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Title: “A Needs Assessment and Program Intervention for Patients in Mental Health Crisis in Lieu of Admission to the Emergency Department (ED) at Rapides Regional Medical Center (RRMC)”

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An abstract of
A thesis submitted to the Faculty of the
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Abstract

A Needs Assessment and Program Intervention for Patients in Mental Health Crisis in Lieu of Admission to the Emergency Department (ED) at Rapides Regional Medical Center (RRMC)
By Daphne Renee Robinson, J.D.

Community-based services for patients in mental health crisis in Rapides Parish, Louisiana, are virtually non-existent. Consequently, persons who suffer from chronic mental illness frequently seek non-emergency services in the Emergency Department (ED) of Rapides Regional Medical Center (RRMC), the largest hospital in central Louisiana. This study is a community needs assessment that focuses for the first time on the needs of the patient population in mental health crisis in central Louisiana and evaluates community-based services that could be successfully implemented to serve those needs.

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Chapter 1: Overview

A. Problem Statement

In 2013, the Louisiana State University Board of Supervisors approved the closure of Huey P. Long Medical Center (HPLMC) in Rapides Parish, Louisiana, one of the ten public hospitals in Louisiana created to provide care to the indigent since 1936 (Becker's Hospital Review 2013). In 2012, Congress reduced Medicaid spending in Louisiana by $523 million dollars (Public Affairs Research Council, 2013). In response, the state of Louisiana chose to apply $329 million dollars in spending cuts to the Louisiana public hospital system forcing the closure of HPLMC in Rapides Parish, Louisiana, as a public hospital, and the creation of a public private partnership between the state of Louisiana and two private hospitals, Rapides Regional Medical Center (RRMC) and Christus St. Frances Cabrini Hospital (Cabrini), to provide a system of safety net services for the poor and uninsured (PAR, 2013). RRMC and Cabrini agreed to take on direct inpatient and emergency care loads from Huey P. Long Hospital (Becker's Hospital Review, 2013). Many individuals with mental illness or substance abuse disorders in the area served by HPLMC often sought non-emergency primary care services in the Emergency Department (ED) of HPLMC because they did not have private insurance or Medicaid and could not afford to pay for services (Hood, 2009).

After the closure of HPLMC and the reduction in community-based mental health services, hospital leadership at RRMC became concerned that the number of patients admitted via physician emergency certificate (PEC) in mental health crisis would increase thereby reducing the quality of services provided to those patients and others in the ED. For the purposes of this study, an individual is considered in 'mental health crisis' in Louisiana when any

physician, psychiatric mental health nurse practitioner or psychologist executes an emergency certificate, after an actual examination of a person alleged to be mentally ill or suffering from a substance abuse disorder. The person must be deemed in need of immediate care and treatment in a treatment facility, by an examining physician, psychiatric mental health nurse practitioner or psychologist, who determines the person to be dangerous to self or others or to be gravely disabled (La. R.S. 28:53, et. seq.). The certificate shall last for a period of seventy-two (72) hours (La. R.S. 28:53, et seq.). After the emergency certificate is issued, the patient may be admitted and detained at a treatment facility for observation for a period not to exceed fifteen (15) days. The patient can be held for an additional fifteen-day period, only if a second emergency certificate is executed (La. R.S. 28:53, et. seq.). Ideally, if the patient is deemed to meet the criteria for a physician emergency certificate (PEC), as defined by the statute, the patient is held for seventy-two (72) hours in a hospital until the patient is stabilized or is discharged to an inpatient facility for further observation and treatment or referred to outpatient services. However, in reality, because of the lack of outpatient resources in central Louisiana and the statewide shortage of inpatient beds in Louisiana, many patients are discharged after the PEC period, only to return to the emergency department again and again in mental health crisis (Hood, 2009).

B. Purpose

The objective of this CNA is to improve access to community-based mental health services for patients in mental health crisis, who otherwise would seek treatment in the ED of RRMC. Included in this study are also the findings of a community health needs assessment (CNA) done in by RRMC, in collaboration with the Rapides Foundation, a local health conversion

foundation, detailing the overall community health of Rapides Parish, Louisiana. This assessment will evaluate the following:

- The demographics of the population in mental health crisis seeking services in the ED of RRMC
- The current state of mental health services in the area serviced by RRMC
- National best practice, community-based models for the treatment of individuals in mental or behavioral health crisis
- Recommendations for evidence-based models that can be replicated in the RRMC service area.

With this data, the community can, hopefully, map out a course of action to make positive and sustainable change in the provision of community-based services for those in mental health crisis.

C. Significance of the project

A needs assessment that focuses exclusively on this patient population would be the first of its kind for central Louisiana and would provide demographic data about this population to the community that was previously unavailable. Additionally, it would provide community leaders and health care personnel with national, best practice models that have been used in other communities that can be replicated in the central Louisiana area.

D. Mental Health in Louisiana

According to Mental Health of America, a nationally recognized mental health advocacy organization, Louisiana is one of four states in the country with the highest prevalence of mental illness and the lowest rates of access to care (Nguyen & Counts, 2015). Over 19.28% of adults 18 and older in Louisiana or 649,000 people suffer from "any form of mental illness," compared to 18.19% nationally (Nguyen, et al, 2015). Over 285,000 people or 8.48% of adults in the state, compared to 8.46% nationally, are dependent on or abuse illicit drugs or alcohol (Nguyen, et al, 2015). The highest percentages of uninsured adults with mental illness are in the Southern and Western states (Nguyen, etal, 2015). Louisiana ranks number 40 among the 50 states in the number of uninsured adults with any mental illness (Nguyen, et al, 2015). In March of 2010, the Affordable Care Act (ACA) was enacted to provide health care and to expand Medicaid coverage to millions of Americans without coverage. However, many states, particularly in the South, did not expand Medicaid to many Americans who otherwise would have received coverage, and thus many individuals suffering from mental and behavioral health conditions in Louisiana were uninsured. On January 12, 2016, the newly-elected Governor of Louisiana John Bel Edwards signed an executive order expanding Medicaid coverage, but prior to this action, over 300,000 citizens in the state were without health care coverage (Litten, 2016a).

In addition to economic barriers to access, Louisianans are faced with barriers resulting from a lack of mental health providers as well. The state is ranked number 45 out of 50 for its lack of mental health provider workforce availability (Nguyen, et al, 2015). The term mental health provider includes: psychiatrists, psychologists, licensed clinical social workers,

counselors, marriage and family therapists and advanced practice nurses specializing in mental health care (MHA, 2016). Nationally, in 2015, there was a ratio of 250 people in the population for every one mental health provider (MHA, 2016). In Louisiana, however, the ratio was 859 citizens for every one mental health provider in the state (MHA, 2016). This means that there is almost four times less access for individuals in Louisiana who need mental health treatment, when compared to the national average (MHA, 2016). Consequently, people with chronic mental illness frequently are forced to seek non-emergency primary care services in emergency rooms throughout the state because they do not have private insurance or Medicaid coverage and cannot afford to pay for services (Hood, 2009).

1. Uncoordinated system of care

To add to the problems associated with accessing mental health treatment in Louisiana, the delivery of behavioral health services in the state is usually separate and uncoordinated from the broader health care delivery system (AHA, 2012). This fragmentation of care can often compromise the quality of care and clinical outcomes for patients with co-morbid behavioral and physical health conditions (AHA, 2012). Unlike the rest of the country in the last 50 years, which was moving towards a community-based model of rehabilitation and recovery in outpatient settings, Louisiana followed a much different path. While Louisiana reduced its resident inpatient population at a rate similar to nationwide reductions, the state prior to Hurricane Katrina in 2005, did not close any of its long-term mental hospital facilities (Hood, 2009). Counter to the trend in other states, Louisiana actually expanded the number of state psychiatric institutions from five to six in the mid 1980's (Hood, 2009).

Prior to Hurricane Katrina, Louisiana essentially had a “two tier” health system, in which the insured population (including those with Medicare and Medicaid) had access to a range of community hospitals and physicians, while the poor and uninsured were mostly cared for through the state-run safety net system of public hospitals (Rudowitz, Rowland, & Shartzer, 2006). There were ten hospitals across the state within the charity system, including Huey P. Long Medical Center in central Louisiana (PAR, 2013). Prior to 2013, the charity hospital system, which had existed in Louisiana since the 1700’s, would treat anyone, who resided in the state of Louisiana, regardless of ability to pay (PAR, 2013). The state public hospitals offered care for acute conditions, but provided fewer options for preventative care for the uninsured (PAR, 2013). Many uninsured in Louisiana lived far from a state public hospital because the hospitals were spread throughout the state (PAR, 2013). Consequently, this has led to an overutilization of expensive emergency care (PAR, 2013). The uninsured in the state with mental and behavioral health disorders often came to rely on being able to receive help in hospital EDs (PAR, 2013). Within the charity system of hospitals, Louisiana had historically high rates of ED visits, which is an indication of the limited access to primary care and preventative services in the state (Rudowitz, et al, 2006). In 2004, the year before Hurricane Katrina, the state ranked fourth in the nation for high ED use, with 548 visits per 1,000 people, compared to the national average of 383 visits (Rudowitz, et al, 2006).

In 2013, after a series of Medicaid cuts by the federal government, the state entered into a series of agreements with private partners to assume responsibility for operating five of the previously state-operated hospitals (PAR, 2013). However, four of the hospitals, which had previously provided a safety net for generations of citizens, would be closed.

2. Cost of mental health treatment

The most striking difference between Louisiana and most other states is the high level of spending for state mental hospitals that provide intermediate to long-term inpatient care (Hood, 2009). According to data provided by the National Association of State Mental Health Program Directors (NASMHPD), national spending on mental health services in 2006 included 28% for state mental hospitals and 70% for community-based services (Hood, 2009). However, in Louisiana, the spending distribution in 2006 was 56% for mental hospitals (which was second highest in the U.S.) and 30% for state community-based care (which was the worst in the U.S.) (Hood, 2009). At the time, per capita Louisiana spent $18.57 on community-based care, compared to $72.97 spent per capita nationally (Hood, 2009). Louisiana was also an outlier when it came to program costs and administration (Hood, 2009). The national average for administrative costs at the time was $2.14 per capita, but Louisiana ranked four times the national average at $8.01 spending per capita (Hood, 2009).

In 2009, during another fiscal crisis in Louisiana, the Louisiana Department of Health and Hospitals moved to merge the Office of Addictive Disorders with the Office of Mental Health, creating the Office of Behavioral Health (OBH) (Hood, 2009). Later, in 2012, the state closed all but two of its mental hospitals. In 2014, the total budget for OBH was $272,888,963 and 54.9% of that amount was still allocated for the two mental health hospitals (Louisiana Office of Behavioral Health, 2015). This was an overall reduction of more than $27 million or 10% from the Office of Behavioral Health from the previous year (NAMI, 2014). Community based services increased to 42.5% of the budget and administrative costs were in line with the national average at 2.5% (OBH, 2015). However, not only did the state reduce the number of

inpatient beds by closing mental hospitals, there were only 65 state supported community-based clinics, of which only 39 provided integrated behavioral and mental health services for the entire state (OBH, 2015). Although the OBH budget remained unchanged in 2015, given the state's current fiscal crisis, which is garnering national attention at this time, the budget for mental health is projected to be cut even further, thereby reducing funds for community-based outpatient services (NAMI, 2015).

F. Mental Health in Rapides Parish

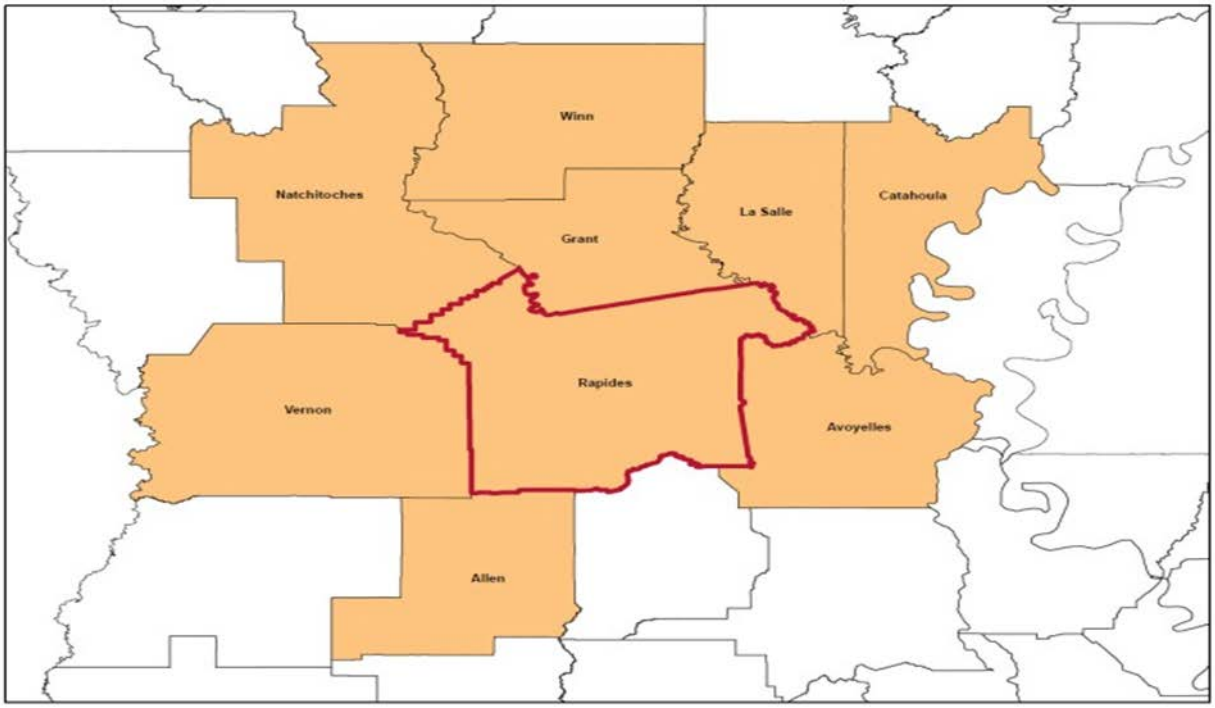
1. Closing of Huey P. Long Hospital

The Louisiana Legislature officially closed Huey P. Long Medical Center, the charity hospital that served Rapides Parish, in May of 2014. However, emergency services were virtually non-existent at the hospital by the summer of 2013 (PAR, 2013). The hospital was built in 1939 and provided medical and psychiatric services to the poor and uninsured in a nine-parish region in the central Louisiana area for over 70 years at little to no cost to the patient. Once the hospital closed, the safety net that existed for these patients and those incarcerated in local jails and the state prisons, was gone. It was expected that many of these patients would be absorbed by RRMC and another local hospital, as a part of the agreement between the two hospitals and the state, to privatize the operations of HLPMC. In 2011, the last year that HLPMC was fully operational, HLPMC saw 37,758 patients in its ED alone (PAR, 2013). In a community with a health professional shortage in primary care and mental health services, the burden on local hospitals to absorb such a large number of patients in mental and behavioral crisis is certainly significant.

2. Demographics of the area

The geographic area of this CNA is Rapides Parish, Louisiana, which includes Alexandria, the largest city in the parish. Rapides and the surrounding parishes are located in the central region of the state and are often referred to as central Louisiana. The total population of Rapides Parish, Louisiana, in 2014 was 132,488. Of that total, 51.7% of the population was female and 48.3% was male.

Figure 1: Map of Rapides Parish, Louisiana (PRC, 2013)



`In 2014, white people made up 63.9% of the total population and African-Americans represented 32.0%. Only 2.8% of the total population was considered Hispanic or Latino (US

Census Bureau, 2016). From 2009 to 2013, 19.9% of the total population lived below the poverty level[1] (US Census Bureau, 2016).

RRMC is a for-profit hospital in Alexandria, Louisiana, owned by Health Corporation of America (HCA). It is the largest hospital in the Rapides Healthcare System of Hospitals and attracts patients from a twelve-parish area with a total population of 431,416 (PRC, 2013). All twelve parishes within the healthcare system are medically underserved areas.

In 2013, mental health was identified as one of the top five health priorities in Rapides Parish, Louisiana, by focus groups because of the lack of mental healthcare providers in the area, the lack of inpatient mental health beds, the overutilization of ED services for patients in mental health crisis, and the lack of community-based services for mental and behavioral health disorders. Rapides Parish is designated as a Health Professional Shortage Area (HPSA) in mental health services and is characterized by high poverty and a large elderly population.

Medically underserved areas/populations are areas or populations designated by the United States Department of Health and Human Services Health Resources and Services

[1] For the purposes of this CNA, the poverty threshold for a family of four is $23,550 annual household income or lower (PRC, 2013).

Administration (HRSA) as having too few primary care providers, high infant mortality, high poverty, and/or a high elderly population (PRC, 2013). This determination involves application of the Index of Medical Underservice (IMU) to data on a service area to obtain a score for the

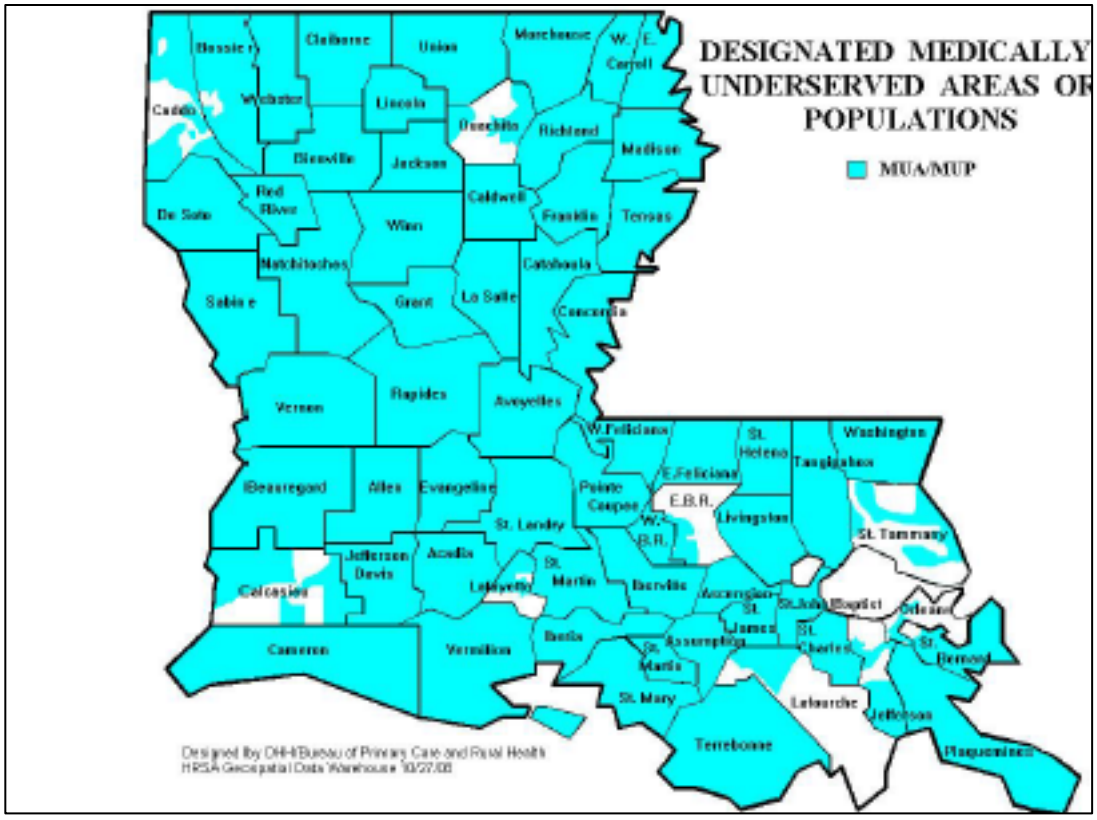


Figure 2: Map of Designated Medically Underserved Populations in Louisiana (PRC, 2013)

area (HRSA, 2016a). The IMU scale is from 0 to 100, where 0 represents completely underserved and 100 represents best served or least underserved (HRSA, 2016b). Under the established criteria, each service area found to have an IMU of 62.0 or less qualifies for designation as an MUA (HRSA, 2016b). Rapides Parish is designated a health professional shortage area or HPSA in primary care by the US Department of Health Statistics (PRC, 2013).

Health Professional Shortage Area (HPSA) designations are approved by the federal Office of Shortage Designation (OSD) in the Health Resources and Services Administration (HRSA) located in Rockville, Maryland. Louisiana's Bureau of Primary Care and Rural Health (BPCRH) typically submit requests pertaining to areas within the state. Designated HPSAs are valid for three years and are reviewed in the last year. Upon review, if the area continues to qualify, an updated request is submitted to OSD (PRC, 2012b).

Primary Care designations pertain to an area's access to physicians that practice principally in one of the following areas: family practice, general practice, internal medicine, pediatrics, and OB/GYN (Professional Research Consultants, 2012b). A geographic area will be designated as having a shortage of primary medical care professionals, if the following three criteria are met:

1. The area is a rational area for the delivery of primary medical care services.
2. One of the following conditions prevails within the area:

   (a) The area has a population to full-time-equivalent (FTE) primary care physician ratio of at least 3,500:1.

   (b) The area has a population to full-time-equivalent (FTE) primary care physician ratio of less than 3,500:1 but greater than 3,000:1 and has unusually high needs

for primary care services or insufficient capacity of existing primary care providers.

3. Primary medical care professionals in contiguous areas are over-utilized, excessively distant, or inaccessible to the population of the area under consideration (HRSA, 2016c).

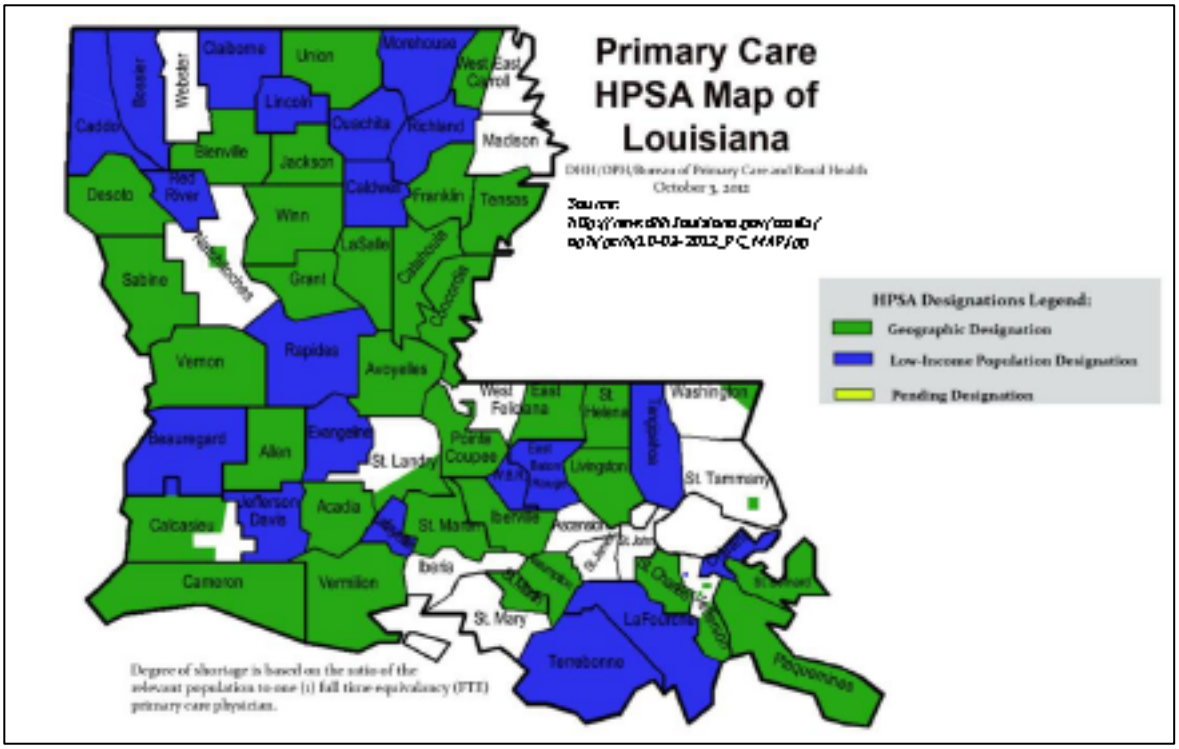
The ratio is 3,000:1 for High Needs (High Needs is used if the 200% Federal Poverty Level for the area is over 20%. Provider FTEs are determined by taking the number of hours per week the physician spends in primary care services, either in-office or on-rounds at the hospital, divided by 40. The total of these FTEs is divided by the total resident/civilian population of the area (HRSA, 2016d).

For each of the three HPSA Designation types, there are three sub-categories, which include:

- **Geographic designations**—these take into account the entire population of the requested area to all available primary care physicians (HRSA, 2016d).
- **Population Group designations**—these are special groups. The most common of these are Low Income and Medicaid-Eligible designations. Low income designations use a ratio built upon the low income population of the area and the physicians providing services to this population. Medicaid-eligible designations are based on the number of Medicaid-eligible people and the physicians that accept Medicaid (HRSA, 2016d).
- **Facility designations**—these look at a facility's outpatient census, waiting times, patients' residences and in-house faculty to evaluate a facility's designation eligibility (HRSA, 2016d).

Rapides Parish is also designated as a low income HPSA (Department of Health & Human Services, 2013).

Figure 3: Primary Care HPSA Map of Louisiana (PRC, 2013)



Additionally, all twelve parishes, including Rapides, suffer because of an inadequate number of psychiatrists and treatment facilities available to address residents' behavioral health needs. There are a limited number of inpatient beds for mentally ill patients in the state, thus creating another reason for patients in the community to turn to hospital EDs when they are in crisis (PRC, 2012).

3. Impact of problem in Rapides Parish

The Rapides Healthcare System conducted a Community Health Needs Assessment (CHNA) in 2013, as a follow up to similar studies conducted in the area in 2002, 2005, and 2010 to determine the health status, behaviors, and needs of residents in Rapides Parish. The CHNA

included a survey instrument for the purposes of the study and included questions from the CDC Behavioral Risk Factor Surveillance System (BRFSS), other public health surveys, and certain customized questions created by the authors of the study (PRC, 2013). The sample design consisted of a random sample of 760 adults over the age of 18 and older in Rapides Parish. Additionally, the authors conducted focus groups of 43 key informants, which consisted of representatives from public health, physicians, other health professionals, social service providers, youth, and community leaders (PRC, 2013). At the conclusion of the key informant focus groups conducted in 2013, participants were asked to write down what they individually perceived as the top five health priorities for the community based on group discussion, as well as their own experiences and perceptions (PRC, 2013). It is interesting to note that mental health was identified by the key informants and the focus groups as one of the top four health priorities in Rapides Parish (PRC, 2013).

Using benchmark data that included the previous surveys conducted in 2002, 2005, and 2010, regional risk factor data, statewide risk factor data, nationwide risk factor data, and objectives from Healthy People 2020, the following significant findings were made regarding mental health in Rapides Parish:

- An increase in the number of suicides
- An increase in the number of individuals without health insurance
- An increase in the number of drug induced deaths
- An increase in the percentage of individuals who view their mental health as fair or poor
- An increase in the percentage of individuals with symptoms of depression lasting for two or more years

- An increase in the percentage of those with chronic depression who were seeking help.

During the focus groups, respondents expressed concerns that many in the community, who suffer from mental illness, also have co-occurring substance abuse issues and self-medicate with drugs or alcohol (PRC, 2013). Overall, the community suffers due to an inadequate number of psychiatrists and treatment facilities available to address residents' behavioral health needs (PRC, 2013). There are only a limited number of inpatient beds for mentally ill patients, so physicians must PEC mentally ill patients in order to obtain inpatient services. This results in people waiting in the emergency room for days (PRC, 2012). One key stakeholder said, when asked about the lack of community-based services for those suffering from mental illness:

> **"It's limited. That's a real mystery to me. All I know is when we have a patient in that situation, the social worker usually ends up calling all over the state. Sometimes they find a place and sometimes they don't. It is very hit or miss" (PRC, 2013).**

Regarding the use of the emergency commitment or the PEC of patients in the ED, one key stakeholder stated:

> **"They're actually putting them in the hall on cots until they can be seen and evaluated and possibly placed. The odds of getting them placed are very slim and what happens [sic] is they go back into the community, they offend, and they end up in jail" (PRC, 2013).**

Respondents during the focus groups were very vocal and felt very strongly that the ED was not an appropriate place for mentally ill patients. Many voiced concerns that the ED did not provide appropriate treatment for the patient and if a patient did not have health insurance, it would be impossible to locate an inpatient bed (PRC, 2013).

Outpatient mental health clinics are scattered throughout central Louisiana, but continuity of care suffers, because of staff turnover (PRC, 2013). There are not enough services for behavioral health in the community, so very ill patients return to the community without acquiring the necessary treatment (PRC, 2013). For those residents who can access behavioral health services, the wait times before appointments exceed several weeks. The current waiting periods may cause patients to go without timely care, which increases the likelihood of needing hospitalization (PRC, 2013). The aforementioned problems in accessing behavioral health care in Rapides Parish contribute to the use of the ED for patients in mental crisis, although it is the least appropriate place for treatment of the mentally ill.

Chapter 2: Literature Review

This chapter provides an overview of research on the impact of mental illness in the United States and the overutilization of emergency services by patients in mental health crisis. It also provides information about the factors that have contributed to the decline in community-based services for those experiencing mental health crises in this country and an examination of best practices for treating these individuals in the community in which they live. The main purpose of the literature review was to collect data and insight about the prevalence of mental illness in the United States, the extent of the use of EDs to treat mental illness, the effectiveness of such treatments, and the kinds of community-level, evidence-based models that are being utilized across the country to treat patients in mental health crisis outside of the ED. Findings specifically related to Louisiana and the use of EDs for treating mental and behavioral crises were quite limited, but it was possible to draw conclusions and make

comparisons using national data.

The review of literature for this CNA includes extensive searches in databases such PubMed, PubMedHealth, Cochrane Library, MedLine, Lexis/Nexis Academic, Emory University's EJournals and Ebooks. These resources were used to search for peer reviewed journal articles and books, scholarly articles, and grey literature (to include government publications, reports, statistical publications, and policy documents). Terms relevant to the study were used as keywords to determine the most appropriate databases. Terms such as emergency rooms, emergency departments, emergency services, mental illness, mental health, mental health disorders, chronic mental illness, psychotic, psychosis, psychiatric, mental health crisis, grave danger to self and others, community based services, mental health hospitals, substance abuse disorder, co-occurring substance abuse disorders, and homelessness. The returns were analyzed and used as guides in narrowing down the types of databases. In this case, the databases with the highest returns were PubMed and PubMedHealth. When keywords were deemed to complement one another, the word "AND" was used to enable the retrieval of a comprehensive set of results (for example, mental health and emergency room). Where keywords were seen as substitutes, the word "OR" was used instead (for example, mental illness or mental health). The results were downloaded into Mendeley, a desktop and web-based program for managing research. This provided the keywords and abstracts for each paper and enabled organization around each topic. The articles were sifted through in order to determine their relevance to the subject of the study. Those articles considered irrelevant were excluded, as were those from other unrelated fields.

Once the articles were organized in Mendeley, the next step was to review the articles

based on a number of criteria: relationship to the theory (the treatment provided to those in mental health crisis in EDs), implications for public health practice, coherence of data and arguments, and contributions to the field of study. The result was the identification of articles and papers that dealt with mental illness and mental health crisis in ED settings and community-based resources for treatment of chronic mental illness and mental health crisis.

Since the purpose of this study was to conduct a community needs assessment of the mental and behavioral health patients in immediate mental health crisis, it was critical to identify from the literature the definition of a community needs assessment. The Centers for Disease Control and Prevention (CDC) define a community needs assessment as a snapshot of local policies, systems, and environmental strategies currently in place and helps to identify areas for improvement (CDC, 2012). With this data, communities can map out a course for health improvement by creating strategies to make positive and sustainable changes in their communities (CDC, 2012).

The next area of significant research included establishing definitions for serious mental illness, substance use disorders, and mental health crisis. According to the Substance Abuse and Mental Health Services Administration (SAMSHA), serious mental illness, among people ages 18 and older, is defined as having, at any time during the past year, a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment, that substantially interferes with or limits one or more major life activities (Pearson, Janz, & Ali, 2013). Serious mental illnesses include: major depression, schizophrenia, and bipolar disorder, and other mental disorders that cause serious impairment (Pearson, et al, 2013). Substance use disorders are defined as mild, moderate, or severe to indicate the level of severity, which is determined

by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home (SAMSHA, 2016). According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria (SAMSHA, 2016). SAMSHA defines co-occurring substance abuse disorder as the coexistence of both a mental illness and a substance use condition (SAMSHA, 2016).

Government publications and statistical reports assisted in establishing the prevalence of the mental illness and substance abuse disorders in the U.S. Studies show that one in four Americans experiences a mental illness or substance abuse disorder each year (American Hospital Association, 2012), In 2009, more than 2 million discharges from community hospitals were for a primary diagnosis of mental illness or substance abuse disorder (AHA, 2012). It is estimated that 1.2 million people in jails and prisons at the state, local, and federal level reported some kind of mental health problem (Johnson, 2014). Fifty-seven (57%) percent of adults with mental illness receive no treatment at all (MHA, 2016). It is estimated that only about 17% of U.S. adults are considered to be in a state of optimal mental health (ODPHP, 2016). An estimated 26% of Americans age 18 and older are living with a mental health disorder (MHD) in any given year, and 46% will have a mental health disorder over the course of their lifetime (ODPHP, 2016).

The World Health Organization (WHO), in collaboration with the World Bank and Harvard University, has determined that the impact of mental illness on overall health and

productivity in the United States and throughout the world is often profoundly under estimated (Professional Research Consultants, 2012b). In established market economies such as the United States, mental illness is on par with heart disease and cancer as a cause of disability (ODPHP, 2016). Suicides, a major public health problem in the United States, occur most frequently as a consequence of a mental disorder (ODPHP, 2016).

Another important area of literature analysis was the examination of the use of EDs by those with serious mental illness and those in mental health crisis. One in eight or nearly 12 million ED visits in the U.S. were due to mental health and/or substance use problems in adults (Bazelon Center, 2007). Of these visits, 63.7% were related to mental health problems, 24.4% involved substance use disorders, and 11.9% involved co-occurring psychiatric and substance use disorders (Bazelon Center, 2007). Among ED visits involving substance use disorders, 42.7% were for mood disorders, such as depression or bipolar disorder, 26.1% for anxiety disorders, and 11.9% for alcohol-related conditions (Bazelon Center, 2007). Using ICD-9 codes, conditions may be classified by EDs as alcohol-related because they include: alcoholic psychoses, alcohol dependence syndrome, nondependent abuse of alcohol, chronic liver disease and, cirrhosis, such as alcoholic liver disease, and alcohol poisoning (NIH, 2013a). Co-occurring substance use and mental health-related diagnoses: include adjustment disorders, anxiety disorders, mood disorders, personality disorders, schizophrenia and other psychotic disorders, and all other mental disorders (NIH, 2013b). Patients with alcohol and substance use related disorders may also present to the ED in violent, suicidal, or homicidal states, as well as with various intentional and unintentional injuries.

One study by the Centers for Disease Control and Prevention (CDC) found that patients

with MHDs use the ED for acute psychiatric emergencies, for injuries and illnesses complicated by or related to their MHD, or when psychiatric or primary care options are inaccessible or unavailable (CDC, 2013). Studies show that individuals with psychiatric illnesses have higher rates of ED use than the general population and that patients with psychiatric disorders are likely to use the ED on multiple occasions and have multiple hospitalizations when compared to patients without psychiatric disorders (Baillargeon, et al, 2008). Between 40% and 50% of patients with a history of repeated psychiatric hospitalizations are readmitted within 12 months (AHRQ, 2014).

Another population with a high rate of mental illness and ED usage is the homeless. Studies suggest that problems with housing contribute to the high rate of relapse among chronically mentally ill patients (Rosenfield, 1991). According to the *2010 Annual Homeless Assessment Report*, among the individuals that were sheltered on a given night over the course of the year 2010, 26.2% of those adults who were homeless had a severe mental illness. (SAMSHA, 2011). And, of those adults who were sheltered on a given night in 2010, 34.7% had chronic substance use issues. (SAMSHA, 2011) Over 60% of the people who are chronically homeless have experienced a lifetime of mental health problems (SAMSHA, 2011). And, over 80% of those who have experienced chronic homelessness have experienced a lifetime of alcohol and drug problems (SAMSHA, 2011). Research indicates that individuals experiencing homelessness, who frequently use emergency departments, are more likely to be diagnosed with either mental illness or substance use disorder (Rief, et al, 2016). Homeless individuals with co-occurring mental illness and substance use disorders are at greatest risk for hospitalization (Rief, et al, 2016). Because social welfare benefits provide these patients with

less than half of a poverty-level income, chronic patients often only have access to substandard housing, if they have access to housing at all (Rosenfield, 1991). Thus, as low cost housing has continued to decline, the significantly mentally ill have increasingly become a part of the homeless population. A growing body of evidence confirms that supportive housing works for people with mental illness, including those with the most severe impairments (Bazelon Center, 2009).

It should be noted that the literature also reveals that the problem of overutilization of EDs is not limited to individuals with mental illnesses (Bazelon Center, 2007). People with various medical conditions are more frequently at EDs and one of the primary reasons is a lack of access to primary care. For example, an examination of safety-net hospitals in Houston, Texas, found that a large proportion of visits to EDs are for non-urgent conditions that could be treated or prevented in primary care setting. (Bazelon Center, 2007). Studies show that for most patients with behavioral health issues, the primary care setting would be the best point of care because most mental health care is provided in the primary care setting (Crowley & Kirschner, 2015). A 2000 survey determined that 32% of undiagnosed, asymptomatic adults would likely turn to their primary care physician to help with mental health issues; only 4% would approach a mental health professional (Crowley & Kirschner, 2015).

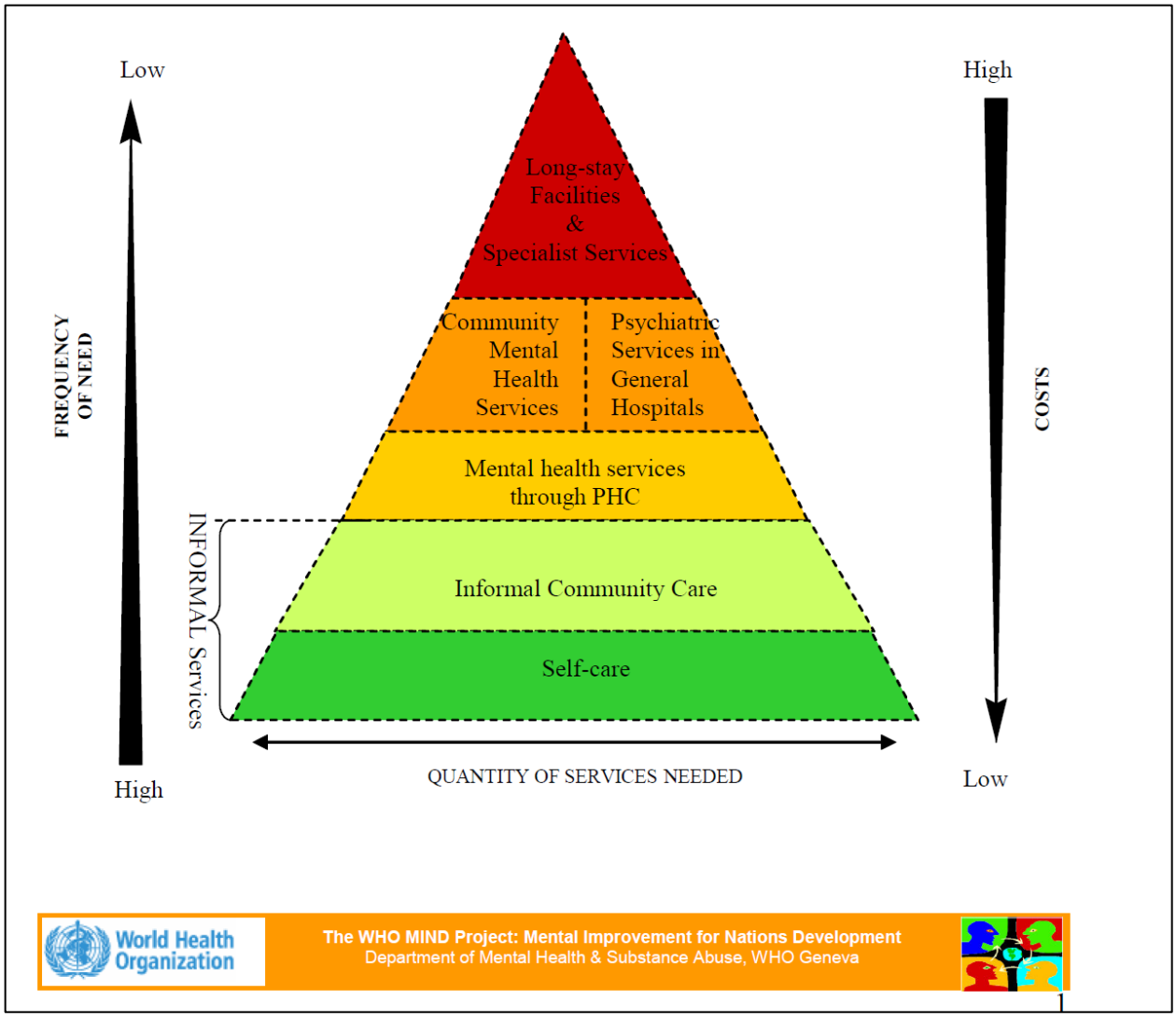
However, research shows that sixty percent (60%) of ED physicians in this country believe the increase in ED visits by individuals with mental illnesses is having a negative impact upon access to emergency medical care for all patients, thereby causing longer wait times, increasing patient frustration and diminishing the capacity of hospital staff (Bazelon Center, 2007). Moreover, the statistics show that ED physicians are caring for people with serious

mental illness, and unlike primary care providers, who might reasonably be expected to address mood disorders associated with chronic disease, ED physicians have neither the training nor the time to do more than identify, stabilize, and refer these patients for additional outpatient services (Rhodes, 2008). Patients often return to the ED because after release, there is very little, if any, follow-up care in the community after discharge for these patients (Bazelon Center, 2007). Additionally, once a patient in mental health crisis leaves the ED, there are insufficient numbers of community-based psychiatric and social service back-ups to refer individuals after they have sought care in the ED (Bazelon Center, 2007).

The World Health Organization has developed the optimal mix of services pyramid framework to provide guidance on how mental health services should be organized in communities (WHO, 2015). As illustrated by Figure 4, the WHO recommends that mental health services be organized as follows:

- Limited Mental Hospitals
- Build Community Mental Health Services
- Develop mental health services in hospitals
- Integrate mental health services into primary care
- Build informal community mental health services
- Promote self-care.

Figure 4: Optimal Mix of Mental Health Community Services (WHO, 2015)



However, without good community level care, people are often left to experience deterioration of psychiatric conditions that may cause them to appear in area EDs for treatment.

Much of the literature reviewed provided a historical context for the lack of community services for patients in mental health crisis in the US. The legacy of many of these problems began with the deinstitutionalization of patients in state mental hospitals because of conditions that were non-clinical and inhumane. In 1963, John F. Kennedy signed the Community Mental

Health Act, which was designed to provide funding to build mental health centers so that individuals with mental illness could live, work, and receive treatment in their own community (Creswell, 2013). Yet, over 50 years later, the initiative begun by Kennedy has evolved into a system of care that is underfunded, fragmented, and difficult to navigate for patients and even providers (Hood, 2009). Funding for mental health services has been the target of nationwide budget cuts. Twenty-eight states and Washington, D.C. reduced their mental health funding by a total of 1.6 billion between fiscal years 2009 and 2012 (AHA, 2012). These cuts not only affect individuals but also affect surrounding community resources, including outpatient psychiatric facilities and correctional facilities (Nesper, 2015). Between 2013 and 2014, states began the process of rebuilding from the sweeping cuts that devastated mental health budgets during the Great Recession, but in 2015 only 23 states' mental health budgets increased, 12 states decreased general funds for mental health, while only 14 states maintained the same budget from the previous year (NAMI, 2015). Specific services that have been eliminated or downsized are those most essential to helping children and adults living with serious mental illness avoid crises and move toward recovery. Some of these services include:

- Acute (emergency) and long-term hospital treatment
- Crisis intervention teams and crisis stabilization programs
- Targeted, intensive case management services
- Assertive Community Treatment (ACT) programs
- Supportive housing
- Targeted case management and clinic services for children and adolescents Access to psychiatric medications (NAMI, 2011).

One-third of individuals with severe mental illnesses who receive community-based, mental health services after lengthy stays in facilities achieve full recovery in psychiatric status and social function, and another third improve significantly in both areas (SAMSHA, 2014). Additionally, with substance abuse treatment, emergency room visits, hospital stays, and periods of incarceration are significantly reduced. Likewise, high-risk and harmful substance use is decreased (SAMSHA, 2014). But, funding drives the availability of many of these community-based, mental health services. It determines the type of services offered and who will be eligible to receive them. Unfortunately, serious mental illnesses such as schizophrenia and bipolar disorder do not disappear when services are not available (Health Management Associates, 2011). Without effective treatment, people with serious mental illnesses tend to manifest behaviors and symptoms that cause them to be brought to state hospitals, local emergency rooms or local jails (HMA, 2011). In effect, the public mental health system is a series of safety nets, with community-based, mental health services serving as the safety net, followed by state mental hospitals, then by services not intended for people with mental illnesses, but which are provided by entities that are forced to step into the breach: local EDs and local jails (HMA, 2011).

When this study began, the state of Louisiana had not expanded Medicaid under the ACA and many of those suffering from untreated mental illness and behavioral health issues in Louisiana were uninsured. In 2014, an estimated 1.9 million low-income uninsured people with a substance use disorder or a mental illness lived in states that had not yet expanded Medicaid under the ACA (Rief, et al, 2016). In addition, people with behavioral health needs (28%) make up a substantial share of all low-income uninsured individuals in these states (Rief, et al, 2016).

The research demonstrates that Medicaid access can improve access to treatment for people with behavioral health needs. Among low-income adults, Medicaid expansion is associated with a reduction in the unmet need for mental health and substance use disorder treatment (Rief, et al, 2016). Adjusting for differences in state programs, researchers found that among low income individuals with serious mental illness, the likelihood of mental health treatment was 30% greater for individuals enrolled in Medicaid (Rief, et al, 2016). This finding is consistent with historical research, indicating that the utilization of mental health services is responsive to prices which are generally lower with insurance, and those with coverage through Medicaid are far more likely to get treatment (Rief, et al, 2016).

In January of 2016, the Governor of Louisiana expanded Medicaid under the ACA. For those that qualify, Medicaid is the most important source of funding for mental health services. In 2008, 46% of state controlled funds for mental health services throughout the US came from Medicaid (NAMI, 2013). The ACA also contains many provisions aimed specifically at improving coverage for mental health services. Some of the most relevant services provided to mental health care patients are preventative services such as an alcohol misuse screening and counseling, and depression screening. (Golden L. & Vail R., 2014). Providing coverage for these screenings would give primary care providers an incentive to conduct them for the target population.

One of the most sweeping changes in the ACA is the expansion of the Mental Health Parity and Addiction Equity Act (MHPAEA), even for those receiving Medicaid, because it requires that coverage for mental illness be comparable to that for physical ailments (Golden L. & Vail R., 2014). The ACA applied MHPAEA to insurers in the individual market and

qualified health plans offered through the exchange or marketplace (Goodell, 2014). And, most importantly, the ACA defined coverage of mental health and substance use treatment as one of the ten essential health benefits (EHBs) (Goodell, 2014). As a result, all health insurance plans in the individual and small-employer markets must include coverage for treatment of mental health and substance use disorders (Goodell, 2014).

Additionally, the ACA created an option for states to establish Health Homes to better coordinate care for people with chronic conditions, such as serious mental illness. Health Homes are not physical structures, but are rather mechanisms for integrating primary and specialty care in a coordinated fashion for people with chronic mental illness (NAMI, 2013). States are afforded flexibility in how they design these systems and receive an enhanced 90% federal Medicaid match for the first two years of implementation. A number of states have implemented or are considering implementing Health Homes, with particular focus on serving individuals with serious mental illness (NAMI, 2013).

The analysis of the literature in all of the significant areas discussed in this chapter informed the theories and eventual framework for this community needs assessment. The cumulative effect of the research findings confirms the hypothesis that presenting to the ED in acute mental and behavioral health crisis can have a detrimental effect on an individual and is usually a greater signal that underlying mental health issues have not been appropriately addressed in the community. If a mental health crisis requires admission to the ED, improving the patient's outcomes and preventing the recurrence of such episodes will require an optimal mix of community-based services to address the patient's unmet needs.

Chapter 3: Data Collection, Analysis and Results

This section details how the data for the Community Needs Assessment was compiled and analyzed, as well as the theoretical framework used to guide this process. It focuses on the definition of mental health, the factors that contribute to the deterioration of mental health, and the social determinants of mental health framework, which explains how factors at multiple levels of the ecological model, particularly the community level, have an impact on individual mental health.

A. Theoretical Framework

1. Definition of mental health

A commonly used definition of mental health is "… a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2012). This definition makes it clear that mental or psychological well-being is influenced not only by individual characteristics or attributes, but also by socio-economic circumstances in which persons find themselves and the broader environment in which they live (WHO, 2012). Mental health is essential to a person's well-being, health, family, and interpersonal relationships, and the ability to live a full and productive life (ODPHP, 2016). People, including children and adolescents, with untreated mental health disorders are at high risk for many unhealthy and unsafe behaviors, including alcohol or drug abuse, violent or self-destructive behavior, and suicide, the eleventh leading cause of death in the U.S. for all age groups and the second leading cause of death among people ages 25 to 34 (ODPHP, 2016).

Mental health disorders also have a serious impact on physical health and are associated with the prevalence, progression, and outcome of some of today's most pressing chronic diseases, including diabetes, heart disease, and cancer. Mental health disorders can have harmful and long lasting psychosocial and economic effects on people living with the disorder, families, schools, workplaces, and communities (ODPHP, 2016).

2. Risk Factors

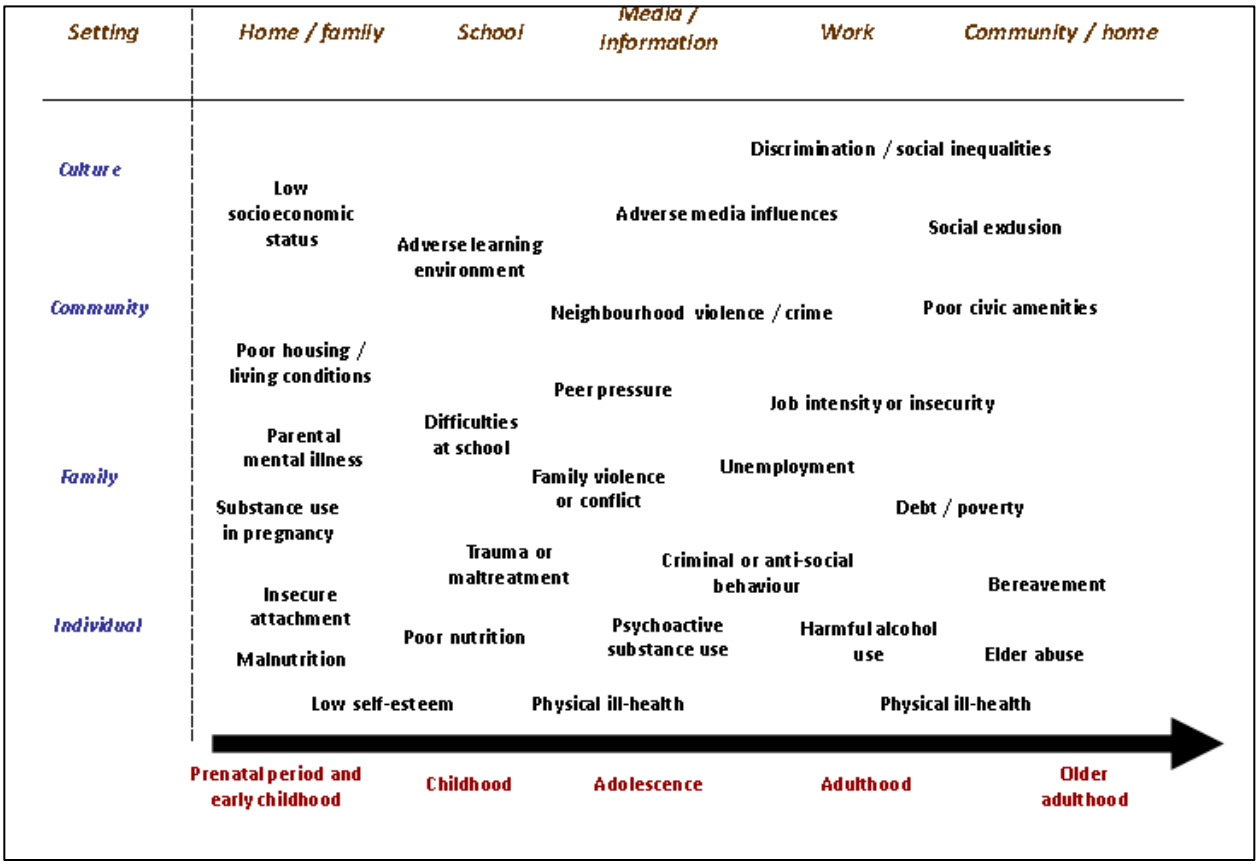
Factors such as interpersonal, family, community dynamics, housing quality, social support, employment opportunities, and work and school conditions can influence mental health (ODPHP, 2016). Several other risk factors have been linked to mental health such as race and ethnicity, gender, age, income level, education level, sexual orientation, and geographic location (ODPHP, 2016). A further critical way in which risks to mental health interact is over age and time. Risks to mental health manifest themselves at all stages in life. (WHO, 2012) Figure 5 shows a schematic overview of some of the significant individual, social, and environmental risks that may arise over the course of a lifetime to affect mental health (WHO, 2012).

3. Social Determinants of Mental Health

It is important to recognize that multiple factors affect mental health and that there is a dynamic relationship between people and the environments in which they live. Where and how people live, work, play, and learn are interconnected factors that affect not just physical health, but mental health as well (CDC, 2015). In order to improve mental health care, efforts need to focus not only on the behavior choices of each individual but also on factors that

influence those choices. The socio-ecological model helps to identify opportunities to promote mental health by recognizing the multiple factors that influence an individual's behavior (CDC, 2015). Efforts to change behavior are more likely to be successful when the multiple levels of influence are addressed at the same time (CDC, 2012). Health behaviors are thought to improve when environments and policies support healthy choices, and individuals are motivated and educated to make those choices.

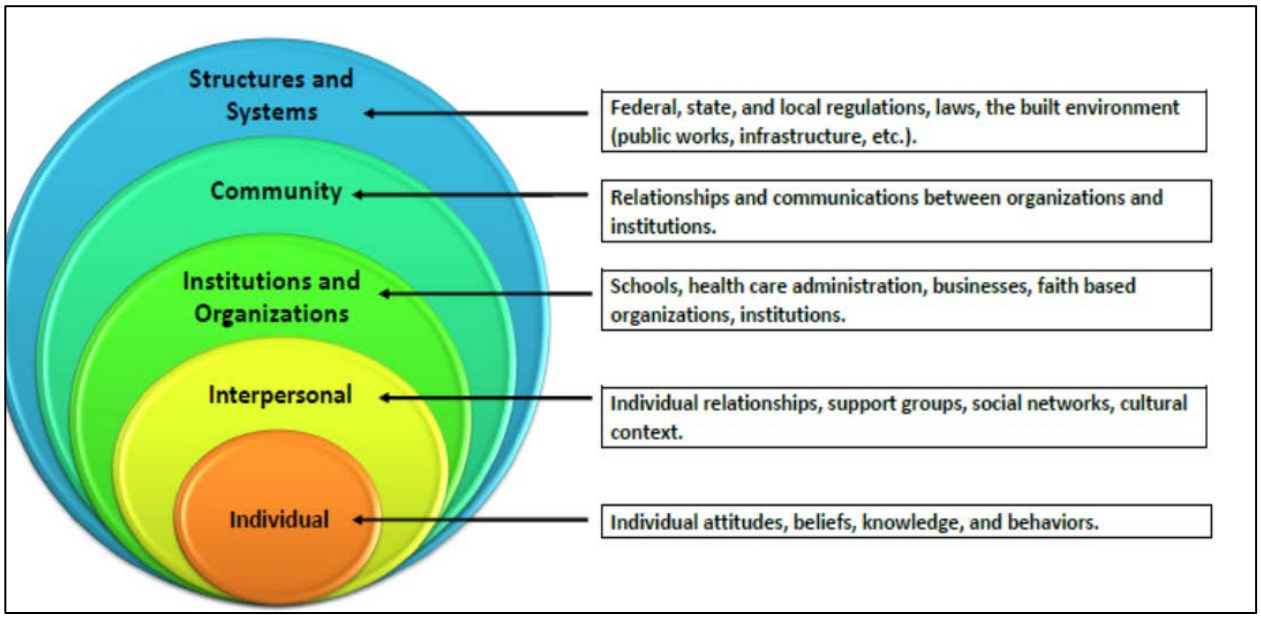
Figure 5: Schematic overview of risks to mental health over the life course (Adapted from: Foresight Project, 2008; Kieling et al, 2011; Fisher et al, 2011) (WHO, 2012)



The socio-ecological model, as shown in Figure 6, acknowledges that it takes a combination of both individual level and community level interventions to achieve changes in health behaviors (CDC, 2012). Social ecological analysis emphasizes the dynamic interplay between situational and personal, rather than focusing exclusively on environmental, biological

or behavioral determinants of well-being (Stokols, 1996). Ecological analyses integrate the

Figure 6: Diagram of the Socio-Ecological Model (CDC, 2015)



community-wide, preventative strategies of public health and epidemiology with the individual-level, therapeutic and curative strategies of medicine (Stokols, 1996). Educating people to make healthy choices when environments are not supportive will not be effective in making behavioral change. Similarly, treating individuals for the manifestations of mental illnesses and returning them to a community that does provide services and supports does nothing to improve long-term behavioral health.

A geographic area typically defines community, but they can also be defined by a set of shared interests or characteristics such as religion, race, age, or occupation. People within a community come from different backgrounds and have unique cultures, customs, and values. Utilizing this wide range of ideas and wisdom is critical to assessing the community needs and strategizing areas for improvement (CDC, 2012). For the purposes of this CNA, the community

is defined as Rapides Parish, located in central Louisiana, which includes, Alexandria, the most populous city in the area.

B. Data Collection and Results

This assessment utilizes a mixed-methods research approach, in which both quantitative and qualitative data were collected.

1. Quantitative Data

The law of Louisiana provides that any physician, psychiatric mental health nurse practitioner or psychologist may execute an emergency certificate, after examining a patient alleged to be mentally ill or suffering from a substance disorder (LA-R.S. 28:53, et seq). In order to issue the emergency certificate, the provider must determine that the patient is a danger to self or others or is considered gravely disabled (LA-R.S. 28:53, et. seq). The certificate lasts for a period of 72 hours and it is during this time that the patient is stabilized by the staff of the ED and an inpatient bed is located for the patient, if necessary, or the person is discharged to out-patient services or the patient is simply discharged to their home (LA-R.S. 28:53, et seq).

The ED does not maintain a computerized database of patient records for this population of patients, but does maintain a paper record that includes the mandatory Form OBH1. The Form OBH1 is a two-part, carbonless copy document sold to hospitals by the Office of Behavioral Health for a cost of $6.55 per pack of 50 that states the reason for certifying the patient and is signed by the physician. The carbon copy is maintained in the file and the original returned to the Louisiana Office of Behavioral Health (OBH). The documents related to the admission of the patient via PEC are separately maintained in a paper file by RRMC and are not

part of any other Electronic Health Record (EHR) maintained by the hospital on the patient. Consequently, much of what is known about PEC patients is anecdotal, thus it is difficult to evaluate patterns or trends. This is the first time that patient data has been collected and analyzed on this specific population using a computerized database.

The quantitative data includes the collection of secondary data from 197 records of patients admitted to the RRMC ED via PEC (Physician Emergency Certificate) from March 2014 to October 2014. From those records, the following information was collected:

- Unique Identifier Number (UIN)
- Date of Birth (DOB),
- Age,
- Gender,
- Race,
- Street Address,
- Parish, City, State, Zip Code,
- Admission Date
- Examination Date,
- ED Physician,
- Primary Care Physician (PCP),
- Insurance,
- Marital Status,
- Street Address,
- Reason for Visit,

- Diagnosis,
- PEC Reason,
- Alcohol Use,
- Drug use,
- History of Mental Illness,
- Suicidal,
- Homicidal,
- Violent, and
- Mental Condition.

Parameters for whether the patient was admitted to a long-term care facility (Admitted) and the facility the patient was admitted to (Facility) were collected for 108 of the patient records.[2] The data collected was then input into a Microsoft Excel Spreadsheet, and later uploaded into **Epi Info7**, a public domain, statistical software for epidemiology developed by CDC in Atlanta, Georgia. After data was entered into the database, Epi Info7 was used to statistically analyze patterns and frequencies of the subject population and to prepare tables and charts. Secondary research from existing population-based databases, such as the American Community Survey and the U.S. Census Bureau, was used for comparison to benchmark data at the state and national levels.

2. Qualitative Data

Qualitative data collected includes primary research gathered through several key

[2]Although the ED staff works very hard to get patients into a long-term care facility after the expiration of the 72 hour hold, the name of the facility was not routinely documented, and thus was not included in the first 87 records.

stakeholder and key informant interviews using an open-ended, semi-structured set of interview questions (Appendix 1). To this end, interviews were conducted with the Ms. Shawn Moreau, a Registered Nurse and the Director of the ED at RRMC, Ms. Lynne Bordelon, a Registered Nurse and ED Case Manager at RRMC, and Ms. Annette Beuchler MBA, FACHE, the Director of Programs and Communications at the Rapides Foundation, a health conversion foundation, via Zoom, a videoconferencing software. The interviews were recorded via Zoom and transcribed using T5 Transcription software and analyzed and coded using Atlas.ti software. Specifically, the qualitative data collection addressed issues regarding the current state of community-based mental health services in the area serviced by RRMC. The interview discussions explored participants' perceptions of the state of mental health services in Rapides Parish and central Louisiana, where patients go in the community to access mental health services, the barriers in the community accessing community services, and the populations affected by those barriers.

The collected qualitative information was coded using ATLAS.ti, qualitative data analysis software, and then analyzed thematically for main categories and sub-topics. Key themes emerged from each of the interviews. In the qualitative findings, the term 'participant' is used to refer to the individuals that were interviewed.

Chapter 4: Discussion

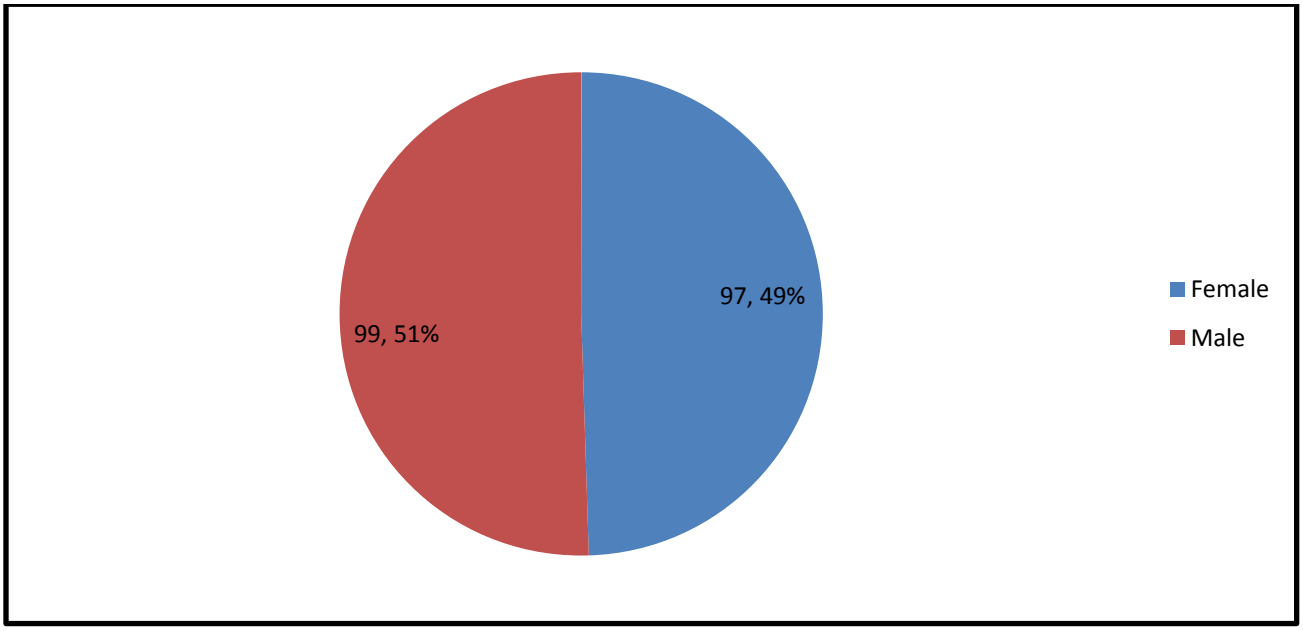
A. Quantitative Data

After conducting a retrospective cohort study of the records of patients, who presented to RRMC ED in mental and/or behavioral health crisis from March 2014 to October 2014, the

data was analyzed and the following findings were made:

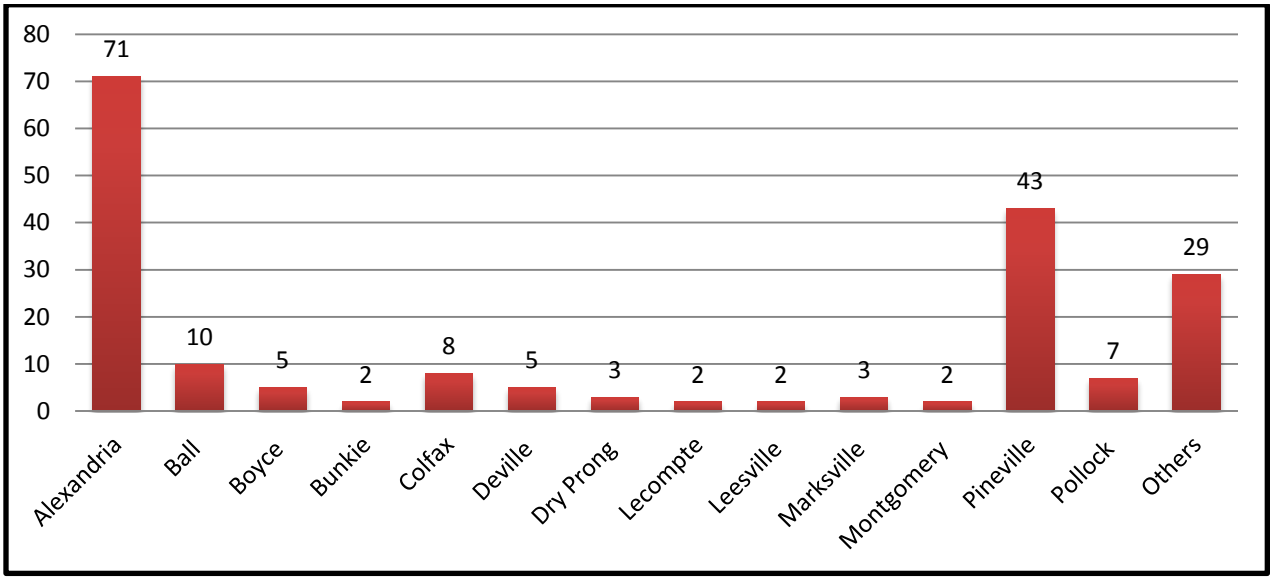
The patient population was evenly divided between female (51%) and male (49%). Over 50% of the patients were single or divorced. The racial makeup of the target population was Black (39%) and White (61%). These numbers approximately reflect both the gender and racial

Table 1: Target Population Breakdown by Gender



make-up of Rapides Parish. The largest percentage of the target population was domiciled in Rapides Parish (73%) and Grant Parish (10%), Louisiana. Patients primarily reside in the two largest cities in Rapides Parish, Alexandria (36%) and Pineville (21%).

Table 2: Target Population by City

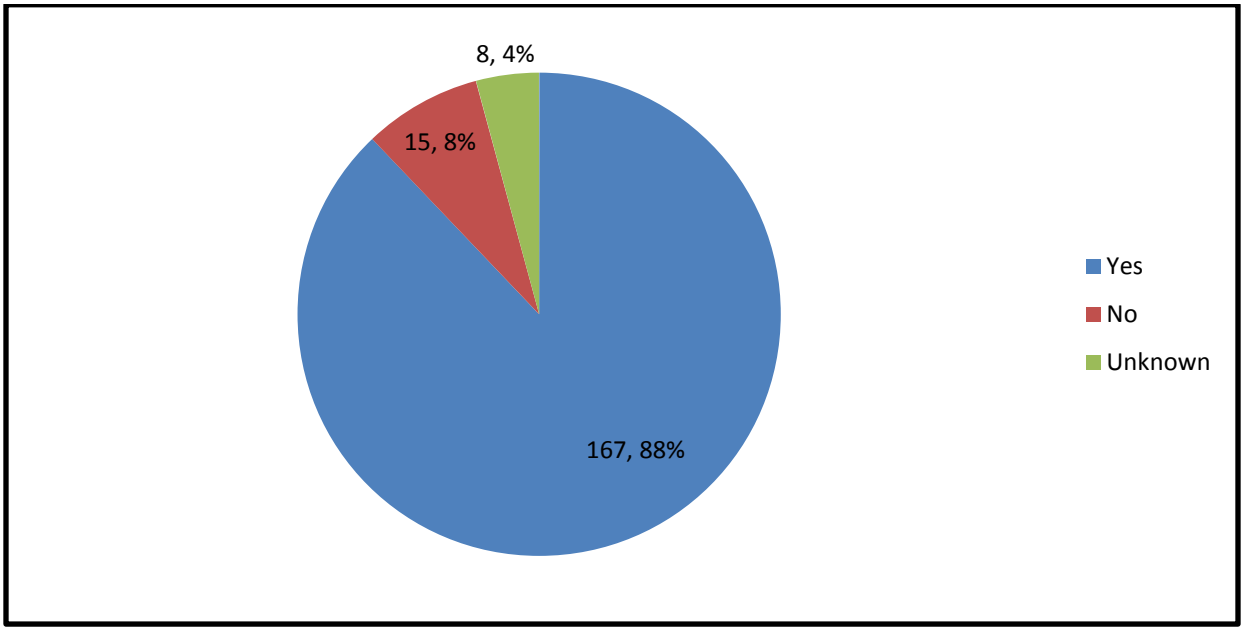


Forty-eight (48%) percent of the population analyzed had private insurance. Surprisingly, only 28% of the patient population was uninsured. Sixteen (16%) percent of the patient population had Medicare and 5% had Medicaid. Three (3%) percent of the patient population had VA benefits.

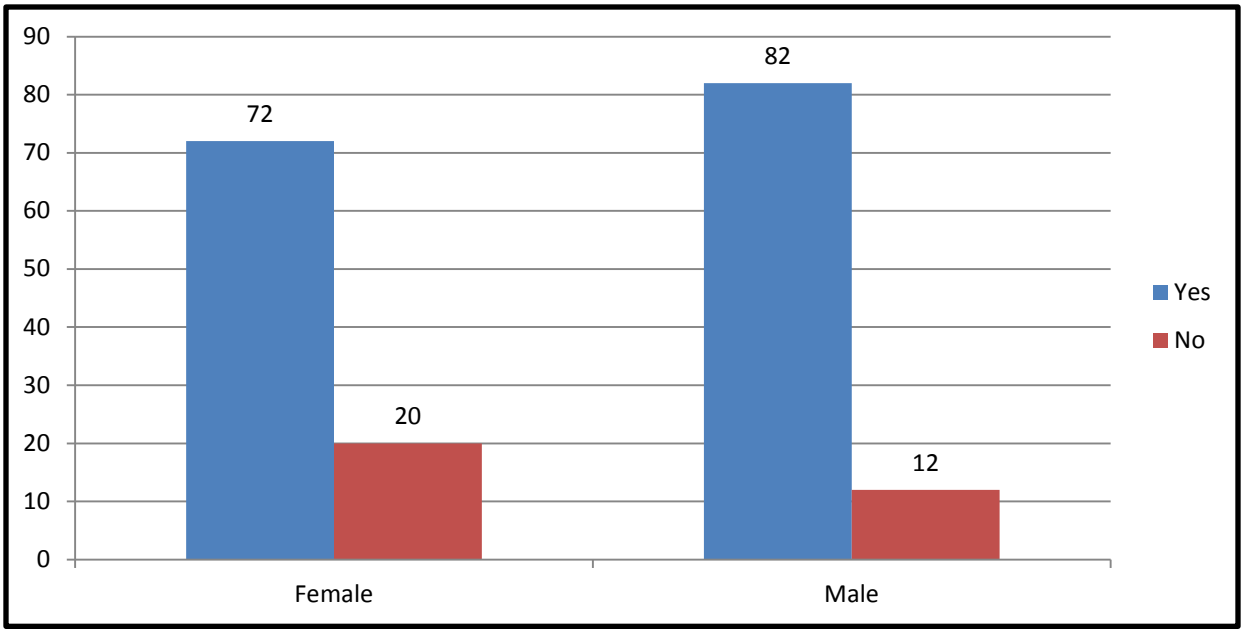
The median age of the patient population was 31. The oldest patient admitted was 75 and the youngest was 7. The mean age of the patient population at the time of admission to the ED was 23.

One of the most significant findings of the study was that the majority of the patient population studied did not have a primary care physician. Sixty-four (64%) percent of the target population reported not having a primary care physician.

Table 3: Target Population History of Mental Illness



Eighty-eight (88%) percent of the target population have a history of mental illness. A majority of the target population (81%) presented to the ED with some type of suicidal ideation.



Seventy-eight (78%) percent of female patients and eighty-seven (87%) percent of male patients were suicidal. Eight-seven (87%) of black patients within the target were suicidal, compared to seventy-four (74%) of white patients within the target population.

Of the target population, only fifteen (15%) percent were deemed homicidal at the time of admission to the ED. Twenty-three (23%) percent of the target population were determined to be violent at the time of admission.

Over sixty (60%) of the entire target population admitted to or tested positive for drug use. Of those that admitted to using drugs at the time of admission or tested positive for drugs at the time of admission, forty-four (44%) percent were women and fifty-six (56%) percent were men. Of those that admitted to drug use at the time of admission or tested positive for drugs at the time admission, forty-three (43%) percent were black and fifty-seven (57%) percent were white. Regarding alcohol use, only twenty-five (25%) percent of the target population admitted to or tested positive for alcohol use at the time of admission.

There are approximately twenty (20) different physicians on duty during the time period

in question. Of those twenty (20) physicians, four (4) physicians admitted forty-eight (48%) percent, or a majority, of the total target population.

Almost all of the patients that presented to the ED with mental or behavioral health problems were actually admitted via physician emergency certificate (93%). The primary reasons given by ED physicians for issuing the emergency certificate were that the patient was a danger to self (49%), a danger to others (32%), and gravely disabled (9%).

From March 2014 to October 2014, 14 people had visited the ED twice, 1 had visited the ED 3 times, and 1 patient had visited the ED 6 times. All of the visits were to address mental and behavioral health issues.

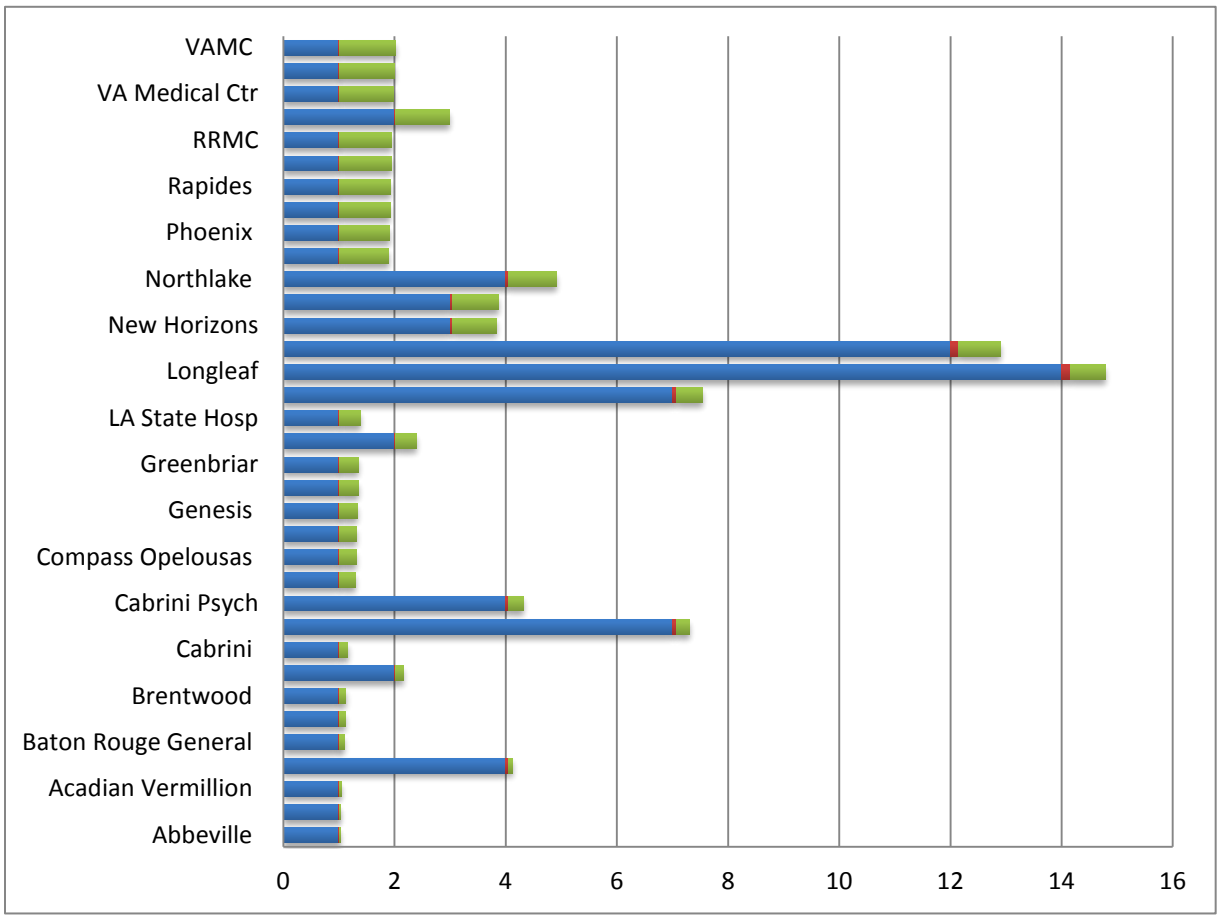
The data defeated several assumptions that hospital staff had about the target population. First, contrary to popular belief, a majority of the patients were insured. Moreover, a majority of those insured were covered by private insurance. However, even patients with health insurance did not have primary care physicians, which may explain why these patients' mental and/or behavioral health issues have gone untreated.

Next, a significant portion of the target population have co-occurring substance abuse concerns, as evidenced by the number of patients, who admitted to or were determined to have used alcohol or drugs. Thus, outpatient providers must be prepared to address co-occurring substance abuse problems.

Third, the racial demographics of the target population roughly reflect the racial makeup of Rapides Parish. Most of the patients are residents of Rapides Parish and live in the two largest cities in the parish, Alexandria and Pineville. This is significant because it indicates where outpatient services should be located in the community.

Finally, only 108 of the 197 patient records were analyzed to determine which in-patient facilities accepted the most patients from the ED. However, of that number, the data shows that the psychiatric unit at Christus St. Francis Cabrini Hospital and Longleaf Behavioral Health Center are the facilities that accepted the most patients from the ED at RRMC. This information helps the hospital staff to determine which in-patient facilities have the best track record of

Table 5: Target Population and In-Patient Facility



B. Qualitative Data

1. Key Informants

Key informant interviews were conducted with three individuals in Rapides Parish that

are very familiar with the target population and the community-based resources available to address their mental and behavioral health needs. Those interviewed include: Ms. Shawn Moreau, a Registered Nurse and the Director of the ED at RRMC, Ms. Lynne Bordelon, a Registered Nurse and ED Case Manager at RRMC, and Ms. Annette Beuchler MBA, FACHE, the Director of Programs and Communications at the Rapides Foundation. These individuals were chosen because of their familiarity with patient population and their familiarity with the landscape of mental health services in Rapides Parish.

As the Case Manager in the ED, Ms. Randall is responsible for assisting the patients that come into the ED in mental health crisis via PEC with finding placement after the expiration of the 72 hour hold and collecting the pencil and paper data that is completed by the ED staff at the time of admission. Ms. Moreau is the Director of the ED at RRMC and is responsible for the operation of the ED and the provision of emergency services. Annette Beuchler is the Director of Programs and Communications at the Rapides Foundation in Rapides Parish, Louisiana. Annette has worked extensively in this area reviewing grants and projects related to mental and behavioral health in central Louisiana.

2. Interview Themes

The interview discussions explored the informants' perceptions about the care of patients in mental health crisis in Rapides Parish, Louisiana. The themes that emerged included the following:

- The state that patients are in when they arrive in the ED,
- The lack of community services for indigent and Medicaid patients,
- Whether the closing of HPLMC increased the number of patients in mental health crisis

seeking care at RRMC, and

- The barriers to accessing community-based, mental health services in Rapides Parish.

a. The state that patients are in when they arrive in the ED

The informants agreed that many patients who arrive in the ED suffering from mental and/behavioral health issues are either brought in by families, the police, or come in voluntarily. Upon presenting to the ED, many of these patients are depressed, suicidal, psychotic, and many are also suffering from co-occurring substance abuse disorders. Many of these patients come to the RRMC ED because they are indigent and homeless and have no other place to go to get their medications. At least one informant acknowledged that some patients may be insured, but are not able to access mental health treatment through a primary care physician in the community because of the shortage of primary care physicians or the primary care physician's unwillingness to treat mental health disorders.

b. The lack of community services for indigent and Medicaid patients

> **"Basically, the biggest problem is [not] having outpatient services for them. Because some of these patients, even if they are [admitted via emergency certificate], and they go in-patient, they will still need the outpatient follow up. I think that's where we are falling off … in providing the follow up services that they need." -- Key Informant**

All of the participants overwhelmingly agreed that although there are a few community-based services for those in mental health crisis in Rapides, they are very limited, particularly for the indigent and those that receive Medicaid. At this time, there is only 1 community-based provider in Rapides Parish that accepts indigent and Medicaid patients, if openings are available. The only other publicly funded option for outpatient and inpatient mental health services in Rapides Parish was Central State Hospital, a state owned and operated mental

health facility. Unfortunately, that facility is now closed.

According to the participants, the greatest improvement that could be made to improve the care of the target population is to provide follow-up care through community-based, mental and behavioral health services for homeless, indigent, and Medicaid patients. If these services were provided, it is believed that the number of patients that utilize the ED for mental and behavioral health treatment would diminish significantly. Another suggestion for care of those patients that present to the ED in mental or behavioral health crisis include the creation of a crisis intervention center or crisis intervention mobile team.

One key informant explained that sometimes she is not sure if there is truly a lack of services in the area or if there is simply not a good system in place to assist people in finding the care or services that they need, especially for mental health. The provision of mental and behavioral health services in the state is seen as disjointed and limited by the lack of funding provided by the state. State legislation mandates that the administration of the Louisiana behavioral healthcare system, including community and residential services, should be operated by independent health care districts or authorities (also referred to as local governing entities or LGEs) (LSA-R.S. 28:22, et seq). However, these entities are poorly funded and offer little, if any, support to the individuals in the community that need them the most. For example, the legislature passed legislation in 2008 to create crisis identification and stabilization services, which would include a coordinated system of entry into the crisis system rather than use of ED services (LSA-R.S. 28:22, et seq). Although this was viewed as an excellent initiative by at least one key informant, the legislation has not been implemented by the Central Louisiana Human Services District, the local governing healthcare entity that

includes Rapides Parish, because of a lack of funding from the state (Torbett, 2014). All of the stakeholders agree that there are many people of good will in Rapides Parish, who recognize the lack of community services for those with mental and behavioral health issues, but admit that without funding it is impossible to achieve progress.

c. Whether the closing of HPLMC increased the number of patients in mental health crisis seeking care at RRMC

Both key stakeholders that work in the ED at RRMC agreed that after the closure of HPLMC, the number of indigent and Medicaid patients presenting to the ED at RRMC seeking treatment for mental and behavioral health issues increased. Although neither had any statistical data evidencing the increase, they both estimated based on their professional experience in the ED that the increase was by as much as 25%. Conversely, Ms. Beuchler, who also admittedly did not have any specific data, believes that when HPLMC first closed in 2013, there was an initial spike in patients presenting to the RRMC ED for all conditions, but that since that time, the number of patients has actually decreased because these patients are now receiving care at three outpatient clinics created after the closure of HPLMC. The opinions of both informants underscore the lack of accurate data and surveillance about the target population.

d. The barriers to accessing community-based, mental health services in Rapides Parish

The lack of community-based outpatient services is seen as the biggest barrier for many of the individuals in the target population. When asked who are the people most impacted by the lack of community-based mental and behavioral health services, one of the informants

interviewed stated:

> **"The uninsured are impacted, but the rest of the community is as well. Earlier we talked about crime. You've got people, who are doing something that looks like a criminal act, when really it is just a cry for help. In that regard, the larger community is affected as well." – Key Informant**

Transportation was also identified as another barrier to access in Rapides Parish. Although the Rapides Foundation has provided funding to Federally Qualified Health Centers (FQHCs) to integrate behavioral health into the primary care setting in Winn and Grant Parishes, both parishes are over 50 miles away from Rapides, creating an access problem for many who do not have transportation to reach these communities.

Another barrier to accessing community-based services is the unwillingness of many primary care physicians in the area to assess and treat mental health conditions. Increased educational opportunities are needed for primary care physicians, who still may not feel comfortable diagnosing a patient with depression or anxiety and providing medication management for these patients.

C. Limitations

There were some limitations related to the research methods that should be acknowledged. First, regarding the quantitative data analysis, the sample size is relatively small and the patient data is only captured for an eight-month window of time. Of course, as with quantitative data collections, there is missing or incomplete data. Patient data for this population is recorded using a paper and pencil method at the time of admission to the ED. Additionally, there are multiple individuals collecting and inputting data, which may result in missing or incomplete data.

Next, secondary data based on self-reports (e.g., 2012 and 2013 Community Health Needs Assessments for Rapides Parish) should be interpreted with particular caution. In some instances, respondents may over or underreport behaviors and illnesses based on fear of social stigma or misunderstanding the question asked. Respondents may be prone to recall bias. Additionally, public health surveillance data has its limitations regarding how the data was collected and reported, who is included in the public health datasets, and whether sample sizes for specific populations are large enough for analysis.

Finally, although the interviews conducted for this study provide valuable insights, the results are not statistically representative due to the small sample size. The individuals interviewed have a significant interest in mental and behavioral issues in central Louisiana. Because of this, it is possible that the responses received only provide one perspective on the issues discussed.

D. Recommendations

In Rapides Parish, the recurrent themes of lack of access to community-based resources and the primary care shortage only contribute to the continued overutilization of ED services for this population of patients. Based on the research and an analysis of the quantitative and qualitative data collected for the purposes of this community needs assessment, the following programs are recommended as national best practice models to assist patients in mental health crisis in Rapides Parish, Louisiana.

1. Assertive Community Treatment (ACT) Model

The first program recommended for implementation in Rapides Parish is the Assertive Community Treatment (ACT) model. ACT is a comprehensive community-based model for delivering treatment support, and rehabilitation services to individuals with severe mental illness (Phillips, et al, 2008). ACT is appropriate for individuals who experience the most intractable symptoms of severe mental illness and the greatest level of functional impairment (Phillips, et al, 2008). Those with severe mental illness are often heavy users of the ED and inpatient psychiatric services and they frequently have the poorest quality of life (Phillips, et al, 2008). ACT originated almost 30 years ago when a group of mental health professionals at Mendota Mental Health Institute in Wisconsin realized that patients were being discharged from the ED with a severe mental illness after stabilization only to return experiencing another mental health crisis after a relatively short period of time. These professionals, rather than accept the repeated hospitalization of these patients, formed a team to evaluate how mental health services were being delivered in the community and tried to determine what could be done to help persons with mental illness live more stable lives in the community (Phillips, et al, 2008). The coalition designed a service delivery model in which a team of professionals provides the specific mix of services needed by the patient for as long as those services are needed. The team ensures that services are delivered within 24 hours a day, seven days a week. The unique feature of ACT is that services are provided in the 'real life' setting and context in which problems arise and skills are needed (Phillips, et al, 2008). The team approach is facilitated by a daily review of each patient's status and joint planning of the team members' daily activities. The program can also be enhanced and adapted to meet the needs of the

Rapides Parish community (Phillips, et al., 2008). Research has shown that ACT is effective in reducing hospitalizations and is no more expensive than other types of traditional community-based care. Additionally, the rate of patient satisfaction is higher for patients and their families (Phillips, et al, 2008).

2. Crisis Intervention Team (CIT) Model

Very often, the people who come in contact with individuals in mental health crisis are members of law enforcement. Unfortunately, in Rapides Parish and in other parts of the country, a significant number of instances of police involvement with individuals in mental health crisis have resulted in injury or even death. The three largest law enforcement agencies in Rapides Parish have had several well reported cases of police encounters with individuals in mental health crisis, particularly since the closing of HPLMC. In a recent article in the *Town Talk*, a local newspaper in Alexandria, Louisiana, Chief of Police Loren Lampert, recalled a recent incident in early 2015 in which Alexandria police took a man into custody at a local hotel because staff said he had a gun and it was not the first time officers had encountered him. Officers disarmed the same man, who was in mental health crisis, a few days before at the same hotel (Gregory, 2015). However, this time the response included the department's Special Response Team because the unidentified man was apparently suicidal and armed with a long gun. Part of the hotel was cleared, as were surrounding areas, and traffic had to be diverted from nearby roadways (Gregory, 2015).

One program touted by SAMSHA and NAMI as a successful collaboration between law enforcement and the mental health community in responding to individuals in the community in mental health crisis is the Crisis Intervention Team (CIT) model (SAMSHA, 2009). This

intervention is considered a best practice model for the diversion of those offenders that are mentally ill out of the criminal justice system (NMHA, 2003). CIT is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. The CIT Model was first developed in the city of Memphis, Tennessee, and has spread to communities throughout the country (Cochran, Pillsbury, Saunders, & Dailey, 2007). Begun in 1988, the intervention is still known as the "Memphis Model." CIT provides law enforcement-based crisis intervention training to assist those individuals with a mental illness, and to improve the safety of patrol officers, consumers, family members, and citizens within the community (Cochran, et al, 2007).

Central to the formation and success of CIT is the role of the law enforcement community. Trained CIT officers are able to act in crisis situations using de-escalation techniques that improve the safety of the officer, consumer, and family members. In addition, the law enforcement community is able to provide care and help to consumers by transporting individuals in need of special treatment to appropriate facilities (Cochran, et al, 2007). It is also critical that all law enforcement officers in the community participate in the formation of CIT and engage in all elements of the planning and implementation stages (Cochran et al, 2007).

Additionally, participation from those in the advocacy community is essential. This partnership provides strong support from passionate and dedicated people whose goal is to improve the quality of life for individuals affected by a mental illness (Cochran, et al, 2007). Leadership roles should develop in the form of liaisons that help voice the support, ideas, and concerns of consumers and family members affected by mental illness. This aspect of CIT brings the program to life by adding insight from those directly affected (Cochran et al, 2007).

This important partnership should be established early in the planning process and should continue as an ongoing operational element of CIT.

The mental health community plays a critical role in the successful implementation, development, and ongoing sustainability of CIT. Mental health professionals provide the treatment, education, and training that result in a wide dissemination of knowledge and expertise to both individuals with a mental illness and patrol officers undergoing CIT training (Cochran, et al, 2007). These partnerships are essential to maintaining access to the health care system and quality treatment.

The use of CIT in Rapides Parish could result in the de-escalation of situations that are life-threatening for the officers and the individuals involved. Moreover, the partnerships developed between law enforcement officers and mental health professionals in the community may provide officers with treatment options for these individuals other than the ED or jail.

3. Integration of Behavioral Health into Primary Care

As demonstrated by the quantitative data analysis of patients admitted via PEC to the RRMC ED, a majority of the patients had private insurance, but did not have a primary care physician. Employers and public and private health insurance payers should work to encourage insureds to have a patient centered medical home (PCMH) by offering incentives for routine screening by crediting premiums and deductibles. These organizations should also work to remove payment barriers that impede the integration of primary and behavioral health care into one setting (Crowley & Kirschner, 2015).

Additionally, physicians also cite educational needs and a lack of training as obstacles to integrated care. The Integrated Behavioral Health Project under the California Mental Health Services Authority identified training gaps that need to be addressed to facilitate integration (Crowley & Kirschner, 2015). The top 3 training needs cited by physicians were "better understanding of the impact of physical disorders on mental health, addressing behavioral health components of physical disorders, and understanding and addressing the psychiatric effects of medications for physical conditions (Crowley & Kirschner, 2015). Cross discipline training is needed to prepare behavioral health workers and primary care physicians to effectively integrate their respective specialties into the primary care setting (Crowley & Kirschner, 2015). Primary care physicians in Rapides need to be trained to screen, manage, and treat common behavioral health conditions before they rise to a level that requires crisis intervention. The ACA established an initiative called the Primary Care Extension Program (PCEP) and authorized the Agency for Healthcare Research and Quality (AHRQ) to create a national model (Phillips, 2013). This section of the law states that the principal charge of the PCEP is to "assist primary care providers to implement a patient-centered medical home to improve the accessibility, quality, and efficiency of primary care services" through local deployment of community-based Health Extension Agents (Phillips, 2013). The PCEP builds upon the US Department of Agriculture's (USDA) highly effective Cooperative Extension model that uses County Extension Agents to educate farmers and by partnering with land-grant universities and local government. (Phillips, 2013). In addition to their practice facilitation roles, these 'health agents' may "collaborate with local health departments, community health centers, tribes and tribal entities, and other community agencies to identify community health

priorities and local health workforce needs, and participate in community-based efforts to address the social and primary determinants of health, strengthen the local primary care workforce, and eliminate health disparities" (Phillips, 2013). This concept is not new, and these local change-agents have previously been referred to as "practice coaches," "practice facilitators," or "practice enhancement assistants" (Phillips, 2013). Though no funding was allocated for a primary care extension program, AHRQ used existing appropriations to launch a pilot initiative in 2011 called Infrastructure for Maintaining Primary Care Transformation (IMPaCT) (Phillips, 2013). IMPaCT awards are supporting PCEPs in 4 states (New Mexico, Pennsylvania, Oklahoma, and North Carolina), each serving as a lead for disseminating PCEP activities to 3 additional neighboring states (Phillips, 2013). Resources and data have already been produced by these states for the benefit of primary care practitioners attempting to integrate behavioral health into their practices.

In addition to concepts such as PCEP, several general sources provide tools and resources to facilitate the introduction of behavioral health into the primary care setting, such as through the SAMSHA-HRSA Center for Integrated Health Solutions and the Services and Tools for Behavioral Health Integration section of the Patient-Centered Primary Care Collaborative website (Crowley & Kirschner, 2015). Primary care physicians in Rapides Parish should be encouraged to utilize these resources for information on how to integrate behavioral health into their practices by local hospitals, the state, the Central Louisiana Human Services Authority and their professional associations.

4. Peer Support Services

Another intervention that may be effective in addressing the shortage of mental health professionals in Rapides Parish and central Louisiana is peer support services. MHA has taken the position that peer support is an essential element of successful communities that effectively address mental and behavioral health issues (MHA, 2016). SAMSHA has identified peer support services as a vital component in recovery (MHA, 2016). Peer-run services are based on the principle that individuals who have shared similar experiences can help themselves and each other (MHA, 2016). Such programs provide an opportunity for communities of consumers who have significantly recovered from their illnesses to help others direct their own recoveries by teaching one another the skills necessary to lead meaningful lives in the community (MHA, 2016). Peer support programs have demonstrated effective outcomes such as reduced isolation and increased empathic responses (MHA, 2016). Research has shown that outcomes improve when consumers serve as peer specialists on case management teams. Peer support services present six advantages over traditional mental health and substance abuse services:

- A sense of gratitude that is manifested in compassion and commitment
- Insight into the experience of internalized stigma
- Peer specialists take away the 'you don't know what it's like excuse'
- Peer specialists have had the experience of moving from hopelessness to helplessness
- They are in a unique relationship of developing a relationship of hope with their peers
- They have developed the ability to manage their own mental and behavioral health illness holistically (MHA, 2016).

Medicaid is increasingly being viewed as a mechanism to fund peer support specialists along with clinical services for the more traditionally underserved. In order to receive reimbursement and to insure quality care for peer services there may be a certification process (MHA, 2016). The state of Georgia became one of the first states to pioneer the use of certified peer specialists in order to provide services to persons with serious and persistent disorders and made these services eligible for Medicaid funding (Sabin & Daniels, 2003). Training and support for individuals that meet the criteria for peer specialists could be one way to address the health care provider shortage in Rapides Parish and an opportunity for individuals in mental health crisis to find someone to help them maneuver through the complex mental health process.

5. Supportive Housing Services for the Homeless Population

All three of the key informants acknowledged that there is a growing homeless population in Rapides Parish and that many of the individuals who find themselves in the ED of RRMC in mental health crisis are homeless. The Central Louisiana Homeless Coalition is non-profit coalition of volunteers, who wanted to streamline the homelessness services in Central Louisiana and seek federal funding for homelessness programs (Central Louisiana Homeless Coalition, 2016). Founded in 1999, the Coalition's membership has evolved to include over 30 members including nonprofit service providers, local law enforcement agencies, faith-based organizations, and individuals who share the mission of ending homelessness in Central Louisiana (CLHC, 2016). According to the organization's website, although Rapides Parish may not have dozens of people lining the major roadways of the area, there is a homeless

population estimated to be about 40 unsheltered, chronically homeless people in Rapides Parish. Many of these individuals live in abandoned buildings and abandoned houses (CLHC, 2016). In addition, there are many families in the area, who are considered the "hidden homeless" (CLHC, 2016). Many of these people live in cars or move from one friend or family member's home every few days. In fact, the Rapides Parish School Board has identified over 300 homeless children and families each school year. Additionally, shelters across the region, serve over 400 people annually and there are over 100 people in shelters throughout the central Louisiana on any given night (CLHC, 2016).

Supportive housing has been endorsed by the federal government, including the Department of Housing and Urban Development, the Surgeon General, the Department of Health and Human Services, and the National Council on Disability (Bazelon Center, 2009). Three basic principles guide supportive housing. First, supportive housing gives participants immediate, permanent housing in their own apartments or homes (Bazelon Center, 2009). Second, individuals in supportive housing have access to a comprehensive array of services and supports, such as access to ACT teams that are interdisciplinary and mobile and can provide mental health and substance abuse treatment so that the individual is able to live successfully in the community (Bazelon Center, 2009). Supportive housing allows an individual to focus on housing first and then recovery (Bazelon Center, 2009). Third, supportive housing allows full integration of the mentally ill into the community through possibilities for employment and education. People recovering from mental illness cannot be expected to succeed without a safe, secure home (Bazelon Center, 2009).

Supportive housing is less costly than other forms of government-financed housing for people with disabilities. Even for patients with the greatest challenges, quality supportive housing, including necessary community treatment and supportive services, compares favorably with the cost of traditional mental health housing and services (Bazelon Center, 2009). Supportive housing also costs far less than other places where people with mental illness end up. According to a survey of costs in several states conducted by the Bazelon Center for Mental Health Law, the cost of serving a person in supportive housing is half the cost of a shelter, a quarter of the cost of being in prison, and a tenth of the cost of a state psychiatric hospital bed (Bazelon Center, 2009). Moreover, most the cost of supportive housing can be funded through existing programs, including Medicaid, federal housing, and rental assistance programs (Culhane, Metraux, & Hadley, 2001).

6. Expansion of Medicaid for ACA

Louisiana became the 31st state in the United States to expand Medicaid after the swearing-in of Governor John Bel Edwards in January of 2016 (Litten, 2016a). Former Governor Bobby Jindal refused to expand Medicaid in Louisiana because of his vehement opposition to the ACA, although, at last estimate, almost 450,000 of the working poor in Louisiana were caught in what is referred to as 'the Medicaid gap,' and left without coverage[3] (Litten, 2016b). With his executive order expanding Medicaid coverage, Governor Bel Edwards made Louisiana the first state in the Deep South to accept Medicaid funding to care for those caught in the gap of coverage (Litten, 2016a). Beginning July 1, 2016, when Medicaid expansion is expected to

[3] In states that have not adopted the **Medicaid** expansion, many poor adults with incomes below the federal poverty level fall into a coverage **gap** because they remain ineligible for **Medicaid,** but earn too little to qualify for premium tax credits for Marketplace. (The Kaiser Family Foundation, 2013)

take effect, Louisiana will be closely watched and evaluated because the state has some of the poorest health outcomes in the country, particularly for those suffering from mental illness.

It is estimated that the percentage of uninsured adults in Louisiana aged 18-64 who had any mental illness or substance use disorder in the past year during the period of 2010-2014 was 28.8% (Rief, et al, 2016).

Table 6: Share of adults in non-expansion states aged 18-64 who had AMI or SU in the past year, 2010 2014 (Rief, et al, 2016)

Table 1. Share of adults in non-expansion states aged 18-64 who had any mental illness (AMI) or substance use disorder (SUD) in the past year, 2010-2014

States	Share with AMI and SUD		
	Full Population	Uninsured Population	Uninsured Population with Income Below 138% FPL
Alabama	25.7	34.0	30.3
Florida	23.7	25.8	27.7
Georgia	23.3	25.1	25.0
Idaho	31.1	36.6	39.0
Kansas	25.5	30.3	31.3
Louisiana**	25.2	28.8	29.5
Maine	26.8	30.1	*
Mississippi	26	30.9	33.8
Missouri	26.6	31.2	34.2
Nebraska	26.2	30.3	31.3
North Carolina	22.6	22.3	26.7
Oklahoma	28.9	29.0	33.2
South Carolina	25.7	30.4	32.4
South Dakota	25.5	28.3	*
Tennessee	28	38.8	35.8
Texas	23.4	24.9	23.2
Utah	28	33.6	40.0
Virginia	25.8	31.9	34.8
Wisconsin	26.1	32.4	*
Wyoming	27.3	33.2	30.2
Total	**24.9**	**27.8**	**28.4**

Source: SAMHSA analysis of 2010-2014 National Survey on Drug Use and Health

Notes: These estimates do not include the institutional population (e.g., hospitals and prisons), and may therefore be low.

* Value suppressed due to low precision.

** Louisiana plans to expand its Medicaid program starting July 1, 2016.

In Louisiana, it is estimated that 176,000 adults aged 18-64 with a mental illness or substance use disorder in the past year in 2014 were uninsured (Rief, et al, 2016).

Table 7: Estimated number of adults in non-expansion states aged 18064 who had AMI or SUD in the past year, 2014 (Rief, et al, 2016)

Table 2. Estimated number of adults in non-expansion states aged 18-64 who had any mental illness (AMI) or substance use disorder (SUD) in the past year, 2014

States	Full Population	Uninsured Population	Uninsured Population with Income Below 138% FPL
Alabama	754,000	181,000	85,000
Florida	2,800,000	726,000	309,000
Georgia	1,445,000	343,000	159,000
Idaho	296,000	67,000	30,000
Kansas	440,000	76,000	34,000
Louisiana**	712,000	176,000	81,000
Maine	221,000	35,000	*
Mississippi	463,000	118,000	61,000
Missouri	976,000	184,000	91,000
Nebraska	295,000	47,000	21,000
North Carolina	1,366,000	256,000	144,000
Oklahoma	666,000	145,000	71,000
South Carolina	748,000	176,000	87,000
South Dakota	128,000	20,000	*
Tennessee	1,120,000	270,000	114,000
Texas	3,830,000	1,047,000	406,000
Utah	482,000	94,000	42,000
Virginia	1,323,000	244,000	102,000
Wisconsin	924,000	116,000	*
Wyoming	98,000	20,000	6,000
Total	**19,107,000**	**4,352,000**	**1,908,000**

Source: SAMHSA analysis of 2010-2014 National Survey on Drug Use and Health; 2014 American Community Survey; ASPE calculations.
Notes: These estimates do not include the institutional population (e.g., hospitals and prisons), and may therefore be low.
* Value suppressed due to low precision.
** Louisiana plans to expand its Medicaid program starting July 1, 2016.

In its report, "*Medicaid Expansion and Mental Health Care*," NAMI estimates that in Louisiana, the fiscal impact of Medicaid expansion from 2013 to 2022 would be an increase of $15,786,000 and an increase of $267,000,000 in uncompensated care savings for the state (NAMI, 2013). Such a fiscal impact to the state leaves mental health advocates hopeful that the

uninsured will be provided with the opportunity to receive community-based mental health treatment in Rapides Parish.

The implications of expanding Medicaid for the uninsured suffering from serious mental illness in central Louisiana and Rapides Parish are significant. Medicaid expansion will offer Louisiana the opportunity to cover a significant portion of individuals experiencing homelessness. It should be acknowledged that expanding Medicaid in Louisiana, particularly for those living with serious mental illness, will be a formidable challenge because the populations that are traditionally hard to reach will be the target populations that are homeless, hospitalized, incarcerated or otherwise limited to access to information and services (NAMI, 2013). Louisiana and Rapides Parish must begin immediately to devise strategies to enroll hard to reach individuals living with mental illness in Medicaid expansion plans. The Centers for Medicare and Medicaid Services (CMS) recently announced the availability of $56 million dollars to support navigators to help provide information to health care consumers about options through the state health insurance marketplace and Medicaid (NAMI, 2013). In Louisiana, CMS should be urged by mental health advocates to award contracts to advocacy organizations, such as the Central Louisiana Homeless Coalition, to conduct education, outreach, and enrollment of hard to reach populations with serious mental illness, including those who are in hospitals, homeless, or involved with the criminal justice system (NAMI, 2013).

7. Creation of Advocacy Group

The primary goal of public health is the protection and promotion of the public's health. Typically, research, surveillance, policies, and programs in public health are focused on the

patterns and factors associated with understanding and improving the health of target populations. These factors go beyond health care to include social, economic, political, and physical environmental conditions which affect people's health (Kieffer & Reischmann, 2004). Historically, many public health interventions required little inherent necessity for community building and capacity, such as the development of water and sanitation or addressing outbreaks of immunization-preventable diseases (Kieffer & Reischmann, 2004). Mass media and the formal public health system were sufficient to address these health problems. However, many of today's problems, particularly those causing large health disparities in marginalized communities, have complex causation and require similarly complex and long-term interventions (Kieffer & Reischmann, 2004).

The lack of a community advocacy organization to organize and mobilize the community around the creation and expansion of community-based resources for individuals in mental and behavioral health crisis in Rapides Parish is one of the most critical missing pieces. To address this public health problem, many of the community health interventions discussed must include a strategy that also focuses on building a coalition of public health practitioners, community leaders, mental health advocates, and volunteers.

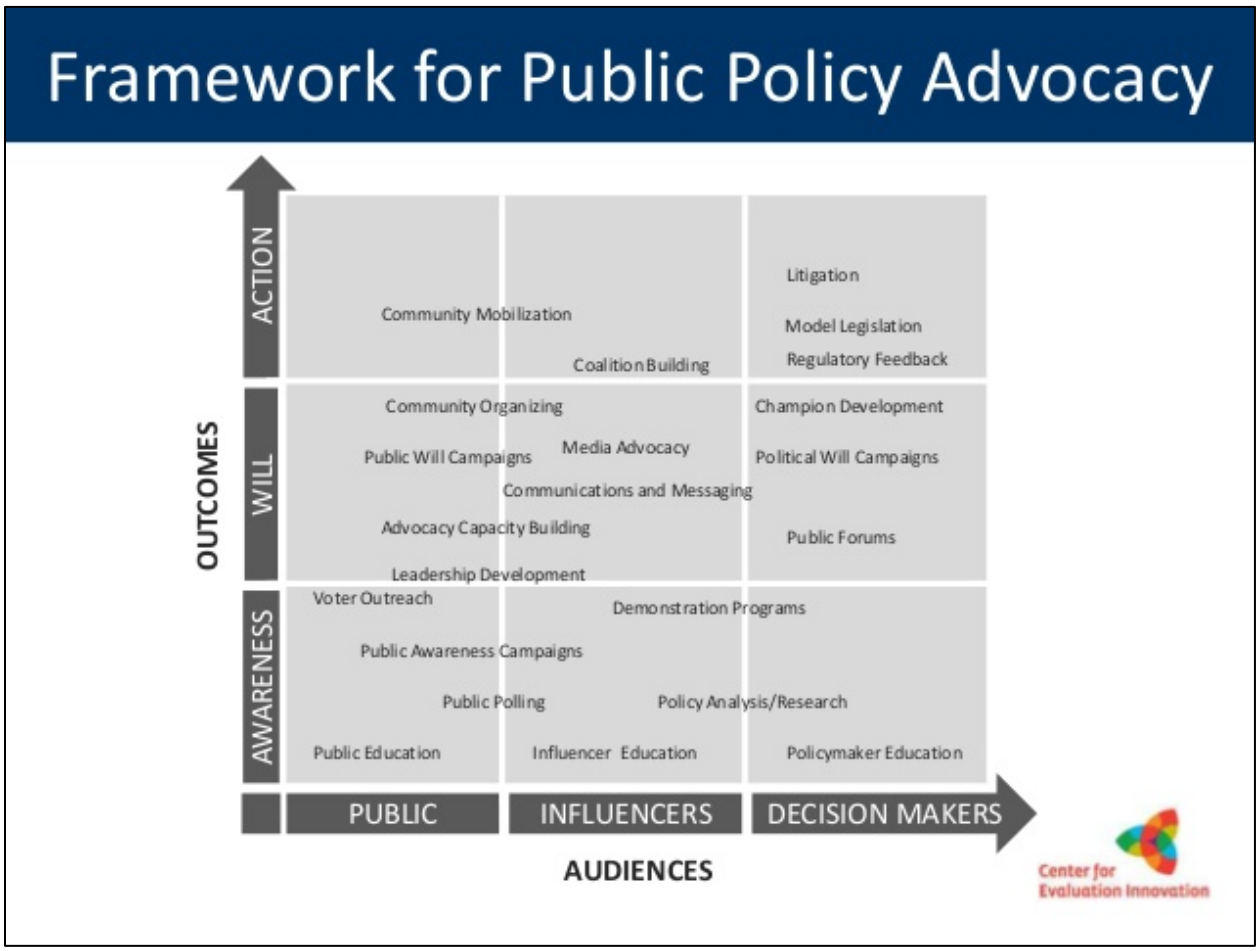
Improving public health often involves policy changes that are the result of complex advocacy efforts (Tabak, Eyler, Dodson, & Brownson, 2014). However, as public health practitioners, little emphasis is placed on the critical role of advocacy in translating research and evidence into policy, practice, and change in public opinion (Chapman, 2001). Everyone involved in public health, social services and direct health care in central Louisiana understands the problem, but little has been done to mobilize the community-at-large to create change.

In Rapides Parish, the approach to crisis services must be forward-looking rather than merely reactive, with success seen as the ability of the population served to return to a stable life in the community. Rather than simply trying to increase the number of beds available for an individual in mental health crisis, the goal must be preventative care and a reduction in the number of crises that occur among people with mental illnesses, and thus a reduction in the need for emergency services. The basic premise of community organizing is that people can change their own environment more effectively by working together, rather than alone (Gomm, et al, 2006). Since reform typically involves changing the status quo with opposition coming from all sides, solid public support is essential for change to occur (Gomm et al, 2006).

There are examples of community organizing and advocacy around issues of mental health crisis in other jurisdictions that can be used as models for Rapides Parish. For example, the National Alliance of Mental Illness (NAMI) of Greater Houston was established in 1988 by a group of family members who were desperate to find adequate and appropriate treatment for their loved ones, who had been diagnosed with a mental illness. By joining together, these parents believed that they could advocate for improved services for persons living in the Greater Houston region (NAMI Greater Houston, 2016). The mission of NAMI Greater Houston is to improve the lives of all persons affected by mental illness through support, education and advocacy (NAMI Greater Houston, 2016). With a growing membership of people in recovery, family members, friends and professionals, NAMI Greater Houston works diligently to improve the quality of life for children, adults and families who are living with a mental illness through the offering of free educational classes, peer-facilitated support groups and grassroots advocacy initiatives (NAMI Greater Houston, 2016).

Creation of an advocacy group in Rapides Parish and central Louisiana will require that several important steps take place. First, a community trigger must be identified. A community trigger is an internal recognition of a threat or problem that is devastating to individuals or families (Kieffer & Reischmann, 2004). An important community trigger could be the increasing necessity of law enforcement personnel to respond to individuals in mental health crisis. Or there may be an external motivation identified, which could include the availability of funding from the state's expansion of Medicaid, to support a community planning process or provide technical assistance to address the public health issues of the mentally ill in crisis (Kieffer & Reischmann, 2004).

Figure 7: The Advocacy Strategy Framework – The framework can be used to illustrate any advocacy strategy. It is organized around two main dimensions of an advocacy strategy: the audiences targeted (x-axis) and the changes desired (y-axis) with those audiences. (Coffman & Beer, 2015)



Next, those organizations or individuals, who will be involved in planning and implementing the goals of the coalition, must be identified (Perumal, 1999). During the CHNA conducted in the service area of RRMC in 2013, the key informants and focus groups identified mental health issues as one of the top four priorities in the region (PRC, 2013). Issues regarding mental health and co-occurring substance abuse arose many times in the discussions and interviews, as well as concerns about the lack of community-based services and the inappropriate use of emergency services to treat mentally ill patients (PRC, 2013). Key

informants and focus groups in the service area included: representatives from public health, individuals who work with low-income, minority or other medically underserved populations, physicians, other health professionals, social service providers, and other community leaders. Participants in the CHNA process were chosen because of their ability to identify the primary concerns of the populations with whom they work, as well as the community overall (PRC, 2012b). This group is the perfect starting place for building a coalition of advocates and volunteers to work collaboratively on resolving these issues.

Next, data concerning the needs of the community must be collected (Perumal, 1999). Third, after a basic sense of the community needs and the coalition priorities are established, the core planning group must be determined and composed of a handful of interested members who are willing to make a commitment to the coalition (Perumal, 1999). This group must guide the actions of the coalition until a formal leader or board is chosen. Their main responsibilities are to assist in the processes of community analysis and priority setting. The core-planning group should also decide upon a mission statement, as well as the development of some short-term and long-term goals (Perumal, 1999).

Once the coalition is organized, it must begin the process of mobilizing the community around the issue. Community mobilization is the process of engaging all sectors of a given population in the effort to address an issue of concern. Mobilizing the community is a central part of almost any campaign because of the importance of getting community support. Creating a public information campaign around the lack of community-based services for those in mental health crisis in Rapides Parish and central Louisiana may include:

- Meeting with leaders at all level (including the hospital leadership, law enforcement leaders, and judges)
- Building a network or coalition of groups, such as the Central Louisiana Human Services District, the Central Louisiana Homeless Coalition, and area churches
- Conducting a media campaign through public presentations
- Conducting and disseminating research, surveys or opinion polls that support the position to create more services
- Developing community materials to share the message (e.g., policy briefs, website, print materials, public presentations, etc.)
- Holding a major event that raises awareness about these issues (CPHA, 2016).

"Community organization is a planned process to activate a community to use its own social structures and any available resources (internal or external) to accomplish community goals, decided primarily by community representatives and consistent with local values. Purposive social change interventions are organized by individuals, groups or organizations within the community to attain and then sustain community improvements and/or new opportunities" (Perumal, 1999).

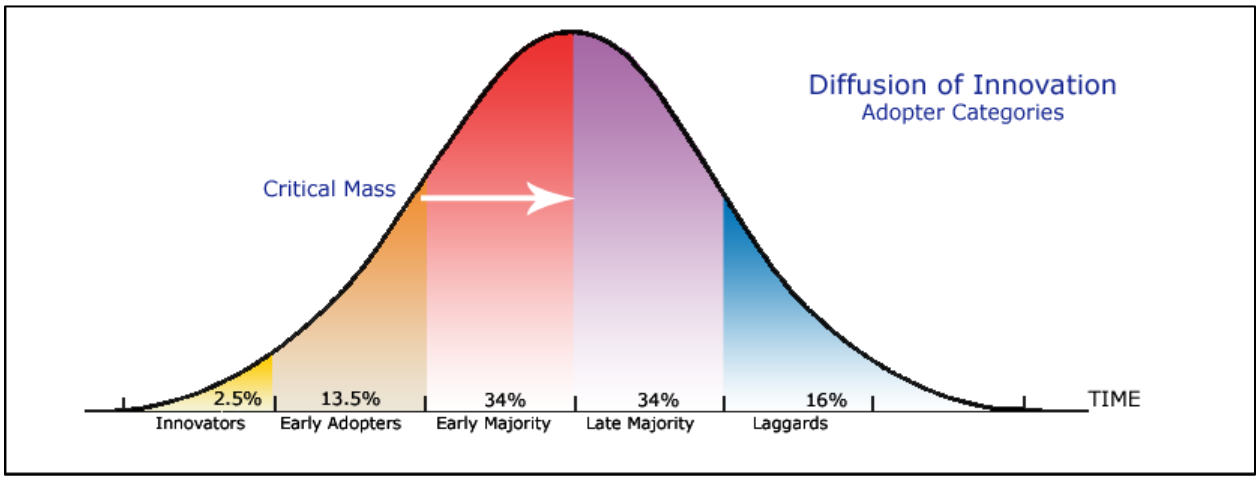
E. Questions That Remain After Data Collection

There are several questions that remain after the collection of quantitative and qualitative data for the purposes of this CNA. First, it is essential that RRMC continue to maintain a computerized database of data for this population of patients that present to the ER in mental health crisis in order to continue to evaluate trends and patterns that evolve. The

current method of maintaining a paper file is outdated and lends itself to inconsistencies and biases. A computerized database should be created that includes the template data from the Form OBH1.

Next, with the expansion of Medicaid in Louisiana under the ACA, hopefully, there will be greater dialogue in the state and the region about the necessity of evidence-based, community services to treat patients in mental health crisis. But, even with Medicaid expansion, one of the most critical missing pieces in central Louisiana and Rapides Parish is the formation of a coalition of community advocates to insure that these services are available to those receiving Medicaid. This work will require a 'public health champion' or 'public health opinion leader,' who is charismatic and can successfully promote the evidenced-based, public health practices discussed here. This model of advocacy is closely associated with the 'diffusion of innovations' model that theorizes how innovative individuals spread new technologies or ideas through social systems (FHI 360, 2010a).

Figure: 8 Diffusion of Innovation Adopter Categories



Most often, a public health champion is an influential leader, health care provider, or other authority figure, who uses his or her expertise and professional contacts to facilitate the application of a new research finding or other innovation into a policy or program, illustrated in Figure 8 (FHI 360, 2010b). Diffusion of innovation is a social process that depends on new ideas being communicated from an individual who is vested in the innovation to others that may be less informed, but want to impact change (FHI 360, 2010b). Creating and facilitating a coalition around these issues in central Louisiana will require a significant amount time, advocacy, and educational effort from the champion, but without this important community leader, obstacles will remain and progress in this area will remain stagnant or incremental at best.

Finally, there is a concern about what the next concrete steps will be from community leaders regarding the lack of community-based services for patients in mental health crisis in Rapides Parish. There does not seem to be a plan to address the lack of community-based services in central Louisiana and Rapides Parish. The responses, if there is any response at all on these issues, seem to be more reactive than proactive and the community seems to be on the verge of an officer-involved shooting or fatality during the arrest or detention of an individual in mental health crisis. In the words of Loren Lampert, the Alexandria Chief of Police, after a recent police encounter with an individual in mental health crisis:

> "The public and emergency personnel often encounter persons in apparent mental health crisis of varying degrees. Although we do have a number of officers certified in Crisis Intervention — we are not mental health professionals. We do the best we can to assist these people and protect the public — at times having violent encounters with the individuals ourselves. There is a paucity of services available, and they seem to be declining regularly. In short, the problem seems to be increasing, while the available resources seem to be decreasing. We are truly thankful for the services provided by local hospitals, agencies, and

volunteers. Often times, [however], this is just not enough to accommodate the problem" (Gregory, 2015).

Chapter 5: Front Page of Journal Article (Appendix 2)

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Appendix 1: Key Stakeholder Interview Questions

My name is Daphne Robinson and I am conducting a community needs assessment in Rapides Parish, Louisiana, about the available resources in the community for the treatment of individuals in mental and/or behavioral health crisis. My assessment includes getting input from key stakeholders in the community, which is why I am conducting this interview with you. Your input will be used to inform the community needs assessment and hopefully, any future action regarding my recommendations.

- Can you describe the state that individuals are in when they present to the Emergency Department (ED) of Rapides Regional Medical Center in mental and/or behavioral health crisis?
- Based on your experience and work in this field, what do you see as the status of community based services in central Louisiana?
- Where do members of the community go to access mental and behavioral health services when they are in mental health crisis?
- What are some of the barriers to accessing mental and behavioral health services in the community?
- Because of this lack of services in the community, who are the people most impacted?
- Do you believe the number of individuals presenting to the Rapides Regional Medical Center (RRMC) Emergency Department (ED) increased as a result of the closing of Huey P. Long Medical Center (HPLMC)?
- What areas of the mental health system do you believe need the most improvement for the population of patients in mental health crisis?
- In your opinion, what kinds of services should be offered to patients in mental health crisis in the community?

Appendix 2: Journal Article

A Needs Assessment and Program Intervention for Patients in Mental Health Crisis in Lieu of Admission to the Emergency Department of Rapides Regional Medical Center, Rapides Parish, Louisiana

Daphne R. Robinson, JD, MPH Candidate (May, 2016)
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Rollins School of Public Health
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Problem Statement

In 2013, the Louisiana State University Board of Supervisors approved a plan to close Huey P. Long Medical Center (HPLMC) in Rapides Parish, Louisiana, one of the ten public hospitals in Louisiana created to provide care to the indigent since 1936 (Becker's Hospital Review 2013). In 2012, Congress reduced Medicaid spending in Louisiana by $523 million dollars (Public Affairs Research Council, 2013). In response, the state of Louisiana chose to apply $329 million dollars in spending cuts to the Louisiana public hospital system forcing the closure of HPLMC in Rapides Parish, Louisiana, as a public hospital, and the creation of a public private partnership between the state of Louisiana and two private hospitals, Rapides Regional Medical Center (RRMC) and Christus St. Frances Cabrini Hospital (Cabrini), to provide a system of safety net services for the poor and uninsured (PAR, 2013). RRMC and Cabrini agreed to take on direct inpatient and emergency care loads from HPLMC (BHR, 2013).

Many individuals with mental illness or substance abuse disorders in the area served by HPLMC often sought non-emergency primary care services in the Emergency Department (ED) of HPLMC because they did not have private insurance or Medicaid and could not afford to pay for services (Hood, 2009). Serious mental illnesses include: major depression, schizophrenia, and bipolar disorder, and other mental disorders that cause serious impairment (Pearson, Janz, & Ali, 2013). Additionally, many individuals in the area served by HPLMC have co-occurring substance abuse disorders (Pearson et al., 2013).

After the closure of HPLMC and the reduction in community-based mental health services, hospital leadership at RRMC became concerned that the number of patients admitted via physician emergency certificate (PEC) in mental health crisis would increase, thereby reducing the quality of services provided to those patients and others in the ED. In Louisiana, any physician, psychiatric mental health nurse practitioner or psychologist may execute an emergency certificate, after an actual examination of a person alleged to be mentally ill or suffering from a substance abuse disorder. The person must be deemed in need of immediate care and treatment in a treatment facility, by an examining physician, psychiatric mental health nurse practitioner or psychologist, who determines the person to be dangerous to self or others or to be gravely disabled (La. R.S. 28:53, et seq). The certificate shall last for a period of seventy-two (72) hours (La. R.S. 28:53, et seq). After the emergency certificate is issued, the patient may be admitted and detained at a treatment facility for observation for a period not to exceed fifteen (15) days. The patient can be held for an additional fifteen-day period, only if a second emergency certificate is executed (La. R.S. 28:53, et. seq).