Initiative to Decriminalize Mental Illness

Recommendations for A Treatment Center and Continuum of Care

Prepared by Health Management Associates



Baton Rouge Area Foundation

HMA

HEALTH MANAGEMENT ASSOCIATES

INITIATIVE TO DECRIMINALIZE MENTAL ILLNESS

PREPARED FOR BATON ROUGE AREA FOUNDATION

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PREFACE

Earlier this year a bond proposal before the East Baton Rouge Metro Council included funding that would support a crisis and jail diversion center. While the Council supported the idea in principle, the proposal did not pass because of a lack of detailed plans. In response, in early 2015, Baton Rouge Area Foundation (the Foundation) convened a Clinical Design Committee of local behavioral health experts, law enforcement officials, and other community leaders to develop a model for a crisis care continuum that would include treatment programs to fit Baton Rouge's needs and utilize existing resources to the extent possible. In addition, Health Management Associates (HMA) was engaged in late summer of 2015 by the Foundation to assist with an assessment of current behavioral health resources, the development of a continuum of crisis services that will help divert people with mental health and substance abuse issues from entering the jail and criminal justice system, and the creation of a business plan for the proposed diversion programs.

HMA was asked, taking into account the model proposed by the Clinical Design Committee, to assess and recommend a comprehensive model of care for individuals in East Baton Rouge (EBR) Parish with behavioral health and substance use needs who, under the current system in place in EBR, may otherwise end up behind bars. HMA's scope of work included an analysis of the operations and business plan components, as well as steps necessary to achieve implementation.[1] More specifically, the Foundation engaged HMA to complete the following scope of work:

1. Complete a community assessment to inventory existing resources and a gap analysis to better understand what services will be necessary to support diversion from the criminal justice system.
    a. Assess access to and capacity of the current mental health and substance abuse programs available to people who enter the criminal justice system.
2. Recommend a model of care in the context of the community assessment and gap analysis and provide a recommended scope of services to be included in the proposed crisis care and diversion center (working name, "the BRidge Center"), which may include sobering and detox services, acute psychiatric services, a peer respite center, and care liaisons.
    a. Identify opportunities to utilize existing resources.
    b. Determine proposed staffing models.
3. Draft a timeline for development of the model of care and prioritize implementation of specific components based on available and needed resources.
    a. Assess and recommend organizational structure of the BRidge Center.
    b. Recommend service provider participation, including leadership of diversion components and service partners.

[1] The information contained in this report was finalized in January 2016. Therefore, no changes or updates occurring after January 2016 have been incorporated. Engagement estimated to total $157,000; generously supported by donors of the Baton Rouge Area Foundation.

    c. Assess and recommend mechanisms or forums that will support community, judicial, and law enforcement buy-in of proposed project.
4. Provide business plan components that detail the above recommendations, including proposed costs/budget, staffing model(s), timeline, and potential funding mechanisms.
5. Provide a high-level implementation plan for the proposed services, including specific action items and resource requirements, identification of champion organizations, and recommended next steps.

EXECUTIVE SUMMARY

Jails and prisons have become the nation's primary default response to managing the chronically mentally ill. Approximately 74% of state prisoners, 63% of federal prisoners, and 76% of all jail inmates meet the criteria for a mental health disorder.[2] Substance abuse disorders often co-occur for this population. Over 40% of state prisoners and nearly half of all jail inmates met the criteria for both a mental health and substance use disorder.[3] Louisiana has the highest per-capita rate of incarceration of any state in the U.S. or any country in the world. According to the U.S. Department of Justice, 847 persons per 100,000 state residents are imprisoned, a rate that is 114% higher than the national average.[4] In response, Louisiana passed legislation, HCR82[5], in June 2015 establishing the Louisiana Justice Reinvestment Task Force charged with developing a report recommending policies that can reduce the number of people incarcerated and reduce spending. Recommendations are to be made by March 2017.[6]

Currently in East Baton Rouge (EBR) when law enforcement encounters a person experiencing a behavioral health crisis that is due to an uncontrolled mental illness or substance use, two options are available to officers: take the person to an emergency department (ED) or take the person to the EBR Parish Prison. Leading up to a crisis, signs and symptoms often are visible. Yet, family may feel helpless to intervene. A more effective, cost-efficient, and humane model of care would provide services that could support individuals as they started to experience worsening symptoms, help the individual recognize that he was getting sicker and provide appropriate care *before* the individual ended up in crisis and ultimately behind bars or in an emergency room. However, given limited resources available within the community and the nature of severe mental illness, far too often a crisis is not averted, and the individual who comes to the attention of law enforcement requires immediate care or must be forcibly restrained in order to stop destructive behaviors.

The option of taking someone to the ED is an expensive choice and is designed to serve people who are considered a danger to themselves or others and are experiencing a crisis that requires the most comprehensive acute psychiatric intervention. The Parish Prison also is not the most appropriate or effective place for many individuals with severe mental illness. The Parish Prison is meant to receive and process people after arrest and to hold people in pretrial detention. It is not designed to be a long-term holding facility, nor is it equipped to provide significant, ongoing medical or psychiatric services. Many individuals who come into contact with law enforcement do not require either of these interventions; however, currently appropriate alternatives do not exist within EBR. As a result, EDs have become congested, and

[2] James DJ, Glaze LE: Mental health problems of prison and jail inmates. Department of Justice, Bureau of Justice Statistics Special Report, September 2006.
[3] James DJ, Glaze LE: Mental health problems of prison and jail inmates. Department of Justice, Bureau of Justice Statistics Special Report, September 2006.
[4] E. Ann Carson: Prisoners in 2013. Department of Justice, Bureau of Justice Statistics Special Report, September 2014.
[5] https://www.legis.la.gov/legis/BillInfo.aspx?i=227820.
[6] http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2015/07/public-safety-in-louisiana.

limited inpatient psychiatric beds get used by people who could have been treated in an alternative, less expensive setting. Many communities have come to recognize that jail is not the proper place to care for someone who is in a behavioral health crisis, who is neither violent, nor demonstrating repeated criminal behavior. However, many communities across the country have been forced to use jails and prisons as a means to manage people with these behavioral health challenges, as funding and resources within the community have shrunk. In response, criminal justice systems have realized growing budgets, yet still lack the resources to appropriately care for these vulnerable members of their community. The result has been poor outcomes for individuals who need services but are instead incarcerated. States and local communities have carried the high costs of treating individuals acutely in emergency departments and inpatient beds while the individuals' long-term needs are not being met. Additionally, local governments are held responsible for maintaining the appropriate standard of care for all who enter their jail or prison. Failing to meet that standard has resulted in tragic individual outcomes and in some cases court-appointed oversight and management of the jail or prison at an exceptionally high cost to the county or parish (e.g., Milwaukee Jail, Chicago's Cook County Jail, New Orleans, etc.)

EBR is experiencing all of these challenges. Community resources are stretched, resulting in long wait times to see a psychiatrist, hospital emergency departments are overwhelmed with people in need, and available inpatient psychiatric beds are scarce. As a result of efforts to access these limited resources, EBR has seen dramatic increases over the last several years in Orders of Protective Custody (OPCs) and Coroner Emergency Certificates (CECs), which require that people experiencing a behavioral health crisis be held against their will and treated. In addition, the Parish Prison reports a rise in the number of inmates housed at the facility and housed in out-of-parish facilities because of lack of space in the EBR Parish Prison. Furthermore, because resources and staff are stretched at the Parish Prison, inmates typically are transferred to hospitals when they are sick, and may get sicker. Over the last several years, George Turner (2012), Daniel Christain Melton (2012), David O'Quinn (2013), Antwoin Haden (2014), Paul R. Cleveland (2014), Jeremy Hilliard (2014), and Lamar Johnson (2015) died while in custody[7]; some of these outcomes might have been avoided.

This dire situation has brought EBR City-Parish officials, the EBR District Attorney's Office, the EBR Sheriff's Office, the Police Department, service providers, the Foundation, and other community stakeholders together. All have recognized that something must be done and that the time to act is now. Collaboration and an interest in finding solutions are actively being pursued. The following report provides a set of recommendations and lays out business plan and implementation components for the BRidge Center that are designed to address the challenges EBR is currently facing, with the goal of stopping the cycle of criminalization of people with behavioral health issues. These recommendations are based on 1) an analysis of the current East Baton Rouge system of care that is available to support people with behavioral health issues, 2) recommendations offered by over 35 behavioral health and criminal justice leaders in EBR, and 3) a review of national best practices and literature.

[7] http://theadvocate.com/news/14237159-123/east-baton-rouge-officials-dispute-claim-that-parish-prisons-health-care-is-deficient-resulting-in-d; http://www.nola.com/crime/baton-rouge/index.ssf/2015/06/lamar_johnson_baton_rouge_deat.html.

The ideal way to divert a crisis is to prevent one in the first place. Like other communities, EBR has a finite set of resources available to address the current problem. Given this limitation, this report focuses on an overall strategy to redesign *existing* community resources so that people can access services appropriate for their level of need and risk, and it recommends the development of a set of targeted interventions that can help provide immediate alternatives to criminalizing people with behavioral health issues. Communities across the country have found effective ways to provide better alternatives. The solution is not one-dimensional or easy. Solutions must involve law enforcement, health care providers, service providers, the judiciary, and community leaders all working together to implement a single, coordinated plan across the community and across diverse systems.

Over the past four months, HMA conducted over 35 interviews with local experts and stakeholders, visited service sites, and toured the Parish Prison. Part of this process included an assessment of publicly available information and data provided over the course of interviews. In addition, we conducted a review of relevant literature and jail diversion best practices in other communities, and a site visit to San Antonio, Texas to meet with leaders who created and operate the Bexar County diversion programs.

Through the course of this analysis, we faced the challenge of accessing data needed to objectively understand the scope of the problem and impacts achieved by the current delivery system. The data that is currently collected is used only within the organization or system where it is collected or to report to funders. While some funder-driven data can be useful, it does not provide the whole picture. Sharing of data and evaluations must be part of the long-term strategy for sustainability and accountability for the proposed BRidge Center and its partners. Currently, most data collection appears to be through paper and stand-alone database systems, making analysis and utilization of these data sets for decision-making and planning a significant challenge. The most important data available is not shared among systems of providers, and as a result mechanisms to understand impacts of current systems are limited. To address these challenges, the following recommendations are included:

1. Determine what data is actually being collected in the current behavioral health and criminal justice systems. Clarify how it is being collected, where it resides, and how it is currently used.
2. Determine if data collection and management can be centralized or managed in such a way that information can be shared and analyzed in total and across systems.
3. Going forward, identify how data might be collected to ensure needed information is available and used to inform decision-making and systems development.
4. Invest in data analytic capacity and technology solutions.
5. As planning for the BRidge Center moves toward implementation, gather and use data available to fine-tune program design, specifically regarding capacity needs.

Many of the critical components of a comprehensive system of care exist within EBR. However, despite their dedication and tireless efforts, current providers and service organizations are operating in silos, collaborating when possible, but out of necessity, and creating critically needed services only as funding streams allow. As a result, the behavioral health care system is fragmented and inefficient and fails to meet the needs of this vulnerable population. Additionally, some critical services are not available at all, because they are not funded. Case management and care management are the most critical areas not present within the current model of care. People with serious behavioral health issues in EBR often are

able to access care only when they get extremely sick and in circumstances that have led to a significant crisis. As a result, behaviors are addressed at inappropriate and expensive levels of care, such as emergency departments and inpatient units, or as often happens, an Order of Protective Custody (OPC) or Corner Emergency Certificate (CEC) is secured to access treatment when scarce resources are overburdened with patients in need of service. For those who aren't aware that they need treatment and are arrested, provisions in the justice system do not exist to direct those individuals to treatment. Assisted outpatient treatment (AOT), court-ordered treatment mandated when people are so ill they cannot recognize the need for care, and forced medication is not practiced at the EBR Parish Prison according to Warden Grimes.[8] All of these factors have resulted in the criminalization of the mentally ill when problematic behaviors become part of the behavioral health crisis. The following recommendations are detailed in this report:

1) Embrace a model of care that promotes a continuum-of-care strategy across the community and that focuses on targeted population health interventions—the provision of services that focus on outcomes for specific groups of people.
    a. Collect, use, and share data to risk-stratify the population, group at-risk people, and target appropriate access to services and interventions.
    b. Redesign where and, when possible, how organizations and services work together on behalf of the target populations.
    c. Should the state decide to implement a Medicaid expansion, engage in the process to ensure that the design of the expansion addresses the behavioral health needs of the target population.
2) Plan and implement a set of priority diversion processes and services, modeled after the diversion programs located in Bexar County, Texas, and tailored to meet the needs of the EBR community.
    a. Based on data mapping completed, the BRidge Center should be located in zip codes 70801 or 70802; zip codes 70805 and 70806 could be considered as alternatives, if needed. Space is currently available and being considered as a potential BRidge Center site at the Baton Rouge Detox Center is located in zip code 70806.
    b. The following service components should be prioritized for planning and implementation:
        i. A BRidge Center Mobile Assessment Team (MAT) staffed by a registered nurse and licensed social worker that will respond to law enforcement calls when people are experiencing a behavioral health crisis. The MAT will complete an assessment and determine what service interventions may be needed, while helping de-escalate the immediate crisis.
        ii. BRidge Sobering beds where people have a safe place to rest and sober up while under the influence of alcohol and drugs. Staff will encourage individuals to engage in ongoing treatment and provide appropriate referrals for ongoing care during the individual's stay.

[8] http://theadvocate.com/news/11017756-123/east-baton-rouge-leaders-consider; HMA interview with Warden Grimes August 26, 2015.

iii. A BRidge Medical Detox program where people withdrawing from substance dependence are evaluated and medically managed, so that physical harm from the detoxification process is minimized. Staff will assess future service needs and connect people to care once any medical danger due to the physical effects of withdrawal has passed.

iv. A BRidge Center Behavioral Health Respite program where people experiencing a psychiatric crisis but not requiring inpatient intervention can be evaluated and stabilized, both psychiatrically and medically, as needed. The program, staffed by licensed professionals and physicians including psychiatrists, will allow people requiring assistance re-starting medications or connecting to community supports to be assessed, and those in crisis managed while referrals and connection to community supports are made.

v. A BRidge Center Care Management Team that will provide ongoing community supports and assertive care management interventions to high-risk individuals and high utilizers of the behavioral health and criminal justice systems. A care team made up of licensed professionals and peer support specialists will recognize potential signs of symptoms and impending crises and help patients navigate systems of care to keep them in the community and out of the hospital.

3) Work toward a system of care that over time includes expansion of services anticipated to leverage the results of implementing the recommendations described above.

The model described above and in detail in this report will require a significant investment of capital and start-up costs as well as ongoing operating support. Total annual operating costs (at full capacity) are estimated at $5.7 million. One-time start-up costs, while substantial, have been minimized, as the Foundation has identified a site located in the highest-need region that is already designed and built out for clinical care. While some capital investments will be needed at this site, additional operating efficiencies would be achieved by co-locating with an existing provider, the Baton Rouge Detox Center, which is currently using approximately 25% of the site for social and medical detox services.

To be financially sustainable, diversion programs generally rely on multiple funding streams including, but not limited to, public (federal, state and local) funding, grants, and local and private philanthropic support. To the extent that programs are able to bill third-party payers (primarily Medicaid) for some services, the need for other funding is decreased. Well-designed diversion programs in other communities have demonstrated significant savings in the form of reduced health care and criminal justice system costs. However, current siloed funding structures often make it difficult to capture and reinvest these savings back into diversion and treatment programs. It will be critical for the BRidge Center to have a robust data collection and evaluation plan in place to track program impact and savings to support the long-term financial sustainability of the program. In addition, the potential for implementation of Medicaid expansion in Louisiana creates a unique opportunity to design a behavioral health program that improves access to services and outcomes for the target population both in East Baton Rouge and statewide.

The need for diversion programming in East Baton Rouge has been broadly recognized, and numerous community leaders have been working on planning for the development of the BRidge Center. Moving from planning to implementation will require increased action by these leaders and others. This report outlines key activities and target dates for work to be completed with a goal of opening the BRidge Center within eighteen months.

Priority actions include:

1) Establish a new non-profit organization with an independent governance structure, including its own Executive Director, to manage and oversee ongoing development and operations of the BRidge Center. The Center will require a shared community strategy as well as the ability to leverage existing resources, build new revenue streams, and invest in new system and service capacity. No one organization in East Baton Rouge is suited to lead this effort. Rather, many organizations have established resources, competencies, and leaders with skills that will be critical for the BRidge Center to be successful. Partnerships and service agreements between the new organization and existing providers will be important to ensure the most effective and efficient delivery of services at the BRidge Center.
2) Convene a stakeholder group made up of behavioral health system and provider leaders to coordinate care across the behavioral health system so that populations with the highest need of care receive the appropriate level of support. This group should also identify opportunities to coordinate transitions across service providers and develop shared resources and tools.
3) Under the direction of the new organization's Executive Director, establish and convene a Steering Committee charged with oversight of BRidge Center development and implementation. Members of this Steering Committee may eventually become part of the governance board of the new organization. Workgroups should be established that support an articulated work plan and formal business plan. The Steering Committee should identify system impacts and shifts across behavioral health and criminal justice systems that will require redesign in order to support diversion programming.
4) Convene a funding workgroup charged with identifying strategy and securing funding resources needed for the BRidge Center.

The graphic below highlights priority actions and a suggested timeline.


Systems and Service Delivery Coordination & Redesign
Quarter One
Funding Strategy and Implementation
Quarter One and Ongoing
Create New Organization, Governance Structure & Hire Executive Director
Quarter One and Ongoing
Steering Committee & Workgroups
Quarter One and Ongoing
Implementation, Operational Work Plans & Secure Site
Quarter Two
Infrastructure Development
Quarter Two and Ongoing
Tool Identification, Health Risk Assessment, Care Plans and Workflow Processes
Quarter Four
Open BRidge Center

MEET VINCENT RIVERS: *A CASE VIGNETTE*

Vincent Rivers[9] is a person living in East Baton Rouge (EBR) Parish whom the BRidge Center is designed to serve. Unfortunately, Vincent's story is not unique. Despite the best intentions of passionate community leaders and organizations that provide services, the current system of care fails to provide supports that Vincent, and others like him, need to live successfully in the community, to be a productive member of society, and to stay healthy.

Vincent is 54 and has worked as a day laborer for general contractors throughout his adult life. He was diagnosed with bipolar and schizoaffective disorders 18 years ago. Although prescribed medications, he refills his medication infrequently, about once a year, and has gone as long as two years without a refill with little to no follow up with a behavioral health specialist. His adult daughter notices something isn't quite right when she sees her father but doesn't know where to turn. Three years ago, Vincent was brought to the emergency department (ED) with a Traumatic Brain Injury (TBI). It was not clear how Vincent was injured, but the doctors suspected he may have fallen or was beaten in an altercation. Vincent recovered from these injuries and was able to return to the community but now had a new diagnosis of a seizure disorder. Over the course of the last three years, Vincent has presented to the ED three to four times per year for seizures. On each of these ED visits, his lab work showed low levels of his seizure medications. Although he has no diagnosis of diabetes or hypertension, his blood sugar was over 300 and his blood pressure was 210/120. Mr. Rivers admitted to not taking his psychiatric medications with regularity. Discharge instructions from the ED directed Vincent to follow up with his behavioral health provider for further evaluation and further recommended that he connect with a primary care provider.

Recently, Vincent was admitted to the hospital for another seizure. He reported that his medications were stolen when he was out during the day. He told the social worker that he has not been getting his medications refilled because he does not have an address to send them to. Mr. Rivers does not have a permanent address and lives with friends or family for as long as he can until he is asked to move. He sometimes stays at shelters and on the streets. He has been kicked out of several homeless shelters for violent and aggressive behavior. Vincent stays in Baton Rouge and is able to pick up work sporadically cleaning job sites for previous employers. However, because most of his family moved to Texas after Katrina, he has limited local support.

Vincent tells the hospital social worker he has a daughter, and he gives permission to the social worker to call her and have her involved in his care. Vincent's daughter is supportive and loves her dad but is afraid of becoming totally responsible for him. The last few times she has been involved, he required resources beyond her means and disrupted her home family life. She would like to support him and be involved but needs him to be emotionally stable before she can be in contact with him.

[9] The story of Vincent River is a compilation of examples of people who have encountered a model of care like the one in EBR. The vignette is based on the current model of care and is meant to illustrate an example of what someone might encounter in EBR.

The social worker contacts Vincent's caseworker at the hospital to see what services are available to help manage his care. The caseworker schedules an appointment with the community mental health provider for Mr. Rivers; however, he has no insurance and his options for treatment are limited. Vincent is discharged from the hospital with an upcoming appointment and a prescription for medications but he has no way to get it filled.

Shortly after being released from the hospital, police are called to address a complaint against Mr. Rivers for stealing alcohol at a convenience store in downtown Baton Rouge. The owner presses charges, stating Mr. Rivers is loud and is disturbing his customers. Mr. Rivers is well known to the police, who have picked him up for similar complaints and other minor infractions frequently over the past year. They take him to the ED, where he is medically cleared, and they then take him to the East Baton Rouge Parish Prison for detention. Mr. Rivers is unable to make bond when it is set, spends 60 days incarcerated, and then is released for time served.

During his incarceration, Vincent missed his appointment with the mental health provider that was scheduled by his caseworker. Once released, he goes to the clinic, where he is told to wait to be seen. After several hours of waiting, he is screened by a mental health worker who makes an appointment for him to see a social worker in two weeks and a psychiatrist in five weeks. He is not restarted on medication until after he completes the visit with the psychiatrist the following month. Mr. Rivers then misses his next appointment because he does not have transportation to the clinic. His mental health condition gets worse, and Vincent continues to use alcohol and other drugs. Again, Vincent comes to the attention of law enforcement. And the cycle continues.

* * * *

The opportunity to intervene and stop the cycle that Vincent and others like him experience is possible. Key components of an effective approach include understanding risk trends and establishing a system of early identification, care management, and population health strategies and interventions. Shortly after Vincent was diagnosed, he failed to fill his medications, and as a result, his psychiatric illnesses worsened, which led to medical complications. Because he was not engaged in care with mental health providers and did not have a primary care provider, Vincent used the ED frequently. A health risk assessment, a questionnaire, and review of health patterns and behaviors could have detected challenges with medication adherence, and care management strategies could have been used to connect Vincent with available community supports.

As Vincent got sicker, it was more difficult for him to work, and he became homeless. Homelessness is the result of many factors, including physical illness, mental illness, substance abuse, domestic violence, poor education, lack of family support, and economic factors. But, regardless of the cause, the impacts can be devastating to the individual and costly to society, as the need for treatment becomes more acute and expenses within the healthcare and criminal justice system increase. Common health issues of people who are homeless include chronic hepatitis, HIV and AIDS, tuberculosis, skin and foot infections, functional and cognitive impairments, and mental health and substance abuse issues. Management of chronic diseases, such as asthma, diabetes, and cardiovascular disease, are less likely to be effective when care is routinely provided in the ED or within the criminal justice system; the result is poor outcomes and increased costs. The problem is compounded further by the fact that once a person who is

covered by Medicaid is incarcerated, Medicaid is suspended or benefits are discontinued after 30 days. As a result, when inmates are released, they are not covered by Medicaid or other insurance and thus have limited access to needed community supports.

THE CURRENT ENVIRONMENT – LOUISIANA AND EAST BATON ROUGE

Louisiana has the highest per capita rate of incarceration of any state in the United States or any country in the world.[10] Louisiana also houses a much higher percentage of its prisoners in local prisons than any other state. Over half of people incarcerated in Louisiana are kept in a local prison, compared to a third nationally. Louisiana is also unique in the length of stay for jail inmates. Length of jail stays have increased significantly across the country over the past two decades, with the national average now 23 days.[11] However, the East Baton Rouge Parish Prison Warden reports much longer stays for the majority of inmates in his facility; many stay for as long as six months before being released for time served at adjudication.[12]

The impact of the state's high rates of incarceration and higher reliance upon local jails to house inmates is evident in the EBR Parish Prison. An older facility characterized by overcrowding and an insufficient number of beds for the ever-growing jail population compelled the Sheriff and other community leaders to push for a bond election to fund construction and operation of a new, larger prison designed to accommodate the most current, effective practices like direct supervision of all inmates and designated areas for comprehensive intake screening. The East Baton Rouge Parish Metro Council rejected this proposal in January of this year[13] and also recently rejected a request from District Attorney Hillar Moore to operate a temporary misdemeanor jail.[14] While city leaders continue to consider the need for a new jail, there is also recognition that further efforts must be made to divert people, particularly those with mental illness and/or substance use disorders, from needing to be incarcerated in the first place. As Metro Councilman John Delgado stated before the vote on the misdemeanor jail proposal, "We incarcerate more people than Cuba, Iran and North Korea combined, and our solution here is to put people in jail for misdemeanors, essentially traffic offenses. This is obscene."[15] District Attorney Hillar Moore agrees with Councilman Delgado that many of the individuals housed in the parish prison should be diverted and treated in a more appropriate setting, "Not everyone housed in our local prison needs to be there. If we

[10] E. Ann Carson: Prisoners in 2013. Department of Justice, Bureau of Justice Statistics Special Report, September 2014.
[11] Incarceration's Front Door: the misuse of jails in America. Vera Institute of Justice, February 2015.
[12] HMA interview with Warden Grimes August 26, 2015.
[13] Samuels, Diana. Baton Rouge Metro Council votes against tax proposal, won't go on May ballot. The Times-Picayune. January 14, 2015.
[14] Roberts, Nigel. Under Pressure, City Council Rejects plan to create misdemeanor jail. The Advocate. Oct. 18, 2015. http://theadvocate.com/news/13708510-123/baton-rouge-metro-council-rejects.
[15] Roberts, Nigel. Under Pressure, City Council Rejects plan to create misdemeanor jail. The Advocate. Oct. 18, 2015. http://theadvocate.com/news/13708510-123/baton-rouge-metro-council-rejects.

used a valid risk assessment tool in our booking processes, our judges would be better able to distinguish between those who absolutely need to be held in prison to protect public safety and those who can be released pending the trial of their case."[16]

Prisons have become the nation's primary response to managing the chronically mentally ill. Approximately 74% of state prisoners, 63% of federal prisoners and 76% of jail inmates meet the criteria for a mental health disorder.[17] Substance abuse disorders often co-occur for this population. Over 40% of state prisoners and nearly half of all jail inmates meet the criteria for both a mental health and substance use disorder.[18] Louisiana, like other states, incarcerates 4.6 times more people with severe mental illness rather than treating someone at a hospital.[19]

The Sheriff, the Warden, law enforcement, and the District Attorney's office all cite untreated mental illness as a significant driver of the parish's incarceration rates. Baton Rouge Chief of Police Carl Dabadie, Jr. confirmed that his law enforcement officers have only two options for where they can take people who have committed only minor infractions or whose only crime is being disruptive as a result of untreated mental or behavioral health needs: jail or the emergency room. These limited options have turned the EBR Parish Prison into a de facto behavioral health crisis unit and have strained limited emergency department resources.

Although the availability of EBR Parish Prison data is limited, Warden Dennis Grimes reports that roughly 20% of the 1,600 or so of the current daily population have a prescription for mental health drugs. Given national statistics, this estimate is likely low. The jail is ill-equipped to manage the care needs of its inmate population. Inmates with severe mental illness are kept segregated from the general population in lock down. Segregation practices like these often exacerbate underlying illness in persons with mental illness. Within the jail and prison system in the U.S., suicide rates are disproportionally high in segregation units. Standard of care would require that physical and mental health staff conduct frequent in-person monitoring on those in segregation units to ensure safety of inmates.

Resources to provide medical and behavioral health assessments and treatment are limited at EBR Prison. It was reported that the jail is launching a new assessment tool to better identify inmates with mental health issues when they enter the jail. However, even if this screening is completed, resources to address needs are scarce. Under current Louisiana law, the EBR Parish Sheriff's Office is responsible only for providing staffing and security at the Parish Prison, which is funded through a property tax for operations, while the City-Parish is responsible for the infrastructure of the prison and for providing medical services within the prison. Emergency Medical Services (EMS) has a contract with the City-Parish to provide medical services to the inmate population at EBR Parish Prison. The current clinical staff for the

[16] Email correspondence with Hillar Moore, January 25, 2016.
[17] James DJ, Glaze LE: Mental health problems of prison and jail inmates. Department of Justice, Bureau of Justice Statistics Special Report, September 2006.
[18] James DJ, Glaze LE: Mental health problems of prison and jail inmates. Department of Justice, Bureau of Justice Statistics Special Report, September 2006.
[19] Torrey, E.F., Kennard, A., Eslinger, D., Lamb, R. & Pavle, J. More Mentally Ill Persons Are in Jail and Prisons Than Hospitals: A Survey of the States. May 2010. http://tacreports.org/storage/documents/2010-jail-study.pdf.

jail's approximately 1,500 inmates consists of two social workers, one of whom is an employee of the Capital Area Human Services District (CAHSD), ten Licensed Practical Nurses spread out over shifts, one Director of Nursing, two Medical Doctors on site three hours per week in total, and a psychiatrist on contract for an additional 12 hours per week.

Exacerbating the growing need for medical and behavioral health resources is the decrease in available emergency and inpatient services in recent years. The closing of the Earl K. Long Hospital and its Mental Health Emergency Room Extension (MHERE) more than two years ago and the recent closing of the Baton Rouge General's Mid-City Emergency Room, along with the downsizing of state mental health facilities, has significantly increased the gap between needed and available services in the community. Between 2011 and 2014, Orders of Protective Custody (OPCs) increased from 473 to 804 per year (Figure 1) and Coroner Emergency Certificates (CECs) increased from 3,152 to 6,518. (Figure 2) [20] Figures 1 and 2 below include OPCs and CECs for 2015.[21]

[20] East Baton Rouge Parish Coroner's Office. Annual Report (2014). http://ebrcoroner.com/media/1799/ebrpco-annual-report-2014.pdf. The East Baton Rouge Parish Coroner may order a person to be taken into protective custody and transported to a treatment facility or the office of the coroner for immediate examination when a peace officer or other credible person executes a statement under private signature specifying that, to the best of his knowledge and belief, the person is mentally ill or suffering from substance abuse and is in need of immediate treatment to protect the person or others from physical harm. The order for custody shall be effective for 72 hours from its issuance. A person who is mentally ill or a person who is suffering from substance abuse may be admitted and detained at a facility for observation, diagnosis and treatment for a period not to exceed fifteen days under an emergency certificate.

[21] Email correspondence with Coroner William Clark 10/22/15. Email correspondence Treva Parolli-Barnes, Chief of Operations, Coroner's Office 1/26/16.

Figure 1

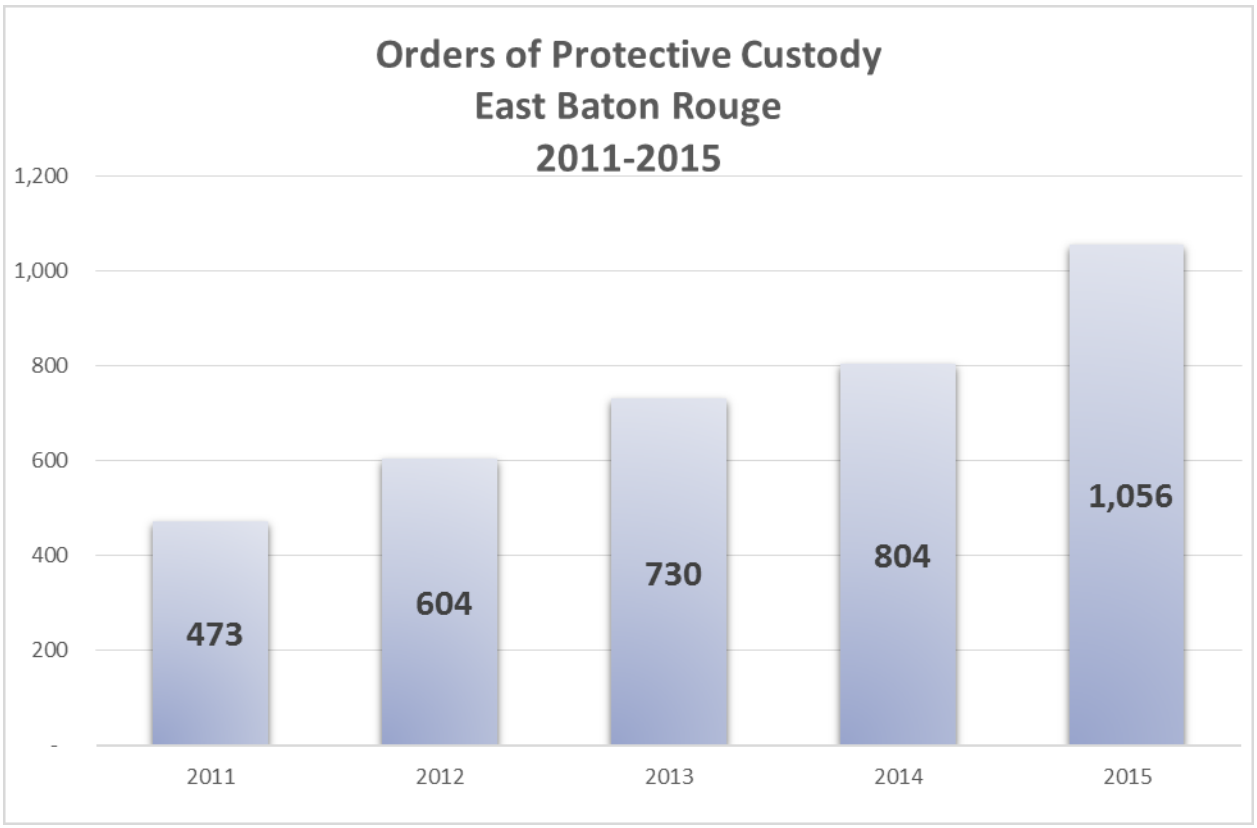
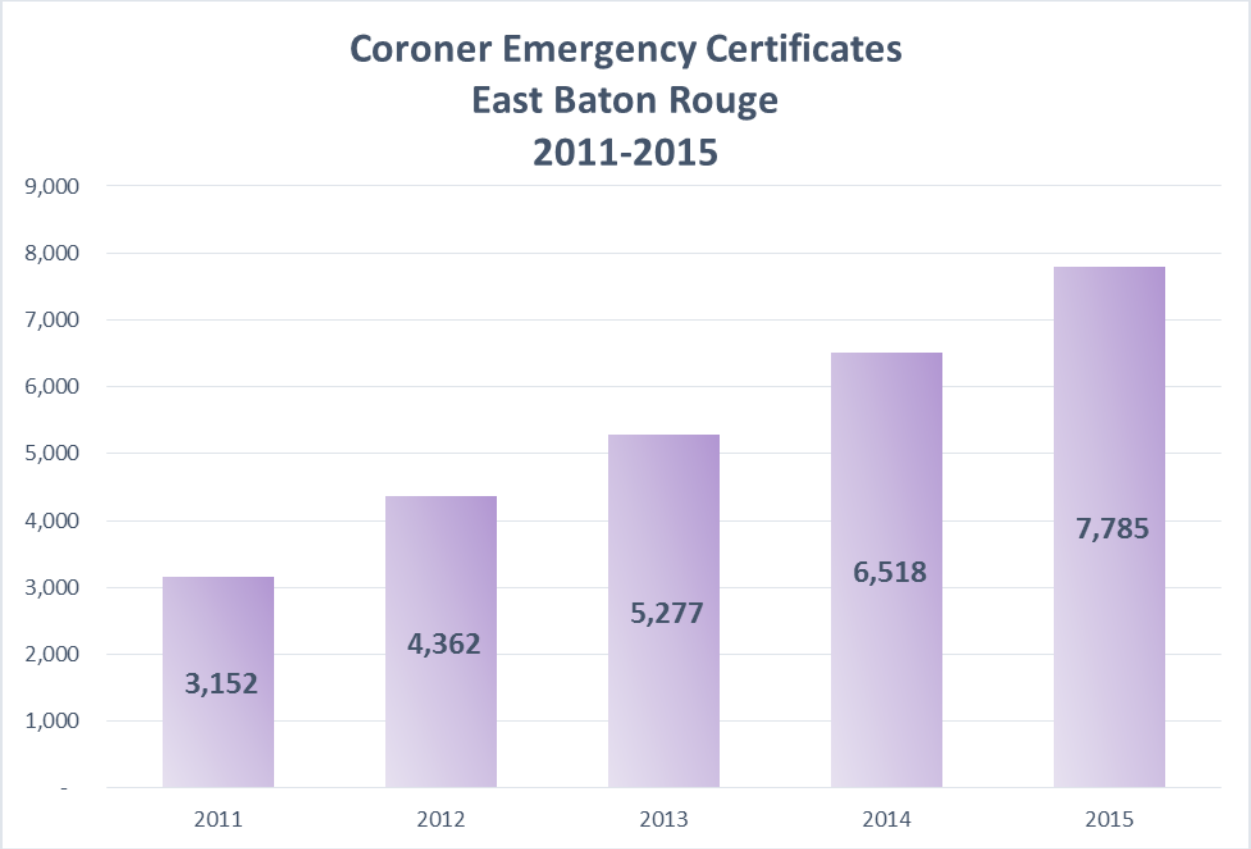

Orders of Protective Custody
East Baton Rouge
2011-2015
1,200
1,000
800
600
400
200
-
473
604
730
804
1,056
2011
2012
2013
2014
2015

Figure 2



Nationally, increased use of emergency departments by people with mental illnesses has contributed to crowding and delays. Mental health-related ED visits increased 75% between 1992 and 2003.[22] People with psychiatric illnesses have much higher rates of emergency department utilization and are also more likely to have multiple hospitalizations.[23] Our Lady of the Lake Regional Medical Center (OLOL) reports seeing a significant increase in the number of people with mental illness coming to the emergency department for treatment. The number of mental health assessments in the ED went up by 42% between 2012 and 2015. Capacity at OLOL has not been able to keep pace with the growing need, and OLOL is forced to send 60% of the patients in need of a psychiatric bed outside the Parish. OLOL staff report capacity challenges are complicated because community resources are limited and patients who are ready to be discharged must be kept longer, some up to nine months.[24]

Despite these challenges, a key strength of East Baton Rouge Parish is the clear commitment among community leaders and stakeholders to reduce unnecessary incarceration and increase the availability of treatment options and support services for people with mental illness and substance use disorders.

[22] Salinsky, E., & Loftis, C. (2007). Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern? National Health Policy Forum, Issues Brief 823, 1-21, George Washington University, Washington, DC.
[23] J. Baillargeon, C.R. Thomas & Williams B.et al., Emergency department utilization patterns among uninsured patients with psychiatric disorders, Psychiatric Services 59 (2008), pp. 808–811.
[24] HMA interview with Coletta Barrett and Deborah Dominick (OLOL) September 15, 2015.

The Mayor's Office, Sheriff, Warden, District Attorney, Public Defender, Coroner, Chief of Police, other law enforcement, and behavioral health and medical providers all voice support for diversion programming in Baton Rouge. In 2014, the Baton Rouge Area Foundation asked Capital Area Human Services District (CAHSD) Executive Director Jan Kasofsky, Ph.D. to establish and chair a Clinical Design Committee, made up of local experts and stakeholders, to develop recommendations for additional behavioral health crisis services in EBR. These recommendations included the development of a crisis call center and crisis intervention team; mobile response teams; and a diversion center (called the "Recovery and Empowerment Center" in the committee's report) that would include a triage/assessment unit, care liaisons and case management, peer-run respite drop-in, sobering beds unit, medical detoxification unit, medical stabilization unit, and separate physical entrance for law enforcement and EMS to drop off patients at the center.[25]

In addition to crisis intervention and diversion programming, stakeholders also recognized significant gaps in other critical services for this population, particularly the lack of housing, including long-term supportive housing, and transportation. The Committee's report, with input from Warden Dennis Grimes also points to the need for increased clinical services within the prison to keep pace with the growing population and the level of care needed to manage the population.

[25] A Proposal for EBR Parish's Behavioral Health Crisis Services, April 2015.

METHODOLOGY

HMA conducted individual and group interviews over the course of three site visits to Baton Rouge, with the purpose of gathering an inventory of existing resources and developing a gap analysis to better understand what services will be necessary to support diversion from the criminal justice system.

As part of this assessment, between August and November 2015 HMA conducted site visits and interviewed over 35 East Baton Rouge (EBR) community leaders (see Appendix A) representing the following organizations:

- Baton Rouge Area Foundation (the Foundation)
- Capital Area Human Services District (CAHSD)
- Louisiana Department of Health and Hospitals (DHH)
- DHH Office of Behavioral Health (OBH)
- DHH Licensing
- EBR Sheriff
- EBR Parish Prison
- EBR District Attorney
- Office of the Mayor of EBR City-Parish
- Our Lady of the Lake Regional Medical Center (OLOL)
- Louisiana Department of Corrections (DOC)
- Psychiatrist for EBR Parish Prison
- EBR Parish Coroner
- EBR Metro Council Members
- Baton Rouge Detox Center
- City of Baton Rouge Police Department
- Emergency Medical Services (EMS)
- Capital Area Alliance's One Stop Homeless Service Center (One Stop)
- EBR Public Defender
- Seaside Healthcare
- Baton Rouge Children's Advocacy Center
- Baton Rouge General Medical Center
- State Senator Sharon Weston Broome
- AmeriHealth Caritas Louisiana
- Amerigroup Managed Care Plan Behavioral Health Team
- Mental Health Association of Greater Baton Rouge
- Grace and Hebert Architects
- Magellan Health in Louisiana

In addition to the interviews and site visits, HMA gathered publicly available reports and requested data from the EBR Parish Prison, EMS, OLOL, the Coroner's Office, the District Attorney's Office, the Baton Rouge City Police Department, DHH and CAHSD. Reports gathered included the report prepared by the Clinical Design Committee; a report prepared by The Perryman Group on the potential economic and fiscal impacts of a jail diversion program in Baton Rouge; DHH's annual Medicaid report; and the Louisiana Medicaid program list of covered services.

Responses to HMA data requests varied, with most people stating that they had and would share data. However, only the Baton Rouge Police Department, OLOL, and the Coroner's Office provided data.

HMA's assessment was based on information gathered through interviews and site visits, an analysis of the limited data available, and a scan of national literature documenting jail diversion programming and best practices. In addition, the HMA team visited San Antonio, Texas, to learn more about the continuum of services in place in Bexar County and to understand the lessons learned as the county has developed its jail diversion programming.

Recommendations formulated in this report are based on these inputs and HMA's experience working across numerous communities and within multiple correction institutions.

THE LITERATURE: WHAT WORKS

The skyrocketing cost of managing jails and prisons has compelled states and local jurisdictions to implement a variety of diversion programs across the country. At least 3,000 law enforcement, pretrial diversion, and pre-plea or diversionary adult drug or mental health court programs currently exist.[26] Researchers are just beginning to identify evidence-based practices in diversion programs, but a number of successful models exist.

The Sequential Intercept Model

Nearly a decade ago, the Substance Abuse Mental Health Services Administration (SAMHSA) National GAINS Center[27] developed the Sequential Intercept Model to provide communities with a framework for the development of mental health and criminal justice collaborations. The model has been successfully used by many communities across the country to understand interactions between mental health and criminal justice systems, to identify where and how diversion activities should be developed within the community, and to identify decision makers and key stakeholders necessary to successfully develop and implement targeted strategies.[28]

The Sequential Intercept Model[29] identifies three major responses needed for every community:

1. **Diversion Programs:** Programs to prevent people with mental illness from entering the criminal justice system.
2. **Institutional Services:** Services within the correctional system that adequately meet the physical and mental health care needs of people with mental illnesses who cannot be diverted from jail or prison because of the severity of their crime.
3. **Re-entry Transition Programs:** Programs to connect people with mental illness to community-based treatment and supportive services, such as housing, peer support, and employment training when they are released.

The model outlines five "intercepts" or points with unique opportunities to connect people with appropriate services and prevent further involvement with the criminal justice system:

1. Law enforcement and emergency services.
2. Post-arrest: initial detention and initial hearings.
3. Post-initial hearings: jails, courts, forensic evaluations and commitments.

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[26] No Entry: A National Survey of Criminal Justice Diversion Programs and Initiatives. Washington, DC: Center for Health Justice, December 2013.

[27] GAINS Center focuses on the following strategies Gather, Assess, Integrate, Network and Stimulate http://www.samhsa.gov/gains-center/about.

[28] Munetz, M.R. & Griffin, P.A. (2006) Use of the sequential intercept models an approach to decriminalization of people with serious mental illness. Psychiatric Services, 57(4), 554-549.

[29] CMHS National GAINS Center. Developing a Comprehensive Plan for Mental Health & Criminal Justice Collaboration: The Sequential Intercept Model.

4. Re-entry.
5. Community corrections and community support.

Without intervention at these stages, individuals will continue to progress and cycle through the criminal justice system.

The ideal point of intervention is through adequate community mental health services before law enforcement is involved or in the earliest stages of involvement, but in a system with appropriate interventions at each intercept, fewer people will progress through the stages of criminal justice involvement or will re-enter the system. As the authors of the model note, "Even the most under-funded mental health systems can work to improve services to individuals with the greatest need, including the group of people with serious and persistent mental disorders who have frequent interaction with the criminal justice system. Such efforts require close collaboration between the mental health and criminal justice systems."[30]

Evidence-Based Interventions

Most of the existing efforts to divert people with serious mental illness from entering the criminal justice system focus on the first intercept of the GAINS Center model – law enforcement and emergency services. By far the most common intervention in communities across the country replicates the Crisis Intervention Team (CIT) model first developed in Memphis, Tennessee.[31]

CIT has been adopted in over 2,000 communities across the country. The goal of CIT is for law enforcement and mental health professionals to work together as a team to respond to people in mental health crisis, prevent them from being arrested and housed in jail, and instead connect them to mental health services.[32] Evidence shows that response by a team of specially trained police officers to a mental health emergency through CIT reduces the inappropriate housing of people with mental health disorders in jail and also helps to avoid officer injury.[33]

Strategies for intervention at the second intercept stage, the post-arrest stage, commonly consist of pretrial diversion programs and specialty drug and mental health courts. Drug courts have been tremendously successful over the past two decades at diverting people with substance use disorders from jail, while connecting offenders with effective substance abuse treatment. Over 2,000 drug courts currently operate in the U.S.[34] The model for the drug court system includes rapid identification of defendants

[30] Munetz, M.R. & Griffin, P.A. (2006). Use of the sequential intercept models an approach to decriminalization of people with serious mental illness. Psychiatric Services, 57(4), 554-549.
[31] Munetz, M.R. & Griffin, P.A. (2006). Use of the sequential intercept models an approach to decriminalization of people with serious mental illness. Psychiatric Services, 57(4), 554-549.
[32] Compton, M.T., Bahora, M., Watson, A. & Oliva, J. A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs. Journal of the Academy of Psychiatry Law 36:1:47-55 (March 2008).
[33] Compton, M.T., Bahora, M., Watson, A. & Oliva, J. A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs. Journal of the Academy of Psychiatry Law 36:1:47-55 (March 2008).
[34] Office of National Drug Control Policy. (2011). Drug Courts. http://www.whitehousedrugpolicy.gov/enforce/drugcourt.html).

who meet local legal requirements and are willing to participate in treatment, and referral to the program; judicial supervision of treatment through regular hearings; a high degree of defendant accountability; and mandatory periodic drug testing.[35]

The success of drug courts led to the development of mental health courts. Mental health courts have historically accepted low-level offenders, but over time more mental health courts have started to accept felony cases as well.[36] Mental health courts work with people who have both mental health and co-occurring substance use disorders.[37] The norm for low-level offenses is to dismiss the charges upon successful completion of the court-appointed mental health program. For higher-level offenses, defendants are expected to enter a plea before being accepted into the mental health court program.[38]

Forensic Assertive Community Treatment (FACT) is another promising post-arrest program. FACT provides intensive case management and mental health and substance use treatment services for people identified as having serious mental health disorders and a high degree of involvement with corrections, including multiple arrests. Receiving FACT services is often a condition of release or parole, with the Parole Office playing an important role in ensuring adherence to the program. Studies of Project Link, a FACT program in Rochester, New York, report cost savings of more than $59,000 per person per year.[39]

Assisted Outpatient Treatment (AOT)

Assisted Outpatient Treatment (AOT) is court-ordered treatment, including medication, for individuals with symptoms of severe untreated mental illness. According to the Treatment Advocacy Center, 45 states permit the use of AOT or outpatient commitment, allowing a judge to issue a court order mandating adherence to a mental health treatment and medication plan as a condition of remaining in the community rather than being committed to a hospital.[40] However, in practice, AOT or outpatient commitment "seems to be used less for prevention and more as a way to shorten a current hospitalization," with 80% to 100% of participants in studies in North Carolina and New York placed in AOT as a step down from in-patient hospitalization.[41]

[35] Belenko, S. (1998). Research on drug courts: A critical review. National Drug Court Institute Review, 1:1, 1-27.
[36] CMHS National GAINS Center. (2007). Practical advice on jail diversion: Ten years of learnings on jail diversion from the CMHS National GAINS Center. Delmar, NY: Author.
[37] Almquist, L. & Dodd, E. (2009). Mental Health Courts: A Guide to Research-Informed Policy and Practice from the Council of State Governments Justice Center, NY.
[38] Almquist, L. & Dodd, E. (2009). Mental Health Courts: A Guide to Research-Informed Policy and Practice from the Council of State Governments Justice Center, NY.
[39] NAMI. Treatment not Jail. http://www.nami.org/.
[40] http://www.treatmentadvocacycenter.org/solution/assisted-outpatient-treatment-laws.
[41] Morrissey JP, Desmarais SL, Domino ME: Involuntary Outpatient Commitment: Current Evidence and Options. Prepared for the Continuity of Care Panel, Maryland Department of Health and Mental Hygiene, October 2013. Available at dhmh.maryland.gov/bh.

Individuals under these court orders also receive intensive case management and court monitoring. Outpatient commitment has been shown to be highly effective in improving medication compliance, doubling the rates of treatment compliance, according to most studies.[42] Studies also show that AOT reduces the risks of hospitalization, arrest and incarceration, and homelessness,[43] but these positive results depend upon adequate funding for community-based mental health services.[44] An analysis of the AOT program in New York found that cost savings to a state can be considerable. Service costs for frequently hospitalized patients with severe mental illness declined by 43% in New York City in the first year participants received AOT after hospital release and an additional 13% in the second year.[45]

Comprehensive Programs

A number of communities across the country have used the Sequential Intercept Model to successfully develop a comprehensive continuum of care across the five intercepts.

Bexar County, Texas Jail Diversion Program

One of the most well-known and successful diversion models is the Bexar County, Texas Jail Diversion Program in San Antonio, on which much of the model recommended by the Clinical Design Committee for Baton Rouge is based. The Bexar County program started as a community collaboration to implement a pre-booking CIT program in 2000 but has since evolved into an array of interconnected services across multiple points of diversion. Program components include a Crisis Care Center (CCC), named the Restoration Center, to provide medical and mental health care services, including a crisis hotline and drop-off point for law enforcement; a Crisis Intervention Team (CIT); a Deputy Mobile Outreach Team (DMOT) to conduct field assessments prior to transportation to crisis care; a Central Magistration Facility that can receive detainees from law-enforcement officers, screen for needed mental health services, work with the mental health court to handle misdemeanors, and divert offenders from jail to the care and services they need; and pre-trial services for offenders already incarcerated.[46] Overall, Bexar County has incorporated jail diversion practices at 46 separate intervention points in the criminal justice and mental health systems.[47]

During the first 5 years of operation after opening in 2003, the programs implemented in Bexar County saved taxpayers over $50 million as a result of successfully diverting over 17,000 people from jail and emergency rooms.[48] As the San Antonio model has proven, it is more cost-effective to provide mental health services and supports at the front-end rather than pay for jail beds and prison time on the back-end. Today, San Antonio's Restoration Center provides services to approximately 25,000 customers

[42] Fuller Torrey, E. & Zdanowicz, M. (March 2001). Outpatient Commitment: What, Why, and for Whom. Psychiatric Services. Vol. 52, No. 3. pp. 337-341.
[43] http://www.treatmentadvocacycenter.org/solution/assisted-outpatient-treatment-laws.
[44] Swanson JW, Van Dorn RA, Swartz MS, et al.: The cost of assisted outpatient treatment: can it save states money? American Journal of Psychiatry 170:1423–1432, 2013.
[45] Swanson JW, Van Dorn RA, Swartz MS, et al.: The cost of assisted outpatient treatment: can it save states money? American Journal of Psychiatry 170:1423–1432, 2013.
[46] Bexar County Blueprint report. http://www.jtvf.org.
[47] Bexar County Blueprint report. http://www.jtvf.org.
[48] http://chcsbc.org/innovation/jail-diversion-program/.

each year and generates savings of at least $11 million a year.[49] Some patients walk in off the streets; others are brought in by police officers or diverted to the Center from programs inside the jail. The programs in Bexar County have also significantly reduced overcrowding in the jail—so much so that the jail went from being over capacity when the collaborative began to now having 500 empty beds.[50]

Many communities have looked to replicate Bexar County's success. Leon Evans, President and CEO of the Center for Health Care Services in San Antonio, Texas, and a key architect of the Bexar County program, recommends a few key strategies[51] for developing new diversion programs in other communities:

1. Stakeholder/partnership engagement is key to success—the outcomes of the model have to be relevant to these stakeholders in order for them to fully engage in implementation and maintenance of the services. This kind of model is more about building collaborative partnerships than building a service array. The focus should be on the strong collaboration first and on the model specifics second.
2. It is essential for the community to understand the problem it is trying to solve. Before developing the specific model, spend time gathering data and identifying the measures that the model needs to target; these are most frequently related to timeliness, access and quality of services (e.g., in Bexar County, one of the main objectives was to reduce police time waiting in the emergency department). The specifics of the model need to be tailored to the unique environment and needs of each county, and the defined measures and objectives should be based on clear data.
3. Incorporate and interpret the language and culture of different systems and providers.
4. Identify champions from critical systems who can engage the right people to include.
5. Involve people in the planning who have experienced incarceration and behavioral health issues, either directly or through a family member.
6. Engage external consultation on the change process to provide objective input.

Milwaukee, Wisconsin

Milwaukee, Wisconsin, is a community that has implemented robust pretrial diversion programs for after an individual is arrested. The County formed a collaborative partnership called the Community Justice Council (CJC) in 2008 with the goal of creating a "fair, efficient and effective justice system."[52] The CJC's efforts began with an analysis of data and cost drivers in the justice system and the development of pre-trial diversion programs. The County contracts with a non-profit organization, JusticePoint, Inc.,[53] to handle the majority of its services, which now include the following:

[49] The economic impact and savings report prepared by the Perryman Group estimated that implementation of similar diversion programs in Baton Rouge would result in direct cost savings of $3.0 million in the first year, $8.1 million per year at maturity, and a total of $24.6 million over the first 5 years of operations. The Perryman Group, The Potential Economic and Fiscal Impacts of a Jail Diversion Program and Restoration Center for Mental Health and Related Disorders in Baton Rouge, April 2015, *available at http://perrymangroup.com/wp-content/uploads/Perryman-Baton-Rouge-Report-4-10-2015.pdf*.

[50] HMA meeting with Leon Evans, October 19, 2015.

[51] HMA Interview with Leon Evans, May 3, 2015.

[52] Milwaukee County Community Justice Council website. http://milwaukee.gov/cjc.

[53] JusticePoint, Inc. website: http://www.justicepoint.org/programs/#mke-county.

- *Universal screening*: 24-hours a day/7 days a week jail screenings to predict an individual's risk for pretrial misconduct and make recommendations to mitigate those risk factors.
- *Central Liaison Unit (CLU):* Supervision and case management for low-risk offenders who enter into pre-charge diversion agreements. The CLU also offers cognitive-based therapy groups using the National Institute of Correction's "Thinking for a Change" curriculum.
- *Treatment, Alternatives and Diversion (TAD) program*: Screening, assessment, and case management for individuals who have entered Deferred Prosecution Agreements, which allow charges to be dismissed or reduced if restorative justice plans are followed.
- *Addiction Severity Index Screening* and *Assessment and Recovery Support Coordinators* to provide access to addictions treatment, as well as *Cognitive Behavioral Therapy* groups and groups to address trauma issues for participants in Milwaukee's Drug Treatment Court.
- As part of this collaboration, Milwaukee County Mental Health and Substance Use Disorder Services provides *Crisis Intervention Services* with a 24/7 Crisis Center and a mobile crisis team. There is also a *24/7 Psychiatric Crisis Line*.
- The *Community Access to Recovery Services Division* provides supportive recovery services for people with severe mental illness and/or substance use disorders.
- *The Service Access to Independent Living (SAIL)* program helps adults with mental illness achieve independence and connect to community-based services and supports, including supportive housing, peer support, medication management, and skill training.
- The *Milwaukee Co-occurring Competency Cadres (MC3)* coordinates and integrates care for people with complex and co-occurring needs.

Funding for much of these services came from a $10 million investment from the state legislature in 2009 to expand community-based recidivism reduction programs, including substance use treatment, employment services, and access to mental health care.[54] Milwaukee County projects that the success of these programs will decrease the jail population by 20% in five years and generate $6.6 million in savings annually.[55]

In a case study focused on its pre-trial diversion efforts, Milwaukee County emphasized the need to include all stakeholders from the beginning and to provide the data and research to support the efforts.[56]

Franklin, Ohio

Recommendations developed as part of a systems improvement project in Franklin, Ohio, conducted by the Council of State Governments Justice Center, provide valuable insight into how a community can best develop a successful diversion program. Franklin County justice and behavioral health systems' leaders worked together to implement an array of services, including CIT training and specialty courts, and expanded access to treatment services for people with mental illness, but they continued to face

[54] Council of State Governments. Justice Center. https://csgjusticecenter.org/jr/wi/.
[55] Center for Effective Public Policy. Justice Reinvestment Initiative at the Local Level: Getting to know Milwaukee County, Wisconsin.
[56] National Association of Counties (NACO). County Jails at a Crossroads: Milwaukee County, WI. July 2015. www.naco.org/CountyJails.

challenges with a growing number of people with mental illness entering jail.[57] After an exhaustive analysis of data from multiple systems and extensive interviews and focus groups with key informants, the CSG Justice Center developed eight recommendations for Franklin County that are relevant to any community developing a diversion program:

1. Develop community-based services that people with behavioral health needs can access directly to avoid unnecessary law enforcement calls.
2. Ensure law enforcement response to people with mental illness promotes safety for everyone involved and facilitates a connection to community-based services rather than the criminal justice system.
3. Use the results of a validated pre-trial risk assessment to inform decisions about pretrial release and detention.
4. Use the results of behavioral health screenings and assessments to inform decisions about the delivery of behavioral health care services in jail.
5. Use risk and behavioral health information to develop comprehensive community-based supervision plans.
6. Connect people in jail with mental illnesses and co-occurring substance use disorders to community-based services prior to their release.
7. Increase the capacity of community-based behavioral health and housing services and give priority to people at risk for reoffending,
8. Develop a process for ongoing system analysis and outcome measurement for continuous system improvement.

[57] Council of State Governments Justice Center. Franklin County, Ohio: A County Justice and Behavioral Health Systems Improvement Project. May 2015.

COMMUNITY BEHAVIORAL HEALTH RESOURCES IN EAST BATON ROUGE

Treatment and crisis services available in East Baton Rouge for people with mental health or substance use disorders vary depending on individuals' ability to pay for care or the type of insurance, if any, accepted by the facility. Several private, for-profit facilities offer a continuum of inpatient, residential, and comprehensive outpatient services. Access to these services is generally limited to people with commercial insurance or Medicare coverage. Individuals most frequently cycling through East Baton Rouge Parish Prison are indigent or qualify for Louisiana's current Medicaid program and are served by the organizations included below.

Medicaid Behavioral Health Services

Louisiana's behavioral health system has undergone significant changes in recent years. In 2012, the Louisiana Behavioral Health Partnership (LBHP) was launched to better manage statewide specialty mental health and substance abuse services for Medicaid-eligible and non-Medicaid eligible adults and children. LBHP is led by the Louisiana Department of Health and Hospitals' Office of Behavioral Health (OBH) and includes Medicaid, the Department of Children and Family Services (DCFS), the Department of Education (DOE), and the Office of Juvenile Justice (OJJ).[58] These state agencies pooled funding into a contract with Magellan of Louisiana to serve as the Single Management Organization (SMO) for the LBHP Medicaid carve-out and non-Medicaid behavioral health services under a 2012 contract. The program operates under a 1915(b) waiver, a 1915(c) home and community-based waiver, and 1915(i) state plan amendment (SPA) for adult mental health rehabilitation. Other funding includes federal block grants and state general funds.[59]

In 2014, 101,099 Medicaid and 22,858 non-Medicaid covered individuals in East Baton Rouge Parish were enrolled in the LBHP.[60] Medicaid and non-Medicaid-eligible adults with behavioral health issues have access to an array of services, including inpatient psychiatric services, outpatient mental health services, rehabilitative substance abuse services, case conferencing services, crisis intervention, psychosocial rehabilitation, and other community psychiatric supports and treatment.[61]

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[58] DHH LBHP website: http://www.dhh.state.la.us/index.cfm/page/453/n/213.

[59] U.S. Department of Health & Human Services Office of the Assistant Secretary for Planning & Evaluation. Strategies for integrating and coordinating care for behavioral health populations: case studies of four states. Jan 2014. Total funding allocated to the LBHP by the Louisiana Legislature for the 2015-16 Fiscal Year was approximately $20.5 million, with approximately half of the funding coming from state general funds and half coming from federal funds. Louisiana State Legislature, Act 16, June 19, 2015 (effective July 1, 2015), available at http://www.legis.la.gov/legis/ViewDocument.aspx?d=960081.

[60] FY2014 Louisiana Behavioral Health Partnership Transparency Report. http://new.dhh.louisiana.gov/index.cfm/page/2094.

[61] DHH LBHP website: http://www.dhh.state.la.us/index.cfm/page/453/n/213.

People who meet the federal definition for severe mental illness have access to more rehabilitation services and case-conferencing services (1915(i) services). For insured adults, with the exception of Medicaid, stays in psychiatric hospitals are covered, but inpatient psychiatric stays in general hospitals are not.[62] As a result, inpatient beds available for non-Medicaid eligible adults are difficult to secure.

In November 2014, the Louisiana Department of Health and Hospitals (DHH) announced that it intended to end the LBHP behavioral health carve out and integrate specialty behavioral health benefits into its five Medicaid Bayou Health managed care plan contracts.[63] The contract with Magellan was renewed for a transition period but ended in December 2015. At the same time, Louisiana's 1915(i) state plan amendment also ended. Starting in December 2015, the state removed the requirement that the Bayou Plans provide services based on the service manual and instead the Plans will have the latitude to provide any services needed through the capitated per member per month (PMPM) payment structure.

Magellan Health recognized in 2012 that the culture of behavioral health service in Louisiana was centered on inpatient hospitalization.[64] They came to understand quickly that the priority was to build capacity within the community. Initially, they focused on expanding Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) across the state. ACT is a SAMHSA-recognized, evidence-based practice that serves people with serious mental illness who often cycle in and out of psychiatric hospitals. It is based on a multi-disciplinary team that provides services and supports to a small caseload (staff to client ratios of 1:10) of clients. The goal is to provide comprehensive, wrap-around services that help people with multiple chronic health issues remain stable in the community. At minimum, clients are seen twice a week, and frequently more often, mostly in the community, by a member of the ACT team.[65] FACT has adapted the ACT model specifically for people who have spent time within the criminal justice system. When Magellan entered the Louisiana market three years ago, the state had only four ACT/FACT teams in place. Magellan contracted with NHS Human Services,[66] a national, community-based nonprofit, human services provider to provide ACT services, and currently two ACT teams operate within Baton Rouge. According to the NHS Human Services 2014 Annual Report, ACT served 640 individuals in the areas of Baton Rouge, Lafayette, Lake Charles, Alexandria, and Shreveport.[67] In addition to ACT expansion, Magellan invested in the creation of a step-down or less intensive community support and Community Psychiatric Service Teams (CPST), and they invested in over 100 teams now offering services for Medicaid recipients across Louisiana.

More recently, Magellan was planning to begin developing crisis services in urban areas of Louisiana, including Baton Rouge, with the goal of providing 23-hour stabilization and possibly expanding to up to 72-hour stabilization as a means of diverting people in crisis from utilizing emergency departments. Two

[62] U.S. Department of Health & Human Services Office of the Assistant Secretary for Planning & Evaluation. Strategies for integrating and coordinating care for behavioral health populations: case studies of four states. Jan 2014.
[63] Shuler, Marsha. State changing Medicaid contracts. The Advocate. Nov., 20, 2014.
[64] HMA interview with Magellan Medical Director, Richard Dalton, MD., November 6, 2015.
[65] Substance Abuse and Mental Health Services Administration. Assertive Community Treatment: Building Your Program. DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2008.
[66] http://www.nhsonline.org/.
[67] http://annualreport.nhsonline.org/2014/review-act.html.

organizations were identified and expressed interest in developing these services: Seaside Health and Brentwood Hospital. Magellan was also moving towards providing housing and housing supports for people experiencing homelessness. These plans stopped when the contract with the state was not extended.[68]

The state of Louisiana issued an RFP to the health plans to manage behavioral health services for the uninsured. No responses to the request were received, and as a result, the Office of Behavioral Health plans to develop a managed care program for the approximately 250,000 residents of Louisiana who are uninsured.

As Dr. Dalton, Medical Director for Magellan, noted, Louisiana has a culture of inpatient psychiatric utilization—a hallmark of how psychiatric care is provided. However, like many communities, both the state of Louisiana and Baton Rouge have a paucity of inpatient beds available for the uninsured. Expert consensus is that at least 50 psychiatric beds are needed for every 100,000 people. No state meets this threshold; in 2010, reports indicated Louisiana had 903 beds, 40% of need.[69] Limited bed capacity has led to an increased use of OPCs and CECs as a means to provide access to an inpatient psychiatric bed. All interviewees commented on the limited number of available inpatient beds and crisis services available to people with Medicaid or no insurance.

Two state-funded Office of Behavioral Health (OBH) psychiatric hospitals provide inpatient beds for the uninsured. The hospital nearest to Baton Rouge is Eastern Louisiana Mental Health System (ELMHS) located in Jackson. ELMHS provides 425 forensic, intermediate or long-term adult beds and 48 acute beds with most stays less than 14 days. The other, Central Louisiana State Hospital located in Pineville, about 120 miles from Baton Rouge, has 120 adult intermediate or longer-term beds. OBH also contracts for 86 adult acute beds at private hospitals.[70]

Within EBR, Our Lady of the Lake Regional Medical Center (OLOL) has the largest behavioral health inpatient bed capacity, with 71 licensed beds (11 geriatric, 14 adolescent, 14 detox, and 22 acute). OLOL is staffed for 69 beds and reports an average length of stay of 11 days. Staff report 30% to 40% of patients stay longer than seven days—typically because an appropriate discharge placement cannot be secured.[71] Nationally, the average inpatient length of stay for a mental disorder is 7.2 days.[72] Baton Rouge General Medical Center has limited inpatient psychiatric inpatient beds, and these are available only for geriatric patients.

[68] HMA interview with Magellan Medical Director, Richard Dalton, MD., November 6, 2015.
[69] Torrey, E.F., Fuller, D., Geller, J., Jacobs, C., & Ragosta, K. (2012). No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals. The Treatment Advocacy Center.
[70] Email correspondence with OBH, Sue Austin, January 5, 2016.
[71] HMA interview with OLOL staff September 15, 2015.
[72] http://www.cdc.gov/nchs/fastats/mental-health.htm.

Community Organizations Serving People with Mental Illness and Substance Abuse Issues in East Baton Rouge

The Louisiana Department of Health and Hospitals (DHH) is organized into ten administrative regions or Local Governing Entities (LGE). Each LGE is allocated funding from the federal block grant and general funds to provide psychiatric, preventive, and rehabilitative services to people with behavioral health issues who do not have insurance. It is up to each regional authority to determine if these funds will be reallocated to other service providers in the region or if services will be provided through the authority or some combination of the two. Region 2 serves the Parish of East Baton Rouge (EBR), where the authority is the Capital Area Human Services District (CAHSD). In addition to serving the uninsured, CAHSD also provides services to people with insurance.

For the most part, CAHSD's annual budget of approximately $27 million provides services through its four main clinics and 10 satellite sites across seven parishes in the district. Services include behavioral health and developmental disability supports for adults, children, and adolescents. According to CAHSD's 2014 Community Health Assessment, CAHSD provided services (across all service sites) to approximately 14,000 people. Specifically, 5,900 adults were provided mental health services, and 1,120 adults received addiction services in fiscal year 2014.[73]

According to CAHSD's Executive Director, Jan Kasofsky, Ph.D., some funds are allocated to other providers within EBR to serve CAHSD patients to provide specific services at O'Brien House (substance abuse services), Baton Rouge Detoxification Center (detox beds), and the Mental Health Association of Greater Baton Rouge (peer supports for drop-in services).[74]

Two of the four main CAHSD clinics where mental health services are provided to adults across the seven parish districts are located in EBR. The largest site, the Center for Adult Behavioral Health Services (4615 Government Street, Building 2) is where any new patient or any returning patient who has missed three appointments must go to access behavioral health services within the CAHSD system. This site is 7.9 miles from the EBR Parish Prison. Many individuals released from the Parish Prison are directed to CAHSD upon release. According to the Baton Rouge Capital Transit Area System (CATS) website (https://www.brcats.com/node), this requires two buses and over half a mile of walking (approximately 52 minutes in total travel time during rush hour and up to 83 minutes during off- peak hours) to get from the prison to the center. The other EBR site, the Margaret Dumas Mental Health Center (3843 Harding Blvd.) is located 1.5 miles from the Parish Prison. Services offered at this site are not described on CASHD's website, and four phone calls to the phone number listed at this site, during open hours, were not answered and no other means to contact staff on-site was offered.

CAHSD's Center for Adult Behavioral Health Services provides walk-in access for new and returning patients five days per week. Patients are able to see a mental health worker who will triage and assess their needs and schedule an appointment with a psychiatrist or social worker. According to receptionist and intake worker estimates, wait times for these appointments range from same day to up to six weeks. CAHSD has recently changed its method for scheduling appointments to move to same-day

[73] Power Point presentation CAHSD Community Health Assessment, August 20, 2015.
[74] HMA interview with Jan Kasofsky, Ph.D. August 25, 2015.

scheduling, yet some stakeholders report recipients continue to experience long wait times before receiving care, especially psychiatric care. It is important to note, according to all interviewees, including leaders at DHH, hospitals, and others from both the behavioral health and criminal justice system, that the only community service provider in EBR that serves people without Medicaid, Medicare or commercial insurance is CAHSD, which does not provide case management, inpatient beds, or emergency department services.

A number of gaps in the continuum of community services were identified. Interviewees consistently mentioned the challenge faced by people trying to access outpatient services within the behavioral healthcare system, particularly for the indigent population. Also frequently noted was the lack of residential supports, both short and longer-term options and, more generally, supportive and transitional housing. There is also widespread recognition that the availability of psychiatric providers in East Baton Rouge is limited. Table 1 shows the types of services offered by EBR community organizations that provide services to the indigent, as well as those with no fee or a sliding fee scale.

Table 1

Services Available by Provider and Payment Mechanisms							
	Mental Health Services	**Substance Abuse Services**	**Residential Treatment or Housing**	**Referral Agency**	**Social Services**	**Accepts Insurance**	**Sliding Scale or No Fee**
Capital Area Human Services District Clinics	✓	✓		✓		✓	✓
Baton Rouge Detoxification Center	✓	✓		✓		✓	
Baton Rouge Crisis Intervention Center	✓	✓					✓
O'Brien House of BR	✓	✓	✓			✓	
Women's Community Rehabilitation Center	✓	✓	✓		✓	unavailable	unavailable
Louisiana Health and Rehab Center	✓	✓			✓	✓	
Mental Health Association of Greater Baton Rouge			✓	✓	✓		✓

Volunteers of America of Greater BR (multiple locations)	✓	✓	✓		✓	✓	
Pocahontas House (through Louisiana Health & Rehab Center)	✓	✓	✓		✓		

For more detailed descriptions of organizations and services that serve indigent people with behavioral health issues or those experiencing homelessness, see Appendix B. In addition, Appendix C includes Louisiana Department of Health and Hospitals information regarding community services available.

BATON ROUGE DEMOGRAPHICS AND DATA

The data below describes the most recent publically available demographics for people residing within East Baton Rouge Parish. The source for the tables below is *U.S. Census Bureau: State and County Quick-Facts.* Data is derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Non-employer Statistics, Economic Census, Survey of Business Owners, Building Permits (Table 2)

Last Revised October 14, 2015[75]

Table 2. Census Bureau Statistics for East Baton Rouge Parish and Louisiana

	EBR Parish	Louisiana
Population, 2014 estimate	446,042	4,649,676
Population, 2010 (April 1) estimates base	440,178	4,533,479
Population, percent change - April 1, 2010 to July 1, 2014	1.3%	2.6%
Population, 2010	440,171	4,533,372
Persons under 5 years, percent, 2014	6.5%	6.6%
Persons under 18 years, percent, 2014	22.8%	23.9%
Persons 65 years and over, percent, 2014	12.4%	13.6%
Female persons, percent, 2014	52.1%	51.1%
White alone, percent, 2014	48.9%	63.4%
Black or African American alone, percent, 2014	46.2%	32.5%
American Indian and Alaska Native alone, percent, 2014	0.3%	0.8%
Asian alone, percent, 2014	3.3%	1.8%
Native Hawaiian and Other Pacific Islander alone, percent, 2014	---	0.1%
Two or More Races, percent, 2014	1.3%	1.5%
Hispanic or Latino, percent, 2014	3.9%	4.8%
White alone, not Hispanic or Latino, percent, 2014	45.7%	59.3%

[75] http://quickfacts.census.gov/qfd/states/22/22033.html.

	EBR Parish	Louisiana
Living in same house 1 year & over, percent, 2009-2013	83.7%	85.8%
Foreign born persons, percent, 2009-2013	4.9%	3.9%
Language other than English spoken at home, percent of persons age 5+, 2009-2013	8.0%	8.7%
High school graduate or higher, percent of persons age 25+, 2009-2013	88.5%	82.6%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	34.2%	21.8%
Veterans, 2009-2013	25,555	304,271
Housing units, 2014	191,203	2,010,868
Homeownership rate, 2009-2013	61.2%	67.0%
Housing units in multi-unit structures, percent, 2009-2013	30.5%	18.3%
Median value of owner-occupied housing units, 2009-2013	$166,000	$138,900
Households, 2009-2013	167,422	1,707,852
Persons per household, 2009-2013	2.57	2.60
Per capita money income in past 12 months (2013 dollars), 2009-2013	$27,505	$24,442
Median household income, 2009-2013	$48,506	$44,874
Persons below poverty level, percent, 2009-2013	19.2%	19.1%

According to 2011 CDC data, 17.7% of the East Baton Rouge population, or an estimated 17,900 people, are uninsured.[76] In 2014, 9.8 million adults (4.1%) had a severe mental illness in the United States.[77] Extrapolating from national estimates of 4.1% of the population having a severe mental illness, East Baton Rouge may have as many as 18,287 people living with severe mental illness according to 2014 population estimates.[78]

[76] http://wwwn.cdc.gov/CommunityHealth/profile/currentprofile/LA/East%20Baton%20Rouge/310021.
[77] Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/data/.
[78] http://quickfacts.census.gov/qfd/states/22/22033.html.

Baton Rouge is required to conduct an annual Point in Time Count (identifying numbers of people staying in shelter and unsheltered environments on a given day/night) to demonstrate need and to compete for available U.S. Department of Housing and Urban Development (HUD) housing funds (Continuum of Care dollars). Baton Rouge conducted its most recent count on January 27, 2015. Table 3 highlights the number and demographics of the people found experiencing homelessness.

Table 3. Point in Time Summary Highlights for East Baton Rouge[79]

	Sheltered	Unsheltered	Total
Total Number of Households	509	69	578
Total Number of Persons	533	74	607
Number of Children (under age 18)	24	1	25
Number of Persons (18-24 years old)	63	2	65
Number of Persons (over age 24)	448	71	517
Female	132	12	144
Male	400	62	462
Transgender	1	0	1
Non-Hispanic Non-Latino	525	72	595
White	280	13	293
Black or African-American	230	59	289
Asian	2	0	2
American Indian or Alaska Native	4	1	5
Native Hawaiian or Other Pacific Islander	0	1	1
Multiple Races	17	0	17

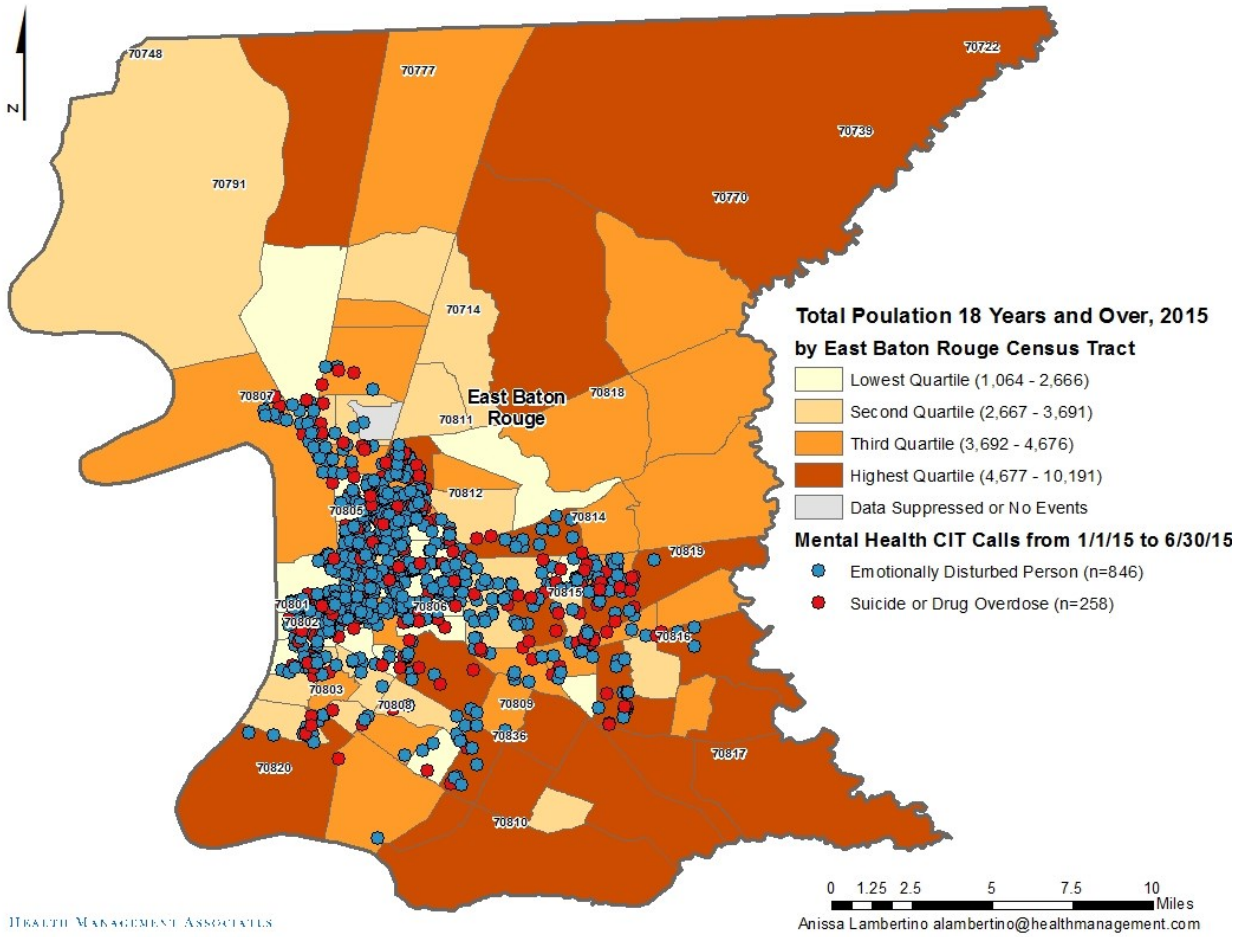
Data Available and What It Tells Us

Although numerous requests for data were made in connection with preparing this report, only the Baton Rouge Police Department and Our Lady of the Lake Regional Medical Center responded. The Baton Rouge Police Department provided data for the first six months of 2015 for calls to the police that resulted in a Crisis Intervention Team officer (CIT) being dispatched. Using that data, HMA mapped calls and was able to compare CIT responses to available Baton Rouge census data. Although the data was limited, it does tell an interesting story and offers some patterns of activity involving people with suspected mental health issues (EDP = Emotionally Disturbed Persons) and people experiencing homelessness. According to Police Chief Carl Dabadie, when a call is made to dispatch, the dispatcher asks a few questions to help determine if a CIT officer should be sent to respond to the call. The caller is asked if he

[79] Point In Time Count data sent to HMA by Randy Nichols, October 1, 2015 email correspondence.

or she knows the person, if they take medications, if they appear intoxicated or are armed, and if other background can be supplied. Based on the response and the description of the activity, a CIT-trained officer, if available, may be involved in the police response.[80]

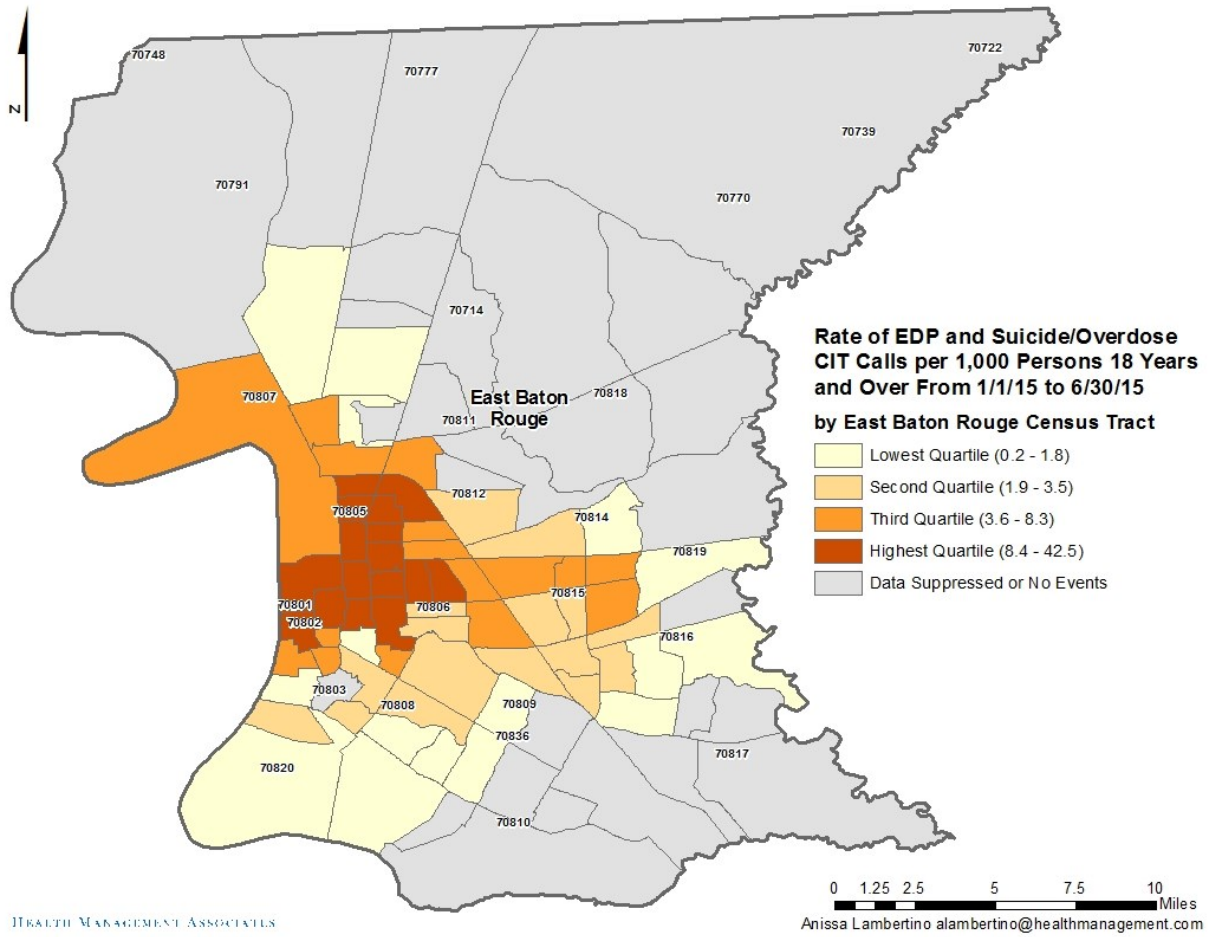
The following maps are designed to show population trends and density of calls based on zip codes. The data source for the maps are: 1) CIT Information from 1/1/15 to 6/30/15 to Emotionally Disturbed People (EDP) and Suicide/Overdose Calls provided by the EBR Police Department, 2) CIT Information for Unique Homeless Person Files provided by the EBR Police Department, and 3) Esri Community Analyst (2015 Total Population 18 Years and Over).[81]



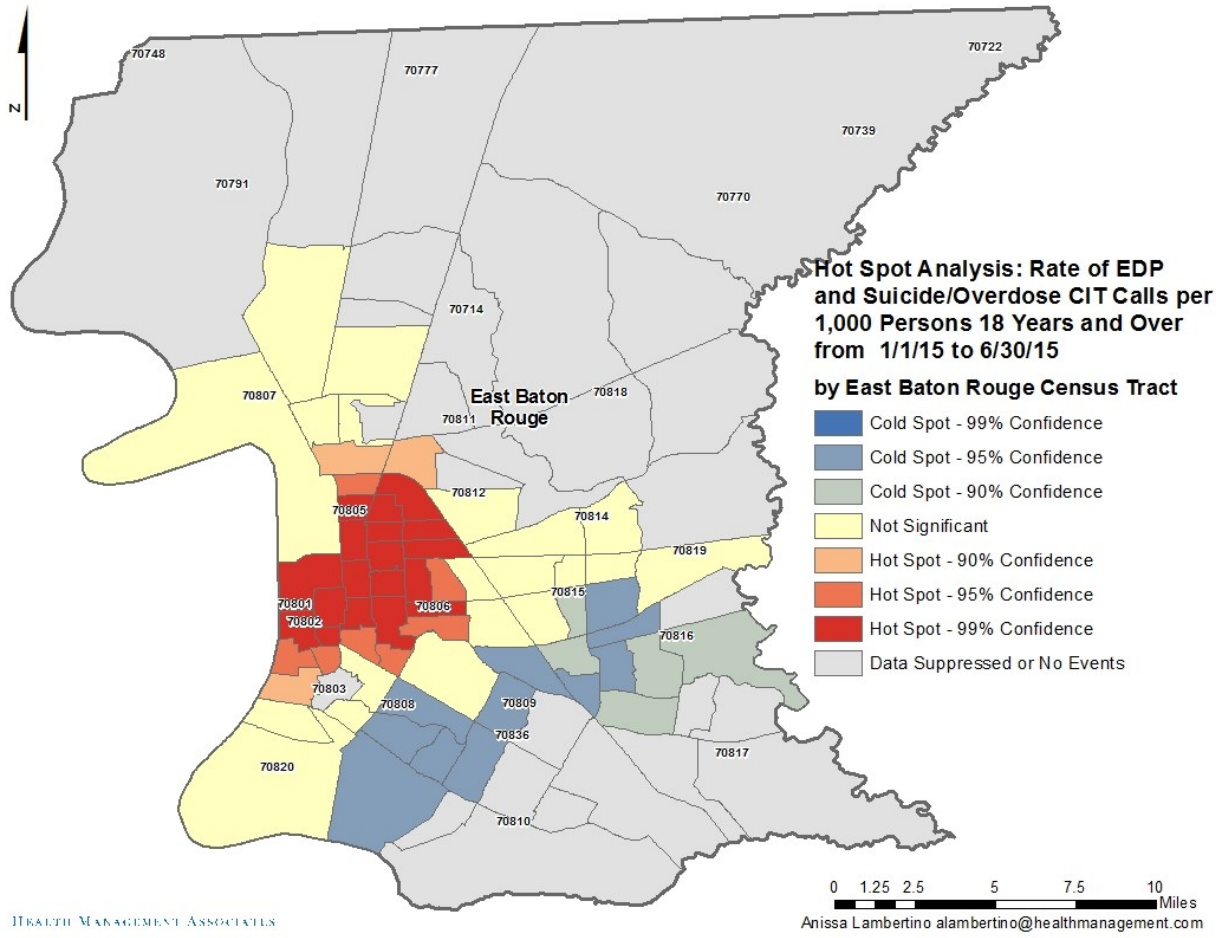
This East Baton Rouge Parish map locates 1,104 mental health-related CIT calls that occurred during the first six months of 2015. A majority of calls were classified as emotionally disturbed person (EDP) (n=846 or 77%, blue symbol), while less than a quarter were classified as suicide/drug overdose (n= 258 or 23%, red symbol). Census tracts are shaded to represent the density of the adult population 18 years and

[80] HMA interview with Chief Carl Dabadie, October 15, 2015.
[81] http://www.esri.com/about-esri.

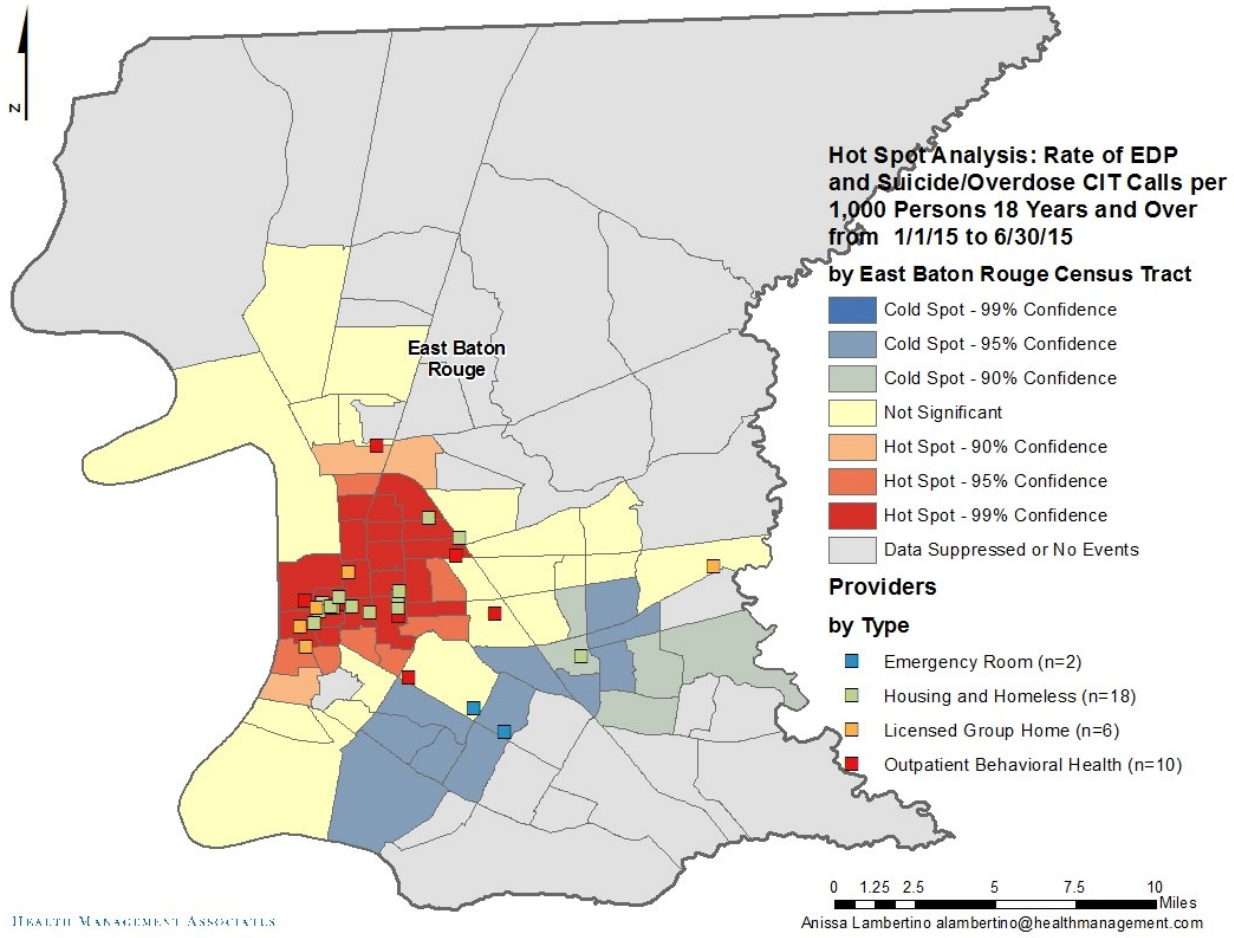
older. The distribution of CIT calls for EDP or suicide/drug overdose occurred most frequently in west central census tracts – areas where the population density is lower.



This East Baton Rouge Parish map shows, by census tract, the relative frequency of calls regarding an emotionally disturbed person (EDP) or a suicide/overdose CIT. The report is based on the 1,104 calls that occurred during the first six months of 2015. The 20% of census tracts with the highest rates are shown in light yellow; the 20% of tracts with the next highest rates are shown in light orange; etc. The highest rates occurred in a cluster of census tracts that intersect the following zip codes: 70801, 70802, 70805, and 70806.



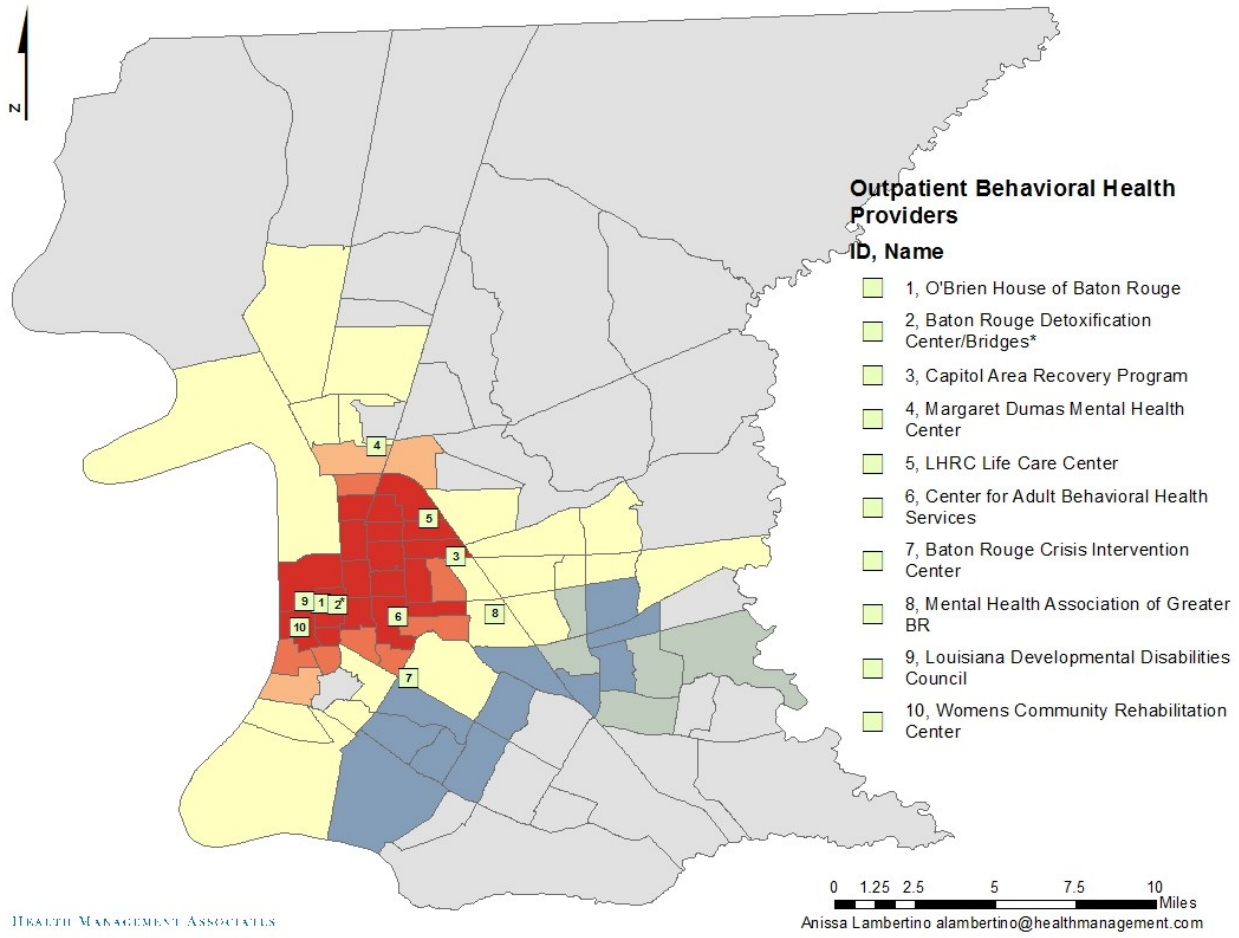
This East Baton Rouge Parish map shows census tracts shaded to represent the results of a hot spot analysis. The analysis was based on the rate of 1,104 EDP and suicide/overdose CIT calls per 1,000 persons 18 years and over. Briefly, hot spot analyses identify patterns of statistically significant clusters of high and low rates. A statistically significant cluster of high rates occurred in a cluster of census tracts that intersect the following zip codes: 70801, 70802, 70805, and 70806. Conversely, a statistically significant cluster of low rates occurred in a cluster of census tracts that intersect the following zip codes: 70808, 70809, 70816, and 70836.



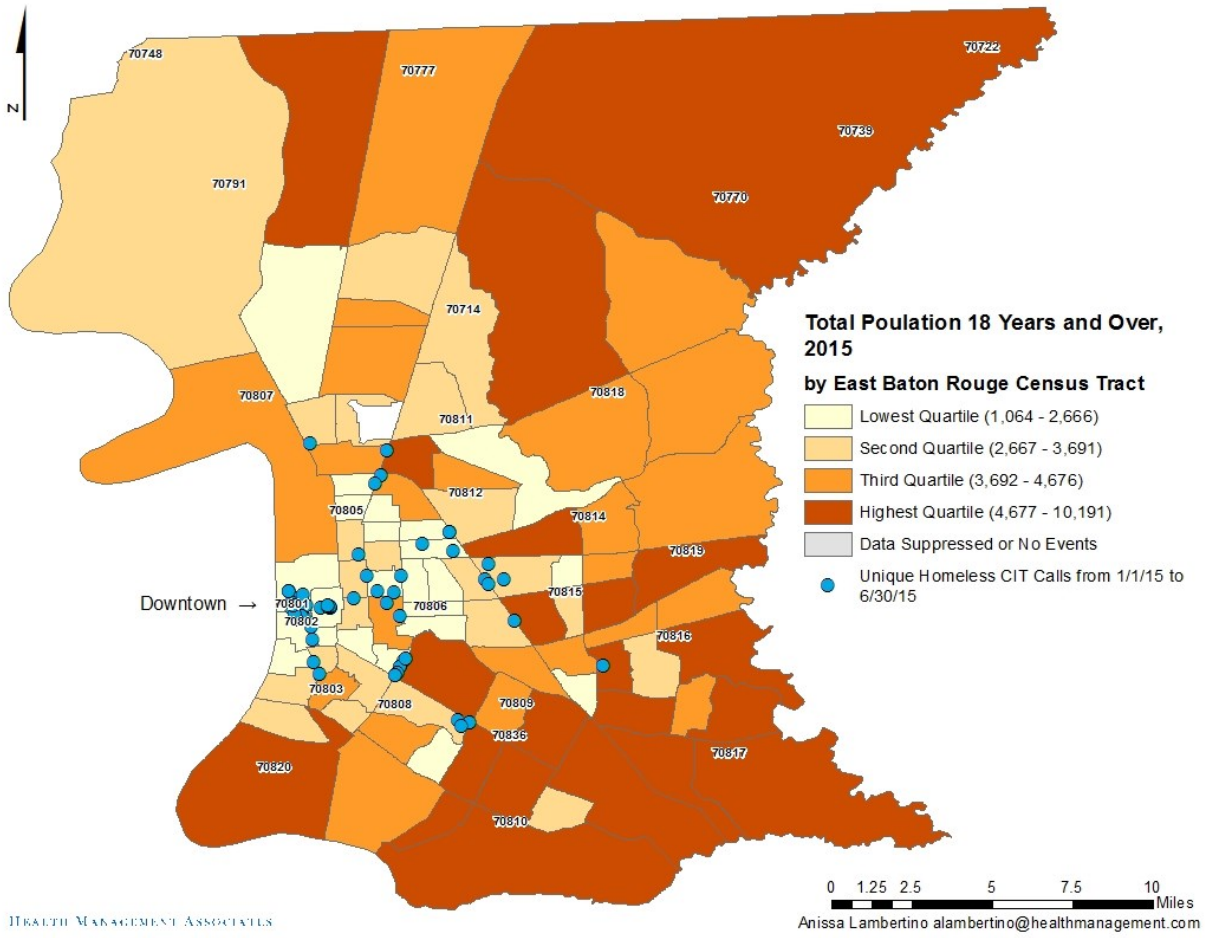
This map starts with the same information depicted in the previous map but adds information about the location of providers by type. It is important because it shows that a majority of EBR providers are located in a cluster of census tracts with a high rate of EDP and suicide/overdose CIT calls.

Provider relationship to hot spot

Type	EBR providers	Number of providers in hot spot (99%)	Percent
Emergency Department	2	0	0%
Housing and Homeless	18	15	83.3%
Licensed Group Home	6	5	83.3%
Outpatient BH	10	7	70%
Total	36	27	75%

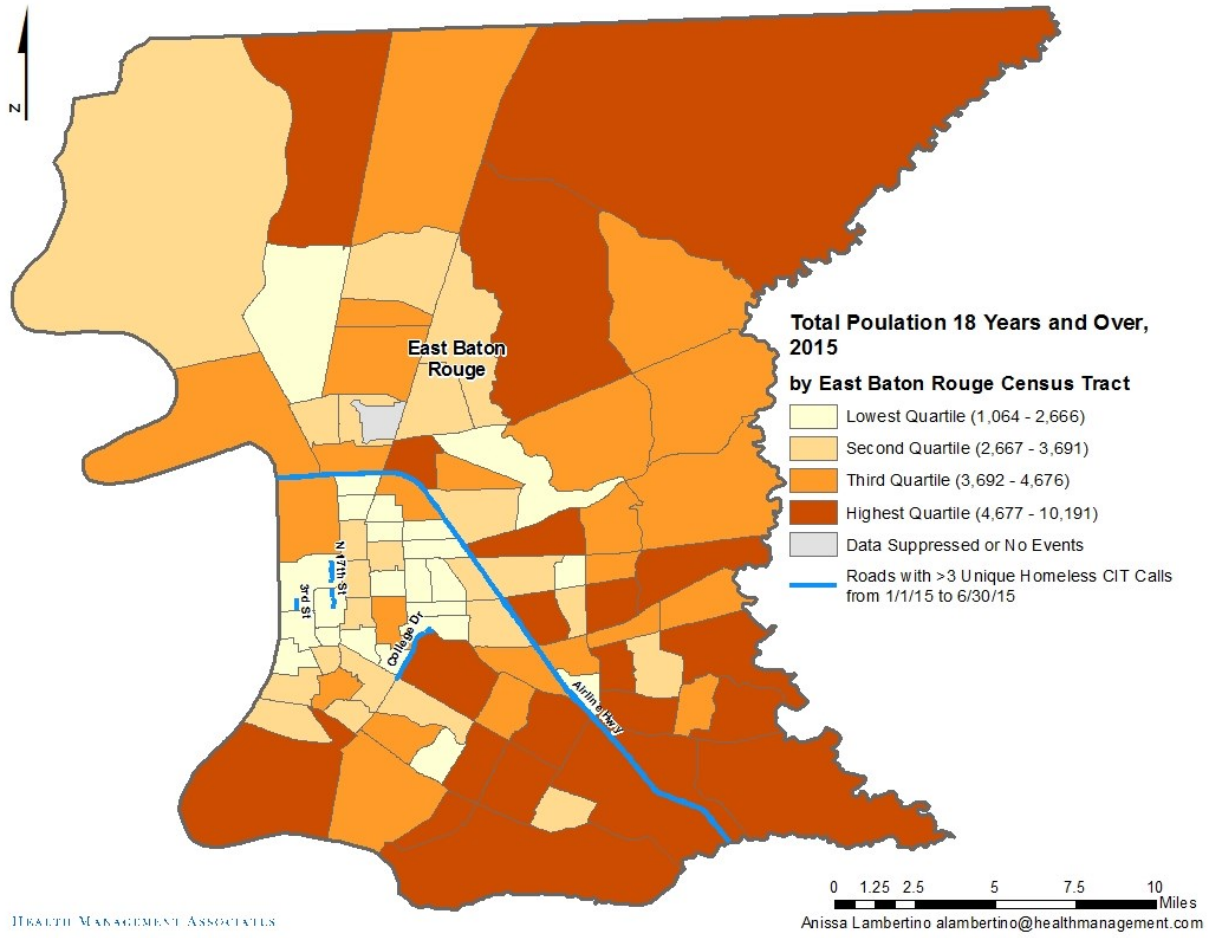


This map identifies and maps the specific Outpatient Behavioral Health organizations providing services to people who are indigent or have Medicaid insurance.



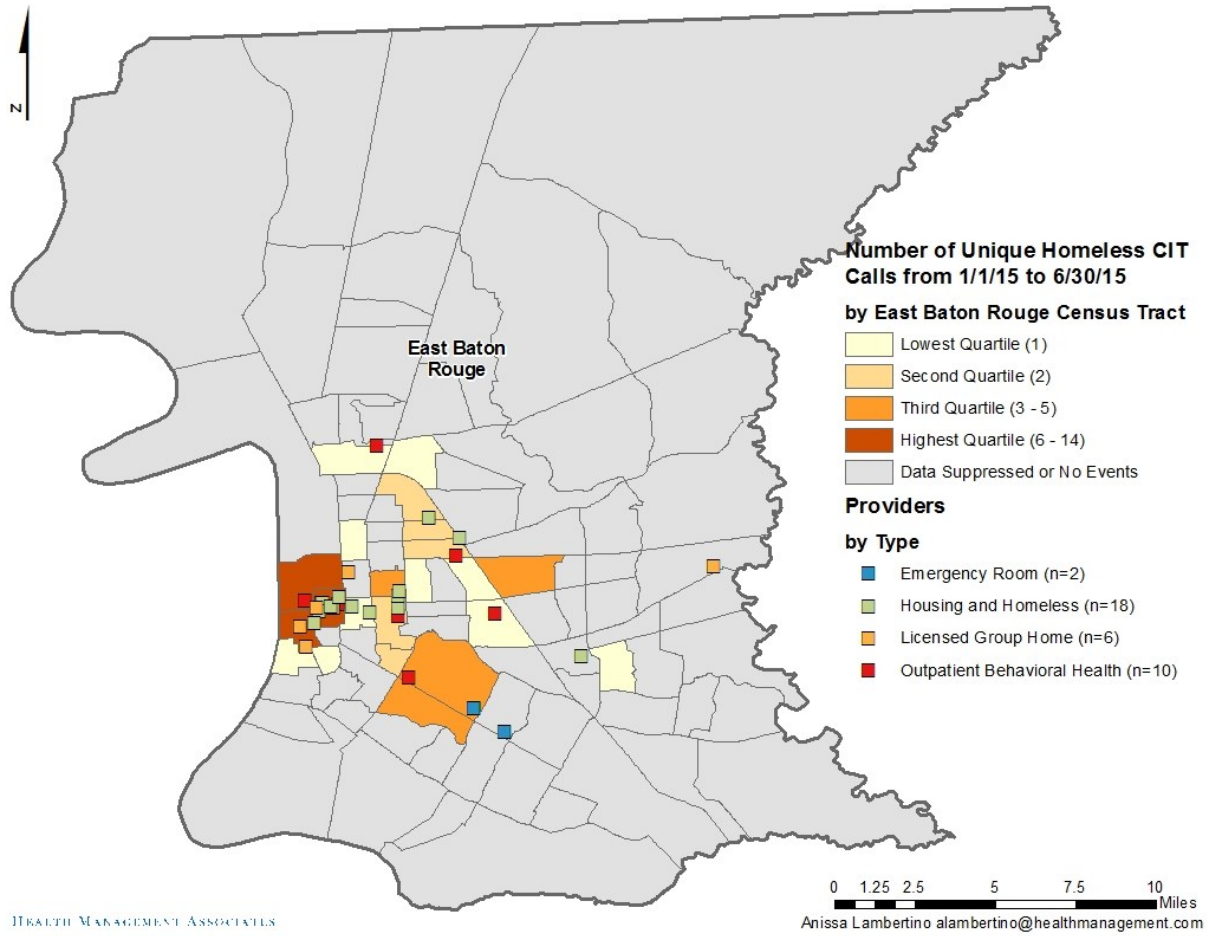
This East Baton Rouge Parish map uses dots to show the location of 70 unique homeless CIT calls that occurred during the first six months of 2015. (One dot may represent multiple calls.) The type of call varied, with more than half classified as arrestee (n=38 or 54%, blue). Less than a quarter of calls were classified as victim (n=23 or 21%). The geographic distribution of CIT calls for homeless occurred in west central census tracts including downtown Baton Rouge. This distribution suggests areas of concentration that may be positively impacted by homeless services expansion/coverage.

We did additional analysis to identify clusters along specific roads. Roads with greater than three calls are presented in the map below.



Addresses with Greater Than Three Unique Homeless CIT Calls from 1/1/15 to 6/30/15

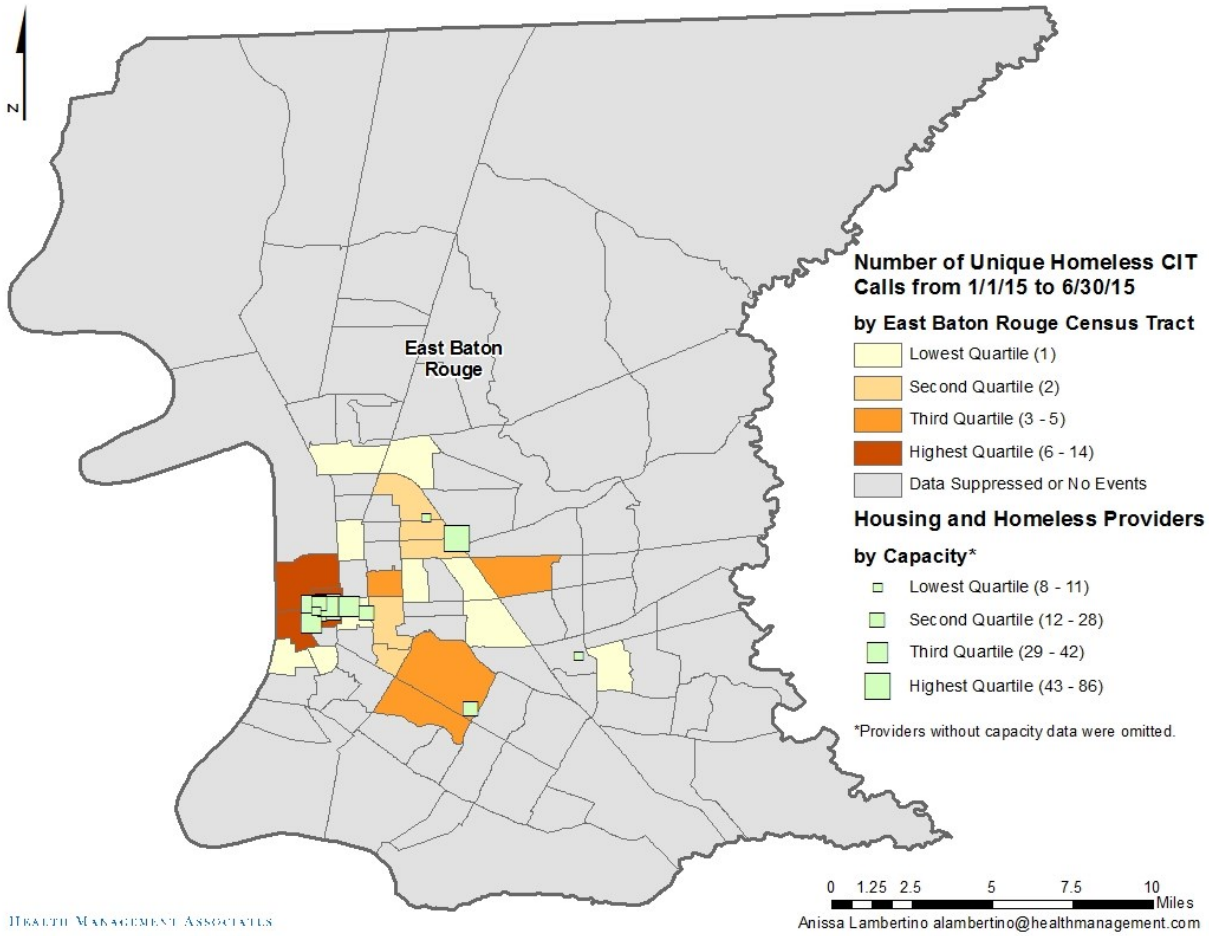
Street number(s)	Street name	Number of calls	Percent of calls
153	N 17th Street	9	12.9%
2600, 2950, 3100, 3145	College Drive	6	8.6%
263, 301	3rd Street	6	8.6%
4388, 8287, 8400, 9110	Airline Highway	4	5.7%



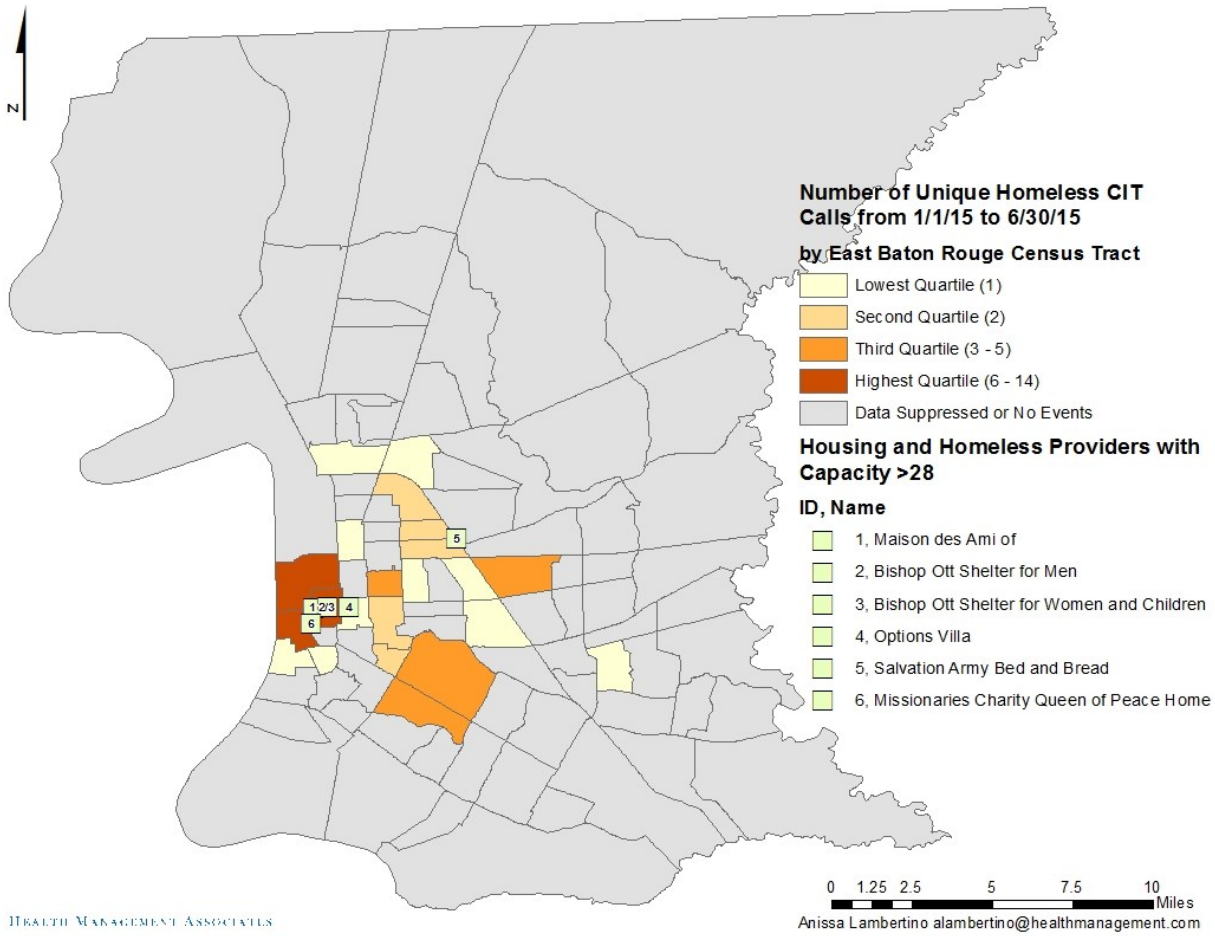
This East Baton Rouge Parish map shows census tracts shaded to represent the frequency of 70 unique homeless CIT calls that occurred during the first six months of 2015. The highest number of calls (more than 5) occurred in a cluster of census tracts that intersect the following zip codes: 70801 and 70802. This map is important because it shows that more than half of providers are located in census tracts with medium to high numbers of calls (3-14).

Provider relationship to census tracts with unique homeless CIT calls greater than two

Type	EBR providers	Number of providers in CTs with >2 calls	Percent
Emergency Department	2	1	50%
Housing and Homeless	18	12	83.3%
Licensed Group Home	6	3	50.0%
Outpatient BH	10	5	50%
Total	36	21	58.3%



This map shows the number of housing units and providers in context with calls that occurred.



This map specifically identifies housing providers with more than 28 units or beds.

RECOMMENDATIONS BASED ON DATA AVAILABLE

Throughout the course of this project as interviews and site visits took place, HMA asked about the availability of data and how data is used for informed decision-making, planning efforts, and utilization of existing resources. Consistently the response was that data is collected and to varying degrees used to guide practice. Data was reported as being collected and recorded on paper or in some form of electronic system. (See Appendix D for specific data requests made.)

As noted earlier, we received only limited data. As a result, it is not possible to point to specific data-based findings to support all of our recommendations. However, we feel confident in making a number of recommendations.

1. It is strongly recommended that through the planning process (described later in this report) a thorough assessment of existing data as related to data points identified in Appendix D be collected and assessed. Several areas of focus should be considered:
    a. Assess what data is being collected now, how is it being collected, where it resides, and how is it used currently.
    b. Determine how data could be collected to ensure needed information is available that will help inform decision-making and systems development.
    c. Work to centralize data or manage data in a way that allows information to be collected and analyzed in total and across systems.
    d. Identify potential funding sources to collect and analyze data across current systems that will allow available resources to be maximized and demonstrate return on investment as programs are implemented.
    e. Invest in data analytics capacity and technology solutions. Both short and long-term investments should be considered.
2. Based on data mapping analysis completed above, we recommend that the BRidge Center be located in one of the identified hot spots. Ideally, a location sited in zip codes 70801 or 70802 should be given highest priority, with zip codes 70805 and 70806 being considered as alternatives, if needed. Space currently available at the Baton Rouge Detox Center is located in zip code 70806.

Diversion Program Recommendations

The East Baton Rouge (EBR) Clinical Design Committee was asked to develop a set of recommendations that could respond to the crisis the EBR community is experiencing—a crisis that results in the criminalization of people with behavioral health issues. The Committee focused its response on the previously described closing of the Earl K. Long hospital and the Mental Health Emergency Room Extension (MHERE) program located at that facility, and the dramatic rise in the number of people being incarcerated that followed. This focus led the Committee to recommend a continuum of crisis services approach

that was modeled largely after the former MHERE program as well as the Bexar County diversion service continuum.

While there is no doubt that a set of crisis services is needed, it became clear over the course of this project that the challenge EBR is facing is more complex and requires a multi-pronged approach that goes beyond development of crisis services.

Like other communities across the country, EBR lacks the capacity needed to provide comprehensive, high-quality, community-based supports for people struggling with serious mental health and substance use issues. Without this range of supports in place and working in concert, development of crisis services alone will not meet the goal of keeping people who require treatment in the community and out of the criminal justice system.

There is no question that the best way to divert a crisis is to prevent one from the outset. However, EBR has only a limited set of resources available to address the current problem. Thus, this report focuses on an overall strategy to redesign *existing* community resources so that people can access services appropriate for their level of need and risk, and it recommends the development of a set of targeted interventions that can help provide immediate alternatives to criminalizing people with behavioral health issues.

Many of the critical components required to have a comprehensive system of care already exist within EBR. However, despite their dedication and tireless efforts, current providers and service organizations within EBR are operating in silos, collaborating when possible, but only out of necessity, and creating critically needed services only as funding streams allow. As a result, the behavioral health care system is fragmented, inefficient, and fails to meet the needs of this vulnerable population. Additionally, critical services are not available, as they have not received funding. Case management and care management are among the most critical areas not available within the present continuum of care. These factors, combined with the realities of the current Louisiana healthcare environment, mean that people with serious behavioral health issues in EBR often are able to access care only when they get extremely sick. The result is a crisis: behaviors are being addressed at inappropriate levels of service such as emergency departments and inpatient units,[82] and the mentally ill are criminalized when resources become overburdened with patients requiring care.

The following recommendations will be discussed in greater detail below:

1. Embrace a continuum-of-care strategy across the community focused on targeted population health interventions. The term population health refers to the health outcomes of a group of people, and the policies and programs that impact the health of the identified group of people.
    a. Collect, use, and share data to risk stratify the population and target appropriate access and interventions.

[82] During the last week of October OLOL, tracked the number of people who came to the ED who they believed could have come directly to the BRidge Center, if doors were open, for care rather than the ED. Eleven individuals presented in that week who were experiencing a behavioral health crisis not in need of the level of care OLOL would provide on an inpatient unit or requiring assessment in the ED. Extrapolated to a year this suggests approximately 572 people might utilize the BRidge Center. Email correspondence from Deborah Dominick, OLOL November 13, 2015.

b. Redesign where and, when possible, how organizations and services work together on behalf of the population(s).
c. Should the state decide to implement Medicaid expansion, engage in the process to ensure that the design of the expansion addresses the behavioral health needs of the target population.

2. Plan and implement a set of priority pre-arrest diversion processes and services, housed within one central location, if possible.
    a. A BRidge Center Mobile Assessment Team (MAT) that will respond to law-enforcement calls and assess level of service intervention needed.[83]
    b. BRidge Sobering beds where people have a safe place to rest while under the influence of alcohol and drugs and staff work to refer patients to ongoing services.
    c. A BRidge Medical Detox program where people withdrawing from substance dependence are evaluated, medically managed and physical harm from the detoxification process is minimized.
    d. A BRidge Center Behavioral Health Respite program where people experiencing a psychiatric crisis, not requiring inpatient intervention, can be evaluated and stabilized.
    e. A BRidge Center Care Management Team that will provide ongoing community supports and assertive care management interventions to high utilizers of the behavioral health and criminal justice systems.

3. Work toward a system of care that over time includes expansion of services anticipated to leverage the results of implementing the recommendations described above.

East Baton Rouge Population Health Strategy

To achieve desired outcomes with finite resources, it is imperative that the right services be available for the right people at the right level of care. Adoption of a population health strategy is crucial to providing adequate care for people with serious behavioral health issues in the community and developing an effective approach to freeing up acute intervention services, including inpatient beds for those requiring that level of support. The population health approach moves the system from a reactive model to a more proactive model and allows for planning and expanding services to meet actual needs. This continuum-of-care approach moves people to their highest level of functioning with interventions at early signs of worsening condition and keeps people functioning within their community. While the building of another emergency department at first glance would appear to address capacity problems, an understanding of the chronicity and trajectory of severe mental illness suggests that the enduring and long-term solution is earlier intervention to avoid the crisis that leads people to seek care in emergency de-

[83] The MAT staff will be employed by the BRidge Center, and be part of the BRidge Center staff. Ideally their office will be sited with the other BRidge Center programs. However, if response times to officers' request for assistance are consistently longer than desired, an alternative site for the MAT may need to be considered.

partments. This approach is similar to the shift we observe in the management of other chronic diseases like heart failure and asthma (historically treated in ICU and emergency rooms), where a costly visit to the emergency department shows a failure to provide early and appropriate care in the community.

Currently in EBR, each organization assesses needs and targets interventions on a case-by-case basis as a person presents to that organization. While individual needs must always be assessed, doing so without understanding how one person's care plan fits in context with other people presenting for care means the system may not always be able to prioritize resources effectively and creates duplication of services.

Typically, people with Medicaid or private insurance coverage receive coordinated care through managed care plans or some other similar entity. No such coordination of care or consistent access to needed services is available for the indigent population. While this may eventually change as the Office of Behavioral Health moves towards a managed care approach for the uninsured, proactive efforts must be made now to coordinate across the system and put in place pathways for specific populations to have access to targeted interventions.

A population health strategy will require community providers and other stakeholders, such as advocacy organizations, family and consumers, community members and payers, to come together and build consensus regarding priority populations and to determine how services and organizations will work together and how available funding will flow to ensure quality services are accessible. While daunting to consider, efforts such as these can result in significant positive results, including improved outcomes and reduced total cost of care. Typically, systems transformation efforts achieve the greatest results by focusing on people who cost the most because of high utilization rates and inappropriate or avoidable utilization of services. Across the country, health care providers are taking on these challenges as integrated delivery systems and accountable care organizations are revolutionizing the way services are offered. Typically, a payer or managed care system offers incentives to providers to work together to achieve a specific set of outcomes that improve population health, improve quality of care, and reduce overall cost of care.

With the transition from Magellan Health managing behavioral health benefits to management across the five Bayou Health Plans, the opportunity to influence the system appears to be optimal. Many of the plans that are working to address both physical health and behavioral health have experience providing comprehensive benefits in other states, but they are new to providing both kinds of services within Louisiana. The two plans we interviewed are probably representative of all five plans in terms of where they are in integrating behavioral health, building a network of providers, and understanding the unique needs that residents and systems of care present in Louisiana. In addition, given that the OBH is working to develop a managed care strategy and mechanism for managing uninsured services, the time is right for service providers and organizations to be proactive.

The following actions are recommended to move towards a population health strategy:

1) Identify a consultant or independent third party with project management expertise to convene stakeholders. Over time, this function could be transferred to the new organization that manages the BRidge Center. The current system of care exists because organizations have developed

over time by following siloed funding streams, nurturing a commitment to specific populations and types of services, and ultimately because they are following a business model intended to keep the doors of that organization open. The idea of redesigning the service system and working toward utilizing resources differently may not be embraced by all organizations. An independent convener can help establish and build trust among organizations that have traditionally competed for limited resources and can break down barriers that make it difficult for stakeholders to step away from the status quo.

2) Constitute a stakeholder group able to influence and modify the existing system of care and invest in achieving agreed upon goals. It will be crucial to engage stakeholders who are strategic decision makers within their organizations and are committed to working toward meaningful system change. Stakeholders should include representatives across the system of care including:
    a. Payers (the five Bayou Health Plans, OBH, DHH, commercial insurers, and parish representatives)
    b. Hospitals (OLOL, Baton Rouge General, other private hospitals)
    c. Community Behavioral Health Organizations (CAHSD, Baton Rouge Detox Center, NHS Human Services and others with significant market share in EBR)
    d. Organizations providing supports to people experiencing homelessness (Capital Area Alliance's One Stop Homeless Service Center, group homes, and continuum of care providers)
    e. Veterans Administration
    f. Organizations providing long-term care and home-based supports (nursing homes, residential services and home health)
    g. Advocates, consumers, and family members

3) Convene stakeholders and establish a shared vision for work to be undertaken.
    a. Document vision and mission of work to be accomplished in a charter, Memorandum of Understanding (MOU), or document that all parties can contribute to and commit to.
    b. Define specific tasks and goals to be accomplished by the group.
    c. Articulate a timeline for work to be completed and a process by which input will be gathered, conflicts resolved, and identified actions completed.

4) Establish stakeholder group accountabilities, frequency of meetings, and expectations each member will be responsible for achieving.

5) Create a culture of change management within the stakeholder group.
    a. Clarify the problems that are the reason for the needed changes and solicit input on how to implement changes needed; identify where there is room for flexibility.
    b. Analyze who stands to lose and gain within a new system (recognize there will be organizational change that will be challenging and identify how the system will ultimately benefit).
    c. Look for opportunities to create win-win strategies.

d. Talk about transition and build supports to help support system change, monitor it, and identify barriers as they come up.
e. Provide multiple mechanisms of communication and be as transparent as possible when implementing changes across an organization or system.
f. Design temporary systems if needed to minimize confusion.
g. Consider using a transition team to help monitor impacts and make adjustments as needed.

6) Determine target or priority populations on which redesign of target interventions will be focused (initial focus should be on high-risk, high utilizers of costly and limited resources).
    a. Analyze available data that provide information, including:
        i. Service utilization patterns
        ii. Claims data, if available
        iii. Costs of care for sample of high-utilizing patients based on diagnosis, if available
    b. Collect anecdotal information:
        i. Ask stakeholders to provide de-identified descriptors of the top 5 to 10 high-risk patients their organization cares for (i.e., diagnosis, level of functioning, challenges encountered, services provided, identified opportunities to be more effective with this type of patient).
    c. Document and define the target populations.

7) Map the current system of care that the defined target populations utilize and identify critical service components (based on outcomes data, if available), gaps or barriers to care, and opportunities to improve.
    a. Identify opportunities to create new services, if possible, when gaps cannot be filled by existing providers.
    b. Analyze current capacity and ability to access services.

8) Redesign workflows that draw on the strengths of the current system and organizations within the community for the target population. Workflows are a series of steps or processes that staff frequently perform, at a specific site or across multiple sites. Mapping these workflows, the steps in the workflow, and which staff perform them, and how they are performed is a means for identifying opportunities to improve efficiencies and to identify current barriers or typical errors that may impact desired outcomes. Specifics to consider include:
    a. Several workflows may need to be created based on available funding.
    b. Points of entry into the system of care ideally will occur at multiple points within the system and at different times in the course of a specific person's course of illness.
    c. Level of intervention needed by a member of the target population will vary over time, and tools will need to be used that help assess individual changes and the system responses to those changes (the level of care will need to be modified based on these assessments).

d. System and specific service capacity will need to be evaluated based on understanding of the volume of target populations.

9) Create assessments and tools that will be implemented across provider organizations when possible to streamline information gathered and used (will require data use agreements and structures that permit sharing of information). Priority considerations for development include:
    a. Health Risk Assessment – A questionnaire designed to gather specific information related to potential health risks and key factors that affect level of risk (see Appendix E).
    b. Screening Tools (e.g., PHQ9,[84] AUDIT,[85] CAGE,[86] ASSIST,[87] GAD-7[88]) – Brief assessments commonly used to assess for depression, substance abuse, and anxiety.
    c. Care Plan – A detailed plan describing treatment goals and what services will be provided, by whom, and how often.
    d. Crisis Plan – A plan describing the course of action when a crisis is encountered by the patient often including a specification of typical signs or symptoms to look for when illness is worsening and actions that have helped divert the crisis previously.
    e. Advanced Directives – Typically directives the patient completes when healthy that identifies desired treatment provider, and specific services, interventions or medications for providers to take into account when the patient, because of illness, cannot provide consent for care.

10) Identify opportunities to streamline work processes and workflows across the system of care. Priority areas of focus include:
    a. Risk stratification methodology (including diagnoses, claims data, functional analysis, and social determinants of health)
    b. Admission and discharge processes (to and from different levels of care)
    c. Transition of care (hand-offs between providers and organizations)
    d. Health registries
    e. Communication protocols and data to be shared
    f. Medication reconciliation
    g. Access and coordination with primary care and specialty care

11) Identify shared outcome goals and metrics that will be used to determine success and allow for the redesigned system to undergo continuous quality improvement activities (identify processes for data collection, analysis of data, and process improvement accountabilities). Priority metrics and outcome indicators to consider include:
    a. Emergency department presentations
    b. Inpatient bed days

[84] http://www.cqaimh.org/pdf/tool_phq9.pdf.
[85] http://www.integration.samhsa.gov/images/res/tool_auditc.pdf.
[86] http://pubs.niaaa.nih.gov/publications/inscage.htm.
[87] http://www.who.int/substance_abuse/activities/assist/en/.
[88] http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf.

c. Readmission rates
d. Medication adherence
e. Other HEDIS measures
f. Total cost of care
g. Use of screening tools to measure impact of care

12) Create work plan and timeline to implement redesign. Priority considerations include:
    a. Specific actions needed by whom and by when.
    b. Determine realistic timelines.
    c. Ensure mechanisms are in place to resolve conflicts and overcome barriers.
    d. Include plans to spread the population health strategy to additional populations over time.

Effective system redesign is crucial for the success of diversion programming in EBR. Without a population health strategy in place, the continued fragmentation of services will make it impossible to keep people with significant behavioral health needs from cycling in and out of care and the criminal justice system.

DEVELOPMENT OF BRIDGE CENTER – A CONTINUUM OF DIVERSION STRATEGIES

As described previously, communities across the country are working to develop systems and strategies to keep people with behavioral health issues from entering or cycling in and out of the criminal justice system. A lesson learned from these communities is clear: the approach taken must be driven by local needs. Collaboration across the behavioral health provider community and criminal justice system is key to success. This section describes a set of priority program components. Specifics related to how to implement and develop the components will be detailed in the following business plan section.

The mission of the BRidge Center[89] is to offer targeted interventions that will provide an alternative to taking people who have encountered the criminal justice system because of uncontrolled behavioral health issues to the Parish Prison or to an emergency department (ED). Brief interventions at the BRidge Center can help stabilize people in crisis who are not in need of inpatient care and can then connect patients back to the community for ongoing needed supports. Psychiatric evaluation at an emergency department will be required when the individual is considered a danger to himself or others or unable to care for himself. If the individual has been court ordered or mandated to seek outpatient treatment (assisted outpatient treatment), this may be an appropriate setting for care.

Within the current system, when law enforcement is called to respond to a disturbance or suspected criminal activity, only two options exist for the officer: take the person who is experiencing a crisis to an emergency department or take the person to Parish Prison. Often, individuals taken to an ED do not need emergency intervention at this level of care or an inpatient stay. But because neither the officer nor Parish Prison staff is medically trained to handle or treat the behaviors observed, a visit to the ED is determined to be warranted rather than immediately taking the individual to the prison. The results are long wait times for officers as medical clearance or admission is determined, increased ED costs and utilization, and diversion of both law enforcement and hospital staff away from where they need to be—which is, focusing their attention on ensuring community safety and responding to those requiring urgent medical and psychiatric care. People who require treatment for medical or psychiatric needs are best served outside of the criminal justice system and in the community, if possible.

Pre-arrest diversion programs are not designed to serve all populations. Thus, from the outset, specific criteria and conditions for eligibility for diversion to the BRidge Center must be specified. Law enforcement officers who encounter individuals suspected of criminal activity will invariably have to use their own judgment in determining whether an individual should be diverted to the Center. Crisis Intervention Training (CIT) for officers will help officers make appropriate judgments, but having objective criteria will also make the task less subjective. Such criteria are also necessary to ensure that violent individuals who need to be incarcerated are arrested and to ensure that resources and services at the Center are utilized at appropriate levels. Over time, opportunities to expand diversion services and the populations

[89] BRidge Center is the working name of the proposed EBR continuum of diversion services.

eligible for the services should be considered. The following recommendations provide a starting point for development of a diversion system in EBR.

In deciding whether to take people to the BRidge Center, law enforcement officers should determine that following conditions are present:

- Mental illness suspected.
- No outstanding warrant.
- Non-violent activity and potential threat is determined to be minimal.
- First-time offender or misdemeanor (could be multiple misdemeanor pattern).
- No potentially life-threatening acute emergent or physical health issues present (see below conditions for immediate ED transport).
- Person is willing to be taken to the BRidge Center.
- Person is 18 years of age or older (a limitation that is based on current staffing patterns and licensing requirements).

Circumstances that would indicate the person should be taken directly to an ED:

- Presence of specific acute physical health conditions, such as chest pain, respiratory distress, large or major wound, loss of consciousness, suspected head injury.
- Breathalyzer > than 0.3.
- Pregnant.
- Victim of assault or rape.
- Suspected overdose.
- Danger to self or others.

Once a person is medically cleared from the ED and the above conditions are determined to be met, a transfer to the BRidge Center is indicated. At times, it may be challenging for law enforcement to determine when it is appropriate to take the person to the BRidge Center. When an officer with CIT training[90] is not available or the specific situation warrants further assessment by a health care professional, the officer should call the Mobile Assessment Team (MAT).

BRidge Center Mobile Assessment Team (MAT)

The MAT is a two-person team able to respond to law enforcement and assess the level of service intervention needed. The MAT is staffed by a registered nurse and licensed social worker and is available by phone and able to respond to law enforcement 24 hours a day, 7 days per week. Depending on the volume of calls, the goal will be to have the team available to respond to calls and complete an in-person assessment, if indicated, within minutes. The MAT team should be housed at a centrally located place where response time to calls can be minimized (please see hot spots described previously), ideally within the BRidge Center.

[90] CIT Training is recommended for all officers. Advanced training may also be desired for a smaller group of officers if resources allow.

Conditions present that might warrant a call to the MAT include:

- Person is agitated.
- No potentially life-threatening acute emergent or physical health issues present (see above conditions for immediate ED transport).
- Breathalyzer < than 0.3.
- Person appears psychotic.
- Officer is unable to determine if inpatient hospitalization may be required for behavioral health or medical issues.
- Person is uncooperative or unable to interact or communicate with officers (perhaps because of substance use).

If the MAT is called, the team should determine if BRidge Center services are indicated and identify alternative service options if BRidge Center services are not an option. This type of mobile assessment and response is needed across EBR and for law enforcement, EMS, and other customers. However, initially, the MAT's primary customers should be law enforcement and EMS to ensure availability of the service for diversion efforts. Later, as volume and call patterns are better understood, expansion can be pursued as funding allows.

Goals of the MAT include:

- Immediate response to law enforcement calls, assessment of situation, and an estimated time of arrival of the MAT.
- Completion of brief screening and a recommended disposition to officers, primarily in person or by phone, within 30 minutes.
- Transfer of screening results and any identified recommendations to the BRidge Center or ED, if indicated.
- In the event that, through the course of brief screening, the officer determines that transfer to Parish Prison is indicated, screening information and recommendations will be sent with officers for Prison Medical staff.

Success of the MAT will be determined by several factors:

- Immediate response by phone to officer calls.
- Accurate time estimates to arrive on the scene for in-person screening, ideally no longer than 30 minutes.
- Ability to screen and determine disposition quickly.
- Team members developing trusted relationships with law enforcement.
- Collaboration with EMS, ED staff, and other urgent care points of contact.

Recommendations to be considered specific to the MAT:

- During the planning phase, identify opportunities for MAT members to meet officers and learn what is required when officers respond to calls and how they work, so that MAT response supports officers' activities.

- Start with creation of a brief screening tool/protocol that blends assessment of the current situation, immediate behavioral and medical health and safety risks, and individuals' ability to take care of themselves (are cognitive concerns present, can instructions be followed, etc.)[91]
- Document screening results, disposition, and any recommendations for officers to provide when transporting.
- Set up tracking mechanisms to document and analyze critical data elements, such as call volume, locations of screens, response time, screening time, disposition, and patterns of calls.
- Review collected data and work with officers to identify opportunities to improve screening and response time based on experience in the field.
- Ensure procedures are in place for MAT staff to connect and interact with other BRidge Center staff and ED/urgent care points of contact to ensure communication mechanisms and systems are effective for various programs.

If an assessment determines that it is appropriate to transfer the individual to the BRidge Center, several service options may be considered. Interventions needed and level of care will be determined when a more thorough assessment is completed on-site at the BRidge Center (see Appendix E).

BRidge Center

Once patients are transported to the BRidge Center, staff nurses with assistance from social workers will triage patients and complete a Health Risk Assessment. Medical care that can be provided by on-site staff to address immediate needs will be identified, and the most appropriate type and level of BRidge Center services will be determined. Planned capacity is 30 beds, including sobering beds, medical detox beds, and behavioral health respite beds. However, depending on the number of people who present at the Center and their specific needs, the number of beds designated to each service can vary based on staffing patterns described in this report. The proposed budget below includes funding 30 beds with the different components staffed accordingly. Several factors apply to all three service components at the BRidge Center. These include:

- Individuals served may be dropped off by law enforcement, transported by emergency departments/hospitals, walk in, or be referred by community partners.
- The Center will be staffed 24 hours per day, 7 days per week.
- Services are voluntary. No one will be held or treated at the Center against his or her will. If OPC or CEC is indicated, the patient should be transported to an ED instead of the BRidge Center. If the patient is at the BRidge Center, transportation to an ED will be provided.[92]
- Medical care should be provided at a level of service consistent with an urgent care setting.

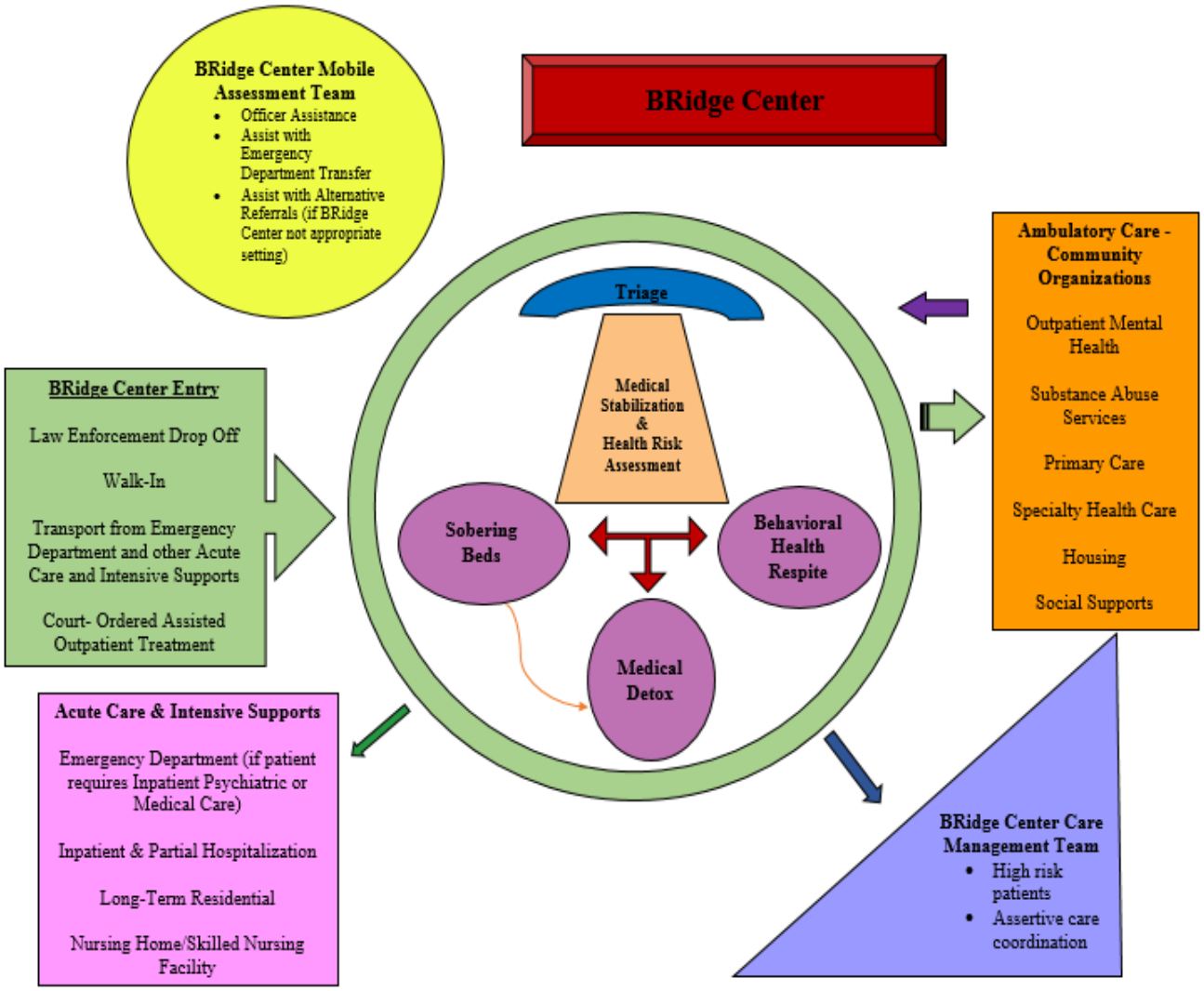
[91] Evidence-based standardized screenings for use by similar mobile teams are not available. Similar models of care, such as in Bexar County, have modified more comprehensive assessments used. Typical elements include: detection of current mental health and substance use symptoms and behaviors, examination of cognitive deficits, and identification of violent tendencies or severe medical problems that require immediate attention.

[92] Individuals requiring transport to an ED from the BRidge Center will follow protocols to be determined (EMT transport standard protocols if a special arrangement cannot be determined).

- Assessment and evaluation of needs is a continuous process.
- SBIRT[93] (Screening, Brief Intervention, Referral and Treatment) protocol for substance use should be practiced as appropriate.
- Staff should be trained in motivational enhancement strategies, interventions, and care plans; discharge plans should take into account the patient's assessed readiness to engage in services and identified stage of change.
- Programming will be based on a trauma-informed philosophy of care (systems and processes developed assume patients are survivors of trauma, and caregivers work to minimize impacts of re-traumatization).
- Discharge planning and connection to community supports and services starts upon entry to BRidge Center services.

The figure below depicts the program components of the BRidge Center, showing how people enter diversion programming and interface with community partner organizations.

[93] http://www.integration.samhsa.gov/clinical-practice/SBIRT.



BRidge Center Fixed Site Components

BRidge Sobering Beds

BRidge Sobering beds will provide a safe place to rest for people under the influence of alcohol and/or drugs. Sobering beds will be staffed by a registered nurse and medical assistant or emergency medical technician. If the potential for withdrawal is indicated and the individual is planning to stop using substances, Medical Detox may be indicated. Length of stay in the Sobering Center is not expected to exceed 12 hours.

Many communities have started to develop capacity to have sobering beds similar to those recommended in this report. The value of these beds is to keep people who are inebriated out of public spaces

and inside where they can be monitored for health concerns. As the effects of the substance use wears off, staff have the opportunity to engage the individual in a conversation and offer assistance including connection to services to address substance abuse and other behavioral health issues. It must be noted that by design, sobering centers have few comforts; mattresses are placed on the floor to minimize falls, and only minimal necessities are offered to patients. The goal is not to encourage people to repeatedly utilize this resource, but rather to ensure their safety, minimize unnecessary use of the ED, limit criminal activity, and refer patients for ongoing care.

Entry to a BRidge Sobering bed is appropriate if:

- The person is intoxicated and has no safe place to stay while inebriated.
- Social detox is not available, is not of interest, or is not an appropriate level of care.[94]
- Physical withdrawal from substances is likely because of the type of substances used, the amount of use, and length of substance use.
- The person is medically stable.

BRidge Sobering beds are intended to:

- Keep the person safe while intoxicated and not vulnerable to victimization.
- Allow the person to rest and sleep off the impacts of substances used.
- Offer SBIRT and potential treatment and referral options, including BRidge Center Medical Detox services, if indicated.
- Reconnect the person to behavioral health services, as needed and desired.

BRidge Medical Detox

BRidge Medical Detox beds are intended for people withdrawing from substance dependence. The unit will be staffed by a registered nurse, advanced practice nurse, and certified alcohol and drug counselor, all of whom have access to a consulting physician as needed. Patients will be evaluated and medically managed so that physical harm from the detoxification process is minimized. Typical length of stay will be determined by substance dependence severity and substances used. The typical length of stay is expected to be between 4 and 10 days and no more than 12 days.

Medical Detox provides:

- Evaluation, including testing for presence and concentration of substances in the bloodstream and screening for co-occurring mental and physical conditions.
- Stabilization, including medication assistance, if indicated, and orientation to treatment and to the patient and family's role in recovery.
- Referral to community treatment and supports.

[94] Social detox is provided in a non-hospital setting and is typically provided by staff who do not follow a medical model of care. Withdrawal likely will not require the use of medications. Social detox emphasizes the impact of support systems. Center for Substance Abuse Treatment. Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 45. DHHS Publication No. (SMA) 06-4131. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

- A first step toward recovery and an entry point into the system of care (individuals who repeatedly utilize medical detox likely require more intensive interventions).

Recommendations specific to Medical Detox include:

- Develop an assessment tool that evaluates key biomedical and psychosocial factors such as: general health history, mental status, physical assessment with neurological exam, temperature, pulse, blood pressure, patterns of substance abuse, urine toxicology screen, past substance abuse treatment or detox, living conditions, violence/suicide risk, transportation, financial situation, legal situation, and physical, sensory or cognitive disabilities.
- Develop training and workflows for staff related to symptoms and signs of conditions that require immediate medical attention.
- Develop guidelines for addressing immediate psychiatric needs.
- Develop guidelines and assessment for determining nutritional status of patients.
- Create health education protocols to inform patients of what to expect during the withdrawal process from specific drugs.

BRidge Center Behavioral Health Respite

The BRidge Center Behavioral Health Respite program is designed to serve people experiencing a mental health or psychiatric crisis who are not deemed harmful to themselves or others and therefore do not require inpatient intervention. Co-occurring substance use, as well as non-acute medical or physical health issues, may be complicating factors. Behavioral Health Respite will be staffed by registered nurses, licensed social workers, certified alcohol and drug counselors, advanced practice nurses, psychiatrists, and a consulting physician. The typical length of stay likely will be between 23 and 72 hours and is not to exceed five days.

Interventions provided to people at Behavioral Health Respite will include:

- Evaluation and assessment.
- Psychiatric stabilization, including assessment and start (or re-start) of psychotropic medications, brief treatment interventions, and crisis counseling.
- Identification of physical health and substance abuse issues that exacerbate mental health issues.
- Assessment of ongoing needed supports and referral or reconnections to community resources.

The goals of the BRidge Center Behavioral Health Respite Unit include:

- De-escalation of the immediate crisis.
- Avoidance of unnecessary hospitalization.
- Identification of ongoing supports and action plans needed to avert future crises.
- Referral and, when possible, warm hand-off to community behavioral health providers.

Recommendations specific to the BRidge Center Behavioral Health Respite program include:

- Development of protocols for brief interventions to be provided while the patient is in respite care.
- Development of health education programs and opportunities to use peers to engage patients and their support systems.
- Identification of services needed and potential organizations to which patients should be referred depending on ongoing needs related to psychiatric and mental health issues, substance use, physical health needs, criminal justice history and patterns, functional status, supports available to the patient, and impact of social determinants of health.
- Development of protocols to determine when a patient is not responsive to interventions and should be transferred to a different level of care.

BRidge Center Care Management Team (BRidge CMT)

Some people will continue to cycle through the behavioral health and criminal justice systems. The BRidge Center Care Management Team, similar to a Forensic Assertive Community Treatment (FACT) team, is designed to coordinate care and provide direct services within the community for up to 100 high-risk BRidge Center high utilizers. The team will include a registered nurse, licensed social worker, certified alcohol and drug counselor, community health worker, an advanced practice nurse, a consulting psychiatrist, and a physician. The care management team will be available by phone 24 hours per day; direct services, provided mostly within the community or individual's home, will be available up to 12 hours per day, 7 days per week. Length of service will be determined on a case-by-case basis. Each patient assigned to the BRidge CMT will work with the full team and be assigned one primary care manager who is then accountable for coordinating care for that person.

Interventions provided by the BRidge CMT will include:

- Assessment and ongoing evaluation of needs.
- Frequent community contact with patients, typically two to five times per week; services include counseling, medication monitoring and reconciliation, health education, case management supports, and identification of possible decompensation or signs of instability that could lead to a crisis or criminal activity.
- Care management with primary care and specialty providers.
- Linkage to housing, employment, or vocational supports.
- Assistance with obtaining and maintaining benefits or entitlements, as appropriate.
- Coordination of interventions based on registries maintained for current caseload.

The goals of the BRidge CMT include:

- Ongoing stabilization of mental health, psychiatric, substance use and medical issues.
- Connection to community services and housing.
- Early identification of escalating symptoms or situations and quick intervention and stabilization to avoid further decompensation.

- Avoidance of inappropriate ED utilization.
- Minimization of need for inpatient stays.
- Reduction in criminal activity.

Recommendations specific to the BRidge CMT include:

- Develop specific eligibility criteria and target interventions.
- Determine indicators for when this level of intervention is no longer needed and develop pathways to alternative levels of care.
- Identify specific workflows and team structures necessary for success, such as daily team meetings, huddles, individual contact assigned to each team member, how the team as a whole will be deployed, and staffing with psychiatrist and other providers.
- Develop staff protocols specific to crisis intervention techniques for office-based and community settings.
- Develop specific tracking systems and registries needed to help monitor interventions and track outcomes.

PHASE II: EXPANSION AND SPREAD OF DIVERSION STRATEGY

The diversion components and strategies described above represent critical pieces of the system of care that must be in place to begin to achieve the goals described above and to shift placement of people with behavioral health issues away from the Parish Prison. Over time, additional services and strategies will need to be considered and implemented. While it is beyond the scope of this report to provide specific details, a number of high-level recommendations have been developed for consideration.

Develop Peer Services

While recommendations described above have focused on targeted treatment interventions, the creation of a drop-in center or BRidge Center component that offers peer supports is a crucial piece of the system of care.[95] The Bridge Drop-in Center would offer access to peers who have behavioral health issues and a history of involvement with the criminal justice system and staff space where individuals could come in to talk with someone, get assistance with service or medication needs, and socialize with others who struggle with similar challenges. These types of supports generally are not eligible for reimbursement through Medicaid or other insurance; however, the investment tends to pay off because peer supports are low-cost and effective at helping people with behavioral health issues avert potential crises and avoid use of higher cost services.

Trained peers often are able to positively influence people struggling with behavioral health issues—often more quickly than trained professionals, because peers tend to be trusted quickly. Having navigated the system of care and managed their own illnesses, peers are excellent at helping others in the following ways:

- Recognize signs and symptoms of relapse and serve as a real-life reminder that recovery is possible.
- Help people navigate the complexities of the healthcare delivery system.
- Build relationships and have conversations about issues that would be more challenging to discuss with a professional.
- Promote health education.
- Offer examples of success, connection to family, and healthy life choices.

Expanding peer supports already offered by the Mental Health Association of Greater Baton Rouge is recommended and would be a way to quickly develop capacity and build upon an existing successful peer-run drop in center.

[95] Center for Substance Abuse Treatment, What are Peer Recovery Support Services? HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

Develop a Continuum of Housing Options

People who are homeless require more support than those who are housed. They usually require a housing unit and a rental subsidy as well as ongoing supportive services that help the individual or family maintain housing. Both components, a subsidy and housing unit, are necessary to help vulnerable people with ongoing behavioral health issues remain stable within the community. Supports can range from intensive Assertive Community Treatment, where treatment providers meet with the individual a minimum of two times per week in the community, to weekly or monthly contact from a case management team. Other supports may include more traditional behavioral health care provided in a clinic or office-based setting.

Permanent supportive housing (PSH), where housing is separated from supportive services, has been demonstrated to be effective in helping people maintain housing and stay healthy. When PSH is provided, the individuals or tenants hold the lease in their name, with no requirements that they get treatment as a condition of maintaining housing. Housing is considered "permanent" with no specific time-limit other than that determined by the leaseholder and landlord. The recipients put their housing in jeopardy if their behavior is such that they are not able to maintain tenancy. Because housing is not contingent upon getting services, when illness gets exacerbated or a crisis occurs, individuals typically are able to maintain relationships with their service providers, maintain their housing and avoid becoming homeless.[96]

People experiencing homelessness and behavioral health issues are likely to be frequent utilizers of both the ED and criminal justice system. Providing supportive housing options in and of itself often helps prevent the cycle of recidivism to both jail and the emergency department.[97]

Access to affordable housing in most communities is limited, and often those most in need are not able to meet requirements to secure a housing unit because access is often limited to people willing to abide by specific rules mandating participation in treatment, adhere to requirements to take medications, and be abstinent from substance use. This type of housing, which is typically highly structured, can be extremely effective for some individuals; however, others require support while they build the motivation to engage in treatment and develop a willingness to take medications. As a result, for some people, alternative housing options may be warranted. Several options should be considered.

"Housing First" programs have been effective in reducing homelessness and frequent use of crisis services and institutions.[98] The Housing First approach reduces barriers for securing a housing unit by allowing entry to individuals who are willing to work with mental health providers but are not yet considered

[96] Substance Abuse and Mental Health Services Administration. *Permanent Supportive Housing: How to Use the Evidence-Based Practices KITs*. HHS Pub. No. SMA-10-4509, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2010.
[97] Srebnik D, Connor T, Sylla L. A pilot study of the impact of housing first-supported housing for intensive users of medical hospitalization and sobering services. Am J Public Health 2013; 103(2):316-21. Clifasefi SL, Malone DK, Collins SE. Exposure to project-based Housing First is associated with reduced jail time and bookings. Int J Drug Policy 2013; 24(4):291-6.
[98] Lipton, F.R. et. al. (2000). "Tenure in supportive housing for homeless persons with severe mental illness," Psychiatric Services 51(4): 479-486. M. Larimer, D. Malone, M. Garner, et al. "Health Care and Public Service Use and

"compliant" with service recommendations or are not abstinent from substance use. Another model that should be considered is "Harm Reduction Housing," often considered "wet" or "damp" housing, where individuals who are active substance users and may not be ready to engage in treatment for an addiction or behavioral health issue work with staff to reduce substance use, engage in mental health care, and learn to be good tenants and community residents.[99]

Identification, Risk Assessment, and Alternative Placement for Inmates within the East Baton Rouge Prison

Priority BRidge Center components should effectively provide pre-arrest diversion interventions. The goal of these services is to effectively assess and divert people *before* they enter Parish Prison. However, for some people, for a variety of reasons (e.g., the individual is acting violently or has committed a felony), pre-arrest diversion to the BRidge Center may not be appropriate. Some of these individuals nonetheless may be suitable candidates for diversion out of the criminal justice system after a brief period of time at the Parish Prison. Systems will need to be developed within the Parish Prison to help identify inmates who could be released with specific supports in place to manage their behavioral health needs. Some of these individuals could be identified by specialty courts, like mental health or drug courts. Others could be determined eligible for diversion prior to making it to a specialty court. Screening and assessment tools, such as a Risk Assessment Tool that is also used to determine bond eligibility, will need to be implemented within the prison, diversion eligibility criteria will need to be determined, and systems will need to be set to connect inmates in the diversion programs to appropriate community interventions. District Attorney Hillar Moore has expressed interest in developing and employing such a tool. Numerous examples of these types of assessments are publically available. It is recommended that EBR identify a tool or adapt one to be used and implement a process for universal screening within the prison. Incorporation of a Risk Assessment Tool is a factor included in the 2015 Justice Study commissioned by the Mayor's Office and Metro Council. That study, which is being completed by Loop Capital Markets[100] and is due in March 2016, was commissioned in response to the need for a new, more modern and efficient Parish Prison. The goal of the study is to determine the appropriate size of the new jail.

Connection to Community Services Post Release

Once inmates are released from Parish Prison, they need community supports to smooth their transition back into the community. Linking the Parish Prison into the overall system of care is crucial to reducing recidivism, and it requires efforts similar to those described above regarding workflows, systems, pro-

Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems." *Journal of the American Medical Association*, April 1, 2009, pp. 1349-1357. Massachusetts Housing and Shelter Alliance. (2007). "Home and Healthy for Good: A Statewide Pilot Housing First Program." Boston.

[99] http://homeless.samhsa.gov/channel/harm-reduction-273.aspx.

[100] http://www.loopcap.com/about-us.

cesses, and transition of care. Priority should be given to ensuring that, while a person is detained, Medicaid benefits are applied for, so that upon release Medicaid benefits are in place and inmates have the ability to access needed services.

It is recommended that specific staff within the prison be responsible for Medicaid benefit applications and for ensuring that benefits are re-established when release nears. This could be a function of social workers or care managers within the Prison Medical team, or Capital Area Human Services District (CAHSD), which already has a social worker and peer supports placed in the Parish Prison, could co-locate additional staff within the prison to assist with benefits and coordinate transitions back to the community and ensure connections to needed services.

Developing a Steering Committee to Create Pre-Arrest Diversion Services

Acting on the recommendations included in this report requires a coalition of community stakeholders who are committed to move from planning to implementation. A BRidge Steering Committee should be convened. The Steering Committee should be made up of strategic decision makers within their systems (many of whom have been meeting over the last year) who will champion the BRidge Center. Steering Committee members should include representatives from the behavioral health and criminal justice systems, including, but not limited to, the following:

- Mayor's Office
- Office of the District Attorney
- Sherriff's Office
- Baton Rouge Police Department
- District and City Court Systems
- Hospitals
- Community Behavioral Health Organizations

Recommendations for the Steering Committee include:

1) Identify an independent third party to convene the Steering Committee and coordinate planning and implementation of the BRidge Center programs. The Baton Rouge Area Foundation (The Foundation) has served in this capacity to date. While the Foundation will likely continue to provide support and resources throughout the process, the Steering Committee should seek to identify and engage a dedicated leader early on who can devote substantial time and energy to implementing the recommendations included in this report. Most likely, this individual will serve as the Executive Director of the new non-profit entity established to raise funds and oversee implementation and operation of the BRidge Center and supporting services, and coordina-

tion with other community resources. The leader may wish to engage outside advisors or consultants, as needed, with specific expertise or skill sets to help move from planning to implementation on certain action items.

2) Identify workgroups that will be necessary to move from planning to implementation, for example, workgroups dedicated to identifying and securing funding, developing and advocating policy or reimbursement model changes, or identifying and securing an appropriate site(s) for services.

3) Convene the Steering Committee, codify a shared vision for work to be undertaken and document the vision and mission of work to be accomplished in a charter, Memorandum of Understanding (MOU), or other document that all parties can contribute to and commit to.
    a. Define specific tasks and goals to be accomplished by the group:
        i. Commit to learning about what motivates different systems, such as use of law enforcement officer time, access to limited behavioral health resources, and impact of staffing at jails.
        ii. Take accountability for reorganizing the current delivery system.
        iii. Create accessible service access points.
        iv. Cross-train providers and law enforcement.
        v. Anticipate details both with potential positive and negative impact.
        vi. Incorporate and interpret language and culture from the behavioral health and criminal justice systems.
    b. Articulate a timeline for work to be completed and process by which input will be gathered, conflicts resolved and identified actions completed.
    c. Establish stakeholder group accountabilities, frequency of meetings and expectations each member will be responsible for achieving.
    d. Engage consumers and front-line service staff (i.e. ED staff, law enforcement officers), when possible, to inform planning.

Over time, the Steering Committee functions should evolve to include the following activities:

1) Evaluate program and disseminate model.
2) Serve as liaisons to Parish government and state legislature for funding purposes.
3) Understand how the processes implemented affect interaction between law enforcement and people with behavioral health issues.
4) Advocate and develop funding strategies with potential payers, including helping to shape expansion of Medicaid covered benefits if Louisiana pursues expansion. This is an area where third-party consultants or subject-matter experts may need to be engaged.

BUSINESS PLAN COMPONENTS

The following section outlines key components of a business plan to move from planning to implementation of the BRidge Center. It is not intended to take the place of a formal business plan. Some elements have been addressed in previous sections, and some will be addressed in detail below. Unfortunately, not all elements can be addressed in the scope of this report.

Content for business plans varies by project. However, several elements are considered essential for most new ventures. The following content areas should be included in a formal BRidge Center business plan developed by executive leadership and approved by the BRidge Center governing board or Steering Committee, described below:

- executive summary
  - organizational description
  - business concept (solution offered)
  - market description
  - value proposition
  - key success factors
  - financial situation and needs
- articulated mission or vision statement
  - milestones
- planning assumptions and literature available
  - summary of current market
  - client or target population characteristics
- proposed actions or solutions
  - program and staffing models
- target goals and success indicators
- implementation work plan
- funding plan, financial assumptions and revenue projections
- operating model and strategies
- risk analysis and proposed mitigation plans

Recommended Service Component Staffing Models and Proposed Budget(s)

Proposed staffing model salaries are based on two sources of HR information available for Baton Rouge, www.Indeed.com and www.salary.com. The Indeed site lists salary averages, while www.salary.com site shows median salary. For the purpose of this budgeting exercise, the average salary was used unless the median was higher. In this case, the two recommendations were averaged to determine salary budget.

Salaries listed were current as of October 2015. Please note that salary figures used should be interpreted as a rough approximation of the amount the various employees would need to be paid rather than as precise amounts.

Job Title	Average Annual Salary (dollars)	Median Annual Salary (dollars)	Salary Used for Budget Projection
Licensed practical Nurse (LPN)	44,000	37,990	44.000
Registered Nurse (RN)	49,000	60,896	54,948
Nurse Practitioner or Advanced Practice Nurse (NP or APN)	83,000	84,891	83,946
Physician Assistant (PA)	57,000	83,107	70,054
Licensed Professional Counselor (LPC)	38,000	32,324	38,000
Licensed Clinical Social Worker (LCSW)	53,000	54,445	53,723
Chemical Dependence Counselor or Certified Alcohol and Drug Specialist (CADC)	33,000	43,354	38,177
Psychiatrist	164,000	178,484	171,242
Emergency Medical Technician (EMT) or Paramedic	20,000	34,719	27,360
Medical Assistant	33,000	28,673	33,000
Licensed Case Manager	60,000	63,201	61,601
Case Manager	40,000	Not available	40,000
Community Health Worker	27,000	Not available	27,000
Certified Peer Specialist	21,000	Not available	21,000
Healthcare Project Manager	81,000	Not available	81,000
Clinical Director*	66,000	Not available	86,000*

*An experienced Clinical Director will be critical to the success of the BRidge Center. As a result, the recommended salary is significantly higher than the current Baton Rouge average.

BRidge Center service providers will work in collaboration to provide a continuum of services. Staff can be cross-trained and used across services. Staffing models are recommended below for each individual

service. Shared infrastructure and administrative staff are included in the rolled-up model only. Personnel will need to be available to cover holidays, vacation, and sick time. Staffing model(s) are based on the assumption that there will be three 8.5-hour shifts.

BRidge Center Mobile Assessment Team – The Mobile Assessment Team (MAT) is available to respond to calls primarily from the Baton Rouge Police Department, specifically CIT-trained officers, the Sheriff's Department, and over time, as available to the Parish Prison. The MAT will be available 24 hours a day, 7 days a week to assist when officers suspect mental health or substance abuse issues are present and when the person(s) involved in suspected criminal activity may be eligible for diversion to the BRidge Center. The MAT will provide on-site assessment and help determine if individuals require treatment at an ED or can be diverted to the BRidge Center.

Position	FTE	Annual Salary per FTE	Fringe (25%)	Total Annual Personnel Budget by Position
RN	3.0	$54,948	$13,737	$206,055
LCSW	3.0	$53,722	$13,431	$201,459
Total Annual Personnel Budget	6.0 FTE $407,514 salary plus fringe			
Additional Items To Be Included in Budget	Vehicle, cell phones, laptops, mobile medical bag(s)			

BRidge Center (fixed site services) – The BRidge Center is designed to include 30 staffed beds that can be used for a specific service depending on current demand. Services include Sobering Beds, Medical Detox, and Behavioral Health Respite. Two triage exam rooms designed to provide assessments or urgent medical care will be available at the center. Staffing models below are based on the service component and recommended number of beds designated for that service for budgeting purposes. All services will be staffed 24 hours, 7 days per week.

BRidge Center service components include:

Sobering Beds –Sobering Beds are designated for people needing a safe place to rest while under the influence of alcohol and other substances. Expected length of stay is less than 12 hours.

Position (based on up to 12 beds)	FTE	Annual Salary per FTE	Fringe (25%)	Total Annual Personnel Budget by Position
RN	3.0	$54,948	$13,737	$206,055
MA (or EMT)	3.0	$33,000	$8,250	$123,750
Total Annual Personnel Budget	6.0 FTE $329,805 salary plus fringe			
Additional Items To Be Included in Budget	Supply of emergency clothes items, access to laundry facilities on-site			

Medical Detox – Medical detox provides a set of interventions (evaluation, stabilization, referral to community treatment) and manages acute intoxication and safe withdrawal from substances. The goal is to minimize physical harm the individual might experience as a result of substance dependence and to identify needed resources for ongoing care post-medical detox. The typical length of stay will be determined by substance dependence severity and substances used. Typical length of stay is expected to be between 4 and 10 days (national average is 7.7 days) and no more than 12 days.[101]

Position (based on 5 beds)	FTE	Annual Salary per FTE	Fringe (25%)	Total Annual Personnel Budget by Position
RN	3.0	$54,948	$13,737	$206,055
CADC	1.0	$38,177	$9,544	$47,721
APN	1.0	$83,946	$20,986	$104,932
Consulting Physician*	208 hours/year (4 hours/week)	$21,216	Not applicable	$21,216
Total Annual Personnel Budget	5.0 FTE plus 208 hours physician time $379,924 salary plus fringe (includes consulting physician)			
Additional Items To Be Included in Budget	Supply of emergency clothes items, laundry facilities on-site			

*Average annual salary in Baton Rouge listed at $169,000. Contracted consultant calculated at $102 per hour (salary plus fringe divided by 52 weeks/40 hours). May choose to use some of this time for psychiatric consultation too.

[101] Center for Substance Abuse Treatment. Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 45. DHHS Publication No. (SMA) 06-4131. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

Behavioral Health Respite – Behavioral health respite provides emergency stabilization for people who are experiencing a mental health or psychiatric crisis. Co-occurring substance use as well as non-acute medical or physical health issues may be complicating factors. Interventions include evaluation and assessment, stabilization, and referral to community resources. Length of stay likely will be between 23 and 72 hours and is not to exceed five days.

Position (based on 15 beds)	FTE	Annual Salary per FTE	Fringe (25%)	Total Annual Personnel Budget by Position
RN	5.0	$54,948	$13,737	$343,425
LCSW	6.0	$53,723	$13,431	$402,919
CADC	1.0	$38,177	$9,544	$47,721
APN	1.0	$83,946	$20,986	$104,932
Psychiatrist	0.50	$171,242	$42,811	$107,026
Consulting Physician*	104 hours/year (2 hours/week)	$10,608	Not applicable	$10,608
Total Annual Personnel Budget	13.5 FTE plus 104 hours physician time $1,016,631 salary plus fringe (includes consulting physician)			
Additional Items To Be Included in Budget	Supply of emergency clothes items, hygiene kits, transportation vouchers, access to laundry facilities on-site			

*Average annual salary in Baton Rouge listed at $169,000. Contracted consultant calculated at $102 per hour (salary plus fringe divided by 52 weeks/40 hours).

BRidge Center Community Care Management Team – The BRidge Center will be successful only if community resources are available and accessible to those most in need. The care management team will be responsible for coordinating care and providing direct services within the community for up to 100 high-risk, frequent BRidge Center utilizers. Length of service will be determined on a case-by-case basis. The goal of the care management program is to support ongoing stabilization, connection to community services and housing, and reduce utilization of EDs and criminal activity. The care management team will be available by phone 24 hours per day, and direct services will be available up to 12 hours per day, 7 days per week.

Position (based on 100 people served)	FTE	Annual Salary per FTE	Fringe (25%)	Total Annual Personnel Budget by Position
RN	2.0	$54,948	$13,737	$137,370
LCSW	2.0	$53,723	$13,431	$134,306
CADC	2.0	$38,177	$9,544	$95,443
CHW or Certified Peer Specialist	4.0	$27,000	$6,750	$135,000
APN	1.0	$83,946	$20,986	$104,932
Psychiatrist	0.25	$171,242	$42,811	$53,513
Consulting Physician*	104 hours/year (2 hours/week)	$10,608	Not applicable	$10,608
Total Annual Personnel Budget	11.25 FTE plus 104 hours physician time $671,172 salary plus fringe (includes consulting physician)			
Additional Items To Be Included in Budget	Supply of emergency clothes items, food vouchers, hygiene kits, transportation vouchers, vehicle(s), cell phones, laptops			

*Average annual salary in Baton Rouge listed at $169,000. Contracted consultant calculated at $102 per hour (salary plus fringe divided by 52 weeks/40 hours).

We recommend that in addition to providing the above service components, the BRidge Center expand over time to include additional mobile assessment services, a 24/7 crisis line (in coordination with mobile assessment services), a drop-in center, and a continuum of residential supports. Please see the recommendation section for more specific detail. These expanded components are not included in the sample budget.

Below is a rolled-up sample budget inclusive of the above direct service components (Mobile Assessment Team, Sobering Beds, Medical Respite, Behavioral Health Respite and Care Management Team). In addition to direct service staff, the budget table below includes administrative staff for the Center and a recommended percent of total budget to cover infrastructure supports. This budget does not include employee overtime, capital or start-up costs.

Staff by Position	Total FTE	Annual Salary plus fringe (25%) per FTE	Total Line Item Budget
RN	16.0	$68,685	$1,098,960
LCSW	11.0	$67,153	$738,683
MA or EMT	3.0	$41,250	$123,750
CADC	4.0	$47,646	
CHW or Certified Peer Specialist	4.0	$33,750	$135,000
Psychiatrist	0.75	$214,053	$160,540
Consulting Physician*	312 hours/year (6 hours/week)	$31,824	$31,824
Float Staff (LPC, Case Manager(2), Certified Peer Specialist)	4.0	Blended salary estimate based on LPC, licensed CM, CM and CPS	$200,751
Reception/Triage	4.5	$37,500	$168,750
Project Manager (Community Liaison)	1.0	$101,250	$101,250
Clinical Director	1.0	$107,500	$107,500
Executive Director	1.0	$162,500	$162,500
Other Costs		**Monthly Budget**	**Annual Budget**
Client Support (food, laundry, transportation)		$10,000	$120,000
Medical Equipment**		$4000	$48,000
Medications		$10,000	$120,000
Furniture (beds, office, exam room)**		$2000	$24,000
IT equipment* (computers, laptops, software)**		$3000	$36,000
Office Supplies and Equipment (paper, copiers, fax machines)		$2500	$30,000
Communications (land lines, cell phones)		$3000	$36,000
Maintenance (janitorial services, cleaning supplies, equipment maintenance)		$8000	$96,000
Security		$15,625	$187,500
Rent and Occupancy (utilities)***		$18,177	$217,408

Staff by Position	Total FTE	Annual Salary plus fringe (25%) per FTE	Total Line Item Budget
Insurance		$3000	$36,000
Staff Training/Professional Development		$1500	$18,000
Travel Expenses		$1000	$12,000
Total Annual Personnel Budget		$3,545,797	
Total Other Costs		$980,908	
Annual Personnel and Other Costs		$3,644,705	
Infrastructure @ 25% per total annual budget (risk management, data collection, quality improvement, HR, recruitment, credentialing, accounting, billing, registration, marketing etc.)		$1,131,676	
Annual Budget Total		**$5,658,381**	

*Does not include EHR or practice management software

**Includes ongoing annual operations budget only. Initial start-up needs not included.

***Based on 17,200 square feet, estimate provided by H.N. "Hank" Saurage IV, CCIM, Saurage Rotenberg Commercial Real Estate, LLC.

Planning for Collection of Data and Outcomes that Will Support Coordination of Care and Demonstrate Return on Investment

As Baton Rouge moves forward with the design and implementation of an evidence-based diversion program, it will be critical that an evaluation plan, including calculation of return on investment (ROI), be included as part of the overall implementation plan and budget. More specifically, an evaluation and ROI calculation will be important for:

- demonstrating the impact of the program to taxpayers, especially if public financing is used to support the start-up and /or operations of the program;
- demonstrating the impact of the program on other funders including, for example, hospitals providing community benefit grant support or social impact bond investors; and
- providing periodic feedback on the program-to-program leadership and stakeholders to inform changes in program design and implementation that can improve outcomes and ROI.

In the current section of this report, we recommend the basic data and design necessary for coordination of care and an evaluation of return on investment (ROI). While an ROI evaluation is beyond the scope of this report, we outline below the basic components and parameters of an ROI analysis that should be included in order to demonstrate the impact of the diversion program and its sustainability over time.

Two basic historical control design strategies may be utilized depending on the availability of previously existing data. The first relies on existing historical data; the second establishes a historical baseline during the period that the diversion program is being designed and implemented (recommended for EBR given current data available):

1. Existing historical control population. Under this approach, a new diversion intervention is used for a group of individuals, and the results are compared to the outcomes in a previous group of comparable individuals receiving a different diversion intervention. This design usually provides stronger evidence concerning the effect of interventions. The historical control or baseline group consists of all individuals with mental illness who were arrested for a misdemeanor in the six months before diversion ramp up and implementation.

2. **Establish new historical control population**. A new diversion intervention is used for a group of individuals, and the results are compared to the outcomes in a previous group of comparable individuals identified during the diversion program planning process. The diversion group consists of individuals who were diverted following implementation of the diversion program over a six-month time period.

Dependent variable: The dependent variables are the outcomes of the effort. Data categories listed below measure the direct impact of the diversion program and are in units of cost per event, cost per day, or cost per individual. Additional secondary impacts (e.g., increased productivity and tax revenues, cost impact on other social services programs including homelessness programs) could be incorporated into the ROI using methods including, but not limited to, a dynamic input-output model outlined in the recent analysis prepared by The Perryman Group.[102]

1. Implementation and ongoing operational costs
    a. FTE (full-time director, others)
    b. Travel for stakeholder group meetings
    c. New facility construction or rental costs
2. Law enforcement costs
    a. Calls for service
    b. Transportation (ambulance or request for transport to ED) calls
    c. Emergency department wait time
    d. Jail wait time
3. Criminal justice costs
    a. Arrest
    b. Court
    c. Incarceration (Jail days)
4. Treatment costs
    a. Inpatient hospital
    b. Emergency department
    c. Medication

[102] The Perryman Group. The Potential Economic and Fiscal Impacts of a Jail Diversion Program and Restoration Center for Mental Health and Related Disorders in Baton Rouge.

    d. Case management
    e. Health care at the jail
5. Other costs

Independent variable: The independent variables are the factors that affect the outcome, that is, the dependent variables. They include diversion status and type (costs will vary by point of diversion).

Control variables: The purpose of calculating a return on investment is to determine whether or not the diversion program (the independent variable) has the desired effect on such things as law enforcement costs, recidivism, use of expensive medical resources, etc. (the dependent variables). The problem in doing such analysis is that it is necessary to control for factors other than the intervention program (confounding variables) that could affect the desired outcomes. Without controlling for these factors, the danger is in drawing a conclusion that the diversion program (the independent variable) had particular effects (the dependent variables) when in fact the change in the dependent variable was due to other factors (confounding variables). The challenge is to do the analysis in such a way that the effect of the confounding variables is controlled for, that is, eliminated.

Stratification by demographic characteristics, criminal history, treatment history, and time at-risk measures is an effective and straightforward means to control for confounding factors. Potential confounders in bold type are key factors that can affect the evidence concerning the effects of diversion.

1. **Gender**
2. **Age**
3. **Race/ethnicity**
4. Education (e.g., less than high school, high school, more than high school)
5. Marital status (e.g., never married, divorced, married)
6. Employment status (e.g., unemployed, employed, student, retired)
7. Residential status (e.g., lives in a nondependent residence, other living situation, homeless)
8. Number of past felonies in previous 12 months
9. Number of past misdemeanors in previous 12 months
10. Received any treatment in the past 6 months
11. Time at-risk (time not in jail, prison, or hospital)
12. Insurance status

Recommended Data Points and Outcomes to be Collected

The following data elements should be collected to do an adequate ROI analysis:

1. Patient demographics
2. BRidge Center referral and service utilization data
3. Primary and secondary diagnoses
4. Recidivism rates specific to BRidge Center services
5. Length of stay by BRidge Center service
6. If possible, ED presentation within 30 days of discharge from BRidge Center by service

7. If possible, inpatient admission and bed days (psychiatric and medical) within 30 days of discharge from BRidge Center
8. Linkage to community referrals (did patient access care?)
9. Calls to law enforcement
10. Arrest frequency within six months and 12 months of BRidge Center discharge by service
11. Number of jail days post BRidge Center utilization within six months and 12 months of discharge

We also recommend that a standard risk assessment be chosen or created that would allow a score to be assigned to each patient, which could be used to predict level of care needed and analyzed to predict outcome.

Potential Funding Mechanisms

A growing body of evidence indicates that well-designed diversion programs can achieve a significant return on investment. Unfortunately, many communities struggle to piece together funding for their jail diversion programs. The factors that make the task difficult include the following:

- *Inadequate insurance coverage*. Some services provided through a diversion program are reimbursable if the individual has Medicare, Medicaid[103] or private insurance coverage. However, in states like Louisiana that have not yet adopted a Medicaid expansion, the majority of the target population is likely to be uninsured. This will likely change, however, as Governor-elect John Bel Edwards has committed to implementing Medicaid expansion early in his administration. The implementation of Medicaid expansion presents a significant opportunity to help shape the coverage and delivery of behavioral health services for low-income Louisiana residents. All newly-eligible Medicaid beneficiaries are enrolled in an "alternative benefits plan", which may be based on certain private health insurance plans or be any coverage approved by the Secretary of HHS, including a state's traditional coverage under the State Plan. In addition, coverage must include the Affordable Care Act's ten categories of Essential Health Benefits (EHBs). Among the mandatory EHB coverage categories for Medicaid alternative benefit plans is coverage of services for mental health and substance use disorders, which must be covered at parity with medical/surgical benefits.[104]
- *Funding silos and misaligned incentives*. Most savings that result from an effective diversion program are realized outside of the program itself, in the form of fewer jail stays, reduced recidivism, reduced ED and inpatient stays, and improved productivity/quality of life for the target population. Secondary savings may also be seen in other areas over the longer term, such as spending on homeless and other social service programs, as frequent users of services become

[103] Individuals have their Medicaid eligibility suspended or terminated when they are incarcerated, but Medicaid eligibility would remain intact if the individual is diverted prior to incarceration.
[104] Justice Center, Council of State Governments, *Collaborative Approaches to Public Safety*, Medicaid and Financing Health Care for Individuals Involved with the Criminal Justice System, December 2013, *available at https://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf*.

more stable. In the near-term, however, spending on these services is likely to increase as linkages and referrals improve. Current financing and reimbursement models are largely insufficient for "capturing" these savings and reinvesting them back into further diversion efforts. Leadership from the criminal justice system, public officials and policymakers will need to collect data and devise systems to calculate cost savings, as well as collaborate to reconfigure current financing and reimbursement models to capture and reinvest savings generated over time from diversion programs.

- *Time lags*. Diversion programs frequently require a substantial up-front investment, but return on investment can take time to materialize. Savings and positive impact in other sectors of the community (e.g., jails, hospitals, courts, etc.) take time to be fully realized because many costs are largely fixed, at least in the near term.

Despite these barriers, there are several strategies that communities can employ (and some have successfully employed) to finance their jail diversion programs. They are explored below.

Grant Support

- *Federal grants.* There are a variety of federal grants available to support the development and implementation of diversion programs. Qualifying criteria, eligible entities, grant cycles and requirements vary, but virtually all federal grants will require a well-defined plan with measurable outcomes and a clear plan for data collection and reporting of measures. The chart below is for illustrative purposes only, as future grant cycles for these grants are not guaranteed, and additional grant opportunities may become available.

Table 1: Examples of Recent (2013-2015) Federal Grants to Support Diversion

Grant	Description	Amount
Substance Abuse and Mental Health Services Administration (SAMHSA)		
Offender Reentry Program	The purpose of this program is to expand and/or enhance substance use disorder treatment and related recovery and reentry services to sentenced substance-abusing adult offenders/ex-offenders who are returning to their families and community from incarceration in state and local facilities including prisons, jails, or detention centers. Applicants are expected to form stakeholder partnerships that will plan, develop, and provide a transition from incarceration to community-based substance abuse treatment and related reentry services. Because reentry transition must begin in the correctional facility before release, limited funding may be used for certain activities in institutional correctional settings in addition to the expected community-based services.	$400,000 max
Law Enforcement and Behavioral Health Partnerships for Early Diversion	The purpose of this program is to address the behavioral health needs of people involved in, or at risk of involvement in, the criminal justice system by providing an array of community-based diversion services designed to keep individuals with behavioral health issues out of the criminal justice system while also addressing issues of public safety. The Early Diversion program is intended for communities to develop effective partnerships between law enforcement and behavioral	$322,222

Grant	Description	Amount
	health providers to divert adults with mental, substance use, and co-occurring disorders from the criminal justice system into community-based service alternatives. These partnerships will make it possible for law enforcement officers to divert adults with mental, substance use, and co-occurring disorders from the criminal justice system to community-based behavioral health services to screen, assess, refer, and treat individuals before arrest while maintaining public safety.	
Develop and Expand Behavioral Health Treatment Court Collaboratives (BHTCC)	The purpose of this program is to allow local courts more flexibility to collaborate with multiple criminal justice system components and local community treatment and recovery providers to address the behavioral health needs of adults who are involved with the criminal justice system and provide the opportunity to divert them from the criminal justice system. The collaborative will allow eligible individuals to receive treatment and recovery support services as part of a court collaborative. This program will focus on connecting with individuals early in their involvement with the criminal justice system and prioritize the participation of municipal and misdemeanor courts in the collaborative.	$348,412
Department of Justice		
Byrne Criminal Justice Innovation Program	Requires a consortium of partners (e.g., health, education, law enforcement) to plan or implement a targeted strategy addressing crime in a specific community.	$175,000
Justice and Mental Health Collaboration Project (JMHCP)	Provides funding that supports collaboration across mental health and criminal justice systems to develop and implement projects for individuals with mental illnesses or co-occurring mental health and substance abuse disorders who come into contact with the justice system.	Maximum awarded $250,000

- *Hospital community benefit grant.* Community benefit grants are a common way for hospitals to support organizations and activities that benefit the community (and the hospital). For example, many hospitals provide community benefit grant support to local federally qualified health centers to support after-hours care, care coordination, and other services that help reduce avoidable ED visits, admissions, and readmissions. Similarly, a community benefit grant to support a diversion program is likely to generate a positive ROI for the grantor in the form of reduced ED visits as well as psychiatric admissions and bed days. The specific level of return is highly contingent on the overall design (and effective implementation) of the diversion program. For example, there is a growing base of experience to indicate that pre-booking diversion programs can result in a significant decrease in unnecessary ED visits.[105] Similarly, to the degree that inpatient psychiatric lengths of stay are excessively long because of the lack of residential treatment options, a diversion program that enhances access to residential services and supports can have a significant positive impact on lengths of stay and can free up bed capacity in a community. Hospitals in Baton Rouge have already identified the need for increased behavioral health

[105] See, for example, National Association of Counties. Blueprint for Success: The Bexar County Model. How to set up a jail diversion program in your community.

services and diversion programs as a priority, both through the Mayor's Healthy City Initiative (MHCI)[106] and the recently created Baton Rouge Health District.[107] Both of these organizations can serve as valuable forums for furthering discussion on how area hospitals and providers can realize positive ROI by investing in the services and programs identified in this report.

Managed Care Contracts

The five Bayou Health Plans may be interested in supporting and funding services offered at the BRidge Center. Representatives of the plans should be convened early in the planning process to identify interest and needs they may have for management of their members. Contracts could be crafted that support discrete services offered on a per diem basis, similar to how the plans currently pay for an inpatient stay. Services offered will be of particular interest if the BRidge Center can demonstrate outcomes and cost savings specifically related to avoidance of ED utilization and reduction in inpatient days.

Tax Support/Public Financing

Given the substantial up-front costs of implementing an effective diversion program, and the limitations and misaligned incentives outlined above, many communities provide partial and, in some cases, substantial, support for diversion programs through dedicated sales or property tax levies. For example, King County, Washington, approved a "Mental Illness and Drug Dependency Action Plan" in late 2008, which included a dedicated sales tax increase to fund multiple strategies, including a "crisis solutions center," a longer-term respite facility, and a mobile crisis team. Cincinnati has historically dedicated a portion of its Health and Hospitalization Indigent Care levy to support jail diversion programs.

Tax increases are always a difficult sell with taxpayers, who – justifiably – want to see their tax dollars invested wisely. Despite growing evidence of the effectiveness of diversion programs, the direct benefits of the program are not always immediately evident to taxpayers, and savings achieved through effective reforms can quickly be eaten up by other budget priorities. At least one state (California) has attempted to implement a model that "captures" savings from criminal justice reforms and shifts them into a human capital investment fund that funds, among other things, additional investments in jail diversion.[108] As the state reports each year the estimated savings from the reforms, an equal amount is automatically deposited into the fund. This model provides some degree of protection for diversion program funding from fluctuating budgets and political priorities. A similar model could be developed at the local level. Another possible approach would be to design a tax levy that, in effect, shares a portion of any realized savings with the taxpayer in the form of reduced taxes over time. For example, after an initial period of implementation and ramp up, maintenance of the levy could be contingent on achieving a positive ROI. In addition, for each dollar of savings realized in the jail, a portion of that amount could be returned to taxpayers in the form of a reduction in tax support (or a reduction in the rate of increase in tax support) for the jail.

[106] http://www.healthybr.com/.
[107] http://www.brhealthdistrict.org/.
[108] Center on Budget and Policy Priorities. Changing Priorities: State Criminal Justice Reforms and Investments in Education. October 28, 2014.

Other potential sources of public financing include bond financing, especially for one-time capital and start-up costs, and general fund support through a reallocation of existing budget resources. The latter could be used to support both start-up and ongoing operating costs.

Social Impact Bond Financing

Social impact bonds are an innovative funding strategy for public projects. Also known as "Pay For Success" programs, under this model private investors invest capital and help manage public projects with the goal of reducing government spending in the long-term. If the project is successful, the investors are paid back by the government and make a profit. For example, the Adolescent Behavioral Learning Experience (ABLE) program at New York City's Rikers Island jail complex was funded via a social impact bond initiative. Under the initiative, the investment banking and securities firm Goldman Sachs provided funding for the program. If the program does not reach its targets in diverting youth from jail, the city is not obligated to repay the loan. If the program succeeds, Goldman Sachs will be repaid and also make a profit.[109] Social impact bond financing should be further explored as a funding source for the BRidge Center, as the Center and its expected outcomes align well with the funding model. If the local governing bodies are supportive of the model, bond financing could come from private investors or, potentially, from foundations. It is important to note, however, that there will need to be a rigorous data collection and evaluation structure in place to measure the impact of the program for purposes of the bond financing. In light of the limited data currently being collected, social impact bond financing is unlikely to be a viable funding source for initial capital and start-up costs. However, if rigorous data collection is implemented and the data reveals positive outcomes (e.g., lower incarceration rates, fewer unnecessary ED visits, taxpayer savings), social impact bonds may be a viable funding source for program expansion.

Medicaid Coverage Options and Administrative Claiming

It is estimated that a significant portion of the target population would be eligible for Medicaid if Louisiana implemented Medicaid expansion up to 138% of the Federal Poverty Level. Medicaid expansion would provide Medicaid coverage to all individuals meeting specified eligibility criteria and would provide a dedicated revenue stream for the program, reducing the reliance on other funding sources. Medicaid expansion could be implemented through a State Plan Amendment (SPA) or through a Section 1115 waiver, with the latter affording the state additional flexibility to design an expansion that is consistent with the state's needs and policy goals. However, while waivers can afford a great deal of flexibility to states, the federal government also has a great deal of discretion in what it approves under a waiver.[110] Therefore, the examples cited below, while approved elsewhere, may or may not be approved in the future. Regardless of whether Medicaid expansion is implemented through a waiver or a State Plan Amendment, the impact on the target population could be significant in two ways. First, some services provided through the diversion program would likely be covered by Medicaid, providing a dependable revenue stream for the program. In addition, and perhaps even more significant, expanded coverage

[109] Bloomberg TV. Social Impact Bond Project on Rikers Island. March 2013. *See also* http://www.goldmansachs.com/what-we-do/investing-and-lending/impact-investing/social-impact-bonds/index.html.

[110] Because Section 1115 waivers are "research and demonstration waivers," the Secretary of the Department of Health and Human Services does not have to approve waivers that the Department does not believe contribute in a meaningful way to the discourse or ongoing improvement of the Medicaid program. Therefore, prior approval of a certain type of waiver does not necessarily guarantee future approval.

should enhance access to services that may help prevent criminal justice interactions among the target population.[111] Waivers and state plan amendments must be submitted to CMS by the State Medicaid agency. Waivers typically take significantly longer to approve than state plan amendments because, by definition, a waiver application is asking the federal government to make exceptions to existing Medicaid rules. Depending on complexity, waivers can take anywhere from six months to over a year from concept to approval.

Under a Section 1115 waiver, states may pursue a range of program reforms including changes to Medicaid benefits, cost sharing, provider rates, and eligibility. Under a full Medicaid expansion[112] (whether implemented through a SPA or 1115), the federal government pays 100% of the costs through 2016, phasing down to 90% of costs by 2020 and thereafter. Under a targeted or regional expansion (see below), traditional federal matching rates would likely apply, and the federal government would be responsible for approximately 62% of the costs. The remaining non-federal share may be financed through a variety of sources, including but not limited to, state general fund revenues, transfers from other units of government, provider tax programs, or, in some instances, "designated state health programs." Under a Section 1115 waiver, CMS may authorize federal matching funds for certain state expenditures that are related to, but not directly covered by, the Medicaid program (e.g., certain state-only behavioral health expenditures). Federal match for these Designated State Health Programs (DSHPs) effectively "frees up" state general fund revenue to support the waiver initiative. Several states, including New York and Oregon, have utilized DSHPs to help finance a portion of the non-federal share of their Section 1115 waiver programs.

Targeted behavioral health waiver – In the absence of full Medicaid expansion, Louisiana may consider a much more limited expansion to provide Medicaid coverage for individuals with mental illness and/or substance use disorders. Virginia's recently approved "Bridging the Mental Health Coverage Gap" ("GAP") waiver is the most recent example of such a targeted waiver. The GAP waiver provides a targeted set of benefits (including a fairly broad array of behavioral health services and primarily outpatient physical health services). Eligibility criteria under the waiver are both clinical (the individual must meet SMI criteria) and income-based. At least one other non-expansion state (Missouri) is currently pursuing a behavioral health waiver similar to the Virginia waiver. Section 1115 waivers must be budget neutral (i.e., they must cost the federal government no more than it would have spent in the absence of the waiver) over the (typically five-year) demonstration period. Targeted behavioral health waivers like the Virginia waiver achieve budget neutrality through a "disability diversion" model, whereby the state is able to demonstrate that by providing coverage (with a more limited, targeted benefit package) early on, it can delay or prevent an individual from declining to the point of qualifying for full Medicaid coverage through a disability determination.

Regional waiver – States may also use Section 1115 waiver authority to implement a geographically limited coverage expansion. Such an expansion is currently operating in New Orleans. Under Section 1115

[111] *See supra* pp. 70-71.

[112] For purposes of this report, "full Medicaid expansion" means an expansion that covers individuals up to 138% of the federal poverty level and that offers a full Medicaid benefits package (or one that is deemed approximately equivalent according to federal standards).

authority, the Greater New Orleans Community Health Connection (GNOCHC) initiative provides primary and behavioral health care for approximately 50,000 individuals age 19 to 65 with incomes below 100% of FPL, regardless of family status. As with a targeted behavioral health waiver, a regional waiver would need to demonstrate budget neutrality.

Medicaid Administrative Claiming

The costs of screening offenders for Medicaid eligibility may be eligible for Medicaid administrative matching funds, thereby freeing up local funds for other purposes. States and their contractors are eligible to receive Medicaid matching funds for certain administrative services necessary to carry out the Medicaid program, including outreach and eligibility determinations. Some jail diversion programs have utilized Medicaid administrative claiming to partially finance these functions within their programs.

Diversion Program Revenue

At this point in the program design, it is difficult to develop a realistic estimate of program revenue because of several factors including, most notably, the lack of insurance status data of individuals who are likely to qualify for diversion. As noted earlier in this report, some portion of services provided through the diversion program will be reimbursable under Medicaid, Medicare, and private insurance, providing a dedicated stream of program income. In the absence of Medicaid expansion in the state, the percentage of individuals with insurance coverage will likely be quite small. If the state implements a Medicaid expansion (either a full expansion or a more limited expansion under Section 1115 waiver authority), some services will be covered, though Medicaid rates typically pay less than the full cost of the service. The degree to which services are covered is contingent on several factors including the benefits package included in the expansion, provider qualification criteria for each service, and payment rates for each service. Certain services (e.g., sobering beds) are generally not reimbursable, while other services (e.g., medical detox, crisis services, case management) often are reimbursable.

A credible estimate of program revenue will require several pieces of data, including expected payer mix for individuals receiving BRidge Center services, covered versus non-covered services, provider qualifications, and fee schedules for all covered services for all major payers. In addition, program revenue in the first year will be highly contingent on how quickly volumes ramp up, which is driven by the implementation plan and outreach and education of key partners. As Louisiana officials begin developing plans for Medicaid expansion, it is critical that the Medicaid expansion includes a robust behavioral health benefit. As noted above, states that implement Medicaid expansion are required to provide behavioral health services for the expansion population[113] and are also required to ensure parity between the behavioral and physical health services.[114] Overall, 14.6% of the Medicaid expansion population is estimated to have a substance use disorder, compared to 11.5% of the current Medicaid population, indicating the

[113] Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges; Eligibility and Enrollment; Final Rule, 78 Fed. Reg. 42160 (July 15, 2013).

114 Mann, C. January 26, 2013. SHO # 13-001/ACA #24. Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans.

need for paying careful attention to benefit design, delivery system, and access to behavioral health services for this population. With Medicaid expansion, Louisiana has an opportunity to develop a thoughtful, evidence-based approach to behavioral health services that will have a long-term positive impact on the state. The Steering Committee convened to continue planning and oversee implementation of the BRidge Center, led by the Executive Director of the new nonprofit entity and possibly supported by an independent, outside consultant(s), should quickly identify individuals most knowledgeable about the state's Medicaid program and health care financing policies and ensure they are able to access state officials and policymakers as they work to develop Louisiana's Medicaid expansion plans.

Governance Development and Organization Recommendations

Development, implementation, and ongoing operation of the BRidge Center will require a shared community strategy, ability to leverage existing resources, build new revenue streams, and invest in new system and service capacity. There is no one organization in EBR suited to lead this effort. Rather, many organizations have established resources, competencies, and leaders with skills that will be critical to tap into for the BRidge Center to be successful. It is in the best interest of the future BRidge Center that a new organization with an independent governance structure be established.

Several factors should be considered when planning the new entity and developing a governance structure that will be accountable for the success, strategic vision, and management of the BRidge Center:

1) A non-profit entity will be best positioned to raise the variety of funds that will be needed to support BRidge Center operations. The funding sources include foundation and individual donor gifts; corporate sponsorship; grant funds; managed care contracts; Medicaid, Medicare and private insurance; Office of Behavioral Health (OBH) funding;, City-Parish funding; and dedicated state resources.

2) A governance structure should be developed that will allow for leveraging critical expertise and nurturing collaboration between the behavioral health and criminal justice systems. It must also be nimble and responsive to the rapidly changing healthcare and criminal justice environments and responsive to strategic business needs.
    a. Board size should be no more than seven to nine directors.
    b. Board committees should focus on BRidge Center critical activities and provide a mechanism for stakeholders to be active participants in the BRidge Center. Committees may include Program/Intervention Development and Finance.

3) The BRidge Center will be best served with an Executive Director who has experience in the following areas:
    a. Building services that support people with both behavioral health and criminal justice involvement.
    b. Managing and leading based on objective data.

c. A demonstrated track record of successful collaboration across systems and providers (specifically behavioral health and criminal justice).
d. A demonstrated track record of leading and managing system and service integration, innovation, and continuous quality improvement.
e. A demonstrated track record of building trusted relationships with a variety of stakeholders and crafting win-win strategies that will allow varied stakeholders to achieve success within their own organizations and systems and also on behalf of the BRidge Center.

4) Several organizations currently active within EBR have competencies and resources that should be leveraged when developing the BRidge Center organization. Specific recommendations include:
    a. Expand peer supports currently offered at the Mental Health Association of Greater Baton Rouge.
    b. Expand, train, and leverage of trauma-informed expertise that has been developed at the Baton Rouge Children's Advocacy Center.
    c. Explore opportunities to partner with the Baton Rouge Detox Center and leverage medical detox and other services already offered at the organization's South Foster Drive location.
    d. Co-locate CAHSD staff at the BRidge Center to foster continuity of care and facilitate transitions of care from the BRidge Center to CAHSD for the indigent population.
    e. Consider expanding co-located CAHSD staff at the Parish Prison with the specific goals of applying for or reconnecting people to Medicaid benefits and assisting with transitioning and connecting people with behavioral health issues to care as they leave the prison.
    f. Expand hours available for drop-in services, peer supports, and services available to people experiencing homelessness at the One Stop (extend hours and service after 3pm and on weekends).
    g. Explore the potential opportunity to partner or engage the Baton Rouge Crisis Intervention Center in providing care management or crisis services.[115]

Implementation Planning

The Steering Committee should approve an implementation timeline and work plan. The checklist and operation model formats below may provide helpful guidance as details are worked through.

New Project/Expansion Implementation Checklist

This checklist is meant to provide a suggested set of tasks to determine and assist with implementation of new program(s) and significant program expansion. This is meant to be a guide. It is not meant to encompass every necessary step. Recommended sequence of actions will vary depending on specific projects undertaken.

[115] http://cicla.org/home.aspx.

Program Parameters

- ✓ The type of service, program design, and outcomes desired
- ✓ The number of staff needed, identified staff positions, and overall staffing model
- ✓ What special skills, staff credentials or competencies, and languages or cultural competencies are necessary
- ✓ Types of management and supervision required
- ✓ Location – Is a new site needed, or can the program be housed in an existing site?
- ✓ Research similar program models, evidence-based practices and available literature that can help inform program design, model, and target outcomes

Model and System of Care

- ✓ Identify target and priority populations to be served
- ✓ Identify and develop interventions and workflows needed
- ✓ Identify tools, screening mechanisms, assessment, and care plans needed
- ✓ Determine potential partners, referral sources, and critical stakeholders

Data Plan, Program Impacts and Outcomes

- ✓ Identify key data elements required to be collected to enable process and continuous quality improvement
- ✓ Research technology systems and solutions available to collect data needed
- ✓ Identify target impacts and outcomes of program that will demonstrate a Return on Investment (ROI)

Business and Funding Plan

- ✓ Identify and assess potential markets, competitors, and business development strategies
- ✓ Articulate value proposition and ROI
- ✓ Identify potential funding sources (public, private, corporate foundations, other) and develop a funding plan
- ✓ Identify if current funding and resources can be leveraged for the new project
- ✓ Develop a draft budget for operations (ongoing program needs) vs. start-up investments
    - ❖ Operation budget considerations
        - Staff model and management patterns
        - Salaries at the middle to high end of current market
        - Salary percentages or management fee to support facilities management, data analysis, needed infrastructure, and project management services when possible
        - Rent and utilities (review market rate rents and consider amount of square footage necessary to effectively run the program)
        - IT costs (include computers, phones and phone system, server costs, wiring, printers, copiers, faxes, and other technology

costs; include one-time point of purchase/installation costs as well as monthly costs for continued service)
        - Transportation (costs of vehicle leasing and insurance as well as monthly staff mileage costs)
        - Employee business expenses and training
        - Office supplies (ongoing)
        - Client support (emergency food/transportation coupons, furniture, clothing, stipends and incentives, program specific needs, and/or starter kits if housing program)
        - Audit and insurance costs
        - Office equipment maintenance
        - Security costs: alarm system maintenance; security officers
        - Office cleaning and maintenance, including waste management costs and site specific facility costs (example: elevator maintenance)
        - Database system licenses, training, and maintenance
    - Start-up considerations
        - Capital required if building purchase desired or if building out or renovating space, include renovation costs
        - Planning process and implementation support
        - Furniture needed to fully furnish the new space (considerations should include desks, chairs, filing cabinets, safes, tables, bookshelves, and program-specific furniture needs)
        - Initial IT needs (software and licensing purchases, hardware, wiring, servers, etc.)
        - Vehicle purchase
        - Office equipment
        - Alarm system Installation
- ✓ Estimate potential revenue based on identified funding streams and assess potential funding gaps; determine options to fill funding gaps

Space Considerations and Action Items

- ✓ Is the space compatible with the program design, staffing pattern, and any accreditation or licensing needs (consider flexible space, counseling and exam rooms, and conference/meeting space)?
- ✓ Does the program require specific certifications or licensures in order to serve its population? If so, begin licensing process. This may include making requests for changes in zoning, fire marshal and other inspections, building permits, and discussions with jurisdictional officials
- ✓ Is it necessary to build out the space?

- ✓ Is the space accessible to the population to be served (consider target population, including cultural considerations, and transportation options)?
- ✓ Are there safety concerns with the building or the neighborhood? Are there ways to mitigate these safety concerns?
- ✓ Engage surrounding residents and businesses early on to educate them on the type of services that will be offered at the BRidge Center, hours of operation, the type of security measures that will be implemented and work to address any specific concerns.
- ✓ Have IT support/consultant walk through final space considerations for a more detailed assessment and quote on initial IT costs.
- ✓ Develop an analysis on space design, location, and cost factors for the final two to three site options. This will provide the opportunity to accurately assess which site is most economical given the specific program design and goals.

Lease Considerations

- ✓ What are the total occupancy expenses? Calculate rent and utilities expenses and try to negotiate having the landlord pay these expenses.
- ✓ Most standard leases do not allow early termination of the lease. Can an early termination clause be negotiated and under what circumstances could this be included? Ideally, no more than a 60- to 90-day notice should be required, but if the space is highly desirable, a requirement for a six-month notice may be acceptable.
- ✓ Often, landlords will take on the costs of meeting build-out needs. If the landlord will not take on these costs, negotiate a lower rental rate, if possible.
- ✓ Attempt to negotiate an arrangement that assigns decorating costs and responsibility for managing the decorating process to the landlord. The burden for the tenant is reduced if the landlord is willing to hire the workers to complete painting, install carpeting, and address other decorating needs.
- ✓ Does the lease allow for signage to be used on the external door or building?
- ✓ Are property tax increases passed onto the tenant or paid by the landlord?

Develop a Work Plan and Timeline for Program Implementation (checklist items may provide examples of actions to be included)

- ✓ Identify specific tasks to be completed and dates for completion
- ✓ Determine lead person responsible
- ✓ Clarify any supports needed to accomplish planned activities

Human Resource Considerations

- ✓ Develop appropriate job descriptions and set job qualifications and expectations
- ✓ Develop a brief description of the program to include in job postings
- ✓ Finalize positions, identify recruitment needs and options, and market positions
- ✓ Establish an employee orientation and training plan, as needed

Develop and Finalize Day-to-Day Program Design and Needs

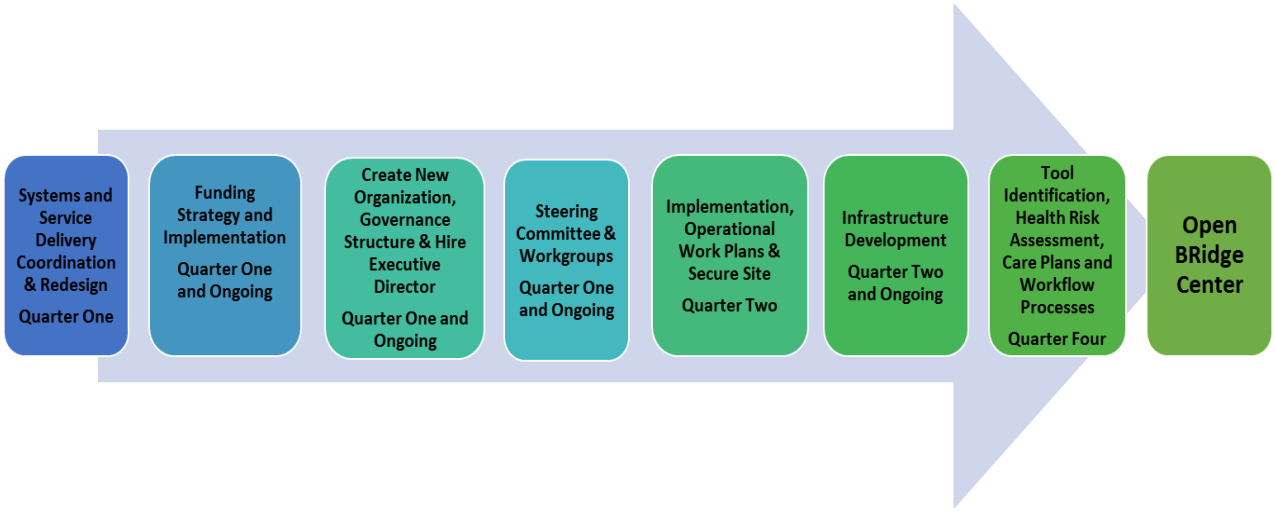
- ✓ Create service and management flow charts
- ✓ If possible, determine electronic system for documentation and billing (electronic health record, practice management system etc.); if necessary draft forms, documentation, and develop a master file
- ✓ Create/update policies and procedures
- ✓ Create necessary quality and risk management processes and forms
- ✓ Determine team meeting schedule, huddles etc. in line with program needs

Determine Facility Needs (examples to consider)

- ✓ Fire extinguishers
- ✓ First aid kits
- ✓ Facility logs
- ✓ Safe
- ✓ Emergency kits for vehicles
- ✓ Vehicle procedures and vehicle logs
- ✓ Supply orders
- ✓ Garbage cans
- ✓ Set up waste management and recycling services
- ✓ Cleaning supplies
- ✓ Maintenance schedule
- ✓ Alarm system codes
- ✓ Emergency preparedness plan including evacuation plans
- ✓ Mandatory labor law signage

Implementation Timeline

The following timeline outlines high-level actions and target dates with the goal of opening BRidge Center programming within eighteen months. For more detail associated with these actions please see Appendix F.



The timeline on the following page provides further detail, including key activities, by quarter for eight quarters, and a target timeline to phase in work and complete necessary actions.

BRidge Center	Quarter	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
		Planning and Implementation							
Priority Areas & Key Activities		**Timeline By Quarter**							
Population Health Strategy									
Redesign current Behavioral Health service system									
Engage independent consultant									
Convene stakeholder work group for monthly meetings (at minimum)									
Draft MOU, work plan and timeline for stakeholder group									
Identify target populations and risk stratification methodology									
Map current system of care, complete gap analysis and identify potential pilot programs									
Create shared tools, as possible, including screens, assessments and care plans									
Redesign workflows and processes as needed across system components									
Establish shared outcomes/metrics and data plan									
Draft work plan and timeline for redesign implementation									
BRidge Center - Care Components									
Develop and Launch BRidge Center Care Programs									
Hire BRidge Center leader; engage independent consultant/project manager									
Convene Steering Committee charged with planning oversight									
Draft MOU, work plan and timeline for Steering Committee and established workgroups									
Convene identified workgroups who will report actions to Steering Committee									
Refine and finalize program components, staffing plan and budget									
Match program components to licensure and certification requirements, plan alignment									
Identify needed screening tools, draft assessments and care plans, as needed									
Identify performance and outcome metrics; establish data management plan									
Confirm BRidge Center site and plan for draft plan for needed rehab and occupancy									
Create Human Resources plan (job descriptions, recruitment, hiring, on-boarding, etc.)									
Research and purchase identified electronic health record; plan for connectivity									
Develop operational work and formal business plan, timeline and accountabilities, and implement									
BRidge Center - Governance and Organization Structure									
Develop new organization to manage BRidge Center									
Apply for 501(c)3 status									
Retain Executive Leader									
Establish by-laws and governance structure									
Establish and convene Board of Directors									
Elect Board Officers									
Establish and Convene Board Committees, as determined									
Draft and adopt BRidge Center Strategic and Business Plan(s) and Budget									
BRidge Center - Funding and Revenue									
Secure funding and revenue streams needed to implement									
Convene funding workgroup (reports to Steering Committee)									
Finalize capital, start-up and operating budgets									
Identify grant and foundation opportunities, apply as appropriate		Ongoing							
Convene Health Plans and identify contract opportunities; package services and pricing									
Work with hospitals to identify opportunities to secure community benefit grants									
Pursue public funding via local (EBR) and state funding		Ongoing							
Advocate with new governor and other officials for Medicaid expansion									
Advocate for covered services needed to provide comprehensive BH care									
Research and pursue, as appropriate, corporate sponsorship, impact bonds, etc.…									
Diversion System Alignment									
Develop systems and processes that will support diversion programming									
Ensure universal Behavioral Health screening within EBR Parish Prison									
Develop, adopt or adapt and implement risk tool for District Attorney and Parish Prison use									
Continue basic CIT training for law enforcement and expand to advanced training									
Work with law enforcement to learn call response processes in preparation for Mobile Assessment Team and plan for responsive call response protocols and placement of MAT									
Work with hospitals to develop care transition protocols (bi-directional)									
Utilize Steering Committee to identify opportunities to improve or redesign processes and interface of Behavioral Health and Criminal Justice systems									

Sample Operating Model and Strategy Format

The following format may be a useful tool for the Steering Committee to highlight key operating components of the different models and to focus strategic planning.

Characteristics	Plan	Target Goals and Outcomes
Priority Customer(s)		
Priority Populations(s)		
Priority Programs, Services and Interventions		
Funding & Revenue Sources		
Value Based Contract Strategies		
Capitalization Structure, if needed		
Organizational Structure		
Governance Structure		
Information Management, Electronic Health Record & Technology		
Marketing and Branding		
Research and Innovation Process		
Program, Service & Intervention Design & Development		
Data and Outcomes		
Continuous Quality Improvement		
Evaluation Process		

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APPENDICES

Appendix A. Interviews conducted between August and November 2015

Individual	Organization or Affiliation
Beverly Haydel, Director of Civic Leadership Initiatives	Baton Rouge Area Foundation
Patricia Calfee, Director of Strategic Consulting Services	Baton Rouge Area Foundation
Raymond Jetson, Board Member	Baton Rouge Area Foundation
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Hugh Eley, Interim Deputy Secretary	DHH
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Dr. Robert Blanch, MD	Psychiatrist for EBR Parish Prison
Dr. William "Beau" Clark, MD	EBR Parish Coroner
Lisa Bailey, Executive Director	Baton Rouge Detox Center
John Delgado	EBR Parish Councilman
Tara Wicker	EBR Parish Councilwoman
Donna Collins-Lewis	EBR Parish Councilwoman
Denise Marcelle	Former EBR Parish Councilwoman
Carl Dabadie, Chief of Police	Baton Rouge Police Department
Bryant Hernandez, Community Integrated Health Program Coordinator, Deputy Shift Commander	Emergency Medical Services

Randy Nichols, Executive Director	Capital Area Alliance's One Stop Homeless Service Center
Michael Mitchell, Public Defender Susan Hebert, Assistant Public Defender	EBR Office of the Public Defender
Denise Dugas, Vice President of Operations	Seaside Healthcare
Sharon Pol, Executive Director	Baton Rouge Children's Advocacy Center
Edgardo Tenreiro, Chief Operating Officer and Executive Vice President	Baton Rouge General Medical Center
Lawrence Lisak, FACHE, Program Administrator Behavioral Health	Baton Rouge General Medical Center
State Senator Sharon Weston Broome	Louisiana State Senate
Kyle Viator, Market President	AmeriHealth Caritas Louisiana
Stacie Zerangue, LCSW, Manager Integrated Health Care Management	AmeriHealth Caritas Louisiana
Brandy White, LA Plan President	Amerigroup RealSolutions in Healthcare
Cheryll Bowers-Stephens, MD, MBA, Medical Director	Amerigroup RealSolutions in Healthcare
Melissa Silva, Executive Director	Mental Health Association of Greater Baton Rouge
Jerry Hebert	Grace Hebert Architects
Gail Fowler, Network Manager	Magellan Health in Louisiana
Dr. Richard Dalton, Medical Director	Magellan Health in Louisiana

Appendix B. Community Organizations (information gathered from websites augmented with stakeholder input)

Please note: The organizations listed below provide services for the indigent. This is not a comprehensive list of all behavioral health organizations providing care within EBR.

Behavioral Health and Substance Abuse Services

Capital Area Human Services District Mental Health Clinics
http://www.cahsd.org

Mission: The mission of Capital Area Human Services District (CAHSD) is to facilitate person-centered recovery by empowering people of all ages with behavioral health and developmental disability challenges to strengthen relationships, establish independence, and enhance their ability to improve their physical health and emotional wellbeing.

Center for Adult Behavioral Health Services
4615 Government Street, Building 2
Baton Rouge, La. 70806
Hours: M - F 8 am - 4:30 pm
M - Th 5 – 8 pm
Phone: (225) 925-1906
Fax: (225) 925-1972

Margaret Dumas Mental Health Center
3843 Harding Blvd.
Baton Rouge, La. 70807
Hours: M - F 7:45 am - 4:15 pm
Phone: (225) 359-9315
Fax: (225) 359-9326

Capitol Area Recovery Program - Addiction Recovery Residential Services
http://www.cahsd.org
2455 Wooddale Blvd,
Baton Rouge, LA 70805
Phone: (225) 922-3169
Fax: (225) 922-3225

Services:

- Adult Behavioral Health
    - Mental health, addiction recovery, co-occurring disorders
- Child/Adolescent Behavioral Health
    - Children's behavioral health, school-based therapy, child/adolescent crisis response, substance abuse/abuse prevention services, support services for DCFS infants/children

exposed to alcohol, drugs or trauma, outpatient psychiatric, counseling and case management services for children under 6 years old

- Developmental Disabilities
    - Psychological services (diagnosis, evaluation, crisis assessment and referrals for behavioral supports), family support, residential placement services, respite services, services coordination, crisis assessment
- Support & Other Services
    - Preventive, primary and behavioral healthcare coordination, nurse-based home visitation services to first time mothers pre/post-natal (through the child's second birthday)
- Staff & Provider Training/Community Training
    - Police Training
    - Relapse Prevention
    - Compulsive Gambling
    - Overview of Developmental Disabilities Services: Who is Eligible and How to Assess Them
    - Side Effects of Medication and Adverse Drug Reactions
    - Working with Intravenous Drug Abusers
    - Confidentiality
    - Assessing the Suicidal Client
    - Working with Clients in Spiritual Crisis
    - Child Abuse/Neglect Reporting Laws
    - Treatment of Clients with Co-occurring Disorders
    - Implementing the Carver Model: Board Governance

Clinical Treatment Teams: May include a psychiatrist, psychologist, social worker, board certified substance abuse counselor and nurse based on an individualized treatment plan. The team may be enlarged to include other specialists.

Fees: Are assessed for each person requesting services based on his/her ability to pay. The sliding fee schedule is based on family income and total number of individuals in the household who are dependent on that income. Medicaid, Medicare, and some private insurance are accepted.

Service Area: Ascension Parish, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, West Feliciana

Baton Rouge Detoxification Center

http://dhh.louisiana.gov/index.cfm/directory/detail/77

1819 Florida Boulevard
Baton Rouge, LA 70802
(225) 389-3325

1767 N Foster Drive
Baton Rouge, LA 70806

Hours of Operation: 7/24 (7 days/week, 24 hours/day)

Population Served: Capital Area Human Services District (primarily)
Criteria for Admission: Need for detoxification. Persons presenting for admission are intoxicated or demonstrating symptoms of withdrawal.

Payment Method: Sliding Fee Scale

Program Synopsis: Services are provided in a supported environment with aftercare planning completed during the detoxification process as well as referral to long-term treatment. Twenty-four (24) beds are available for admissions

Services provided:

- Monitoring of all client activities
- Review of vital signs on a scheduled basis
- Referral to hospital or other medical care if required
- Emergency medical transportation if needed.
- Medications for detoxification as prescribed by referral hospital
- Nutritional care program
- General health/hygiene program
- Educational program on the disease concept, relapse, STD's
- Educational program for the families of clients on the disease concept.
- Introduction to self-help groups such as AA, NA with both open and closed groups
- Introduction to Big Book studies
- Work on relapse prevention
- Introduction to treatment programs for referral
- Experimental groups
- Individual and group counseling
- Referral to appropriate long-term treatment as available.

Baton Rouge Crisis Intervention Center
http://www.brcic.org
4837 Revere Avenue
Baton Rouge, LA 70808
(225) 924-1431

Mission: To offer prevention, intervention and post-intervention services that provide support in times of crisis and reduce the impact of suicide in the community.

Baton Rouge Crisis Intervention Center, Inc. strives to reduce emotional distress, raise hope, save lives, and save the community money through the utilization of crisis intervention services and traumatic loss services. BRCIC began in 1970 as THE PHONE – a 24-hour confidential telephone crisis counseling service on the campus of Louisiana State University. Over the years, this project developed into a nationally certified Crisis Intervention Center that is locally supported and a member agency of the Capital Area

United Way. BRCIC's role in crisis intervention and counseling has expanded to comprise all facets of traumatic loss, and focuses on one of the most traumatic, suicide.

BRCIC's goal is to reduce emotional distress that can lead to destructive behaviors, especially suicide, for those experiencing a crisis, and to advance the field of crisis prevention through early intervention and post-intervention.

Services include:

- Crisis Intervention Services - THE PHONE, Crisis Chat, and 2-1-1 Information and Referral provide free, 24-hour emotional support to the community.
- Traumatic Loss Outreach (TLO) - offers immediate emotional first aid to those in the community who have experienced or witnessed a death by a traumatic event. The traumatic events may include, but are not limited to such things as drownings, vehicular crashes, accidental shootings, drug overdoses, and suicide.
- Survivor Services -offers free, weekly, peer facilitated support groups for those who have lost a loved one to suicide, and is the local, ongoing support resource for this group.
- Traumatic Loss Counseling - offers individual counseling for people who have experienced the traumatic loss of a loved one, family member, friend, or acquaintance. Services are provided on a fee per hour basis and a sliding scale fee schedule is also available upon request.
- Voices of Hope for victims of homicide - offers counseling and a supportive network of individuals who have felt the impact of losing a loved one to homicide.
- Education and Training - Topics include issues related to: suicide and risk assessment, intervention and prevention, coping skills, stress management, and bereavement. Trainings and consultations are available for teachers, clergy, hospital staff, general public, and other community gatekeepers and may be customized to target special audiences.

O'Brien House of Baton Rouge, Louisiana

www.obrienhouse.org
1231 Laurel St
Baton Rouge, LA
(225) 344-6345

*Mission***:** The O'Brien House was established in 1971 to serve adult recovering alcoholics and drug addicts.

Services: O'Brien House offers a comprehensive range of treatment programs focusing on four areas: Residential Treatment, Outpatient Treatment, Adult Education, Prevention Programs and Veteran Services. This also includes housing and meals, a structured environment with individual and group counseling, and active involvement in 12-step programs.

Other Programs:

- ASEP – Adult Substance Education Program approved by the East Baton Rouge District Attorney's Office, Hillar Moore. ASEP is open to all adults that require: Pre-trail intervention, individuals interested in educating themselves on substance abuse, people court orders for educational intervention and individuals required to gain education due to work related substance abuse issues.

  This ASEP program is offered in a hands-on classroom environment and/or offered as an interactive internet education program by a Qualified and Licensed Substance Abuse Counselor. This is a six-week course offered one night a week for six weeks. One random drug screen is given and ASI-Addiction Severity Index is required.

- IOP – Intensive Outpatient Program is dedicated to helping individuals uncover the underlying causes of their addiction, develop healthier coping skills and build a recovery support network.

  IOP is a four -week comprehensive, multi-phase program for male and females, ages 18 and older. Group Sessions are 3 times a week (Monday, Tuesday and Thursday 4pm-7pm) with each session lasting 3 hours for a total of 9 hours a week. At the end of the four weeks participants will have a total of 36 hours of didactic instruction taught by addiction counselor.

Organizational Structure:

- 60 residential treatment beds and 10 inpatient beds
- Undetermined staffing profile

Women's Community Rehabilitation Center (WCRC)
http://wcrcbr.com/
855 Saint Ferdinand Street
Baton Rouge, LA
(225) 336-0000

Mission: WCRC serves women with severe and persistent mental illness, who are most often homeless, in a safe and secure home-like setting, providing mental health care through a structured program focusing on education, therapy, and vocational development.

Services: WCRC is a state-licensed treatment center that provides:

- Individual counseling and group therapy, intervention counseling
- Budgeting/Financial Counseling
- Medication monitoring and management training system
- Psychosocial skills training and self-enrichment programs
- Vocational counseling and placement

- Employment, school, and/or training opportunities
- Recreational group/individual outings
- Substance abuse surveillance
- Room and board, transportation and personal necessities
- Follow-up services and Alumni Club for aftercare support and individual counseling and crisis intervention

Admissions Criteria:

1. That the person have a major diagnosis of a severe mental illness which severely impairs her daily living functions in areas such as employment, personal relations, and living arrangements, in need of a structured, supportive environment.
2. That the person be female, at least 18 years of age.
3. That the person not be imminently suicidal or homicidal.
4. That the person not require 24-hour highly secure psychiatric environment.
5. That the person have complete independent toileting and eating skills.
6. That the person be willing to enter the program on a voluntary basis and sign a program contract agreeing to comply with the WCRC Rules and Regulations.
7. That the person demonstrate sufficient motivation and adapt to structured group living environment, seek employment, and utilize community resources.
8. That the person not be physically assaultive.

Louisiana Health & Rehab Center- LHRC Life Care Center
http://www.lahealthandrehab.org/life-care-center/
4225 E. Brookstown Drive
Baton Rouge, LA 70805
(225) 927-0770

Life Care Center offers Adult and Adolescent Intense Outpatient (IOP) and Outpatient (OP) programs that provide rehabilitative services to people with substance use disorder as well as those with co-occurring disorders. LHRC additionally offers children's prevention and Children of Alcoholics (COA) programs. The person-centered treatment modalities at LHRC-Life Care Center holistically address clients' needs through the provision of outpatient substance abuse treatment, life skills, and case management services.

Eligibility Criteria:

- Adults must be 21 years old or older.
- Adolescents must be 13-20 years old.
- Children must be 5-12 years old.
- Must have a primary diagnosis of Substance Use Disorder.

- Applicants must commit to actively participate in treatment goals as specified by the Treatment Plan.

Clients are admitted to LHRC–Life Care Center by referral from detoxification facilities, inpatient facilities, residential facilities, adult and juvenile criminal justice systems, lawyers, probation and parole officers, re-entry programs, and the Department of Children and Family Services, etc. A pre-admission screening is done to determine if eligibility criteria are met and the guidelines for denial are not reflective of the applicant.

Method of Payment:

- Medicaid
- Private Insurance
- Private Pay
- Sliding Fee Scale

Services Provided:

- Psycho-Social Assessments
- Substance Use Group Sessions
- Substance Use Individual Sessions
- Spiritual Formation
- Psycho-Social Education Groups
- Relapse Prevention Groups
- Family Sessions
- Life Skills Training
- Anger Management
- HIV Education
- Care Coordination

Mental Health Association of Greater Baton Rouge
http://mhagbr.com/
544 Colonial Drive
Baton Rouge, LA 70806
(225) 929-7674

Mission: To provide services for persons with or at risk for mental health and substance abuse issues.

Services: MHA of Baton Rouge serves adults 18 years of age and older. Clients suffer from chronic mental illnesses such as schizophrenia, bipolar disorder, chemical dependency and dual diagnoses (mental illness and substance abuse). MHA does not provide counseling or therapy, and does not have licensed therapists or physicians on staff. The Mental Health Association works closely with community mental health centers and private providers in coordination of care for clients.

The Alliance House Drop In Center's day program is designed to both support clients and is consumer-run, meaning the staff are mental health consumers that assist with the daily operations of the program. The goal of the program is to keep clients well and out of the hospital, shorten the length of stay for any hospitalizations and maintain clients in the least restrictive living environments of their choice.

The Alliance House Residential Center is a transitional housing facility that houses 11 men and 13 women with substance addiction and co-occurring disorders (substance abuse and mental illness). The average length of stay is 3 to 6 months and all clients admitted to the program must have completed inpatient treatment for substance addiction prior to admission. Goals of the program are to maintain sobriety, to secure and maintain employment, to participate in financial education and establish financial stability, and finally, to transition into independent living/permanent housing.

Louisiana Developmental Disabilities Council
www.laddc.org
626 Main Street
Baton Rouge, LA
(225) 342-6804

Mission: To lead and promote advocacy, capacity building, and systemic change to improve the quality of life for individuals with developmental disabilities and their families

Organizational Structure: The Louisiana Developmental Disabilities Council is a federally funded planning and advocacy body regarding disabilities and is comprised of people from every region of the state who are appointed by the governor to develop and implement a five-year plan to address the needs of persons with disabilities. Membership includes persons with developmental disabilities, parents, advocates, professionals, and representatives from public and private agencies. Several members rotate off the Council each year and nominations for new members are always welcomed.

Developmental Disabilities Councils were founded in 1970 as a result of the passage of the federal Developmental Disabilities Assistance and Bill of Rights Act. The Louisiana Council was established in 1971. Councils were created to engage in advocacy, capacity building and systems change activities and contribute to a coordinated, consumer- and family-centered, and consumer- and family-directed comprehensive system of community services, individualized supports, and other forms of assistance that enable individuals with developmental disabilities to exercise self-determination, be independent, be productive, and be integrated and included in all facets of community life.

Volunteers of America of Greater Baton Rouge (Mental Health & Co-Occurring Disorders)
http://behavioralhealth.voa.org/gbr-our-services
Greater Baton Rouge – 1-877-291-6807
mentalhealth@voagbr.org

Mission: Volunteers of America is a national nonprofit human services organization that, for more than a century, has led the nation in transforming the lives of America's most vulnerable. As pioneers of coordinated care, VOA works closely with community provider-partners to address the full range of each person's needs. Every day, an army of nearly 16,000 paid professional employees in 46 states uses its unique legacy of expertise to create greater wellness for more than 2 million people, rebuilding lives and restoring hope.

Service Area: Volunteers of America Greater Baton Rouge (VoAGBR) serves a 19-parish area that includes Baton Rouge, Lafayette and Lake Charles.

Fees: Accepts public and private insurances as well as private pay

Services:

- Intensive Case Management and Support Coordination - Case management and support coordination programs offer an array of services focusing on the strengths of each individual, to improve quality of life, reduce/prevent hospitalization and out-of-home placements, and alleviate symptoms of mental illness. VoAGBR also helps people apply for benefits. Individual support services are delivered in the office, in clients' homes or in the community.
- Assertive Community Treatment (ACT) - ACT is an effective evidence-based, outreach-oriented approach for helping people with severe and persistent mental illnesses who have avoided or not responded well to traditional outpatient mental health care and psychiatric rehabilitation services. Using a treatment team approach, staff provides comprehensive community-based psychiatric treatment, rehabilitation and support.
- Out-of-Home Services - Drop-in, outreach and referral services screen walk-in individuals in order to link them to appropriate behavioral health services and resources. Crisis stabilization services are also available to adults in an emergency mental health situation who do not require psychiatric hospitalization. During a brief stay, adults receive individualized help that includes one-on-one support as well as supportive counseling with an emphasis on medication compliance and management, interpersonal skills, and crisis response and prevention.
- Children and Family Services - Behavioral health services are provided for children and families in need. These include a therapeutic group home, intensive case-management services, Homebuilders family preservation and reunification services, therapeutic foster care placement and support, and outpatient counseling.
- Outreach - Regularly-scheduled and ad hoc outreach services seek out and build relationships with people who are homeless, with the goal of connecting them to basic services, community resources and housing opportunities. Connecting homeless adults with mental illness to appropriate treatment is a special focus.

- HIV/AIDS individual and group therapy - Psychological and counseling services are offered to people with HIV/AIDS and a co-occurring mental health and/or a substance abuse diagnosis. Services are conducted by a mental health professional in both group therapy and individual settings.

Housing and Homeless Services

Volunteers of America of Greater Baton Rouge (Garfield House)
http://www.voagbr.org/veterans-services
153 North 17th Street
Baton Rouge, LA
(225) 388-5800

The Veterans Transitional Housing program provides housing to homeless veterans who have a mental illness or who are dually diagnosed with a substance abuse problem. Case Managers work with the veterans, ensuring they receive benefits entitled to them, employment assistance, address social and physical needs along with basic aid in housing, clothing and food.

Volunteers of America of Greater Baton Rouge (Affordable/Transitional Housing)
http://behavioralhealth.voa.org/gbr-our-services
Greater Baton Rouge – 1-877-291-6807
mentalhealth@voagbr.org

Services:

- Permanent Affordable Housing for People with Mental Illness - Affordable housing is provided for low-income people over the age of 18, who have been diagnosed with a chronic mental illness, but who are able to live independently. Some programs also provide supportive services in addition to housing, so that individuals can continue to live independently in the community.
- Short-Term Transitional Housing for People with Mental Illness - Crisis Supportive Housing provides residential care for adults who need temporary housing with supportive services following a hospitalization. Short-term housing through HUD, paired with supportive services, gives people an opportunity to stabilize and find permanent housing.
- Affordable Housing for Adults in Recovery - Permanent housing is available for men and women who have been in recovery for six months or more. Skilled staff provides case management and mental health services in a stable environment, to encourage growth, independence and the self-confidence to rejoin the community.

Catholic Community Services – Families First Program
https://brgov.com/dept/ocd/ccsfs.htm
(225) 336-4406 or 336-8700 ext. 413
Fax (225) 336-8745
Capacity - 25
Serving – two parent families - homeless intact families

Catholic Charities of the Diocese of Baton Rouge

Joseph Homes, Inc.
http://www.ccdiobr.org/programs/community-social-responsibility/19-joseph-homes
130 South 11th Street
(225) 336-8770 Fax (225) 336-8745
Capacity - 9
Serving - recently released male ex-offenders who are homeless

Bishop Ott Shelter for Men
http://www.svdpbr.org/Shelter.aspx
Ph. 225-383-7343
Address: 1623 Convention St.,
Baton Rouge, LA
Capacity - 56
Serving - unaccompanied men over age 18

Bishop Ott Shelter for Women and Children
http://www.svdpbr.org/Shelter.aspx
Ph. 225-383-7341
Address: 1623 Convention St.,
Baton Rouge, LA
Day Center, Sweet Dreams Shelter
Capacity - 36
Serving - unaccompanied women, homeless women accompanied by children with a special focus on women with male children over the age of five

Missionaries Charity Queen of Peace Home
(no website)
737 East Blvd
Baton Rouge, LA
(225) 383-8367
Capacity - 42
Serving - unaccompanied women and female youth, single parent families - no males over 6 years of age, female ex-convicts and pregnant women

Maison Des Amis of Louisiana
http://www.maisonbr.org
1050 Convention St.
(225) 343-3827 Fax (225) 343-3861
Capacity - 46
Serving – homeless men and women who are severely mentally ill

Youth Oasis Children's Shelter
http://www.youthoasis.org/
260 South Acadian Thruway
(225) 343-6300 Fax (225) 343-6303
Capacity - 12
Serving - unaccompanied youth, homeless or runaway youth - male & female 10 - 17 years of age

The Salvation Army Bed and Bread Shelter
http://salvationarmyalm.org/batonrouge/emergency-shelter/
7361 Airline Highway
Baton Rouge, LA
(225) 355-4483 Fax (225) 355-7393
Capacity - 86
Serving - unaccompanied men

St. Anthony's Home – Our Lady of the Lake Regional Medical Center
https://fmolhs.org/ololrmc/Pages/All-Care-and-Services/St.-Anthonys-Home.aspx
(225) 765-8917 or (225) 923-1389
Capacity - 12
Serving - St. Anthony's Home is an assisted living residence for people who require support due to being disabled from HIV/ AIDS, sponsored by Our Lady of the Lake Regional Medical Center

Louisiana Health & Rehab Center
Pocahontas House (http://www.lahealthandrehab.org/pocahontas-house)
4225 E. Brookstown Drive
Baton Rouge, LA 70805
(225) 927-0770

Mission: Louisiana Health and Rehab Center (LHRC)–Pocahontas House provides quality, comprehensive treatment to functionally homeless substance use disordered men and women who also have a positive diagnosis of HIV/AIDS or other physical conditions or stabilized mental illness in a safe, caring and supportive environment.

Capacity: Housing – 11 bed capacity

Eligibility Criteria:

- Must be 21 years old or older
- Must have a primary diagnosis of substance use disorder
- Must actively participate in treatment as specified by the Individualized Treatment Plan
- Must agree to allow LHRC to assist in money management
- Must commit to a 60-day residency

- Must actively participate in competitive employment and housing placement initiatives—job search and/or academic pursuits
- HIV and other physical conditions or mental illness must be stabilized

Services:

- Home-like atmosphere
- Nutritious Meals
- Support Groups
- Substance Use Disorder Evaluations/Assessments
- Substance Use Disorder
- Group Counseling
- Substance Use Disorder
- Individual Counseling
- Spiritual Formation
- Family Sessions (as needed)
- Aftercare Group Sessions
- Nutrition Education
- Permanent Supportive Housing
- Housing Placement
- HIV Education
- Medical and Non-medical Case Management
- Budgeting and Money Management
- Life Skills Training
- Job Search and Job Placement Assistance
- Transportation

Hours: 24/7 Hours of Operation

Capital Area Alliance for Homeless (CAAH)
http://www.homelessinbr.org/
153 North 17th Street
Baton Rouge, LA
(225) 388-5800

Mission: To provide a continuum of care network for the homeless in the Capital Area (comprised of the civil parishes of Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, and West Feliciana) through a coordinated body of diverse organizations and individuals. CAAH addresses issues of homelessness in the capital area parishes; affects the development of resources to meet the needs of the homeless; provides for a formal assessment of homeless needs; and educates the community on homeless issues, needs, and priorities.

CAAH is a non-profit organization of homeless service providers dedicated to ending homelessness through

- Direct Services,
- Development of Affordable Housing, and
- Advocacy on Homeless Issues

The coalition is comprised of diverse agencies providing Housing and Support Services for homeless persons in the greater Baton Rouge. The services offered by member agencies include:

- Emergency Shelter,
- Transitional Housing,
- Permanent Housing,
- Case management,
- Mental health counseling,
- Substance abuse treatment,
- Life Skills training, and
- Employment/ Job Assistance

The work of Capital Area Alliance for the Homeless has been furthered this year through grants from:

- St. James Episcopal Outreach Committee
- University Presbyterian Mission and Peacemaking
- Louisiana Office of Community Development
- Baton Rouge Office of Community Development
- U.S. Department of Housing and Urban Development
- Credit Bureau of Baton Rouge
- Pennington Family Foundation
- Walmart Foundation - State Giving Program
- Huey & Angelina Wilson Foundation

Below is a list of Capital Area Alliance for the Homeless agencies and organizations serving the homeless in Baton Rouge:

Mind Body Medicine Center of LA
http://mindbodyla.org/
PO Box 78041
Baton Rouge, LA 70837
(225) 678-9950

Iris (Domestic Violence Program)
http://stopdv.org/
P.O. Box 52809
Baton Rouge, LA 70892
(225) 389-3001

HAART – HIV/AIDS Alliance for Region 2
http://haartinc.org/
4550 North Blvd. Ste. 250
Baton Rouge, LA 70806
(225) 927-1269

Housing Authority of East Baton Rouge Parish
http://www.ebrpha.org/
4731 North Street
Baton Rouge, LA 70806
(225) 923-8100

Living Water Outreach Ministry (transitional Housing Program)
http://www.livingwatersomb.org/substanceabuse/housing.html
803 North 48th Street
Baton Rouge, LA 70806
(225) 248-1054

Office of Community Development – City of Baton Rouge – Homeless Assistance
(Emergency Solutions Grants (ESG) program)
https://brgov.com/dept/ocd/esgp.htm
The purpose of the ESG program is to assist individuals and families quickly regain stability in permanent housing after experiencing a housing crisis or homelessness. The ESG program provides funding to:

1. Engage homeless individuals and families living on the street;
2. Improve the number and quality of emergency shelters for homeless individuals and families;
3. Help operate these shelters;
4. Provide essential services to shelter residents;
5. Rapidly re-house homeless individuals and families; and
6. Prevent families and individuals from becoming homeless.

Continuum of Care Supportive Housing Program
https://brgov.com/dept/ocd/continuum.htm
The program is designed to assist individuals (including unaccompanied youth) and families experiencing homelessness and to provide the services needed to help such individuals move into transitional and permanent housing, with the goal of long-term stability. More broadly, the CoC Program is designed to:

- Promote community-wide planning and strategic use of resources to address homelessness;
- Improve coordination and integration with mainstream resources and other programs targeted to people experiencing homelessness;
- Improve data collection and performance measurement; and,
- Allow each community to tailor its programs to the particular strengths and challenges in assisting homeless individuals and families within that community.

Options Foundations
www.optionsfoundation.com
8540 Quarters Lake Road
Baton Rouge, LA 70809
(225) 388-5045

Mission: Options Foundation Inc. is a 501(c)3 Non-Profit Organization dedicated to providing quality, affordable housing options for over 100 mentally ill adults. Options currently has four housing programs in the Baton Rouge and the surrounding area. Option's housing facilities have program directors, LPNs, mental health technicians, caseworkers, tenant facilitators and resident managers who work on a daily basis assisting the residents. Options is currently offering educational/support groups at its housing programs in life skills/job training nutrition/exercise, art therapy and drug abuse.

Facilities:

Options for Living - Independent Living Facility with supportive services.
101 Memorial Dr.
Donaldsonville, LA
Phone: 225-746-0101
18 one-bedroom apartments

Villa Care (LA state Licensed Group Home)
2624 Toulon Dr.
Baton Rouge, LA
Phone: 225-293-4115
8-bed facility

Options Villa (independent living facility w/supportive services)
2426 Convention St.
Baton Rouge, LA
Phone: 225-389-9400
20 two-bedroom apartments

Raven's Outreach
www.ravensoutreachcenter.com/

1913 North Street
Baton Rouge, LA 70802
(225) 300-8642
Mission: Raven's Outreach Center is a non-profit organization created to provide housing for homeless Veterans who are placed with Raven's Outreach Center by the Department of Veteran Affairs Healthcare for Homeless Veterans (HCHV) Case Managers.

Appendix C. Community-Based Resources in Baton Rouge

Provided by Louisiana DHHS, Office of Behavioral Health[116]

Mental Health

Types of Services Provided

- Capital Area Human Services District (CAHSD)
    - Adult Mental Health
        - Screening/referral for services and psychiatric hospitalization; social, psychological, and psychiatric evaluations; medication evaluation/ management; individual, group, and family counseling; aftercare program; treatment for sexual abuse victims; emergency respite; mobile treatment services; tobacco cessation classes; post-incarceration services; housing and employment services for CAHSD clients; case management; outpatient mental health services for the homeless
    - Children's Mental Health
        - Behavioral Health: Referrals to satellite offices, screening and assessment for outpatient/inpatient/emergency services, medication evaluation/ management, individual/group/family therapy, psychological testing, Interagency Service Coordination, substance abuse prevention, treatment for victims of sexual abuse, education/counseling for emotional disorders/substance use, discharge planning, in-home crisis intervention/wrap-around, respite services
        - School-Based Services: Services are provided during school hours to students referred by the school or parent who meet CAHSD criteria. Focused on reducing absenteeism, suspensions, expulsions and improving grades. Services include individual/family/group counseling, referrals to community resources, parent support groups, crisis consultation/intervention, education on child/adolescent behavior topics
        - Child and Adolescent Response Team (CART): Assists during times when an emotional crisis becomes overwhelming. Available 24 hours, 7 days a week. Services include risk assessment; stabilization of youth in least restrictive level of care using family and community-based interventions; reduction of risk/dangerousness/acuity of immediate crisis; referral and linkage to ongoing services
        - Infant Child and Family Center (ICFC): Outpatient services for children birth to age 6 who are involved with DCFS or have been exposed to alcohol, drugs, or other trauma. Services include: behavioral/psychological treatment; emotional, social, and relationship/attachment therapy; fine motor, self-care skills, and sensory processing treatment; parenting support; school consultation; home visits

[116] Email correspondence Sue Austin, Ph.D., Psychologist, Program Manager 4, Louisiana Office of Behavioral Health October 19, 2015.

- Early Childhood Support and Services (ECSS): Outpatient psychiatric, counseling, and case management service for children under 6 years of age.

Substance Abuse

Types of Services Provided

- Capital Area Human Services District (CAHSD)
  - Outpatient level 1
    - Definition: Professionally directed assessment, diagnosis, treatment and recovery services provided in a non-residential treatment setting. These services include, but are not limited to, individual, group, family counseling and psychoeducation on recovery and wellness. These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but are fewer than nine contact hours or less per week.
    - Eligibility Criteria
      - Acute intoxication and/or withdrawal potential – No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in an outpatient setting.
      - Biomedical conditions and complications – None, or sufficiently stable to permit participation in outpatient treatment.
      - Emotional, behavioral or cognitive conditions and complications – None or minimal. If present, symptoms are mild, stable and do not interfere with the patient's ability to participate in treatment.
      - Readiness to change – Participant should be open to recovery but require monitoring and motivating strategies to engage in treatment and to progress through the stages of change but not be in need of a structured milieu program.
      - Relapse, continued use or continued problem potential – Participant is able to achieve abstinence and related recovery goals, with support and scheduled therapeutic contact to assist with issues that include, but not limited to, ambivalence about preoccupation of alcohol use or other drug use, cravings, peer pressure and lifestyle and attitude changes.
      - Recovery environment – Environment is sufficiently supportive that outpatient treatment is feasible, or the individual does not have an adequate, primary or social support system but has demonstrated motivation and willingness to obtain such a support system.
  - Intensive Outpatient Treatment
    - Definition: Professionally directed assessment, diagnosis, treatment and recovery services provided in a non-residential treatment setting. These services include, but are not limited to, individual, group, family counseling and psychoeducation on recovery; as well as monitoring of drug use, medication management, medical and psychiatric examinations, CI coverage and orientation to

community-based support groups. Intensive outpatient program services should include evidence-informed practices, such as cognitive behavioral therapy, motivational interviewing and multidimensional family therapy. These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but must be a minimum of nine contact hours per week for adults, age 21 years and older, (six hours per week for adolescents, age 0-21 years) at a minimum of three (3) days per week.

- Eligibility Criteria:
  - Acute intoxication and/or withdrawal potential – No signs or symptoms of withdrawal, or withdrawal can be safely managed in an intensive outpatient setting.
  - Biomedical conditions and complications – None, or sufficiently stable for participation in outpatient treatment.
  - Emotional, behavioral or cognitive conditions and complications – None to moderate. If present, client must be admitted to either a co-occurring disorder capable or co-occurring disorder enhanced program, depending on the client's level of function, stability and degree of impairment.
  - Readiness to change – Participant requires structured therapy and a programmatic milieu to promote treatment progress and recovery. The participant's perspective inhibits their ability to make behavioral changes without repeated, structured and clinically directed motivational interventions.
  - Relapse, continued use or continued problem potential – Participant is experiencing an intensification of symptoms related to substance use, and their level of functioning is deteriorating despite modification of the treatment plan.
  - Recovery environment – Insufficiently supportive environment and participant lacks the resources or skills necessary to maintain an adequate level of functioning without services in intensive outpatient treatment.

- Methadone Treatment is available from the following providers:
  - Baton Rouge Treatment Center
  - Hatem Hamed, M.D.
    606 Colonial Drive Suite A
    Baton Rouge, LA70806
    (225) 927-6368 Phone

Housing for the Homeless

Types of Services Provided

- **Licensed Group Homes** (for more detail see the chart below)
  - House of Destiny

2351 Jefferson Ave
Baton Rouge, LA 70802

- Legacy Recovery
  168 West Washington Street
  Baton Rouge, LA 70802
- Magnolia Care Center
  16950 Florida Blvd
  Baton Rouge, LA70819
- Maison Des Ami
  1050 Convention Street
  Baton Rouge, LA 70802
- WCRC
  855 St Ferdinand Street
  Baton Rouge, LA 70802

- **Unlicensed Group Homes**
  - Brittany's Place
    7170 Burbank Drive
    Baton Rouge, LA 70820
  - Prosperity House (Men & Women)
    9725 Greenwell Springs Road
    Baton Rouge 70814
  - Prosperity House (Men & Women)
    855 North Carrollton Street
    Baton Rouge, LA 70806
  - Prosperity House (Men Only)
    9986 Greenwell Springs Road
    Baton Rouge, LA 70814
  - Macey's Men's Shelter
    5245 Winbourne Ave
    Baton Rouge, LA 70805
  - Glory House
    8356 Tom Drive
    Baton Rouge, LA 70815
  - Metamorphosis, Inc.
    1913 Carolina Street
    Baton Rouge, LA
    2353 Jefferson Ave
    Baton Rouge, LA 70802

IMD or Nursing Home Supports

<u>Types of Services Provided within Nursing Homes</u>

- Outpatient mental health and substance use treatments
- Inpatient psychiatric hospital services

- Residential substance use treatment
- Psychiatrists or medical psychologists
- Med Management by the NF
- Short term counseling to adjust to the nursing facility
- Short term counseling on interpersonal relations
- Family involvement
- Training in ADLs, independent living skills, and communication skills
- Assistance in obtaining medical appliances and devices
- Behavioral-based treatment plan
- Structured work and leisure activities
- Occupational and physical therapy evaluations
- Physical therapy evaluation
- Referrals to other agencies or community programs (please specify)
- Audiological evaluation
- Dental evaluation
- Vision evaluation
- Foreign language services
- Services for the visually/hearing impaired
- Evaluation for a diagnosis of dementia (Alzheimer's or other organic mental disorder)
- Ongoing evaluation of the effectiveness of current psychotropic medications to target symptoms.
- A guardian / conservator for decisions regarding health and safety
- Crisis intervention plan/safety plan
- Medication education
- Speech/Language services

<u>Nursing Homes</u>

- Affinity Nursing & Rehab Center
  4005 North Blvd.
  Baton Rouge, 70806
- Baton Rouge General Medical Center, SNF
  3600 Florida Blvd.
  Baton Rouge, 70806
- Baton Rouge Health Care Center
  5550 Thomas Road
  Baton Rouge, 70811
- Baton Rouge Heritage House II
  1335 Wooddale Blvd.
  Baton Rouge, 70806
- Capitol House Nursing & Rehab Center
  11546 Florida Blvd.

Baton Rouge, 70815

- Care Center (The)
  11188 Florida Blvd.
  Baton Rouge, 70815
- Carrington Place of Baton Rouge
  8225 Summa Avenue
  Baton Rouge, 70809
- Colonial Care Retirement Center
  14686 Old Hammond Hwy.
  Baton Rouge, 70816
- Flannery Oaks Guest House
  1642 N. Flannery Road
  Baton Rouge, 70815
- Guest House (The)
  10145 Florida Blvd.
  Baton Rouge, 70815
- Heritage Manor of Baton Rouge
  9301 Oxford Place Drive
  Baton Rouge, 70809
- Jefferson Manor Nursing & Rehab Ctr, LLC
  9919 Jefferson Highway
  Baton Rouge, 70809
- Landmark of Baton Rouge
  9105 Oxford Place Drive
  Baton Rouge, 70809
- North Point Healthcare Center
  4100 North Blvd.
  Baton Rouge, 70806
- Nottingham Regional Rehab Center
  2828 Westfork
  Baton Rouge, 70816
- Old Jefferson Community Care Center
  8340 Baringer Foreman Road
  Baton Rouge, 70817
- Ollie Steele Burden Manor
  4250 Essen Lane
  Baton Rouge, 70809
- Regency Place Nursing & Rehab Center
  14333 Old Hammond Hwy.
  Baton Rouge, 70816
- Sage Rehabilitation Hospital (SNF)

8000 Summa Avenue
Baton Rouge, 70809

- St Clare Manor
  7435 Bishop Ott Drive
  Baton Rouge, 70806
- St James Place Nursing Care Center
  333 Lee Drive
  Baton Rouge, 70808
- Sterling Place
  3888 North Blvd.
  Baton Rouge, 70806

Eligibility Criteria

- These services are available to Medicaid recipients living in nursing homes for whom the services have been deemed medically necessary

Pending CMS approval, the service array may expand to include rehabilitation services such as skills training and crisis intervention.

The following are services provided to Medicaid individuals in nursing homes through providers under the Managed Care Organization:

- Med Management
- Short term counseling to adjust to the nursing facility
- Short term counseling on interpersonal relations
- Family involvement
- Training in ADLs
- Training in independent living skills
- Training in communication skills
- Assistance in obtaining medical appliances and devices
- Behavioral-based treatment plan
- Structured work and leisure activities
- Occupational therapy evaluation
- Physical therapy evaluation
- Referrals to other agencies or community programs
- Audiological evaluation
- Dental evaluation
- Vision evaluation
- Foreign language services
- Services for the visually/hearing impaired
- Evaluation for a diagnosis of dementia (Alzheimer's or other organic mental disorder)

- Ongoing evaluation of the effectiveness of current psychotropic medications to target symptoms.
- A guardian / conservator for decisions regarding health and safety
- Crisis intervention plan/safety plan
- Medication education
- Speech/Language services

Currently, Medicaid recipients living in nursing homes may receive the following mental health and substance use services if medically necessary:

- Outpatient mental health and substance use treatments
- Inpatient psychiatric hospital services
- Residential substance use treatment
- Psychiatrists or medical psychologists

Please note: Pending CMS approval, the service array may expand to include rehabilitation services such as skills training and crisis intervention. DHH will provide more details as they become available. All mental health and substance use services will be managed by the recipient's managed care organization.

Licensed Group Home Detail

Facility	Address	Disability Population Served	Age Served	Open	Services Provided	Serve Women or Men
Almor Ponderosa (318)425-2146	830 McKeithen Drive Alexandria, LA 71303	Mental Illness (Disable Veterans)	26-75	Open 24 Hrs/staff always present onsite	Group Home	Both
Beau Provence (504)861-4530	100 Beau West Drive Mandeville, LA 70471					
Dear's Serenity House (504)943-4100	2478 Jasmine Street New Orleans, LA 70122	MH/Elderly	27-96	Open 24 Hrs/1 staff always present onsite	Group Home	Both
Fairhaven Homeless Shelter (318)343-9200	1900 Garret Road Monroe, LA 71202	Homeless	18-65	Open 24 Hrs/ 10 staff Mon-Fri & 1 staff on weekends, afternoons, and nights	Homeless Shelter	Both

Facility	Address	Disability Population Served	Age Served	Open	Services Pro-vided	Serve Women or Men
Home Again (504)362-1066	1417 Nunez Street New Orleans, LA 70114	Homeless	18+	Open 24hrs	Group Home	Both
House Of Destiny (225)383-1422	2351 Jefferson Ave Baton Rouge, LA 70802	Physical/ Mental	18+	Open 24hrs/1-2 staff al-ways pre-sent	Group Home	Women
Hummingbird Group Home (985)626-6538	63051 Hum-mingbird Lane Mandeville, LA 70448	Mental Illness	18+	Open 24hrs/2st aff during the day & 1 staff night shift	Perma-nent Group Home for Men	Men
Jackson House (318)410-1751	820 Jackson Street Monroe, LA	Mental Illness	18+	Open 24hrs/4 staff on day shift, 2staff on night shift	Group Home	Men
Legacy Recovery (225)300-8091	168 West Wash-ington Street Baton Rouge, LA 70802	Mental Illness	30+	Open 24hrs/	Group Home	Both
Magnolia Care Center (225)273-7274	16950 Florida Blvd Baton Rouge, LA70819	Mental Illness	35+	Open 24hrs/ 2 staff per shift	Group Home	Men
Maison Des Ami (225)343-3827	1050 Convention Street Baton Rouge, LA 70802	Mental Illness	20+	Open 24hrs/ 7 staff dur-ing the day, 2 staff dur-ing night shift	Group Home	Both
Project Reach (318)865-1422	1101 Highland Ave Shreveport, LA 71101	Dual Diagno-sis (Sub-stance abuse & Mental Health)	18+	Open 24hrs/1-2 always present	Group Home (Transi-tional Housing)	Both
River Oaks Es-tates (225)778-0042	9475 Petit Road Baker, LA 70714	Mental Illness	18+	Open 24hrs/ 8 staff al-ways pre-sent	Group Home	Men

Facility	Address	Disability Population Served	Age Served	Open	Services Provided	Serve Women or Men
Serenity Senior Residence 2 (504)481-4357	817 Aurora Ave Metairie, LA 70005	Alzheimer's/Mental Illness & Physical	55+	Open 24hrs/2-3 staff during the day & 1 staff at night	Group Home	Both
Transitional Living Center (985)879-3966	137 New Orleans Blvd Houma, LA 70360	Mental Illness	18+	Open 24hrs/1 staff on each shift	Transitional Living (3 months max)	Both
Trinity House (504)947-4100	1422 Kerlerec Street New Orleans, LA 70116	Mental Illness (Referral have to come through Ryan White case management)	18+	Open 24hrs/2 staff always present	Group Home	Both
Volunteers of America GAPS I (318)221-5565	458 Herndon Street Shreveport, LA 71104	Mental Illness	18+	Open 24hs / 1 staff each shift	Group Home	Woman
Volunteers of America GAPS II (318)221-5886	1554 Magnolia Street Shreveport, LA 71104	Mental Illness	18+	Open 24hs / 1 staff each shift	Group Home	Men
Volunteers of America LA-HOPS (318)221-2608	420 Washington Street Shreveport LA 71105	Mental Illness	18+	Open 24hs / 1 staff each shift	Group Home	Both
Westbank Lighthouse (504)931-6048	1712 Holiday Drive New Orleans, LA 70114	Alzheimer's/Mental Illness	18+	Open 24hrs/ 2 staff per shift	Group Home	Both
WCRC (225)336-0000	855 St Ferdinand Street Baton Rouge, LA 70802	Mental Illness	18-62	Open 24hrs/ staff during the day, staff at night	Group Home	Women
Woody's Home for Veterans (318)425-1928	448 Jordan Street	Veterans Only	30+	Open 24hrs/3	Group Home	Men

Facility	Address	Disability Population Served	Age Served	Open	Services Provided	Serve Women or Men
	Shreveport LA 71101			staff during the day, 2 staff during night shift		
Woody's Home for Veterans (318)425-1928	442 Jordan Street Shreveport LA 71101	Veterans Only	30+	Open 24hrs/3 staff during the day, 2 staff during night shift	Group Home	Men
Wren Way Transitional Housing (Women) (985)626-6538	63046 Wren Way Mandeville LA 70448	Mental Illness	18+	Open 24hrs/ 2 staff during the day & 1 staff during night shift	Transitional Group Home	Women
Wren Way Transitional Housing (Males) (985-626-6538	63052 Wren Way Mandeville LA 70448	Mental Illness	18+	Open 24hrs/ 2 staff during the day & 1 staff during night shift	Transitional Group Home	Male

Appendix D. Data Requests

The following data request was made to the Baton Rouge Area Foundation (the Foundation), August 31, 2015. Previous attempts by the Foundation to collect like data went unanswered.

East Baton Rouge Parish Prison

- Current Daily Population including separate breakdown for detainee/inmates with substance abuse and/or serious mental illness; please specify pre-sentencing, DOC, sentenced or other classifications
- Average Daily Census (ADC) for last 5 years including separate breakdown for detainee/inmates with substance abuse and/or serious mental illness; please specify pre-sentencing, DOC, sentenced or other classifications
- Average Daily Admissions for Last 5 years including separate breakdown for detainee/inmates with substance abuse and/or serious mental illness; please specify pre-sentencing, DOC, sentenced or other classifications
- Total Admissions for last 5 years including separate breakdown for detainee/inmates with substance abuse and/or serious mental illness; please specify pre-sentencing, DOC, sentenced or other classifications
- Recidivism Rates and Total Annual Re-admissions for last 5 years including separate breakdown for detainee/inmates with substance abuse and/or serious mental illness; please specify pre-sentencing, DOC, sentenced or other classifications
- Inmates placed in lock down/segregation with substance abuse and/or serious mental illness days per month compared to total population, if possible for last 2 years
- Medical Infirmary ADC and Total Admissions for last 2 years including average length of stay (LOS), range of LOS from lowest to highest
- Social Worker caseload ADC breakdown for detainees/inmates with substance abuse and/or serious mental illness for last 2 years
- Number of inmates receiving psychotropic medications (daily or weekly counts if available) for last 2 years
- Chronic Medical Diagnoses (Insulin, HD, CPAP, Anti coag, Disabled, Infectious Diseases –all identified chronic care cases etc.) –ADC/Annual Admissions for last 2 years
- Number of inmates transferred to inpatient medical care, daily count for the last 12 months
- Number of inmates taken for medical care outside of Baton Rouge, daily count for the last 12 months
- Detox Population - ADC, Annual Admissions for last 2 years, average length of stay and range of LOS
- Zip Codes by individual for patient-detainee population with substance abuse diagnoses for last 12 months
- Zip Codes by individual for patient-detainee population with serious mental illness diagnoses for last 12 months

- List of Existing Community Medical and Mental Health Linkages/Affiliations Mental Health, Substance Abuse, SNF/Nursing Home, Primary medical Care

Community Resources

- List of Existing Community-based Treatment (Mental Health, Substance Abuse, Primary Care) programs noting capacity and occupancy, if available
- Existing reports and surveys on capacity and occupancy of Community-based treatment programs, if available
- List of Housing and Homeless resources available in the community noting capacity and occupancy, if available

Pre-Arrest Diversion Programs

- List of any mobile crisis units that respond directly to court and law enforcement requests for mental health / substance abuse evaluation and intervention
- Number of crisis trained law enforcement officers
- List of social detox programs that respond to and assist LE officers

Court Programs

- List of Drug Courts and capacity, if available
- List of Veterans Courts and capacity, if available

Post Court Community-Based Residential Programs or Intensive Case Management Programs

- List of any available programs (Substance Abuse, Mental Health, Veterans) and capacity, if available

Based on the Foundation's previous experience with data requests, on September 30, 2015, the data requests were prioritized and the following requests were made to the specific entity where data was thought to exist.

East Baton Rouge Parish Prison

- Current Daily Population including separate breakdown for detainee/inmates with substance abuse and/or serious mental illness if possible (sample week of numbers if possible)
- Inmates placed in lock down/segregation with substance abuse and/or serious mental illness days per month compared to total population (sample week if possible)
- Daily Admissions for sample week including separate breakdown for detainee/inmates with substance abuse and/or serious mental illness

Prison Medical Data

- Social Worker caseload sample census for one-week breakdown for detainees/inmates with substance abuse and/or serious mental illness, if possible
- Number of inmates receiving psychotropic medications (weekly count if available)

- List of Existing Community Medical and Mental Health Linkages/Affiliations Mental Health, Substance Abuse, SNF/Nursing Home, Primary medical Care EMS uses when inmates discharged back to the community

EMS

- 911 call log information (sample week, zip codes if possible where calls are made from; type of call and behavioral health issue, if known, would be helpful)

District Attorney Office

- Sample week new cases (numbers; type of charge; zip codes if available)

Point in Time Homeless Count (received for January 27, 2015 count)

Follow-up email communication and phone calls were made to discuss potential data available with the following entities:

- Capital Area Human Services District
- Our Lady of the Lake
- Baton Rouge Police

Appendix E. Sample Health Risk Assessment (*for illustrative purposes only)*

Name_____ DOB ___/___/_____ Date_____

SSN ____-_____-____ ☐ Male ☐ Female ☐Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Race/ethnicity_____ Primary language_____

Preferred communication ☐ Oral ☐Written ☐Sign

Individual has:
Representative payee ☐ No ☐ Yes
Guardian ☐ No ☐ Yes

Name _____
Address: _____
Phone _____

Current living situation: ☐ Rental apartment ☐ Own home or condo
☐ Homeless ☐ Supported housing ☐ Other _____
If homeless, how long? _____How many times in last 3 years? _____

Is there a referring organization? *(specify)*

How did you hear about BRidge Center (or other provider)?

How can we contact you?
Home Phone_____
Cell Phone _____
Email address_____

May we leave you confidential voicemails on your phone?
May we text you health information?
Do you have access to the internet regularly?

Health Care Providers

Who is the provider (medical, behavioral health, other) you consider most responsible for your overall care?
Where does that provider see you?
When was your last visit with that provider?
When is your next visit scheduled with that provider?
Do you see other providers? (mental health, dental, specialists)
What are their names and locations?
Do you have a case manager?
Where are they located?
What services do they help you with?
Do you receive any services in your home?

HEALTH ASSESSMENT

1. In general, would you say your health is:
    a. Excellent
    b. Very good
    c. Good
    d. Fair
    e. Poor

2. Compared to a year ago, how would you rate your overall health?
    a. Excellent
    b. Very good
    c. Good
    d. Fair
    e. Poor

3. Have you had a major life event in the last 6 months (ex. New diagnosis, loss of job, loss of loved one, a move, etc.)
4. What health problems do you have now
5. Have you needed to be transported by ambulance to an Emergency Department in the last year?

If so, when, where, and for what condition?

6. How many times have you gone to the Emergency Department in the last year?
    a. When, where and for what conditions?
    b. Did you contact your PCP first?
7. How many times have you been hospitalized in the last year?
    a. When, where, and for what conditions?
8. Have you been in a nursing home in the last year?
    a. When, where, and for what condition?
9. Have you been in jail or prison in the last year?
    a. Any details that you can provide regarding why and how long you were detained?

(# arrests_____# convictions_____)

List the prescriptions you are taking below

Medication	For what condition?	Prescribed by whom?	Are you taking currently?	Any concerns with this medicine?

10. List any over the counter or herbal remedies below

OTC/Herbal	For what condition?	Are you taking currently?	Any concerns?

11. How many doses have you missed in the last 2 weeks?
12. Do you use medicines in ways other than prescribed (ex. Frequency, for what condition?

13. Do you have any allergies to medications or food?

Allergic to what?	What was your reaction?

14. Do you test your own health at home (blood pressure, sugar, etc.)?
    a. For what?
15. During the past year have you had any serious falls?
16. Do you currently smoke?
    a. If so, how much and for how many years?
    b. If so, have you thought about quitting?
    c. Have you been able to quit before?
    d. Are you experiencing any problems with smoking (health or social)?
    e. If you do not currently smoke, have you ever smoked?

17. Do you currently drink alcohol?
    a. If so, how much and for how many years?
    b. If so, have you thought about quitting?
    c. Have you been able to quit before?
    d. Have you experienced withdrawal?
    e. Are you experiencing any problems with alcohol (health or social)?
    f. If you do not currently drink alcohol, have you ever?

18. Do you use street drugs?

a. If so, which ones and what route?
b. If so, how much and for how many years?
c. If so, have you thought about quitting?
d. Have you been able to quit before?
e. Have you experienced withdrawal?
f. Are you experiencing any problems with street drugs (health or social)?
g. If you do not currently use street drugs, have you ever?

If moderate or greater use of either alcohol or other drugs, ask the following:

	No	**Yes**	*(If participant answers* **Yes** *to a question, circle* **drinking** *or* **drug use***)*
CAGE			Have you ever felt you ought to **C**ut down on your **drinking** or **drug use**?
			Do you get **A**nnoyed at criticism of your **drinking** or **drug use**?
			Do you ever feel **G**uilty about your **drinking** or **drug use**?
			Do you ever take an **E**arly-morning **drink** (eye-opener) or use **drugs** first thing in the morning to get the day started or to eliminate the "shakes"?

19. Do you have access to enough food?
    a. Do you eat three meals per day?
    b. Is your diet well-balanced with protein, fruits, and vegetables?
    c. How many times have you eaten fast-food in the last week?
20. Have there been any threats to your safety in the last 6 months? (ex. violence, gangs, DV)
    a. In the last month?
    b. Ongoing threat?
21. Have you ever had a head trauma?
    a. Ever lost consciousness?
    b. Ever had a concussion?
    c. Ever been diagnosed with Traumatic Brain Injury?
22. Have you ever sought help for a mental health concern?
    a. If yes, describe
    b. Any psychiatric hospitalizations?
    c. Any psychiatric medications?
    d. Any current mental health symptoms?

23. Depression Screening Tool: Patient Health Questionnaire (PHQ-2)

Over the past 2 weeks, have you often been bothered by:
1. Little interest or pleasure in doing things? Yes No
2. Feeling down, depressed, or hopeless? Yes No
If “yes” to either question, follow-up using the PHQ-9, a nine-item, self-administered questionnaire.

24. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much:
    a. Moderate activities such as moving a table, pushing a vacuum cleaner
        i. Yes, limited a lot
        ii. Yes, limited a little
        iii. No, not at all limited
    b. Climbing two flights of stairs
        i. Yes, limited a lot
        ii. Yes, limited a little
        iii. No, not at all limited

25. During the past 4 weeks, have you had any of the following problems with your work or other daily activities as a result of your physical health?
    a. Accomplished less than you would have liked to?
        i. All of the time
        ii. Most of the time
        iii. Some of the time
        iv. A little of the time
        v. None of the time
    b. Were limited in the kind of work or other activities?
        i. All of the time
        ii. Most of the time
        iii. Some of the time
        iv. A little of the time
        v. None of the time
    c. Did work or other activities less carefully than usual?
        i. All of the time
        ii. Most of the time
        iii. Some of the time
        iv. A little of the time
        v. None of the time

26. During the past 4 weeks, have you had any of the following problems with your work or other daily activities as a result of your emotional health?
    a. Accomplished less than you would have liked to?
        i. All of the time
        ii. Most of the time
        iii. Some of the time
        iv. A little of the time
        v. None of the time?
    b. Were limited in the kind of work or other activities?
        i. All of the time

ii. Most of the time
iii. Some of the time
iv. A little of the time
v. None of the time

c. Did work or other activities less carefully than usual?
i. All of the time
ii. Most of the time
iii. Some of the time
iv. A little of the time
v. None of the time

27. During the past 4 weeks, how much did pain interfere with your normal work (both work outside the home and housework)?
a. Accomplished less than you would have liked to?
i. All of the time
ii. Most of the time
iii. Some of the time
iv. A little of the time
v. None of the time?

b. Were limited in the kind of work or other activities?
i. All of the time
ii. Most of the time
iii. Some of the time
iv. A little of the time
v. None of the time

c. Did work or other activities less carefully than usual?
i. All of the time
ii. Most of the time
iii. Some of the time
iv. A little of the time
v. None of the time

SOCIAL AND RECOVERY ENVIRONMENT

28. Where do you live/stay? How long have you been there?
29. Who else stays there?
30. Describe any relationship problems with family
31. Do you have any problems with day-to-day tasks (*e.g., cooking, cleaning, shopping, and getting around the city)*?
32. Describe education/literacy level *(include highest grade, any specialized training*
33. Military service? ☐No ☐ Yes
34. Employment history Last date employed

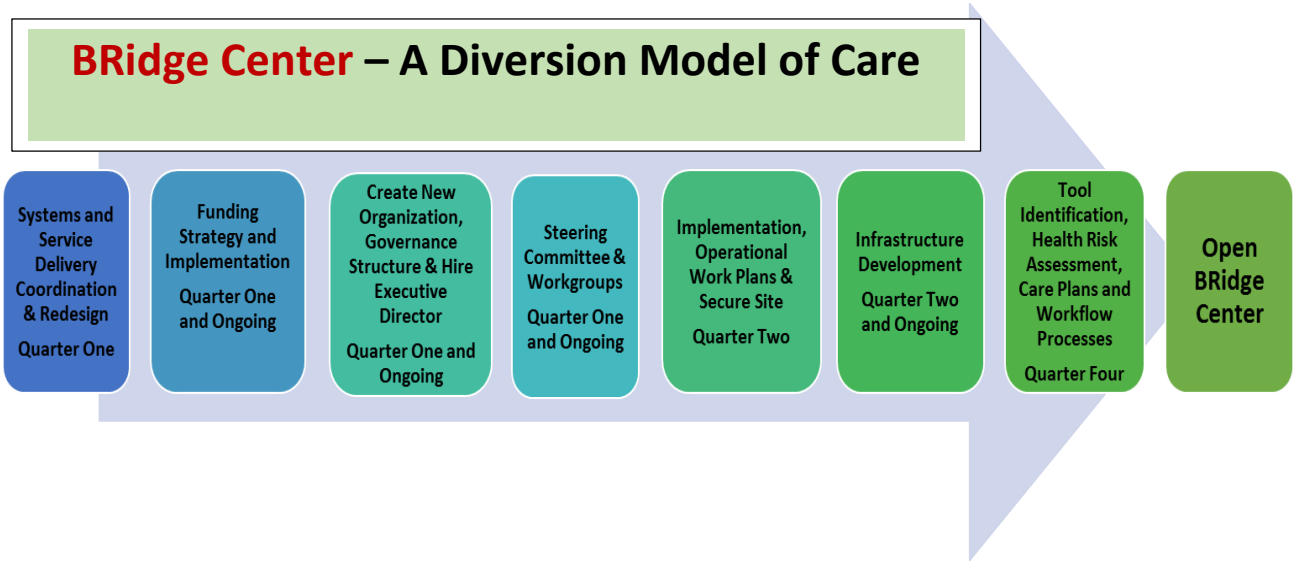
35. Are you mandated to treatment? ☐No ☐ Yes
36. Describe financial status ☐SSI ☐SSDI ☐LINK ☐WIC ☐TANF ☐Medicaid ☐Medicare ☐VA
37. Other benefits? ☐No ☐ Yes
38. What strengths or skills do you have?
39. Describe your social and cultural support system

40. How, where, with whom do you spend most of your time
41. Describe your spiritual beliefs

Patient Goals

42. I see my most urgent or critical need to improve my health is:
43. This is what I can do to improve or better manage my health:

Appendix F. Diversion Model of Care Timeline



Systems and Service Delivery Coordination and Redesign – Convene stakeholder group and identify opportunities to coordinate care across the Behavioral Health system so that populations with the highest need of care receive the appropriate level of support. Identify opportunities to coordinate transitions across service providers and develop shared resources and tools.

Funding Strategy and Implementation – Convene funding workgroup charged with identifying the strategy and securing revenue resources needed for the BRidge Center (sub-groups may be required, for example, a sub-group devoted specifically to working with state officials and policymakers to ensure the state's Medicaid expansion plans adequately cover individuals with behavioral health needs and substance use disorders).

Organization Established, Governance Structure Developed and Hire Executive Director – Submit application to establish a new 501(c)3 organization. Draft organization by-laws and determine governance structure including identifying board members able to strategically lead development and implementation of the BRidge Center. Hire Executive Director and create an organization strategic plan. Hiring of an Executive Director may also take place earlier, to the extent a strong candidate is identified by the Steering Committee.

Steering Committee and Work Groups – Steering Committee charged with oversight of BRidge Center development, securing funding and implementation. Workgroups to be established based on work plan needs. Persons accountable for actions, timeline and resources needed to be determined. Steering Committee should identify systems impacts and needed shifts across Behavioral Health and Criminal Justice that will require redesign in order to support diversion programming.

Implementation, Operational Plans and Secure Site – Several work plans, including a formal business plan will be required to implement the BRidge Center. Plans should build upon draft timeline(s) and include specific activities needed to open the BRidge Center such as: site location, capital, start-up and operational funding, information technology, performance metrics and data collection, human resources plan and infrastructure development.

Infrastructure Development – BRidge Center infrastructure needed includes: marketing, data and management, health information technology, HR, financial management, purchasing, grants management, billing, quality management, risk management, etc.

Tool, Workflow and Processes Development – Develop and document tools to be used (screens, assessments, documentation), policies and procedures, and how work gets completed across BRidge Center components and in collaboration with community partners.