolled families that are going through similar experiences. Liaisons from the Office of Behavioral Health (OBH) and representatives from the Statewide Management Organization (SMO) are also responsible for identifying and meeting training needs within assigned geographic regions.

In addition to these initial CSoC trainings, OBH is collaborating with the Louisiana State University School of Public Health Institute for Public Health and Justice to establish a process for needs assessment, evidence-based practice identification, and ultimately dissemination. This process is currently being developed in the northeastern portion of the state.

The CSoC team at OBH has developed the certification requirements for the Wraparound Agencies and the Family Support Organizations. The CSoC staff is responsible for reviewing and approving the certification applications and ensuring that the agencies and the Statewide Management Organization (SMO) are informed of the certification status of the WAA and FSO.

Emergency and Disaster Response

After several years of dealing with the event of hurricanes as well as the aftermath of these destructive storms, Louisiana has established a core response effort to disasters in the state. Each year, the state has continued to face disasters of a different sort, and has been able to activate the core of the Louisiana Department of Health and Hospitals (DHH) disaster infrastructure to address these needs. The Disaster Preparedness Section, within the Administration Division of the Office of Behavioral Health (OBH), readies OBH to respond rapidly and effectively to natural and man-made disasters, whether it is an oil spill, act of terrorism, or a hurricane**.** The OBH workforce is alerted in the event of a storm threat or other disaster. Employees are expected to be activated during a crisis and stand willing and able to assist and report to their assigned placement. Communication needs for staff have resulted in extensive uses of technology. Response staff members have been issued blackberry devices and have access to available 800 MHz radios for use in disasters. Employees have access to electronic bulletin boards or websites that allow communication between staff, supervisors, and administration.

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. 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 mental

health, stress management, and multiple agencies' response to disaster incidents. Emergency preparedness, response, and recovery have become a part of every healthcare provider's job function, and 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 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
- OBH coordinates additional trainings as requested to other professional and para-professional medical staff to provide expanded capacity to address adverse emotional reactions encountered in hospital or emergency care environments
- Through various forums, offers skill-based psychological first aid and self-care training to teachers and school administrators
- OBH/Office of Public Health/Governor's Office of Homeland Security/Emergency Preparedness support training to parish level police/fire/EMS workers including:
    - Crisis intervention techniques to first responders
    - Critical incident management
    - Behavioral health disaster services
    - Bio-terrorism preparedness
    - Behavioral health response to mass casualties
    - Coordination of behavioral health first responder resource
    - Stress management for first responders

OBH conducted, either directly or indirectly, four tabletop exercises (behavioral health inpatient facilities, regions and central office) between April 2012 and August 2012. Behavioral Health first responders participated in the Bus Triage tabletop exercise in August 2012 and designated behavioral health staff participated in two functional exercises conducted by the Emergency Operations Center. Additional trainings included two Psychological First Aid (PFA) trainings held in Alexandria and Baton Rouge, one Skills for Psychological Recovery (SPR) training held in Slidell, and two suicide prevention trainings (ASIST) in New Orleans and Houma for Hurricane Isaac related responders and available regional staff in January. Disaster readiness briefings were also conducted with OBH Central Office staff and behavioral health first responders. Stress management training and services were provided to the Departments of Culture and Tourism, Children and Family Services, Emergency Medical Services, and the local governing entities of Metropolitan Human Services District (MHSD), Florida Parishes Human Services Authority (FPHSA), Jefferson Parish Human Services Authority (JPHSA), and South Central Louisiana Human Services Authority (SCLHSA) post Hurricane Isaac.

In June 2012, OBH conducted a two-day training in New Orleans entitled, "*Collaborative Efforts toward Understanding Disasters and Future Preparedness in the Gulf Coast: Knowledge Dissemination, Planning, and Readiness.*" This training was an effort to share lessons learned from the Deepwater Horizon Gulf oil spill disaster. The conference provided a venue for dissemination of data and knowledge gleaned across the tri-state region, as well as to educate leaders and providers across the Gulf Region in planning and readiness both for continued response to the oil spill as well as preparedness for future disasters that may occur along the Gulf Coast. Training and presentations were provided by 25 national, regional and local presenters who are experts in the oil spill, disasters, and disaster response.

Hurricane Isaac

On Tuesday, August 28, 2012, Hurricane Isaac made landfall near the mouth of the Mississippi River in Plaquemines Parish as a Category 1 hurricane. OBH provided immediate support to survivors impacted by Hurricane Isaac using existing behavioral health resources. Members of the behavioral health first responder team and the local governing entities (LGEs) in the impacted regions were deployed to assist with the evacuation and sheltering of individuals pre- and post-landfall. OBH coordinated the provision of crisis support and psychological first aid for survivors evacuated to medical special needs shelters (MSNS) and critical transportation needs shelters (CTNS) across the state. Stress management and first responder teams were activated to deploy as needed to local and state emergency operations centers, parish pick-up, and bus triage sites. In addition to sheltering-in-place patients and staff, the three inpatient psychiatric hospitals in the state also repositioned staff and resources to accommodate a surge of psychiatric patients from private hospitals and emergency departments who had evacuated from flooded areas. The total number sheltered in the state inpatient psychiatric hospitals was 835 patients and 435 staff. Behavioral health teams were deployed statewide to address behavioral health needs of more than 6,353 individuals evacuated to medical special needs and general shelters. The state also provided 24/7 phone support access to assist individuals in need of services and support throughout the duration of the storm.

Louisiana Spirit Project: OBH and the LGEs identified 14 of the 24 parishes that were determined eligible by presidential declaration for Federal Emergency Management Agency (FEMA) Individual Assistance and were in need of services to respond to Hurricane-Isaac related need beyond what the system and existing resources could provide. OBH applied for and was awarded grant funds for a Crisis Counseling Assistance and Training Program (CCP) Immediate Services Program (ISP) for the period from September 14, 2012 through February 24, 2013. OBH submitted a grant application for the second phase of the crisis counseling program and was awarded funds for continued services under the Regular Services Program (RSP) covering the period from February 25, 2013 through November 24, 2013. The CCP is a program funded by the Federal Emergency Management Agency (FEMA) and administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). It is anticipated that this grant project will serve approximately 49,986 survivors who would potentially benefit from CCP primary services. Currently, crisis services are being delivered in all 14 impacted parishes via the LGE structures of Metropolitan Human Services District (MHSD), Florida Parishes Human Services Authority (FPHSA), Jefferson Parish Human Services Authority (JPHSA), and South Central Louisiana Human Services Authority (SCLHSA). OBH is providing ongoing oversight, monitoring, training, and technical assistance to support the nine teams deployed by the LGEs.

Overview of the Louisiana Mental Health Service System

Mental Health Service System Array *(CMHS Block Grant Criterion 1 and Criterion 3)*

As the Office of Behavioral Health (OBH) directs the integration of behavioral health services and implements major Medicaid reform, it continues to be responsible for the operation and support of day-to-day clinical service delivery. Thus, the OBH must manage the maintenance of day-to-day operational issues, (i.e. planning, developing, operating, and evaluating public mental health services and addictive disorder services for the citizens of the State) along with managing the system since its overhaul.

By the end of FY 2012, the Louisiana behavioral health service delivery system found itself in the midst of major transformation as well as the ongoing continuation of the more historic aspects of the service delivery system that have been the mainstays of care. Mental health services are designated to provide care for the high need populations of the state. State-supported mental health services target adults with a severe mental illness, children and adolescents with a serious emotional/behavioral disorder, and all people experiencing an acute mental illness. There is no separate state-wide division for children's services, but the OBH has targeted specific improvements in the provision of Child/Youth Best Practices. During FY 2013, OBH restructured the state office to include a Child, Youth, and Family Services Division.

Clinics

OBH continues to strive to maintain appropriate access to a wide continuum of mental health services. State-supported Community Mental Health Clinics (CMHCs) or Behavioral Health Clinics continue to exist as a mainstay of the service system. All are enrolled as providers with the Statewide Management Organization (SMO). The clinics have continued historically 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 2012 show that over 47,000 unique individuals were provided basic mental health care services through the clinic- based delivery system.

AGE GROUP	TOTAL	
	N	%
CHILD (0-12)	4,921	10.3%
ADOLESCENT (13-17)	3,687	7.7%
ADULT (18-64)	37,918	79.1%
SENIOR (65+)	1,417	2.9%
TOTAL	47,943	100%

The clinic-based services in most regions and LGEs offer an array of services including crisis services, screening and assessment, individual evaluation and treatment, psychopharmacology, clinical casework, specialized services for children and youth, and in some areas, specialized services for those in the criminal justice system and for persons with co-occurring mental and addictive disorders. The clinics have continued to provide some of the safety net services as the state of Louisiana proceeds through Medicaid Reform for its behavioral health services. Although the community clinics operate with somewhat traditional hours, crisis services are available on a 24-hour basis. The clinic-based services are designed to provide an easily accessible level of care to

persons who are experiencing acute distress. Services include telephone counseling and referrals, face-to-face screening and assessment, community housing for stabilization, crisis respite in some areas, and access to inpatient care. The federal fiscal support through Medicaid has changed from the Clinic Option to that of the Home and Community Based Services Option (1915(i) Waivers). The backbone of the clinic-based services consists of the medication management and individual counseling interventions, which continue to be accessed through the Medicaid reform package. Transformation of the clinic-based system resulted in a number of previously mental health only clinics being integrated and able to provide both mental health and addictive disorders services. Through the strategic process of co-location, some of the CMHCs were re-assessed with regard to fiscal viability and downsized, streamlined, or eliminated.

Contractual Community Based Programs

The OBH has substantially enhanced the array of community-based private providers through contractual relationships generated at the Central Office, regional, and LGE level. Typically, through these contracts, OBH has been able to seed unique, innovative programs that may not be reimbursable through Medicaid or other third party payers. These innovative programs include Supported Living, Supported Employment, family/consumer support and educational services (e.g., case management, respite, drop-in centers, crisis services, consumer liaisons, transportation, housing supports, and bridge funding), homeless outreach, and school-based mental health services.

As Louisiana has struggled fiscally as a result of the national economic downturn and large state budget deficits, the OBH has made it a priority to direct critically necessary funding to support much needed community-based services that target the severely mentally ill population. For years, OBH and the associated regions and LGEs maintained pockets of evidence-based practices such as Assertive Community Treatment teams, but there had not been a comprehensive statewide, systematic implementation of such services. In spite of the economic downfall, the OBH executive leadership recognized that stronger more comprehensive levels of high intensity care for persons with serious mental illness would be required to transform the behavioral health system and reduce reliance on expensive more intensive levels of care. By more systemically investing in community-based services, the Louisiana behavioral health system could move away from inpatient care and develop an outpatient system with the necessary supports and service array to manage persons with more complex needs. The investments in community-based services during fiscal year 2011 were primarily targeted toward the development and implementation of Assertive Community Treatment (ACT) teams and Intensive Case Management (ICM) teams, with one or both types of service offered in each Region and LGE. ACT services and services similar to ICM (through Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) services) are now reimbursable through Medicaid and the Louisiana Behavioral Health Partnership. In addition, some regions and LGEs have opted to contract for these services in order to provide ACT and ICM services to individuals who are not covered by Medicaid.

Evidence-Based Practices (EBPs) Implementation in Community-Based Services

The Office of Behavioral Health (OBH) continues to explore its ability and capacity to expand the provision of EBPs through interdepartmental relationships with state agencies and with Magellan through the Louisiana Behavioral Health Partnership (LBHP). The Office of Behavioral Health has also partnered with the Institute for Public Health and Justice and the MacArthur foundation to explore a dissemination model for EBPs statewide, based on the Institute's prior success in implementing EBPs for youth involved in the juvenile justice system statewide over the past five to six years. This grant will initially focus on needs assessment and implementation strategies in one

region of the state, with the expectation of developing a replicable model for implementation of EBPs statewide over the course of the next year. This represents a collaboration of local providers and state agencies and has included Magellan of Louisiana to assure that the outcomes are consistent with the LBHP managed care model and goals.

OBH and the LBHP continue to offer statewide evidence-based practices (such as Cognitive Behavioral Therapy and Prevention) and evidence-based programs (such as Assertive Community Treatment, Permanent Supportive Housing, Multisystemic Therapy, and Functional Family Therapy) as services integral to the expected outcomes of the statewide managed care initiative. These EBPs continue to support the most at-risk individuals, those individuals more adversely impacted by the symptoms of severe mental illness, and persons being discharged from intermediate care psychiatric facilities. Permanent Supportive Housing (PSH) certification and ongoing monitoring to assure fidelity to the adopted model are ongoing efforts. Providers are being enrolled into the LBHP and will be monitored to the accepted standards. Within the PSH program, individuals being discharged from psychiatric institutions are provided a "super-preference" for access to a PSH unit.

Early in the developmental phase of the implementation of the Louisiana Behavioral Health Partnership, the Office of Behavioral Health and partner agencies formed a committee to review and recommend screening and assessment tools for use within the LBHP. This process provided the opportunity to review a wide range of tools and discuss their use and benefit to the populations served, informing others within OBH of the depth and breadth of such tools as discussions continued around LBHP implementation.

The process undertaken by the OBH Assessment and EBP Committee included the review of several documents and completion of a cross-walk reference document to develop criteria for selecting screening and assessment tools. The criteria listed in the chart below served as the primary guide for accepting or rejecting screening and assessment tools for recommended use by the LBHP.

Screening Criteria	**Assessment Criteria**
Primary	**Primary**
Includes the following within the assessment tool	Includes the following within the assessment tool
a. Detect acute conditions: risk assessment and victimization/trauma	a. Detect acute conditions: risk assessment and victimization/trauma
b. Determine level of care	b. Determine severity of mental illness/substance use disorder
c. Identify strengths and supports	c. Determine level of care
	d. Determine diagnosis
	e. Determine disability and functional impairment
	f. Identify strengths and supports
	g. Identify cultural and linguistic needs/supports
	h. Identify external problem domains
	i. Determine stage of change/treatment

	j. Plan treatment
Secondary	**Secondary**
Norms Available	Norms Available
Reliability on Re-Administration	Reliability on Re-Administration
Validity	Validity
Overall Accuracy: Sensitivity/Specificity	Overall Accuracy: Sensitivity/Specificity
Tertiary	**Tertiary**
Purpose	Purpose
Age	Age
Culturally sensitive	Culturally sensitive
Time Taken for Administration	Time Taken for Administration
Administration/Skill Level Requirement	Administration/Skill Level Requirement
Intensity of Required Training	Intensity of Required Training
Alternate Language Version Available	Alternate Language Version Available
Reporter(s)	Reporter(s)
Method of Administration	Method of Administration
S=Self Report	S=Self Report
I=Structured Interview	I=Structured Interview
C=Computer Administered	C=Computer Administered
In Public Domain	In Public Domain

The research into these tools was not exhaustive, but numerous sources were reviewed. The outcome of these efforts resulted in the development of a list of screening and assessment tools that met the criteria established above and offered additional technical guidance around provider selection of these tools for use with their clients. The LBHP screening and assessment process for youth includes a brief Child and Adolescent Needs Screening (CANS) and referral to a Wraparound Agency for service planning. Adults are screened by independent evaluators utilizing an assessment tool developed with guidance from the 1915(i) waiver and Magellan's experience in other states. The tool utilized for level of care determination is the Level of Care Utilization System (LOCUS). To date, over 340 independent assessors have been trained in the use of the LOCUS tool and over 100 individuals have been trained in the use of the CANS.

The chart below identifies the current number of providers offering specific evidence-based practices through the LBHP:

Evidence-Based Practice	Number of LBHP Providers
Multi-Systemic Therapy	24
Access to Recovery	34
Functional Family Therapy	8
Homebuilders	13
Permanent Supportive Housing	9

Some Regions and Local Governing Entities (LGEs) continue to contract to provide evidence-based practices to individuals who are not covered by Medicaid.

Medicaid Mental Health Rehabilitation Services

Historically, the state mental health office, previously known as the Office of Mental Health (OMH), operated as a managed care agent of the state Medicaid agency to authorize and monitor the mental health rehabilitation services provided through a private provider network. During fiscal year 2010, the Mental Health Rehabilitation (MHR) program was transferred in its entirety to the Bureau of Health Services Financing/Medicaid Services within the Department of Health and Hospitals. Currently, legacy MHR providers have been enrolled in the Louisiana Behavioral Health Partnership (LBHP) through the Statewide Management Organization (SMO), Magellan, and have been incorporated into a larger group of Behavioral Health Organizations for whom the State is drafting licensing requirements. The foundational organizing work of Medicaid, the Department of Health and Hospitals, and the Office of Behavioral Health, was instrumental in developing certification requirements for these agencies and other providers who have since been enrolled (credentialed and contracted) with the SMO under the LBHP to provide a similar array of services. Accreditation remains a requirement for organizations providing Community Psychiatric Supports and Treatment, Psychosocial Rehabilitation and Crisis Intervention, the core legacy MHR services.

Service access, utilization, and quality are being tracked by Magellan and the Office of Behavioral Health as part of their ongoing implementation and monitoring efforts, through specified monitoring teams and quality improvement committees. Efforts are currently underway to bring these quality improvement processes together under an inter-departmental monitoring process that would streamline review of RFP deliverables, quality measures, and corrective action plans.

The array of services available has not been diminished and the number of organizations providing these services has increased, allowing greater statewide access than prior to implementation of the LBHP on March 1, 2012. In fact, a substantial improvement in the service array has been the enrollment of substance abuse providers statewide into the managed care program allowing them to bill and receive payment from Medicaid.

Year to Date Youth Receiving Services	
Total	33,704
Selected Services:	
Psychosocial Rehabilitation	15,291
Community Psychiatric Supports and Treatment	16,195
Functional Family Therapy	1,800
Multi-Systemic Therapy	230
Homebuilders	188

*Source: Magellan

Year to Date Adults Receiving Services	
Total	32,731
Selected Services:	
Assertive Community Treatment	1,309
Psychosocial Rehabilitation	2,625

Community Psychiatric Supports and Treatment	3,808
Residential Substance Abuse	988
Group or Other Independent Licensed Practitioner	19,794

*Source: Magellan

Community-Based Crisis Services

The Office of Behavioral Health crisis response system is composed of locally-developed crisis response services maintained through collaborations between the state, local communities, and local stakeholders. Each OBH region or Local Governing Entity (LGE) employs a crisis response process utilizing existing resources specific to the needs of their community. Services are coordinated to ensure efficient and effective crisis response services to assist individuals twenty-four hours a day, seven days a week. The crisis response may include but is not limited to crisis lines that are accessible 24 hours a day, mobile crisis teams, crisis support and counseling, crisis stabilization, environmental interventions, follow-up and referral, advocating, collaborating, and monitoring and evaluation.

Hospitals

OBH provides for a continuum of care process to facilitate access to acute and/or 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 regional service system, 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. These include Eastern Louisiana Mental Health System (ELMHS) in Jackson and Central Louisiana State Hospital (CLSH) in Pineville. Collectively, both hospitals operate 544 intermediate care beds. One hospital (ELMHS) includes a division that is solely designated for the treatment of the forensic population; this setting 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.

State Supported Psychiatric Hospitals		City	ICF Beds (1/2013)
Central Louisiana State Hospital (CLSH)		Pineville	120
Eastern Louisiana Mental Health System (ELMHS)	East Division	Jackson	69
	Forensic Division	Jackson	355
TOTAL			**544**

Acute psychiatric inpatient units are short-term (generally less than 14-day) programs utilized to stabilize persons showing emergency need so as to return them back to community functioning as soon as possible. ELMHS operates 48 acute mental health beds. 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 neuropsych program (DNP) for adolescents. OBH has recently established Cooperative Endeavor Agreements with MBH of Louisiana, LLC 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 DNP beds on the former SELH campus, now called Northlake Behavioral Health System. Agreements were also made with the Washington-St. Tammany Parish Hospital (a LSU facility) in Bogalusa and Community Care (a privately operated psychiatric hospital in New Orleans), each for eight adult acute beds. In addition, River Oaks Hospital in Harahan agreed to provide services for eight children ages seven to 12.

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, there is a Community Forensic Services (CFS) division that operates two distinct programs; these programs are described and detailed in the table below.

The 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 competency assessments, treatment, and evaluation services. The evaluation report generated by this effort is the procedure by which those regaining competency in the jails are moved from the waiting list for inpatient without the necessity of hospitalization and thus diverting the need for lengthy inpatient stays. (La.C.Crm.Pro. Art. 649).

The Conditional Release Program (ConRep) and Assertive Community Services are designed for forensic patients [Not Guilty By Reason of Insanity *(NGRI)* and Incompetent to Proceed *(ITP)* 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 mode for psychiatric aftercare. These teams also provide assertive crisis intervention services together with monitoring for the court. In New Orleans, from which 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 public safety (i.e., harm to others) is not jeopardized.

FORENSIC PROGRAM	PURPOSE	NUMBER SERVED
Community Forensic Services 1 Attorney (Program Director), 17 DHH District Forensic Coordinators (DFCs), 1 social services counselor, 1 social worker	Competency restoration (jail-based and community-based) for pretrial detainees identifies as incompetent Intensive supervision and consultation to forensic patients (NGBRI, 648B and ITP) who are discharged or diverted from DHH inpatient units	300 per year on conditional release 200 per year who are ITP in jail/community
Forensic Aftercare Clinic 2 forensic psychiatrists,	Multidisciplinary team, intensive supervision, case monitoring, mental health and substance	40 clients at any given time – includes

1 forensic psychologist, 1 forensic psychology intern, 2 RNs, 2 addictions counselors, 1 sex offender therapist, 1 case monitor, 1 social services counselor, 1 administrative coordinator, 1 social worker/clinic manager	abuse treatment and/or sex offender treatment to forensic patients (NGBRI, 648B, and ITPs) who are discharged or diverted from DHH inpatient units	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 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 first full year under the requirements of the consent decree at a rate of 99.5% compliance. As a result of this legal action and the OBH's general initiative to become less dependent upon more intensive and more 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, which 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 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 supervised residential housing in the community Services as daily living skills, symptoms management, legal rights, medication management and other clinical groups necessitated by the individualized person-centered treatment plan	40 civil beds for individuals determined to be not restorable and 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
Group Home for Females	Aftercare services to females discharged from FFF	6 beds contracted through private provider

Special Array of Children's Mental Health Services *(CMHS Block Grant Criterion 3)*
The Office of Behavioral Health (OBH) recognized that multiple child-serving state agencies encountered children and youth with behavioral health needs whose needs were not being adequately met under the siloed systems of these agencies. There was high variability in the types of services offered, as well as the costs of these services and their associated outcomes. Children with behavioral health needs were not consistently or thoroughly assessed and may have been treated in a variety of settings. To address this issue, Louisiana recently created the Louisiana Behavioral Health Partnership (LBHP) and transformed the behavioral health system array significantly. The State Medicaid Plan was revised and additional waivers for children were obtained. The major child-serving state agencies, the Department of Education (DOE), the Office of Juvenile Justice (OJJ), and the Department of Children and Family Services (DCFS) collaborated with OBH to design a system that was more coordinated and more inclusive of children and their families in treatment planning. This new system:

- Provides comprehensive assessment to help assure that services are matched to client needs
- Enhances access to a broad array of services that can meet the variability of youth and families' needs
- Demonstrates increased coordination and collaboration
- Is inclusive of youth and family voice at all levels (service delivery, planning, 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, as well as 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 including individualized care planning, parent and youth support and training, crisis intervention and stabilization, short-term respite, and independent living/skills building and Recovery Support Services (RSS)

On March 1, 2012, the Office of Behavioral Health (OBH) launched this system, the Coordinated System of Care (CSoC), in conjunction with the Louisiana Behavioral Health Partnership (LBHP), which is a system of care for Medicaid and non-Medicaid adults and children who require specialized behavioral health services. CSoC provides evidence-based services to children who are in out of home placement or at risk for out of home placement.

CSoC, which is managed by the Statewide Management Organization (Magellan Health Services of Louisiana), is a joint effort of Magellan, OBH, Medicaid, Office of Juvenile Justice (OJJ), 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. The focus is not on looking to the State to maintain current operations or to expand already available services. Instead, CSoC offers the opportunity to partner with child-serving entities in communities and transform the care delivery system. Through the 1915(c) waiver, 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 Family Support Organization (FSO) that provides the services and support of youth and family mentors within the child and family teams on a fee for service basis through youth support and training and parent support and training. The CSoC funds these additional services by braiding Medicaid, Medicaid waivers, and non-Medicaid funds. Families are viewed as critical to supporting their child's mental health and wellness. Five geographic regions of the state were selected as the initial CSoC implementing sites. These sites were selected based on their readiness and the presence of necessary infrastructure, such as community collaborative being in place. During phase two, CSoC will be expanded to achieve statewide implementation.

Children and youth eligible for the CSoC (1915c) waiver, who live in regions of the state where CSoC has not yet been implemented are eligible to access many of the same comprehensive services that are managed through resiliency care management as opposed to wraparound services. Like the CSoC waiver services, all children's behavioral health services are managed through the Statewide Management Organization (SMO).

Children who are not eligible for CSoC (1915c waiver), are eligible for 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 intensive levels of care such as child Therapeutic Group Homes (TGH); Psychiatric Residential Treatment Facilities (PRTFs); and inpatient hospitalization and substance abuse 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): Goal directed supports and solution focused interventions intended to achieve identified objectives on the individualized treatment plan. It is a face to face intervention with the individual present; however family or other collateral support may also be involved.
Psychosocial Rehabilitation (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. It is a face-to-face intervention with the individual present.
The following services are provided to develop a residential treatment network:
Psychiatric Residential Treatment Facility (PRTF): PRTFs are a new residential option in Louisiana. Currently, there are 124 beds across three different facilities. 24 of these beds are specifically for sexual offenders. The other 100 beds accommodate mental health, substance abuse 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 Homes (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 is currently one such facility 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 partnership, 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.
In addition to the previously cited EBPs that are supported through Medicaid, the Louisiana Children's Health Insurance Program (LaCHIP) provides behavioral health services to many children who are eligible for Medicaid. These services include mental health clinic services, psychological tests, and therapy.

Prior to implementation of the LBHP and revised State Plan waivers, the State underwent other efforts to improve the capacity and quality of children's services in Louisiana. As a result, there was a steady increase in the number of children served by the system. In part, this increase in number served was facilitated through the implementation of increased access with child specialists in the community clinics, implementation of some child evidence-based practices (EBPs) in the communities, the development of a statewide crisis response program for children, and expansion of school-based services. The core children and adolescent services in many ways mirror the adult service array within the state-managed system. Clinic-based services including counseling, psychopharmacologic interventions, and comprehensive evaluations provided for children and adolescents.

One of the ways in which OBH has enhanced children's services is through implementation of evidence-based practices (EBPs). OBH has secured Medicaid funding for evidence-based practices for children and adolescents, including both Functional Family Therapy (FFT) and Multisystemic Therapy (MST) services. FFT teams can serve children with a variety of behavioral health needs, from conduct disorder to substance abuse. All parishes have developed local FFT teams that can provide a proven community-based treatment alternative to out-of-home placement. 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. This program is operating in most service areas of the state, including MHSD, CAHSD, SCLHSA, AAHSD, Region V, Region VI, Region VII and JPHSA.

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. Crisis services for children and youth involved in CART are provided twenty-four hours a day, seven days a week. These crisis services are generally available in most Regions/LGEs. CART crisis services are available to all children and their families, not just those eligible for state mental health clinics. 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, crisis transportation, 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. In SFY 2012, statewide implementation indicates that there were 2,229 youths screened. Of those screened, 1,105 (50%) required a face-to-face assessment, and only 135 (6%) resulted in the child or youth's psychiatric hospitalization; thus demonstrating the effectiveness of CART's diversion. Approximately 63% (1,397) of those served by CART were staffed for additional services. 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 SED in the child welfare, juvenile, or criminal justice system. 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 has focused in part on expansion of treatment alternatives to incarceration. This has been a particularly effective collaboration in the Monroe area of Region VIII. In this area of the state, 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 youths served in this area. This is inclusive of an effective District Attorney diversion program and an enhanced system of managing and diverting the extensive referrals from the local schools. 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.

The goal for the transformed children's system is for children, youth and families to have increased and simplified access to a more comprehensive array of both services and providers. New provider and service types previously unavailable will be available to support youth and families in communities whenever possible. More intensive and restrictive out of home settings will be used for stabilization and brief intervention, with a return to the community occurring as soon as possible. Access to care will be simplified; anyone seeking behavioral health treatment – a parent, school staff member, pediatrician, child-serving state agency personnel – will call one number 24/7 for the child's behavioral health issues to be appropriately assessed and proper services identified.

Further, the entire children's behavioral health system and the partnering state agencies will continue to work to infuse Louisiana's system of care values into their respective settings. These include being:

- Family-driven
- Youth-guided
- Home and community-based
- Strength-based and individualized

- Culturally and linguistically competent
- Integrated across systems
- Connected to natural helping networks
- Data-driven and outcomes-oriented

The transformation that will occur in Louisiana will move the child serving systems into closer alignment with nationally recognized best practices and allow families to remain together while obtaining the right services at the right time for the right duration. OBH is committed to its goals to improve access, offer appropriate services, and monitor outcomes - all of which allow OBH to ensure that children, youth and families receive the best possible care.

Management Systems *(CMHS Block Grant Criterion 5)*

Community Based Resources, Staffing, and Training of Providers

Budget issues, physician shortages, and hiring freezes all continue to challenge the State as it strives to improve the service delivery system. As the state oversees managed care for service delivery of behavioral health services, workforce development activities have been recognized as being essential to success. Each of the components of the overall Medicaid reform package requires extensive focus on workforce development, which serves to address concerns regarding recruitment and retention of qualified staff as OBH continues to focus on competency development, enabling staff to maintain the skills necessary to perform job functions.

The OBH integration initiative to facilitate the successful integration of clinical and business models into a single, seamless practice model for behavioral health was entering its second year when the implementation of the Louisiana Behavioral Health Partnership began. Trainings were provided to help each practice guild (mental health and addictive disorders) understand the other's philosophy, including the practical application of clinical and business practices in order to assess efficiencies and opportunities to synthesize and merge philosophies in the best interest of smooth, efficient clinic operations and to ensure that services are provided within the best possible contemporary milieu. Cultural competency was identified as a core competency required of direct care across the initiatives outlined above.

As OBH continues with the implementation of Medicaid reform (i.e., the Louisiana Behavioral Health Partnership), cultural competency remains an area of focus for assuring competent service delivery statewide. The Office of Behavioral Health, working with the Statewide Management Organization (SMO), Magellan, developed and provided access to cultural and linguistic competency training to providers enrolling in the Louisiana Behavioral Health Partnership. To date, 943 staff statewide have been trained. The time documented for combined OBH and LBHP provider training in cultural competency year to date is approximately 2,000 hours.

The Office of Behavioral Health continues to make use of the Learning Management System, Essential Learning, and will be incorporating the use of this platform and the Statewide Management Organization's Achieve site to ensure wide availability of training statewide. OBH continues to work with Essential Learning to ensure that courses are provided in an efficient manner, saving time and money. To ensure that training knowledge is transferred into practice, OBH will continue to measure outcomes and the application of learning objectives and will provide follow up review. The system will also allow the tracking of "live" trainings, and this capability will improve the ability to consolidate training data and records, as well as report out on training

provided and completed. OBH currently has over 3,700 staff enrolled in this EL system. Since July, 2012, OBH staff has completed over 21,000 hours of training. Over 1,000 LBHP providers have been trained in the OBH standard training package on the Statewide Management Organization's training site, logging over 6,000 additional training hours.

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.

In spite of the expansion of the behavioral health workforce through Medicaid transformational activities, the state continues to require management of employee operations for state-operated hospitals, clinics, and facilities. As indicated, the state-operated systems have struggled with access to prescribers. In general, as a result of budget deficits, the state-supported workforce has been downsized. There has been an insufficient number of direct service providers to address basic treatment and support needs of the community service population. A common complaint expressed in surveys of consumers is not being able to see their therapist or doctor often enough and having to participate in group treatment rather than more individualized treatment. Fortunately, through gubernatorial executive order, direct care workers have been excluded from the state-wide hiring freezes. To further enhance access to skilled prescribers, the OBH has developed a policy that permits local CMHCs to contract with or employ Medical Psychologists and Nurse Practitioners who can prescribe psychotropic medications.

In the several tables provided below, the hospital workforce at the end of SFY 2012 is detailed.

State Psychiatric Facilities Statewide Staffed Beds
(6/30/2012)

Facility			Adult Acute Beds	Adult Civil Intermediate Beds	Adult Forensic Beds	Child and Adolescent Beds	Specialty Child and Adolescent Beds	TOTAL
OBH HOSPITALS	Central State Hospital		0	60	0	0	0	**60**
	Eastern Louisiana Mental Health System	Jackson Campus	48	60	75	0	0	**183**
		Feliciana Forensic Facility	0	0	255	0	0	**255**
		Total for ELMHS	48	60	330	0	0	**438**
	Southeast Louisiana Hospital (Mandeville, LA)		32	94	0	25	20	**171**
TOTAL STAFFED BEDS			**80**	**214**	**330**	**25**	**20**	**669**

* Data from Daily Census Report

Total Number of Hospital Intermediate Care Beds by Facility (6/30/2012)

	Licensed Beds on 6/30/2012	Staffed Beds on 6/30/2012	% Staffed Average for Fiscal Year	% Occupancy Average for Fiscal Year
Central Louisiana State Hospital	196	60	31.1%	100%
East Louisiana State Hospital	270	135	51.2%	98.4%
Southeast Louisiana State Hospital	288	139	47.9%	95.9%
Feliciana Forensic Facility	255	255	100%	98.8%
TOTAL	**1,009**	**589**	--	--

* Data from Patient Population Movement Report and Daily Census Report

Special Services and Supports

Housing Services and Homelessness *(CMHS Block Grant Criterion 4)*

The job crisis and lack of sufficient income continues to deny many individuals and families the opportunity to participate in the free market society without supports to bridge the gaps to obtaining and maintaining housing and financial resources to prevent homelessness. The unemployment rate is still over 9% which translates into approximately 14 million individuals and or families. 44.4 % of these individuals and families have been out of work longer than 6 months. Many of those that have a job work reduced hours or temporary work for economic reasons. The new faces of the homeless are changing and a direct result of the struggling economy created by the housing crisis, record breaking unemployment, and inflation that makes housing impossible to afford without subsidized assistance and services for the individuals and families served. Supportive housing is a combination of affordable permanent housing and appropriate support services for low-income and disabled persons to gain access to community housing that is safe and intergrated with mainstream society. The economy, along with affordable housing opportunities, is critical to restoring individuals from homelessness to jobs and housing stability. This is particularly significant since the areas of the state that were the most directly hit by the hurricanes of 2005 and 2008 were the areas that have traditionally had the greatest population, and therefore the highest rates of homelessness, as well as the highest numbers of people with mental illness. State housing recovery efforts for affordable housing continue amidst multiple barriers including changes in real estate development costs at all levels and local resistance to affordable housing development projects. After the devastating hurricanes, many individuals and families experienced homelessness for the first time. It was, ironically, not the last time for many of these individuals, since their housing assistance came to an end again with the closing of FEMA programs in 2009 and the limited funding with Housing Prevention and Rapid Rehousing Program (HPRP). It is difficult to estimate the number of people who continue to be affected by the hurricanes, because many of them have been in and out of different housing situations since the hurricanes occurred. The metropolitan areas around New Orleans continue to report problems, as do other areas affected by the hurricanes. The housing stock of affordable housing units with a subsidy is limited or in high crime areas that are undesirable.

Individuals with financial concerns, including many people with disabilities, are having an increasingly difficult time in retaining their housing and are at risk for homelessness. Those already

homeless are facing significant barriers to obtaining housing they can afford. According to the National Low Income Housing Coalition, in Louisiana the Fair Market Rent for a two bedroom apartment is $994 per month. In order to afford this level of rent and utilities without paying more than 30% of income on housing, a full time work wage of $40,000 per year is required while the Supplemental Security Income is $710.00 per month or $8,520.00 per year. It is important to note that this includes the latest cost of living raise after two years with no increase for the most vulnerable disabled populations with insufficient disability income from the federal government. In a defined time period following the 2005 hurricanes, the average SSI payment increased 16.4% from $579 to $674 per month. During that same time period, the federal minimum wage level increased 27.2% from $5.15 to $6.55. In contrast, the fair market rent for a 1-bedroom apartment, including utilities, in the Greater New Orleans area increased 52.4% from $578 to $881. As a result, many consumers were unable to maintain independent housing. Many of them lived with family members or friends, often in overcrowded environments. Some of them ended up in homeless shelters or on the streets because they were unable to stay permanently with family or friends.

Homelessness Estimates

The HUD 2012 Homeless Point in Time report for the state of Louisiana indicates that there are over 3,975 unsheltered individuals in households without children and 139 individuals with children that are unsheltered. A total of 7,771 were reported to be homeless. The Point in Time survey is a HUD tool used to count the number of homeless individuals on specific days, usually doing a 48 hour time period. Each continuum participates by actually counting the homeless in their particular region. The report also documented that there were 1,364 individuals and families in emergency shelters and 2,432 that were in transitional housing programs. The survey is an unduplicated statewide count of the number of homeless individuals served by the homeless continuum in the State for the year. More specifically, it was documented that in the metropolitan area of Orleans Parish there were 3,439 of the 3,975 unsheltered in 2012. In other words, 87 percent of the homeless that are unsheltered were reported to be in the New Orleans metropolitan area. Moreover, the 2013 Point in Time survey conducted by UNITY, the homeless continuum in New Orleans, specifically reported that the numbers are decreasing. The survey data indicated the following for the subpopulations present in metropolitan New Orleans: severe mental illness – 766 (27 percent); chronic homelessness – 649 (23 percent); HIV/AIDS - 102 (4 percent); substance abuse - 888 (32 percent); veterans - 211 (7 percent); and domestic violence – 212 (7 percent). Experience suggests that persons with mental illness are underserved in the general shelter population because of their psychiatric need and, therefore, there may be significant numbers of *unsheltered* homeless who have a mental illness. It is also likely that there are a number of persons *sheltered* who are undisclosed as having a mental illness and, therefore, their mental illness is undetected and not included in the count. In addition, prevalence of substance abuse among adults with serious mental illness is between 50-70%. Taking those factors into consideration, some sources use the higher percentage of 30% in estimating persons with mental illness among homeless. The Shelter Survey is broken down by sub-population in the following table. This sub-population breakdown relates to the primary reason a person is homeless, although it is recognized that homelessness is multi-factorial, and some individuals may fall into more than one category.

Sub-population	Number	Percentage of Total
Severely mentally ill	766	27%
Chronic homeless	649	23%

HIV/AIDS	102	4%
Substance Abuse	888	32%
Veterans	211	7%
Domestic Violence	212	7%
TOTAL	2,828	

The recent Point in Time (P-N-T) survey (2012) reported the total number of "literally homeless" persons in all of Louisiana was 5,994. The total numbers for 2013 are not complete for the entire state. Literally homeless persons are those who live in emergency shelters or transitional housing for some period of time, or who sleep in places not meant for human habitation (streets, parks, abandoned buildings, etc.) and may use shelters on an intermittent basis. The P-N-T survey was a statewide count of homeless persons done during the 24-hour period on January 28th and noon, January 29th. It should be noted that the Point in Time survey is limited in its population coverage; for instance, unsheltered persons are difficult to identify and count, not all identified persons are willing to release information, and/or persons are undocumented because they do not seek services from a participating provider during the survey period. Therefore, by a conservative estimate, on any given day there may be as many as twice the *reported* count of homeless adults and children living in Louisiana.

Other more local estimates of homelessness include the annual application from Louisiana Projects to Assist in Transition from Homelessness (PATH); estimates reflect that providers served 3,638 homeless persons with mental illness during FY2012 with Federal and matching PATH funds and other sources of funding. Annual data reported by PATH providers for the number of individuals enrolled in PATH in 2012 was 1,151 (unduplicated count). This is less than a statewide estimate as PATH programs are not available in every Region/LGE. UNITY of Greater New Orleans, a non-profit organization for the homeless, estimates that there are approximately 8,725 homeless persons on any given day in the Greater New Orleans area alone who are in need of housing and supportive services, and approximately 40% or 3,490 have a mental illness.

Taken together, the deficits in affordable housing and the drastic increase in the cost of living in many areas of the state have generated a homeless crisis. The homeless crisis disproportionately affects the chronically mentally ill, most of whom are on a fixed budget and lack support systems. Particularly in urban areas, thousands of people inhabit abandoned homes, nearly 500 people fill the emergency shelters every night, and there are countless numbers of individuals living from 'pillow to post' and on the street. It is noted that U.S. Department of Housing and Urban Development (HUD) does not consider people who are in shelters, supportive housing and FEMA housing as "homeless" and therefore numbers that include people who are *displaced from their homes* are not technically 'homeless' and these numbers are actually much greater than reflected in the HUD counts. Moreover, locating affordable housing in the larger metropolitan areas where the majority of Louisiana homeless populations are located in Orleans parish is a struggle. Compounding the situation, the fair market rent for a one bedroom apartment is higher than the SSI disability benefits at $ 710.00 per month. Housing without a subsidy is not affordable since Hurricane Katrina wiped out a lot of affordable units according to UNITY for the Homeless.

Housing Programs

There are multiple providers of homeless programs in each area of the state. Each Region/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 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. Services targeted to the elderly, children, and youth and their families who are homeless have been generally limited in the past; however, there have been strides to identify and improve a number of service gaps for children and youth who are homeless across the state. For example, The Office of Behavioral Health has been converted to a managed care system. The Statewide Management Organization (SMO) manages the delivery of healthcare services and has developed a network of providers who offer services to the adult and child populations that are Medicaid eligible. There is also a provision for services for indigent children and adults. Efforts to enroll eligible individuals and family groups in Medicaid have increased. Healthier people can make more informed decisions about their health and welfare. One of the greatest needs in Louisiana is the creation of Supportive Housing that is affordable to persons living at an income level that is comparable to that of SSI recipients. 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 Block Grant along with 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% of Median Income. Experience has taught the State that supportive services are necessary to assist an individual in remaining housed.

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. Developers are given tax credits for creative financing opportunities with return value of dedicating 5% of the project units for persons with disabilities. Access to support services continues to be a priority. The State is using a Housing First model, where the overall framework is that housing is a necessity and the primary need is to obtain housing first without any preconditions to services. The cause of homelessness should be addressed with a client-centered approach that helps individuals identify why they became homeless and avoid situations that cause homelessness to reoccur. Moreover, housing is a basic right and should not be denied to anyone, even if they are abusing substances or refusing mental health treatment services. Housing First is endorsed by HUD and considered to be an evidence-based practice and a solution to addressing the chronically homeless. OBH has a strong commitment to keeping families together and to increasing affordable housing stock.

The American Reinvestment and Recovery Act of 2009 includes about $13.61 billion for projects and programs that are currently being administered by the Department of Housing and Urban Development. One goal of the Act was to stimulate the ecomony through access to affordable housing and protecting those in greatest need. The state has continued to pursue housing resources

through the HUD McKinney-Vento funding streams such as the Continuum of Care Supportive Housing Program (SHP) for the Homeless populations and other HUD programs. The Section 811 and Section 8 programs are more housing resource programs with specific emphasis on the Project Base Voucher (PBV) and the Shelter Plus Care (S+C) for the homeless and disability populations. In addition, OBH was awarded 200 Section 811 Project Based Vouchers (PBV) for fiscal year 2013. The funding will provide additional affordable housing units across the state. Rural Development housing programs and state Housing Authorities are also housing resources that are being utilized. The American Reinvestment and Recovery ACT of 2009 has expired but was a welcome housing resource that stimulated recovery and provided bridge subsidy funds for some of the most vulnerable homeless and/or disability populations. An OBH goal is to continue collaboration across departmental agencies like the Department of Children and Family Services (DCFS), Center for Medicaid Services (CMS), and the Office of Public Health (OPH), along with state and local Housing Authorities, to utilize all available housing funding resources to develop or partner with housing providers to develop a sufficient housing stock of affordable housing. While shifts in HUD policy have created barriers to persons with mental illness qualifying for housing resources through the Continuum of Care, and the Section 811 and Section 8 programs have been severely reduced, the HUD programs continue to be a focus of development activities. OBH Regional Housing Coordinators are active participants in the regional housing/homeless coalitions. In some cases, these coordinators are in leadership positions in their local coalitions. 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, UNITY, a local homeless continuum in metropolitan New Orleans, has recently responded to an RFP from SAMHSA with a proposal for the New Day Grant and was funded the CABHI grant, focused on the chronically homeless in Orleans Parish. In addition, the State is currently in the process of responding to a SAMHSA RFP for the Cooperative Agreements to Benefit Homeless Individuals for States (CABHI-States). Along with the CABHI-States RFP, the State is also developing a ten year plan to end chronic homelessness with technical assistance form SAMHSA. It is essential and critical that housing development continue with particular emphasis on strategies to coordinate tax credits, rental vouchers (Section 8 and Shelter + Care) and affordable financing.

Projects to Assist in Transition from Homelessness (PATH)

The Projects for Assistance in Transition from Homelessness (PATH) program of CMHS is targeted specifically towards those homeless persons with severe mental illness and/or severe mental illness with a co-occurring disorder. Louisiana's PATH program provides a significant amount of *outreach* activity as well as other support services. The annual reports from Louisiana PATH providers for FY 2012 indicated that 3,638 homeless individuals were served; however, 1,151 were enrolled. The PATH program expanded services to 8 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 2012, the match amount was $315,425.00. 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.

Permanent Supportive Housing (PSH)

The Louisiana Road Home Recovery Plan, an initiative of the Office of Community Development (formerly the Louisiana Recovery Authority) through the Louisiana Housing Corporation, has included the rebuilding of affordable housing in the areas most impacted by Hurricanes Katrina, Rita, Gustav and Ike, known as the "Gulf Opportunity Zone". This has been accomplished through a system of funding incentives that encourage the creation of mixed income housing developments. This plan targets not only the metropolitan areas impacted by the hurricanes but also several of the rural parishes that were impacted by hurricane Rita. Included in this plan is the use of Permanent Supportive Housing (PSH) as a model for housing and supports for people with special needs, such as people with disabilities, older people with support needs, families with children/youth who have disabilities, and youth aging out of foster care. It is a model that provides for housing that is fully integrated into the community. The model does this through setting aside a percentage of housing units within each housing development built to be used for persons in special population categories, and includes support services that are delivered in the individual's (or family's) home. Adults with SMI, families of children with emotional/behavioral disorders, and the frail elderly are included within the identified special needs population targeted for the supportive housing set aside units. The services delivered to persons/families in the target population were those services likely to help them maintain housing stability. Effort and dollars have been put into Family Support Services, housing with individualized in-home supports, and other community-based services throughout the State.

The current PSH Initiative within OBH has been largely based upon the housing successes of the 2008 post-Hurricane Katrina era, when Louisiana advocated successfully with the United States Congress to provide 3,000 units of Permanent Supported Housing (PSH) to address the demand for affordable housing with support services in response to Hurricanes Katrina and Rita. OBH, in partnership with other offices in DHH, disability advocates, and advocates for people who are homeless, actively pursued the inclusion of people with disabilities in all post-disaster development of affordable housing. These efforts resulted in a Permanent Supportive Housing (PSH) Initiative which successfully gained a set aside of 5% of all units developed through a combination of disaster-related housing development programs (including Low Income Housing Tax Credits) targeted to low income people with disabilities. With additional efforts to enhance the program through the integration of Shelter Plus Care units and other Tax Credit properties, there are currently 3,248 units affiliated with this program across the Gulf Opportunity Zone, approximately three quarters of which have already been leased. Once full lease up occurs, units will only be available upon turnover. Through applications for funding with HUD, it is hopeful that additional units can be expanded to the northern part of the state in addition to supplementing those areas of the state which continue to experience the greatest need. Presently, the Louisiana Housing Corporation administers the PSH program with a subsidy administrator. The program continues to operate with support services transitioning to Medicaid reimbursement, with Community Development Block Grant funding for those who are currently non-Medicaid. This continued transition to Medicaid-reimbursable services will allow for the sustainability of the program beyond the original funding period. Within OBH, the PSH program will take advantage of an enhanced service package, including an array of in home supports and Assertive Community Treatment. These services were originally implemented during the deinstitutionalization process of 2011 in which 118 intermediate care hospital beds were eliminated, and 206 individuals were discharged into the community. This right sizing of the state system of care was improved upon a community model of service delivery; further ensuring that individuals are provided treatment in the least restrictive environments of care. An additional benefit during this discharge process, which has

continued, is the superpreference rating given to individuals being discharged from institutions as they move onto the PSH waiting lists. Through this special superpreference option, over 37 persons discharged from the intermediate care psychiatric facilities have been able to access housing with supportive services. Throughout the overall program, it is estimated that 60% of the total number housed receive, or are eligible for, behavioral health services; further research, however, may prove this is an underestimate with percentages increasing to upwards of 70% of the total population served.

An additional programmatic modification to the PSH program, intended to ensure program sustainability, is the transition of a component of current operations to the organization which currently acts as the Statewide Management Organization (SMO) for the Office of Behavioral Health. Through this transition, which is scheduled to be completed by June, 2013, the SMO will take over responsibilities of screening and accepting housing applications, in addition to linking individuals with supportive services and ensuring tenancy issues are resolved. Continued collaboration with other DHH program offices will ensure fidelity to this cross disability program.

Homeless Coalition

Each Region/LGE has a Homeless Coalition, an organization that addresses systems issues and coordinates services for the homeless. The Regional Homeless Coalitions incorporate a complete continuum of care 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 abuse and mental health services. Services targeted to children, youth and their families who are homeless have been generally limited in the past; however, there have been strides to identify and improve a number of service gaps for children and youth who are homeless across the state. Each year the state homeless coalitions host a statewide homeless conference to educate and promote homeless services and assistance along with presentations of evidence-based/best-practice programs that are successfully implementing homeless services.

Children's Housing Services

Programs and services targeted to children, youth, and their families who are homeless have been generally limited in the past; however, there have been strides to identify and improve a number of service gaps for children and youth who are homeless across the state. Many of the child-serving housing programs are specific to the local areas of Louisiana. A well known homeless coalition called UNITY for the Homeless has been successful at identifying HUD and SAMHSA housing and service grants. The New Day SAMHSA CABHI services grant along with their Supportive Housing Programs that fund an array of services is essential for single adults, families, and adolescent outreach services. The Office of Behavioral Health has contracted with Magellan to coordinate children's behavioral health services and assistance in a coordinated system of care to ensure that providers are addressing the clinical needs of the youth population. The goal is to provide inpatient services required in a timely manner and have youth return back to the community with appropriate support services approved within the State Medicaid Plan. Moreover, the managed care provider coordinates services to assist homeless and other youth up to 21 years of age who are in need of health care services. Magellan also coordinates placement into therapeutic group homes, psychiatric residential treatment facilities and therapeutic foster homes, reducing victimization/exploitation. In 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. Runaway children and youth have been identified who are

in need of housing, medical, mental health, and substance use disorder services. The homeless coalition has developed a program (Gulf Coast Teaching Family Services) funded by HUD (Basic Center Grant Program) that provides outreach, respite care, individual and family counseling, and case management to runaway homeless children and youth. The goal is to unite the children and youth with their parents. Another example exists in AAHSD, where "Project Matrix" 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. In Region V, there is Education Treatment Council's Harbor House and Transitional Living Program (TLP). Harbor House is a temporary shelter (standard stay is less than 45 days) for homeless youth. TLP is an 18 month, independent living program 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. They provide minimal outreach services as part of this program.

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 (shelters, food banks, and community agencies) for homeless families; 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, camping 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: runaways and abandoned youth
- Highly-mobile families and youth

Employment Services

The Office of Behavioral Health (OBH) recognizes that work is a major component in the recovery process and supports consumers who have work as a goal. OBH had 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. At this time, however, most Regional Employment Coordinators have additional duties and on average devote less than 25% of their time to employment issues. The merger of offices and subsequent layoff of staff, have left the position vacant in some regions. Each of these issues has served to hamper efforts to increase employment initiatives. Though several regions 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 expand employment of persons with severe mental illness, OBH has promoted a strategy to actively seek and access opportunities external to OBH at the state and federal level to fund the further development of such services which 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, Workforce Commission (formerly Department of Labor), 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 has had active linkages to, and representatives serving on the advisory body of, the Louisiana Medicaid Infrastructure Grant (which facilitated the organization of the Medicaid Purchase Plan) prior to its sun setting in 2012. Additionally, staff coordinates with other programs and program offices, such as the Disability Navigator initiative through the Louisiana Workforce Commission (formerly Department of Labor), 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. This committee is comprised of community partners and is intended to further the employment of individuals with disabilities in the state of Louisiana. OBH is also working as a collaborative partner on both a state and regional level in the development and implementation of job fairs for individuals with disabilities throughout the state.

OBH Employment Liaisons and Consumer Liaisons continue to receive training in Benefits Planning, One-Stop, and Ticket-To-Work topics relevant to mental health consumers through Social Security Benefits Planning and the Workforce Commission (formerly Department of Labor). 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, as well as other program offices, seeking opportunities for increased collaboration for training and improvements in program design in order to better serve individuals as they transition to work. Specific areas of training include issues related to employment, recovery, and evidence-based practices such as Supported Employment.

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 SSDI and/or SSI benefits want to work or increase their work activity. 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 improved community partnerships. Benefit specialists, called Community Work Incentive Coordinators, provide services to all Louisiana SSDI and SSI beneficiaries age 14 and older who have disabilities. OBH clinic staff and clients are able to work with Coordinators to help navigate

the various work related resources (as 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.

OBH has participated in the development and implementation of Supported Self-Employment (Micro enterprise) pilots in different regions of the state, and in the previous development and establishment of intensive employment placement and support pilots (Employment Recovery Teams) in two regions. OBH has also supported the continued implementation of an employment program through the Jefferson Parish Human Services Authority's community mental health clinic. The program continues with great success as the JPHSA staff collaborates with LRS, DOL and the Career Solution Centers, as well as actively works with their clinician promoting employment as a path to recovery.

Act 378 funds for adults can be used in any manner to assist the individual in remaining in the community. Should they need any type of job training or assistance in obtaining a job, or a job coach, these funds can cover those costs.

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. The national economy and recent disasters impacting the state have made this goal an extremely 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 interviewing skills.

Profile of Persons Served (CMHC)
Adult Mental Health Clients by Employment Status
Louisiana OBH Outpatient Data PERSONS SERVED Unduplicated FY2012

	Age 18-20			Age 21-64			Age 65+		TOTAL			TOTAL
	Female	Male	Unk.	Female	Male	Unk.	Female	Male	Female	Male	Unk.	
Employed: Competitively Employed Full or Part-time (includes Supported Employment)	60	43		1,260	691	9	8	5	1,328	739	9	2,076
Unemployed	144	160	3	2,625	1,906	47	19	9	2,788	2,075	50	4,913
Not in Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc)	292	274	1	5,994	3,918	19	206	87	6,492	4,279	20	10,791
Employment Status Not Available	265	305	7	10,996	7,277	133	766	288	12,027	7,870	140	20,037
TOTAL	761	782	11	20,875	13,792	208	999	389	22,635	14,963	219	37,817

Employment status at admission. Data from CMHC data: OBHIIS, JPHSA, and Clinical Advisor. Unduplicated across regions/LGE by client.
URS Table 4. URS Table 4 Profile of Persons Served CMHC, Adult Clients by Employment Status

Employment Services for Youth

There are limited and generally locally developed employment programs for youths in the state. Many of these are disability specific but can be accessed by youths with behavioral health involvement. Some of the Regions/LGEs have highlighted some of these programs:

- In the Jefferson Parish Human Services Authority (JPHSA) area, youth between the ages of 14 and 20 are served through a program that offers job readiness curriculum support.
- In the greater Baton Rouge area, the Capital Area Human Services District (CAHSD) partners with Instructional Resource Centers and Transition Core Teams in local school systems to provide services to youth, especially as they transition from educational to vocational systems. Through efforts including planning meetings, transition fairs, interagency service coordination, and family support coordination, CAHSD provides services for transition-aged clients with developmental disabilities, mental health disorders, and/or addictive disorders. Louisiana Rehabilitation Services serves youth ages 16 to 21 with job placement services. The Transitional Core Team serves youth ages 16 to 21 with job fair and placement services. LSU Youth Employment serves youth ages 16 to 21 with on campus employment.
- In the Acadiana Area Human Services District (AAHSD) area, Louisiana Rehabilitation Services assists individuals with disabilities to obtain job training or education and the National Guard Youth Challenge Program (ages 16 to 18) assists high school dropouts to obtain job training and a GED. The Lafayette Parish School System/Connections Program assists high school students to obtain a certificate in a vocation when a high school diploma will not be obtained.
- Region V refers transitional age youth to Transition Workshops for training on adult issues, resume building, and networking. Calcasieu Parish Schools Job for Americas also offers a program in Region V to help high school students with job training, mentoring and job placement. Louisiana Rehabilitation Services (LRS) has a transitional age program to assist with job readiness and placement for individuals 17 years of age and older who are graduating from high school. Families Helping Families holds transition fairs and offers resources from area agencies to youth in grades 11 and 12.
- In Region VII, the Special Education Transition Team helps special education students connect with vocational services, trainings, and sheltered workshops. In addition, Goodwill Industries in Region VII has youth employment programs that include: 1) Youth Employment Services Programs for at risk or disadvantaged youth ages 15 to 22 in the Shreveport/Bossier City area in need of assistance gaining and maintaining employment. Services include job readiness and life skills training, mentoring services and job placement/retention services. 2) GoodStart Program partners Goodwill with Caddo Parish School Board's Career and Technology Center and Jobs for America's Graduates Program providing activities aimed at increasing independent living, job readiness skills, and career exploration. 3) Education + Employment=Success Program for at-risk youth between the ages of 17 and 22 provides free GED instruction, life skills, work readiness, and financial literacy training and offers employment at Goodwill while completing their training.
- In the Florida Parishes Human Services Authority (FPHSA) area, The Youth Career Development Project, funded by a grant from the US Department of Labor, teaches construction skills to youth between the ages of 16 and 24 with little or no work history. Additionally, the public school system in this area offers various on-the-job trainings to students in special education classes. These trainings are provided by local businesses.

Educational Services

Louisiana OBH Supported Education is a program based on a 1997 OMH/Louisiana State University (LSU) joint research project concerning theories and models of Supported Education nationwide, and development of a '*Louisiana Model*' for Supported Education based on that research. The Louisiana Office of Mental Health initially funded the LSU Supported Education Program for students with Serious Mental Illness (SMI). LSU became one of the first four year universities in the nation to have a supported education program in place and operational, with initiation of the program in 1997. Upon LSU's agreement to continue the program, OMH then moved the funding to the University of Louisiana at Lafayette (ULL). The ULL program became operational in the Fall Semester of 2000, with the University being fully able to sustain it internally as of 2006. Both LSU and ULL initially received funding with 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" ended. To date, though the programs have continued at both LSU and ULL, there has been neither expansion to other post-secondary educational settings nor any continued financial support from OBH. However, 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, while OBH remains able to provide technical assistance if needed. In both instances, the Supported Education Advisor serves those students identifying themselves as persons with Serious Mental Illness (SMI). The OBH-sponsored supported education programs provide both individual and group support to students with serious mental illness pursuing post-secondary education. Students also receive 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 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 the world of work in a career field of the student's choice. The program targets students with SMI of all ages, both those who are older and are (re) entering a secondary educational setting after years of mental health treatment, as well as 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 OBH 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.

Physical Health Integration

Individuals with serious mental illnesses and addictive disorders often have co-occurring chronic medical problems. Therefore, it is important to enhance a collaborative network of primary health care providers within the total system of care. Individuals who receive behavioral health services through the State behavioral health system or Medicaid-funded behavioral health services also benefit from a systematic health screening. Thus, all clients receive a service plan that addresses all health needs including mental health and addictions. The OBH clinics work very closely with

private health providers. There is a requirement that every individual who is Medicaid eligible has an assigned primary health care provider through one of the Medicaid Bayou Health plans. With the client's consent, behavioral health providers must provide any medical information received to the primary health care provider. Providers are also required to coordinate care with publically-funded health care providers for individuals who are not covered by Medicaid.

In some regions, hospitals began offering onsite medical services at the mental health clinics. Some clinics continue to integrate primary care activities into their main clinics, along with smoking cessation programs, diabetes screenings, and hypertension and cholesterol screenings. Wellness clinics and Medication Management clinics are becoming commonplace in the regions. Integrated services already provided in addictive disorder programs include contractual services with primary care physicians five to 10 hours per week at residential facilities and in some outpatient clinics. These physicians provide screenings, interventions, and referrals for medical concerns as a result of laboratory work or patient report. Integration of services for mental illness with primary health occurs at various levels in inpatient and outpatient settings in the State.

The Statewide Management Organization (SMO) is required to determine if its members have a primary care physician (PCP) established and to refer members to a PCP in one of the Medicaid Bayou Health plans if the individual does not have a primary care physician established. If the individual being served agrees, a signed release of information is obtained in order to coordinate care with the PCP or other health care providers, including notifying primary care physicians of the individual's treatment, such as the initiation of or change to psychotropic medications.

The Department of Health and Hospitals (DHH) Office of Behavioral Health (OBH) participated in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Region VI Primary Behavioral Health Care Integration State Team Meeting, September 27, 2012. In addition to representatives from OBH, the Louisiana Team included representatives from DHH - Medicaid, DHH - Louisiana Birth Outcomes Initiative, DHH - Office of Public Health, The Louisiana Public Health Institute, Louisiana Primary Care Association, Odyssey House, Capital Area Human Services District, Magellan of Louisiana, and The Extra Mile.

On March 28, 2013, the Louisiana State Team for Primary and Behavioral Health Care Integration in partnership with SAMHSA sponsored a Health Summit entitled *Advancing Behavioral Health and Primary Care Integration: The Louisiana Summit.* The Summit was hosted by the OBH and facilitated by expert consultants from the National Council for Community Behavioral Healthcare. There were over 100 individuals in attendance from behavioral health and primary care agencies statewide. The Summit allowed participants to: 1) Establish a commitment from meeting participants to make integration a priority within their sphere of influence; 2) Identify key priorities and next steps; and 3) Potentiate networking for the local program development needed to further promote integration of primary care and behavioral health across Louisiana. Another Summit is scheduled for June 25, 2013.

The Louisiana Adolescent School Health Initiative Act (R.S. 40:31.3) authorizes the Office of Public Health to facilitate and encourage the development of comprehensive health centers in Louisiana's public schools, School-Based Health Centers (SBHCs). Mandatory staffing in the SBHC must include a master's level mental health provider and must include behavioral health services. Social services include assistance with Medicaid/LaCHIP and other health insurance application. Other services include primary and preventive health care services (such as

comprehensive exams and sports physicals, immunizations, health screenings, acute care for minor illness and injury, and management of chronic diseases), health education and prevention, case management, referral to specialty care, and in some cases, dental services. There were 69 School-Based Health Clinics (SBHCs) in 27 parishes during the 2012-2013 school year (http://dhh.louisiana.gov/assets/oph/pcrh/adolescent/2012-13DocumentsAndForms/12-13_updated_SBHC_Administrators.doc). The SBHCs in Louisiana follow the *Principles, Standards and Guidelines for SBHCs in Louisiana (http://dhh.louisiana.gov/assets/oph/pcrh/adolescent/2012-13DocumentsAndForms/Principles_tandards_and_Guidelines_7-2012_FINAL.doc).*

Special Populations

Older Persons *(CMHS Block Grant Criterion 4)*

Even though the system of care provides statewide access to mental health services for adults with SMI, including the population of older persons, services specific to older adults, aged 65 and older with SMI, are a statewide area of need. The DHH recognized this need in recent years and developed the Office of Aging and Adult Services (OAAS). Although this office is not limited to serving persons with mental illness, there has been increasing and stronger collaboration across the program offices within DHH. The OBH continues to develop holistic initiatives that offer comprehensive and blended services for vulnerable adults experiencing psychiatric and physical trauma, including those in acute crisis. However, the OBH has no specific treatment programs for older adults. Specific regions and LGEs have some programming that targets older citizens; however, the needs are great and services are not consistent across the State for older adults.

Services typically provided to the general adult population with SMI include psychiatric evaluation, bio-psychosocial assessments, individual therapy and specialized group therapies and other evidence-based treatments based on unique individual needs. Some clinics have benefits specialists who work with all populations, but particularly the elderly, to ensure that they receive individualized case management. Some clinics have assigned a registered nurse (RN) to deliver specialized health needs to the elderly population. Informal collaborative agreements exist with Federally Qualified Health Centers (FQHC) regarding persons with SMI who are older than 65. Mobile outreach teams provide therapeutic respite and linkage to community services.

Aggregate data for SFY 2012 indicate that more than seven thousand (7,005) mental health services have been delivered to Louisiana seniors (aged 65 and over) throughout the OBH Regions and LGEs, with the overwhelming majority (6,550) being delivered in-person. The following tables represent the distribution of delivered services to seniors by OBH Region and LGE during SFY 2012:

OBH Regions

SERVICE METHOD	REGION										TOTAL	
	Region 4		Region 5		Region 6		Region 7		Region 8			
	N	%	N	%	N	%	N	%	N	%	N	%
IN-PERSON	766	100%	174	97%	375	100%	185	98%	604	100%	2104	99.6%
TELE-VIDEO	.	.	5	3%	.	.	4	2%	.	.	9	0.4%
TOTAL	766	100%	179	100%	375	100%	189	100%	604	100%	2113	100%

Local Governing Entity (LGE)

SERVICE METHOD	LOCAL GOVERNING ENTITY (LGE)										TOTAL	
	2-CAHSD		3-SCLHSA		9-FPHSA		JPHSA		1-MHSD			
	N	%	N	%	N	%	N	%	N	%	N	%
IN-PERSON	1,402	100%	1,453	96%	835	100%	130	25%	626	99%	4,446	91%
TELE-VIDEO	.	.	55	4%	.	.	.	.	6	1%	61	1%
missing/ unknown	.	.	.	.	.		385	75%	.	.	385	8%
TOTAL	1,402	100%	1,508	100%	835	100%	515	100%	632	100%	4,892	100%

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 below tables represent the distribution of primary admitting diagnoses for seniors:

OBH Regions

PRIMARY DIAGNOSIS AT ADMISSION	REGIONS										TOTAL	
	Region 4		Region 5		Region 6		Region 7		Region 8			
	N	%	N	%	N	%	N	%	N	%	N	%
ADJUSTMENT DISORDER	2	1%	.	.	.	.	2	6%	2	3%	6	2%
ANXIETY DISORDER	4	2%	1	3%	2	3%	.	.	3	4%	10	3%
DEMENTIAS	1	1%	.	.	.	.	.	.	.	.	1	
DEPRESSIVE DISORDER	5	3%	2	5%	3	4%	1	3%	1	1%	12	3%
DIAGNOSIS DEFERRED	10	6%	1	3%	.	.	.	.	.	.	11	3%
MAJOR AFFECTIVE DISORDER	97	54%	17	44%	13	18%	12	39%	24	32%	163	41%
MENTAL RETARDATION	2	1%	.	.	.	.	.	.	.	.	2	1%
OTHER DISORDERS	3	2%	.	.	1	1%	1	3%	3	4%	8	2%
PSYCHOTIC DISORDER	45	25%	16	41%	25	35%	11	35%	33	43%	130	33%
SUBSTANCE/ETOH ABUSE DISORDER	.	.	.	.	1	1%	.	.	.	.	1	
missing/unknown	12	7%	2	5%	26	37%	4	13%	10	13%	54	14%
TOTAL	181	100%	39	100%	71	100%	31	100%	76	100%	398	100%

Local Governing Entity (LGE)

PRIMARY DIAGNOSIS AT ADMISSION	DISTRICTS										TOTAL	
	2-CAHSD		3-SCLHSA		9-FPHSA		10-JPHSA		1-MHSD			
	N	%	N	%	N	%	N	%	N	%	N	%
ADJUSTMENT DISORDER	1		4	2%	4	3%	.	.	4	2%	13	1%
ANXIETY DISORDER	6	2%	5	2%	1	1%	.	.	6	3%	18	2%
DEMENTIAS	.	.	1		.	.	.	.	1	1%	2	
DEPRESSIVE DISORDER	9	3%	6	2%	6	4%	2	2%	10	5%	33	3%

DIAGNOSIS DEFERRED	.	.	4	2%	1	1%	.	.	6	3%	11	1%
MAJOR AFFECTIVE DISORDER	76	29%	141	54%	59	40%	14	11%	75	38%	365	37%
OTHER DISORDERS	1		7	3%	10	7%	4	3%	4	2%	26	3%
PERSONALITY DISORDERS	1		.	.	.	.	.	.	.	.	1	
PSYCHOTIC DISORDER	54	21%	77	30%	67	45%	12	10%	52	26%	262	26%
SUBSTANCE/ETOH ABUSE DISORDER	.	.	4	2%	.	.	.	.	1	1%	5	1%
missing/unknown	113	43%	10	4%	.	.	91	74%	40	20%	254	26%
TOTAL	261	100%	259	100%	148	100%	123	100%	199	100%	990	100%

In addition to community based services for older persons, OBH works collaboratively with Medicaid, the Office of Aging and Adult Services (OAAS), and the Office for Citizens with Developmental Disabilities (OCDD) in identifying and monitoring individuals with behavioral health disorders who are nursing facility applicants and who 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 placed appropriately, 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:

Total Reviewed through the PASRR Process	**1,708**	**100%**
Recommended Nursing Home Placement	**1,572**	**92%**
Recommended for Temporary Nursing Home Placement	91	6% of recommended NH
Exempted Hospital Discharges not requiring PASRR process for first 30 days	84	5% of recommended NH
Denied Nursing Home Placement	**136**	**8%**
Resident Reviews Performed after a Significant Change in Status	**176**	**10%**
Recommended for Specialized Behavioral Health Services	**470**	**28%**

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 addiction services while in the nursing facilities.

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 the Office of Aging and Adult Services, Office of Citizens with Developmental Disabilities, private hospital and providers. OBH staff also represents the state as a member of the National Association of State Mental Health Directors, 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, best practices, and to provide consultation and collaboration on mental health issues pertaining to older persons.

Rural Populations *(CMHS Block Grant Criterion 4)*
Although OBH has placed many effective programs in rural areas, barriers, especially transportation, continue to restrict the access of consumers to rural mental health programs. 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 to employment and educational opportunities. The resulting increased social isolation of many OBH clients with serious mental illness who live in these areas is a primary problem and focus of attention for OBH. Efforts to expand the number of behavioral health programs and providers and recruiting of transportation providers in rural areas are ongoing goals. However, due to fiscal reductions, some of the less productive satellite and outreach sites were eliminated. In many cases, community-based services such as ACT or ICM have been made available to serve some of these populations. One desired outcome of the transfer of the management of behavioral health services to the Statewide Management Organization is the expectation that they will be able to build a more robust provider network, even in the more rural areas of the state. The ability of the Statewide Management Organization to use mapping technology to monitor services and service providers throughout the state will continue to help in shaping the network of providers and services by identifying gaps in services and locating where additional providers may be needed.

Service Members, Veterans and their Families
A Louisiana delegation attended the Service Members, Veterans, and their Families (SMVF) Policy Academy. This consisted of members of Louisiana Department of Veterans Affairs, OBH, Louisiana State University (LSU) Health Sciences Center, 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 as well as the decision to form a veteran's coalition. The State is currently in the process of developing an MOU between veteran serving agencies in order to strengthen collaboration and communication between the various SMVF agencies. In addition, SAMHSA has selected Louisiana to participate in the Substance Abuse Treatment Initiative (SATI) with the Louisiana Army National Guard (LAARNG). Through this initiative, OBH Central Office staff will be providing suicide prevention trainings to LAARNG Units.

Overview of the Louisiana Addictive Disorder Service System

Addictive Disorder Service System Array

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, 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 2012, OBH admitted a total of 27,283 individuals into its substance use disorder treatment continuum, and a total of 289,428 services were provided, inclusive of all levels of care, as per the Louisiana Addictive Disorder Data System (LADDS) and Clinical Advisor (CA). 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.

Since the Office for Addictive Disorders merged with the Office of Mental Health to become the Office of Behavioral Health (OBH), barriers to accessing coordinated care for co-occurring disorders have been greatly reduced. Since FY2011, services for both mental health and addictive disorders have been provided by one organization, and in many areas, by the same clinic.

The Office of Behavioral Health'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 the target population and appropriate service mix, implementing centralized screening and scheduling, and instituting walk-in appointments, wait lists for services were dramatically reduced. In some cases, clinics maintain no wait lists, and in others wait lists have been reduced from months to weeks or days. These activities have expanded access, improved provider productivity, and have 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 *(SAPT Block Grant Federal Goal 1: Improving Access to Prevention and Treatment Services*).

The most commonly abused substances reported in Louisiana by individuals admitted in SFY 2012 include alcohol, marijuana, opiates, cocaine, heroin, and methamphetamine, as depicted in the table below. SFY 2012 data about the substance use disorder treatment population indicates that of the individuals engaged in treatment, 15% were admitted with an alcohol problem only, 32% were admitted for treatment of a drug addiction only, and 49% were admitted for treatment of both alcohol and drug addiction. The percentage of the population admitted for treatment of both alcohol and drug addiction was higher during SFY 2012 than during the previous SFY (2011), during which this was the case for 39% of the population.

MOST COMMONLY ABUSED SUBSTANCES (SFY 2012)		
#	Substance	% of Population
1	Alcohol	24%
2	Cocaine	12%
3	Marijuana	16%
4	Opiates	15%
5	Heroin	8%
6	Methamphetamine	3%
7	Methadone	<1%

In addition to the populations previously mentioned, individuals admitted for the treatment of gambling addiction represented 2% of the population. The table below shows the distribution by age group of individuals served in SFY 2012. The percentage of individuals served who were 51 years of age and over was slightly higher than during the previous SFY, at 13% compared to 9%.

INDIVIDUALS SERVED BY AGE (SFY 2012)	
Age Group	% Served
18 and Under	7%
19 – 30	35%
31 – 50	45%
51 and Over	13%

The Office of Behavioral Health 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 the assessment of severity of an individual's substance use disorder. Louisiana's continuum of care is modeled on the American Society of Addiction Medicine (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 (*SAPT Block Grant Federal Goal 10: Process for Referring).* The Office of Behavioral Health 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 American Society of Addiction Medicine (ASAM).

The Office of Behavioral Health 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 *(SAPT Block Grant Federal Goal 2: Primary Prevention Services).* 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 continues with the vision that prevention is a process that helps create, reinforce, and support healthy behaviors and lifestyles through the lifespan. As part of the merger of mental health and addictive disorders, prevention planning efforts expanded in scope and not only consist of educating citizens about addiction, but about mental health issues as well, more 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. Following are examples of specific planned and completed activities that are targeted to Louisiana's diverse minority populations:

- Revising the Prevention Management Information System (PMIS) to include additional data elements in order to ensure adherence to the HHS published final 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 the following:
    - Providing information about substance use and pregnancy to women who are pregnant, perinatal, or of child-bearing age at large events held at a local hospital 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, and
    - 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, and sensitivity to, cultural differences;
- 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; and
- Including a professional with strong ties and experience working with the LGBTQ population on the Louisiana Partnerships for Success Stakeholder Group.

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 the lifespan; particularly by providing services geared toward adults beyond student populations located at institutions of higher education. Examples of prevention services targeted toward adults are as follows:

- Programming geared toward parents and families;
- SafeTALK suicide prevention training;
- The Strong Choices Prevention Program for the Louisiana National Guard, which will be rolled out during calendar year 2014;
- 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 Health Connections Program, in which local paraprofessionals are hired and trained as community health workers to assist adult residents in the community to find and use health resources and to learn how to improve their health and live a healthier lifestyle;
- The Alcohol Information School, which is a court approved program for DWI offenders that is available in English and Spanish; and
- 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/newsletter, and public service announcements;
    - Referral guides that include information about regional resources;
    - Websites that include treatment resources and educational publications; and
    - Outreach to the public at health fairs, sorority and fraternities events, and coalition events.

Examples of prevention services targeted toward children and youth are as follows:

- 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 relationship by strengthening problem-solving, decision-making, and communication skills;
- Summer youth programs sponsored through partnerships with agencies such as the local YMCA and Arts Council;
- The Student-Created Aggression Replacement Education (SCARE) program, which is offered by The Alcohol and Drug Abuse Council for children and adolescents and is an anger and aggression management program intended to teach young people about emotions and to help them recognize alternatives to violent behavior and aggressive responses;
- 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;
- The Communities Mobilizing for Change on Alcohol, which is a community organizing strategy designed to reduce the ability of adolescents (ages 13 to 20) to access alcohol by including a media campaign with billboards targeted at educating parents, youth, and vendors on underage drinking laws and consequences and an education component that is utilized for underage offenders to provide education on Louisiana laws concerning alcohol and persons under the age of 21; and
- SafeTALK suicide prevention trainings to youth.

Prevention Strategies

During SFY 2012, 54 Community-Based Prevention Providers and 10 Community Synar Projects were funded and provided services in the areas of Information Dissemination, Education, Alternative Activities, Problem Identification and Referral, Community-Based Process, and Environmental. The Community-Based Prevention Providers implemented 17 evidence-based programs. The Synar Projects and the evidence-based programs funded by the Block Grant were 100% evidence-based.

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 (1) Regional Alcohol and Drug Awareness Resource (RADAR) Associate Network in each of the ten (10) Regions/Local Governing Entities (LGEs). OBH, through its Prevention Management Information System (PMIS), confirms that this Information Dissemination strategy impacted 343,862 citizens and delivered 326,154 pieces (126,799 by contractors; 199,355 by agency staff) of ATOD literature during SFY 2012. Contract staff dedicated 1% of staff time to the strategy of Information Dissemination. OBH agency staff dedicated 6% of staff time to this strategy. Provider and agency staff provided the following services: ATOD literature, audiovisual materials, clearing house, curriculum materials, attended health fairs, health promotion events, media campaigns, printed material, public service announcements, RADAR, resource directory, speaking engagements, and telephone information.

Education: OBH contract providers provide on-going prevention education from evidence-based curriculums to enrollees in their respective program(s). During SFY 2012, OBH confirmed through its Prevention Management Information System (PMIS) that evidence-based services were provided to 77,078 enrollees, exceeding the 72,358 target. Also, 675,829 pieces of ATOD prevention literature were distributed. OBH provider facilitators delivered 45,607 lessons from the programs listed in the table below during SFY 2012. Of the 77,078 individuals enrolled in evidence-based programs, 5,293 were from a SPF-SIG sub-recipient. The SPF-SIG sub-recipients implemented the Staying on Track program. The following table lists the 17 Evidence-Based Educational Programs that were funded during SFY2012 designated by Universal, Selective, or Indicated.

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

Selective Evidence-Based Program
Children Program Kit
Strengthening Families
Selective Program Total: 2

Indicated Evidence-Based Program
Leadership and Resiliency
Insight Class Program
Indicated Program Total: 2

Five areas of the state exceeded the state average of 7,717 enrollees per Region/LGE - MHSD, AAHSD, Region VI, Region VII and Region VIII. These Regions/LGEs registered a total of 53,536 enrollees in their programs, representing 69% of the services delivered. Contractor staff dedicated 97% of services to the strategy of Education, exceeding the 80% target.

Alternatives: Prevention contractors have the option of providing alternative strategies through in-kind contributions to their respective target population(s) as appropriate. OBH, through its PMIS system, confirms contractor staff dedicated 1% of services to the strategy of Alternatives during SFY 2012, which is well below the 5% maximum target. Provider staff provided alcohol, tobacco and other drug-free events; community drop-in center activities; community services; and youth and adult leadership functions to 6,619 participants during the target period and distributed 6,048 pieces of ATOD literature. OBH also implemented the evidence-based Leadership and Resiliency Program. These programs served an additional 1,091 enrollees with program-specific alternative activities and distributed 1,205 pieces of ATOD literature.

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. OBH, through its Prevention Management Information System (PMIS), confirms that less than 1% of provider services were dedicated to the strategy of Problem Identification and Referral, and providers disseminated 1,331 pieces of literature to 863 participants during SFY 2012. 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. According to the Prevention Services SFY 2012 Report, OBH staff dedicated 1% of staff time to the strategy of Problem Identification and Referral, and EAP services were provided to 49 state employees, with a total of 161 referrals to services being made. Problem Identification and Referral was done chiefly by phone, but also in person at meetings and through presentations. Agency staff disseminated 1,208 pieces of literature to 994 stakeholders. The following are examples of presenting problems: Abuse, Child Welfare, Elderly Issues, Employment, Family Counseling, Financial, Insurance, Legal, Medical and Mental Health, Retirement, Substance Abuse, Support Groups, Student Assistance, and Other Reasons.

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/referral for issues such as child abuse or bullying is made available to the facilitators as well.

Community Based Process: The Office of Behavioral Health (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. This Framework includes the following steps: 1) Needs and Resources Assessment; 2) Assess and Build Capacity; 3) Select Appropriate Programs, Policies and Practices; 4) Implement Selected Programs, Policies and Practices; and 5) Evaluate Outcomes. OBH, through its Prevention Management Information System (PMIS), confirms that OBH agency staff dedicated 90% of staff time to the strategy of Community-Based Process during SFY2012, exceeding the 40% target. Providers dedicated 3.5% of staff time to the strategy of Community-Based Process. 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. Agency staff provided community-based process

services to 34,366 participants and distributed 24,240 pieces of ATOD prevention literature. In addition, provider staff provided community-based process services to 32,266 participants and distributed 15,778 pieces of ATOD prevention literature.

Environmental: OBH continues to fund a Synar Contractor in each region of the state in an effort to maintain no more than a 10% 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 (i.e. Coalition for Tobacco Free Living, Students Against Destructive Decisions, 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 purchased, minimum age of seller requirements, policies concerning cigarette vending machines, and alcohol restrictions at community events. These activities by agency and provider staff impacted 889 participants and distributed 30,396 pieces of ATOD prevention literature. OBH, through its PMIS system, dedicated 1% of agency staff time to Environmental strategies during SFY2012. Synar provider staff dedicated 100% of provider staff time to Environmental Strategies and provided merchant education to 4,361 retail outlets.

Louisiana Caring Communities Survey

OBH co-sponsored, along with the Department of Education (DOE), the 2010 Louisiana Caring Communities Survey (CCYS) for 6th, 8th, 10th, and 12th graders. 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 Local Education Agencies (LEAs), with 62 parishes participating. 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 parish. OBH will provide a community tool for reviewing CCYS Reports. PowerPoint templates for state, regional and parish level data are being distributed to OBH and DOE to ensure consistency and accuracy of presentations made utilizing CCYS data. Technical assistance will be provided as needed to the Regions/LGEs as they present the data to their LEAs. The 2012 Louisiana Caring Communities Survey was coordinated and administered in fall 2012, with results released in early spring 2013.

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 5-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 5-Year Strategic Plan to raise awareness around this serious problem. The State has begun implementation of the State's 5-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 2012. LaHEC stimulated vision and commitment for the LaHEC mission within/among all institutions through collaboration among higher education staff/faculty as well as key community and state stakeholders. LaHEC facilitated communication within/among all member institutions through monthly emails and telephone communication with liaisons at the thirty-five institutions of higher education.

OBH sponsors the administration of the bi-annual CORE Alcohol and Drug survey for institutions of higher education across the state of Louisiana. The CORE survey was conducted in spring 2013. Additional capacity among Louisiana institutions of higher education was also sought during SFY 2012 as evidenced by extending invitations to nine (9) technical colleges, seven (7) two-year community colleges, seven (7) private four-year colleges, and 16 public universities, for a total of 39 institutions of higher education, to join the statewide coalition and participate in the 2013 administration of the CORE survey. A new LaHEC website was launched to make data from the CORE Alcohol and Drug survey for institutions of higher education and other useful resources available to LaHEC institutions.

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, policy development, policy enhancement, and policy enforcement (using a public health model). On-site regional and individual institution technical assistance and coalition building took place at four sites in different regions of the state during SFY 2012.

OBH also sponsors an annual LaHEC Summit to assess and address high risk behaviors and plan interventions for institutions of higher education. The SFY 2012 LaHEC Professional Development Summit was held on August 11-12, 2011 with the overall goal of mobilizing institutions of higher education and community stakeholders to address the issue of alcohol, tobacco, and other drugs in collegiate populations by utilizing empirical data to inform interventions, programs, and policy change. There were 128 participants registered for the two-day Professional Development Summit, representing 25 institutions of higher education and various state agencies and community stakeholders. A total of six sessions were provided, including presentations on 2011 Core Survey Results; Statewide Trends in High School Students' Substance Use and Antisocial Behavior; Contemporary Issues in Campus Alcohol Enforcement; Substance Abuse Awareness Initiatives in Historically Black Colleges and Universities (HBCU's); Shaping Healthy Collegiate Environments to Reduce the Harms Resulting from College Student Drinking; and The Application of Core Data to Inform Programming and Interventions at LaHEC Institutions. All of the Summit presentations as well as educational documents/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 was prepared by LaHEC staff.

Prevention Workforce Development

OBH Prevention Services (through a contractual agreement with Southern University Baton Rouge) offers web-based courses 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. Two courses (Prevention Professional Seminar and Tobacco Seminar) are provided online and two courses are offered onsite (Prevention Ethics and Cultural Competence). Courses provided online utilize a real-time web-based platform called WIMBA. In WIMBA, participants and a facilitator(s) log on at a prescribed time and are able to interact, view the same documents, and discuss materials simulating a classroom setting.

The Prevention Professional Seminar 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 two onsite courses were offered in two regions of the state during each semester (Fall, Spring, Summer). Exam preparation sessions are offered four times each year to four regions of the state the month prior to the actual exam in an effort to cost-effectively make training accessible across the state.

Through a contractual agreement with Southern University in Baton Rouge beginning Fall 2011 through Summer 2012, 10 online courses and two (2) off campus courses were provided with 387 students completing the courses. The courses are offered to meet the needs of the prevention field throughout the state. Agencies whose staff has participated in the courses include the Department of Health and Hospitals, the Department of Education, and the Governor's Office. Safe and Drug Free School and Communities grantees are also encouraged to participate in the training. Additionally, the field of prevention is an academic option in the Department of Psychology at Southern University; students are recruited into the field through this mechanism.

OBH also hosted and participated in 5th Annual Suicide Prevention and Awareness Conference, 2011 Louisiana Safe and Drug Free Summit, 5th Annual Children's Mental Health Summit, and Strategic Prevention Immersion Follow-up Training with a total of 118 participants and 19.8 contact hours being provided.

OBH, in partnership with the Governor's Office and Southern University, provided training in the Strategic Planning Framework Curriculum and State Prevention Enhancement January 19-20, 2012. Forty-six individuals were in attendance to include OBH Regional Staff, SPF-SIG and staff. Follow-up trainings have been scheduled for the remainder of the calendar year to refresh participants on the components outlined in the SPF Curriculum.

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, with 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 data (federal, state, and local) within trainings and to assess need and make decisions about training needs;
- The ability to be flexible and change/evolve as needed;
- The sustainability of partnerships among the Louisiana prevention service system and providers, sub-recipients, and coalitions;
- Demonstration of excellent communication; and
- Provision of cost effective and fiscally sound training efforts.

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;
- The availability of updates to programs, electronic systems, and/or treatment practices;
- Staff development training for providers regarding analyzing data (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 (*SAPT Block Grant Federal Goal 8: Tobacco Products*) as required by the Synar Amendment to the Public Health Service Act (PL 102-321) which ensures future SAPT Block Grant funding for the State. Louisiana has in effect a law prohibiting 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%. OBH's overall success rate at reducing the availability of tobacco products to minors has been consistently far below 20% and Fiscal Year 2012 was no different, with a reported non-compliance rate of 4.1%.

OBH funds 10 regional Synar contractors to provide merchant education through unconsummated compliance checks of tobacco retailers. OBH also contracts with the Office of Alcohol and Tobacco Control 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 Office of Alcohol and Tobacco Control (OATC). OATC 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. Each agent, who is employed by the Office of Alcohol and Tobacco Control, reviews the tobacco retailer compliance check form before submitting the form to his/her supervisor. Then, the supervisor reviews the form before sending the

form to OATC Headquarters. Finally, the State Synar Coordinator reviews each form before sending to the Synar Principal Investigator. Synar Contractors are monitored programmatically on a monthly basis by OBH Regional Prevention Coordinators (RPC's) who conduct monthly Statement 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

The Office of Behavioral Health maintains a continuum of substance use disorder treatment services throughout the State (*SAPT Block Grant Federal Goal 1: Improving Access to Prevention and Treatment Services*).

Screening and Referral for Pregnant Women

OBH has coordinated efforts with the Office of Public Health to improve statewide birth outcomes via ongoing implementation of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative, aimed at enhancing statewide education and screening of pregnant women for addiction, 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. Based on the World Health Organization's *Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)* instrument, LaHART screens for prenatal tobacco, alcohol, and drug use as well as domestic violence. This is in keeping with SAMHSA's long range goal of incorporating substance use screenings as a routine component of primary healthcare. The Louisiana Department of Health and Hospitals (DHH) will use state general funds to draw down Medicaid dollars and provide reimbursement to private physicians for screening pregnant women for alcohol and tobacco use. In 2011, under the DHH Birth Outcomes Initiative, the project was elevated to a health care priority under the DHH Office of the Secretary.

The Office of Behavioral Health is collaborating with the Birth Outcomes Initiative (BOI) by providing advisory support and assuming a liaison role between the BOI and the Statewide Management Organization (SMO), Magellan, in addition to OBH's role in monitoring the SMO contract. Additionally, all OBH offices/contractors work to assure timely access to services for pregnant women by adhering to priority admission guidelines.

Screening and Referral for Military Personnel

The Substance Abuse and Mental Health Services Administration (SAMHSA) has 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 limited substance abuse treatment options for any substance abuse cases. The ARNG has the highest illicit drug positive rate in the comparison to the Active Duty Army and 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%. In FY 2012, the LAARNG percentage of illicit drug positives was 3.82%, which was the highest in the nation. Access to Recovery (ATR) Providers who choose to participate in the SASI will be providing screening, brief intervention, and referral to treatment to LAARNG Soldiers who are referred for services. OBH Central Office staff will be providing suicide prevention trainings to LAARNG Units.

Detoxification Services

Detoxification treatment offers a range of intensity of services. This level of care can be provided in an outpatient, inpatient or residential setting if the individual's biomedical conditions or complications are severe and acute enough to warrant primary medical and psychiatric care on a twenty-four hour basis. Treatment in this level 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: This level of care is an organized outpatient service, which may be delivered in an office setting, health care, or addiction treatment facility by trained clinicians, who provide medically supervised evaluation, detoxification, and referral services. 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. Ambulatory detoxification is provided in conjunction with intensive outpatient treatment services (Level II.1).

Level III.2-D Clinically Managed Residential Detoxification: Residential programs provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring, observation, and support in a supervised environment for a person served, to achieve initial recovery from the effects of alcohol and/or other drugs. Provides 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.

Level III.7-D Medically Monitored Residential Detoxification – Adult: Medically monitored residential detoxification is an organized service delivered by medical and nursing professionals, which provide for 24-hour medically supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care

Level IV-D Medically Managed Intensive Inpatient Detoxification: Full-service hospital setting with 24-hour availability of nursing and physician care for medication dispensation and monitoring of all medical and withdrawal symptoms.

During SFY 2013, the service delivery system for detoxification services consisted of three Clinically Managed Residential and five Medically Monitored Residential programs with a total capacity of 74 beds (28 beds and 46 beds, respectively) provided through state-operated and contract facilities. According to the Louisiana Addictive Disorders Data System (LADDS), there were 6,251 client admissions during SFY 2012 to detoxification programs statewide - 994 to

Clinically Managed Residential facilities, 3,253 to Medically Monitored Residential facilities, and 2,004 to Medically Managed Residential facilities. OBH strives to maintain bed capacity for detoxification services; however, reductions in social detoxification bed capacity occurred for SFY 2012 due to budget deficits as well as changes in the service delivery system through privatization efforts. However, OBH expects an expansion of Louisiana's network of providers through the Louisiana Behavioral Health Partnership (LBHP), which will expand services for individuals in need of detoxification services.

Outpatient Treatment

Outpatient services represent the least restrictive and lowest intensity of 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, 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 OBH 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.

With the merger of the Offices of Addictive Disorders and Mental Health into the Office of Behavioral Health, several Regions elected to implement a combined access unit that screened for both mental and addictive disorders and referred to addiction, mental health, or co-occurring services. Others designated an access point, such as one clinic, which completed all admissions. Adaptation of screening, assessment and referral protocol have continued to accommodate the implementation of the Louisiana Behavioral Health Partnership (LBHP). With the implementation of the 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

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 frequency 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 for at least nine hours per week for adults, and at least six hours per week for adolescents, three or four times a week. During SFY 2012, OBH had a total of 363 intensive outpatient client admissions and provided 10,427 services in the intensive outpatient setting per LADDS.

Residential/Inpatient Treatment

Following the completion of primary inpatient 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/inpatient level of care provides services for those individuals who need relatively intense 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 severity of the individual's disorder, and are available twenty-four hours a day, seven days a week. The Office of Behavioral Health (OBH) funds residential/inpatient programs in every Region/LGE of the state. OBH also funds one residential program for compulsive gambling treatment that provides services for the entire state.

Population Served	# Programs	# Beds
Adult	25	600
Adolescent	3	48
Women and Dependent Children	7	88

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 2013, OBH maintained twenty-five adult short-term residential programs, located in five Regions and four Local Governing Entities (LGEs) throughout the state, having a total bed capacity of 600. There were a total of 3,605 admissions to inpatient adult programs and 3,752 admissions to residential programs.

Following 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 per week of a combination of low-intensity clinical and recovery-focused services. 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 per week of a combination of medium-intensity clinical and recovery-focused services. 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: Designed to treat persons who have significant social and psychological problems. Programs 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, 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, COD treatment providers must have experience and preferably licensure and/or certification in both addictive disorders and mental health.

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, the ATR program provides both clinical treatment and recovery support services to persons with addictive disorders. ATR's treatment model design impacts the addictive disorders population who does not typically engage in traditional treatment models; offers a service system of faith and community-based providers who are accustom to the cultural needs of the populations within their local communities; and provides additional recovery support services which help ATR clients to maintain abstinence and a lead recovery-oriented lifestyle.

The United States Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) awarded Louisiana its first Access to Recovery grant (ATR-I) in 2004. The Access to Recovery program was created as a Presidential initiative to provide client choice among substance abuse clinical 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 5 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 and methamphetamine users.

Through the ATR grant awards, Louisiana developed a unique and comprehensive electronic voucher and clinical case record system which advocates "client choice." The maximum lifetime of a client's voucher is four months, with the average cost per voucher being $1,410 (including administrative costs) for SFY 2012. The administration of the program involves remote on-line and on-site monitoring by a highly skilled team of Office of Behavioral Health (OBH) program managers and program monitors 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 have been included in dialogue regarding plans to pursue and achieve accreditation standards in order to serve the Medicaid population.

DHH's Limited Liability Schedule expands services to the indigent adult population with clinical treatment and recovery support services, along with the adolescent population (18 years and under) who do not qualify for Medicaid. The Louisiana Behavioral Health Partnership (LBHP) serves the Medicaid population and does not currently provide Recovery Support Services for persons with addictive disorders.

ATR has a total of 42 providers. 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 eight (8) Regions/Local Governing Entities (LGEs) throughout the State:

Access to Recovery (ATR) Providers	
Region or LGE	**ATR Vendors**
MHSD	3
CAHSD	9
SCLHSA	2
AAHSD	5
Region V	0
Region VI	0
Region VII	2
Region VIII	9
FPHSA	4
JPHSA	8
Total – June 30, 2012	**42**

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

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.

ATR will continue to provide payment to providers for clinical services not reimbursable under the LBHP, including drug screening and GPRA discharge.

Approximately 2,979 persons received ATR services during the SFY 2012, of which 70% completed treatment. As of June 30, 2012, the ATR budget was $4.2 million for SFY 2013 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 Gant option to maintain a revolving loan fund process for the development of recovery group homes (*SAPT Block Grant Federal Goal 7:*

Development of Group Homes). Historically, home loans were made available by the State for the development of Oxford homes - 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 2012, 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 Regional/LGE Administrators continue collaborations to locate and lease housing to serve recovering individuals. Oxford homes are currently in all Regions/LGEs of the state (except SCLHSA) with 67 operational homes and a total of 493 beds. Of these homes, 48 are for men with 362 beds, 15 are for women with 100 beds, and 4 are for women and children with 31 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 discussed as well. Oxford House, Inc. opened its first women and children's home in the Baton Rouge Chapter in 2011. Due to budget restraints, OBH no longer pays for resident attendance at the Oxford national conference but continues to provide funding for the state conference.

Co-Occurring Disorder Treatment for Adults

Reports published in the Journal of the American Medical Association (JAMA) indicate that approximately half of individuals with severe mental health disorders are also affected by addiction. The same reports reveal that 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness, and that out of all those diagnosed with mental illness, approximately 29% abuse either alcohol or drugs. Current data indicate that out of all individuals treated in mental health programs, 49% have a co-occurring addictive disorder. It is also estimated that 46% of consumers treated for addictive disorders have concurrent mental illness.

Evolution of Integrated Treatment

In 2003, the State of Louisiana was part of the first cohort of states awarded the Co-Occurring State Infrastructure Grant (CoSIG) – an integrative project between the Office of Mental Health (OMH) and the Office for Addictive Disorders (OAD). 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 the Offices of Mental Health and Addictive Disorders 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 Region and 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.

Recent Co-occurring Efforts

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. Rule writing is currently underway.

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:

- Co-occurring Disorder Competency Assessment Instrument for use by licensing boards to demonstrate how licensure may/may not satisfy the adopted COD competencies and an accompanying instructional document

- Co-occurring Disorder Portfolio Review Form to measure practitioner adherence to the adopted COD standards and an accompanying instructional document
- Draft OBH and Licensing Board Meeting Agenda and Outline

Currently, the State is exploring ways to incentivize the credential and similar efforts in other states that have implemented managed care for behavioral health services, and is preparing to host a meeting with representatives of each licensing board in order to move toward implementation of the co-occurring disorder credentialing process. During the meeting, the State will review with board representatives the assessment instrument so that each can complete the assessment process on behalf of their respective discipline.

During SFY 2013, OBH maintained the Red River (Pathways) twenty-seven (27) bed Level III.7 Medically Monitored Intensive Residential Treatment (Co-occurring Unit) in Pineville, Louisiana (Region VI). Red River was one of six facilities included in the current statewide plan for privatization of adult inpatient and residential services that began in SFY 2010, as privatization is considered a more efficient means to deliver services. Through the RFP process, a contract was awarded to Pathways Community Behavioral Healthcare, Inc. and the facility was transferred to their operation in February, 2011. The Red River Co-occurring Inpatient Unit administered by Pathways will continue operations addressing all four behavioral health quadrants - low mental health/low substance abuse, high mental health/low substance abuse, high substance abuse/low mental health, and high mental health/high substance abuse - for individuals diagnosed as having both mental health and addictive disorder needs.

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 twenty-four hour facilities accept statewide admission. Outpatient programs are also available statewide.

OBH has continued to maintain specialized intensive outpatient treatment (IOP) programs for adolescents throughout the state until recent budget cuts reduced those services. Adolescent IOP programs are presently funded with state general funds, and several Regions/LGEs were unable to maintain their adolescent IOP programming due to budgetary cutbacks. At the time of this reporting, there are two adolescent IOP programs statewide located in the following Regions: Lake Charles (Region V) and Alexandria (Region VI).

During SFY 2013, OBH maintained three adolescent residential programs with a total statewide bed capacity for adolescents of 48. The three facilities are Gateway Adolescent Treatment Center, Cavanaugh Center, and Odyssey House, located in the Alexandria (Region VI), Shreveport (Region VII), and New Orleans (MHSD) areas, respectively.

Gateway Adolescent Treatment Center provides residential treatment services for sixteen adolescents, ages 12 through 17. Ten of these beds were allocated as male beds and six beds were allocated as female beds. Bed capacity was reduced from 26 to 16 beds in order to meet Centers for Medicare & Medicaid Services (CMS) IMD requirements. The average length of stay at Gateway Treatment Center was between 45 and 50 days. 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. The average length of stay at this facility was between 60 and 120 days. 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.

Comprehensive Screening and Assessment for Adolescents

The Office of Behavioral Health and its treatment providers continue to utilize an electronic version of the Comprehensive Adolescent Severity Inventory (CASI) for adolescents. This comprehensive assessment guides patient placement decision making. The assessment tool, developed by Kathleen Meyers, Ph.D., incorporates best practices for adolescents and addresses the client's health status, stressful life events, educational status, social networks and support, peer relationships, sexual behavior, family relationships, legal issues, mental health status of the adolescent client, and other pertinent issues. Training and proficiency on the administration of the CASI is a requirement before a treatment provider can utilize the instrument. During SFY 2013, due to implementation of the Louisiana Behavioral Health Partnership (LBHP), providers are currently administering the CASI using the Statewide Management Organization (SMO) web-based system, Clinical Advisor.

Treatment Models Utilized for Adolescent Substance Use Disorder Treatment

Regions and 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 twelve 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 model available through Hazelden and addresses teen drug use of any type.

- *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.

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) will serve adolescents ages 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. Through the development of two learning laboratories with collaborating local community-based treatment provider sites during year one and five additional sites during each of years two and three, Louisiana will be 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. 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. Data collection will occur through the Access to Recovery (ATR) electronic health record that was created exclusively for the reporting of National Outcomes Measures (NOMs) through GPRA survey collection. Data will be analyzed by a professional grant evaluator to ensure that both process and outcome objectives have been met.

Addressing Needs and Gaps – Future Planning

Adolescents are underserved in comparison to other populations in need of treatment. Of primary concern has been the absence of a full array of services for adolescents. Areas of focus for program development include adoption of evidence-based practices for assessment and outpatient treatment as well as establishment of an appropriate range of inpatient/residential options. Through the implementation of the Coordinated System of Care (CSoC), adolescents with co-occurring disorders and a significant level of need can access a host of specialized services, including individualized care planning through a Wraparound Agency, parent and youth support and training, crisis stabilization, short-term respite, and independent living/skills building. Recovery Support Services (RSS) will also be expanded for more adolescents.

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 *(SAPT Block Grant Federal Goal 12: Coordinate 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 & 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. 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 both state-operated and 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, 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.

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 eighty-eight 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 Regions/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 Elaine Hunt Correctional Center for Women. OBH has a 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. 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. Juvenile judges often order youth to DHH/OBH custody as a diversion which requires OBH to place the youth in the hospital and then to find 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 Regions/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 are currently under review by the Bureau of Health Standards and are being prepared for review by the public during SFY 2013. In addition to this process, the Office of Behavioral Health proposed to collate the Addiction and Mental Health Standards to create one Behavioral Health Minimum Standards.

Medicaid

OBH worked with the Louisiana Department of Health and Hospitals (DHH) Bureau of Health Services Financing Authority to obtain Medicaid funding for substance use disorder treatment services. In SFY 2011, DHH made the decision to include treatment services for substance use disorders in the Medicaid Bayou Health plans, for both adolescents and adults. OBH collaborated with Medicaid to bring this plan to fruition, including revisions of service definitions.

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 *(SAPT Block Grant Federal Goal 9: Pregnant Women Preferences).* This approved policy has been posted on the agency SharePoint site whereby Region/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.

OBH state-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 Region/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% capacity. Eventually, this management component will be incorporated into Clinical Advisor, which is the Statewide Management Organization's (SMO's) web-based system.

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 (*SAPT Block Grant Federal Goal 16: Disclosure of Patient Records*).

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.

During SFY 2012, confidentiality training was provided or made available online to staff in both state operated and contract programs in OBH Regions/LGEs. 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 Region/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

Beginning in SFY 2005, the Office for Addictive Disorders engaged in training activities geared toward implementation of Charitable Choice regulations *(SAPT Block Grant Federal Goal 17: Charitable Choice)*. These regulations are federally mandated under 42 U.S.C. 300x-65 and 42 C.F.R. The goal of Charitable Choice is not to support or sponsor religion, but to ensure fair competition among providers of services whether they are public or private, secular or faith-based.

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, and OBH implements this policy 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 state-operated and contract provider programs, to prohibit the use of SAPT Block Grant funds to provide individuals with hypodermic needles and syringes *(SAPT Block Grant Federal Goal 14: Hypodermic Needle Program).* 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 *(SAPT Block Grant Federal Goal 3: Providing Specialized Services for Pregnant Women and Women with Dependent Children).* 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.

During SFY 2012, there were at total of 240 pregnant women admissions and 327 pregnant women served. OBH provided approximately 3,437 services to this client population. According to the Block Grant Set Aside Reports, OBH provided 997 interim services to pregnant women during SFY 2012. 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.

According to LADDS, there were a total of 4,845 women with dependent children admissions and 6,230 women with dependent children served. OBH provided 62,717 services to this population during SFY 2012.

In urban areas, OBH may have more than one residential facility providing services in an area, such as in the New Orleans area. There are also a couple of Regions/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 in another Region/LGE where services are available.

OBH monitors pregnant women and women with dependent children services, using admission data generated by the LADDS Data System. Regional/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. Regions/LGEs and OBH Central Office staff also monitor the adequacy of efforts to meet the specific needs of women by reviewing admission data and census data (Monthly Production and Utilization Reports), which include waiting list reports and field surveys.

OBH 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 2012:

1) CENLA Chemical Dependency Council, Alexandria (Region VI), maintained a bed capacity of 14 for women and children under the age of 12. This program provided a community-based rehabilitation program in a residential house setting.
2) Odyssey House of Louisiana, Inc. (OHL), New Orleans (MHSD), provided substance use disorder services to high-risk pregnant women, single women, and women with dependent children in a multi-collaborative therapeutic community setting. OHL maintained its capacity to serve a total of twenty-seven (27) women and their children at any given time.
3) Grace House, New Orleans (MHSD), maintained 20 beds for women only. The average length of stay at this facility is between three to six months.
4) Rays of Sonshine, Rayville (Region VIII), maintained 15 beds at this facility reserved for women, including pregnant women. This facility utilizes a therapeutic community model with some emphasis on the 12 Step Model.
5) The Alcohol and Drug Unit, Mandeville (FPHSA), is a twenty-eight day inpatient unit for 12 women and 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), is another twenty-eight day inpatient facility that serves 14 male and female clients, including 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.

7) Louisiana Health and Rehabilitation Center-Options, Baton Rouge (CAHSD), provides services for 17 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.

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 (*SAPT Block Grant Federal Goal 4: Services to Intravenous Drug Abusers*). 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 Region/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:

(a.) pregnant injecting drug users first
(b.) other pregnant substance abusers second
(c.) other injecting drug users third
(d.) all other individuals fourth

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 Regional/LGE contract monitors review this stipulation for compliance on a quarterly basis.

During SFY 2012, there were a total of 4,715 IDU client admissions and 5,219 IDU clients served across all levels of care. This population received approximately 16,861 services. The Block Grant Set Aside Reports for SFY 2012 submitted by the Regions/LGEs recorded 2,415 interim services and 1,641 outreach services provided to this population.

42 U.S.C. 3000x-23 (a)(1) requires that any program receiving amounts from the SAPT Block Grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. To monitor program compliance with this statute, OBH conducts executive staff and quarterly meetings with regional administrators/LGE executive directors and generates special reports (Utilization Report, Productivity Report and LADDS Reports). State operated and contract programs utilize the web-based daily census to report and document when 90% capacity is reached or exceeded. OBH regional administrators/LGE executive directors and OBH Central Office staff also conducts periodic reviews and compare available data regarding capacity and IDU admissions.

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 state-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 organization 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 directly, or through arrangements with other public or private entities, routinely makes available tuberculosis (TB) services to each individual receiving addiction treatment and monitors TB treatment service delivery (*SAPT Block Grant Federal Goal 5: Tuberculosis Services*). 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 Regions/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 U.S.). 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 2012, OBH provided tuberculosis testing to 7,899 clients admitted to treatment programs and 174 yielded positive results. According to the Block Grant Set Aside Reports, OBH provided a total of 24,902 TB related services, with 14,426 of these services offered to TB positive clients.

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

Programs are monitored to ensure compliance with guidelines and requirements. Each Region/LGE submits quarterly reports to OBH Central Office documenting services provided, which include number of services, number of tests, and number tested positive. During compliance checks, if programs are cited, they must develop and submit corrective action plans to correct noted findings. OBH adheres to 42 CFR and all department confidentiality policies in providing TB services.

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 *(SAPT Block Grant Federal Goal 6: HIV Services).*

At least 5% of Block Grant allocations are spent on HIV services. All clients are screened for risk behaviors and offered an HIV test. In SFY 2012, OBH tested 2,807 clients for HIV. Of those tested, 29 were positive for HIV. OBH provided 27,491 HIV services to this population. Of those services, 16,334 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. State operated and contract providers offered 2,768 pre-test counseling services and 2,760 post-test counseling services across all levels of care during SFY 2012.

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 Regions/LGEs are providing Rapid Testing and completing pre-test and post-test counseling. The Block Grant Set Aside Report has been revamped, in order to improve the monitoring of each state facility or state contract which submits quarterly set-aside numbers. This new report was utilized during the FY 2012 reporting period.

Each Region/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, contract monitoring, and 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, Regions and 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 Region and LGE.

Addictive Disorder Service Provider Independent Peer Review

The Office of Behavioral Health (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 (*SAPT Block Grant Federal Goal 15: Independent Peer Review*).

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 Regional/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 Region/LGE (total of 10 treatment programs reviewed annually). This represents approximately 21% of the total number of

substance use disorder treatment programs and exceeds the 5% 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.

During 2011, due to travel restrictions and budget cutbacks, OBH obtained permission to use video conferencing as an alternative option to statewide travel. During 2012, OBH completed the annual peer review process as detailed in the table below:

Region/LGE (Reviewer)	Region/LGE - Program Reviewed	Date of Review
MHSD	SCLHSA - OP	12/20/2011
CAHSD	AAHSD – Administration	3/20/2012
SCLHSA	MHSD – OP	12/20/2011
AAHSD	CAHSD - Administration	3/27/2012
Region V	Region VI – OP	4/12/2012
Region VI	Region V – OP	4/10/2012
Region VII	Region VIII – OP	5/31/2012
Region VIII	Region VII - OP	6/1/2012
FPHSA	JPHSA - Administration	8/28/2012
JPHSA	FPHSA – Administration	8/28/2012

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 Regions/LGEs and the OBH Central Office staff representative; Regional/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.

Regions and LGEs are paired to review continuum of care components (outpatient, inpatient, detoxification, residential), including administrative services. Assessment tools are utilized for treatment and administrative services. The Regions and LGEs assigned are rotated. Each continuum of care is reviewed before rotation. An OBH Central Office staff person, the Regional/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

The Office of Behavioral Health (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 (*SAPT Block Grant Federal Goal 11: Continuing Education)*. 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 (Essential Learning) to identify current and/or immediate training needs at the state, regional/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 regional/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 Region/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. To date during FY 2013, OBH has provided over 3,000 hours of training specific to substance abuse treatment and prevention and had approximately 900 Louisiana Behavioral Health Partnership (LBHP) providers trained in co-occurring disorders as part of their required orientation to the new managed care model of treatment managed through the LBHP. Assessment training during the past year and presently has been focused primarily on the Addiction Severity Index (ASI), with training documented for over 60 staff statewide year to date.

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. The 2012 NASW annual conference was held in Baton Rouge, Louisiana on March 14th through 16th. During the conference, there were 70 different sessions focused on topics such as veterans, children and youth (including bullying prevention), aging, criminal justice/corrections, mental health and addiction, suicide intervention, PTSD, ethics, trauma, and grief and loss. The conference provided an opportunity for staff to earn up to 21 hours of CEUs. The DHH Deputy Assistant Secretary and the OBH Assistant Secretary presented a plenary session entitled "Health and Human Services: the Months Ahead," on the major Medicaid reforms changes occurring in the state and implementation of the Louisiana Behavioral Health Partnership (LBHP). The LASACT conference was held in Baton Rouge, Louisiana on July 29th through August 1st, 2012. The theme for the conference was "Practical Applications to Effect Positive Change". Dr. Rochelle Head-Dunham, the OBH Director of Adult Operations and Medical Director, provided a series of six presentations, including the following: "ASAM PPC, Introduction and Key Concepts," "Components and Process: An Overview," "Components and Process I and II: Application," "Service Authorization Criteria," and "Billing and Coding."

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

Training Topic	**Participants**
Science Behind Addiction	37
Gambling Addictions	33
Psychopharmacology	27
Trauma Informed Services	34
Risk and Resiliency Prevention Basics	16
Applied Suicide Intervention Skills	38
Serving Federal Probation and Parole Clients	43
Smoking Cessation	18
Pharmacotherapy for Co-Occurring Disorders	12
Substance Abuse v. Dependence	19
Adolescent Brain Development & Substance Abuse	75
Confidentiality of Substance Abuse Treatment Information	72

PLANNING STEP TWO: IDENTIFICATION OF UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM

Comprehensive Behavioral Health Services – Needs and Gaps

Adults and Children/Youth

In the National Alliance on Mental Illness (NAMI) 2009 Report Card, Louisiana continued to maintain a poor grade of "D." This ranking had not changed in the previous several years with noted problems related to access and overutilization of the correctional system to house and treat the SMI population. According to a November, 2011 report by NAMI (*State Mental Health Cuts: The Continuing Crisis*), Louisiana was one of 29 states with reduced state mental health budgets from FY 2009 to FY 2012. The State's per capita spending on mental health services ($71.80) was below the national average of $122.90 during FY 2009. Based on data from the Centers for Disease Control, Louisiana ranked 34th among the states in its rate of suicides during 2010, which was lower than the State's ranking during the previous year (28th). The State's rate of suicides per 100,000 population (12.3) was slightly lower than the national rate (12.4). Per the Center for Behavioral Health Statistics and Quality at SAMHSA, National Survey on Drug Use and Health 2010 and 2011, Louisiana is among the top ten states with the highest rates of the following:

- Past Month Cigarette Use among those 12 and older (26.99%) and specifically among those age 26 and older (27.76%)
- Needing but not Receiving Treatment for Illicit Drug Use among those age 26 and older (1.47%)

Louisiana is among the top twenty states with the highest rates of the following:

- Past Month Use of Illicit Drugs Other than Marijuana among those 12 to 17 (4.39%)
- Past Year Nonmedical Pain Reliever Use among those 12 and older (4.87%) and specifically among those ages 18 to 25 (11.6%)
- Past Month Alcohol Use among those ages 12 to 17 (14.1%)
- Past Month Tobacco Product Use among those 12 and older (30.73%) and specifically among those age 26 and older (31.47%)
- Past Month Cigarette Use among those ages 12 to 17 (9.14%)
- Past Year Any Mental Illness among those ages 18 and older (21.11%) and specifically among those age 26 and older (19.52%)

Per the Kaiser State Health Facts (2011), approximately 35% of the adult population in Louisiana reported "poor mental health" during the past 30 days. This figure has increased since the previous year, during which 32% of adults reported "poor mental health." 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 89,873 adults with serious mental illness (SMI) in Louisiana, OBH reported a caseload of 30,308 adults at the end of SFY 2012 (as of 6/30/12). Of the estimated 256,007 persons aged twelve and older in need of substance use disorder treatment in Louisiana, OBH reported a total of 33,396 persons served in SFY 2012.

In the Annie E. Casey Foundation Kids Count Data Book (KID Count, 2012), Louisiana continues 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 improvement

from the 2011 publication, in which Louisiana was ranked 49th. Louisiana ranked poorer than the nation for the following indicators:

	Louisiana	United States
Economic Well-Being Indicators (Rank = 47th)		
• Children in poverty: 2010	27%	22%
• Children whose parents lack secure employment: 2010	36%	33%
• Teens not in school and not working: 2010	14%	9%
Education Indicators (Rank = 45th)		
• Fourth graders not proficient in reading: 2011	77%	68%
• Eight graders not proficient in math: 2011	78%	66%
• High school students not graduating on time: 2008/2009	33%	24%
Health Indicators (Rank = 39th)		
• Low-birth weight babies: 2009	10.6%	8.2%
• Child and teen deaths per 100,000: 2009	43	27
Family and Community Indicators (Rank = 48th)		
• Children in single-parent families: 2010	45%	34%
• Children in families where the household head lacks a high school diploma: 2010	17%	15%
• Children living in high-poverty areas: 2006-2010	17%	11%
• Teen births per 1,000: 2009	53	39

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 100,638 children with serious emotional/ behavioral disorders (SED) or Emotional Behavioral Disorders (EBD) in Louisiana, OBH reported a caseload of 6,342 children and youth at the end of FY 2012 (as of 6/30/12), revealing that 6% of the estimated children with serious emotional disturbances (SED) were being served in OBH clinics. The children's behavioral health system in Louisiana was historically fractured, with several child-involved agencies providing duplicative and inefficient behavioral health services in an attempt to overcome these failings. The Louisiana Behavioral Health Partnership (LBHP), and in particular, the Coordinated System of Care (CSoC), were implemented during 2012 in order to address these gaps. During the first year of LBHP implementation (March, 2012 through February, 2013), approximately 63,000 adults and 54,000 children were served, including 1,300 children and youth served through CSoC.

Older Adults

Services for older persons with behavioral health disorders are a statewide area of need. Within the Department of Health and Hospitals, the Office of Aging and Adult Services collaborates with OBH to address the needs of older adults. Specific Regions and LGEs report having some programming that targets older citizens, however, the need is great, and the services are not consistently available across the state.

Evidence-based Practices

The Office of Behavioral Health (OBH) continues to explore its ability and capacity to expand the provision of Evidence-based Practices (EBPs) through interdepartmental relationships with state

agencies and through the Louisiana Behavioral Health Partnership. The Office of Behavioral Health has also partnered with the Institute for Public Health and Justice and the MacArthur foundation to explore a dissemination model for EBPs statewide, based on the Institute's prior success in implementing EBPs for youth involved in the juvenile justice system statewide over the past five to six years. Further development of the community-based system of care in order to successfully manage and support persons in community settings remains a focus for the State.

Recovery Support Services

Multiple mental health recovery support services are available for persons with SMI/EBD statewide; however, the sole OBH initiative addressing substance use disorder recovery support services is the Access to Recovery initiative, which is not consistently available due to limited funding. The Louisiana Access to Recovery program has demonstrated that use of recovery supports like transportation, child care, parenting and life skills training increases positive outcomes by 20%. OBH intends to focus on the expansion of recovery support service development.

Transportation: Louisiana is a largely rural State, with approximately 27% of the total population living within rural areas per the U.S. Census Bureau (2010 Census). Consumer surveys consistently rate transportation as a major impediment to the receipt of behavioral health services. The lack of transportation resources not only limits access to mental health and substance use disorder services, but also limits access to employment and educational opportunities.

Housing: Adequate, safe, and affordable housing for persons with serious mental illness and substance abuse continues to be a great need within the state. Aside from the dire need for rental subsidies and the increase of affordable available housing, there is a considerable need for community based support services to assist people with mental health and substance use disorders. At a minimum, an increase in available outreach programs, such as those provided through the Projects to Assist in the Transition from Homelessness (PATH), that include assessments, stabilization and preliminary treatment services, transportation, and advocacy is needed. Easy availability to resource centers for use as address and telephone communication sites are also needed.

The HUD 2012 Homeless Point in Time report for the state of Louisiana indicates that there are over 3,871 unsheltered individuals in households without children and 81 individuals with children that are unsheltered. A total of 7,771 were reported to be homeless. The report also documented that there were 1,364 individuals and families in emergency shelters and 2,432 that were in transitional housing programs. More specifically, it was documented that in the metropolitan area of Orleans Parish there were 3,439 of the 3,975 unsheltered in 2012. In other words, 87 percent of the homeless that are unsheltered were reported to be in the New Orleans metropolitan area. The survey data indicated the following for the subpopulations in metropolitan New Orleans: severe mental illness – 766 (27 percent); chronic homelessness – 649 (23 percent); HIV/AIDS - 102 (4 percent); substance abuse - 888 (32 percent); veterans - 211 (7 percent); and domestic violence – 212 (7 percent). Experience suggests that persons with mental illness are underserved in the general shelter population because of their psychiatric need and, therefore, there may be significant numbers of *unsheltered* homeless who have a mental illness. It is also likely that there are a number of persons *sheltered* who are undisclosed as having a mental illness and, therefore, their mental illness is undetected and not included in the

count. In addition, prevalence of substance abuse among adults with serious mental illness is between 50-70%.

The recent Point in Time (P-N-T) survey (2012) reported the total number of "literally homeless" persons in all of Louisiana was 5,994. The total numbers for 2013 are not complete for the entire state. Literally homeless persons are those who live in emergency shelters or transitional housing for some period of time, or who sleep in places not meant for human habitation (streets, parks, abandoned buildings, etc.) and may use shelters on an intermittent basis. The Point in Time survey is limited in its population coverage; for instance, unsheltered persons are difficult to identify and count, not all identified persons are willing to release information, and/or persons are undocumented because they do not seek services from a participating provider during the survey period. Therefore, by a conservative estimate, on any given day, there may be as many as twice the *reported* count of homeless adults and children living in Louisiana.

The goal of having available, accessible rural mental health services and services for homeless consumers across the state remains a challenge, and has become more so, given strained resources, staffing shortages, and the economy. Rural services, transportation, and services for the homeless populations will continue to be priorities for the State. One desired outcome of the transfer of the management of behavioral health services to the Statewide Management Organization is the expectation that they will be able to build a more robust provider network, even in the more rural areas of the state. The ability of the Statewide Management Organization (SMO) to use mapping technology to monitor services and service providers throughout the state will continue to help in shaping the network of providers and services by identifying gaps in services and locating where additional providers may be needed. Increased availability of recovery support services is necessary to fit the needs and individual aspirations of persons with severe mental illness and substance use disorders.

Fiscal and Workforce Constraints

Fiscal and workforce constraints have created a situation where there is demand for services beyond what the system is able to supply. The economic downturn has placed additional pressure to this vulnerable service system. Insufficient numbers of direct service providers to address basic treatment and support needs of the community service population continues to be problematic. The State has struggled with providing adequate access to services, and many citizens have not been served. The lack of treatment resources inhibits the ability of the State to provide as much in the way of outreach programming as would be ideal.

Office of Behavioral Health System Data Epidemiology – Incidence & Prevalence Estimates

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. Effective March 1, 2013, 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. As such, the means of capturing and reporting the number and characteristics of persons served through behavioral health programs and services statewide resides in their proprietary system called Clinical Advisor (CA). CA also provides the means for reporting the number of persons served relative to the estimated prevalence of need in the-general population (discussed further below). In addition to Magellan's CA, OBH has continued to operate the legacy system called the Louisiana Addictive Disorders Data System (LADDS) for addictive disorders providers not currently using Clinical Advisor. A description of additional systems utilized by OBH, such as those used for prevention services and the state-operated inpatient psychiatric facilities, can be found in Section IV – Q. Data and Information Technology.

When OBH was reorganized, a Business Intelligence (BI) Section was created, integrating the staff and organizational functions that were formerly separate under the former Offices of Mental Health and Addictive Disorders. The mission of the Business Intelligence Section is 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 BI group regularly provides information, training, and technical assistance to regional, Local Governing Entity (LGE), clinic, facility, state office, and private provider staff/personnel on how to access and utilize program data.

Electronic Behavioral Health Record System Initiative

To effectively coordinate care in a fractured system, the Louisiana behavioral health providers use the Clinical Advisor application, which is built upon the ClaimTrak platform. This application offers providers a Web-based, fully customized electronic health record designed specifically for use by the behavioral health profession. This health information technology solution gives providers the advantages of greater data functionality without additional infrastructure investment for their practices.

Louisiana's chosen Statewide Management Organization (SMO) vendor has committed to fully certifying its EHR by an Office of the National Coordinator for Health Information Technology (ONC) Accredited Certifying Body. Providers and the vendor will continue to improve their meaningful use of the system according to ONC and Centers for Medicare & Medicaid Services (CMS) guidance under the Medicaid and Medicare EHR Incentive programs. Central to meaningful use is the ability for clinical data to be shared between disparate care settings and providers. Clinical Advisor will interface with the Louisiana Health Information Exchange (LaHIE) to allow the sharing of a continuity of care document. Through LaHIE, behavioral health providers will be able to directly download physical health clinical data to their EHR (if they so choose). The system

offers role-based functionality for multiple staff groups including prescribers, nurses, residents, case managers, behavioral health specialists, therapists, and administrative and executive level staff.

OBH Data Warehouse/Business Intelligence 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, 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, that 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 Region/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 LA 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.

OBH is also in the process of creating a more comprehensive and integrated Data Warehouse/Business Intelligence (DW/BI) system to address the agency's needs for managing and evaluating the operations of the Statewide Management Organization (SMO). This more comprehensive DW/BI system will build upon the foundation of the existing system. It will need to address the wide-range of reporting requirements outlined in the Quality Management Strategy for the SMO.

Data Definitions & 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 or 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 (i.e., 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, whose thinking is frequently confused, whose behavior may be grossly inappropriate and bizarre, and whose 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 whose 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. This category 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) There is substantial risk that the impairment or pattern or inappropriate behavior(s) will persist for an extended period;
3) There is a 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

Assessment of Need: Services and System Infrastructure

Louisiana Population and Prevalence Estimates *(CMHS Block Grant Criterion 2)*

For years, Louisiana population figures were extremely difficult to estimate based on the mass evacuations and relocations following Hurricanes Katrina and Rita in 2005, and Hurricanes Gustav and Ike in 2008. The *2005 American Community Survey Gulf Coast Area Data Profiles: September through December, 2005 (revised July 19, 2006)* was released in an attempt to measure the population post–hurricanes, and at that time there had been a dramatic loss in population. There were estimated to be 3,687,996 individuals in Louisiana (2,742,070 adults, and 945,926 children). The Population Division of the US Census Bureau recently published the *Annual Estimates of the Resident Population by Single-Year 7/1/2011 - State Characteristics Population Estimates (Released May, 2012)*. The data are listed in the tables below. A comparison of these sets of figures shows that the trend is for Louisiana's population to once again increase, now having passed the 2005 levels. The 2011 numbers indicate that there were **4,574,836** persons living in the state, showing that the population has rebounded from the post-hurricane drop as compared to the 2000 Census, when there were a total of 4,468,978 persons living in Louisiana.

POPULATION BY AGE

State's Population By Age Range*		
Age Range	**Number of Persons**	**Percentage of State's Population**
0-17	**1,118,196**	**24%**
18+	**3,456,640**	**76%**
TOTAL	**4,574,836**	**100%**

*Based on Annual Estimates of the Resident Population 7/1/2011 Annual State Population Estimates by Demographic. Estimates Source: Population Estimates Division, US Census Bureau. Release Date: May, 2012.

Mental Health: Population and Prevalence Estimates

According to the *2011 Annual Estimates of the Resident Population 7/1/2011 State Characteristics, Population Estimates Division, U.S. Census Bureau (released May, 2012)*, the total number of adults in Louisiana is **3,456,640**. Of these, according to national benchmarks, **2.6%** are expected to have Serious Mental Illness (SMI). That translates into a total of **89,873** 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 **1,118,196**. Of these, according to national benchmarks, **9%** are expected to have an Emotional or Behavioral Disorder (EBD). That translates into a total of **100,638** children and youth with an EBD in Louisiana based on national prevalence rates.

Statistics show that 26,744 adults with SMI received outpatient services through OBH and the LBHP in FY 2012 in Community Mental Health Clinics. Of the total number of adults served, both with and without SMI (37,817), 71% met the definition of Seriously Mentally Ill (SMI). Statistics show that 4,679 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 (8,527), 55% 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 regions and LGEs.

Estimates of the prevalence of mental illness within the state, parishes, regions, 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, 2011 - (Released May, 2012)

	Child/Youth = 9%		Adult = 2.6%		Total	
Statewide	Population Count	Prevalence Count	Population Count	Prevalence Count	Population Count	Prevalence Count
	1,118,196	100,638	3,456,640	89,873	4,574,836	190,510

* **2011 Annual Estimates of the Population for Parishes of Louisiana**

Estimates Source: Population Division, US Census Bureau. Release Date: May, 2012.
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 Region/LGE and Parish (July 1, 2011 Pop Est)*

Region/LGE	PARISH	CHILD/ YOUTH (Age 0-17) Population Estimate	CHILD/ YOUTH (Age 0-17) Prevalence Estimate	ADULT (Age 18 and up) Population Estimate	ADULT (Age 18 and up) Prevalence Estimate	TOTAL Population Estimate JULY 1, 2011	TOTAL Prevalence Estimate
Metropolitan Human Service District (MHSD)	Orleans	77,248	6,952	283,492	7,371	360,740	14,323
	Plaquemines	6,459	581	17,169	446	23,628	1,028
	St. Bernard	10,183	916	29,375	764	39,558	1,680
Total for MHSD		93,890	8,450	330,036	8,581	423,926	17,031
Capital Area Human Service District (CAHSD)	Ascension	31,178	2,806	78,807	2,049	109,985	4,855
	East Baton Rouge	101,644	9,148	339,794	8,835	441,438	17,983
	East Feliciana	4,136	372	15,981	416	20,117	788
	Iberville	7,365	663	25,865	672	33,230	1,335
	Pointe Coupee	5,470	492	17,233	448	22,703	940
	West Baton Rouge	5,978	538	18,131	471	24,109	1,009
	West Feliciana	2,607	235	12,853	334	15,460	569
Total for CAHSD		158,378	14,254	508,664	13,225	667,042	27,479
South Central Louisiana Human Services Authority (SCLHSA)	Assumption	5,542	499	17,611	458	23,153	957
	Lafourche	23,418	2,108	73,248	1,904	96,666	4,012
	St. Charles	13,894	1,250	38,623	1,004	52,517	2,255
	St. James	5,509	496	16,275	423	21,784	919
	St. John the Baptist	12,009	1,081	33,212	864	45,221	1,944
	St. Mary	13,651	1,229	40,559	1,055	54,210	2,283
	Terrebonne	28,896	2,601	83,021	2,159	111,917	4,759
Total for SCLHSA		102,919	9,263	302,549	7,866	405,468	17,129
Acadiana Area Human Services District (AAHSD)	Acadia	16,800	1,512	45,182	1,175	61,982	2,687
	Evangeline	9,096	819	24,800	645	33,896	1,463
	Iberia	19,846	1,786	53,554	1,392	73,400	3,179
	Lafayette	54,588	4,913	169,802	4,415	224,390	9,328
	St. Landry	22,697	2,043	60,855	1,582	83,552	3,625
	St. Martin	13,818	1,244	39,099	1,017	52,917	2,260
	Vermilion	15,491	1,394	42,785	1,112	58,276	2,507
Total for AAHSD		152,336	13,710	436,077	11,338	588,413	25,048

Region/LGE	PARISH	CHILD/ YOUTH (Age 0-17) Population Estimate	CHILD/ YOUTH (Age 0-17) Prevalence Estimate	ADULT (Age 18 and up) Population Estimate	ADULT (Age 18 and up) Prevalence Estimate	TOTAL Population Estimate JULY 1, 2011	TOTAL Prevalence Estimate
Region 5	Allen	5,848	526	19,909	518	25,757	1,044
	Beauregard	9,332	840	26,797	697	36,129	1,537
	Calcasieu	48,760	4,388	145,332	3,779	194,092	8,167
	Cameron	1,655	149	5,075	132	6,730	281
	Jefferson Davis	8,397	756	23,297	606	31,694	1,361
Total for Region 5		73,992	6,659	220,410	5,731	294,402	12,390
Region 6	Avoyelles	10,062	906	31,833	828	41,895	1,733
	Catahoula	2,341	211	7,984	208	10,325	418
	Concordia	5,226	470	15,650	407	20,876	877
	Grant	5,048	454	17,083	444	22,131	898
	La Salle	3,517	317	11,468	298	14,985	615
	Rapides	34,030	3,063	98,344	2,557	132,374	5,620
	Vernon	14,327	1,289	37,780	982	52,107	2,272
	Winn	3,380	304	11,700	304	15,080	608
Total for Region 6		77,931	7,014	231,842	6,028	309,773	13,042
Region 7	Bienville	3,285	296	11,050	287	14,335	583
	Bossier	30,550	2,750	89,182	2,319	119,732	5,068
	Caddo	63,116	5,680	193,935	5,042	257,051	10,723
	Claiborne	3,223	290	13,691	356	16,914	646
	De Soto	6,597	594	20,215	526	26,812	1,119
	Natchitoches	9,394	845	30,048	781	39,442	1,627
	Red River	2,294	206	6,596	171	8,890	378
	Sabine	5,934	534	18,592	483	24,526	1,017
	Webster	9,692	872	31,596	821	41,288	1,694
Total for Region 7		134,085	12,068	414,905	10,788	548,990	22,855

Region/LGE	PARISH	CHILD/ YOUTH (Age 0-17) Population Estimate	CHILD/ YOUTH (Age 0-17) Prevalence Estimate	ADULT (Age 18 and up) Population Estimate	ADULT (Age 18 and up) Prevalence Estimate	TOTAL Population Estimate JULY 1, 2011	TOTAL Prevalence Estimate
Region 8	Caldwell	2,327	209	7,730	201	10,057	410
	East Carroll	1,953	176	5,677	148	7,630	323
	Franklin	5,281	475	15,504	403	20,785	878
	Jackson	3,724	335	12,599	328	16,323	663
	Lincoln	9,448	850	37,408	973	46,856	1,823
	Madison	2,979	268	9,025	235	12,004	503
	Morehouse	6,815	613	20,793	541	27,608	1,154
	Ouachita	40,509	3,646	114,410	2,975	154,919	6,620
	Richland	5,336	480	15,602	406	20,938	886
	Tensas	1,237	111	3,829	100	5,066	211
	Union	5,171	465	17,561	457	22,732	922
	West Carroll	2,834	255	8,735	227	11,569	482
Total for Region 8		87,614	7,885	268,873	6,991	356,487	14,876
Florida Parishes Human Services Authority (FPHSA)	Livingston	35,342	3,181	94,909	2,468	130,251	5,648
	St. Helena	2,741	247	8,208	213	10,949	460
	St. Tammany	59,886	5,390	176,899	4,599	236,785	9,989
	Tangipahoa	30,626	2,756	91,945	2,391	122,571	5,147
	Washington	11,779	1,060	35,360	919	47,139	1,979
Total for FPHSA		140,374	12,634	407,321	10,590	547,695	23,224
Jefferson Parish Human Services Authority (JPHSA)	Jefferson	96,677	8,701	335,963	8,735	432,640	17,436
STATE TOTAL		1,118,196	100,638	3,456,640	89,873	4,574,836	190,510

http://www.census.gov/popest/datasets.html

Annual Estimates of the Resident Population for Parishes of Louisiana: April 1, 2010 to July 1, 2011 (CO-EST2011-AGESEX-[ST-FIPS])

Source: Population Division, U.S. Census Bureau

Release Date: May, 2012

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.*

LOUISIANA OBH COMMUNITY MENTAL HEALTH CLINICS DATA
UNDUPLICATED COUNT OF PERSONS RECEIVING SERVICES
FROM JULY 1, 2011 TO JUNE 30, 2012

REGION / LGE	UNDUPLICATED PERSONS RECEIVING SERVICES		TOTAL
	CHILD (0-17)	ADULT (18+)	
REGION 1 CHILD/YOUTH CLINICS	763	7	770
MHSD	1,911	5,862	7,773
CAHSD*	865	6,538	7,403
SCLHSA	552	4,518	5,070
AAHSD	431	2,220	2,651
REGION 5	328	2,836	3,164
REGION 6	551	2,577	3,128
REGION 7	228	3,128	3,356
REGION 8	1,290	4,587	5,877
FPHSA	2,617	6,536	9,153
JPHSA	132	6,203	6,335
TOTAL	9,668	45,012	54,680

Data Source: OBHIIS, JPHSA, and Clinical Advisor

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, 2012
WITH SMI/EBD; PERCENTAGE OF SMI/EBD

CASELOAD ON June 30, 2012 for Inpatient and Outpatient Facilities	ADULT: SMI CHILD: SED		OTHER/MISSING		TOTAL
	COUNT	Percent	COUNT	Percent	
Child/Youth (Age 0-17)	3,579	56%	2,804	44%	6,383
Adult (Age 18+)	22,448	73%	8,473	27%	30,921
TOTAL	**26,027**	**70%**	**11,277**	**30%**	**37,304**

Data from CMHC data: OBHIIS, JPHSA, Clinical Advisor and PIP data.

Louisiana Community Mental Health Clinics
ADULTS – CMHC PERSONS SERVED
UNDUPLICATED FY11-12

Regions / LGEs	Adults with SMI Served (persons served)	Total Adults Served	% SMI
1-MHSD	4,021	5,325	76%
2-CAHSD	4,515	5,359	84%
3-SCLHSA	4,747	5,658	84%
AAHSD	3,220	4,298	75%
REGION 5	1,756	2,049	86%
REGION 6	1,191	2,520	47%
REGION 7	2,043	2,418	84%
REGION 8	2,181	2,577	85%
9-FPHSA	2,702	3,016	90%
10-JPHSA	368	4,597	8%
TOTAL	26,744	37,817	71%

Data Source: OMHIIS, JPHSA, Clinical Advisor

Louisiana Community Mental Health Clinics
CHILD/YOUTH – CMHC PERSONS SERVED
UNDUPLICATED WITHIN REGIONS/LGEs FY11-12

Regions / LGEs	Children/Youth with EBD Served (persons served)	Total Children/Youth Served	% SMI
1-MHSD	11	144	8%
REGION 1 CHILD/YOUTH CLINICS	531	764	70%
2-CAHSD	1,661	1,913	87%
REGION 3	504	736	68%
AAHSD	377	542	70%
REGION 5	355	399	89%
REGION 6	101	259	39%
REGION 7	393	511	77%
REGION 8	146	171	85%
9-FPHSA	548	896	61%
10-JPHSA	52	2,192	2%
TOTAL	**4,679**	**8,527**	**55%**

Data Source: OBHIIS, JPHSA, Clinical Advisor

CMHC ADULT MENTAL HEALTH CASELOAD SIZE ON LAST DAY OF FY2011 & FY2012

Region/LGE	FY10-11			FY11-12		
	Age 18-64	Age 65+	TOTAL 18+	Age 18-64	Age 65+	TOTAL 18+
MHSD	5,393	213	5,606	3,629	148	3,777
CAHSD	4,569	256	4,825	4,331	234	4,565
REGION 3	4,839	263	5,102	4,525	229	4,754
AAHSD	3,866	181	4,047	3,546	160	3,706
REGION 5	1,666	39	1,705	1,545	33	1,578
REGION 6	1,939	70	2,009	1,944	59	2,003
REGION 7	1,619	24	1,643	1,890	28	1,918
REGION 8	1,938	70	2,008	2,004	60	2,064
FPHSA	2,610	135	2,745	2,409	135	2,544
JPHSA	4,065	120	4,185	3,316	83	3,399
TOTAL	**32,504**	**1,371**	**33,875**	**29,139**	**1,169**	**30,308**

Data from CMHC data: OBHIIS, JPHSA, and Clinical Advisor

CMHC CHILD/ YOUTH MENTAL HEALTH CASELOAD SIZE ON LAST DAY OF FY2011 & FY2012

Region/LGE	FY10-11			FY11-12		
	Age 0-11	Age 12-17	TOTAL 0-17	Age 0-11	Age 12-17	TOTAL 0-17
SELH CHILD/YOUTH CLINICS	317	321	638	280	230	510
MHSD	.	2	2	95	42	137
CAHSD	751	980	1,731	774	789	1,563
REGION 3	190	317	507	277	341	618
AAHSD	178	230	408	193	190	383
REGION 5	122	114	236	143	154	297
REGION 6	78	113	191	90	79	169
REGION 7	165	152	317	155	171	326
REGION 8	29	60	89	36	47	83
FPHSA	358	358	716	379	355	734
JPHSA	530	564	1,094	786	736	1,522
TOTAL	**2,718**	**3,211**	**5,929**	**3,208**	**3,134**	**6,342**

Data from CMHC data: OBHIIS, JPHSA, and Clinical Advisor

CASELOAD SERVED COMPARED TO PREVALENCE ESTIMATES AND CENSUS DATA FY 2012

Age Range	LA Population Estimated*	National Prevalence Rate	Est. Number of persons in LA Population with SMI/EBD
Child/ Youth* 0-17	1,118,196	9%	1,118,196 X .09 = **100,638**
Adult 18+**	3,456,640	2.6%	3,456,640 X .026 = **89,873**
Total	**4,574,836**	-----	**190,511**

*Based on Annual Estimates of the Population for Parishes of Louisiana. Estimates Source: Population Estimates Division, US Census Bureau. Release Date: May, 2012.

Age Range	Est. Number of persons in LA population with SMI/EBD	Number of Persons with SMI/EBD in OMH Caseload*	Louisiana Percent of Prevalence Served*
Child/ Youth 0-17	**100,638**	3,579	3,579 / 100,638 = **3.6%**
Adult 18+	**89,873**	22,448	22,448/ 89,873 = **25%**
Total	**190,511**	**26,027**	26,027 / 190,511 = **13.7%**

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 Office of Behavioral Health 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. After Hurricane Katrina/Rita the population of the state decreased, and efforts to reach the SMI population intensified. Through these efforts it appears that the percent of prevalence in years after Hurricane Katrina/Rita increased somewhat. 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. However, the State has faced new challenges with data collection since implementation of the Louisiana Behavioral Health Partnership in March, 2012. As a result of the steep implementation schedule and revisions to the Statewide Management Organization (SMO) data system, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with the statewide management organization that specifically target claims and clinical outcomes data. This will allow OBH to better analyze data of interest to use in planning efforts.

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 in a community or inpatient setting.
- Denominator: 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 2009	29,189 / 85,873 X 100 = 33.9%
FY 2006	24,667 / 71,294 X 100 = 34.6%	FY 2010	24,368 / 87,586 X 100 = 27.8%
FY 2007	25,604 / 71,294 X 100 = 35.9%	FY 2011	26,916 / 88,799 X 100 = 30.3%
FY 2008	27,619 / 83,555 X 100 = 33.05%	FY 2012	22,448 / 89,873 X 100 = 25.0%

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

Addictive Disorders: Population and Prevalence Estimates

The Office of Behavioral Health 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 (*SAPT Block Grant Federal Goal 13: Assessment of Need*).

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 Regions and Local Governing Entities (LGEs) 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.
- As a result of the steep implementation schedule and revisions to the Statewide Management Organization (SMO) data system, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with the statewide management organization that specifically target claims and clinical outcomes data. This will allow OBH to better analyze data of interest to use in planning efforts.

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	423,926	357,293	185,765	26,654	2,932	1,108	122	13,858	1,524	2,000	2,868	5	182	26
CAHSD	667,042	557,145	286,044	41,563	4,572	1,727	190	21,339	2,347	3,293	4,471	8	219	18
SCLHSA	405,468	334,670	171,131	24,966	2,746	1,037	114	12,766	1,404	2,284	2,686	5	31	11
AAHSD	588,413	482,087	249,577	35,964	3,956	1,494	164	18,618	2,048	2,621	3,869	7	56	16
Region 5	294,402	243,275	123,057	18,148	1,996	754	83	9,180	1,010	1,898	1,953	3	41	11
Region 6	309,773	255,346	127,563	19,049	2,095	792	87	9,516	1,047	1,687	2,050	4	41	9
Region 7	548,990	455,184	237,540	33,957	3,735	1,411	155	17,720	1,949	3,143	3,654	7	66	12
Region 8	356,487	295,470	159,396	22,042	2,425	916	101	11,891	1,308	1,892	2,372	4	38	19
FPHSA	547,695	451,264	232,669	33,664	3,703	1,399	154	17,357	1,909	3,584	3,622	7	43	12
JPHSA	432,640	364,945	188,906	27,225	2,995	1,131	124	14,092	1,550	1,873	2,929	5	79	15
TOTAL	**4,574,836**	**3,796,679**	**1,961,648**	**283,232**	**31,155**	**11,769**	**1,294**	**146,337**	**16,096**	**24,275**	**30,474**	**55**	**796**	**149**

[1] The estimates for Total Population by Sub-state Planning Area (SPA) were obtained from the US Census Bureau's 2011 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 2010 and 2011 National Survey on Drug Use and Health (NSDUH) was used to estimate the Total Population Needing Treatment Services by SPA. According to the 2010 and 2011 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 **7.46%.** The 12+ Population for each SPA was multiplied by **7.46%** 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 2010-2011 NSDUHs.* http://www.samhsa.gov/data/NSDUH/2k11State/NSDUHsae2011/NSDUHsaeStateTabs2011.htm#Tab48

[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 2011 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 2010 and 2011 National Survey on Drug Use and Health (NSDUH) was used to estimate the Total Number of Women Needing Treatment Services by SPA. The prevalence estimate of **7.46%** 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 2011 were obtained from the Louisiana State University, Highway Safety Research Group's *2011 Number of Arrests and DWI by Parish* Report.
http://datareports.lsu.edu/Reports/DWIReports/2011/dwi_parish.asp?p=dwi&sec=parish&yr=2011

[10] Information from the Federal Bureau of Investigations, Crime in the United States, 2011 Report was used to estimate the Number of Drug Related Arrests for Calendar Year 2011. According to this report, there were 30,474 drug related arrests in Louisiana in 2011 (14,925 Drug Abuse Violations + 6,032 Driving Under the Influence + 6,723 Liquor Law Violations + 2,794 Drunkenness = 30,474). Parish estimates for the Number of Drug Related Arrests were calculated by multiplying this figure (30,474) by the Parish percentage of the total state 12 years and older population estimate. United States Department of Justice, Federal Bureau of Investigation. (September 2012). *Crime in the United States, 2011*: http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2011/crime-in-the-u.s.-2011/tables/table_69_arrest_by_state_2011.xls. Table 69 Arrests by State, 2011.

[11] According to the CDC, Louisiana's incidence rate for Hepatitis B in 2010 was 1.2/100,000 (Viral Hepatitis Surveillance – United States, 2010; Table 3.1: Reported cases of acute, symptomatic hepatitis B, by state — United States, 2006 – 2010 http://www.cdc.gov/hepatitis/Statistics/2010Surveillance/PDFs/2010HepSurveillanceRpt.pdf). This estimates 55 cases (.000012*4,574,836) for the total population. Parish estimates for Incidence of Hepatitis B/100,000 were calculated by multiplying this figure (55) by the Parish percentage of the total state population estimate.

[12] According to the CDC, Louisiana's incidence rate for AIDS in 2011 was 18.4/100,000 (HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2011; Vol 23; February 2013 http://www.cdc.gov/hiv/pdf/statistics_2011_HIV_Surveillance_Report_vol_23.pdf). This estimates 842 cases for the total population. The 2011 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 2011, which are provided in the estimates table. http://new.dhh.louisiana.gov/assets/oph/Center-PHCH/Center-PH/hiv-aids/2013/2011STDHIVPROGRAMREPORT.pdf

[13] According to the Louisiana Department of Health and Hospitals Tuberculosis Control Program, Louisiana's incidence rate for Tuberculosis in 2012 was 3.3/100,000 (Louisiana TB Morbidity Report – 2012: Louisiana Tuberculosis (TB) Cases/Rates http://www.dhh.louisiana.gov/assets/oph/Center-PHCH/Center-PH/tuber/2012TBMorbidityTable.pdf). This estimates 149 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	**19,396** (7%)	6,282	5,899	3,211	3,015	10	9	160	150	60	56	170	160	110	103	9,573	8,989	430	404
18-24	**80,443** (29%)	25,307	25,212	12,935	12,887	40	40	645	642	242	241	685	682	443	442	38,564	38,420	1,733	1,726
25-44	**71,770** (26%)	22,361	22,711	11,430	11,609	36	36	570	579	214	217	605	615	392	398	34,075	34,609	1,531	1,555
45-64	**71,596** (26%)	21,840	23,122	11,164	11,819	35	37	556	589	209	221	591	626	383	405	33,282	35,235	1,495	1,583
65 & Over	**34,106** (12%)	9,108	12,310	4,656	6,292	15	20	232	314	87	118	247	333	160	216	13,880	18,760	624	843
Total	**277,312** (100%)	**84,898**	**89,254**	**43,395**	**45,622**	**135**	**142**	**2,163**	**2,274**	**811**	**853**	**2,298**	**2,416**	**1,487**	**1,563**	**129,374**	**136,013**	**5,813**	**6,111**
		62.8%		**32.1%**		**0.1%**		**1.6%**		**0.6%**		**1.7%**		**1.1%**		**95.7%**		**4.3%**	

The estimates for Age categories were obtained from the US Census Bureau's 2011 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 2010-2011 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 2010 and 2011 State Estimates for Louisiana, the prevalence estimate for Past Year Alcohol or Illicit Drug Dependence or Abuse is **5.64%** for the age group 12-17, **16.66%** for the age group 18-25, and **5.97%** 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/NSDUH/2k11State/NSDUHsae2011/NSDUHsaeStateTabs2011.htm#Tab48*)

TREATMENT ADMISSIONS AND PERSONS SERVED COMPARED TO PREVALENCE ESTIMATES AND CENSUS DATA SFY 2012

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 7.46% was used to determine the number of persons in each Region/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 SFY2012 is compared to the total estimated number needing treatment services to determine the *percent of prevalence served* in Louisiana.

TOTAL POPULATION

Region/LGE	*Needing Treatment Services*	That would seek treatment	Admissions*	*Total Served**	Percent of Prevalence Served
MHSD	26,654	2,932	4,644	*5,315*	5,315 / 26,654 = 19.94%
CAHSD	41,563	4,572	3,079	*4,307*	4,307 / 41,563 = 10.36%
SCLHSA	24,966	2,746	2,662	*3,619*	3,619 / 24,966 = 14.50%
AAHSD	35,964	3,956	2,184	*2,849*	2,849 / 35,964 = 7.92%
Region V	18,148	1,996	1,962	*2,351*	2,351 / 18,148 = 12.95%
Region VI	19,049	2,095	3,393	*4,109*	4,109 / 19,049 = 21.57%
Region VII	33,957	3,735	2,786	*3,322*	3,322 / 33,957 = 9.78%
Region VIII	22,042	2,425	3,857	*4,854*	4,854 / 22,042 = 22.02%
FPHSA	33,664	3,703	1,888	*2,670*	2,670 / 33,664 = 7.93%
TOTAL	*256,007*	28,160	26,455	*33,396*	**33,396 / 256,007 = 13.04%**

*Unduplicated; Source: Louisiana Addictive Disorders Data System (LADDS) which does not include data for JPHSA; Clinical Advisor (CA); Total Served figures do not include 2,979 clients engaged in ATR services in SFY2012.

INJECTING DRUG USERS (IDU)

Region/LGE	*Needing Treatment Services*	That would seek treatment	Admissions*	*Total Served**	Percent of Prevalence Served
MHSD	*1,108*	122	1,854	*1,978*	1,978 / 1,108 = 178.52%
CAHSD	*1,727*	190	401	*472*	472 / 1,727 = 27.33%
SCLHSA	*1,037*	114	293	*321*	321 / 1,037 = 30.95%

AAHSD	*1,494*	164	183	*209*	209 / 1,494 = 13.99%
Region V	*754*	83	258	*283*	283 / 754 = 37.53%
Region VI	*792*	87	551	*615*	615 / 792 = 77.65%
Region VII	*1,411*	155	316	*355*	355 / 1,411 = 25.16%
Region VIII	*916*	101	517	*558*	558 / 916 = 60.92%
FPHSA	*1,399*	154	330	*416*	416 / 1,399 = 29.74%
TOTAL	*10,638*	1,170	4,703	*5,207*	**5,207 / 10,638 = 48.95%**

* Unduplicated; Source: Louisiana Addictive Disorders Data System (LADDS) which does not include data for JPHSA; Clinical Advisor (CA); Total Served figures do not include 461 IDU clients engaged in ATR services in SFY2012.

WOMEN

Regions/LGEs	*Needing Treatment Services*	That would seek treatment	Admissions*	*Total Served**	Percent of Prevalence Served
MHSD	*13,858*	1,524	1,613	*1,816*	1,816 / 13,858 = 13.10%
CAHSD	*21,339*	2,347	917	*1,308*	1,308 / 21,339 = 6.13%
SCLHSA	*12,766*	1,404	883	*1,193*	1,193 / 12,766 = 9.35%
AAHSD	*18,618*	2,048	844	*1,100*	1,100 / 18,618 = 5.91%
Region V	*9,180*	1,010	727	*881*	881 / 9,180 = 9.60%
Region VI	*9,516*	1,047	1,332	*1,598*	1,598 / 9,516 = 16.79%
Region VII	*17,720*	1,949	1,153	*1,384*	1,384 / 17,720 = 7.81%
Region VIII	*11,891*	1,308	1,053	*1,331*	1,331 / 11,891 = 11.19%
FPHSA	*17,357*	1,909	755	*1,049*	1,049 / 17,357 = 6.04%
TOTAL	*132,245*	14,546	9,277	*11,660*	**11,660 / 132,245 = 8.82%**

* Unduplicated; Source: Louisiana Addictive Disorders Data System (LADDS) which does not include data for JPHSA; Clinical Advisor (CA); Total Served figures do not include 560 women engaged in ATR services in SFY2012.

Race/Ethnicity and Age Compared to SFY2012 Population Profile

Race/Ethnicity	Needing Treatment Services	Population Profile
White	62.8%	64%
Black/African American	32.1%	34%
Native Hawaiian /Other Pacific Islander	0.1%	0.05%
Asian	1.6%	0.07%
American Indian /Alaska Native	0.6%	0.75%
More than One Race Reported	1.7%	0.54%
Unknown - Other	1.1%	0.91%
Hispanic or Latino	4.3%	2%
Not Hispanic or Latino	95.7%	98%

Age	Needing Treatment Services	Population Profile
17 & Under	7%	5%
18-24	29%	15%
25-44	26%	57%
45-64	26%	22%
65 & Over	12%	1%

Gender	Needing Treatment Services	Population Profile
Male	48.5%	66%
Female	51.5%	34%

Source: Louisiana Addictive Disorders Data System (LADDS); Clinical Advisor (CA)

State Epidemiology Workgroup

The State Epidemiology Workgroup (SEW) developed as a result of the Strategic Prevention Framework State Incentive Grant (SPF-SIG). OBH also continues to provide prevention and treatment data to the workgroup for inclusion in the State SEW Report. With the heightened awareness of substance abuse prevention activities and the data driven model that has been introduced to the prevention system in Louisiana through the Strategic Planning Framework, the State Epidemiology Workgroup (SEW) members began to re-evaluate their ongoing mission and, in particular, their membership. The need for members from every agency that houses data relevant to prevention activities began to be greatly reduced by both the establishment of relationships with the SEW and, more importantly, the creation and propagation of the Louisiana Drug Policy Board policy related to data sharing. The outcome is that when data are available within Louisiana's government agencies, they are usually readily shared with the SEW. This 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.

The Office of Behavioral Health Prevention and Treatment Services have a standing seat on the State Epidemiology Workgroup and attended four quarterly meetings during SFY 2012. These meetings focused on increased knowledge of the Strategic Planning Framework, implementation of State Epidemiology Workgroup Action Plans, updates on subcommittee progress (SEW Data Gaps, Sustainability, and Community Level Data Collection). During SFY 2011 OBH Prevention Services updated the 2010 Caring Communities Youth Survey, the 2011 Higher Education CORE Survey and provided the resources to sustain the SEW web-based Community Needs Assessment Website.
http://www.bach-harrison.com/lasocialindicators/Default.aspx

Please see the table on the following page for SEW membership during SFY 2012.

STATE EPIDEMIOLOGICAL WORKGROUP (SEW) MEMBERSHIP

Member	Agency
Albin, Stacie	Department of Children and Family Services (DCFS), Office of Family Assistance Program Policy Section
Asmus, Dr. Gary	University of Louisiana at Lafayette-Center for Child Development, SEW Co Chair
Balsamo, Dr. Gary	Department of Health and Hospitals (DHH), Office of Public Health (OPH), Infectious Disease Epidemiology, SEW Chair
Barnum, Layne	State Police
Blackmon, Bret	Louisiana State University (LSU) - Louisiana Center Addressing Substance Use
Blanchard, Bill	DHH, Office of Behavioral Health (OBH)
Bourgeois, Brandi	DHH, OPH, Bureau of Primary Care and Rural Health
Burns, Lillie	Department of Education (DOE)
Cataldie, Louis	Coroner
Childers, Cathy	Louisiana Highway Safety Commission
Diez, Dawn	Governor's Office – State Prevention Enhancement Grant Project Director
Gettys, Vivian	Capital Area Human Services District, Project Manager, FASD Prevention Collaborative
Giroir, Annette	DHH , Office of Behavioral Health
Graves, Missy	Governor's Office of Safe and Drug-Free Schools
Harrison, Dr. Murelle	Southern University, Psychology Department
Lars, Sonya	Louisiana Commission on Law Enforcement
Richard-Griffin, Avis	DHH, OPH
Richardson, Henry	Drug Enforcement Administration
Roussel, Ellis	Governor's Office Safe & Drug Free Schools & Communities
Straif-Bourgeois, Suzanne	DHH, OPH, Assistant State Epidemiologist
Starszak, Robert	DHH, Office of the Secretary
Wilson, Ivory	DHH, OBH
Vacant	National Guard
Vacant	Governor's Office of Elderly Affairs
Of Counsel	**Agency**
Andrieu, Chris	LA Supreme Court
Freeman, Leslie	DHH, OBH
Cummins, Dortha	Louisiana Highway Safety Commission
Jackson, Danny	LA Sheriff's Association
Johnson, Felecia	DHH, OBH
Johnson, Mary	DHH, OPH
Lemoine, Dr. Randall	DHH, OBH
Patterson, Karen	Division of Administration – Electronic Services
Pugh, Audrey	DHH, OPH
Robinson, Dr. Billy	DHH, OPH, LSU Health Sciences Center
Schneider, Dr. Helmut	LSU ISDS Research for Highway Safety
Theall, Dr. Katherine	LSU School of Public Health
Thompson, Louis	Office of Alcohol and Tobacco Control
Wright, Nancy	DCFS

Prevention

Problem Assessment (Epidemiological Profile)

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

The rationale for prioritizing primary prevention programs in Louisiana is to address the fundamental substance abuse-related issues in the State. The basis for judging the most pressing needs in Louisiana are found in the data. For instance, LifeSkills Training, Project Northland, and Too Good for Drugs account for 72% of all enrollees in SFY 2012. 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 Caring Communities Youth Survey (CCYS), the CORE Alcohol and Drug Survey, which are both funded by OBH, and the State Epidemiology Workgroup (SEW) report.

Using alcohol as an example of what the data reveal; the CCYS 2010 indicated that 22.8% of 6th grade, 46.5% of 8th grade, 64.9% of 10th grade, and 73.5% of 12th grade students used alcohol in their life time. Additionally in CCYS 2010, 8.1% of 6th grade, 21.8% of 8th grade, 35.3% of 10th grade and 45.7% of 12th grade students reported using alcohol in the past 30 days. The SEW report cites data from the Louisiana Department of Education (DOE) that states there were 410 suspensions 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 2010 finding that the age of first use of alcohol in Louisiana is 11 or younger. Providing prevention programs to children should contribute to a downward trend in college consumption patterns over time.

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 Central Office staff annually reviews epidemiological data with Regional, District and Authority staff. It is important to note that the three core reports that provide epidemiological data are collected bi-annually. 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.

Louisiana is interested in expanding prevention services across the lifespan, particularly services geared toward adults beyond those located at institutions of higher education. In order to identify and understand need, the state requested and has been receiving technical assistance from the

Southwest Resource Team (SWRT) and Johnson, Bassin, and Shaw (JBS) to identify additional data sources beyond the Caring Communities Youth Survey (CCYS), as CCYS is only specific to youth that are in school. Per the current service plan for 2013-2014 with SWRT, customized consultation will be provided to the National Prevention Network (NPN) representative, Leslie Brougham-Freeman, other State prevention staff, and the State Epidemiological Outcomes Workgroup (SEOW) on identifying data sources that the state could utilize to expand their epidemiological profile and provide local community level data that will assist the state with prevention planning related to the Block Grant and PFS 2013 funding. The SWRT will also provide technical assistance on other methods of collecting and analyzing local and community data. Customized technical assistance will also be provided to Louisiana on incorporating data across the lifespan into the epidemiological profile and ways in which to use the data to plan and select evidence-based interventions, including environmental strategies. The goal is to move the state into a paradigm shift from school-based interventions to incorporating environmental approaches. The SWRT has provided two documents ("Data Sources Used by States and Tribes in the CAPT Southwest Resource Team Service Area" and "Additional Data Sources"), whose content will be incorporated into future planning at the state and community level.

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 ten (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.

Regions and 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 six primary prevention strategies with block grant funds.

All regional 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, Regional, 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, Underage and High Risk Drinking Task Force, 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, Department of Education, Office of Public Health, local media outlets, universities, citizens, youth, recovering community, elected officials, alcohol and tobacco industry, and community leaders.

Prevention System Capacity Development

Three primary needs assessment sources used by OBH are the Caring Communities Youth Survey (CCYS), the CORE Alcohol and Drug Survey, which are both funded by OBH, and 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.

OBH is in the process of expanding the implementation of a formal community readiness and resource assessment. These assessment tools will not only determine a community's awareness of substance abuse problems and related problems, but will also determine the community's capacity to address identified problems.

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 age 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 to the elimination of Title IV funding. 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, with an increasing use of Spanish; 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

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. 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 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.

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, 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.

After the proposed action plans are reviewed at the regional level, they are submitted and reviewed by Central Office Prevention staff. OBH Prevention Services has established cost bands for direct universal and selective services. Indicated services are evaluated individually.

Written recommendations are sent to the Regions for corrections. A third review is completed by the Regional administrators, state Prevention staff, and state fiscal staff for corrections or to answer fidelity questions. Each action plan is required to use an external evaluator to determine statically significant outcomes. Corrections are made and the action plans are processed as a contract.

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 implemented the rollout of the curriculum during January 2011. Tier 1 of the rollout included the training of OBH state and regional staff, Governor's Office staff, and SPF-SIG sub-recipients. Tier 2 included the training of sub-recipients from community based partners, OBH, Governor's Office, and Department of Education. Additional trainings are made available to interested staff and partners as requested.

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. Also collected are population-based services to include 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. 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 ten 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 will administer the pre- and post-test that was developed and validated by each evidence-based program's developer. Since FFY 2012, 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 age 12 and above are measured. Evaluation outcomes will determine if there has been an increase, maintenance or decrease.

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. The medium income is $42,460 per household with 17.6% of all persons living below the poverty level *(2010 Census Bureau Quick Facts)*.

Louisiana

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

Louisiana

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 in both upper and lower socioeconomic classes living in both urban and rural areas. In the State of Louisiana, the annual economic cost of substance abuse is approximately $4 billion dollars, which translates into a cost of $943 per every man, woman, and child. Included in this cost is medical, criminal, property damage, costs associated with 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 2010 reflects lifetime and 30 day use among Louisiana youth in the tables below.

Caring Communities Youth Survey

Table 4. Percentage of Students Who Used ATODs during Their Lifetime

	Grade 6			Grade 8			Grade 10			Grade 12		
Drug Used	2006	2008	2010	2006	2008	2010	2006	2008	2010	2006	2008	2010
Alcohol	24.4	25.7	22.8	47.8	4934	46.5	67.8	67.6	64.9	73.3	73.9	73.5
Cigarettes	14.5	12.6	10.6	30.0	27.7	24.6	41.7	38.4	34.9	48.0	44.3	41.9
Chewing Tobacco	5.8	5.6	4.7	11.4	10.8	10.9	15.8	15.6	15.3	17.9	15.7	17.6
Marijuana	2.0	2.0	1.8	9.1	9.6	10.2	19.8	20.2	22.0	27.9	27.5	30.3
Inhalants	7.2	8.9	7.6	10.5	12.1	11.7	9.0	10.3	9.0	6.3	6.8	9.5

(Formerly the Communities That Care Survey)

Caring Communities Youth Survey

Table 4. Percentage of Students Who Used ATODs during Past 30 Days

	Grade 6			Grade 8			Grade 10			Grade 12		
Drug Used	2006	2008	2010	2006	2008	2010	2006	2008	2010	2006	2008	2010
Alcohol	5.7	9.5	8.1	18.7	23.9	21.8	35.1	37.8	35.3	44.6	46.9	45.7
Cigarettes	3.1	3.0	2.3	8.8	9.0	7.8	15.0	15.3	13.1	21.1	20.7	19.7
Chewing Tobacco	2.1	2.0	1.7	5.1	5.0	4.9	7.2	7.7	7.5	8.0	7.7	8.8
Marijuana	0.6	0.8	0.7	3.7	4.2	5.1	8.1	8.9	10.6	11.4	11.2	14.6
Inhalants	2.6	3.7	2.8	3.9	4.4	4.4	2.2	2.5	2.2	1.0	1.2	1.2

(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; and

- *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).

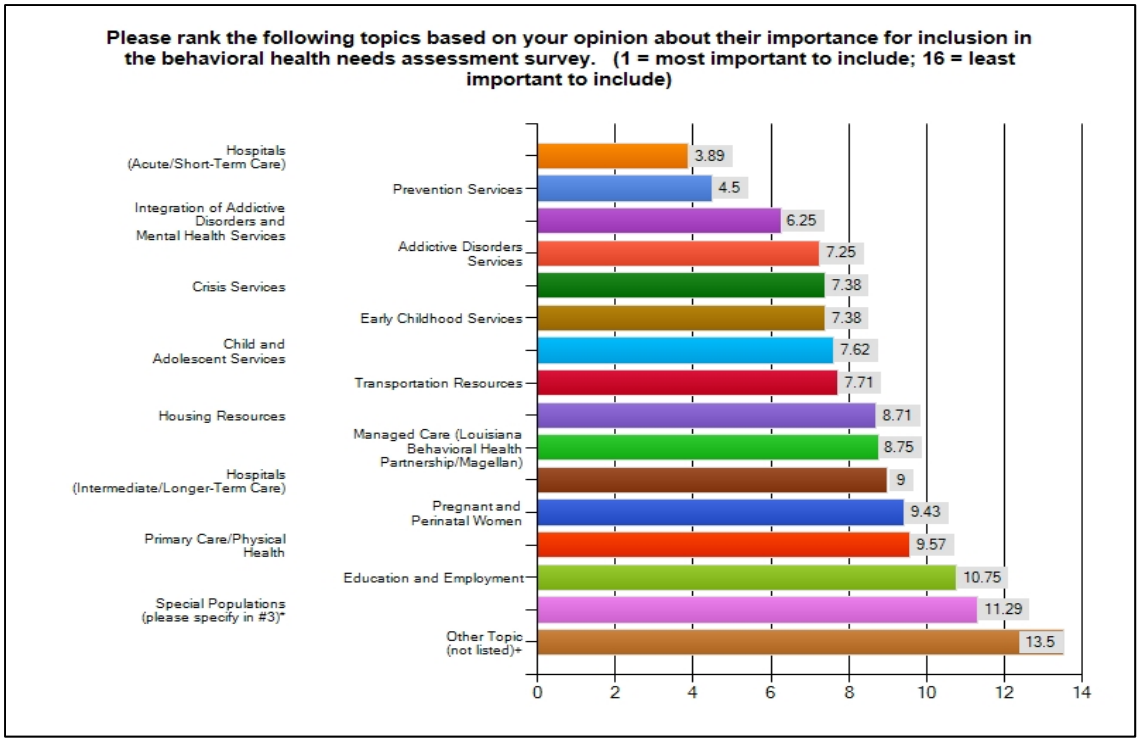
Although it is important to recognize that not all use is necessarily problematic, for some, experimental use will inevitably escalate to regular or heavy use. In fact, a study of Louisiana youth focusing on problem substance use found that approximately 13.5% of adolescents (57,503) may need some form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

Historically, the Office of Addictive Disorders has conducted annual Public Forums in each of the ten Regions/Local Governing Entities (LGEs) 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. The Office of Behavioral Health continues this effort on an annual basis. During the FY 2012 Public Forums, a primary discussion topic was the recent implementation of the Louisiana Behavioral Health Partnership (LBHP), including the Louisiana Coordinated System of Care (CSoC) initiative for children/youth with extensive behavioral health needs either in or at-risk of out-of-home placement. Discussions focused on the current status of implementation. Stakeholders expressed concern about the potential for necessary services not being provided, or the transition to managed care resulting in shorter lengths of stay for inpatient/halfway house services. Additional concerns were noted regarding treatment services, including a lack of available services in certain geographical areas (St. Bernard Parish), for particular populations (those ages 18 to 20), of certain types ("medically accurate" teen pregnancy prevention, evidence-based programs, medical detox, sober living environments, and a Christian faith-based program with aftercare), and provided by psychiatrists or Multisystemic Therapy providers. Another area of concern relates to the availability of recovery and support services, including transportation to and from treatment services, housing resources, increased outreach and peer support through recovery speaker bureaus, education for family members and loved ones regarding intervention techniques and avenues for clients to enter treatment.

As part of the State's needs assessment process, a survey of Regional Advisory Council (RAC) chairpersons was conducted in order to identify the "top ten" topics to include on a more in-depth needs assessment survey, with the intention that the identified topics would be addressed in more detail on a subsequent survey to be distributed more widely, including to all members of the Louisiana Behavioral Health Advisory Council and other consumers, providers, advocates, and behavioral health stakeholders. Survey responses were received from the majority of RAC Chairpersons.

As part of this initial brief survey, respondents were asked to rank order each topic from 1 to 16, with 1 being assigned to the topic that they believed to be the most important to include and 16 being what they viewed as being the least important topic to include. The graph below depicts the average ranking for each of the 16 topics.



Respondents were asked to list the special population groups whose needs they believed should be assessed as part of the needs assessment survey process. Following is a summary of populations identified:

- Elderly
- Persons with mental health disorders
- Substance abusing population
- Persons with intellectual/developmental disabilities, including those who also have a mental health disorder
- Persons with addictive disorders and a mental health disorder
- Incarcerated populations
- Persons with multiple hospitalizations in a twelve month period
- The Pinecrest Hospital population
- Persons for whom English is not their first language
- Homeless individuals, including those living on the street and those rotating between the homes of friends and relatives until their welcome is worn out
- Persons living in rural areas
- Persons who are under-employed
- The African-American community, including African American males age 24-45 years
- HIV-positive individuals
- Victims of violence
- Displaced youth

As part of the State's needs assessment process, a survey of Regional Advisory Council (RAC) chairpersons was conducted in order to identify the "top ten" topics to include on a more in-depth needs assessment survey, with the intention that the identified topics would be addressed in more detail on a subsequent survey to be distributed more widely, including to all members of

the Louisiana Behavioral Health Advisory Council and other consumers, providers, advocates, and behavioral health stakeholders. Survey responses were received from the majority of RAC Chairpersons.

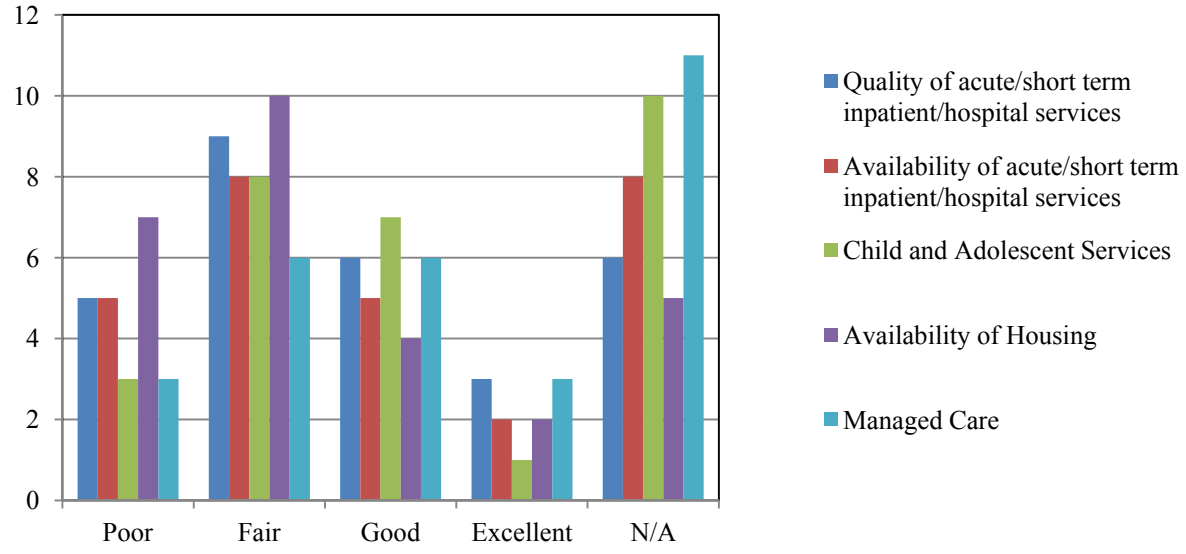
A follow up survey was administered to the Louisiana Behavioral Health Advisory Council. The representative from each Regional Advisory Council (RAC) was asked to take the survey back to their community and have them completed by fellow RAC members, consumers, family members, advocates, and providers. Of the ten regions in the state, only two were able to provide survey results. The following data is based on 29 responses from the Louisiana Behavioral Health Advisory Council, Region 6, and Region 8.

This survey provided a more in-depth look at the priority areas that were identified by the previous survey. Of the respondents, 30.77% identified themselves as a consumer, 30.77% as a parent/guardian of a child/youth consumer, 19.23% as a family member of an adult consumer, 53.85% as an advocate, and 30.77% as a provider of services. These figures suggest considerable overlap and indicate that many of these individuals play several roles in the behavioral health care system.

Respondents were asked to rate on a scale of zero ("Poor") to three ("Excellent") the following services in Louisiana:

- Quality of acute/short term inpatient/hospital services
- Availability of acute/short term inpatient/hospital services
- Child and adolescent Services
- Availability of housing
- Managed care

The following chart indicates the ratings for each service. While the majority of respondents rated these services to be at least "Fair," there were a large number of responses for "N/A." This suggests that respondents did not feel qualified to rate the services.

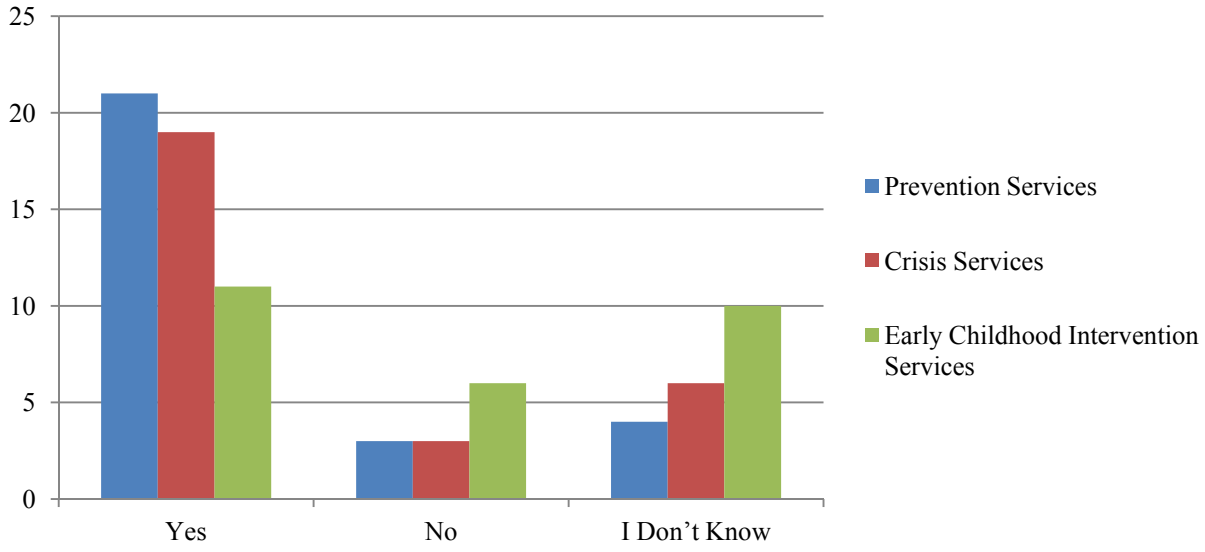


An overwhelming 85.19% of respondents indicated that they felt that Louisiana has an insufficient number of inpatient beds for acute/short term behavioral health patients. A follow-up question revealed that 80% of respondents felt a need for more beds for both adults and children/adolescents.

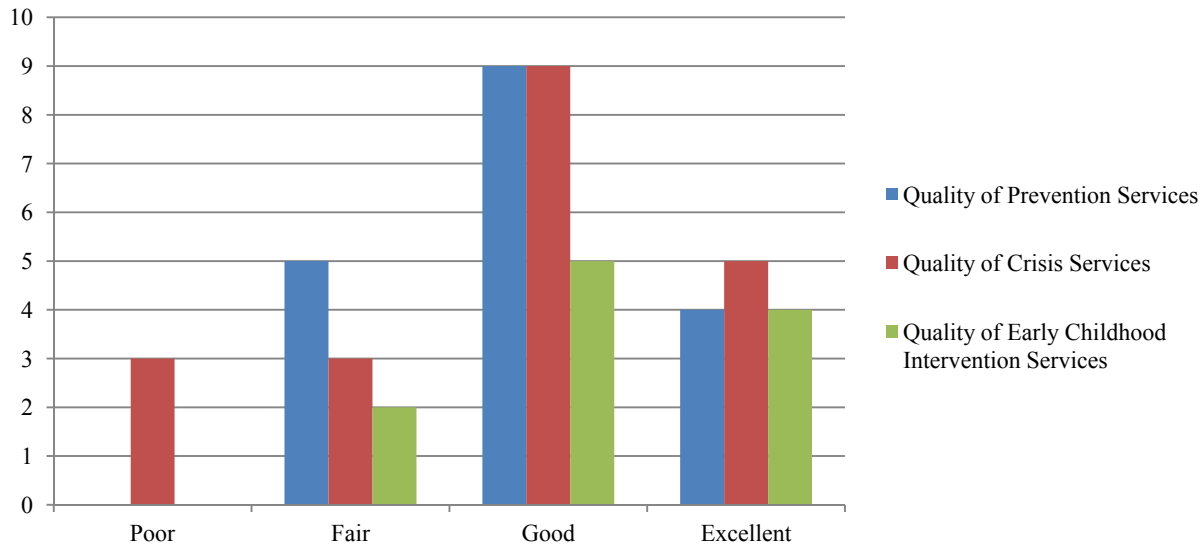
Additional questions were asked to determine if the following services were available in each community:

- Prevention services
- Crisis services
- Early childhood intervention services

A remarkable number of respondents indicated that they did not know if the services were available in their community.



The following chart shows the rating of each service:


10
9
8
7
6
5
4
3
2
1
0
Poor
Fair
Good
Excellent
Quality of Prevention Services
Quality of Crisis Services
Quality of Early Childhood Intervention Services

PLANNING STEPS THREE AND FOUR:
PRIORITY AREAS AND ANNUAL PERFORMANCE INDICATORS

Many of the identified service gaps and needs in the State are addressed by the recent dramatic systems change in Louisiana, whereby OBH became a purchaser of services through a Statewide Prepaid Inpatient Health Plan (PIHP) rather than a provider. This systems change was intended to increase access to and availability of behavioral health services, while increasing the funding potential of recovery support services through block grant funds. The State has also transitioned from a centrally controlled set of Regions to a system of independent healthcare districts or locally controlled authorities. This model affords opportunity for greater accountability and responsiveness to local communities since it is based on local control and local authority. OBH has implemented these major system changes and is now focused on expanding and refining the new system.

Abbreviations:

Priority Type:

SAP = Substance Abuse Prevention; SAT = Substance Abuse Treatment, MHP = Mental Health Promotion; MHS = Mental Health Service.

Population (for Substance Abuse Treatment and Mental Health Service Priority Areas):

SMI = Adults with Serious Mental Illness; SED = Children with a Serious Emotional Disturbance; 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

Priority Area (1)	**Behavioral Health System Transformation through Medicaid Reform**
Priority Type	SAT, MHS
Population(s)	SMI, SED, PWWDC, IVDUs, HIV EIS, TB, Other
Goal	Increase access to and capacity of the state-supported behavioral health system.
Strategies	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 a Statewide Management Organization (SMO). 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 Statewide Management Organization (SMO). The SMO enrolls and reimburses for services for an increased number of mental health recipients in SFY 14 and SFY 15 as compared to those served in SFY 13.
Baseline	The number of persons receiving mental health services through the Louisiana

Measurement	Behavioral Health Partnership (LBHP) in SFY 13.
First Year Target/Outcome Measurement	The number of persons receiving mental health services through the Louisiana Behavioral Health Partnership (LBHP) in SFY 14.
Second Year Target/Outcome Measurement	The number of persons receiving mental health services through the Louisiana Behavioral Health Partnership (LBHP) in SFY 15.
Data Source	This data will be collected from the data systems of the Statewide Management Organization (SMO).
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 and revisions to the Statewide Management Organization (SMO) data system, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with the SMO that specifically target claims and clinical outcomes data. 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 Statewide Management Organization (SMO). The SMO enrolls and reimburses for services for an increased number of substance use disorder recipients in SFY 14 and SFY 15 as compared to those served in SFY 13.
Baseline Measurement	The number of persons receiving substance use disorder services through the Louisiana Behavioral Health Partnership (LBHP) in SFY 13.
First Year Target/Outcome Measurement	The number of persons receiving substance use disorder services through the Louisiana Behavioral Health Partnership (LBHP) in SFY 14.
Second Year Target/Outcome Measurement	The number of persons receiving substance use disorder services through the Louisiana Behavioral Health Partnership (LBHP) in SFY 15.
Data Source	This data will be collected from the data systems of the Statewide Management Organization (SMO).
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 and revisions to the Statewide Management Organization (SMO) data system, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with the SMO that specifically target claims and clinical outcomes data. 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

	14 and SFY 15 as compared to those served in SFY 13.
Baseline Measurement	The number of persons served in each of the SAPT and CMHS Block Grant populations of focus during SFY 13.
First Year Target/Outcome Measurement	The number of persons served in each of the SAPT and CMHS Block Grant populations of focus during SFY 14.
Second Year Target/Outcome Measurement	The number of persons served in each of the SAPT and CMHS Block Grant populations of focus during SFY 15.
Data Source	This data will be collected from the data systems of the Statewide Management Organization (SMO).
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 and revisions to the Statewide Management Organization (SMO) data system, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with the SMO that specifically target claims and clinical outcomes data. This will allow OBH to better analyze data of interest to use in planning efforts.
Indicator (4)	Maintain Coordinated System of Care (CSoC) operations in the five initial implementing regions and expand into the remaining four regions of the state by the end of SFY 14. The Statewide Management Organization (SMO) enrolls and serves 1,800 children and youth statewide during SFY 14 and enrolls and serves 2,400 children and youth statewide during SFY 15.
Baseline Measurement	The number of children enrolled in the CSoC and receiving CSoC waiver services at the end of SFY 13.
First Year Target/Outcome Measurement	The number of children enrolled in the CSoC and receiving CSoC waiver services at the end of SFY 14.
Second Year Target/Outcome Measurement	The number of children enrolled in the CSoC and receiving CSoC waiver services at the end of SFY 15.
Data Source	This data will be collected from the data systems of the Statewide Management Organization (SMO).
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	As a result of the steep implementation schedule and revisions to the Statewide Management Organization (SMO) data system, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with the SMO that specifically target claims and clinical outcomes data. This will allow OBH to better analyze data of interest to use in planning efforts. 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 may experience a delay in this start date as CMS has not approved the current waiver amendment adding three additional parishes to the program. Full statewide implementation will also require another CMS amendment. If waiver amendments are not approved by CMS, this will hinder expansion.

Priority Area (2)	Integration of Behavioral Health Services
Priority Type	SAT, MHS
Population(s)	SMI, SED, PWWDC, IVDUs, HIV EIS, TB, Other
Goal	Integrate substance use and mental health disorder services.
Strategies	Expand the network of Louisiana Behavioral Health Partnership (LBHP) providers who are able to provide both mental health and substance use disorder services. Implement behavioral health clinic licensure standards.
Indicator (1)	Increase the number of providers in the Louisiana Behavioral Health Partnership who are credentialed to provide integrated mental health and substance use disorder services.
Baseline Measurement	The number of providers in the Louisiana Behavioral Health Partnership who are credentialed to provide integrated mental health and substance use disorder services in SFY 13.
First Year Target/Outcome Measurement	The number of providers in the Louisiana Behavioral Health Partnership who are credentialed to provide integrated mental health and substance use disorder services in SFY 14.
Second Year Target/Outcome Measurement	The number of providers in the Louisiana Behavioral Health Partnership who are credentialed to provide integrated mental health and substance use disorder services in SFY 15.
Data Source	This data will be collected from the Statewide Management Organization (SMO).
Description of Data	The number of providers in the Louisiana Behavioral Health Partnership who are credentialed by the Statewide Management Organization (SMO) to provide integrated mental health and substance use disorder services at the end of the SFY (as of June 30).
Data Issues/Caveats	None anticipated.
Indicator (2)	Increase the number of individuals receiving services from providers in the Louisiana Behavioral Health Partnership who are credentialed to provide integrated mental health and substance use disorder services.
Baseline Measurement	The number of persons served by providers in the Louisiana Behavioral Health Partnership who are credentialed to provide integrated mental health and substance use disorder services in SFY 13.
First Year Target/Outcome Measurement	The number of persons served by providers in the Louisiana Behavioral Health Partnership who are credentialed to provide integrated mental health and substance use disorder services in SFY 14.
Second Year Target/Outcome Measurement	The number of persons served by providers in the Louisiana Behavioral Health Partnership who are credentialed to provide integrated mental health and substance use disorder services in SFY 15.
Data Source	This data will be collected from the Statewide Management Organization (SMO).
Description of Data	The number of persons served by providers in the Louisiana Behavioral

	Health Partnership who are credentialed by the Statewide Management Organization (SMO) to provide integrated mental health and substance use disorder services during the SFY (July 1 – June 30).
Data Issues/Caveats	As a result of the steep implementation schedule and revisions to the Statewide Management Organization (SMO) data system, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with the SMO that specifically target claims and clinical outcomes data. This will allow OBH to better analyze data of interest to use in planning efforts.
Indicator (3)	Implement legislation that created one behavioral health license for clinics to become providers for mental health and substance use disorder services.
Baseline Measurement	N/A. Legislation establishing the behavioral health license was passed during the 2013 Legislative Session.
First Year Target/Outcome Measurement	The number of facilities that have obtained behavioral health licensure through the Louisiana Department of Health and Hospitals - Bureau of Health Standards by the end of SFY 14.
Second Year Target/Outcome Measurement	The number of facilities that have obtained behavioral health licensure through the Louisiana Department of Health and Hospitals - Bureau of Health Standards by the end of SFY 15.
Data Source	This data will be collected from the data systems of the Louisiana Department of Health and Hospitals - Bureau of Health Standards.
Description of Data	The number of facilities that have obtained behavioral health licensure at the end of the SFY (as of June 30).
Data Issues/Caveats	None anticipated.

Priority Area (3)	Increased Efficiency in the Utilization of Inpatient Levels of Care
Priority Type	MHS
Population(s)	SMI, SED
Goal	Reduce reliance on and length of stay at the state-managed intermediate care psychiatric facilities.
Strategies	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 13.
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 14.
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 15.
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 (4)	Re-balancing Community Based Services
Priority Type	SAT, MHS
Population(s)	SMI, SED
Goal	Maintain a robust community-based system of care that is able to adequately manage and support persons discharged from institutional levels of psychiatric care in order to make community living successful.
Strategies	The Office of Behavioral Health will monitor the use of institutional levels of care and community-based levels of care in the state. The Office of Behavioral Health will continue to implement the Louisiana Behavioral Health Partnership (LBHP) through the Statewide Management Organization (SMO).
Indicator (1)	There is a decreased number of persons served in inpatient psychiatric settings (both acute and intermediate) during SFY 14 and SFY 15 as compared to the number served in SFY 13.
Baseline Measurement	The number of persons served in inpatient psychiatric settings (both acute and intermediate) during SFY 13.
First Year Target/Outcome Measurement	The number of persons served in inpatient psychiatric settings (both acute and intermediate) during SFY 14.
Second Year Target/Outcome Measurement	The number of persons served in inpatient psychiatric settings (both acute and intermediate) during SFY 15.
Data Source	This data will be collected from the Inpatient Hospital Database System (PIP) and the data systems of the Statewide Management Organization (SMO).
Description of Data	The number of persons served in OBH-managed acute and intermediate care psychiatric facilities or receiving acute psychiatric services through the SMO provider network during the SFY (July 1 – June 30).
Data Issues/Caveats	As a result of the steep implementation schedule and revisions to the Statewide Management Organization (SMO) data system, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with the SMO that specifically target claims and clinical outcomes data. This will allow OBH to better analyze data of interest to use in planning efforts.
Indicator (2)	There is an increased number of persons receiving behavioral health services in outpatient community-based settings through the implementation of the Louisiana Behavioral Health Partnership (LBHP) during SFY 14 and SFY 15 as compared to the number served in SFY 13.
Baseline Measurement	The unduplicated number of persons receiving behavioral health services in outpatient settings through the implementation of the LBHP during SFY 13.
First Year Target/Outcome Measurement	The unduplicated number of persons receiving behavioral health services in outpatient settings through the implementation of the LBHP during SFY 14.
Second Year Target/Outcome	The unduplicated number of persons receiving behavioral health services in outpatient settings through the implementation of the LBHP during SFY 15.

Measurement	
Data Source	This data will be collected from the data systems of the Statewide Management Organization (SMO).
Description of Data	The unduplicated number of persons receiving behavioral health services in outpatient settings through the implementation of the LBHP during the SFY (July 1 – June 30).
Data Issues/Caveats	As a result of the steep implementation schedule and revisions to the Statewide Management Organization (SMO) data system, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with the SMO that specifically target claims and clinical outcomes data. This will allow OBH to better analyze data of interest to use in planning efforts.
Indicator (3)	There is an increased number of persons served through evidence-based programs through the implementation of the Louisiana Behavioral Health Partnership (LBHP) during SFY 14 and SFY 15 as compared to the number served in SFY 13.
Baseline Measurement	The unduplicated number of persons served through evidence-based programs through the implementation of the LBHP during SFY 13.
First Year Target/Outcome Measurement	The unduplicated number of persons served through evidence-based programs through the implementation of the LBHP during SFY 14.
Second Year Target/Outcome Measurement	The unduplicated number of persons served through evidence-based programs through the implementation of the LBHP during SFY 15.
Data Source	This data will be collected from the data systems of the Statewide Management Organization (SMO).
Description of Data	The unduplicated number of persons served through evidence-based programs through the implementation of the LBHP during the SFY (July 1 – June 30).
Data Issues/Caveats	As a result of the steep implementation schedule and revisions to the Statewide Management Organization (SMO) data system, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with the SMO that specifically target claims and clinical outcomes data. This will allow OBH to better analyze data of interest to use in planning efforts.

Priority Area (5)	Primary Healthcare
Priority Type	SAT, MHS
Population(s)	SMI, SED, PWWDC, IVDUs, HIV EIS, TB, Other
Goal	Improve access to behavioral health services and engagement with physical health providers through relationships with the Medicaid Bayou Health plans.
Strategies	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)	There is an increased percentage of Medicaid Bayou Health plan/Medicaid legacy plan enrollees who are also enrolled with the Louisiana Behavioral Health Partnership (LBHP) during SFY 14 and SFY 15 as compared to SFY 13.
Baseline Measurement	The percentage of Medicaid Bayou Health plan/Medicaid legacy plan enrollees who are also enrolled with the Louisiana Behavioral Health Partnership (LBHP) during SFY 13.
First Year Target/Outcome Measurement	The percentage of Medicaid Bayou Health plan/Medicaid legacy plan enrollees who are also enrolled with the Louisiana Behavioral Health Partnership (LBHP) during SFY 14.
Second Year Target/Outcome Measurement	The percentage of Medicaid Bayou Health plan/Medicaid legacy plan enrollees who are also enrolled with the Louisiana Behavioral Health Partnership (LBHP) during SFY 15.
Data Source	This data will be collected from the Statewide Management Organization (SMO) and Bayou Health data if needed.
Description of Data	The number of Medicaid Bayou Health plan/Medicaid legacy plan enrollees who are also enrolled with 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 and revisions to the Statewide Management Organization (SMO) data system, the State has experienced temporary disturbances in data collection, particularly in its outcomes measurement systems. The State has proactively initiated corrective action steps with the SMO that specifically target claims and clinical outcomes data. This will allow OBH to better analyze data of interest to use in planning efforts. Reporting on this indicator will require the establishment of an effective linage between the data systems utilized for the Medicaid Bayou Health plans and the Statewide Management Organization (SMO). Thus, the ability of the State to report on this indicator is contingent on a successful linkage between the data systems.

Priority Area (6)	Primary Prevention Services
Priority Type	SAP
Goal	Prevent the onset and reduce the progression of substance abuse and other high-risk behaviors.
Strategies	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 13.
First Year Target/Outcome Measurement	The number of persons served in evidence-based prevention programs during SFY 14.
Second Year Target/Outcome Measurement	The number of persons served in evidence-based prevention programs during SFY 15.
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 13.
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 14.
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 15.
Data Source	Responses to GPRA questions are collected on Scantron pre-post tests administered to those individuals ages 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 (7)	Preventing Access of Tobacco Products to Minors
Priority Type	SAP
Goal	Reduce the access of tobacco products to individuals under the age of 18.
Strategies	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 10%.
Baseline Measurement	Annual SYNAR Retailer Violation Rate (RVR), as reported in 2013 Annual SYNAR Report.
First Year Target/Outcome Measurement	Annual SYNAR Retailer Violation Rate (RVR), as reported in 2014 Annual SYNAR Report.
Second Year Target/Outcome Measurement	Annual SYNAR Retailer Violation Rate (RVR), as reported in 2015 Annual 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.

LOUISIANA

FY 2014
Combined Behavioral Health Assessment and Plan

Part III
Use of Block Grant Dollars for Block Grant Activities

Part III: Use of Block Grant Dollars for Block Grant Activities

State Agency Planned Expenditures

(Table 2 of the FY2014 Block Grant Application)

State Agency Planned Expenditures (Substance Abuse) - Table 2

The table below details the projected total expenditures for the FY 2014 Substance Abuse Block Grant award.

States should project how the SSA will use available funds to provide authorized services. Plan Table 2 must be completed for the planning period.

Table 2 State Agency Planned Expenditures [SA]

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Planning Period - From SFY 2014 to SFY 2015

Activity (See instructions for using Row 1.)	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	$17,738,880		$	$1,675,867	$28,738,650	$	$5,825,221
a. Pregnant Women and Women with Dependent Children*	$ 4,091,235		$	$	$	$	$
b. All Other	$ 13,647,645		$	$ 1,675,867	$ 28,738,650	$	$ 5,825,221
2. Primary Prevention**	$ 5,068,251		$	$	$	$	$
3. Tuberculosis Services	$		$	$	$	$	$
4. HIV Early Intervention Services	$ 1,267,063		$	$	$	$	$
5. State Hospital			$	$	$	$	$
6. Other 24 Hour Care			$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care			$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$ 1,267,063		$	$	$	$	$
9. Subtotal (Row 1, 2, 3, 4 and 8)	$25,341,257	$	$	$1,675,867	$28,738,650	$	$5,825,221
10. Subtotal (Row 5, 6, 7 and 8)	$1,267,063	$	$	$	$	$	$
11. Total	**$25,341,257**	**$**	**$**	**$1,675,867**	**$28,738,650**	**$**	**$5,825,221**

State Agency Planned Expenditures (Mental Health) - Table 2

The table below details the projected total expenditures for the FY 2014 and FY 2015 Mental Health Block Grant awards.

States should project how the SMHA will use available funds to provide authorized services. Plan Table 2 must be completed for the planning period.

Table 2 State Agency Planned Expenditures [MH]

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Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	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			$	$	$	$	$
6. Other 24 Hour Care		$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care		$ 10,340,52	$ 15,177,69	$ 943,945	$ 98,708,68	$	$ 8,705,313
8. Mental Health Primary Prevention		$	$	$ 500,000	$	$	$
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)		$	$	$	$	$	$
10. Administration (Excluding Program and Provider Level)		$	$	$	$	$	$
11. Total	**$**	**$10,340,528**	**$15,177,699**	**$1,443,945**	**$98,708,684**	**$**	**$8,705,313**

* Prevention other than primary prevention

Substance Abuse Block Grant Planned Expenditures

(Table 4 of the FY2014 Block Grant Application)

The table below details the projected total expenditures for the FY 2014 Substance Abuse Block Grant award.

Substance Abuse Block Grant (SABG) Planned Expenditures - Table 4

States should 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 2014 and FY 2015 SABG awards.

Table 4 SABG Planned Expenditures

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Planning Period - From SFY 2014 to SFY 2015

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$ 17,738,880	
2 . Primary Prevention	$ 5,068,251	
3 . Tuberculosis Services	$	
4 . HIV Early Intervention Services**	$ 1,267,063	
5 . Administration (SSA Level Only)	$ 1,267,063	
6. Total	**$25,341,257**	

* Prevention other than primary prevention

** HIV Early Intervention Services

Primary Prevention Planned Expenditures

(Tables 5a, 5b, and 5c of the FY2014 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 would, 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 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 FY2014 SAPT Block Grant Award for Primary Prevention activities.

Substance Abuse Block Grant (SABG) Primary Prevention Planned Expenditures - Table 5a

States should project how they will use SABG funds to conduct and/or fund primary prevention and §192641-related activities. Primary prevention activities are those directed at individuals who do not require treatment for substance abuse. Plan Table 5a must be completed for the FY 2014 and FY 2015 SABG awards. The total amounts should equal amount reported on Plan Table 4, Row 2, Primary Prevention.

Strategy	IOM Target	SABG FY 2014
Information Dissemination	*Universal*	$611,289
	Selective	
	Indicated	
Information Dissemination Total		**$611,289**
Education	*Universal*	$3,886,162
	Selective	$21,200
	Indicated	$61,600
Education Total		**$3,968,962**
Alternatives	*Universal*	$50,000
	Selective	
	Indicated	
Alternatives Total		**$50,000**
Problem Identification and Referral	*Universal*	$50,000
	Selective	
	Indicated	
Problem Identification and Referral Total		**$50,000**
Community-Based Process	*Universal*	$140,000
	Selective	
	Indicated	
Community-Based Process Total		**$140,000**
Environmental	*Universal*	$100,000
	Selective	
	Indicated	
Environmental Total		**$100,000**
Section 1926 Tobacco	*Universal*	$148,000
	Selective	
	Indicated	
Section 1926 Tobacco Total		**$148,000**
Total Prevention Expenditures		**$5,068,251**
Total SABG Award		**$25,341,257**
Planned Primary Prevention Percentage		**20%**

Substance Abuse Block Grant (SABG) Primary Prevention Planned Expenditures - Table 5b

States should 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 2014 and FY 2015 SABG awards. The total amounts for each award should equal amount reported on Plan Table 4, Row 2, Primary Prevention.

Table 5b SABG Primary Prevention Planned Expenditures

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Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	$ 3,803,362	
Universal Indirect	$ 1,182,089	
Selective	$ 21,200	
Indicated	$ 61,600	
Column Total	**$5,068,251**	
Total SABG Award	**$25,341,257**	
Planned Primary Prevention Percentage	**20.00 %**	

Substance Abuse Block Grant (SABG) Planned Primary Prevention Targeted Priorities- Table 5c

States should identify the categories of substances and the special population categories the State BG Plans to target with primary prevention set-aside dollars from the FY 2014 and FY 2015 SABG awards.

Table 5c SABG Planned Primary Prevention Targeted Priorities

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

Targeted Populations	
Students in College	☑
Military Families	☑
LGBTQ	☐
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 FY2014 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.

Substance Abuse Block Grant Resource Development Activities Planned Expenditures - Table 6a

States should project how they will use SABG funds to conduct and/or fund resource development activities. Plan Table 6a must be completed for the FY 2014 and FY 2015 SABG awards.

Table 6a SABG Resource Development Activities Planned Expenditures

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Planning Period - From SFY 2014 to SFY 2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$ 449,139	$	$	$449,139				
2. Quality Assurance	$	$	$	$				
3. Training (Post-Employment)	$ 214,750	$	$	$214,750				
4. Education (Pre-Employment)	$	$	$	$				
5. Program Development	$	$	$	$				
6. Research and Evaluation	$ 226,460	$	$	$226,460				
7. Information Systems	$ 15,000	$	$	$15,000				
8. Total	$905,349	$	$	$905,349				

Mental Health Block Grant Non-Direct Service Activities Planned Expenditures

(Table 6b of the FY2014 Block Grant Application)

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

States should project how they will use MHBG funds to conduct and/or fund non-direct service activities.

Table 6b MHBG Non-Direct Service Activities Planned Expenditures
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Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	$ 267,259
MHA Planning Council Activities	$ 173,549
MHA Administration	$
MHA Data Collection/Reporting	$ 128,811
Enrollment and Provider Business Practices (3 percent of total award)	$
MHA Activities Other Than Those Above	$ 1,000
Total Non-Direct Services	$570619

Comments on Data:

Figures are based on CMHS Block Grant Intended Use Plan allocations for FY 2014.
Technical Assistance Activities include staff development (training and technical assistance).
Data Collection/Reporting includes consumer monitoring and evaluation.
Other includes Block Grant printing costs.

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Section C: Coverage for M/SUD Services

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA. Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?

2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their 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?

Louisiana has opted for a federally-facilitated Health Insurance Exchange. Health plans sold through that Exchange will primarily be regulated by the federal Center for Medicare and Medicaid Services (CMS), which has entered into a cooperative agreement with the Louisiana Department of Insurance to provide some enforcement functions related to the consumer protections of the Patient Protection and Affordable Care Act and the Mental Health Parity and Addiction Equity Act.

The Louisiana Department of Health and Hospitals is focused on strengthening and improving its current programs. The state has recently undergone two major transformations designed to better coordinate care and deliver better health outcomes: Bayou Health and the Louisiana Behavioral Health Partnership. Bayou Health allows over 900,000 Medicaid recipients to participate as members of a health plan, which are accountable for ensuring adequate provider networks and additional services like chronic disease management. The Louisiana Behavioral Health Partnership provides a single coordinating entity for behavioral health services for Louisiana's Medicaid and uninsured populations, and has allowed the state to expand its provider network and the number and types of services available through its Medicaid state plan.

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Section D: Health Insurance Marketplace

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities. Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

7. For the providers identified in Table 8 "Statewide Entity Inventory" of the FY 2012 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Louisiana has opted for a federally-facilitated Health Insurance Exchange. Health plans sold through that Exchange will primarily be regulated by the federal Center for Medicare and Medicaid Services (CMS), which has entered into a cooperative agreement with the Louisiana Department of Insurance to provide some enforcement functions related to the consumer protections of the Patient Protection and Affordable Care Act and the Mental Health Parity and Addiction Equity Act.

The Louisiana Department of Health and Hospitals is focused on strengthening and improving its current programs. The state has recently undergone two major transformations designed to better coordinate care and deliver better health outcomes: Bayou Health and the Louisiana Behavioral Health Partnership. Bayou Health allows over 900,000 Medicaid recipients to participate as members of a health plan, which are accountable for ensuring adequate provider networks and additional services like chronic disease management. The Louisiana Behavioral Health Partnership provides a single coordinating entity for behavioral health services for Louisiana's Medicaid and uninsured populations, and has allowed the state to expand its provider network and the number and types of services available through its Medicaid state plan.

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Section E: Program Integrity

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

At this point in time, many states will know which mental health and substance abuse services are covered in their benchmark plans offered by QHPs and Medicaid programs. SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (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 utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

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. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. 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. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

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

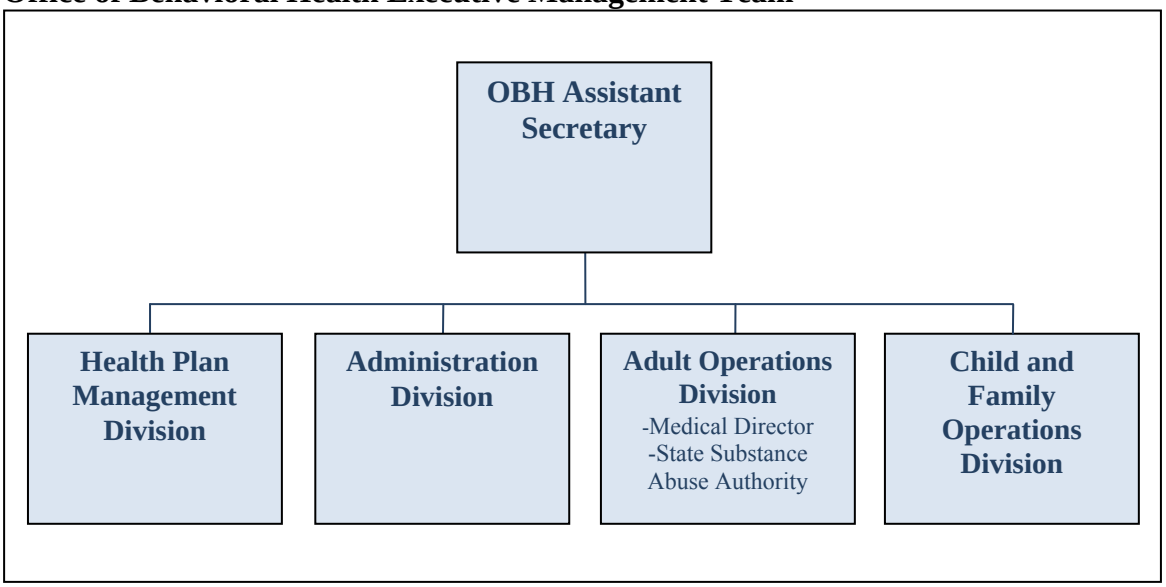
OBH utilizes a number of strategies in order to ensure Block Grant program integrity. The Regions and Local Governing Entities (LGEs) collect Block Grant information from local provider organizations via the quarterly Block Grant Set-Aside report. Regional and LGE staff conduct onsite visits, during which they review a sample of records to verify the information local provider organizations submit each quarter and review service billing. OBH Central Office staff also conducts onsite peer reviews, which occur on an annual basis. OBH staff reviews a sample of clinical records to document clinical practices and compliance with Block Grant requirements. In addition, OBH uses a contract attachment for all contracts that involve providing services funded by the Block Grant. This attachment outlines all contractual requirements, including all Block Grant requirements. OBH also requires that a Medicaid application be completed on everyone presenting to the clinics. The billing system is configured

to ensure that the appropriate payer is billed for services.

2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?

There are multiple functions within the Office of Behavioral Health (OBH) that have been implemented in order to ensure program integrity. The ultimate responsibility for program integrity lies with the OBH Executive Management Team (EMT), which consists of the Assistant Secretary of the Office of Behavioral Health and the Directors of the Health Plan Management, Administration, Adult Operations, and Child and Family Operations Divisions (see figure below).

Office of Behavioral Health Executive Management Team



3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds?

The State uses the following program integrity activities in order to monitor the appropriate use of Block Grant funds:

- Conducting provider compliance and financial audits.
- Reviewing claims for medical necessity by program monitors and contracted intermediaries.
- Identifying and investigating fraud during monitoring and audit processes.
- Ensuring that Block Grant funds are used only for services applicable to Block Grant objectives.
- Training and educating providers on Block Grant billing procedures through program personnel.
- Identifying improper billing practices and maintaining the integrity of the system in place.

Please indicate if the state utilizes any of the following monitoring and oversight practices:
a. Budget review;
b. Claims/payment adjudication;
c. Expenditure report analysis;
d. Compliance reviews;
e. Encounter/utilization/performance analysis; and
f. Audits.

The State utilizes all monitoring and oversight practices listed above.

4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?

The State monitors methodologies of systems and procedures to facilitate disclosure of material variances from estimated values. Audit procedures include verifying claims entered into the claims system to source documents and checking calculations to assure that these transactions are properly presented and accounted for.

5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

Each provider has a set of safety standards and policies and procedures in place to ensure safety and quality in their operations. In addition, 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.

6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

The State monitors methodologies as systems and procedures to facilitate disclosure of material variances from estimated. Audit procedures include verifying claims entered into the claims system to source documents and checking calculations to assure that these transactions are properly presented and accounted for.

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Section F: Use of Evidence in Purchasing Decisions

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. SAMHSA is requesting that states respond to the following questions:

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

The Louisiana Office of Behavioral Health has engaged in the implementation and monitoring of evidence-based practices for several years. Specific program staff works with EBP implementation, including Assertive Community Treatment, Permanent Supportive Housing, Multisystemic Therapy, Functional Family Therapy, Wraparound process, Cognitive Behavioral Therapy, Co-occurring Disorders Treatment, CASI, and ASI. Given the wide range or variety of EBPs being implemented, the responsibility for monitoring these implementations is shared across multiple staff. OBH also collaborates with other agencies, foundations, and/or grant funding sources to ensure monitoring of EBPs.

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
a) What information did you use?
b) What information was most useful?

Early in the developmental phase of the implementation of the Louisiana Behavioral Health Partnership (LBHP), the Office of Behavioral Health and partner agencies formed a committee to review and recommend screening and assessment tools for use within the LBHP. This process provided the opportunity to review a wide range of tools and discuss their use and benefit to the populations served, informing others within the Office of Behavioral Health (OBH) of the depth and breadth of such tools as discussions continued around LBHP implementation.

The process undertaken by the OBH Assessment and EBP Committee included the review of several documents and completion of a cross-walk reference document to develop criteria for selecting screening and assessment tools. The criteria served as the primary guide for accepting or rejecting screening and assessment tools for recommended use by the LBHP. The research into these tools was not exhaustive, but numerous sources were reviewed. The outcome of these efforts resulted in the development of a list of screening and assessment tools that met the criteria established and offered additional technical guidance around provider selection of these tools for use with their clients.

The Coordinated System of Care (CSoC) component of the LBHP was based upon research-based standards from the National Wraparound Initiative. 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 and are expected to adhere to these guidelines in all of their work. Services included in the Coordinated System of Care were based on evidence-based practices that provide fidelity to the integration of Wraparound Agencies (WAAs) and Family Support Organizations (FSOs) and the delivery of children's services.

The evidence-based information used in developing the Louisiana Behavioral Health Partnership (LBHP), including the Coordinated System of Care, was essential in developing, implementing, and refining the LBHP.

3) How have you used information regarding evidence-based practices?
a) Educating State Medicaid agencies and other purchasers regarding this information?
b) Making decisions about what you buy with funds that are under your control?

The State used information about evidence-based practices in order to incorporate evidence-based practices in the State Medicaid Plan. Specific evidence-based practices include the following:

- Assertive Community Treatment – an intense team approach to provide mental health treatment and support to people who have serious mental illness such as schizophrenia
- Multisystemic Therapy – a comprehensive family and community based treatment model for youth with the primary goal of keeping them from being placed in a juvenile correctional facility or other out of home placement
- Functional Family Therapy – a family based treatment model for youth ages 11 to 18 who are risk for or already involved in the juvenile justice system
- Homebuilders – an intense family and community-based family preservation treatment model to prevent children from being place outside their homes

The State has incorporated these evidence-based services in the reimbursable service array for the Louisiana Behavioral Health Partnership (LBHP) and continues to strive to expand the availability of these services. In addition, this information has informed the selection of the type of providers that are eligible to be credentialed as providers in the LBHP and funded for services. The State uses information regarding EBPs as a resource in discussions with agencies to inform recommendations for programs funded by various funding streams and encourages contractors to use information to drive changes in their programs in order to affect outcomes.

The Louisiana State Adolescent Treatment Enhancement and Dissemination Program (LA-SAT-ED), funded by SAMHSA, will serve adolescents ages 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. Through the development of two learning laboratories with collaborating local community-based treatment provider sites during year one and five additional sites during each of years two and three, Louisiana will be able to not only improve substance abuse assessment and treatment services for adolescents and their families, but also to identify barriers to accessing treatment and test solutions that can be applied throughout the state.

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Section G: Quality

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	**Substance Abuse Treatment**	**Mental Health Services**
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections – Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

The State looks forward to utilizing the Behavioral Health Barometer in planning efforts. Additional measures of interest include the following:

- Access to Behavioral Health Treatment
- Integration with Primary Healthcare
- Access to Prevention Services

2) Please provide information on any additional measures identified outside of the core measures and state barometer.

The State has identified a number of specific performance measures that address the areas of interest listed above. Following are examples of these measures:

- Access to Behavioral Health Treatment
    - The Louisiana Behavioral Health Partnership (LBHP), through the Statewide Management Organization (SMO), enrolls and reimburses for services for an increased number of mental health recipients in SFY 14 and SFY 15 as compared to those served in SFY 13.
    - The Louisiana Behavioral Health Partnership (LBHP), through the Statewide Management Organization (SMO), enrolls and reimburses for services for an

increased number of substance use disorder recipients in SFY 14 and SFY 15 as compared to those served in SFY 13.
    - There is an increased number of persons served through evidence-based programs through the implementation of the Louisiana Behavioral Health Partnership (LBHP) during SFY 14 and SFY 15 as compared to the number served in SFY 13.
- Integration with Primary Healthcare
    - There is an increased percentage of Medicaid Bayou Health plan/Medicaid legacy plan enrollees who are also enrolled with the Louisiana Behavioral Health Partnership (LBHP) during SFY 14 and SFY 15 as compared to SFY 13.
- Access to Prevention Services
    - The number of individuals served in evidence-based prevention programs.

3) What are your state's specific priority areas to address the issues identified by the data?

- Priority Area 1: Behavioral Health System Transformation through Medicaid Reform
- Priority Area 5: Primary Healthcare
- Priority Area 6: Primary Prevention Services

4) What are the milestones and plans for addressing each of your priority areas?

Please refer to Planning Steps Three and Four for more detail regarding strategies to address each priority area as well as the baseline and follow-up measurement that will be used to assess progress toward achieving the goals for each priority area.

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Section H: Trauma

In order to better 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 care approach consistent with SAMHSA's trauma-informed care definition and principles. 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 more supportive and avoid being traumatized again. Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

Trauma-related training opportunities are offered by the State in order to encourage trauma-informed care. 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. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

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. Magellan utilizes the CPG Workgroup to assist with policy development around clinical best practices. Utilizing trauma-focused therapy remains under active consideration. Currently, many CBT approaches are utilized by network practitioners.

3. Does your state have any 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.

4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?

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), Magellan will offer providers support on providing trauma-informed care.

5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

OBH offers access to courses within the learning management system on trauma-informed care and has in the past offered training opportunities by selecting expert speakers on the subject to provide face-to-face training sessions. 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 Mental Health Awareness Summit during the summer of 2012 for parents, providers, and other stakeholders with the theme "Trauma and Resiliency: Heroes of Hope." Objectives of the summit included helping attendees to gain an understanding of the pervasive nature of traumatic experiences among youth and the long-range effects relative to social, academic, emotional, and physical development and increasing awareness of trauma and associated resiliency among youth addressing processes that either promote well-being or protect against overwhelming influencing risk factors. The keynote speaker during the summit was an expert in the trauma field. The focus of the keynote address was "Why Trauma Matters and the Implications for System Transformation." Breakout sessions were offered that focused on trauma-related topics, such as "Essential Ingredients of a Trauma-Informed System" and "Art by Traumatized Children: Use of Art with Children as a Method of Communication."

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.

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Section I: Justice

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 abuse 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. [42,43] *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 utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.*[44]

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. 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 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. Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems 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.

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

Each parish government has their own method of dealing with individuals with mental health and/or substance use disorders. Several have excellent mental health or substance use disorder courts that divert individuals from the jail into treatment. Others have none. The Office of Behavioral Health (OBH) has ongoing projects with several regions to provide diversion services for those individuals. For example, OBH recently obtained a grant from SAMHSA that will fund data collection and analysis, as well as publish a model program, for the diversion of adults

with mental illness in Lafayette Parish, which has developed a diversion program for individuals with mental illness and a re-entry program for individuals returning from state prisons.

3. Are your SMHA and SSA coordinating 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?

OBH has a MOU 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. Juvenile judges often order youth to DHH/OBH custody as a diversion which requires OBH to place the youth in the hospital and then to find resources upon discharge.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

Anyone who is eligible is enrolled in Medicaid. Since many of the youth involved in the juvenile justice system are placed in DHH/OBH custody, their discharge planning involves issues specific to their juvenile justice involvement.

5. What cross-trainings do you provide 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 Juvenile Justice and Children's Services where information is shared in regard to obtaining services for juveniles. 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.

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42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman,2000.
43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.
44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

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Section J: Parity Education

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. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.)?

3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

OBH recognizes the importance of parity education in order to increase knowledge of the benefits of behavioral health services and to increase access to services. The State envisions utilizing the Statewide Management Organization (SMO), Magellan, and its provider network communication infrastructure to educate and raise awareness among stakeholders about parity-related matters. In addition, OBH will work with the Louisiana Behavioral Health Advisory Council and other advocates in order to communicate information about parity to stakeholders; particularly consumers and those in need of behavioral health services.

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Section K: Primary and Behavioral Health Care Integration Activities

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 rewarded to coordinate 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 answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

On March 1, 2012, the Louisiana Behavioral Health Partnership (LBHP) was implemented statewide. Prior to implementation of the LBHP, behavioral health services were delivered in a fragmented fashion. People experiencing mental health or addictive disorder challenges had to go through multiple systems to get the treatment they needed. The LBHP provides a new approach to both delivering and financing behavioral health services for Louisiana's children and adults through a fully integrated, single point-of-entry system. This new service delivery model creates an integrated public behavioral health service system drawing on the strengths of the private, public and non-profit sectors. The goals are to provide enhanced access to a more complete and effective array of evidence-based behavioral health services and supports and improve individual health outcomes.

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

Louisiana has multiple newly implemented initiatives to coordinate both primary healthcare and behavioral healthcare for residents, which includes the Bayou Health and Louisiana Behavioral Health Partnership (LBHP) initiatives, respectively.

The LBHP initiative is managed by Magellan of Louisiana, which credentials and oversees the provider network, as well as coordinates and approves services for members presenting for behavioral health services. Within the LBHP is Louisiana's Coordinated System of Care (CSoC). Louisiana's CSoC is a multi-agency effort that brings together the Office of Juvenile Justice (OJJ), the Department of Children and Family Services (DCFS), the Department of Health and Hospitals (DHH), and the Department of Education (DOE) to serve children and youth that have significant behavioral health challenges or co-occurring disorders and are in or at imminent risk of out of home placement.

On February 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 offers 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.

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

The Department of Health and Hospitals (DHH) Office of Behavioral Health (OBH) participated in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Region VI Primary Behavioral Health Care Integration State Team Meeting, September 27, 2012. In addition to representatives from OBH, the Louisiana Team included representatives from DHH - Medicaid, DHH - Louisiana Birth Outcomes Initiative, DHH - Office of Public Health, Louisiana Public Health Institute, Louisiana Primary Care Association, Odyssey House, Capital Area Human Services District, Magellan of Louisiana, and The Extra Mile.

On March 28, 2013, the Louisiana State Team for Primary and Behavioral Health Care Integration in partnership with SAMHSA sponsored a Health Summit entitled *Advancing Behavioral Health and Primary Care Integration: The Louisiana Summit.* The Summit was hosted by OBH and facilitated by expert consultants from the National Council for Community Behavioral Healthcare. There were over 100 individuals in attendance from behavioral health and primary care agencies statewide. The Summit allowed participants to: 1) Establish a commitment from meeting participants to make integration a priority within their sphere of influence; 2) Identify key priorities and next steps; and 3) Potentiate networking for the local program development needed to further promote integration of primary care and behavioral health across Louisiana. Another Summit was held in June 2013.

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

State-operated behavioral health clinics and facilities have tobacco-free policies and protocols in place to address nicotine dependence. These policies outline procedures for screening, assessing, and treating nicotine dependence. In January 2013, OBH developed a strategic plan to enhance tobacco cessation services to more effectively treat the tobacco dependent population. In February 2013, OBH partnered with the Office of Public Health (OPH) to train employees on screening, referral, and treatment for persons seeking tobacco services. This partnership offered the opportunity to provide statewide trainings in four areas of the state *(Alexandria, Shreveport, Baton Rouge and Lake Charles)*. Staff from across the state participated in this workshop entitled "Brief Treatment of the Tobacco Dependent Patient" by Thomas J. Payne, Ph.D. In addition, staff was trained on OPH's Fax to Quit and the Quit line Program, which offers coaching and mentor services via the phone line.

Smoking Cessation Protocol for Hospitals

Louisiana hospitals developed policy and procedures to stop the use of tobacco. The program was fully implemented on March 31, 2013 and the hospitals are now 100% tobacco free. The following procedure is used in the hospitals to address the use of tobacco.
Upon admission, all patients go through an intake interview in which they are questioned about their tobacco use.

- Patients who have not used tobacco in the past two weeks are given a handout with the tobacco policy and a summary of available help, which is a brief written and/or verbal summary of available materials, groups, and Nicotine Replacement Therapy.
- 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 next steps:

FTND or FTND-ST Score	**Rating**	**Action**
0-2	Low Dependence	**+ Benefits of Quitting**: Printed summary of benefits of living tobacco-free **+ Tips to Manage Craving**: Printed list of appropriate suggestions to cope with tobacco craving and withdrawal
3-5	Moderate Dependence	**+ Offer Kicking Butts Group**: Open-ended support group **+ Information on Nicotine Replacement Therapy (NRT)**: Printed and/or verbal information on NRT that may be available to some patients
6-10	Severe Dependence	**+ Medical Assessment for Nicotine Replacement Therapy (NRT)**: Medical staff determine: a) whether patient can safely use any NRT product; b) which form of NRT is most appropriate; c) starting dose and projected tapering schedule **+ Offer Stress Busters Group**: Closed group to teach stress management techniques **+ 30-day Screening for Depression, Anxiety:** Brief assessment for any clinically significant symptoms of depression or anxiety that may have emerged since tobacco cessation
		+ Nicotine Replacement Therapy (NRT): Patch lozenges, gum, etc. If offered, must include training on proper use, dangers, side effects, and signs of nicotine poisoning.

Since the hospitals are now 100% tobacco free, only newly admitted individuals are assessed for current use. If they have used tobacco in the past two weeks, the steps listed above are followed. For current patients, they 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; therefore CO monitoring is not necessary.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

State-operated behavioral health clinics have tobacco-free policies and procedures in place to treat the nicotine-dependent person seeking services. The procedures outline the use of evidence-based models and tools, such as the Fagerstrom Test for Nicotine Dependence, the 5 A's Brief Intervention Model (Ask, Advise, Assess, Assist, and Arrange), Motivational Interviewing and the use of nicotine-replacement medications. In an effort to continue with OBH's strategic plan to enhance tobacco cessation services, OBH offered state employees the opportunity to participate in the Certified Tobacco Treatment Specialist Training (five day) during the week of May 6th through May 10th, 2013. This program prepares professionals with appropriate educational and experiential backgrounds to deliver a high-intensity, evidence-based, cognitive-behavioral treatment for nicotine dependence. It emphasizes the acquisition of fundamental knowledge and skills relevant to understanding the addictive nature of tobacco use, its impact on health and other factors, and key clinical activities for assessing and treating the nicotine dependent individual. A unique aspect of this program is that clinical skills are taught within the context of mastering Tobacco Treatment protocol. This manualized, evidence-based approach is the product of many years of testing and experience, and represents an effective balance of state-of-the-art clinical procedures. This training will allow employees the opportunity of becoming a Certified Tobacco Specialist.

6. Describe how your behavioral health providers are screening and referring for:
a. heart disease,
b. hypertension,
c. high cholesterol, and/or
d. diabetes.

Each individual is medically screened during the intake process. The medical screen is reviewed by medical staff and when necessary, individuals are referred to their primary care physician, a Federally Qualified Health Center (FQHC), or an urgent care/emergency room. Medical histories are also collected as a component of the nursing assessment, psychosocial assessment and the Addiction Severity Index (ASI), with appropriate referrals made as previously indicated.

Region/ LGE	Heart Disease	Hypertension	High Cholesterol	Diabetes
AAHSD	Medical History Addiction Severity Index (Psychiatric Section)	Medical History Addiction Severity Index (Psychiatric Section)	Medical History Addiction Severity Index (Psychiatric Section)	Medical History Addiction Severity Index (Psychiatric Section)
Region 5	Initial Assessment and during review of systems and medical history	Nursing assessment - vital signs – initial and return physician visits	Initial Assessment Lab work prior to starting medicines and ongoing depending on medicine protocol	Initial Assessment Nursing assessment- vital signs – initial and return physician visits
Region 6	Medical History History of medical	Medical History History of medical	Medical History History of medical	Medical History History of medical

	illness in psychiatric evaluation (for co-occurring), medical history, baseline labs, nursing flow sheet	illness in psychiatric evaluation (for co-occurring), medical history, baseline labs, nursing flow sheet	illness in psychiatric evaluation (for co-occurring), medical history, baseline labs, nursing flow sheet	illness in psychiatric evaluation (for co-occurring), medical history, baseline labs, nursing flow sheet
Region 7	Nursing Assessment - Review of Systems	All clients receive blood pressure screening during initial medical assessment	Nursing Assessment - Review of Systems; Psych Eval and baseline lab	Nursing Assessment - Review of Systems; Psych Eval and Baseline Labs; fingerstick glucometer testing available in every clinic
Region 8	Medical History for AD; Clients with AD/MH issues - History of medical illness in psychiatric evaluation, Medical History, and nursing flow sheet.	Medical History and vitals obtained for AD clients; For clients with AD/MH issues – Medical History, Vitals, History of medical illness in psychiatric evaluation, and nursing flow sheet.	Medical History for AD; Clients with AD/MH issues – History of medical illness in psychiatric evaluation, Medical History, baseline labs, nursing flow sheet.	Medical History for AD; Clients with AD/MH issues – History of medical illness in psychiatric evaluation, Medical History, baseline labs, nursing flow sheet.

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Section L: Health Disparities

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). 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, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, 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, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

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. In order 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).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

The Office of Behavioral Health (OBH) recognizes that for a behavioral health system to be effective, it must respect and make every effort to understand and be responsive to cultural differences among the various populations served and in need of services. OBH ensures that information is used to explore, acknowledge, and address disparities in access to care and outcomes among those served. The Louisiana Behavioral Health Advisory Council has recently restructured its membership composition in order to include representatives from various populations (such as elderly, LGBTQI, Native American, transition aged, and homeless individuals) who can provide a voice to speak to unique needs that need to be addressed by the behavioral health system. OBH requires the Statewide Management Organization (SMO) to develop and implement a Cultural Competency Plan with specific goals and measurable outcomes that address the impact of culture, ethnicity, race, gender, sexual orientation, and social class with the service delivery process, the ability of individuals and families/caretakers to access and use services, and how systems within and across each region operate. In addition, the plan must address the fit and relevance of services and service providers to the communities within each region and strategies to optimally engage individuals and families/caretakers in ways that reflect their culture and experiences. The SMO Outcomes Management and Quality Improvement Plan must include racial and ethnic disparities (under-utilization of services by

particular populations) and disproportional use of out-of-home services (over-utilization of out-of-home services by particular populations). The Race Equity Department with the SMO receives and reviews on a quarterly basis demographic statistics from Coordinated System of Care (CSoC), My Life, and information from the data and claims systems based on members with authorizations.

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?

The SMO care managers and member services representatives are trained to connect members with language needs to a translator contracted with the SMO. There is no reporting system to track the number of language need requests at this time.

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?

The SMO Race Equity department has developed a Provider Self Assessment Tool to help providers review their cultural competency and have the availability to access technical assistance or training from the Race Equity Department to help them in providing fair and equitable access to services for all Louisiana residents.

4. How will you use Block Grant funds to measure, track and respond to these disparities?

Information about disparities is used to inform and make necessary adjustments to budgeting. Additionally, OBH funds supplemental services to disparate populations, inclusive of education dissemination, webinars, and forums on topics relevant to promoting access and desire for treatment and prevention services.

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Section M: Recovery

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, 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. Please answer yes or no to the following questions:

Indicators/Measures

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

Yes – Louisiana has adopted the definition of recovery as stated by Recovery Innovations in Arizona. The definition is: "Recovery is finding your strengths, and using those 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.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

Yes - 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.

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

Yes – these are all tenets of care as provided through the Louisiana Behavioral Health Partnership. Additionally, OBH has been instrumental in bringing initiatives such as WRAP to Louisiana through which trainers are functioning throughout the state.

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

Yes – Peers are currently working throughout the service system providing recovery supports to individuals enrolled in services.

5. 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, LGBTQ populations, and families/significant others?

Louisiana is currently involved in the Service Members, Veterans, and their Families Policy Academy, the Substance Abuse Treatment Initiative (SATI) – partnering with the Louisiana National Guard, and the Policy Academy on Reducing Chronic Homelessness, which will assist the state with expanding and enhancing peer-delivered services to better meet the needs of many of these populations of focus.

6. 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?

Louisiana is currently working with Recovery Innovations in Arizona to develop a training program for service providers and their staff. Peer Support Specialists are trained and certified through a 72 training program.

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

No – Louisiana does not currently have a certification or accreditation program for peer run services. However, through the International Certification & Reciprocity Consortium (IC&RC), standards for a Peer Recovery (PR) Credential are currently under development for states to further the contribution of those in recovery helping those seeking recovery from mental illness and addictions. The Louisiana Association of Addiction Counselors and Trainers is working in tandem with the IC&RC to develop the training curriculum. Louisiana has a 72 hour training program to certify Peer Support Specialists, and is currently working on an advanced level IC&RC certification.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Recovery support services have proven to be an effective and efficient way to support persons in recovery and improve outcomes in Louisiana; therefore, the state has a history of supporting and funding recovery support services in behavioral health programs. Since 2005, Louisiana has operated an Access to Recovery (ATR) program that funds treatment, recovery support services, and care coordination services for persons with addictive disorders. When federal funding to the ATR program ended in 2010, the State chose to continue funding this program due to the

successful performance and outcomes. The Permanent Supportive Housing (PSH) program also provides recovery support and peer services to persons with mental disorders and co-occurring disorders.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must 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 actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

The Office of Behavioral Health (OBH) has actively recruited and trained peers in both Wellness Recovery Action Plan (WRAP) and Peer Support since 2008. As a result of these trainings there are now over one hundred six peers employed throughout the system of care to serve as hope builders who utilize strengths-based techniques in a peer-to-peer role. The programmatic structure and implementation was spearheaded by peers in collaboration with advocates, state employees, and peer/family members. This was primarily accomplished by the WRAP/PSS Steering Committee, in operation since 2008, and by the regional leads who "bought into" the program from the outset.

Through the block grant, the OBH supports peer drop-in-centers in every Region/Local Governing Entity (LGE) except the Florida Parish Human Service Authority (FPHSA) area. OBH recognizes that peers can be included at an increased rate and level; therefore, in FY2013 the program coordinator for consumer affairs will continue the process of developing regional-based groups of WRAP Facilitators, Advocates, and Peer Support Specialists who will provide input into and suggestions for the creation and enhancement of peer services. Individuals from these groups will be selected to form a statewide team whose purpose will be to provide input into and ultimately shape future services offered by OBH.

The Louisiana Coordinated System of Care (CSoC) is led by the CSoC Governance Board, which includes youth and family members. The State Coordinating Council includes representatives from all regions, with half of each region's representatives being youth or family members. OBH recently added a full-time family member to OBH Central Office staff to help inform and guide decision-making by the Director of the Child and Family Operations Division and other OBH leadership staff. The Statewide Management Organization also employs family members in order to provide a family/youth voice to its operations. In addition, the Behavioral Health Advisory Council includes members who are behavioral health consumers, family members of individuals with behavioral health disorders, and parents of children and youth with behavioral health disorders.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

The Louisiana Behavioral Health Advisory Council, originally established as a Mental Health Planning Council under PL 99-660 guidelines, is integrally involved in statewide planning and development of mental health services. The current Council includes 40 members consisting of consumers, family members of adults with serious mental illness, family members of children with emotional/ behavioral disorders, advocates, Regional Advisory Council representatives, local governing entity representatives, and state agency employees. The Advisory Council also monitors, reviews, and evaluates the allocation and adequacy of mental health services within the state. The ten local Regional Advisory Councils (RACs), similar in purpose to the Advisory Council, focus on the issues and needs specific to their respective geographic areas. The RACs are the lead agencies in advising how Block Grant funds will be allocated locally. RAC membership is reflective of that of the Advisory Council, in that it consists of members who are primary consumers, family members, family members of children with emotional/behavioral disorders, advocates, and state agency (Region or LGE) employees. In FY2013, the State Behavioral Health Advisory Council continued the process of further integrating the Council to better address the identified needs of the behavioral health service system within Louisiana (*see Section W: State Behavioral Health Advisory Council*).

The OBH continues to support the annual Public Forums in each Region/LGE. Historically a function of the Office for Addictive Disorders, focusing on substance use disorder prevention and treatment, this series of statewide forums now includes increasing community awareness of behavioral health services, and obtaining local feedback from stakeholders regarding the behavioral health service system. The forum format offers an opportunity to assess consumer needs, as well as to establish a common ground for providing information to the community and for receiving input from stakeholders. During FY 2012, the Public Forum discussions focused on the implementation of the Louisiana Behavioral Health Partnership (LBHP), including the Louisiana Coordinated System of Care (CSoC) initiative for children/youth with extensive behavioral health needs either in or at-risk of out-of-home placement, and the impact of this transition on the Office of Behavioral Health (OBH) infrastructure. Stakeholder input is used, along with other needs assessment data, to guide the State planning process for service delivery priorities.

A goal of the OBH consumer affairs section was to develop more consumer and family services meetings in FY 2013.

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

In addition to the efforts of the aforementioned Peer Specialists and WRAP Facilitators network within Louisiana, the Access to Recovery (ATR) program offers individuals the opportunity to proactively engage and participate in their ongoing care. Supported by state general funds, ATR provides client choice among substance use disorder clinical treatment and recovery support providers, and expands client access to a comprehensive array of clinical treatment and recovery

support options, including faith and community-based organizations. A key feature of the ATR program is that individuals have a free choice of treatment and recovery support providers through each level of their continuum of care. ATR providers facilitate individual choice and promote individualized pathways to recovery through the provision of evidence-based substance abuse treatment and recovery support services. Each client is issued a voucher for services that is based on his/her informed understanding and independent selection of providers from an available list of recommended options.

The philosophy of the Coordinated System of Care (CSoC) initiative is focused on self-directed treatment planning and care. CSoC responds to the needs of Louisiana's highest-need young people and their families through wraparound services to reduce the number of children and youth in detention and residential settings. The CSoC institutionalizes wraparound facilitation and involves children and their families in the development of an intensive, individualized care planning and management process. The family, the youth, and the family support network comprise the core of each family's team members, joined by parent and youth support staff, providers involved in the care of the family, representatives of agencies with which the family is involved, and natural supports chosen by the family. The organizations providing Wraparound Facilitation in Louisiana's CSoC are identified as Wraparound Agencies (WAAs).

The WAAs are the locus of accountability for developing a single plan of care and providing intensive care coordination for children and their families. The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network. A critical component and source for the family-to-family supports is the creation of Family Support Organizations. A Family Support Organization (FSO) is a family-run, nonprofit corporation governed by a board of directors known as its Local Coordination Council (LCC). The FSO is charged with building capacity and providing certified family support specialists and youth support specialists who participate in the child and family team process coordinated by the WAA. Through the FSO, system-experienced families and youths can work in partnership with the identified family unit. The FSO provides a unique and effective manner of ensuring that family involvement becomes routine as opposed to the exception.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Currently, the state sponsors and provides technical assistance as requested to Mental Health America and the National Alliance on Mental Illness utilizing, at least partially, Block Grant dollars. These organizations provide educational trainings, sponsor advocacy awareness events and serve as resources for peers and families in Louisiana. Examples of programs include BRIDGES (Building Recovery of Individual Dreams and Goals through Education and Support), Family to Family, and Behavioral Health Advocacy training. In addition, all trainings and

continuing education opportunities for WRAP Facilitators and Peer Support Specialists are funded through Block Grant support for recovery support services.

The Office of Behavioral Health is committed to encouraging and supporting the development of recovery homes for persons recovering from a substance use disorder, through an ongoing partnership with Oxford House, Inc. Oxford House, Inc. is a non-profit corporation that serves as the umbrella organization connecting all Oxford Houses and allocating resources to duplicate the Oxford House Model where needs arise. An Oxford House describes a democratically run, self-supporting, and drug free home. OBH contracts with Oxford House, Inc. to expand recovery home capacity throughout Louisiana, conduct outreach services in the community in order to engage referrals, and to conduct advocacy services in order to reduce stigma related to persons recovering from a substance use disorder. Oxford Homes are currently in all Regions/Local Governing Entities of the state with 67 operational homes, having a total of 493 beds.

OBH also continues to support National Recovery Day in September of each year. During FY2011 and FY2012, Recovery Day was promoted throughout the State in specific ways designed to reach the Recovery Community and to reduce the stigma associated with Recovery. Each Region/Local Governing Entity (LGE) conducted various activities and initiatives related to recovery (see detail in list below). OBH Central Office also participated in Recovery Day by hosting an art exhibit open to the public entitled "The Art of Recovery," which showcased artwork created by individuals served by OBH programs, obtaining a proclamation issued by the Governor declaring September as Recovery Month in Louisiana, hosting a brown bag lunch to celebrate and discuss recovery, facilitating discussions about recovery during staff meetings, and hosting screenings of the film *Healing Neen*.

Examples of recovery-oriented activities conducted by Regions/Local Governing Entities (LGEs) in various parts of the state during the month of September, 2012 include the following:

- Counselors conducted depression screenings and substance abuse screenings.
- Staff set up recovery themed bulletin boards or banners in clinic lobbies and set up tables with materials such as pamphlets, bookmarks, key chains and pens available for clients, including materials specifically targeted toward children and youth. Materials were distributed at events and public locations as well.
- Staff played treatment-related films in the clinic.
- Staff implemented recovery-themed activities, including artwork and displays showcasing work done by clients, opportunities for clients to share their stories of recovery, and events such as barbecues and games.
- Staff facilitated recovery month proclamations from local mayors' offices and attendance at recovery events by elected and other governmental officials.
- Staff conducted a "Day of Sharing," utilizing Peer Support Staff to establish groups to share their recovery stories.
- Peer support staff held a function during the month of September at a NAMI housing location.
- Prevention specialists conducted presentations and seminars on recovery, including at local college campuses and to members of the clergy.

- Staff participated in a recovery-oriented event offered by the Veteran's Administration and a local homeless coalition, during which they shared information about recovery and available services.
- Staff worked with local newspapers or radio stations to release content about recovery, including specific recovery-related activities and available resources.
- Staff and clients participated in annual suicide prevention walks and organized recovery-oriented walks.
- Staff conducted weekly recovery-oriented discussion groups and classes.

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

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 over arching 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 waiver. 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.

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

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 is working with the Louisiana Housing Corporation, previously called the Louisiana Housing Finance Agency, to advocate and request inclusion for 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.

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Section N1: Evidence-Based Prevention and Treatment Approaches for the SABG

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.
The SABG statute directs states to implement strategies including: (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies. States should provide responses to the following questions:

1. How did 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 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.

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, 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.

After the proposed action plans are reviewed at the regional level, they are submitted and reviewed by OBH Central Office Prevention staff. OBH Prevention Services has established cost bands for direct universal and selective services. Indicated services are evaluated individually. Written recommendations are sent to the regions and Local Governing Entities (LGEs) for corrections. A third review is completed by the regional administrators, state Prevention staff, and state Fiscal staff for corrections or to answer fidelity questions. Each action plan is required to use an external evaluator to determine statically significant outcomes. Corrections are made and the action plans are processed as a contract.

The state has relied heavily on the Caring Communities Youth Survey (CCYS) to identify and implement evidence-based prevention programs in school-based settings. The state requested and has been receiving technical assistance from the Southwest Resource Team (SWRT) and Johnson, Bassin, and Shaw (JBS) to identify additional data sources beyond the CCYS, as the CCYS only provides data regarding need among youth who are in school. Per the current Service Plan for 2013-2014 with the SWRT, the following services will be provided:

- Customized consultation to the National Prevention Network (NPN) representative, Leslie Brougham-Freeman, state prevention staff, and the State Epidemiological Outcomes Workgroup (SEOW) on identifying data sources that the state could utilize to expand their epidemiological profile and provide local community data that will assist the state with prevention planning related to the Block Grant and PFS 2013 funding. The SWRT will also provide technical assistance on other methods of collecting and analyzing local and community data.
- Customized technical assistance to Louisiana on incorporating data across the lifespan into the epidemiological profile, and how to use the data to plan and select evidence-based interventions, including environmental strategies. The goal is to move the state into a paradigm shift from school-based interventions to incorporating environmental approaches.

The SWRT has provided two documents ("Data Sources Used by States and Tribes in the CAPT Southwest Resource Team Service Area" and "Additional Data Sources"), whose content will be incorporated into future planning at state and community levels.

The Service Plan also includes a section related to working with members of the military and their families. The SWRT will facilitate webinar sessions to increase the capacity of prevention staff to provide substance abuse prevention services to members of the military and military families. The purpose of the webinars will be to strengthen the capacity of prevention staff to deliver culturally competent prevention interventions to the military and their families, as defined by SAMHSA under Strategic Initiative Three. The State has also requested that the SWRT provide access to a training portal on understanding military culture and the military family to prevention staff. In addition, as part of the Substance Abuse Services Initiative (SASI),

OBH Prevention staff will be proving suicide prevention trainings (safeTALK and ASIST) and the Strong Choices Prevention Program to National Guard units statewide.

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

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.

The following school-based evidence-based programs are funded: LifeSkills Training, Project Northland, Too Good for Drugs, Second Step, Coping Skills, Positive Action, Project Alert, Al's Pals, Protecting You-Protecting Me, Guided Imagery Program, Project Toward No Tobacco Use, Keep a Clear Mind, Strengthening Families, and Insight Class Program. By partnering with the Louisiana Department of Education to provide these school-based services, 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 also funds evidence-based environmental strategies to include tobacco compliance checks and unconsummated compliance checks coupled with merchant education.

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.

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. Louisiana's prevention system is changing from the original ten regions to the formation of Local Governing Entities (LGEs). Six of the ten regions are already LGEs and the other four are scheduled to become LGEs by 2014. OBH maintains a functional relationship with both LGEs and Regional Prevention

Coordinators (RPCs) through regularly scheduled telephone conversations. RPCs are monitored via OBH's 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. OBH continues to sustain its partnerships with the Department of Education, the Governor's Office, and others. 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 RPCs, providers, and other partners to build prevention workforce capacity.

4. What outcome data 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?

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 eight 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 evaluator to conduct 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. It was noted that this action on the part of OBH led to an evaluation tool for three promising programs being implemented.
- 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. State and regional staff review these reports to determine fidelity improvement needs by content area of each program. It also helps strengthen the monitoring process of the evaluation cycle. Quarterly reviews of process and monitoring data ensures a stronger outcome evaluation system.

The following are examples of desired outcomes from LifeSkills Training, Strengthening Families, and Project Northland:

- Decreased substance use
- Development of resistance to peer/media pressure to use substances
- Development of a positive self-image
- Development of decision-making/problem-solving skills
- Improved ability to manage anxiety

- Improved communication, including between parents and children regarding alcohol
- Building and maintain healthy relationships, including family relationships
- Increased youth self-confidence in social situations
- Impact on children's internalizing and externalizing behaviors
- Improved parenting practices/parenting efficacy
- Identification of reasons to not use alcohol

The purpose of collecting and analyzing outcome data is to evaluate how well school-based evidence-based programs are being implementing and how successful they are at achieving intended outcomes by individual program. In an effort to gather more specific data, GPRA measures have been added to the developer created pre and post tests related to consumption of tobacco, alcohol, and other drugs for those individuals who are enrolled in on-going school-based prevention programs. The state is receiving technical assistance in identifying programs and strategies to expand services across the lifespan (beyond school-based prevention programs), along with collecting and analyzing outcome data for these services.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

Louisiana has supported the implementation of the Strategic Prevention Framework (SPF) statewide. OBH Prevention Services has been involved in the development of multiple strategic plans, including the SPF 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.

Training and technical assistance regarding the SPF process will continue to be implemented statewide. Both the SPF curriculum and CAPT's Substance Abuse Prevention Skills Training (SAPST) are available to key prevention stakeholders on an on-going basis throughout the year. SABG dollars are utilized to fund staff both at the state and sub-state (community) levels as well as to fund needs assessment surveys, necessary for community planning.

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

Approximately 95% of the SABG prevention set-aside goes directly to local communities through contractual agreements for evidence-based programs as well as local prevention coordinators who provide technical assistance, support, monitoring, and serve as community mobilizers. The remaining 5% of the SABG prevention set-aside goes to the state. State funds are utilized to fund state-level Prevention leadership as well as contractual agreements for needs assessment surveys, workforce development, Synar, and evaluation.

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

95% of the prevention set-aside goes to fund evidence-based practices and environmental strategies. Environmental strategies funded include: 1) A contractual agreement with the State Office of Alcohol and Tobacco Control to conduct tobacco compliance checks; and 2) A contractual agreement with a community-based organization in each of the ten geographic areas of the state to work with community volunteers to conduct 400 unconsummated compliance checks coupled with merchant education**.** These visits are an important part of reinforcing youth tobacco access laws and educating merchants about penalties.

Universal, indicated and selective evidence-based programs are funded by the prevention set-aside. Universal programs funded include LifeSkills Training, Project Northland, Too Good for Drugs, Second Step, Coping Skills, Positive Action, Project Alert, Al's Pals, Protecting You-Protecting Me, Guided Imagery Program, Project Toward No Tobacco Use, and Keep a Clear Mind. Indicated programs funded include Strengthening Families. Selective Programs include Insight Class Program.

In addition, a portion of statutorily dedicated gambling monies received by OBH fund Kids Don't Gamble…Wanna Bet? statewide, which is an interdisciplinary program designed for youth in the 3rd to 8th grade to discourage underage gambling through improved critical thinking and problem solving.

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Section N2: Evidence-Based Prevention and Treatment Approaches for the MHBG

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process.

States should describe how they intend to implement the competitive grants and/or sub award process.

Following is Louisiana's plan for complying with the Evidence-Based Prevention and Treatment Approaches for the MHBG set-aside, with plan implementation being contingent upon the President's proposed FY 2014 budget with the set-aside included being passed. The Office of Behavioral Health (OBH) allocates a portion of the MHBG to each of the 10 regions and Local Governing Entities (LGEs). OBH will establish a competitive framework for selection of a sub-recipient (contractor) in each of the LGEs to implement effective evidence-based prevention and treatment approaches focusing on promotion, prevention, and early intervention. All potential sub-recipients (contractors) will be required to submit a proposal to their respective region or LGE. These proposals must include the following components: 1) Demonstration of Need; 2) Identification of Appropriate Evidence-Based Programs, Policies, and Practices; 3) Action Plan Outlining Implementation; and 4) Commitment and Demonstration of Capacity to Collect Required Process and Outcome Data. OBH will provide necessary technical assistance (TA) and support to the regions and LGEs in the selection of sub-recipients and will also provide ongoing TA and support to those sub-recipients who are selected.

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Section O: Children and Adolescents Behavioral Health 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 over 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.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, 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 answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with 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 includes five of the state's nine regions. 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. Within Central Office at OBH, 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. In addition, through the Statewide Management Organization (SMO), those regions not included in Phase One have access to specialized care planning processes for youth who meet this same level of need. The teams at both the State Office and the SMO are charged with training, technical assistance, monitoring, and quality assurance activities to ensure that the system of care approach is generalized and implemented.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with 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 both the state and the SMO teams and a random sample will be reviewed as part of planned evaluation activities for CSoC (including partnership with the Wraparound Evaluation and Research Team based at the University of Washington). For youth in non-implementing regions, individualized care planning is 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. Each participating state agency participated in extensive planning for a new behavioral health system for children, youth, and their families that would ensure access to appropriate services and supports for their respective populations. Culminating from this effort, each agency has contributed funding to finance this system. 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.

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?

Following 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 Louisiana State Adolescent Treatment Enhancement and Dissemination Program (LA-SAT-ED) will serve adolescents ages 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. Through the development of two learning laboratories with collaborating local community-based treatment provider sites during year one and five additional sites during each of years two and three, Louisiana will be 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. 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. Data collection will occur through the Access to Recovery (ATR) electronic health record that was created exclusively for the reporting of National Outcomes Measures (NOMs) through GPRA survey collection. Data will be analyzed by a professional grant evaluator to ensure that both process and outcome objectives have been met.
- The Office of Behavioral Health and the Institute for Public Health and Justice received a $300,000 MacArthur Grant in December 2012 for the purpose of identifying, developing, and disseminating a model for the implementation of EBPs across Louisiana. Building on the success of the School of Public Health's MacArthur initiatives from the past several years implementing EBPs for youth involved in the juvenile justice system, the Office of Behavioral Health proposed a partnership, to learn from their implementation

expertise. This grant will begin in the Northeast Region of the State with plans to disseminate the implementation model (best practice) statewide once completed.

- A recent 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) has retained dollars to support Homebuilders training. The OBH continues to certify MST, FFT, and Homebuilders programs, assuring that they are current with their proprietary agent in meeting fidelity reviews and standards.

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.

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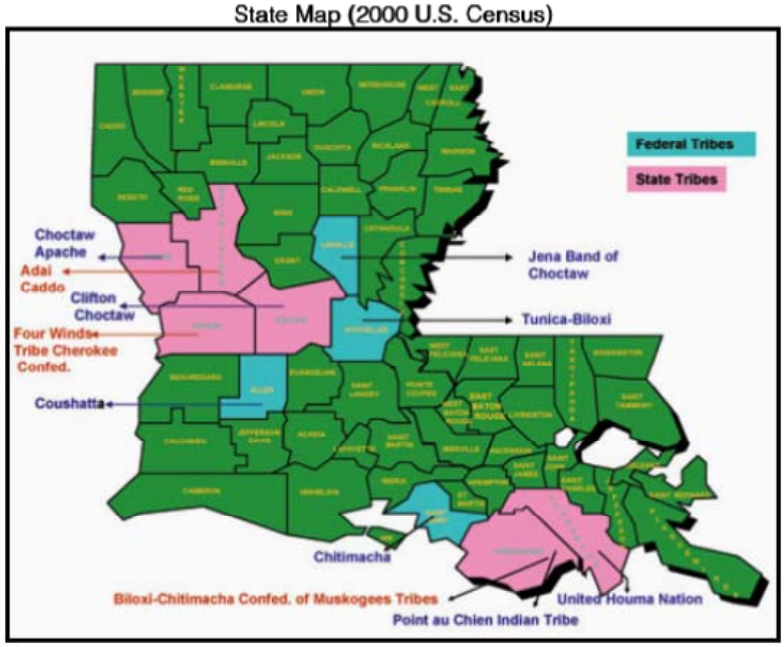
Section P: Consultation with Tribes

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. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants 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.

SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order 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. For states that are currently working with tribes, a description of these activities must be provided in the area below.

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 2011 US Census estimates, the Louisiana population is 0.6% 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. 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

State Map (2000 U.S. Census)



employment, health, education, financial status, recreation, social adjustment, or other conditions affecting the welfare of the Indian people. The Office of Indian Affairs is to submit 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. The Office of Indian Affairs 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.

The Louisiana Behavioral Health Planning Council in its efforts to further evolve into an integrated Council has taken on the responsibility of reaching out to Native American representatives. A recent change to the Council has been the inclusion of representatives of special populations, including a representative of a federally recognized tribe, in the Council membership composition. An ongoing goal is to recruit representatives from tribal communities to participate in the advocacy associated with the Advisory Council activities. Further community level assessment is needed to determine the best approaches to successfully reaching this population.

In an effort to build 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 began building a communication forum and notifying Louisiana Indian tribes of the major healthcare reforms and current initiatives. 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. For example, the Jena Band of Choctaw Indians has worked closely with the Department of Child and Family Services foster children, private adoptions, schools, FINS (Families in Need of Services), and drug and alcohol rehabilitation. This tribe also works to connect its members to appropriate services within the tribal services and through referrals to state-managed agencies outside of the reservation. 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.

The Department of Health and Hospitals has contacted each of the chiefs associated with the Louisiana tribes. In turn, each of the chiefs has identified a point of contact within their respective tribal governments, who will offer comment on health care issues and initiatives. There were preliminary meetings with tribal leadership to discuss improved communications and collaboration with the tribes. Specifically, the DHH Medicaid Director and the Department's Undersecretary visited the Coushatta Tribal Council. Results of these attempts have guided future efforts of the Department.

With both the development of the physical health Medicaid reform package through the Medicaid Bayou Health plans and with the behavioral health reform through the Louisiana Behavioral Health Partnership, the Louisiana Department of Health and Hospitals, specifically the State Medicaid Office, reached out to the Native American Tribes in Louisiana. The four federally recognized tribes of Louisiana were invited to participate in public forums to discuss

the opportunities and expectations with regard to these transformative operations. In attempts toward transparency and improved communication, all tribal nations were alerted to review all documentation on the DHH website and provide written or verbal feedback relative to the proposed Medicaid reform. With regard to the Medicaid reforms and changes to the Medicaid State Plan, these initiatives and plans were shared with each of the tribal nations. The tribes did not offer any comment or concern relative to these health care changes that the State was pursuing.

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Section Q: Data and Information Technology

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- *Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;*
- *List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;*
- *Provide information regarding its current efforts to assist providers with developing and using EHRs;*
- *Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and*
- *Identify the specific technical assistance needs the state may have regarding data and information technology.*

Please provide an update of your progress since that time.

1) List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:

- **Provider characteristics**
- **Client enrollment, demographics, and characteristics**
- **Admission, assessment, and discharge**
- **Services provided, including type, amount, and individual service provider**
- **Prescription drug utilization**

Clinical Advisor – As the Statewide Management Organization (SMO) of the Louisiana Behavioral Health Partnership (LBHP), Magellan manages the care of behavioral health in Louisiana funded through state agencies. As the monitor of the SMO, The Office of Behavioral Health (OBH) requires that Magellan provide all data elements necessary for reporting. Magellan's data collection system is called Clinical Advisor (CA) and it is a proprietary system of Magellan Behavioral Health. CA is a web-based comprehensive information system capturing data for OBH mental health clinics, addictive disorders clinics, and contracted programs statewide. At the present time, it does not capture admissions and discharges. However, OBH is working with Magellan to re-design CA to support an entire episode of care. All client socio-demographic data, assessment data, services provided, and provider data are reported. CA is the major source of client-level data for the CMHS Uniform Reporting System (URS) data tables. CA data are stored and processed in the OBH data warehouse, which is described below.

Clinical Advisor also functions as the front-end for claims entry. Billable progress notes are generated by Clinical Advisor and transfer to the Magellan claims adjudication system. Payment is made to the provider by Magellan Health Services based upon a successful claims submission. Additionally, Clinical Advisor has been enhanced to deliver some practice management functions to its users. These include authorization tracking, third party billing, OBH fee assessment alerts, the ability to track private payments, DWI and urine screen copays, statement generation, and collections and bad-debt write-off activities.

More enhancements are planned for the statewide electronic behavioral health record in the coming years. These include e-prescribing, medication reconciliation, CCD submission to the state health information exchange, and certification for meaningful use.

LADDS – The Louisiana Addictive Disorders Data System is a web-based comprehensive information system for all OBH addictive disorders clinics, contracted programs, and residential programs statewide that have not transitioned to Clinical Advisor at the present time. It captures the unique number of individuals admitted, receiving services, and discharged. All client socio-demographic data, assessment data, services provided, and provider data are reported. LADDS is the major source of client level data for the CSAT Treatment Episode Data Set data tables, and produces a report of performance indicators for each of the National Outcomes Measurement System domains. LADDS data are stored and processed in the OBH data warehouse, which is described below. LADDS interfaces with LASIS, the Louisiana Addiction Severity Index System, a web-based system that supports electronic client assessment through the Addiction Severity Index (ASI) and the Comprehensive Adolescent Severity Inventory (CASI) (proprietary). The system generates a narrative report of the assessment for the clinician and an American Society of Addiction Medicine level of care for each client. LADDS is supported under contract with Click Here, Inc.

CRIS – The Crisis Response Information System is a web-based system that supports the Child and Adolescent Response Team (CART), a short-term mental health crisis intervention program operating statewide. The system captures individual client and service data on all crisis episodes and provides reports for providers, managers and central office staff. CRIS is supported under contract with Click Here, Inc.

PRISM – PRISM is the pharmacy management system operating in each of the regional OBH pharmacies. It automates prescription processing, inventory and management reporting, especially statewide monitoring of the utilization and costs of pharmaceuticals. Data are regularly uploaded to the OBH data warehouse for statewide reporting. These data are critical for reviewing and managing the ever increasing cost of pharmaceuticals. PRISM is seamlessly integrated with the M&D CARES system which automates and simplifies the Patient Assistance Program. PRISM and M&D CARES are proprietary systems supported under contract with New Tech Computer Systems, Inc.

ATR – The Access to Recovery data system is a web-based voucher management and clinical case record system that captures the number of individuals admitted in and receiving treatment and recovery support services through the program. All ATR client data, assessment data, services provided, and outcomes are reported into this database. ATR is supported under contract with the Center for Business and Information Technology, University of Louisiana, Lafayette.

PMIS – The Prevention Management Information System captures the number of individuals enrolled in and receiving ongoing prevention services. In addition, PMIS captures the number of individuals that receive services in one-time prevention events (health fair, rally, etc). PMIS is supported under contract with Click Here, Inc.

PIP/PIF/ORYX – The Patient Information Program (PIP) is a comprehensive LAN-based information system for the state psychiatric hospitals and regional acute units operated by OBH. It is the primary source of counts of persons served, diagnoses, lengths of stay, and bed utilization. These data are utilized for the URS tables and NOMS. The financial module (PIF) supports billing and accounts receivables, and the ORYX module supports performance reporting for Joint Commission accreditation, including the new core measures for reporting of screening (trauma, substance abuse), medication management (antipsychotic monotherapy), and continuity of care (reducing the time for needed care information to be sent to the aftercare service unit). The system also interfaces with a comprehensive incident reporting system. PIP/PIF/ORYX is supported under contract with LAN Services, Inc.

2) As applicable, for each of these systems, please answer the following:

- **For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?**

  Clinical Advisor will have national provider identifiers stored in that they are required for third party billing purposes.

- **Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?**

  All of the above listed systems utilize a unique provider identifier that provides the ability to aggregate information by provider.

- **Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?**

  All of the above listed systems utilize a unique client identifier that allows for unduplicated counts of clients.

- **Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?**

  LADDS and ATR collect service encounter data and support claims processing. CA collects service data and supports claims processing (episode of care functionality in progress).

- **Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?**

  LADDS, PRISM, and CA utilize ICD-10, CPT, and HCPCS codes.

3) As applicable, please answer the following:

- **Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?**

  Yes; Social Security Numbers and Medicaid Identification Numbers.

- **Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?**

  This has not been done routinely. There have been such efforts related to special ad-hoc reports. There is also an increased sharing of data, particularly fiscal projection data between Medicaid and OBH in preparation and development of the managed care system.

- **Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?**

  There have been routine meetings and some planning at a departmental level that is examining the health care exchanges and federal standards related to information technology in light of the Affordable Care Act. The Louisiana Medicaid Office and the OBH have worked collaboratively over the last year in the design of State Management Organization and development of a behavioral health Medicaid managed care system.

- **Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?**

  Yes, the Louisiana Health Information Exchange (LA-HIE). OBH participated in the strategic planning and has been kept informed during the implementation process. LA-HIE is managed by a non-profit known as the Louisiana Health Care Quality Forum. The Statewide Management Organization's system connects to the Louisiana Health Information Exchange, specifically the electronic exchange of the Continuity of Care Document.

- **Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?**

  Yes. The State Medicaid agency is in the process of replacing and modernizing the MMIS.

4) In addition to the questions above, please:

- **Provide information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.**

OBH is in the process of working with Magellan to transform their Clinical Advisor system into an EBHR. OBH has developed standards for uploading of client-level data from Clinical Advisor to the OBH data warehouse for purposes of state and federal reporting.

- **Identify the barriers that your State would encounter when moving to an encounter/claims based approach to payment.**

  An encounter/claims based approach to payment is now being utilized.

- **Identify the specific technical assistance needs your State may have regarding data and information technology specifically in Section 3.k of this application.**

  No assistance is needed at this time.

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Section R: Quality Improvement Plan

In the FY 2012/2013 Block Grant application, 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, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in 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, states must submit a CQI plan for FY 2014/2015.

Quality Management Strategy

The role of the Office of Behavioral Health now includes that of being purchaser of a service network. As part of the OBH's efforts to further leverage funding and increase access through Medicaid reform, the state's services are provided through a Statewide Management Organization (SMO), responsible for managing the care of individuals with behavioral health needs, including Medicaid and non-Medicaid eligible adults and youth.

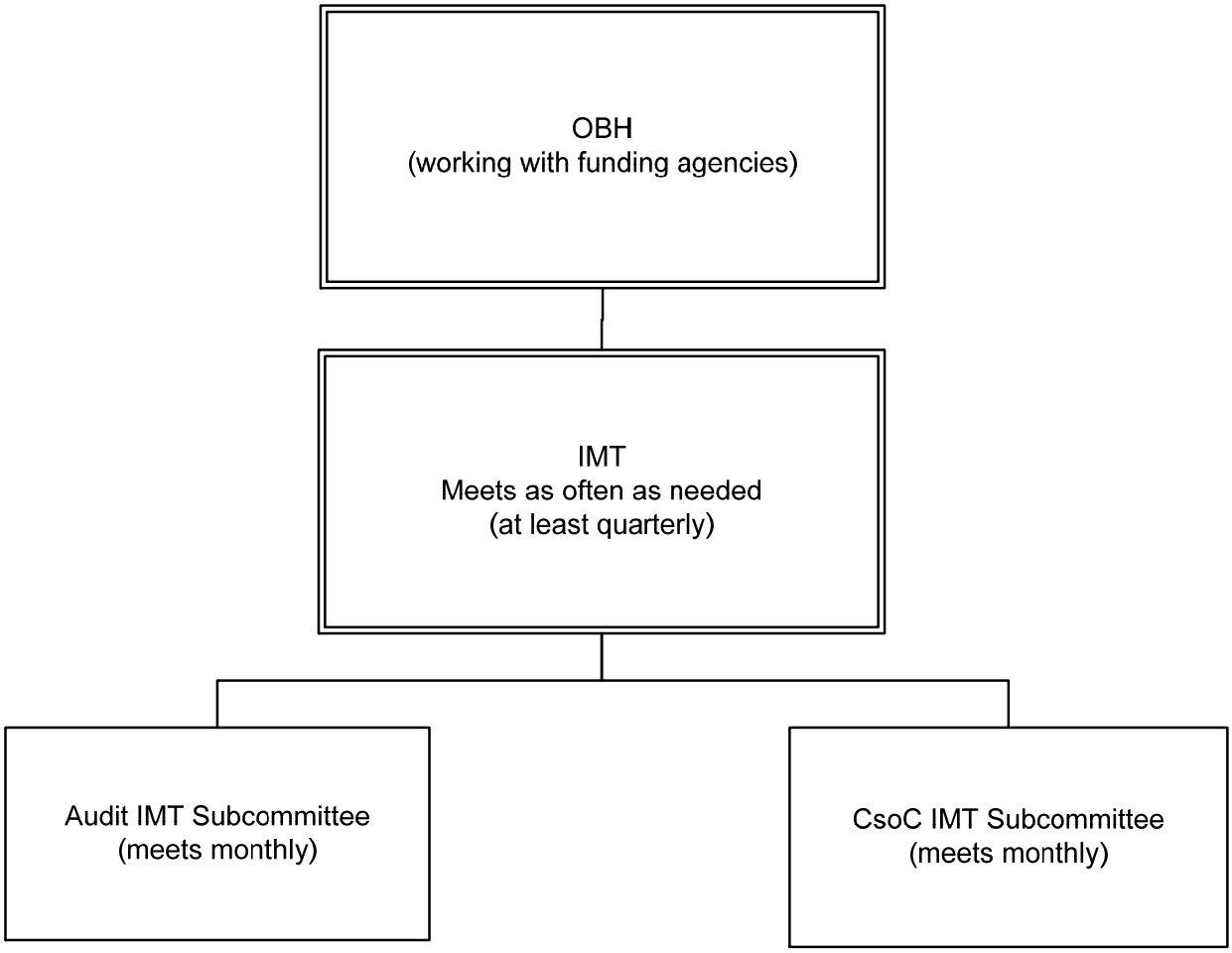
The OBH is the purveyor of the SMO and is responsible for, in addition to other activities, the monitoring of the SMO for compliance with the contractually mandated deliverables. In addition, OBH is required to implement a revised Quality Management Strategy (QMS) that details the process for OBH quality management of the SMO and identifies both performance indicators and outcome measures. The QMS has been revised since the previous application and is supplied as an attachment in WebBGAS (see *Quality Strategy for the Louisiana Behavioral Healthcare Prepaid Inpatient Healthcare Plan Waiver; October 24, 2012*).

As the state plan amendments, 1915(i), 1915(c) waiver, and 1915(b) waiver were approved and the Louisiana Behavioral Health Partnership was implemented, with the Statewide Management Organization beginning operations, over the past year, the Office of Behavioral Health began to implement its Quality Strategy and Interdepartmental Monitoring Team processes. As the agency with primary responsibility for implementation, management, reporting, and monitoring of the programs under the 1915(c) and 1915(b) waivers, the Office of Behavioral Health (OBH) has established Inter-Departmental Monitoring Teams (IMTs) to facilitate the development and implementation of its Quality Strategy. The IMTs include representatives from Health and Human Services, Bureau of Health Services Financing (BHSF), OBH, the Department of Children & Family Services (DCFS), the Office of Juvenile Justice (OJJ) and the Department of Education (DOE). OBH, which facilitates the IMTs, has the oversight responsibility for the development and implementation of the Quality Strategy. Three main sources of information guide the updates to the Quality Strategy: the external quality review (EQR) technical report; feedback from governmental agencies, the SMO, providers, consumers, and advocates; and the IMT's annual review of the effectiveness of the quality plan. This combined information assists

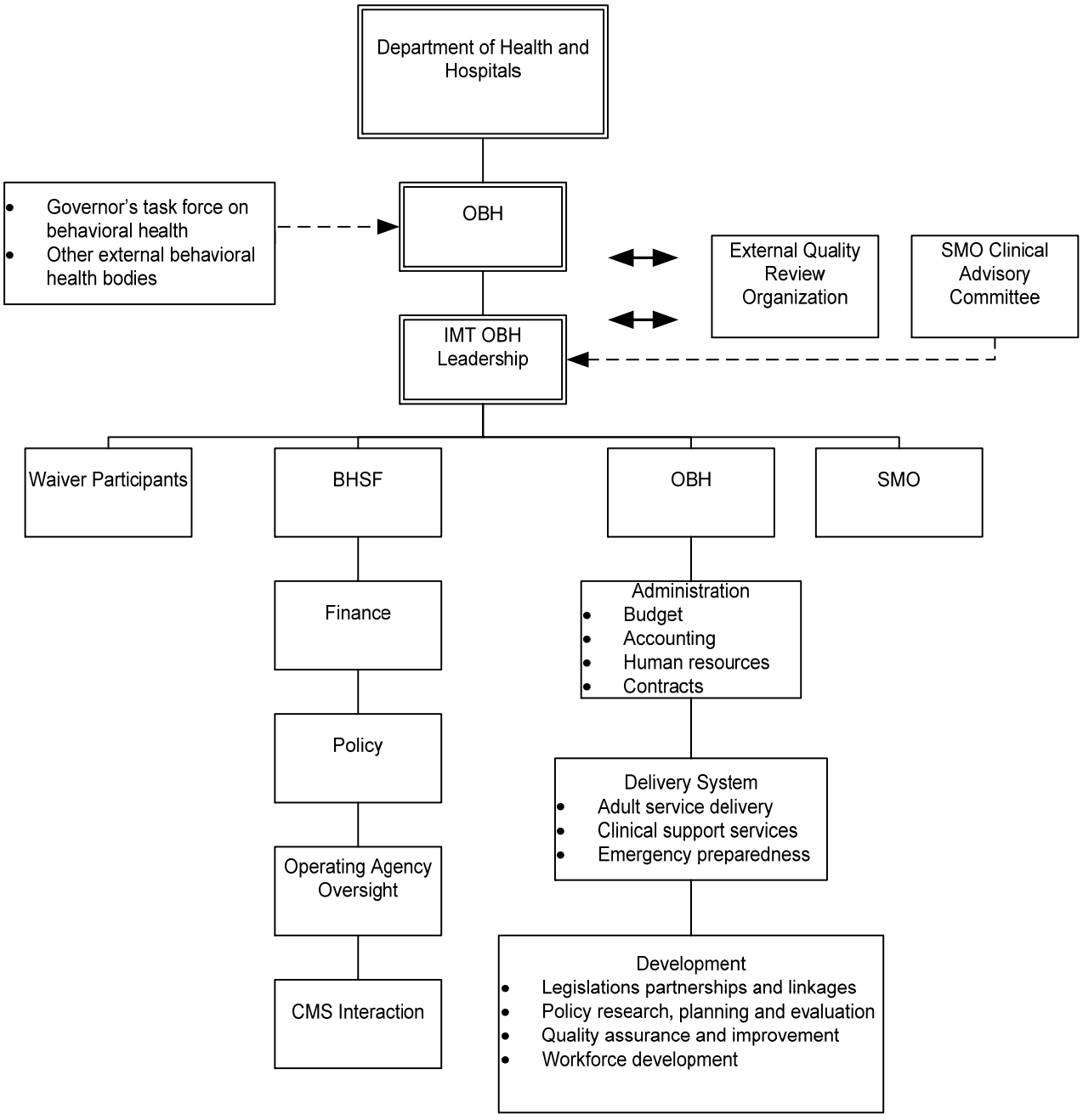
the IMTs and the SMO to identify quality initiatives and metrics of importance to the Medicaid population.

The following diagrams visually represent participants of the IMT and the Governance Structure for 1) adults, 2) CSoC children and youth, 3) Non-CSoC children and youth, demonstrating levels of oversight accountabilities and communication flows. The structure is developed to maximize integration, seek opportunities for collaboration, and ensure a rigorous QIS is in place for all waiver populations.

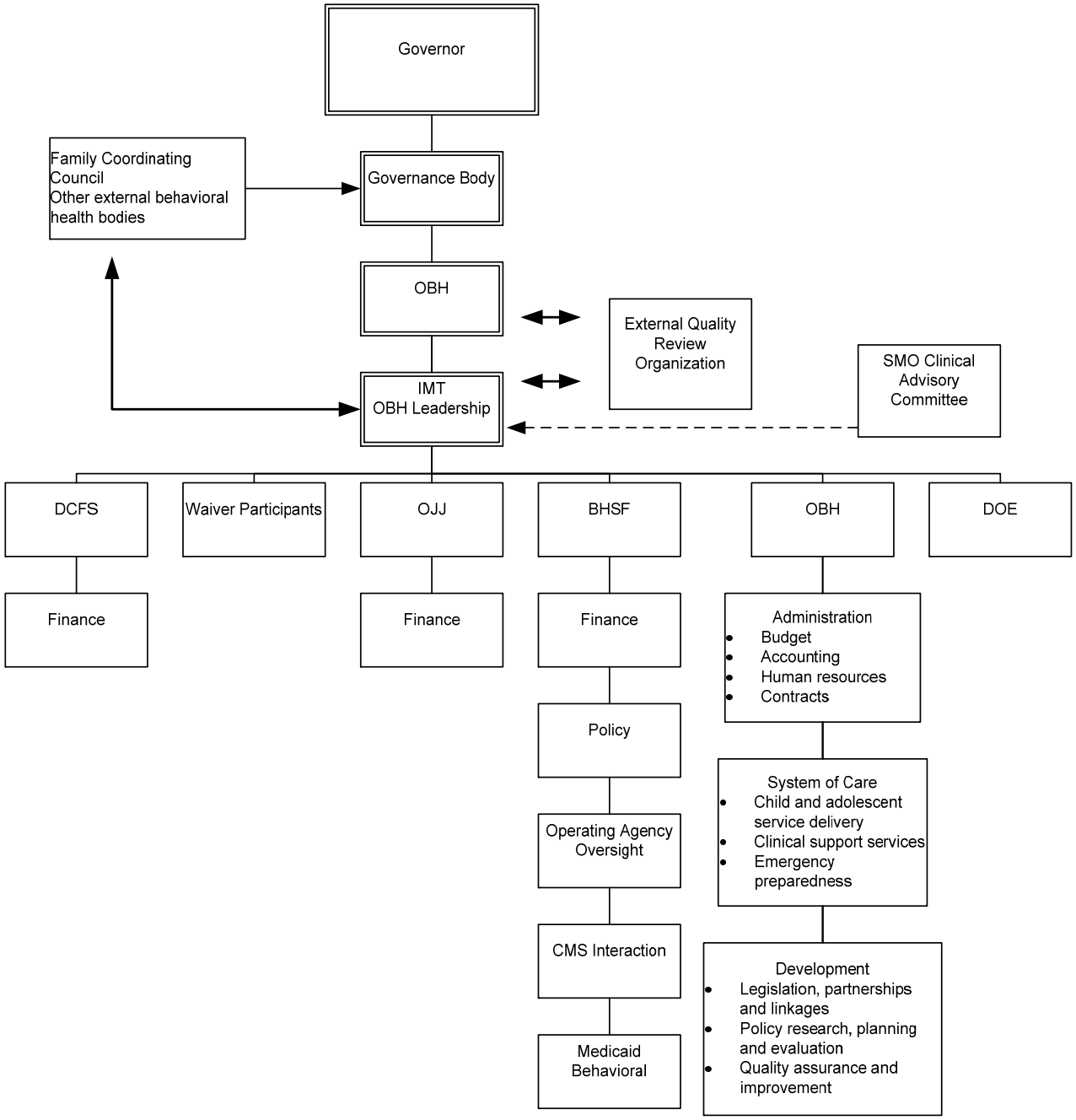
Interdepartmental Monitoring Teams:



Governance Structure for Adults:



Governance Structure for CSoC Children and Youth:



Consumer Satisfaction and Perception of Care

The OBH currently uses two methods to survey its mental health service recipients for their satisfaction with services. Both methods use the national standard *Mental Health Statistics Improvement Project (MHSIP)* survey for adults and the *Youth Services Survey for Families* (YSS-F) survey for parents of youth. To collect adult surveys, a team of specially trained peer surveyors travels around the state and spends up to three weeks at a behavioral health clinic. During this time, the surveyors approach individuals who are in the clinic waiting room and ask them to participate in a satisfaction survey. This method has been used since the mid 1990's to collect data for performance improvement and to report to the federal government on required Mental Health Block Grant and NOMS indicators. The data collected using this method is rolled up into a standard report that is issued to the clinic manager for the local performance improvement plan and is also posted on the OBH website for review. The Statewide Management Organization is also required to administer a member satisfaction survey on an annual basis. This is a mail out survey that follows the national MHSIP survey.

The second method of collecting data is through an on-line system, the Telesage Outcomes Measurement System (TOMS). This system allows service recipients to access the standard MHSIP and YSS-F surveys via a touch screen computer located in the waiting room of the clinics. The OBH uses this system to collect all of its youth satisfaction survey data and it is also used to supplement the data collected by the peer survey team for adults. The TOMS system enables providers to track individual client treatment outcomes at repeated intervals over the course of treatment and measures a wide range of relevant treatment outcomes. The TOMS website provides longitudinal aggregated reports of client data to support quality improvement and performance accountability and data related to changes in living status, employment status, and arrests that will be utilized in the client level NOMS reporting this fiscal year. OBH has extended the TOMS to provide standardized outcomes for addiction clients and is exploring the option of extending the TOMS to provide standardized quality of care assessments for addiction clients.

Addictive Disorder service providers continue to measure consumer satisfaction using a client self-administered survey that is uniform for most Regions/LGE's. Some Regions/LGEs have enhanced the survey instrument by adding additional questions. The satisfaction survey is conducted at various points throughout the treatment process: at admission, during treatment, and at discharge. The instrument includes a number of measures that assess client satisfaction with the overall treatment experience, scheduling convenience, performance of the counselor, partnership in the treatment process, cultural sensitivity, and more. The OBH staff review the results and use findings to inform provider technical assistance and training. Again, OBH is exploring ways to integrate the satisfaction survey process to include both mental health and substance use disorder clients.

Complaints, Grievances, and Critical Incidents

Complaints and grievances are received at the OBH clinics and reviewed by the clinic and Regional Managers. Analysis of these complaints is intended to generate local performance improvement/action plans.

At present, all critical incidents are immediately reported to the OBH executives and to DHH leadership via a standardized form. This immediate report is followed by submission of details of the incident on a standardized reporting form that includes a description of the plan of action. This is submitted within 24 hours of the incident. Finally, a follow-up report is submitted within 72 hours of the incident with any additional details and/or results of the plan of action. The immediate, 24 hour, and 72 hour reports are reviewed by OBH program staff. They evaluate the completeness, accuracy, and significance of the report. These directors can request additional information or require additional actions to be taken. In cases of a significant event, a Root Cause Analysis (RCA) can be ordered and when completed will result in further corrective action, along with a performance improvement plan. OBH keeps a central record of all critical incident reports and RCA reports for analysis to inform policy development.

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Section S: Suicide Prevention

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- *Provide the most recent copy of your state's suicide prevention plan; or*
- *Describe when your state will create or update your plan.*

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time.

Louisiana Partnership for Youth Suicide Prevention (LPYSP)

The Louisiana Partnership for Youth Suicide Prevention, funded by a Substance Abuse and Mental Health Services Administration (SAMHSA) grant, targets 15,000 youth and young adults ages 10 to 24 years old consisting of middle school, high school, and college students, as well as professionals that serve this population across the state of Louisiana (such as Office of Behavioral Health, Department of Education, Veterans Administration staff, as well as 211 providers). A high priority of this program is early intervention, prevention, and assessment services to youth and young adults who are at risk for mental or emotional disorders, or substance use disorders that may lead to suicide or suicide attempts. Through partnerships across systems, the integration of suicide prevention resources and services in schools, universities, juvenile justice systems, substance abuse and mental health programs, foster care systems, and other child youth support agencies that target the at-risk youth population will increase their competence and awareness of youth suicide risk.

In 2006, Louisiana was awarded funds under the Garrett Lee Smith Memorial Act from SAMHSA to implement statewide youth suicide intervention and prevention strategies. Applied Suicide Intervention Skills Training (ASIST) is one of several trainings which were initiated by this funding initiative. ASIST is a unique program that teaches a concise, face-to-face suicide intervention model that focuses on the reduction of the immediate risk of suicide. Participants in the training learn about their own attitudes concerning suicide, how to recognize and assess the risk of suicide, how to use an effective suicide intervention model, and about available community resources. ASIST is a model of suicide intervention for all gatekeepers and caregivers utilizing techniques and procedures that anyone can learn. The training is designed to increase skill levels, improve the ability to detect problems, and provide meaningful support to individuals experiencing emotional distress and serious mental health problems. The workshops are offered to those gatekeepers that serve this population, such as educators, law enforcement, mental health professionals, clergy, medical professionals, administrators, and volunteers. The program has been made available to government agencies, consumer/advocacy agencies, emergency service providers, schools, and families to help reduce the incidence of suicide in Louisiana. As of April 2013, there were 34 ASIST trainers and 15 safeTALK trainers available across the state. ASIST, safeTALK, and Suicide 101 trainings have been conducted statewide. This series of evidenced-based trainings reached over 861 people in SFY2012. The LPYSP will be hosting a Trainer's Conference in SFY2014 where active trainers will be provided with upgraded ASIST materials as well as training on these new materials.

Through the successful development of five suicide prevention coalitions in Shreveport (Region VII), Lake Charles (Region V), Lafayette (AAHSD), Jefferson (JPHSA), and Baton Rouge (CAHSD), the Partnership assisted communities to develop competence related to suicide risk identification and prevention activities, improved local collaboration, and promoted the coordination of culturally appropriate resources and services for the prevention of suicide. In SFY2012, three new suicide prevention coalitions were developed in Morehouse, Ouachita, and Orleans Parishes. Over 43,500 individuals attended suicide prevention presentations/trainings, health fairs, and suicide prevention walks given by the LPYSP and coalitions; 450 youth participated in TeenScreen; and over 389 students from 62 schools participated in the poster and essay contest.

LPYSP partnered with the Louisiana Department of Education (DOE) in FY 2012 to provide 40 school personnel with suicide prevention training for trainers (T4T) in order to meet the ACT 219 (Jason Flatt Act) requirement. These trainers will then train school personnel in their districts.

Louisiana Suicide Prevention Plan

In 2001, Louisiana released *STAR: The Louisiana Plan for Youth Suicide Prevention (see attached – appendix)*. This strategic plan was developed by the Louisiana Task Force for Youth Suicide Prevention, appointed in 1999 following the U.S. Surgeon General's Call to Action. Known as the STAR Plan, this comprehensive statewide suicide prevention plan for youth in Louisiana (under the age of 25, including university students) includes four key dimensions reflected in its acronym title – S: Suicide Prevention for all Louisianans; T: Training and Education; A: Awareness and Advocacy; and R: Research and Resources.

After receiving funding under the Garrett Lee Smith Memorial Act from the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2006, the previously established Task Force transitioned into the Louisiana Partnership for Youth Suicide Prevention (LPYSP) which serves as the governing body to provide oversight, development, monitoring, and evaluation of program activities to reduce youth suicides and suicide attempts in Louisiana. The LPYSP is comprised of a broad range of public and private partners, and it expands the youth suicide prevention efforts of the 2001 Louisiana Youth Suicide Prevention Task Force across the entire state.

At the July 2011 meeting of its State Advisory Board, the LPYSP reviewed and discussed the need to update the STAR Plan. An updated strategic plan would focus on the sustainability of current suicide prevention efforts within Louisiana, and could include continued training of gatekeepers in the ASIST and safeTALK models, development of suicide prevention coalitions in the remaining five Regions/LGEs that currently do not have one, and expansion of peer support resources within the school systems. LPYSP currently includes Veterans Administration staff in its training opportunities in order to reach the veteran population. The process to develop an updated strategic plan would also consider ways in which the State's suicide prevention efforts could be expanded to better serve military personnel and their families, as well as opportunities to reach American Indians; the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community; and other underserved populations. The LPYSP State Advisory Board, which includes members of the original Task Force that developed the STAR

Plan, supports the effort to develop a new strategic plan. The Louisiana Partnership for Youth Suicide Prevention received a no-cost extension through September 29, 2013. Office of Behavioral Health staff will complete an update of the STAR-Louisiana Plan for Youth Suicide Prevention by January 31, 2014.

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Section T: Use of Technology

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- *What strategies the state has deployed to support recovery in ways that leverage ICT;*
- *What specific application of ICTs the State BG Plans to promote over the next two years;*
- *What incentives the state is planning to put in place to encourage their use;*
- *What support system the State BG Plans to provide to encourage their use;*
- *Whether there are barriers to implementing these strategies and how the State BG Plans to address them;*
- *How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;*
- *How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and*
- *What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.*

States must provide an update of any progress since that time.

a) What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?

In an attempt to alleviate access problems, OBH has available teleconferencing systems at 65 sites across the State (*see table at end of this narrative section*), including behavioral health clinics, mental health hospitals, OBH regional offices, and OBH Central Office. Some sites have multiple cameras, with some of these cameras dedicated to Telemedicine (clinician/client session) while the others are used for Teleconferencing (meetings, education, etc). Other sites use their single cameras for both Telemedicine and Teleconferencing. The sites continue to upgrade their technology through the purchase of High Definition Cameras per Department of Health and Hospitals (DHH) regulations.

Telecommunication has become the primary mode for communication within OBH. In an average week there are multiple and sometimes simultaneous meetings conducted through teleconference and videoconference, including regular meetings of the Regional Management Teams, Medical Directors, Monthly Performance Improvement Team, Monthly Regional Advisory Council, Hospital Discharge, Regional Peer Specialists, and the Pharmacy and Therapeutics Committee. In addition, DHH continues to use desktop video conferencing, the software interface that allows connection into the existing video network from individual desktop PCs.

OBH has utilized telemedicine extensively for the past several years primarily for psychiatric evaluations where a psychiatrist is not available. For example, forensic patients at East Louisiana Mental Health System (ELMHS) outside of Baton Rouge, Louisiana are assessed by Tulane University Psychiatrists in New Orleans. Acadiana Area Human Services District has utilized telemedicine extensively given its severe shortage of psychiatrists. This service

is now reimbursable by Medicaid. Several years ago, the state of Louisiana passed into law that persons can be evaluated for psychiatric hospitalization by a psychiatrist/psychologist via telemedicine as long as there is a mental health professional present with the consumer. DHH is working with lawmakers to allow for the host sites to bill for the visit. Currently only the provider conducting the assessment is allowed to bill. Lawmakers recognize that host clinics incur the costs of providing the mental health professional and other administrative staff.

OBH regional meeting rooms have been setup for telemedicine and standard conferencing that can be launched from the sites to enable patient care, medication management appointments and patient assessments. This is especially helpful in an emergency that happens outside normal work hours. Telemedicine has resulted in more efficient communication between various sites across the state.

b) What specific application of ICTs does the State plan to promote over the next two years?

OBH, through its Statewide Management Organization, Magellan Health Services, will implement and expand the use of mobile phones to engage consumers in making health care decisions. Magellan's Mobile Phone Support and Messaging, powered by SafeLink, provides eligible Medicaid recipients with a free mobile phone and monthly airtime to give them easy access to care manager support and helpful health messaging. As a result, members will experience easier access to care and additional support to clinic-based services that may improve quality of care and outcomes. The purpose of Magellan promoting this product is to assist those members who are typically hard to engage or experience challenges accessing appropriate services due to lack of connectivity.

The Federal Communications Commission (Commission or FCC) has implemented the statutory mandate for universal service by, among other things, creating the Rural Health Care (RHC) program to improve access to communications services for eligible health care providers. In recent years, broadband has become increasingly vital to the effective delivery of health care, and it can be uniquely transformative in rural areas, where distance poses a substantial challenge. In recognition of this, the Commission in 2006 launched the Rural Health Care Pilot Program (Pilot Program), which awarded 69 projects one-time funding for a defined period of time (a total of $418 million) to cover up to 85 percent of the cost of construction and deployment of broadband networks that connect participating health care providers in rural and urban areas. Louisiana was awarded $15.9 million to expand and enhance its network.

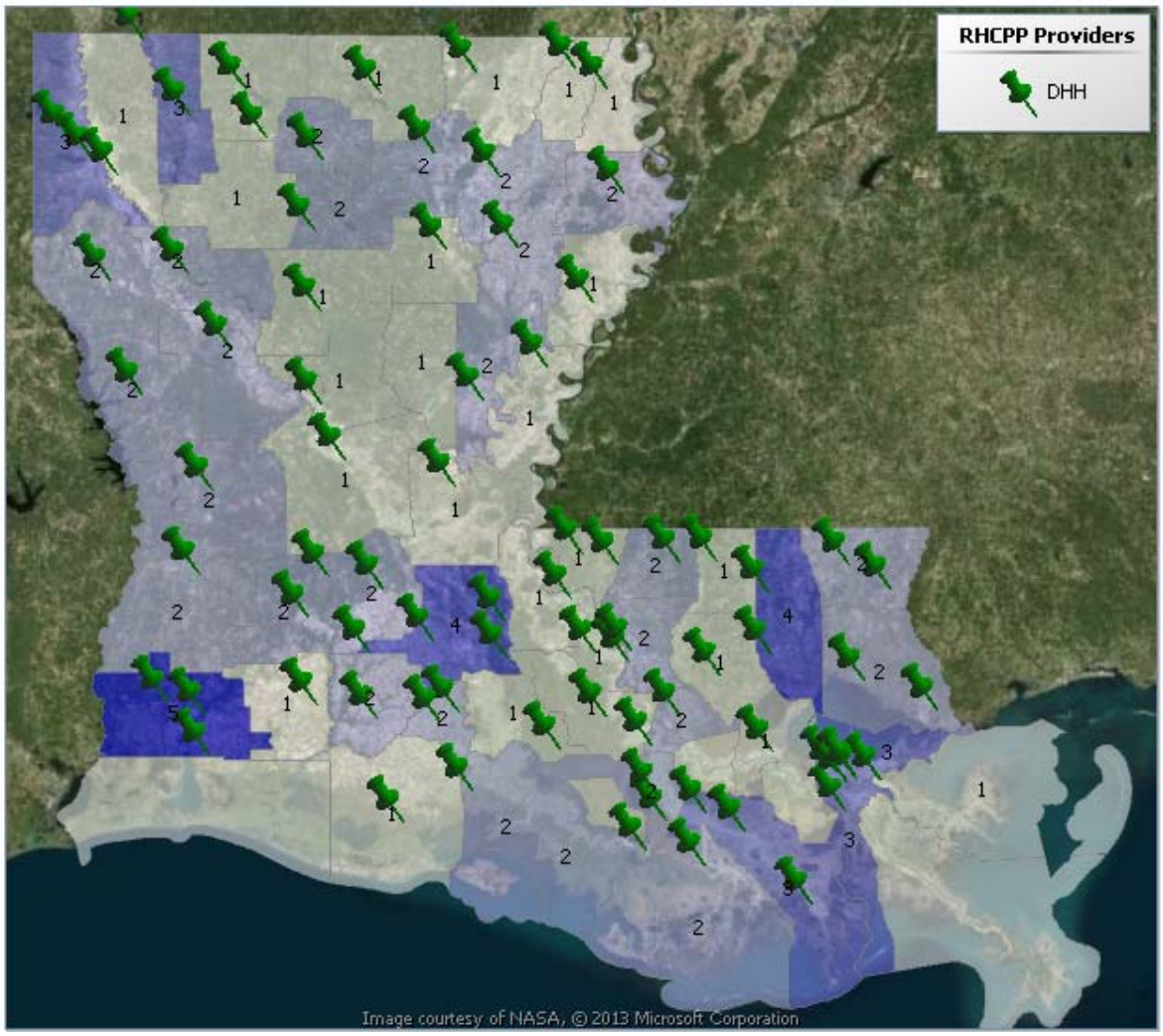
Support through the Pilot Program has helped health care providers obtain broadband capability to implement telemedicine and telehealth applications. Telemedicine and telehealth applications improve the quality of health care delivered to patients in rural areas, generate savings in the cost of providing health care, and reduce the time and expense associated with travel to distant locations to receive or provide care.

c) What incentives is the State planning to put in place to encourage their use?

The Mobile Phone Support and Messaging pilot encourages members to participate by providing them with a free basic handset, 250 anytime minutes that include national long distance, voice mail, and unlimited texting.

The goal of the Rural Health Care Pilot Program in Louisiana (described above) is to make health care more accessible and efficient. In Nov 2007, LA DHH was awarded $15.9M. This money will cover up to 85% of eligible network costs with participating health care providers (HCPs) contributing the remainder.

Below is a map of publically-funded clinics that will participate in this initiative.



Those delivering behavioral health care services are:

Allen Behavioral Health Center	Red River Behavioral Health Center
Ville Platte Behavioral Health Center	Crowley Behavioral Health Center
Rosenblum Behavioral Health Center	Beauregard Behavioral Health Center
Lurline Smith Behavioral Health Center	Jonesboro Behavioral Health Center
River Parishes Behavioral Health Center	Lake Charles Behavioral Health Center
Opelousas Behavioral Health Center	Mansfield Behavioral Health Center
Terrebonne Behavioral Health Center	Many Behavioral Health Center
New Iberia Behavioral Health Center	Minden Behavioral Health Center
St. Mary Behavioral Health Center	Monroe Behavioral Health Center
Leesville Behavioral Health Center	Natchitoches Behavioral Health Center
Dr. Joseph Henry Tyler, Jr. Behavioral Health Center	Lafourche Behavioral Health Center
Ruston Behavioral Health Center	Richland Behavioral Health Center
Shreveport Behavioral Health Center	Tallulah Behavioral Health Center
Winnsboro Behavioral Health Center	

d) What support system does the State plan to provide to encourage their use?

DHH has centralized its IT functions and user support across the state. DHH supports all users of the state-funded videoconferencing service and provides technical assistance when requested. As OBH operated clinics transition out of state control and into independent human service districts and authorities, DHH will continue to offer technical assistance with all telehealth systems. Furthermore, DHH's Medicaid agency will explore expanding the service array to include telemonitoring services where appropriate. Currently, Medicaid only covers the cost of this telemonitoring service for those on approved home and community based services waivers administered by the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities. Medicaid will offer policy and programmatic support to OBH to explore adding these ICT-based services to federally-subsidized mental health and addictive disorders programs, where appropriate.

e) Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?

One potential barrier to successful implementation of the Mobile Phone Support and Messaging pilot is a lack of consumer engagement. This potential barrier will be addressed through targeted member services and communications efforts.

Potential barriers to the Rural Health Care Pilot Program include a tight implementation timeline, complicated by the lengthy state contracting process. This concern will be addressed by engaging executive management within the Department of Health and Hospitals, including the chief information officer and the secretary of the Department.

f) How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?

OBH utilizes telemedicine to link community based psychiatrists to assess patients in forensic psychiatric hospitals. These options may be explored once the healthcare systems have stabilized with regard to the transformative Medicaid reform for both physical and behavioral health services.

OBH is also planning a care coordination pilot that will integrate behavioral health and primary care through the use of the state's health information exchange. The first phase of this pilot will allow behavioral health care managers to securely communicate with the member's primary care physician using directed health information exchange. OBH will pilot this model with one Medicaid managed care organization and study the results. If the intervention proves successful, the initiative will be expanded to all MCOs.

g) Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?

There are no plans at present to expand the use of ICTs for collecting data for program evaluation at both the client and provider levels.

The Office of Behavioral Health (OBH) will continue utilization of the Telesage Outcome Measurement System (TOMS) to collect data on client satisfaction with services rendered. This system allows service recipients to access the standard *Mental Health Statistics Improvement Project (MHSIP)* and *Youth Services Survey for Families (YSS-F)* surveys via a touch-screen computer kiosks located in the waiting room of clinics. OBH uses this system to collect all of its youth satisfaction survey data and it is also used to supplement the data collected by the peer survey team for adults (*See Section F: Quality Improvement Reporting for additional information*).

h) What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

OBH will analyze client-level data on participants in the Mobile Phone Support and Messaging pilot. Currently, this program is only open to Medicaid eligible adults who are frequent utilizers of crisis services. If the intervention proves to be successful at decreasing crisis service utilization rates, OBH will consider expanding the service to other populations.

OBH Video Conferencing Sites - April, 2013			
	Site	**Parish**	**City**
1.	Allen Behavioral Health Clinic	Allen	Oberlin
2.	Avoyelles Behavioral Health Clinic	Avoyelles	Marksville
3.	Bastrop Behavioral Health Clinic	Morehouse	Bastrop
4.	Beauregard Behavioral Health Clinic	Beauregard	DeRidder
5.	Behavioral Health Clinic of Central LA	Rapides	Pineville

6.	CLSH (Admin Bldg)	Rapides	Pineville
7.	CLSH (Education Room 103)	Rapides	Pineville
8.	CLSH (Education Room 128)	Rapides	Pineville
9.	Columbia Behavioral Health	Caldwell	Columbia
10.	Crowley Behavioral Health Clinic	Acadia	Crowley
11.	Dr. Joseph Tyler BHC / Auditorium 1	Lafayette	Lafayette
12.	Dr. Joseph Tyler BHC / Auditorium 2	Lafayette	Lafayette
13.	Dr. Joseph Tyler BHC / Auditorium 3	Lafayette	Lafayette
14.	ELMHS (Cedarview)	East Feliciana	Jackson
15.	ELMHS (Center Bldg.)	East Feliciana	Jackson
16.	ELMHS (CRU)	East Feliciana	Jackson
17.	ELMHS (Evangeline House)	St. Tammany	Mandeville
18.	ELMHS (Gabriel House)	East Baton Rouge	Greenwell Springs
19.	Florida Parishes	St. Tammany	Mandeville
20.	Central Office Conference Room 453	East Baton Rouge	Baton Rouge
21.	Jonesboro Behavioral Health Clinic	Jackson	Jonesboro
22.	Jonesville Mental Health Clinic	Catahoula	Jonesville
23.	Lafourche Mental Health Clinic	Lafourche	Raceland
24.	Lake Charles BHC / Regional	Calcasieu	Lake Charles
25.	Lake Charles BHC / Room 105	Calcasieu	Lake Charles
26.	Lake Charles BHC / Small Group Room Telemed	Calcasieu	Lake Charles
27.	Leesville Behavioral Health Clinic	Vernon	Leesville
28.	Mansfield Behavioral Health Clinic	De Soto	Mansfield
29.	Mansfield Behavioral Health Telemed	De Soto	Mansfield
30.	Many Behavioral Health Clinic	Sabine	Many
31.	MHSD / General DeGaulle	Orleans	Algiers
32.	Minden Behavioral Health Clinic	Webster	Minden
33.	Minden Behavioral Health Telemed	Webster	Minden
34.	Monroe Behavioral Health Clinic / Auditorium	Ouachita	Monroe
35.	Monroe Behavioral Health Clinic / Regional	Ouachita	Monroe
36.	Monroe Mental Health	Richland	Delhi
37.	Natchitoches Behavioral Health Clinic	Natchitoches	Natchitoches
38.	New Iberia Mental Health Clinic	Iberia	New Iberia
39.	OBH Children's Services / Chartres	Orleans	New Orleans
40.	OBH Children's Services / DNP Canal	Orleans	New Orleans
41.	OBH Central Office (2 rooms)	East Baton Rouge	Baton Rouge
42.	Opelousas Mental Health Clinic	St. Landry	Opelousas
43.	Ouachita ECSS	Ouachita	Monroe
44.	Red River Mental Health Clinic	Red River	Coushatta
45.	Red River Mental Health Telemed	Red River	Coushatta
46.	Region 6 Office	Rapides	Pineville
47.	Region 8 Headquarters	Lincoln	Ruston
48.	River Parishes Mental Health Clinic	St. John the Baptist	LaPlace
49.	Ruston Behavioral Health Clinic	Lincoln	Ruston
50.	Ruston Mental Health Clinic	Lincoln	Ruston
51.	SELH / Education Bldg	St. Tammany	Mandeville
52.	SELH / Telemed	St. Tammany	Mandeville
53.	SELH / Youth Services	St. Tammany	Mandeville
54.	Shreveport Behavioral Health Clinic/Room 111	Caddo	Shreveport
55.	Shreveport Behavioral Health / Room 145	Bossier	Shreveport
56.	Shreveport MHC/Children Services	Caddo	Shreveport

57.	St. Mary Mental Health Clinic	St. Mary	Morgan City
58.	St. Mary Mental Health Clinic	St. Mary	Morgan City
59.	Tallulah Mental Health Clinic	Madison	Tallulah
60.	Terrebonne Mental Health Clinic	Terrebonne	Houma
61.	Terrebonne Mental Health Clinic	Terrebonne	Houma
62.	Transfer to OBH for Tulane or FRC	Orleans	New Orleans
63.	Tyler	St. Martin	St. Martinville
64.	Ville Platte Mental Health Clinic	Evangeline	Ville Platte
65.	Winnsboro Mental Health Clinic	Franklin	Winnsboro

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Section U: Technical Assistance Needs

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?

The State is participating in a SAMHSA Prevention Policy Academy and participated in a SAMHSA Service Members, Veterans, and their Families (SMVF) Policy Academy. The State recently received technical assistance through the Center for Substance Abuse Treatment (CSAT) State Systems Technical Assistance Project (SSTAP). This involved four separate technical assistance projects, each focused on various areas of need that were identified following the 2011 SAPT Block Grant Core Technical Review. The State and the Louisiana Behavioral Health Advisory Council are currently participating in a National Learning Community through Advocates for Human Potential to identify best and promising practices in transitioning to a behavioral health planning council and to develop a manual of best and promising practices for transitioning to a behavioral health planning council in order to help the Louisiana Behavioral Health Advisory Council to further integrate substance abuse and mental health.

2. What are the sources of technical assistance?

All of the technical assistance initiatives referenced above were made available through SAMHSA.

3. What technical assistance is most needed by state staff?

State staff from the Child and Family Division has been engaged in developing the Coordinated System of Care (CSoC) initiative for the past two years. One component of this effort is creation of a viable and sustainable structure for delivering family support services (Parent Support and Training and Youth Support and Training) which are covered services in the 1915c Waiver. Developing a fiscally viable approach for the Family Support Organization (FSO) has been challenging given the need for the FSO to be sustaining on Medicaid fee-for-service revenue. Technical assistance that helps the Division staff to create a more sustainable and values aligned FSO structure would be useful to the state.

Additional technical assistance that would validate enforcement of SAPT Block Grant requirements by systematic review of monitoring instrument specifications (Clinical Advisor) would be beneficial to the State. The technical assistance received through the "LA-9" technical assistance project through the Center for Substance Abuse Treatment (CSAT) State Systems Technical Assistance Project (SSTAP) could be used as a starting point and then progress further to determine if Episode of Care and other system enhancements determined to be needed through this previous technical assistance project have been implemented and work as designed for block grant reporting. The State has preference for the same consultant to return and continue working with the OBH Business Intelligence group.

4. What technical assistance is most needed by behavioral health providers?

Despite a growing body of evidence on the benefits of health information technology use by behavioral health providers, behavioral health providers, including psychiatric hospitals, continue to be excluded from federal health information technology (HIT) programs.

For example, a study published in the December 2012 issue of the International Journal of Medical Informatics found that behavioral health professionals with access to electronic health record systems reported lower readmission rates for their patients. The study's conclusion supports the argument long made by behavioral health provider organizations that EHR systems can improve the quality of care to behavioral health patients.

Behavioral health care providers are severely limited in their ability to adopt health information technologies largely due to the high cost of replacement systems and shortage of HIT professionals specialized in behavioral health. HITECH excluded most behavioral health providers from participating in the Medicare and Medicaid EHR Incentive programs. This program is the single most important driving force in the State of Louisiana for encouraging adoption of HIT. Louisiana's Office of Behavioral Health has conducted a preliminary analysis of the financial benefits deprived of its state psychiatric hospitals as a result of this exclusion. Central Louisiana State Hospital reported 22,458 hospital days in state fiscal year 2012. This high occupancy rate along with the fact that 99.65% of its costs are uncompensated would otherwise have entitled the hospital to a total Medicaid EHR Incentive Program payment of $2,170,508 had psychiatric hospitals been included in the program. Similarly, East Louisiana Behavioral Health System with 25,932 hospital days and a 99.83% uncompensated care ratio, would have received $2,858,007.

Without federal HIT incentives, behavioral health providers have lagged behind other medical disciplines in adopting EHR systems. Behavioral health professionals also rarely coordinate care despite evidence that doing so improves the quality of care being delivered.

More than 64 percent of all hospitals have adopted some kind of EHR system, according to data from the Centers for Medicare & Medicaid Services.

The hospitals where behavioral health records were not stored electronically had significantly higher readmission rates for psychiatric patients, 7 percent versus 5.1 percent, the study said. Readmissions rates at hospitals that did not make electronic behavioral health records available

to nonpsychiatric staff were also higher compared to those that did, 13 percent and 8 percent respectively.

According to "Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014," SAMHSA is focusing on HIT in general and EHRs specifically to ensure that behavioral health is integrated in to the Nation's broader health system. This proposal for SAMHSA technical assistance is in keeping with strategic initiative number six in this report: To deliver technical assistance to State HIT leaders, behavioral health and health providers, patients and consumers, and others to increase adoption of EHRs and HIT with behavioral health functionality.
While OBH, in partnership with its statewide management organization for the delivery of behavioral health services, has made considerable progress in facilitating adoption of a single EHR capable of interfacing with the Louisiana Health Information Exchange, there has been little progress in transitioning our health information management operations at the state psychiatric hospitals from paper to electronic. The main basis for this lack of progress lies with the fact that the state does not have the resources or expertise to effectively manage such a transition. For this, OBH requests technical assistance to facilitate EHR adoption and use and provide project management support for inpatient psychiatric settings.

The scope of services requested includes:

- Consultation and Planning
- Vendor Selection
- EHR Implementation, Technical Assistance, and Project Management
- Practice and Workflow Redesign
- Meaningful Use Achievement and Clinical Quality Improvement
- Functional Interoperability and Health Information Exchange
- Privacy and Security Best Practices
- Education and Outreach

OBH recommends that this technical assistance be developed through the use of the Louisiana Health IT Resource Center (ONC REC).

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Section V: Support of State Partners

The success of a state's MHBG and SABG 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. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process.

The Office of Behavioral Health (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 Office of Behavioral Health 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 (OBH) contracting with a Statewide Management Organization (SMO). 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 Office of Behavioral Health (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 – Birth Outcomes Initiative

OBH has coordinated efforts with the Office of Public Health to improve statewide birth outcomes via ongoing implementation of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative, 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. Based on the World Health Organization's *Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)* instrument, LaHART screens for prenatal tobacco, alcohol, and drug use as well as domestic violence. This is in keeping with SAMHSA's long range goal of incorporating substance use screenings as a routine component of primary healthcare. The Louisiana Department of Health and Hospitals (DHH) will use state general funds to draw down Medicaid dollars and provide reimbursement to private physicians for screening pregnant women for alcohol and tobacco use. In 2011, under the DHH Birth Outcomes Initiative, the project was elevated to a health care priority under the DHH Office of the Secretary. In April 2011, the Office of Behavioral Health entered into an Interagency Agreement (IAT) with the Office of Public Health (OPH) for the sharing of resources and services for the Birth Outcomes Initiative (BOI). The Office of Behavioral Health is collaborating with the Birth Outcomes Initiative by providing advisory support and assuming a liaison role between the BOI and the Statewide Management Organization (SMO), Magellan, in addition to OBH's role in monitoring the SMO contract. Additionally, all OBH offices/contractors work to assure timely access to services for pregnant women by adhering to priority admission guidelines.

Office of Public Health – HIV/AIDS, TB, and STD testing

OBH will continue to collaborate with the Office of Public Health (OPH) on activities that address HIV/AIDS, tuberculosis (TB), and sexually transmitted diseases (STD's) through a Memorandum of Understanding that was executed in July 2009. OPH provides workforce development opportunities for OBH staff and providers on HIV/AIDS, HIV rapid testing, TB, and STD's, provides testing supplies, and serves as a referral resource for clients. OBH ensures that clients have access to HIV rapid testing with pre/post test counseling, access to TB and STD testing, and appropriate referral options.

Office of Public Health – Pregnancy Testing

Through an on-going partnership with the Office of Public Health (OPH), the Office of Behavioral Health (OBH) offers voluntary pregnancy testing to women seeking treatment. Through this agreement, OPH provides pregnancy tests and a written protocol for pre and post test counseling. OPH also provides training/technical assistance to OBH staff, and facilitates access to prenatal care at local Parish Health Units. OBH staff provides education to all female admissions on the advantages of pregnancy testing and abstinence from alcohol and drugs during pregnancy, as well as pre and post test counseling.

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.

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Section W: State Behavioral Health Advisory Council

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.). Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council. There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- *What planning mechanism does the state use to plan and implement substance abuse services?*
- *How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?*
- *Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.*
- *Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?*
- *Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?*
- *Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.*

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 reported at its quarterly meeting that the expansion and the development of the behavioral health advisory council would likely incur significant additional expenses at the state and regional levels for organizational development, membership recruitment, advocacy training, substance use education and cross training. As such, the Council requested financial support from the Substance Abuse and Prevention Treatment Block Grant or State General Fund resources, to provide for the inclusion of substance use and addictive disorder advocates and activities into a proposed behavioral health advisory council. The

Assistant Secretary of the Office of Behavioral Health responded to this request by offering a one-time allotment of $5,000 to each Regional Advisory Council (RAC), and an additional one-time allotment of $25,000 to the Behavioral Health Advisory Council (BHAC) for these activities.

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 1984, the Governor of Louisiana appointed the Louisiana Commission on Addictive Disorders, whose mission 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 disorder services and the clients who need them. While the scope of their work is similar to that of the LBHAC, there are no plans to merge the two. However, two members of the Commission, including its chair, currently serve on the LBHAC, and continued efforts are being made by both organizations to work together.

There is a local variation of a planning council within each of the regions/Local Governing Entities (LGEs), known as the Regional Advisory Council (RAC). As independent LGEs replace the centrally managed Regions, there is even more emphasis on the need for the development and sustainability of the statewide Planning Council and the ten local Regional Advisory Councils (RACs) to address needs for mental health services across the state. The RACs are similar in purpose to the LBHAC, but with interests specifically geared toward activities in their respective areas. The RACs are the lead agencies in advising how Block Grant funds will be allocated locally. Each regional manager or LGE executive director has been directed by the OBH Assistant Secretary (Commissioner) to allocate a minimum of $5,000 (to be split between children/youth and adults) yearly of Block Grant funding to their respective RACs to support the functioning of the Regional Advisory Councils. Regional managers have been instructed to work with the RACs to develop an annual budget. RAC membership is reflective of that of the Planning Council, in that it consists of members who are primary consumers, family members, family members of children with emotional/behavioral disorders, advocates, and state agency (region or LGE) employees. Members of the Planning Council have emphasized the importance of Regional Advisory Councils (RACs) playing a more active role in initiating ongoing dialogue with their regional managers/executive directors. The RACs ideally are in communication with regional/LGE leadership and contract monitors to support the use of best practices, and funding of programs that reflect the priorities of the Planning Council. It is through this personalized local/regional partnership that the LBHAC can ensure that consumers are receiving the necessary access to services and best quality of care. 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.

With the development of an overall integrated Behavioral Health Advisory Council, all RACs have been urged to revise their councils to broader their scope of work by including addictive disorders and substance abuse as well as mental health. As such, the RACs have been asked to

ensure that their membership is representative of both the mental health and addictions communities. In many of the Regions and LGEs that have already integrated clinic and service delivery, many of the RACs seem to be naturally forming.

A state summit was held September 13, 2012 in Alexandria, Louisiana, which is in the central part of the state. The summit provided an opportunity for state Council members to interact with RAC members as well as the executive management teams from both the local and State offices. Technical assistance was provided by Bruce Emery, Advocates for Human Potential. Mr. Emery discussed several topics, with the main focus being integration. The Louisiana Behavioral Health Advisory Council Summit also included a component on council member roles and responsibilities and how this relates to the Block Grant.

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 Region or Local Governing Entity (LGE), in partnership with their local Regional Advisory Council (RAC). This is an opportunity for each Region or 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 local Regional Manager or LGE Executive Director. Once modifications are made and the Regional Manager or 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 Region or 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. 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 Committee on Finance is charged with overseeing Block Grant budget allocations and Intended Use Plans. The *Joint Block Grant Budget Review Committee* (JBGBRC) was established by state policy in 2006 to monitor the expenditure of Block Grant funds, and included members of the OBH Planning Division, the OBH Fiscal Division, and the Finance Committee of the Planning Council. In April 2012, the Finance Committee requested that a subcommittee of the Louisiana Behavioral Health Advisory Council, Committee on Finance be established and serve in place of the previously established Joint Block Grant Budget Review Committee. The subcommittee membership would be comprised of the Chair of the Louisiana Behavioral Health Advisory Council, Chair of the Committee on Finance, the State Planner, and one additional person from the Committee on Finance (appointed by the Chair of the Committee on Finance). The subcommittee will 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. This proposal was accepted and what was formerly the Joint Block Budget Review Committee is now a subcommittee of the LBHAC Committee on Finance.

In its continuing efforts at fiscal oversight, the Committee on Finance has been requesting additional and more detailed information from the Central Office of OBH regarding the expenditures of Block Grant monies. 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. While Council members and RAC members are involved at the end of the budget decisions and have opportunity to review and comment on plans, their involvement in the actual development of the behavioral health plan remains minimal. Efforts are being taken by the current chair of the Council to engage members and empower them to be proactive in establishing dialogues with their local and state authorities. Additionally, Louisiana is receiving technical assistance from Advocates for Human Potential and is a part of the National Learning Committee. The LBHAC has identified a need for developing a strategic plan, including ways in which members can become more involved in the planning process. As a part of the technical assistance, this plan will be developed, and subsequent training for Council members will be done.

Currently, the LBHAC includes seats for 40 members consisting of consumers of both mental health and addiction services, family members of adults with serious mental illness and substance abuse disorders, family members of children with emotional/behavioral disorders, 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 recent change to the Council has been the inclusion of representatives of special populations, namely the following: representatives of the managed care industry, substance abuse 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 actively recruiting individuals to fill newly created 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 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). He has also been instrumental in assisting with the protocol for bylaw amendments and has provided suggestions as to how to best transition the current council into a behavioral health council.

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.

Louisiana Behavioral Health Advisory Council Members – 2013

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 Individuals 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	Williams, Dr. Kashunda	State Employee	Office of Behavioral Health 628 N. 4th Street P.O. Box 4049 Baton Rouge, LA 70821-4049 225- 225-324-1984 (Fax) Kashunda.Williams@LA.Gov
State Planner (Child)	2	Tonguis, Joanna	State Employee	Office of Behavioral Health 628 N. 4th Street P.O. Box 4049 Baton Rouge, LA 70821-4049 Joanna.Tonguis@LA.Gov
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
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
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)

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
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	Zapata, Amy	State Employee	Maternal and Child Health Program 1010 Common St. Suite 2710 New Orleans, LA 70112 504-568-3505 504-568-3503 (Fax) Amy.Zapata@LA.Gov
ADVOCACY ORGANIZATIONS MANDATED IN STANDING RULES				
Louisiana Commission on Addictive Disorders	14	Landry, Freddie	Other (not state employee or provider)	1901-B Airline Drive Metairie, LA 70001 504-833-4673 504-885-0400 (fax) FreddieL@CelebrationHopeCenter.org
Louisiana Federation of Families for Children's Mental Health	15	Bell, Maria	Parents or Caregivers of Children 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
Advocacy Organization	16	*Vacant*		

Mental Health America of Louisiana	17	Thomas, Mark Council Chair	Family Members of Individuals in Recovery	5721 McClelland Drive Baton Rouge, LA 70805 225-978-2176 225- 356-3704 (Fax) MTMHAL@gmail.com
National Alliance on Mental Illness - Louisiana	18	Precise, David	Other (not state employee or provider)	P.O. Box 40517 Baton Rouge, LA 70835 225-291-6292 225-291-6244 (Fax) NamiLaDPrecise@bellsouth.net
The Extra Mile	19	Boudreaux, Linda	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 Region/ LGE
MHSD	20	Valteau, Brenda	Parents or Caregivers of Children or Youth with Behavioral Health Problems	New Orleans, LA 70117
CAHSD	21	Kauffman, Steve	Other (not state employee or provider)	Advocacy Center 8225 Florida Blvd., Ste. A Baton Rouge, LA 70806 225- 925-8884 225-281-6131 (cell) SKauffman@AdvocacyLA.org
SCLHSA	22	Hadley, Joyce	Family Members of Individuals in Recovery	157 Twin Oaks Drive Raceland, LA 70394 985-537-6823 (work) 985-226-0584 (cell) Joyce.Hadley@LA.Gov
AAHSD	23	Thorpe, Jennifer	Individuals in Recovery (from mental illness and/or addictions)	222 May Street Lafayette, LA 70501 337-232-3888 (home) 337-849-9248 (work) 337-849-9248 (cell) Mrbehaviorinterventioncenter13@hotmail.com
Region 5	24	Maurer, Shirley	Family Members of Individuals in Recovery	1923 Nicholas St. Lake Charles, LA 70605 337-309-1260 Shirley.maurer@juno.com
Region 6	25	Dennis, Jr. Victor B. Council Vice Chair	Family Members of Individuals in Recovery	257 Stilley Road Pineville, LA 71360-5934 318-473-2273 318-623-4547 (cell) VDennisj@bellsouth.net
Region 7	26	Bradley, Debra	Individuals in Recovery (from mental illness and/or addictions)	934 Unadilla Street Shreveport, LA 71106 318-868-6964 318-564-2853 DBradl6@bellsouth.net
Region 8	27	Goldsberry, Kristi	Individuals 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

FPHSA	28	Richard, Nicholas	Family Members of Individuals in Recovery	100 Saint Anne Circle Covington, LA 70433 985-626-6538 (work) 877-361-1631 (fax) NRichard@NamiStTammany.org
JPHSA	29	Noble, Rubye	Family Members of Individuals in Recovery	POB 8857 Metairie, LA 70011 504-835-5427 504-835-5424 (fax) RubyeNoble@ren.nocoxmail.com
INDIVIDUAL REPRESENTATIVES These individuals are involved in advocacy for specific special populations from the state at-large.				
Parents	30	Cobb, Cynthia	Parents or Caregivers of Children or Youth with Behavioral Health Problems	P.O. Box 5334 Alexandria, LA 71307 318-709-1575 (c) CCobbLAFF6@yahoo.com
Parents	31	Davis, Gloria	Parents or Caregivers of Children or Youth with Behavioral Health Problems	Shreveport, LA 71107 318-617-0320 GDavis2450@aol.com Gloria.davis@LA.Gov
Family Members	32	Leary, Kathleen	Family Member of Individual in Recovery	212 Lake Crescent Circle Houma, LA 70360 985-868-4826 (home) 985-226-5768 (cell) WrLeary@LouisianaLap.com
Family Members	33	*Vacant*		
Managed Care Industry	34			
Substance Abuse Treatment	35	Rowan, Tom	Individuals in Recovery (from mental illness and/or addictions)	703 Hutchinson Street Mandeville, LA 70448 985-626-6402 Thomas.Rowan@LA.Gov
Elderly	36	*Vacant*		
Federally Recognized Indian Tribe	37	*Vacant*		
Homeless Population	38	*Vacant*		
Transitional Youth	39	Prejean, Katherine	State Employee	Office of Behavioral Health 628 N. 4th Street P.O. Box 4049 Baton Rouge, LA 70821-4049 Katherine.Prejean@La.Gov
Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI)	40	Stone, Christopher	Individuals 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

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Louisiana Behavioral Health Advisory Council
Composition by Member Type

Type of Membership	Number & Percentage of Total Membership
TOTAL MEMBERSHIP	**40 # 100 %**
Individuals in Recovery (To include adults with SMI who are receiving, or have received, mental health services)	5
Family Members of Individuals in Recovery (To include family members of adults with SMI)	7
Parents of Children with SED	4
Vacancies (Individuals and Family Members)	6
Others (Not State employees or providers)	3
Total Individuals in Recovery, Family Members & Others	**25 # 62.5 %**
State Employees	14
Providers	1
Federally Recognized Tribe Representatives	0
Vacancies	0
Total State Employees & Providers	**15 # 37.5 %**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	9
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**9 # 23%**
Persons in Recovery from or Providing Treatment for or Advocating for Substance Abuse Services	6

Notes:
1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council. Percentage of family members of children with SED to total members 4/40 = 10%.

2) State employee and provider members shall not exceed 50% of the total members of the Planning Council. Percentage of state employees and providers 14/40 = 35 %.

3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support activities.

4) The council is committed to working towards diversity, and consideration is given towards representation of diverse groups in representation on the council

The Council is actively recruiting individuals to fill newly created positions for representatives of various population groups of interest, including Elderly Adults, Federally Recognized Indian Tribes, and Homeless Individuals.

Louisiana Behavioral Health Advisory Council

BYLAWS

Amended May 7, 2012

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.

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 special 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. 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.

Section 2. Standing Committees.

A. The chairman of the council shall appoint the following committees:

1. 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 and chairmen of the other standing committees of the council. 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. The council chairman shall appoint the chairman of the committee on advocacy from among the council members who serve as RAC representatives, or those who serve as regional representatives to the council. The committee on advocacy shall otherwise be composed of the members of the council who represent the several advocacy organizations on the council and any other council members the council chairman may appoint.

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. The Council chairman shall appoint the chairman of the committee on finance. The committee on finance shall otherwise be composed of members appointed by the council chairman and shall include all members of the council who are representatives of the state agencies involved in the block grant finance and budgeting

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 mental health programs and services in the state. The council chairman shall appoint the chairman of the committee, and shall appoint to the committee at least one council member from each of the ten regions.

C. A state block grant planner shall be ex officio a member of each standing committee.

Section 3. 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 4. 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 5. 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 May 7, 2012 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

Two members from OBH responsible for the preparation of the block grant plan.

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)

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:

Six members, one from each of the following:

(1) Meaningful Minds of Louisiana
(2) Louisiana Commission on Addictive Disorders
(3) Louisiana Federation of Families for Children's Mental Health
(4) National Alliance on Mental Illness – Louisiana
(5) Mental Health America of Louisiana
(6) The Extra Mile

Appointed from OBH regional advisory councils (RAC):

Ten members, one from each RAC.

B. Individual Members

Eleven members, representing specific special populations from the state at-large.

1. Parent or Caregiver of Children or Youth with Behavioral Health Problems
2. Parent or Caregiver of Children or Youth with Behavioral Health Problems
3. Family Member of Individuals in Recovery
4. Family Member of Individuals in Recovery
5. Representative of Substance Abuse Treatment
6. Representative from the Managed Care Industry
7. Representative of the Senior Population
8. Representation of the Tribal Population
9. Representative of Homeless Population
10. Representative of Youth in Transition Population
11. Representative of Lesbian, Gay, Bisexual, Transgender, and Questioning Population

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 behavioral health services, or
2. Family members of adults with behavioral health care needs, or
3. Children and youth with serious emotional, behavioral, or substance abuse disorders who are receiving or have received behavioral health services and related support services, or
4. Parents and family members of children/youth with a serious emotional, behavioral, or substance abuse disorder, or
5. Advocates for individuals with behavioral health care needs,

   or
6. Individuals, including providers, who are concerned with the need, planning, operation, funding, and use of behavioral health services and related support services.

Consideration should be made to insure that membership does not exceed 50 percent from one geographic area.

Consideration should be made to insure that state employee membership does not exceed 50 percent.

Consideration should be made to insure that the needs of children are adequately represented on the Council.

Revised November 5, 2012

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 May 2, 2011

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

3. 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 measureables are related to outcomes. (Sept & March) Look back to see expenditures and whether measurable 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 measureables 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.

Mental Health Services and Substance Abuse Prevention and Treatment
Combined Behavioral Health Assessment and Plan
LOUISIANA - FY 2014

Section X: Improving Enrollment Processes and Provider Business Practices

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system.

The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- *Outreach and enrollment support for individuals in need of behavioral health services.*
- *Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.*
- *Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.*
- *Third-party contract negotiation.*
- *Coordination of benefits among multiple funding sources.*
- *Adoption of health information technology that meets meaningful use standards.*

Louisiana has opted for a federally-facilitated Health Insurance Exchange. Health plans sold through that Exchange will primarily be regulated by the federal Center for Medicare and Medicaid Services (CMS), which has entered into a cooperative agreement with the Louisiana Department of Insurance to provide some enforcement functions related to the consumer protections of the Patient Protection and Affordable Care Act and the Mental Health Parity and Addiction Equity Act.

The Louisiana Department of Health and Hospitals is focused on strengthening and improving its current programs. The state has recently undergone two major transformations designed to better coordinate care and deliver better health outcomes: Bayou Health and the Louisiana Behavioral Health Partnership. Bayou Health allows over 900,000 Medicaid recipients to participate as members of a health plan, which are accountable for ensuring adequate provider networks and additional services like chronic disease management. The Louisiana Behavioral Health Partnership provides a single coordinating entity for behavioral health services for Louisiana's Medicaid and uninsured populations, and has allowed the state to expand its provider network and the number and types of services available through its Medicaid state plan.

Mental Health Services and Substance Abuse Prevention and Treatment
Combined Behavioral Health Assessment and Plan
LOUISIANA - FY 2014

Section Y: Comment on the State Block Grant Plan

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) 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 BG 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 the Secretary of HHS.

Louisiana encourages and provides an opportunity for public input and comment on the Block Grant State Plan through a variety of means.

Historically, the Office of Addictive Disorders conducted annual Public Forums in order to assess consumer needs, as well as to establish a common ground for providing information to the community and to receive input from stakeholders. The Office of Behavioral Health continues this effort each year and conducted Public Forums in each of the ten (10) Regions/LGEs throughout the State during FY 2012. Six hundred sixty-five (665) stakeholders/community members attended these Forums (see table below).

Region / District	Date/Time	Location	Regional Coordinator	OBH Representative
Region VI **83 Participants**	Wednesday, June 13, 2012 9:00 a.m. – 11:00 a.m. 8:00 a.m. breakfast	Pineville Community Center 708 Main Street Pineville, LA 71360	Tremeka Johnson	Dr. Rochelle Dunham Brenda Lands Felecia Johnson Tricia Hensarling Tommy Prejean
AAHSD **91 Participants**	Wednesday, June 13, 2012 3:00 p.m. – 5:00 p.m.	Clifton Chenier Center 220 B Willow Street Lafayette, LA 70501	Joyce Ben	Dr. Rochelle Dunham Ken Saucier Brenda Lands Felecia Johnson Tricia Hensarling Tommy Prejean
Region V **52 Participants**	Friday, June 15, 2012 10:00 a.m. – 12:00 p.m.	Lake Charles Civic Center Mezzanine 900 Lake Shore Drive Lake Charles, LA 70601	Charmaine Landry	Dr. Rochelle Dunham Ken Saucier Leslie Freeman Tommy Prejean
MHSD **40 Participants**	Monday, June 18, 2012 6:00 p.m. – 8:00 p.m.	Nunez Community College 3710 Paris Road Chalmette, LA 70043	Cathy Storm Kelly Bertrand	Dr. Rochelle Dunham Ivory Wilson Bill Blanchard
FPHSA **60 Participants**	Tuesday, June 19, 2012 9:00 a.m. – 11:00 a.m.	The Edson Facility Florida Parishes Human Services Authority – Suite B 835 Pride Drive Hammond, LA 70401	Sue Kennedy Jaime Bruins	Dr. Rochelle Dunham Felecia Johnson Tom Dumas Tricia Hensarling Charlene Gradney Deanne Mills
CAHSD **118 Participants**	Thursday, June 21, 2012 9:30 a.m. - 11:30 a.m.	State Archives Building 3851 Essen Lane Baton Rouge, LA 70809	Charlene Gillard	Dr. Anthony Speier Cindy Rives Leslie Freeman Tom Dumas Charlene Gradney
Region VII **48 Participants**	Thursday, June 21, 2012 12:00 p.m. – 2:00 p.m.	Brentwood Hospital Gymnasium 1006 Highland Avenue	Wendy Goad	Ken Saucier David McCants

		Shreveport, LA 71101		Megan Fontenot
Region VIII **13 Participants**	Friday, June 22, 2012 9:00 a.m. – 11:00 a.m.	Public Health Community Room Ouachita Parish Health Unit 1650 Desiard Street Monroe, LA	Jessica Dreher	Ken Saucier David McCants Bill Blanchard Megan Fontenot
JPHSA **85 Participants**	Tuesday, June 26, 2012 6:00 p.m. – 8:00 p.m.	Jefferson Parish Human Services Authority - East Jefferson facility 3616 South I-10 Service Road Metairie, LA 70001	Julie Shaw	Dr. Anthony Speier Ivory Wilson Bill Blanchard
SCLHSA **75 Participants**	Wednesday, June 27, 2012 10:00 a.m. – 12:00 p.m.	Terrebonne Library North Branch 4130 West Park Avenue Gray, LA 70359	Theresa Hardin Misty Hebert	Dr. Anthony Speier Bill Blanchard Quinetta Womack

Members of the Louisiana Commission on Addictive Disorders are key attendees at the annual Public Forums. This Commission was created through Act 899 of the 1984 Regular Legislative Session, and its statutory duties and responsibilities include advising the State on policy with respect to addictive disorders, recommending program initiatives and goals, and serving as liaison among all State and Local Government Entities concerning addictive disorders. The Commission is comprised of clinical experts, providers, consumers, and/or persons in recovery, as well as members of the alcoholic beverage industry.

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, consisting of 40 members representing all geographic areas of the State, 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. As discussed earlier (*Section W: State Behavioral Health Advisory Council*), the Louisiana Behavioral Health Advisory Council is in the process of expanding in order to advise and consult on behavioral health issues and services for persons with or at risk of substance abuse and substance use disorders.

OBH makes the Block Grant State Plan available for review, encouraging public comment and 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. Email notices are sent to the Regional Managers, LGE Executive Directors, and Advisory Council members when the Block Grant State Plan is initially placed on the website. The current draft of the Block Grant is placed on the OBH website publication link, 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.

Bound hard copies of the 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.

PUBLIC 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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