

The New Orleans Behavioral Health Crisis System

2017 REPORT



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EXECUTIVE SUMMARY

In the last several years, Orleans Parish has climbed the county health rankings chart to 40th of 64 parishes. While New Orleans has made progress, the city continues to rank low in Louisiana and the U.S. overall on many socioeconomic factors such as poverty and employment, housing security, and violent crime.

To address many of these challenges and continue progress toward a healthy community, the New Orleans Health Department and Metropolitan Human Services District co-chair the New Orleans Behavioral Health Council (NO-BHC) that is comprised of about 54 organizations across four sectors: education, housing, criminal justice, and health and hospitals. The members of the council are key stakeholders in transforming the behavioral health delivery system.

To better understand these barriers across programs and services for adult crisis, the Louisiana Public Health Institute (LPHI) partnered with Baptist Community Ministries (BCM), the New Orleans Health Department (NOHD), and the Metropolitan Human Services District (MHSD) to conduct a preliminary assessment of the current state of the behavioral health crisis system in Orleans Parish focusing on adult services. To best understand the realities of people involved directly in crisis response, interviews of front-line staff of organizations involved in behavioral health crisis were conducted.

This report is part of an ongoing process to assess and improve the behavioral health continuum of care in New Orleans, and should be considered a tool to support the NO-BHC and key stakeholders to make informed decisions. Several system assets and challenges were identified. From those, opportunities for further improvement and discovery were uncovered.

The crisis system assets identified in this report include the following:

- trained and engaged first responders,
- engaged criminal justice sector,
- growing hospital capacity, and
- strong networks of community-based safety net service providers.

The crisis system challenges identified in this report include the following:

- redundancy and inefficiency in crisis response protocols,
- lack of crisis receiving services,
- police and ems wall time,
- long wait times and slow patient flow in hospitals,
- gaps in hospital discharge planning and transitions of care,
- limited availability of substance use treatment services,
- delays in access to outpatient mental health services,
- few residential treatment options,
- limitations of case management programs, and

- homelessness and housing insecurity.

Opportunities to enhance the crisis response system include many elements:

- clarity and standards on roles, responsibilities, and safety protocols
- pathways for inter-agency alignment and collaboration
- specific cost analysis
- exploration of evidence-based models
- enhance data collection, analysis, and use for decision making
- increasing training for providers
- clarity of the pathway for the establishment of licensed group homes within the Greater New Orleans area

Throughout the key informant interviews, representatives of all sectors and organizations expressed interest in working together to address the systemic challenges facing individuals and families, service providers, and other stakeholders in the behavioral health crisis system.

There are two priority opportunities to activate immediate next steps in working toward the desired future state and to enhance local capacity for system-wide change, which are described below.

First, the New Orleans Behavioral Health Council must double down on prior commitments to fulfill its role as: the central facilitator of shared decision making and priority setting across sectors and settings, the hub for collaboration and ongoing education, and the leader of continuous behavioral health improvement and monitoring efforts.

Second, the financial costs and benefits associated with operating the behavioral health system must be determined and analyzed to incorporate cost considerations into the strategic planning and prioritization of system improvement activities. There is a need to understand what each entity in the system (insurers, health and social service providers, the criminal justice system, and other local and state agencies) is paying for to identify any redundancies, inefficiencies, or gaps in city-wide investments.

To supplement this preliminary assessment and to most effectively pursue the opportunities and next steps identified here, a larger-scale assessment and planning process is needed to enable system-wide progress toward achieving NO-BHCs' vision for the future. LPHI, NOHD, and MHSD are actively pursuing additional grant funds for that purpose.

INTRODUCTION

The New Orleans behavioral health crisis system – spanning multiple sectors from police to hospitals – strives to provide person-centered and recovery-oriented behavioral health and support services across the continuum of care (prevention, early intervention, treatment, post-treatment) to serve those with mental illnesses and addictive disorders and to prevent exposure to behavioral health risk factors before a behavioral health crisis occurs. The New Orleans Health Department and Metropolitan Human Services District co-chair the New Orleans Behavioral Health Council (NO-BHC) that is comprised of about 54 organizations across four sectors: education, housing, criminal justice, and health and hospitals. The members of the council are key stakeholders in transforming the behavioral health delivery system. To that end, New Orleans' Behavioral Health Council envisions a Recovery-Oriented System of Care (ROSC) in which a network of diverse collaborators come together around a unifying purpose of achieving high-quality, person-centered, and accessible behavioral health care.¹ By including non-traditional partners for example, faith-based organizations, a ROSC integrates comprehensive health and social supports, and invests in preventive solutions that improve the overall health and wellbeing of communities.

Some progress has been made in building a ROSC in New Orleans. However, in its current state, the behavioral health crisis system struggles to meet the needs of the community. Individuals, families, and a range of service providers report that behavioral health services remain in siloes. For example, individuals interviewed for this report stated that community-based and hospital-based services are disconnected. Numerous barriers like months-long wait times for an appointment make accessing treatment in the community difficult. Pathways and patient ownership throughout the system are unclear and often uncoordinated; for example, there is a lack of follow-up and comprehensive support after hospital discharge. These barriers prevent individuals from receiving adequate, continuous care to enable successful recovery, leading those with the greatest needs to cycle through the health and criminal justice systems.

To better understand these barriers across programs and services, the Louisiana Public Health Institute (LPHI) partnered with Baptist Community Ministries (BCM), the New Orleans Health Department (NOHD), the Metropolitan Human Services District (MHSD), and the NO-BHC over a 12-month period (October 2016 - September 2017) on a project to conduct a preliminary assessment of the current state of the behavioral health crisis system in Orleans Parish focusing on adult services. To best understand the realities of people involved directly in crisis response, interviews of front-line staff of organizations involved in behavioral health crisis were conducted.

¹ Substance Abuse and Mental Health Services Administration. Recovery-Oriented Systems of Care (ROSC) Resource Guide (2010, September). Retrieved from: https://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

This report is part of an ongoing process to assess and improve the behavioral health continuum of care in New Orleans, and should be considered a tool to support the NO-BHC and key stakeholders to make informed decisions.

The purpose of this project was to:

- 1) understand the current state of crisis services through a series of key informant interviews,
- 2) present key issues and opportunities to decision makers engaged in ongoing behavioral health programming and coordination, and
- 3) support next steps in the development of a comprehensive model of behavioral health care and system-wide improvement.

While this assessment reveals a strong connection between the challenges in the crisis system and other parts of the behavioral health continuum, this project did not include a comprehensive assessment of the full continuum of care. This report draws on the information and insights shared by interviewees to describe existing assets, critical challenges, and key opportunities to address problems in crisis services through system-wide improvements to the community-based system of care. To supplement the preliminary findings and opportunities identified, a larger-scale assessment and planning process is needed to enable system-wide progress toward achieving NO-BHCs' vision for the future. LPHI, NOHD, and MHSD are pursuing additional grant funds for that purpose.

BEHAVIORAL HEALTH IN NEW ORLEANS

New Orleans is home to approximately 389,617 residents.ⁱ Table 1 below summarizes New Orleans' and Louisiana's demographic and socioeconomic makeup. New Orleans ranks low in Louisiana and the U.S. overall on many socioeconomic factors such as poverty and employment, housing security, and violent crime. New Orleans' poverty rate is 27%, is higher than Louisiana's rate of 19.6% and nearly double the national average of 15.5%. Poverty in New Orleans highlights major disparities across racial lines. Thirty-five percent of African Americans live below the federal poverty line compared to 13.2% among whites. Poverty and other socioeconomic indicators are closely linked to health and wellbeing.

Table 1. Demographic and Socioeconomic Data

	New Orleans	Louisiana
Total Population ⁱ	389,617	4,670,724
Race ⁱ		
Black	60.0%	32.6%
White	35.0%	59.1%
Hispanic	5.6%	5.0%
Asian	3.1%	1.8%
American Indian/Alaskan Native	0.3%	0.8%
Native Hawaiian/Other Pacific Islander	0.1%	0.1%
Poverty Rate ⁱ	24.0%	20.2%
Median Household Income ⁱ	\$36,792	\$45,047
Below High School Education ⁱ	14.8%	16.6%
Unemployment Rate ⁱ	6.5%	6.3%
Severe Housing Problems ⁱⁱ	28.0%	16.0%
Food Insecurity ⁱⁱ	24.0%	17.0%
Violent Crime ⁱⁱ	862 per 100,000	510 per 100,000

Sources: ⁱ [American Community Survey, 2016](#); ⁱⁱ [County Health Rankings](#); ⁱⁱⁱ [BRFSS, 2015](#); ^{iv} [Dartmouth Atlas, 2014](#)

According to County Health Rankings, Louisiana ranks last in overall health outcomes compared to other states. New Orleans ranks 40th out of 64 parishes on health outcomes compared to the rest of the state. Table 2 below presents several indicators of healthcare access and health outcomes in New Orleans. While New Orleans ranks low on health outcome indicators, Census data show New Orleans has more mental health care service providers per capita than the national average ratio of mental health service providers per capita.

Table 2. Health Care Access and Outcomes

	New Orleans	National Average
Primary Care Physician Ratio ⁱⁱ	1,175:1	1,320:1
Mental Health Provider Ratio ⁱⁱ	340:1	500:1
Hospital Discharges for Ambulatory Care-Sensitive Conditions ^{iv}	52.0 per 1,000	49.9 per 1,000
Poor or Fair Health ⁱⁱ	23.0%	15.0%
Poor Physical Health Days ⁱⁱ	4.2	3.6
Poor Mental Health Days ⁱⁱ	4.4	3.7
Adult Smoking ⁱⁱ	22%	18%
Excessive Drinking ⁱⁱ	19%	18%
Ever Told You Had a Form of Depression ⁱⁱⁱ	21.1%	22.0%
Years of Potential Life Lost ⁱⁱ	10,400 per 100,000	6,600 per 100,000

Sources: ⁱ Census, 2015; ⁱⁱ County Health Rankings; ⁱⁱⁱ BRFSS, 2015; ^{iv} Dartmouth Atlas

Several historical events as well as ongoing policy and infrastructure developments continue to impact New Orleans' behavioral health delivery system in both positive and negative ways. Therefore, when assessing behavioral health in New Orleans, it is important to understand the following contextual factors.

Loss of Psychiatric Inpatient Facilities. New Orleans continues to experience impacts from decades of deinstitutionalization through continuous closure of state hospitals and the subsequent loss of psychiatric beds for individuals with mental illness. These closures have eliminated treatment options for those needing inpatient hospitalization, especially over the last decade as health system infrastructure was challenged by Hurricane Katrina. The closure of one local hospital, Charity Hospital, resulted in the loss of 92 psychiatric beds.² This closure and the closures of the New Orleans Adolescent Hospital and state hospitals led to a dearth of inpatient services for the Greater New Orleans area. Between 2010 and 2016 over 280 psychiatric beds were eliminated in Louisiana, leaving 13.2 beds available per 100,000 people.³ According to the Treatment Advocacy Center's 2016 report on Trends and Consequences of Eliminating State Psychiatric Beds, empirical research to relate bed availability to outcomes has not been conducted; however, "health policy experts converge around a minimum of 40 to 60 inpatient beds per 100,000 people to meet demand."³

Loss and Reestablishment of Community Safety Net Health Systems. In 2004, Louisiana ranked fourth in the nation for high ED use, with 548 visits per 1,000 people, which is an indication of limited access to primary care and preventive services.⁴ New Orleans uninsured and low income residents relied primarily on the "safety-net" Medical Center of Louisiana at New Orleans run by Louisiana State University (LSU), which consisted of Charity and University Hospitals for emergency, inpatient, and outpatient health care services. Over 80% of all inpatient and outpatient uncompensated care costs in the New Orleans area were accounted for by Charity Hospital just before Hurricane Katrina struck in 2005.⁴

After Hurricane Katrina, Charity hospital's closure disrupted many needed health services. As the Gulf Coast's only Level 1 Trauma Center emergency services and the psychiatric crisis response system were also compromised.⁴ The closure also complicated medical training programs that supplied staffing for the city's behavioral health services.

Since the closure of Charity Hospital, two major investments in the local health care safety net have improved access to and quality of care in New Orleans. In May 2007, the Louisiana Department of Health (LDH) was awarded a \$100 million Primary Care

² Conrad, E. J., Townsend, M. H., & Buccola, N. Restoration of Mental Health Services in New Orleans (2008). *American Journal of Psychiatry*. 165(1), 33. Retrieved from: <https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2007.07101697>

³ Fuller, D., Geller J., Quanbeck, C., Sinclair, E., & Snook, J. Going, Going, Gone Trends and Consequences of Eliminating State Psychiatric Beds (2016). *Office of Research and Public Affairs*. Retrieved from: <http://www.treatmentadvocacycenter.org/going-going-gone>

⁴ Rudowitz, R., Rowland, D., & Shartzter, A.. Health Care in New Orleans Before And After Hurricane Katrina (2006). *Health Affairs*. 25(5), 393-406. Retrieved from: <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.25.w393>

Access Stabilization Grant (PCASG).⁵ The purposes of the grant were two-fold. First, to restore and expand access to primary, mental health, and dental care services regardless of a patient's insurance status or ability to pay. Second, to decrease reliance on emergency room use for primary care services, through the reestablishment of community-based primary care services. Currently, over 90 primary care and behavioral health clinics including Federally Qualified Health Centers serve residents of Orleans, Jefferson, St. Bernard, and Plaquemines parishes. In 2012, the New Orleans Charitable Health Fund administered by LPHI invested approximately \$8 million to further integrate behavioral health, primary care, and social services in six organizations across the greater New Orleans area. Since, BCM has supported an ongoing integration Learning Community which provides technical assistance and training to behavioral health providers across the Greater New Orleans area. In August 2015, University Medical Center (UMC) opened its doors, filling the roles of safety-net hospital and Level 1 Trauma Center that Charity Hospital once filled.

Expansion of Coverage

In 2014, Medicaid paid for 25% of mental health spending and 21% of addiction spending nationally.⁶ In 2016, Governor John Bel Edwards signed an executive order to initiate Medicaid Expansion through the Affordable Care Act (ACA). Services expanded to newly eligible populations on July 1, 2016. About one year later, Louisiana had 427,883 newly insured residents 51,310 live in New Orleans.⁷ A recent estimate indicates that Louisiana's number of uninsured residents was nearly cut in half from 21.7% in 2013 to 12.5% in late 2016 due to Medicaid expansion and other insurance reforms under the ACA.⁸ The additional Medicaid funding for behavioral health services brings new opportunity to behavioral health systems. To advance gains made by increased coverage, more change is needed at the delivery system level - especially in the community setting - to ensure availability of and access to comprehensive behavioral health services.

The Criminal Justice System

The unconstitutional conduct, civil rights violations, and other misconduct of the New Orleans Police Department (NOPD), led the City of New Orleans including the NOPD to enter into a Consent Decree with United States Department of Justice (DOJ) in 2012.⁹ This was "with the goal of ensuring that police services are delivered to the people of New Orleans in a manner that complies with the Constitution United States."¹⁰ The Consent Decree details for action in several specific areas including but not limited to: policies and training, use of force, crisis intervention team, bias free policing, community

⁵State of Louisiana Bureau of Health Services Financing. Greater New Orleans Community Health Connection Provider Manual (2011). Retrieved from: <http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GNOCHC/GNOCHC.pdf>

⁶ The Henry J. Kaiser Family Foundation. Medicaid's Role in Behavioral Health (2017, May 5). Retrieved from: <http://www.kff.org/infographic/medicaids-role-in-behavioral-health/>

⁷ Louisiana Department of Health. Healthy Louisiana LDH Medicaid Expansion Dashboard. Retrieved from: <http://www.ldh.la.gov/healthyladashboard/>

⁸Witters D. Kentucky, Arkansas Post Largest Drops in Uninsured Rates (2017, February 8). *Gallup News*. Retrieved from: <http://www.gallup.com/poll/203501/kentucky-arkansas-post-largest-drops-uninsured-rates.aspx>

⁹ Consent Decree, U.S. vs. City of New Orleans (No. 2:12-cv-01924-SM-JCW, July 24, 2012). Retrieved from: <https://www.nola.gov/getattachment/NOPD/About-Us/NOPD-Consent-Decree/NOPD-Consent-Decree-7-24-12.pdf/>

¹⁰City of New Orleans. NOPD Consent Decree (2017, July 31). Retrieved from: <https://www.nola.gov/nopd/nopd-consent-decree/>

engagement, officer assistance and support, misconduct complaints, transparency, and oversight. Included in the Consent Decree was the provision that “*NOPD agrees to minimize the necessity for the use of force against individuals in crisis due to mental illness or a diagnosed behavioral disorder.*” This NOPD practice could directly impact the experiences and health outcomes of individuals in behavioral health crisis who interact with the criminal justice system.

Cross-Sector Collaboration to Improve Behavioral Health

The complex relationships and opportunities related to behavioral health in New Orleans that span multiple sectors should be considered when seeking to improve the Behavioral Health system. In 2012, the City of New Orleans released a Behavioral Health Strategic Plan and established a cross-sector Behavioral Health Council (NO-BHC) with the aim to ensure a comprehensive, coordinated, and cohesive system of behavioral health care.¹¹ The Council achieves this aim through 1) community-wide education and information-sharing; 2) development of system-level strategies to improve coordination; and 3) advocacy for policies that improve behavioral health for all. The NO-BHC is co-chaired by NOHD and MHSD leadership, guided by a core group, and coordinated by NOHD staff. In addition to a core group, there are four focused workgroups: Criminal Justice, Education, Housing, and Health and Hospitals. The NO-BHC has supported program development and behavioral health information sharing through a monthly mental health dashboard. In July 2017, the NO-BHC hosted a public forum that emphasized its new level of focus and commitment toward establishing a ROSC to meet New Orleans’ behavioral health and social support needs. The NO-BHC is poised to serve as the backbone for community collaboration and mobilization to improve systems and achieve better outcomes related to behavioral health. As described throughout this report, there is significant opportunity for the NO-BHC to lead the decision making, planning, and implementation activities needed to create system-wide change.

ASSESSMENT APPROACH

To inform programming in Orleans Parish, LPHI interviewed 20 individuals representing key stakeholder groups. Interviewees included residents with experience in the behavioral health system, MHSD, NOPD, local hospital emergency department (ED), the New Orleans Emergency Medical Services (EMS), social service and behavioral health agencies, Medicaid managed care, and the Orleans Parish Coroner’s Office. In order to capture information that best reflects the current state of the crisis system and the experiences of those involved in the system, most interviewees identified to participate in this project were in roles that involve daily contact with individuals in crisis or recovering from crisis, or their family members. A full list of organizations represented in the interviews is included in Appendix A.

¹¹ New Orleans Health Department. Behavioral Health Strategic Plan (2012). Retrieved from: <https://www.nola.gov/health-department/behavioral-health/behavioral-health-strategic-plan/>

The interviews were held during an eight-month period between October 2016 and June 2017. To facilitate the interviews, LPHI developed an interview guide, which is included in Appendix B. The guide was adapted from an interview guide utilized by LPHI in a previous project entitled Transforming the St. Tammany Behavioral Health System.¹² To tailor the interview questions to this project, LPHI modified several topical areas of particular interest to the New Orleans community. During meetings held between August and December 2016 with partners and key stakeholders, a list of community-identified crisis needs and themes was captured during a three-month period prior to the interviews to inform the interview guide development and this report. These meetings included ongoing community-based working groups, behavioral health project advisory boards, the Behavioral Health Council's workgroup meetings, and other convenings hosted by various organizations and government agencies. Additional input on the interview guide was provided by the New Orleans Behavioral Council Steering Committee.

Information gathered through these sources was also used to create an initial map of the current state of the behavioral health crisis system, included in Appendix C. Portions of the map were adapted from a sequential intercept mapping process completed as part of the AcademyHealth Community Health Peer (CHP) Learning Program, which focused on the experiences of patients enrolled in Assertive Community Treatment or Forensic Assertive Community Treatment programs. This map is intended to illustrate at a high level the common patient pathways through the crisis system. It does not capture all possible pathways or detail the important decision points or gaps in the system. Additionally, while not pictured, it is important to consider this map in the context of the broader behavioral health system, of which the crisis system is only a small part.

CRISIS SYSTEM ASSETS

New Orleans' current behavioral health crisis system has a number of unique and foundational assets. Although the key stakeholder interviews focused primarily on system challenges, stakeholders were quick to point out existing resources, services, and trends that add value to the system. The assets identified most frequently are described below. Challenges with some of these services were identified and are described in the Crisis System Challenges section.

Trained and Engaged New Orleans First Responders:

- ***The Crisis Intervention Team (CIT)***. As a result of the Consent Decree Regarding the NOPD, the NOPD has taken steps to ensure effective,

¹² Louisiana Public Health Institute. (2014). Transforming the St. Tammany Behavioral Health System. New Orleans, La: Gentry, L., Farb, H., Canfield, C., Capobianco, J., Reynolds, K., & Robert, J. Retrieved from: http://lphi.org/wp-content/uploads/2016/09/TransformingtheSt.TammanyBehavioral-HealthSystemReport_BehavioralHealth.pdf

constitutional, and professional law enforcement. To “minimize the necessity for the use of force against individuals in crisis due to mental illness or a diagnosed behavioral disorder,” the NOPD agreed to implement a Crisis Intervention Team (CIT) program.⁹ The CIT model is a nationally recognized approach to recognize and manage behavioral issues that may be attributable to a mental health disorder.¹³ The program requires that all officers receive eight-hours of crisis intervention and de-escalation training.¹⁴ The program also creates a specialized team of voluntary CIT officers who receive 40-hours of intensive training.¹³ NOPD reported that they place one or two CIT officers per shift per district. As of the end of February 2017, 144 CIT officers have been trained and certified.¹⁵

Over half of the stakeholders interviewed praised the recent NOPD CIT initiative and reported improvements in response and de-escalation for behavioral health crises. One interviewee reported that officers are “more prepared” and “you can tell from looking at officers if they’ve been CIT trained because of how they behave.” In its most recent report, the Consent Decree Monitor stated that “the results, so far, have been positive. NOPD officers and community members uniformly praise the CIT program.”¹⁵ To supplement the NOPD officer training, CIT trainers provided an eight-hour mental health training to 9-1-1 staff, which one interviewee reported has improved 9-1-1 staff’s ability to assess mental health needs and triage services.

- **Community-Engaged EMS.** New Orleans EMS actively engage in conversations and activities related to behavioral health improvement. EMS’s Patient Advocacy and Community Health arm, allows the agency to consistently contribute to inter-organizational collaboration and improvement activities. A dedicated staff person to support EMS engagement and activation in policy and systems change is a unique asset to New Orleans.

Engaged Criminal Justice Sector: Recent funding opportunities like the MacArthur Safety and Justice Challenge, and the AcademyHealth CHP Program gave several organizations the space and resources to begin work on large-scale projects to align the health care and criminal justice sectors. Most notable from the work is the criminal justice sector’s representation and engagement in community and governmental discussions about transforming the behavioral health system. Interviewees referenced a few projects and programs throughout the city that seek to bridge the gaps between the criminal justice and healthy systems including:

- **The Community Alternatives Program (CAP).** Operated by NOHD and the Municipal Court, the CAP assists an average of 50 low-level offenders with mental illness in the Municipal Court per year by connecting them to treatment services and legal support to divert them from the justice system.¹⁴
- **Medicaid Enrollment and Outreach Upon Reentry Program.** To maximize the impact of Medicaid Expansion for individuals involved in the criminal justice

¹³ New Orleans Police Department. Crisis Intervention Team 2016 Annual Report (2016). Retrieved from: <https://www.nola.gov/getattachment/NOPD/NOPD-Consent-Decree/CIT-2016-Annual-Report.pdf/>

¹⁴ NO-BHC Public Forum (2017, July).

¹⁵ Consent Decree Monitor. Report of the Consent Decree Monitor for the New Orleans Police Department Decree Covering the Third and Fourth Quarters of 2016 (2017, June 19). Retrieved from: <http://nopdconsent.azurewebsites.net/Media/Default/Documents/Reports/525%20Quarterly%20Report%20for%20the%20Third%20and%20Fourth%20Quarters%20of%202016.pdf>

system, the Department of Health (LDH) and the Department of Corrections (DOC) teamed up to create an automated enrollment process for eligible inmates to receive Medicaid coverage on the day that they are released from state prisons. The automatic enrollment process also identifies individuals with high medical needs so that Medicaid Managed Care Organizations (MCO) can reach out and provide case management services to ensure that they have access to necessary care upon re-entry into the community.^{16, 17}

- **The McArthur Safety and Justice Challenge Grant Project.** In April 2016, the City of New Orleans was awarded a grant from the Safety and Justice Challenge to implement strategies to reduce the average daily jail population in Orleans Parish over the next two years by reducing arrests and the incarceration of residents with mental health and addiction issues.¹⁸
- **The AcademyHealth Community Health Peer (CHP) Learning Grant Project.** In June 2015, LPHI received a two-year planning grant through the AcademyHealth CHP Program. LPHI brought together an advisory board of local health care and criminal justice representatives who explored targeted issues that impact high utilizers of the health care and criminal justice systems through a community-driven planning process. The group identified several data-driven strategies to enhance data sharing and improve care coordination across the continuum of behavioral health services. From the project, linkages between the Orleans Parish Prison (OPP) and the Greater New Orleans Health Information Exchange (GNOHIE) were established. Additionally, the NOPD CIT now transmits data to the University Medical Center Emergency Department.

Growing Hospital Capacity:

- **New Facilities.** Louisiana historically had high rates of Emergency Department (ED) visits, particularly at public hospitals. According to Kaiser Family Foundation, “Louisiana: Hospital Emergency Room Visits per 1,000 People, 2004,” in 2004 the state ranked fourth in the nation for high ED use, with 548 visits per 1,000 people; the national average was 383 visits.¹ Charity Hospital’s closure, put a greater strain on New Orleans’ emergency and acute care services. Now, with University Medical Center (UMC) operational, residents have access to a 60-bed inpatient psychiatric unit and a 26-bed behavioral health emergency room. Many interviewees attributed the increase in access to emergency and inpatient services, for individuals in behavioral health crisis, to the new facility’s opening. At a meeting for the AcademyHealth CHP Program in February 2017, one meeting attendee remarked: *“Just now when we walked through the ED I saw EMS from two counties, police, and people from the department of corrections escorting men from jail out of here. Everyone is using this place.”*

¹⁶ Lipinski, J. State prisons to enroll ex-inmates in Medicaid starting Jan.1 (2016, December 12). *The Times-Picayune*. Retrieved from: http://www.nola.com/health/index.ssf/2016/12/louisiana_medicaid_prison_re-e_1.html

¹⁷ Louisiana Department of Health. Department of Health and Department of Corrections teams up to provide healthcare coverage for newly released offenders (2017, March 1). *DHH Newsroom*. Retrieved from: <http://dhh.louisiana.gov/index.cfm/newsroom/detail/4170>

¹⁸ Safety and Justice Challenge. New Orleans Safety and Justice Challenge Fact Sheet (2017, April). Retrieved from: <http://www.safetyandjusticechallenge.org/wp-content/uploads/2017/04/New-Orleans-Safety-Justice-Challenge-Fact-Sheet-2.pdf>

- **High Quality Hospital-Based Emergency and Inpatient Care.** Despite ongoing challenges related to hospital wait times and the transition of care from hospital to the community, many interviewees referenced the high quality of care that patients received at the newly-opened UMC hospital. In particular, interviewees highlighted that the inpatient psychiatric unit delivers “*very good care*” and that acute psychiatric conditions and psychiatrists “*really try to account for social issues.*” As one interviewee pointed out, that when patients are in the hospital they “*are well taken care of.*”

Strong Networks of Community-Based Safety Net Service Providers: A long list of safety-net community-based programs, organizations, and services in New Orleans were highlighted by interviewees. The most frequently identified programs are described below.

- **Metropolitan Human Services District (MHSD).** MHSD is the state-designated entity responsible for delivering publicly-funded, community-based mental health, addictive disorders, and developmental disabilities services in Orleans, St. Bernard, and Plaquemines Parishes. MHSD serves uninsured or Medicaid eligible residents. While a few interviewees reported that funding and resource restrictions limit MHSD’s reach and effectiveness, interviewees praised its work. MHSD’s Care Center provides a single point of entry to the range of services offered by MHSD and its partner organizations. A contracting program of MHSD, Resources for Human Development’s Metropolitan Crisis Response Team (MCRT) offers a crisis hotline and has behavioral health specialists and peer supports available for in-person response. Several interviewees noted the value of MCRT’s access to a psychiatrist after hours for patient assessments.
- **Case Management and Other Supportive Services.** Interviewees reported that case management is a key service of community-based treatment, particularly for individuals with long-term and intensive behavioral health needs. Several case management programs were noted by interviewees to be critical system assets within the crisis response system. For example, the Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) were named. The ACT and FACT programs are well-established, evidence-based models of care that use a multidisciplinary team approach to provide community-based psychiatric treatment, rehabilitation, therapy, crisis intervention, and social support. ACT and FACT services are tailored to meet an individual’s needs, and help individuals avoid costly and otherwise preventable hospital utilization. New Orleans’ two ACT and two FACT teams each serve 100 patients. Interviewees identified the ACT and FACT teams as an important resource for patients with complex care needs. Results from an LPHI analysis of hospital utilization data show that among individuals with serious and persistent mental illness ACT and FACT patients are not the highest utilizers of ED or inpatient services.¹⁹ This finding is one indicator that the program successfully manages patients’ conditions and keeps them out of the hospital.

¹⁹ Crescent City Participant Community Action Plan: Produced as part of the AcademyHealth Community Health Peer Learning Program, with support from the Office of the National Coordinator for Health Information Technology. Retrieved from: <https://allin.healthdoers.org/wp-content/uploads/bp-attachments/2711/LPHI-CAP-upload.pdf>.

Another program mentioned, Health Guardians, is operated by Catholic Charities Archdiocese of New Orleans (CCANO) and another valued case management program. Health Guardians is an intensive and integrated care model that removes and addresses barriers - clinical, social, and financial - to receiving effective health care. Through one-on-one behavioral care navigation, Health Guardians incorporates the many health and social services provided by Catholic Charities and its partner organizations. The program focuses on uninsured individuals who are high utilizers of ED services. According to a study done with Louisiana State University Health Sciences Center, “over 72% of the clients in the study were able to decrease their visits to emergency room and inpatient care by half.”²⁴ CCANO and several other organizations in New Orleans provide case management services through Permanent Supportive Housing (PSH), a national best practice and cost-effective intervention that provides housing and services to housing-insecure and homeless individuals with a serious mental illness.²⁰ Clients receive wrap-around services, including but not limited to transportation, employment assistance, public assistance applications, counseling, linkage healthcare resources, crisis management, and relationship management with landlords and communities. In 2016, New Orleans had 2,792 PSH units, which generally remained filled to capacity with a low turnover rate and a waiting list. Several interviewees praised the work of PSH case managers in de-escalating crises and maintaining long-term relationships with clients.

- **Advocacy and Social Services Organizations:** Advocacy and social services organizations were portrayed very positively by interviewees. In particular, National Alliance on Mental Illness (NAMI) New Orleans was highlighted as a major asset for individuals and their families. NAMI is a key provider of support groups, peer-to-peer connections, training and education. One interviewee said that NAMI is a “major asset and can have a big impact on families,” and recommended that hospitals provide information about NAMI services to patients and families upon discharge.

CRISIS SYSTEM CHALLENGES

While several assets in the New Orleans’ crisis system were identified as critical elements, interviewees identified a range of challenges: limited capacity in crisis response and support services and gaps in available services across the behavioral health continuum that result in more crisis. This section describes the challenges identified most frequently by interviewees, and depicts how these challenges impact other settings and service providers across the continuum. Additionally, this section outlines potential opportunities for improvement that should be considered in the development of a comprehensive plan for behavioral health transformation in New Orleans.

²⁰ PSH case management providers include: Crescent Care/NO AIDS Task Force, UNITY of Greater New Orleans, CCANO www.ccano.org, City of New Orleans, Covenant House, First Evangelist Housing and Community Development, MHSD, NAMI, Responsibility House, Shelter Resources, Start Corporation, Travelers Aid, Volunteers of America, Ozanam Inn, Salvation Army, DePaul USA, Harry Tompson Center, Odyssey House, and Goodwill Industries.

CHALLENGES IN CRISIS RESPONSE:

Redundancy and Inefficiency in Crisis Response Protocols. The roles, responsibilities, capacities, and protocols of the various crisis response services in New Orleans are unclear, suggesting that there may be redundancies and inefficiencies in crisis service offerings. Nearly all interviewees reported that individuals with behavioral health needs often access services through 9-1-1, which is operated by the Orleans Parish Communications District. 9-1-1 serves as an assessment and triage center for emergency calls in the area, which are triaged to either the NOPD, EMS, or Fire Department. NOPD responds to crises most frequently among crisis responders. NOPD, specifically CIT, is a primary responder to behavioral health crises and is the designated responder for all orders of protective custody (OPCs) for involuntary commitment. Table 3 below presents recent data on the crisis response services provided by NOPD. Overall, key informant interviews revealed the substantial role that NOPD officers, primarily CIT, play in serving individuals with the greatest behavioral health needs - through crisis response and through ongoing contact and support. One interviewee described that CIT officers see these individuals the most and “*are acting as de facto case managers.*” In fact, while being interviewed for this project, a CIT officer received a phone call from someone identified as an ACT/FACT patient and a high utilizer known by crisis service providers. This incident illustrated the officer’s comment, also alluded to by other interviewees, that “*CIT officers are the closest thing to ownership*” of care for individuals with the greatest behavioral health needs.

Table 3: NOPD Crisis Intervention Team

Average Daily CIT Calls for Service ⁱ	17
CIT Calls for Service, by Type ⁱ	
Mental health	84.2%
Violation of protective order	10.5%
Suicide	5.3%
CIT Calls for Service, by Emergency Level ⁱⁱ	
Emergency (dispatch code 2)	72%
Non-emergency (dispatch code 1)	28%
CIT Incidents, by Alcohol and Drug Involvement ⁱⁱⁱ	
Unknown	71%
Alcohol	16%
Drugs	8%
Alcohol and drugs	5%
CIT Incidents, by Transportation from Scene ⁱⁱⁱ	
By police unit	75%
No transport	15%
By EMS	8%

By Crisis Transportation Service ²¹ (also known as NOPD's volunteer-based Mobile Crisis Unit)	2%
CIT Incidents, by Disposition ⁱⁱ	
Involuntary commitment by officer's assessment	40.1%
Stabilized on scene	22.9%
Voluntary commitment	18.1%
Involuntary commitment by OPC/PEC/CEC	17.8%
Unfounded	0.7%
Arrest	0.3%
Summons	0.3%

Sources: ⁱ NOHD Behavioral Health Dashboard, April 2017; ⁱⁱ [Consent Decree CIT Report](#); ⁱⁱⁱ NOPD CIT Planning Committee meeting presentation, November 2016

New Orleans has at least two additional crisis support and response services:

- the Metropolitan Crisis Response Team (MCRT), which provides 24-hour telephone and face-to-face triage, assessment, and intervention
- VIA LINK, which operates the National Suicide Prevention Lifeline and the 2-1-1 hotline with crisis counseling and information referral.

Table 4 below details MCRT's crisis response services.

Table 4: Metropolitan Crisis Response Team

Average Daily MCRT Calls for Service	8
Total Adults Served by Disposition	128
Referred to a community provider	64.8%
Refused/unable to contact	12.5%
MHSD clinic	10.2%
Transported to hospital	10.2%
ACT/FACT	2.3%

Source: NOHD Behavioral Health Dashboard, April 2017

However, no other agency is equipped to handle potentially violent situations like the NOPD. As a result, NOPD dispatches officers when MCRT and other services are unable to safely defuse a potentially violent situation. For example, to assess all crisis calls, MCRT uses a crisis acuity scale with 1 being the lowest acuity and 5 being the highest acuity. Any calls that receive a 5, or where violence or a medical emergency appear to be imminent, MCRT protocols recommend that operators call 9-1-1 to deploy NOPD officers. Likewise, when crisis responders outside of NOPD successfully respond to and de-escalate a crisis, the responders may need to call on NOPD to provide secure transportation to bring the individual to the appropriate destination.

²¹ New Orleans Police Department Public Information Office. NOPD Crisis Transportation Looking for Volunteers to Serve as Mental Health Technicians (2016, November 4). Retrieved from: <https://content.govdelivery.com/accounts/LANOLA/bulletins/1704cf1>

Interviewees attributed these and additional redundancies to callers and other service providers not knowing each entity's role. For example, interviewees reported that individuals and their families sometimes misunderstand MCRT to be affiliated with the police and are unaware of VIA LINK's services. Furthermore, interviewees reported that many service providers and crisis responders do not know the phone numbers for either of those services: MCRT or VIA LINK. Interviewees also expressed challenges and deficiencies in coordination and communication between crisis service providers. For example, while interviewees generally viewed NOPD as the fastest and safest responder to crisis incidents, two interviewees reported difficulty connecting to NOPD when requesting assistance for a crisis incident. This suggests redundancies and inefficiencies in the delineation of crisis response services provided by various agencies, resulting in the overuse of crisis response resources and prolonged crisis incidents. Most interviewees expressed that improved relations and coordination between crisis agencies could help support system improvements.

OPPORTUNITY

These reported crisis response practices speak to the opportunity to analyze and align the response protocols of all crisis intervention services to:

- clarify roles for crisis responders and identify opportunities to streamline crisis response for behavioral health crises,
- standardize coordination protocols between NOPD and other crisis services when police support is needed,
- decrease the burden on an already over-utilized police force to respond to non-dangerous cases, and -prevent criminalization of individuals in crisis.

Specifically, there is opportunity to explore inter-agency alignment of protocols on key factors of crisis response including the following: the assessment of acuity and safety, determination of when and how to deploy response teams for each entity, expectations for response timeliness, strategies for communicating roles and responsibilities of each entity to the public and to other behavioral health service providers. To this end, a comprehensive review of protocols and practices is needed to reach a more efficient and effective approach to crisis response.

To build on NOPD's successes of training officers on CIT competencies and implementing a specialized CIT team, there is opportunity to expand training to other crisis services to equip them with the same skillsets. This has already begun to occur at a small scale. NOPD has recently provided a CIT training to OPCD 9-1-1 dispatch staff.

There is also opportunity to explore national models of embedded interagency partnerships between law enforcement and crisis response/behavioral health providers. An embedded model may help to reduce redundancies and inefficiencies due to multiple providers arriving on scene and offering duplicate services. By enhancing the clarity and coordination around interagency crisis response protocols

and resource deployment, a new model could increase the quality of initial service provision, which could reduce unnecessary hospitalization and criminalization.

Lack of Crisis Receiving Services. There is consensus among stakeholders that the emergency department (ED) is used as a single point of entry for individuals in crisis to receive medical and behavioral health care services. This is not simply a result of individuals self-referring to the ED, but primarily because of the design of the current behavioral health system. Regarding crisis services within the behavioral health system, aside from the ED, there is nowhere for EMS, NOPD, and other first responders to bring individuals who are intoxicated or have other low acuity needs that do not require hospital-based care. At a recent meeting of the *New Orleans Behavioral Health Council's Care Navigator Subgroup*, crisis response representatives reported that most of the individuals who are intoxicated or have low acuity needs “*just need six to eight hours to sleep it off.*” Almost every interviewee, particularly the first responders, explicitly stated the need for more crisis receiving and sobering services outside of an ED or hospital setting. One interviewee stated, “*without a crisis sobering center, the response is doomed to fail.*” While a variety of terms (crisis receiving center, crisis stabilization center, medically assisted detox, crisis sobering center, or sobering center) were used, all interviewees referred to needing a physical center with basic medical, mental health, and detox services where first responders could bring individuals for immediate attention, triage to appropriate care, and access sobering facilities. As a result of the current approach patients, first responders, and hospitals face numerous challenges: overcrowding of the ED, long wait times for patients and for the first responders escorting them, lack of follow up and connection to appropriate long term treatment, and uncoordinated care among high utilizers of hospital services.

OPPORTUNITY

There is opportunity to explore the need and national best practice models for a crisis receiving center with basic medical, mental health and detox services. National models of crisis receiving centers, including the Bexar County Model in San Antonio and the Crisis Solutions Center in Seattle, have shown this to be successful at diverting individuals with mental illness away from the ED and jail.^{22, 23} Further research should include examination of successful national models that have integrated crisis receiving centers into other crisis services (e.g. partnering with an ED to support provision of medical services) or established connectivity and care pathways to appropriate levels of community-based care (e.g. developing standard referral protocols and providing warm hand-offs to services).

Additional local assessment and research are needed to determine the most pressing services that should be included in the facility, the appropriate size of the facility, and

²² Evans, L. Blueprint for Success: The Bexar County Model How to Set Up a Jail Diversion Program in Your Community (2014, September 8). *Center for Health Care Services*. Retrieved from: <http://www.equitasusa.org/wp-content/uploads/2014/09/San-Antonio-Jail-Diversion-Kit.pdf>

²³ DESC. Crisis Response. Retrieved from: <https://www.desc.org/what-we-do/crisis-response/>

other considerations for customizing this model to a local context. For example, nearly all interviewees spoke of medically assisted detox services as the most critical need. Furthermore, when exploring this opportunity, it will be important to clarify accountability of crisis responders, the receiving center, and other relevant service providers regarding ownership of patients, inter-agency protocols and coordination, and responsibilities for achieving defined goals and outcomes.

Police and EMS Wall Time. When NOPD and EMS escort individuals to the ED but a bed is not available, they must remain at the hospital until the patient is moved to a bed, an issue that is referred to as “wall time.” Wall time can last for hours and prevents NOPD and EMS from returning to the field and responding to other community safety needs and crises. While wall time appears to affect both EMS and NOPD, stakeholders have repeatedly identified NOPD wall time as a priority issue for the community to address. NOPD officers described unclear protocols regarding the roles and responsibilities of police and hospital staff when transporting and transferring patients to the hospital, even for individuals who have not committed a crime. During the period when patients in crisis enter the hospital premises through the point of being moved to a bed, there is a lack of clarity of each agency’s liability and authority when it comes to protecting and securing individuals. This prevent officers from returning to the field.

The financial costs of the wall time problem are substantial. An analysis conducted by the California Hospital Association describes how far-reaching the financial implications of EMS wall time can be and provides an example of how New Orleans may be able to estimate the local financial impact.²⁴ The California report estimates that the cost to EMS to supply and staff an ambulance for one hour, also called a “unit hour,” is \$100. Two California counties, Riverside and San Bernardino, had a total of \$3 million in lost unit hours in 2012 due to delays in patient offload time. That number would be even greater if accounting for lost revenue. The downstream effects of these delays impact other service providers in the crisis system, including hospitals and fire departments. For example, the Sacramento Metro Fire Department offers some of its paramedic firefighter capacity to support EMS when multiple ambulances are delayed. In 2012, this contributed to delays in the Fire Department’s patient offload time that cost the system \$2.6 million. According to data provided by New Orleans EMS, the agency received about 63,000 calls for service in 2016. Using the California cost estimate of \$100 per unit hour delay, if EMS experienced just one hour of wall time for just 25% of its calls, it would cost over \$1.5 million per year. A more comprehensive cost analysis is needed to illustrate the size and scope of the problem and determine how the financial costs are impacting the City of New Orleans.

²⁴ California Hospital Association. Toolkit to Reduce Ambulance Patient Offload Delays in the Emergency Department: Building Strategies for California Hospitals and Local Emergency Service Agencies (2014, August). Retrieved from: https://www.calhospital.org/sites/main/files/file-attachments/ambulancepatientoffloaddelaytoolkit_web.pdf.

OPPORTUNITY

There is a critical need to conduct a cost analysis and a root cause analysis to better understand the size and scope of the wall time problem. Additional data and information is needed regarding length and frequency of wall time, nature of the delay, hospital saturation, and other contextual factors. These analyses would also include opportunities or recommendations related to interagency strategies between NOPD, EMS, and hospital services to reduce wall time. The Los Angeles Fire Department demonstrated the potential impact of conducting such an analysis in 2013 when it produced a report showing that wall time due to hospital bed shortages delayed ambulance crews nearly 37,000 hours per year, costing the city about \$6 million.^{25 26}

In addition, there is opportunity to achieve greater clarification of hospital and NOPD roles and responsibilities regarding safety protocols that could better clarify patient custody, responsibility, monitoring, and warm handoffs. Understanding these factors will enable the two entities to engage in open discussion and make informed decisions regarding changes to the process. Community stakeholders have pointed to a Louisiana law on mental health (LA Rev Stat § 28) as a source for more information and insight into who is responsible for patients in these situations, and may help clarify potential approaches to reducing wall time.²⁷

Lastly, exploring the opportunity for a crisis receiving center, described above, would also help address this issue. As one interviewee stated, having a place other than the ED to bring patients would “*massively help*” the wall time problem.

CHALLENGES IN HOSPITAL SETTINGS:

Long Wait Times and Slow Patient Flow. Due to the over-reliance on EDs as a point of entry into the health care system for individuals in crisis, EDs are regularly overcrowded and have long wait times. Patients served in the ED who require inpatient hospitalization can also experience long wait times before an inpatient bed becomes available, thereby taking up an ED bed for longer than necessary and further impacting ED wait times. Not only do these delays in care negatively impact patient experience, particularly among individuals in crisis, but they also create a vicious cycle of workflow disruption throughout the hospital that can lead to an overextended workforce.²⁸ The Center for Medicare and Medicaid Services’ (CMS) Hospital Compare tool, a publicly available source for hospital-level quality data derived primarily from Medicare data sources, provides several measures indicative of patient flow challenges in New Orleans hospitals. For example, patients at UMC spend an average of 51 minutes

²⁵ Los Angeles Fire Department. Ambulance Augmentation Staffing Configuration. (2013, May 21). Retrieved from: http://ens.lacity.org/lafd/lafdreportarchv/lafdreport186482481_05162013.pdf

²⁶ Arevalo, P. Report: Ambulance Slowed by Filled-to Capacity Hospitals. (2014, April 23). *Patch*. Retrieved from: <https://patch.com/california/echopark/report-ambulances-slowed-by-filledtocapacity-hospitals-echopark>

²⁷ 2011 Louisiana Laws Revised Statutes Title 28- Mental Health. Retrieved from: <http://law.justia.com/codes/louisiana/2011/rs/title28>

²⁸ National Association of Public Hospitals and Health Systems. Perfection Patient Flow: America’s Safety Net Hospitals and Emergency Department Crowding. (2005). Retrieved from: <http://med-fom-emerg.sites.olt.ubc.ca/files/2013/10/PerfectingPatientFlow1.pdf>

waiting in the ED before being seen by a healthcare professional. The average in Louisiana is 30 minutes, and the U.S. average is 29 minutes.²⁹ Similarly, the average time patients spend in the UMC ED after the doctor decides to admit them and before leaving the ED for their inpatient room was 210 minutes, a much longer wait time compared to other very high-volume hospitals in Louisiana (122 minutes) and the U.S. (136 minutes).²⁹

There are likely several factors contributing to these delays, such as high inpatient saturation rates delaying patient flow from ED to inpatient beds. According to NOHD's June 2016 Behavioral Health Dashboard, local hospital psychiatric units had an average daily bed saturation rate of 85%. At UMC between June 2015 and 2016, there was a saturation average of 100% despite UMC increasing its bed count from 38 to 45 during that period.³⁰ Overall, available data and key informant interviews suggest that hospitals in New Orleans are struggling to meet the demand for services for individuals with behavioral health needs. Experts in health systems operations have identified "three ways to create capacity for patients who need emergency behavioral health care: decrease arrivals to a system, decrease length of stay, or increase the number of beds available."³¹ Best-practices emphasize that examining capacity as a system-wide issue rather than a hospital issue is critical because there are many contributing factors that lie outside of the hospital. For example, the number of patients arriving at the ED is heavily influenced by crisis response protocols and the availability of crisis receiving and stabilization services in the community. Similarly, hospital length of stay is influenced by the availability of appropriate types and levels of care in the community to allow hospitals to more easily find placements for their patients and safely discharge them to the community. Challenges related to discharge planning are discussed further in the Hospital Discharge Planning and Transitions of Care section below.

OPPORTUNITY

There is great opportunity to expand and leverage NOHD's monthly Behavioral Health Dashboard as a consolidated data tracking and dissemination tool. With enhanced data collection and analytics capacity, the Behavioral Health Dashboard could enable tracking of a more comprehensive set of indicators related to patient flow through the hospital and across other settings of care. National experts have long urged health systems to commit themselves to rigorous data collection and quality improvement methods because "we can't fix what we can't measure."²⁸ There is a critical need to assess patient flow across the continuum of care to better understand the root causes of access and capacity issues.

Furthermore, there is opportunity to consider other valuable analyses and reports that could support hospital improvement efforts. This might include an annual report that

²⁹ Medicare.gov Hospital Compare. Hospital Profile University Medical Center New Orleans Retrieved from: <https://www.medicare.gov/hospitalcompare/profile.html#profTab=0&vwgrph=0&ID=190005&loc=70130&lat=29.9335594&lng=-90.0700051&name=UNIVERSITY%20MEDICAL%20CENTER%20NEW%20ORLEANS&Distn=2.3>

³⁰ New Orleans Health Department. New Orleans Behavioral Health Dashboard. (2016, June). Retrieved from: <https://www.nola.gov/getattachment/Health/Behavioral-Health/NO-Behavioral-Health-Dashboard-June-2016.pdf/>

³¹ Murrell, K. Improve ED Flow by Improving Behavioral Healthcare. *Institute for Healthcare Improvement*. (2017, May 3). Retrieved from: <http://www.ihl.org/communities/blogs/improve-ed-flow-by-improving-behavioral-health-care>

depicts longitudinal trends in hospital capacity and flow with multi-year data on hospital utilization, length of stay, bed saturation rates, and other key indicators to assess whether current beds and workforce are adequate to meet the needs of the population. Other examples include regular reports on hospital wait times and how they correlate with ED and inpatient bed saturation, workflow and triage processes, and custodial transfers with law enforcement and other first responders. These analyses could potentially provide information to support the exploration of a crisis receiving and sobering center, which could divert some patients away from the ED, as well as the increased availability of rehab/detox beds, which could ease hospital discharge planning and shorten length of stay.

Hospital Discharge Planning and Transitions of Care. The majority of interviewees described the existing continuum of behavioral health care as an “*all-or-nothing*” model. In other words, patients are either admitted to the hospital where they “*are well taken care of,*” or they are released to the community where they are “*on their own.*” When preparing for discharge from the hospital, whether straight from the ED or after a psychiatric inpatient stay, hospital staff and patients face pervasive challenges in finding and accessing community-based services.

For patients in the ED who do not require admission to inpatient care, hospital staff have a few hours to make appointments and pull together referrals for community-based treatment options and resources required to meet patient needs upon leaving the ED. Staff described the difficulty of arranging these services, which could include everything from a psychiatrist appointment and intensive case management services to housing and transportation. “*Today, I waited four hours for an agency to tell me they don’t have a bed,*” one interviewee said. The most frequent referrals from UMC’s Behavioral Health ED are Odyssey House and MHSD clinics. Interviewees reported that while patients always leave the hospital with a referral, sometimes the referral is only for clinic walk-in hours because of the difficulty to be scheduled for an appointment. Staff also give patients the number for MCRT in case of another crisis episode to prevent an unnecessary ED visit. Additionally, housing and transportation were identified as some of the greatest barriers for individuals leaving the hospital after a behavioral health crisis. Stakeholders highlighted that consistent and reliable transportation is rare for this population and that transportation access is an obstacle to accessing a variety of healthcare and other services. In some instances, cab vouchers are given upon discharge from the hospital to help individuals get to follow-up appointments. Interviewees also identified housing as one of the greatest barriers facing individuals who have experienced behavioral health crises. Housing issues are described in more detail in the Housing section below.

For patients hospitalized in an inpatient unit, a typical length of stay is 7-10 days.³² Compared with staff in the discharge planning process in the ED, hospital staff on inpatient units may have more time to arrange for post-discharge services but they face

³² Source: UMC staff at a recent Behavioral Health Council Care Navigator subgroup meeting

just as many barriers, if not more. Several interviewees described that hospitals “release patients too early” before they are fully stabilized. However, hospital staff pointed out that they are limited by the insurer’s determination of medical necessity. When an inpatient level of care is no longer medically necessary, the hospital can no longer be reimbursed for inpatient services and must discharge the patient. This causes a significant problem when the limited availability of detox beds and other community-based services causes a several day gap between when a patient is released from the hospital and when a bed becomes available. At a recent meeting of the Behavioral Health Council’s Care Navigators subgroup, hospital staff reported that they choose to keep patients for an extra day or two about 50% of the time, rather than send them out into the community without an available bed. In these situations, the hospital pays for the total cost of care during the extra time that the patient is there.

OPPORTUNITY

There is opportunity to explore national models and practices that support warm handoffs and smooth transitions of care from the hospital to the community setting. Several models of hospital-embedded case management have proven successful at facilitating warm handoffs to community-based services, engaging traditionally hard-to-reach patients in care, and improving relations and coordination between the hospital and the community-based organization. For example, the Camden Coalition of Healthcare Providers is a care management initiative that coordinates with hospitals and other service providers to engage high utilizer patients at the hospital bedside, support a safe transition home, and provide connections to all needed health and social services.³³ One interviewee specifically suggested embedding a MHSD staff person at the hospital to support warm handoffs to community-based services. At several recent gatherings hosted by the Behavioral Health Council, stakeholders representing both community and hospital settings have expressed interest in allowing community-based case managers meet patients at the bedside prior to discharge from the ED to enable warm handoffs and face-to-face coordination.

Additionally, establishing same and next day appointment access at community-based providers would enhance access to care. This opportunity is described in more detail in the Delays in Access to Outpatient Mental Health Services section below.

To address challenges related to determination of medical necessity, hospital staff at a recent Behavioral Health Council Care Navigator subgroup meeting proposed increasing in-service training for providers regarding clear and uniform documentation of patient medical necessity. This would help ensure that when insurance companies review the documentation, they have all of the information they need to approve care for patients who need it.

³³ Camden Coalition of Healthcare Providers. Case Management Initiatives. Retrieved from: <https://www.camdenhealth.org/programs/care-management-program/>

CHALLENGES IN COMMUNITY-BASED SETTINGS:

Limited Availability of Substance Use Treatment Services. Substance use was by far the most mentioned behavioral health condition during the key informant interviews (mentioned 31 times compared to just six times for the second-most frequently mentioned condition). According to the 2015 National Survey on Drug Use and Health (NSDUH), about 7.5 million adults needed substance use treatment in the last year but less than 20% received treatment.³⁴ Several interviewees, including treatment providers, emergency responders, and advocates, identified individuals with substance use disorders as the top priority in the community and nearly every interviewee emphasized the unique challenges of serving those with co-occurring mental health and substance use disorders. When asked which populations have the greatest behavioral health needs, one interviewee responded by saying: *“if you’re talking about saving lives, people with drug issues come first.”* Another interviewee identified individuals with co-occurring conditions as having the greatest needs because *“many emergencies are a combination of both.”*

In characterizing the nature of this problem, numerous interviewees described the challenge of finding an available bed at one of the few drug rehab/detox facilities in the Greater New Orleans area for patients being discharged from the hospital, both from the ED and inpatient care. Existing rehab/detox facilities were described as *“always full”* and *“nearly impossible to get people in the same day.”* One interviewee lamented that *“even with good connections it’s impossible to get someone in.”* Additionally, private psychiatric hospitals that also provide addiction treatment services tend to not accept patients referred from UMC or patients that have Medicaid as their primary source of coverage. Other frustrations include:

- very limited availability of specialty services for special populations (e.g. pregnant women, adolescents, etc.)
- limited reimbursement coverage for services
- high likelihood that patients will change their minds about wanting to receive treatment by the time a spot becomes available to them
- loss of contact and difficulty following-up with individuals between hospital discharge and engagement in secondary substance use treatment services

While one interviewee described that *“with Medicaid expansion, substance use services is the biggest area of growth,”* particularly in outpatient and residential services, it is clear that the volume and type of existing services do not sufficiently meet the demand in New Orleans. The rate of substance use disorders among Louisiana’s Medicaid expansion population alone is reported at approximately 18.8%, well above the national average of 14.

³⁴ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Results from the 2015 National Survey on Drug Use and Health: Detailed Tables. (2016, Sept 8). Retrieved from: <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf>

OPPORTUNITY

There is opportunity to enhance data collection and tracking of the availability of substance use treatment services throughout the city through tracking measures on available beds, appointments, program slots, wait times, etc. Obtaining and sharing such data could support meaningful care coordination between service providers at the point of care and influence care delivery and referral decisions. Additionally, clear and reliable data illustrating limited service availability and denials for service could serve as a persuasive tool in advocating for additional resources and assist providers in establishing collective contracting with other facilities to increase access. Hospitals and community-based providers already submit some data to NOHD for the monthly Behavioral Health Dashboard. Existing processes of data submission, aggregation, analysis, and reporting should be leveraged when considering future enhancements to community-wide data transparency initiatives.

Delays in Access to Outpatient Mental Health Services. For all individuals with a mental health condition, particularly those with a recent hospital encounter, timely access to the appropriate outpatient services is critical to managing their condition, accessing and adhering to prescribed medication, and avoiding future crises. Hospital and Medicaid MCO staff interviewed reported that patients never leave the hospital without a referral in hand. However, the effectiveness of the referral varies significantly based on the availability of services. As one emergency responder lamented, *“from the initial call to getting a client into treatment takes months.”* According to interviewees, scheduling an appointment at MHSD’s Care Center will likely involve a three to four month wait. The Care Center has walk-in appointment times but it can require waiting for hours. Long wait-times are a major deterrent and barrier for individuals with mental illness and often inhibit access to a range of critical services. *“People aren’t getting services or appointments until it’s very bad,”* one interviewee said.

Interviewees identified medication access as an unmet need, which is closely related to delays in accessing outpatient services. Patients generally receive a five to seven-day supply of medication when released from the hospital, but long wait times for psychiatric appointments and transportation barriers can prevent individuals from accessing a prescribing provider, which could result in another crisis episode and hospital encounter. In addition to medication access, strong medication management is important for individuals with complex conditions taking multiple medications, particularly those with frequent hospital utilization. There has been some local movement to improve the process of obtaining prescriptions for high need individuals. For example, Health Care for the Homeless has developed a medication access program that accepts deliveries from a pharmacy and allows patients to pick up medications directly from their health center. However, overall, much of the progress only impacts select subgroups of the population as opposed to the majority of individuals with unmet mental health needs.

OPPORTUNITY

There is opportunity to focus on implementing the national best practices of same-day and next-day access to critical outpatient services and prescribing.³⁵ Offering same- or next-day appointments would greatly reduce barriers to access, decrease patient no-show rates, and prevent avoidable crisis events and hospital utilization. As a foundational community-based behavioral health provider, MHSD clinics may be an appropriate place to begin implementing these practices.

To further ease access to prescription medication, there is opportunity to explore evidence-based models for enhancing access to prescribing and medication management services in various community-based settings of care. For example, medication extender models and co-location of pharmacy services in existing clinic facilities have demonstrated success at improving adherence and patient outcomes. Interviewees expressed the need for pharmacy services to be made available in central locations that are known to be easily accessible to patients, specifically near the Central Business District and Tulane-Gravier areas as opposed to Central City. Additionally, transitional care management models that incorporate medication reconciliation and management should be explored to meet the needs of high needs patients transitioning out of the hospital and back into the community.³⁶

Few Residential Treatment Options. With substance use treatment and housing identified as two of the greatest needs for this population, it is not a surprise that interviewees characterized residential treatment options as lacking. Specifically, interviewees pointed to gaps in respite care and groups homes as community priorities to address. Until recently, there was only one respite care center in New Orleans but the facility has since closed. One person reported that when it was open, it often had availability owing to overly restrictive criteria that required patients to have records of a recent psychiatric evaluation. One MCO representative reported that insurers are trying to incentivize less costly, community-based services as alternatives to higher levels of care such as respite care. As a result, these more intensive residential services may not be reimbursed well enough to stay in business or attract new facilities including a possible voluntary respite program co-located in the proposed crisis receiving center.

Multiple interviewees described a disturbing current state of group homes in New Orleans. They reported that only one of the numerous group homes in the city is a licensed and legally operating facility, and 7 other licensed group homes are operating throughout the state of Louisiana. Similarly, there are great disincentives to maintain current group home capacity, let alone expand it. Interviewees admitted that the

³⁵ National Council for Behavioral Health. Same day access to behavioral health. Retrieved from: <https://www.thenationalcouncil.org/areas-of-expertise/same-day-access/>

³⁶ American Pharmacists Association and American Society of Health- Systems Pharmacists (2013,February). *ASHP-APhA Medication Management in Care Transitions Best Practice*. Cassano ,A. Retrieved from: http://media.pharmacist.com/practice/ASHP_APhA_MedicationManagementinCareTransitionsBestPracticesReport2_2013.pdf

Medicaid reimbursement for services barely covers the cost of operating a group home. Additionally, the state licensure requirements make barriers to enter into group home service provision high. For example, before issuance of a license for a level of care, the prospective licensee must be fully staffed and operational; thus, raising the costs of entering legally into group home service provision.

OPPORTUNITY

There is opportunity to gain a clearer understanding of the pathway for the establishment of licensed group homes within the Greater New Orleans area. This would help determine whether policy and rule changes could enhance the availability of services while also maintaining high standards of quality. Furthermore, there is opportunity to explore alternative means of financing for group homes and other service models that offer more intensive support than traditional outpatient services but still provide care in a community setting.

Limitations of Case Management Programs. While interviewees reported that New Orleans has several strong case management programs that are considered great community assets, case management services overall are variable in their quality and reach. Some programs serve only select subpopulations that meet specific eligibility criteria. For example, to be eligible for ACT or FACT case management services, individuals must have a severe and persistent mental illness diagnosis, two or more hospitalizations in the last six months, and a history of unsuccessful treatment in other programs, among several other criteria. Similarly, PSH case management programs serve a narrow portion of individuals Medicaid enrollees. Other local programs have shifted their target populations and therefore their intervention models when transitioning from one grant funding source to another. Even with relatively narrow populations, case management programs are often lean operations and work with some of the most resource-intensive individuals in New Orleans. They reported that if they had more money, they might be able to do more, such as increased coordination with other providers and agencies that serve their clients. In addition to restrictive eligibility criteria, several other gaps and deficiencies among existing case management services were reported, including:

- A small proportion of all case managers whose sole function is case management
- Limited coordination between case management and providers
- Patient cost sharing requirements for needed services (e.g. medication, supplies, bus passes, clothes, etc.)
- Difficulty engaging those with the greatest needs as they are most likely to refuse care³⁷
- Lack of accountability for clients among some case managers
- Limited ability to quickly respond to crises, leaving the burden on police and other first responders

³⁷ Rosenbaum, L. (2016, October 13). Liberty versus Need-Our Struggle to Care for People with Serious Mental Illness. *N Engl. J. Med.* Vol 375. 1490-1495

The underlying causes of many of these deficiencies can be traced back to prescriptive regulations and incentives tied to funding sources used to finance case management services. Most programs continue to rely on grant funding and other time-limited funding sources that often require organizations to tailor services to funders' sometimes narrow goals. For example, when the Health Guardians program first began, it served primarily homeless individuals and others with extensive social and medical needs. A few years later, the program's grant funding was expiring and it received a grant from another funder that was focused on primary care, leading Health Guardians to adjust its case management model as it was serving relatively healthier individuals with less intensive needs. Few programs report billing and receiving reimbursement for case management services from insurers. Those that do report billing Medicaid, such as ACT, FACT, and PSH case management, are still generally only able to do so for limited populations, thus forcing programs to exclude others in need.

Overall, the interviews suggested that there is a need for increased case management capacity. Half of all respondents expressed concern that there was no "intermediate" level of care, referring to a wide gap in access to services that fall between intensive hospital care and low-touch outpatient care. Several interviewees specifically identified community-based case management, particularly for those who may not meet ACT or FACT eligibility criteria, as an important component of filling that gap. However, the current financing mechanisms are insufficient to enable and incentivize case management programs to provide high quality, community-based services to the broad majority of individuals who need care.

OPPORTUNITY

There is opportunity to explore how other states, cities, and service organizations across the country are leveraging Medicaid funding to sustainably finance case management services. Some states have used Medicaid 1115 waivers to provide broader coverage of and reimbursement for case management services.^{38 39} One example to look to is San Antonio in Bexar County, Texas, which is working with clinics in the area to begin coding for all case management services provided to build the case for an 1115 waiver. This and other approaches to collective negotiations with state and federal Medicaid authorities could help garnish support for enhancing case management pilots and programs.

It will be important to articulate the target population of interest and the set of health and social services needed to serve that population prior to defining an appropriate financing model. For example, highly flexible financing models have been shown to support improvements in health outcomes for individuals with extensive social needs.

³⁸ Townley, C. & Dorr, H. (2017, July). Strategies to Strengthen Health and Housing Partnerships Through Medicaid to Improve Healthcare for Individuals Experiencing Homelessness. *National Academy for State Health Policy*. Retrieved from: <http://nashp.org/wp-content/uploads/2017/07/Strategies-to-Strengthen-Health-and-Housing-Partnerships.pdf>

³⁹ Hinton, E., Musemeci, M., & Rudowitz R. (2017, Sept) Section 1115 Medicaid Demonstration Waivers: A look at the Current Landscape of Approved and Pending Waivers. *The Henry J. Kaiser Foundation*. Retrieved from: <http://www.kff.org/medicaid/issue-brief/3-key-questions-section-1115-medicare-demonstration-waivers/>

The Program of All Inclusive Care for the Elderly (PACE) is one of the only CMS-funded programs with the ability to pay for non-medical services (e.g. air conditioning, pest control) that are not traditionally reimbursable services but can directly impact their patients' health outcomes. CCANO, which operates PACE in the Greater New Orleans area, applied a similar financing model to Health Guardians so it could better support patients' social and environmental needs.

Additionally, there is opportunity to provide technical assistance to help local organizations take advantage of growing opportunities to bill for care management and coordination, and to further integrate peers into service delivery and coordination. LDH and/or the Louisiana Medicaid MCOs may be able to offer this service, which the New Orleans Behavioral Health Council could arrange and organize for interested providers.

Homelessness and Housing Insecurity. Numerous interviewees reported housing as one of the greatest challenges for individuals with behavioral health needs in New Orleans. They described housing as a problem for homeless individuals who often “*have nowhere to go*” as well as housing-insecure individuals who may be at risk of losing public housing or other subsidies due to criminal justice involvement or a history of disruption related to their behavioral health condition. High rates of poverty, stagnant wages for low-income workers, and a severe shortage of affordable housing, among other factors, too often results in homelessness. These risks disproportionately impact individuals with behavioral health conditions, which can lead to a vicious cycle of instability and crisis. According to UNITY of Greater New Orleans, which operates the region's homeless registry, there were 1,703 homeless people on any given night in Orleans and Jefferson Parishes as of 2015, the majority of whom were unsheltered.⁴⁰ Of those, 445 were adults with a serious mental illness.

While New Orleans services are moving towards a Housing First model, an approach that does not require sobriety, public housing and other subsidies still remain restrictive for many individuals with behavioral health conditions. Many services, such as temporary and permanent supportive housing, are only available to individuals who have been homeless for at least one year due to the federal government's definition of homeless. As one interviewee described, “*the problem with Housing First is that it's not set up with medication management.*” Additionally, long waitlists prevent people from getting help when they need it most. Interviewees described several homeless outreach efforts that have become trusted sources of care, transportation, and other resources for many homeless individuals, including the NOPD's Homeless Assistance Unit and the New Orleans Street Medicine program. However, the capacity and scale of these programs are insufficient to reach everyone in need and provide the extensive navigation and coordination required to help this population.

⁴⁰ Unity of Greater New Orleans. A Home for Every New Orleanian: A Report on Progress Toward Ending Homelessness Since Hurricane Katrina. (2015, August). Retrieved from: <http://unitygno.org/wp-content/uploads/2015/08/A-Home-for-Every-New-Orleanian.pdf>

Since 2011, local officials have been exploring the opportunity for a new low-barrier shelter to help address homelessness. In spring 2017, the old Veterans Affairs hospital building in the Central Business District was selected as the site for the shelter, building on a Community Resource and Referral Center already located there.⁴¹ Several interviewees mentioned the need for a no-barrier or low-barrier to serve the homeless population and to link individuals to other needed resources related to healthcare and social support that could potentially be co-located for ease of access.

OPPORTUNITY

There is opportunity to explore national models and best practices that support homeless and housing-insecure individuals who have behavioral health needs. Some successful models include Houston's Integrated Care for the Chronically Homeless Initiative and the King County Navigation Center in Seattle.^{42, 43}

There is opportunity to support the low barrier shelter with a monitoring and evaluation plan so that the model identified is implemented as envisioned by key stakeholders.

SYSTEMS THEMES

Virtually all of the challenges in the crisis system identified through this project are rooted in deeper, systemic issues that span the full continuum of the behavioral health system. A key takeaway is that problems in crisis services, or in any single care setting or pathway, cannot be sufficiently examined or resolved in a vacuum. A clear understanding of the big picture is needed to assess root causes and identify effective solutions. Through this preliminary assessment of the crisis system, several thematic findings were drawn from the crisis setting that can be applied to the broader continuum.

- **Ownership of Outcomes.** Several challenges related to crisis response and care coordination can be linked back to lack of clarity around accountability for certain processes and ownership of certain goals or outcomes of interest. There is opportunity to create a structure to enhance clear roles and responsibilities for service providers across the continuum of care.
- **Understanding of Costs and Finance Streams.** Operational limitations and other unintended consequences caused by funding sources was a common theme across the challenges identified. There is opportunity to assess the financial costs of operating the crisis system and the broader behavioral system (including who incurs those costs) and to explore alternative means of financing.

⁴¹ Ferrand, C. City approves new homeless shelter at old VA hospital. *WDSU News*. (2017, April 6). Retrieved from: <http://www.wdsu.com/article/city-approves-new-homeless-shelter-at-old-va-hospital/9243292>

⁴² Corporation of Supportive Housing. Integrated Care for the Chronically Homeless. (2016, January). Houston, Texas. Retrieved from: https://www.nhchc.org/wp-content/uploads/2011/10/houstonfrequentuserinitiativeprofile_jan16.pdf

⁴³ DESC. Navigation Center. Retrieved from: http://www.desc.org/navigation_center.html

- **Data Sharing and Monitoring.** Overall, there was frustration over the system’s limited ability to track patients’ needs and utilization across the continuum and provide actionable information to providers at the point of care. There is opportunity to enhance data collection and dissemination of meaningful measures in the Behavioral Health Dashboard to enable ongoing assessment of the behavioral health system’s performance against community-wide goals and to facilitate alignment of complementary partnerships for care coordination.
- **Awareness of Services.** Several of the challenges identified are often complicated by limited awareness of available services among individuals, families, and other service providers. There is opportunity to explore ways to support service providers in increasing awareness of their services in the community. The opportunity includes awareness in understanding and communication of true wait times for services and criteria for eligibility.
- **Diverse Network of Partners.** The assessment further validated the need for a structured network of diverse partners to unify and centralize community-wide planning and implementation of systems improvement activities. In addition to the sectors and organizations already represented in the Behavioral Health Council, non-traditional partners such as faith-based organizations are needed to tackle systemic challenges. A major barrier facing the behavioral health field is that those with the greatest needs are often the least likely to accept care. Diverse partnerships can help expand the reach and impact of improvement activities to new and hard-to-reach populations.

OPPORTUNITIES AND NEXT STEPS

Opportunities to enhance the crisis response system include many elements:

- clarity and standards on roles, responsibilities, and safety protocols
- pathways for inter-agency alignment and collaboration
- specific cost analysis
- exploration of evidence-based models
- enhance data collection, analysis, and use for decision making
- increasing training for providers
- clarity of the pathway for the establishment of licensed group homes within the Greater New Orleans area

Throughout the key informant interviews, representatives of all sectors and organizations expressed interest in working together to address the systemic challenges facing individuals and families, service providers, and other stakeholders in the behavioral health crisis system.

The vision for the desired future state is a ROSC that is driven by a guiding set of principles:

- person-centered
- focused on continuity of care

- integrates comprehensive health care (somatic, mental health, and substance use services) and social supports (housing, transportation)
- outcomes-driven
- informed and supported by recovering individuals and their families
- rooted in evidence and best practices
- adequately and flexibly financed⁵⁰


Some components of a ROSC are already in place, including, but not limited to: a city-wide infrastructure for multi-sector collaboration on behavioral health, a community-based behavioral health organization responsible for the serious and persistently mentally ill with the greatest need, an expanded set of hospital-based services dedicated to behavioral health, and highly engaged police and EMS services. Still, substantial effort and resources are needed to address systemic challenges and fully achieve New Orleans' vision for the future.

Many engaged service providers have come together through the Behavioral Health Council and other multi-sector groups, both formal and informal, to identify and implement solutions to many of the current problems (e.g. high utilizers, continuity of care for justice-involved individuals, etc.). However, this project has revealed that many of these efforts face substantial operational barriers and resource limitations, leading many to be abandoned or achieve impact for only a minority of the individuals or cases it intended to reach. As a result, many “band-aid” solutions and programs exist that don't meet the needs of the vast majority of individuals with behavioral health needs. A new approach is needed to effectively resolve the systemic problems described in this report, particularly with limited financial resources.

Alternatively, a more centralized approach is needed to facilitate shared decision making on city-wide priorities, investments, activities, and accountabilities. **As such, there are two priority opportunities to activate immediate next steps in working toward the desired future state and to enhance local capacity for system-wide change, which are described below.**

First, the New Orleans Behavioral Health Council (NO-BHC) must continue to double down on prior commitments to fulfill its role as: the central facilitator of shared decision making and priority setting across sectors and settings, the hub for collaboration and ongoing education, and the leader of continuous behavioral health improvement and monitoring efforts.

- The NO-BHC should help to clarify service providers' accountability for patients, processes and protocols, and outcomes in order to effectively improve how behavioral health system manages and coordinates care for the population.
- The NO-BHC should determine how to meaningfully use NOHD's Behavioral Health Dashboard to monitor performance on system goals, population outcomes, and other important trends. There is substantial opportunity to use the Dashboard to provide ongoing information to stakeholders about the performance on goals at the system-level and organizational-level, and to



facilitate decisions about adjusting inter- and intra-organizational practices in support of improved care across the continuum.

- The NO-BHC should align dashboard measures with decisions about accountability and ownership focusing on measures that can facilitate public monitoring of performance.

Second, the financial costs and benefits associated with operating the behavioral health system must be determined and analyzed to incorporate cost considerations into the strategic planning and prioritization of system improvement activities.

There is a need to understand what each entity in the system (insurers, health and social service providers, the criminal justice system, and other local and state agencies) is paying for to identify any redundancies, inefficiencies, or gaps in city-wide investments.

- The financial costs resulting from inefficient and ineffective processes described in the System Challenges section of this report (e.g. police and EMS wall time, long wait times to access care, etc.) must be determined.
- The funding allocated to behavioral health services in the jail and in other areas of the City's budget must be determined to fully understand the financial costs of providing behavioral health services for individuals involved in the criminal justice system.

To supplement this preliminary assessment and to most effectively pursue the opportunities and next steps identified here, a larger-scale assessment and planning process is needed to enable system-wide progress toward achieving NO-BHCs' vision for the future. LPHI, NOHD, and MHSD are actively pursuing additional grant funds for that purpose.



Appendix A: List of Organizations Interviewed

Catholic Charities Archdiocese of New Orleans (CCANO)

Individual with Lived Experience

Louisiana Medicaid Managed Care Organization

National Alliance on Mental Illness (NAMI) New Orleans

New Orleans Emergency Medical Service (EMS)

New Orleans Health Department (NOHD)

New Orleans Police Department (NOPD)

Orleans Parish Communications District

Orleans Parish Coroner's Office

Resources for Human Development (RHD), a contractor of Metropolitan Human Services District (MHSD)

Street Medicine New Orleans

University Medical Center (UMC)

VIA LINK

Appendix B: Interview Guide

Area of Focus	Question
BH Needs and Issues	<ul style="list-style-type: none"> - What are the greatest BH issues/ diagnoses/ needs of community? - How do you know these are the greatest issues? - Who in your community has the greatest BH needs?
	Have there been any recent changes in the community's BH needs/ issues? How so? Why?
BH Services Utilization	How do community members find information on BH crisis services? Or, preventive care?
	We already know about [list BH crisis services]. Are there any others that the community uses?
	Have there been any recent changes in the availability of BH crisis services?
	Who is utilizing these services? Who is not utilizing these services? Why?
	Are community members seeking care outside of the parish? <i>Who? Why?</i>
	<i>[For consumers only]</i> How have your experiences with the M/BH crisis system been? How would you describe the care/ services you have received? Did the care/services meet your need?
Access to Care	How do people access BH crisis services? What are the access points into the BH crisis system? How are individuals referred? How are services coordinated?
	What are barriers to accessing crisis services? Who is most affected?
Gaps in Services	What are the limits of the current BH crisis system?
	Are some services missing from the continuum of care? Which ones?
	What services in the continuum of care could be improved?

Stakeholder/ Sectors Collaboration	- What resources could your organization commit to improving the BH crisis system? - What would you be willing to do?
	- Is there collaboration across sectors for BH crisis services? - What mechanisms are in place for collaboration across sectors? - What has been done to improve the BH crisis system in the past? - What worked? Why did they work? What didn't work? Why not?
Resources/As sets & Solutions	- What is the current crisis response system doing well now? - How can we build on what it's doing well? - Beyond the stakeholders already mentioned, what are other resources/ assets in the community? - Can these resources/assets be leveraged? Which ones? How?
	- What are barriers to the implementation of these improvements? - What are barriers to community acceptance/utilization of these improvements?
	- If we conduct client interviews, what questions would you like us to ask them?
Services Capacity	- Does your organization currently provide crisis services? If yes, how so?

