After the initial failure of the tax in 2016, the Bridge Center hired Emergent Method, a local consulting firm, to review the Bridge Center model. This report evaluates opportunities for collaboration, potential funding opportunities for the Bridge Center, and outlines a path forward for the Bridge Center board leadership.

In particular, this report examined behavioral health care along the continuum of care in Baton Rouge in the hopes of identifying collaborative ways to partner. Circumstances have changed since this report was written and so for that reason some recommendations contained herein may no longer be relevant. For example, as a result of some of this work, the Bridge Center board worked closely with the Crisis Intervention Center (CIC) as they transitioned THE PHONE to ViaLink and as CIC established themselves as a suicidology training hub. Additionally, at the time of publication, the Baton Rouge Detox Center had not been operational. However, our understanding is that the Detox Center is now seeing patients and filling a critical need in the community.

This report represents the culmination of work by the Bridge Center board to understand the evolving dynamic in Baton Rouge around behavioral health care delivery. And, more specifically, to solidify the model and services necessary for a successful implementation. This report ultimately determined that without a public infusion of dollars, the Bridge Center as envisioned would not be achievable. The recommendations related to the Bridge Center remain as relevant and critical as when the report was first released. This report provides a blueprint to guide the implementation of the Bridge Center, in concert with community feedback, licensing requirements, and best practices of crisis care delivery around the country.

Kathy Kliebert
Chair
REIMAGINING THE BRIDGE CENTER

PREPARED FOR: THE BRIDGE CENTER FOR HOPE

DATE: FEBRUARY 22, 2018
A SPECIAL THANKS TO THE BRIDGE CENTER FOR HOPE (BRIDGE CENTER) BOARD OF DIRECTORS FOR THEIR TRUST, KNOWLEDGE AND PARTICIPATION IN THE EFFORT THAT LED TO THIS REPORT, AND FOR THEIR COMMITMENT TO IMPROVING BEHAVIORAL HEALTH IN BATON ROUGE AND ACROSS LOUISIANA:

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DR. JAN KASOFKSY
DISTRICT ATTORNEY HILLAR MOORE
RANDY NICHOLS
MARY ANN STERNBERG
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19TH JUDICIAL DISTRICT COURT
Judge Donald Johnson, Civil Court Judge
Judge Anthony Marabella, Criminal Court Judge

BATON ROUGE AREA ALCOHOL AND DRUG CENTER, INC
Tommy Reeves, Board President
Frank Perez, Board Vice President
Larry Lampin, Board Treasurer
Amber Landry, Interim Director

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John Spain, Executive Vice President
Patricia Calfee, Director of Strategic Consulting Services
Lauren Crapanzano Jumonville, Director of Civic Leadership Initiatives
Sarah Gardner, Project Manager

BATON ROUGE CITY COURT
Judge Kelli Terrell Temple
Judge Tarvald Smith

BATON ROUGE COMMUNITY COLLEGE
Dr. Bridget Sonnier-Hillis, Assistant Professor of Psychology, Department of Social Sciences and History

BATON ROUGE GENERAL
Angela Clouatre, Director of Behavioral Health Services

BATON ROUGE POLICE DEPARTMENT
Interim Chief of Police Jonny Dunnam
Sergeant Darryl Honore’
Captain Tim Browning, Uniform Patrol
First District Precinct
Second District Precinct

BATON ROUGE HEALTH DISTRICT
Suzy Sonnier, Executive Director

BLUECROSS BLUESHIELD OF LOUISIANA FOUNDATION
Michael Tipton, Executive Director

BREAIZEALE, SACHSE & WILSON, LLP
Jim Raines, Partner Attorney
Greg Frost, Partner Attorney

CAPITAL AREA ALLIANCE FOR THE HOMELESS
Randy Nichols, Executive Director

CAPITAL AREA HUMAN SERVICES DISTRICT
Dr. Jan Kasofsky, Executive Director

CAPITAL AREA UNITED WAY
George Bell, President and CEO

CRISIS INTERVENTION CENTER
Aaron Blackledge, Former Executive Director
Amy Vidrine, Accounting and HR Manager
Becky Young, Volunteer Coordinator
Cody Johnson, Resource Manager
Margot Abadie, Clinical Director
Monique Gauthier, Contact Center Coordinator
Rick Jackson, Clinical Coordinator
Sarah Backstrom, Clinical Supervisor
Sherrard Crespo, Operations Coordinator
INTRODUCTION

THE CHALLENGE
In recent years, the deinstitutionalization of mental health care facilities in Louisiana, combined with several years of state budget cuts for mental health services, have led to a reduction in options for individuals in need of critical long-term solutions for chronic mental health issues. As a result of improper care and the co-occurring patterns of substance abuse that often result, these individuals tend to find themselves in patterns of crisis, and usually in these times of crisis, law enforcement officers are called out to the scene and solve the issue. For 20 months before its closure on April 15, 2013, the Mental Health Emergency Room Extension (MHERE) at the former Earl K. Long Medical Center in Baton Rouge provided a national model for crisis stabilization and connecting patients to ongoing care (Kasofsky, 2014). Today, the only options officers have for managing these crisis situations are to bring the individuals in crisis to the Emergency Department (ED) or to incarcerate them for an offense, and neither of these represent an option for providing the services needed to properly care for persons with mental illness. This situation results in a number of negative consequences, including but not limited to overpopulated prisons overburdened with needs to care for persons with mental illness, substantial populations of individuals with chronic mental health and substance abuse issues slipping through the cracks, over-crowded emergency rooms struggling to provide care for patients, increased taxpayer spending on “band-aid” solutions to fill gaps in services, and a community that is less prepared to support this population overall, both for the general public and for the individuals with mental health issues that find themselves in difficult living situations, struggling to survive. Furthermore, the constantly evolving landscape of health care, funding, providers, and regulations only contribute to the instability of the situation.

WORKING TOWARD A SOLUTION
In 2015 and 2016, the Baton Rouge Area Foundation (BRAF) engaged Health Management Associates (HMA) to design a behavioral health care center that would address these gaps in mental health care and substance abuse services in Baton Rouge. The resulting report, entitled Initiative to Decriminalize Mental Illness, recommended a comprehensive model, summarized in this report, and business plan for the Bridge Center, which would serve as a “bridge” to stabilize people in crisis and get them on the path to recovery and appropriate mental health management (Health Management Associates, 2016). The Bridge Center model took into account the results of a study conducted by a Clinical Design Committee assembled by Dr. Jan Kasofsky, executive director of the Capital Area Human Services District (CAHSD). The Clinical Design Committee’s study, entitled A Proposal for East Baton Rouge Parish’s Behavioral Health Crisis Services, recommended a behavioral health crisis continuum that included many of the components of the eventual Bridge Center model, including triage, stabilization, care management, acute care, and connections to ongoing treatment as needed (Capital Area Human Services District, 2015).

According to a study by the Perryman Group in 2015, the creation of the Bridge Center would generate the following direct cost savings for the Baton Rouge community:

- $3.0 million in the initial year of operation of the program,
- $8.1 million per year once the program reaches a mature state,
- $24.6 million in total over the first five years, and
- $54.9 million in total over the first 10 years.

(The Perryman Group, 2015)

In addition to these studies, Loop Capital published a Justice Center Study in June of 2016 for East Baton Rouge Parish, which concluded that, among other findings, prison overpopulation and excessive lengths of imprisonments could be improved through focused pre-trial diversion services as well as mental health and substance abuse treatment options – both concepts
that factor heavily into the proposed Bridge Center solution developed by HMA and expanded upon in this report (Loop Capital, 2016).

The HMA effort resulted in the creation of the Bridge Center Board of Directors, comprised of a spectrum of community leaders and elected officials all with an interest in the behavioral health space, and the formation of a 501(c)3 nonprofit organization to carry out the recommendations in the report. The Bridge Center business model developed by HMA required an operating budget of over $5.6 million that, due to uncertainties in reimbursements and a lack of stable revenue sources, the board elected to pursue fulfilling through a dedicated 1.5-mill tax proposition in coordination with the City-Parish in 2016. The tax, which would have generated $5.8 million annually to fund the center, was narrowly defeated by East Baton Rouge Parish voters at a margin of 51% to 49%, or 3,142 votes.

The Bridge Center board, recognizing these services needed to be addressed despite the setback, decided to remain intact and explore alternatives for how to improve upon the status quo in the absence of a Bridge Center facility. Service options for persons with mental illness in crisis were not getting any better and traumatic events, such as the Great Flood of 2016, only exacerbated the situation for individuals at risk of crisis. In addition, Governor John Bel Edwards issued an executive order in January 2016 to initiate statewide Medicaid expansion, creating an opportunity for greater coverage among populations suffering from forms of mental illness.

In 2017, while continuing to study potential path(s) forward for the organization, the Bridge Center began operating a pre-trial release program launched through generous seed grants from the John D. and Katherine T. MacArthur Foundation (MacArthur Foundation) in coordination with the Urban Institute and BRAF, with a focus on identifying newly arrested inmates with mental health concerns and connecting them with appropriate services. Through Mayor-President Sharon Weston Broome’s proposed 2018 budget allocation of $260,000 that was confirmed by the Metropolitan Council in December 2017, the program will be sustained through City-Parish funding during the upcoming calendar year. This program is reactive in that it addresses individuals who have already been incarcerated, while ultimately the Bridge Center’s mission is focused more on diversion at an earlier stage. Still, intercepting people at this point provides an important opportunity to help those who may have slipped through the cracks of more preventative measures. In the absence of a sophisticated bond court and specialty courts system, the program fills a critical need.

CAHSD has also grown its long-standing role working with the prison and Warden Dennis Grimes to administer mental health screenings and develop discharge plans for outbound inmates so they can receive the ongoing care they need. These efforts are conducted with the goal of reducing recidivism rates.

From June 2017 to January 2018, concurrent with many of these developments, the Bridge Center contracted Emergent Method – a Baton Rouge-based management and strategy consulting firm – to assess how the current state environment of behavioral health care in Baton Rouge has evolved since the HMA study, ascertain which critical providers are succeeding or struggling, and identify ways in which the Bridge Center can strategically advance short- and long-term solutions to improve the landscape of options in this space.

**METHODODOLOGY**

The approach for this planning effort was developed to capitalize on the knowledge of a variety of experts, both within and outside of Baton Rouge, incorporating varying perspectives and interests in solving for these service-related challenges. Key elements of the process included the following:

- Secondary research of successful behavioral health care models in other communities
- A presentation and discussion with CAHSD’s Behavioral Health Collaborative, a monthly convening of public and private behavioral health providers and stakeholders from across the region
- Interviews with 73 subject matter experts and community stakeholders representing 40 organizations
An in-depth current state assessment and set of sustainability-focused recommendations for the Crisis Intervention Center, an organization that fills a critical need in Baton Rouge’s behavioral health continuum but is currently facing operational and financial challenges

- Work with St. Tammany Parish stakeholders and community leaders to learn from the successes of St. Tammany’s Behavioral Health Task Force efforts
- Gap analysis of the Baton Rouge area behavioral health landscape
- Collaboration with the District Attorney and 19th Judicial District Court Judges to advance the concept of a Mental Health Court in Baton Rouge
- Development of recommended public policy measures to inform ongoing improvements in the local behavioral health landscape
- Development of a phased model for implementation of the Bridge Center concept, including corresponding financial pro formas

EXECUTIVE SUMMARY

The visions created by the Clinical Design Committee and HMA are still as or more relevant and necessary than when they were first developed, and both serve as foundational elements of the recommendations outlined in this report. These recommendations are focused on making optimal use of existing resources and opportunities to address as many needs as possible in the short-term, while recognizing the gap between what can be done now through efficiency and collaboration measures and the effort of standing up a facility capable of achieving the original Bridge Center vision, which is still the long-term goal.

In addition, there are two service areas that have been historically addressed in Baton Rouge but currently represent critical needs: crisis intervention services and medical detoxification. Given the importance of these services within the overarching continuum of care, the Bridge Center Board of Directors recognized the obligation that exists for this community to stabilize such services and ensure they are provided to the thousands who currently rely upon them. As such, both services represent key components for Bridge Center planning to address in the short term. Through the ongoing, stable provision of crisis intervention services and medical detoxification, other elements of the Bridge Center vision can be informed and achieved.
In addition to vetting the model above, an objective of this study was to identify where service gaps exist along this continuum, and to identify short- and long-term strategies for filling them. In the short term, this means looking at existing resources and developing efficient plans to maximize what can be done to support persons in crisis and connect them to helpful resources. In the long term, it means understanding the true cost of delivering on the continuum above, and the service models that have proven to be effective in crisis stabilization. A critical piece of this research was to look to best practices in communities dealing with similar issues and to understand where and how these models could be applied in the Baton Rouge community.

Another key finding of this effort is that, in addition to the need for services along the continuum of care, models for collaboration and accountability in other communities have resulted in positive shifts for behavioral health. Collaboration must be inclusive and embraced by community leaders, officials, and decision makers. Accountability applies not only to empowering the public to hold leaders accountable, but to empowering thought leaders in the behavioral health space to rely on each other and hold one another accountable. A model for implementing such collaboration and accountability is included in this report.

As recommended herein, the remainder of the original Bridge Center concept has been restructured to accommodate a changed service delivery environment – one that is consistent with best practices and feasible funding mechanisms for both the short- and long-term – with implementation measures that include:

- Recommendations for effective, intentional community collaboration
- A phased approach for standing up the Bridge Center over time
- A detailed description of what should be included in Phase 1 of Bridge Center operations
- Key funding opportunities to support the recommended phased approach
- Pro formas with assumptions included for itemized Phase 1 revenues and expenses
Estimated funding gaps for Phase 2 that may require a restructured tax proposition submitted and marketed to voters for approval in the coming years

WHERE TO FOCUS

While the subsequent sections of this report document the following items to a greater level of detail, these immediate action items represent key next steps for the Bridge Center in 2018.

- First new hire – The Bridge Center Board of Directors will need to hire an executive director or project manager to carry out the tall order of standing up the Bridge Center. While hiring a project manager is a feasible option, this person will be building indispensable institutional knowledge through the start-up process, as well as developing critical relationships with community partners, providers, and current and potential funders. As such, it is both logical and defensible to bring on an executive director now – one who can catalyze shorter-term operations and ongoing planning efforts while sustaining knowledge and relationships for the long-term. At the same time, hiring someone on a temporary basis with deep experience in starting up health care facilities and/or other service models should be the priority, and this may be an easier proposition if the position is defined as temporary or stint based. This person will be responsible for executing upon the recommendations that follow in alignment with the vision of the Bridge Center Board of Directors, as well as recruiting and hiring clinical staff to position the Bridge Center for Phase 1 and subsequent phases of operations.

- Community collaboration – As observed in St. Tammany Parish and Bexar County, Texas, launching a structured program for community collaboration like the one detailed in this report can be a powerful catalyst for making both incremental and strategic change to better serve entire populations.

- Redefined tax proposition – The breadth of services needed for the Bridge Center to fully serve its purpose of connecting populations suffering from mental illness to the long-term treatment they need will inevitably include components that are not reimbursable and/or not profitable. The recommendations contained within this report will guide the Bridge Center toward a lean startup model that only touches some of those service components, but stabilizes the organization and begins to have a positive impact. Once the Bridge Center is able to move forward with some or all of these immediate, short-term recommendations, it will also communicate a clear message to East Baton Rouge Parish voters that community leaders are working as expeditiously as possible to provide better services to residents with mental illness by leveraging and better mobilizing existing resources, independent of a new tax. This visible evidence of such commitment and action will be critical, as financial projections indicate a substantial funding gap for future state operations without the introduction of a new and dedicated funding stream. It is expected that a return to the ballot will be necessary, this time for a smaller ask, to sustain a broader, more complete service model. As such, Bridge Center leadership will need to plan for a forthcoming tax proposition in 2018 or 2019, including the necessary ask from voters based upon the successes of Phase 1 efforts, and begin to make the case to voters that it is a responsible use of public funds that both makes the community safer and generates tax savings by reducing health care and incarceration expenses. This report includes estimated amounts for that proposition that will need to be further refined prior to submitting to the City-Parish for introduction to parish voters, and a planned expense category in the financials that should include funds needed to implement a campaign for the future public ask.

- Managing the CIC transition – Given the unstable and unsustainable financial position of the Crisis Intervention Center (CIC) – a situation discussed in further detail in this report – there is great urgency to stabilize the services currently provided by the organization. The Bridge Center faces a choice between two options: encourage CIC to take into account the recommendations detailed in a separate report prepared for the Bridge Center by Emergent Method and delivered in November 2017, Crisis Intervention Center Current State Analysis, and consider opportunities in the future to partner and possibly pursue joint funding, or subsume the crisis intervention services currently performed by CIC and financially support those operations (Emergent Method, 2017). If the Bridge Center is to assume responsibility for CIC contact center services, the organization will also be responsible for transitioning CIC organizational elements, including addressing the following:
  - Facilities – The two buildings owned by CIC represent both opportunity and responsibility. Whether and how the Bridge Center utilizes these facilities will be an important situation to resolve.


- CIC contracts – CIC provides services beyond community resources such as THE PHONE through a number of fee-for-service contracts. Bridge Center resources will need to analyze current service agreements, work to transfer sustainable services, and make an effort to renegotiate or end those that do not cover associated expenses for the organization.

- Employees – CIC employees maintain strong industry credentials and offer a depth of experience in delivering services. It should be a priority of Bridge Center leadership to review the qualifications and performance of current employees, and to oversee their transitioning from CIC. Some CIC employees may be well suited to transfer to VIA LINK, the recommended service provider should the Bridge Center assume responsibility for CIC contact center services, and continue providing crisis intervention services on behalf of the Bridge Center. In addition, others may represent ideal candidates to work with the Bridge Center for the provision of other core services. Other logistical and financial aspects of employment transition will also need to be managed, including working with current CIC administrative resources to perform these tasks.

- Other Services – If CIC contact center services are transferred to VIA LINK, there are still a number of critical community services offered currently by CIC that will need to be transferred to in-market organizations that can deliver them. In particular, trauma and loss support counselling are greatly valued services depended upon by a number of people in the Baton Rouge community, and thus the Bridge Center should work expeditiously to identify organizations that can and are willing to assume the responsibilities moving forward associated with such service delivery.

### Identifying a Facility

Facility cost estimates are built into the financial models in this report, but the need for a facility will ultimately be driven by how and to what degree Bridge Center leadership moves forward with the implementation of phased operations. Key factors for location considerations include the following.

- The buildings owned by CIC could provide a temporary or long-term location for some Bridge Center services.

- The Baton Rouge General Medical Center’s Mid-City Campus represents a strong candidate for future state Bridge Center operations given its central and accessible location near areas where police officers are often responding to calls related to behavioral health crises. In addition to location-driven considerations, the adjacent infrastructure offered by hospital operations represents much of the necessary equipment and structural design to support effective care delivery, thereby minimizing operating costs. Furthermore, being collocated with a hospital could bolster the Bridge Center’s eligibility for Low Income Needy Care Collaboration Agreements (LINCCA), a funding mechanism described within this report that could potentially provide critical support ongoing Bridge Center financial sustainability. Previous conversations with the Baton Rouge General estimate rental costs per square foot at $18.50-$19.50 annually.

- Diverting individuals with behavioral health issues away from EDs will prevent costly psych consults, and therefore a measurable savings to Baton Rouge hospitals should be recognized upon creation of the Bridge Center. Because of this benefit to hospitals, it is likely there will be operational funds to be gained through community impact grants from hospitals; however, another consideration may include working with the Baton Rouge General for potential in-kind support through rent-free provision of facility space in the currently unutilized space at the Mid-City Campus.

### Negotiating third-party support

Given the lean start-up model recommended for initial Bridge Center operations, the organization will need to outsource several critical services that may be candidates for future insourcing in later phases of Bridge Center operations. Examples of third-party support to be addressed during Phase 1 of operations include the following.

- VIA LINK services – The Bridge Center has already received quotes from VIA LINK for stratified call volume levels in anticipation of immediate transition needs required due to CIC’s current financial state. The VIA LINK contract should be negotiated and agreed to base on the best available call volume data originating from CIC systems, but negotiated thereafter if volumes are different than expected.

- Medicaid administration – An example of standard pricing for Medicaid and other reimbursements administration is included in this report; however, Bridge Center leadership should pursue additional quotes and negotiate service agreements with providers and Healthy Louisiana plans to ensure the organization is receiving the most optimal reimbursements for corresponding services.

### Reimbursement modeling

As a behavioral health care provider, Bridge Center leadership must focus on establishing optimal reimbursement agreements to cover as much of the cost of care delivery as possible, including through the following mechanisms.
- Reimbursement Coding Model – As a fundamental early step for the organization, Bridge Center leadership should consult with Medicaid administration vendors to build the optimal coding model based on the organization’s mission and services.
- Pursue Partnerships with Managed Care Organizations (MCOs) – MCOs have a vested interest in diverting their members from costly, less effective treatments through value-driven preventative care and diversion. As described in this report, opportunities exist to partner with MCOs to fund Bridge Center services, and Bridge Center leadership should work to meet with these organizations and explore opportunities to bolster coverage opportunities.
- Capital Area Human Services District – Although CAHSD’s funding has been reduced in recent years, the local government entity serving the Capital Region has historically helped with coverage of indigent populations not covered by Medicaid, Medicare, or private carriers, in addition to providing services for those who are covered. While funding mechanisms and services coverage are volatile factors, it will be important to work with CAHSD to clarify its role and relationship with the Bridge Center to understand how best to provide services to the greatest number of people with maximum positive benefit.
- Sobering reimbursements – Due to a lack of information regarding future potential for reimbursements for sobering services, it is included in the financial modeling of this report as a pure expense. Bridge Center leadership will need to work with the Louisiana Department of Health’s Medicaid office to identify potential opportunities to fund sobering, which should be a determinant for whether the Bridge Center provides sobering services during start-up operations.
- Planning for disruption of the Affordable Care Act (ACA) – During the development of this report, Congress passed a tax package signed into law by President Trump that will remove the health care mandate component of the ACA. It is unclear at this time what the repercussions of this action will be in terms of escalating costs associated with indigent populations using high-cost services through EDs and/or how Medicaid expansion efforts that have taken place at the state level will be affected. Long-term, these policy changes may significantly impact the percentage of Bridge Center clients with some level of coverage and thus increase indigent care service volumes.

- Explore expanded detox services – The only form of detoxification services included in the financial modeling of this report is medical detoxification. However, other area providers have begun to enter into this space in recent years and additional revenue-generating opportunities may exist in offering ambulatory detox or social detox services, which the Bridge Center may opt to provide. Regardless, detoxification services could be an anchor for the ongoing sustainability of the Bridge Center given the clear need within the Baton Rouge area market and reimbursable Medicaid revenue streams attached to such services. Given this, investigating ways to expand these services and associated revenues will contribute to stronger stability for the organization.

IN FOCUS: BEST PRACTICE MODELS

Through this work to assess current market conditions and identify a recommended path forward for the Bridge Center, Emergent Method identified and examined behavioral health models in other cities and regions for concepts, practices, or other model elements that could be applied within the Baton Rouge marketplace – whether directly advanced by the Bridge Center organization or in collaboration with the appropriate community partners. The following summaries highlight key insights drawn from these models.

MEMPHIS, TN
RAPID ASSESSMENT DECISION AND REDIRECTION PROGRAM (RADAR)

One out of every five phone calls to 911 in Memphis, TN is actually a non-emergency. Beginning in April 2017, the city evaluated this problem and created the Rapid Assessment Decision and Redirection program, or RADAR. RADAR focuses on weekday daytime calls to 911 through a partnership with Resurrection Health, a faith-based organization, to redirect citizens away from emergency rooms and directly to a health-care provider.
When a call is redirected to RADAR, a city paramedic with a Resurrection Health doctor is dispatched in a car, rather than an ambulance, to evaluate the caller on site. By bringing the medical screening to the site, this process frees up room in the ED. The RADAR team carries a full line of emergency supplies and, if needed, can serve as first-responders.

The RADAR process removes pressure off of the emergency dispatch system and limits individuals using 911 for basic health care needs. The program is run by Memphis’s Community Health Steering Committee which includes stakeholders from the public-health department, city council, hospitals systems and non-profit organizations.

Substantial cost savings have been recorded through this process. Currently, Medicaid only covers $224 of the $1,000 ambulance ride to the hospital and $140 of the $1,000 ED visit. By reducing the number of ED visits for unnecessary emergencies, the city has been able to save close to $2,000 per visit. Resurrection Health doctors are donating their time while Memphis Fire provides the paramedics.

As of fall 2017, the city of Memphis has incorporated a specialized nursing unit into the program. If a RADAR team is not available, a nurse can take the call instead. These nurses will follow up with citizens to check on status and ensure medical appointments have been kept (Capps, 2017).

MEMPHIS POLICE DEPARTMENT CRISIS INTERVENTION TRAINING (CIT)

In September 1987, a mental health incident in a Memphis housing project spurred the creation of the Memphis Police Department’s Crisis Intervention Team. This team is comprised of officers who voluntarily attend a 40-hour training program to learn skills such as empathy and listening in an effort to calm down citizens during an escalating mental health crisis. As of April 2017, 285 officers, or 15% of the total Memphis Police squad, have been trained in crisis intervention.

This CIT team initiative has reduced time and money spent transporting a citizen to jail and the fees associated with housing an inmate in mental health crisis. In 2016, 3% of the 18,000 calls that enacted the CIT team resulted in actual arrests and instead led to a situation de-escalation and an appointment with an appropriate health care provider (Connolly, 2017).

Identified Funding Sources: Resurrection Health provides physicians for the RADAR program at no cost to the city. Mental health and other community professionals in Memphis joined forces to train and consult with CIT officers at no cost to the city. To start CIT programs in other communities, the University of Memphis recommends acquiring state funding as well as grants from the National Alliance on Mental Illness.

Application to Bridge Center: The Memphis model demonstrates the demand for community collaboration, the importance of specially-trained police officers, and the need to reduce the reoccurrence of ED use as a replacement for regular or primary care. Crisis response is now immediate and the number of arrests and use of force by police officers has decreased. By tackling these issues using a collaborative approach across Memphis Community, the city has been able to substantially reduce city spending and provide a new level of health care to its population.

The incorporation of the Memphis CIT Team process can be counted as a “win” for the Bridge Center. After discussions with Interim Police Chief, Jonny Dunnam, CIT training will be implemented into yearly officer continuing education initiatives. With the arrival of new Police Chief Murphy Paul, the Bridge Center can work to establish an ongoing relationship that will help the citizens of Baton Rouge during a mental health crisis.

In Baton Rouge, over 500 law enforcement officers have been trained in CIT based on the Memphis model and over 1,300 have received an abbreviated version of the 40-hour CIT course. This training, conducted by professional certified CIT trainers, is provided free of charge by CAHSD. The 40-hour training course has been added to recent training academies so
that all new recruits have CIT training, and about 1/3 of the current police force has received CIT training, including specialized divisions.

LONG BEACH, CA
MENTAL HEALTH AMERICA OF LOS ANGELES

Mental Health America of Los Angeles stands as one of the oldest non-profits in the US. With a focus on service, education, advocacy and training, this facility provides care through a number of different outreach programs in the Long Beach area. This recognition of the need for social outreach and help based on demographics has proven beneficial to the local community (Mental Health America of Los Angeles, n.d.).

Outreach Programs:

- **Homeless Innovations Program with Street Team**
  - The Homeless Innovations Program approach integrates mental and physical health services using “Street Medicine”. Through staff in the medical field and volunteers, a collaborative team walks the streets of Los Angeles focusing on the homeless population and providing “street-side” checkups and mental health evaluations. If interested, this hard-to-engage population is offered affordable, safe and permanent housing with support for success in the future.

- **Operation Healthy Homecoming**
  - Operation Healthy Homecoming provides support to veterans and their families who are homeless or at serious risk of homelessness. Aid is given for urgent need funds, rapid identification of safe housing and long-term care for health, financial, paid work and any other family needs. Plans are created based on family necessities and include forming connections for individuals with Veteran Affairs and other public benefits and resources.

- **TAY (Transition Age Youth) Academy**
  - TAY Academy provides help to young adults ages 18-25 who are experiencing emotional, behavioral and mental health difficulties. Many of these individuals have aged out of foster care and have little skills needed to transition to adulthood. Many also need support for drug or alcohol addiction. This program matches youth to a mentor who works with them on a one-on-one basis and in groups to develop the necessary skills to care for themselves and live safely in the community. Emphasis is put on continuing education and job finding as well as overcoming past traumas through therapy and psychiatric support.

- **The Village in Long Beach**
  - The Village in Long Beach blends all the parts of mental health recovery – treatment, rehabilitation, family and community support, and self-help – to provide the help adults with mental illness need for self-sufficient lives. Mental health diagnosis, social skills and financial sustainability lessons are provided through supporting services that are tailored to the individual. This program has been recognized as an “exemplary practice” nationally and a “best practice” in the state of California.
The Wellness Center
- The Wellness Center provides opportunities for individuals to learn skills for self-reliance, develop natural supports and access local resources that help them grow in their well-being through staff-member partnerships and member-driven services. The facility works with those with a mental illness diagnosis to safely make the transition to independent community-based support services. This encompasses a broader effort of a dedication to personal empowerment and self-responsibility given to each member of the Wellness Center community.

BEHAVIORAL HEALTH URGENT CARE CENTER

In May 2017, the city of Long Beach approved the first around-the-clock psychiatric urgent care facility with a focus on offering an alternative to incarceration or emergency room treatment. This 24-hour mental health center will be able to admit up to 12 adults and 6 adolescents as well as provide a walk-in center for those in crisis.

The center will reduce the burden on law enforcement, decrease incarceration rates and hospitalization, and connect patients to the most-relevant form of treatment. While details are still being worked out, the center plans to open sometime in late 2018 (Tompkins, 2017).

Identified Funding Sources: The large majority of Mental Health America of Los Angeles’ revenue comes from contracts, grants, and fundraising activities. Additionally, some funding for The Village and their homeless assistance programs comes from the Mental Health Services Act (MHSA), Medi-Cal, U.S. Department of Housing & Urban Development, Department of Mental Health, and the Federal PATH Program.

Application to Bridge Center: The Bridge Center operations would benefit from mimicking several aspects of the Long Beach model as it pertains to the entire mental health spectrum from treatment to family support to learning daily skills and re-entry into society. A physical Bridge Center facility could aim to operate as a 24-hour facility accepting walk-in patients at a time of crisis. Building relationships with non-profit organizations, including those whose leadership serves on the Bridge Center Board, could allow for focus on specific demographics of the population such as the homeless, youth or veterans.

MIAMI, FL

CRIMINAL MENTAL HEALTH PROJECT (CMHP)

Miami-Dade County holds the largest percentage of citizens with serious mental health illnesses than any other urban community in the US. While fewer than 13% of these individuals receive the correct care that they need, law enforcement has become the main responders to those in crisis. On any given day, the Miami-Dade County Jail holds about 1,200 individuals with a serious mental illness representing about 17% of the total inmate population and costing taxpayers more than $50 million annually.

The Honorable Steve Leifman and the Eleventh Judicial Circuit Court has created the Criminal Mental Health Project to divert non-violent offenders out of the jail system and into community-based treatment programs. The project currently consists of pre-booking and post-booking diversion as well as a Crisis Intervention Team comprised of law enforcement. This provides a cost-efficient solution to a large problem in the Miami community.

Pre-Booking Diversion
- Using the Crisis Intervention Training model developed in Memphis, TN, the Miami CIT-trained police officers are diverting those with mental health challenges from jail and into crisis care centers across the community. CIT officers perform regular duties as patrol officers but are trained to respond to those in mental health crisis. Officers train for 40 hours on topics such as psychiatric diagnoses, suicide intervention, and de-escalation techniques. These officers can provide resources for the families of persons with mental illness and educate on mental health and substance abuse.
laws. As a result, fewer individuals in mental health crisis are being brought to prison saving money for both the city and its taxpayers.

### Post-Booking Diversion

- While the Pre-Booking Diversion program came first, the city then recognized a need for a Post-Booking system. All defendants who are arrested go through a mental illness screening process. Those who are identified as having a possible mental illness are sent to the correctional facility psychiatric staff for a thorough evaluation. Citizens being charged with a misdemeanor are transferred to a community-based center and out of the jail within 48 hours of booking. This process reduces recidivism and increases the availability to receive the appropriate mental health services.
- Individuals charged with felonies may volunteer to enter into a jail diversion program with approval from the State Attorney's Office but must be able to access benefits such as Supplemental Security Income, Social Security Disability Insurance, and Medicaid. By entering the program, these individuals are connected with community-based treatment, support and housing services that provide the elements to become a safe and productive member of society.

While Miami plans to develop a physical mental health facility, the diversion program serves as an effective solution in the meantime. As of late 2017, construction had not begun on this facility and plans have been in place for the last ten years (Eleventh Judicial Circuit of Florida, n.d.).

**Identified Funding Sources:** Miami-Dade County has provided some of the funding necessary to keep the Criminal Mental Health Project appropriately staffed. Additional government and private funding is responsible for a portion of the program's success, but reallocation of existing resources is the primary driver of the program's success.

**Application to Bridge Center:** Similar to the Miami model, the Bridge Center can champion successes before an actual facility has been built. Miami has instituted a diversion program, a way to establish funding, and has provided basic resources to community members with mental illness without ever building a structure. The Bridge Center can point to successes such as current efforts to implement a behavioral health court and increased support for CIT training – two initiatives that gained momentum through this study and are being actively supported by CAHSD – and other “low-hanging fruit” accomplishments in order to provide community understanding and support. In addition, the Bridge Center’s implementation of a pre-trial release program in the spirit of CMHP’s Post-Booking Diversion is a significant accomplishment. These efforts are designed to reduce recidivism and allow citizens to access the mental health care that they need.

**ST. TAMMANY PARISH, LA**

**ST. TAMMANY SAFE HAVEN**

St. Tammany’s initiative to serve residents with mental illness began with Parish President Pat Brister and the collaborative Behavioral Health Task Force. The parish has future plans to build a Safe Haven community. This facility will be open to drop-off/walk-in services including those arriving with the police. The model contains detox and respite care, outpatient treatment and intensive and acute services. There will also be a process to place patients in safe housing locations. As this facility serves as the future plan for St. Tammany, the parish has developed small programs in the meantime to aid those with serious mental illness.

**BEHAVIORAL HEALTH COURT**

The Behavioral Health Court came into play through a focus on specialty courts, most specifically traffic court. By introducing the specialty court system in this manner, collaboration was a win for all areas of government who were involved. This transformed into the development of over 12 different kinds of specialty courts, one being bond court which led specifically to behavioral health.
In St. Tammany, all defendants are issued bond within 12 hours arrest. Just by incorporating this practice alone, the parish saw a reduction in recidivism. In order for this process to work, all judges on duty must make issuing bond a priority. This also allows for a faster incarceration check in at the jail and through a review by the jail medical services. Inmates with potential mental issues can be placed on the list to attend Behavioral Health Court that next week and so the process begins.

The St. Tammany Behavioral Health Court is championed by the Honorable Peter J. Garcia and his team of court coordinators, case managers and probation officers. Court is held every Wednesday beginning with a briefing of all upcoming cases for that day. The court works on a system of three consecutive phases based on defendant status in receiving mental illness treatment and therefore depicting positive behavioral changes. At any time, Judge Garcia can move someone back a phase or send them to jail for not working with their case manager and social worker or medical representative to move forward. Defendants volunteer to participate in Behavioral Health Court and it is to their benefit to get the help that they need. At this point, their other option is to go to jail.

**NAMI ST. TAMMANY AND SHERIFF’S CIT TEAM**

A large component of St. Tammany’s mental health initiative is served through a collaboration between the National Alliance on Mental Illness (NAMI) St. Tammany and the Sheriff’s CIT Team. Not only is NAMI St. Tammany a large player in the Behavioral Health Court system, it has created an app to work with the Sheriff’s office in providing on-site resources to citizens in mental crisis. Police can use this app to help family members file an Order of Protective Custody (OPC) with the coroner’s office who can immediately sign and allow for police to escort the person to a treatment facility. The app can also be used to show family members where to take a family member in mental crisis without having to go through the process of police arrest.

The CIT team aids in this manner through the provision of on-site de-escalation techniques. St. Tammany sends some of its officers to receive training at the nationally-known Bexar County site in San Antonio. St. Tammany Police spend a week training and performing in ride-alongs with the units in Texas. Through this process, the CIT team in St. Tammany uses an approach that divides the parish in half to be patrolled by rotating CIT-trained officers.

**Identified Funding Sources:** The Safe Haven NAMI Day Center is funded by a Community Development Block Grant under Title 1 of the Housing and Community Development Act of 1974, the funds for which were requested by Parish President Pat Brister. St. Tammany Parish provides some of the funding for both the Safe Haven Center as well as the case management services associated with the Behavioral Health Court. The majority of funding for NAMI St. Tammany comes from grants, contracts, and fundraising. The St. Tammany Coroner’s office funds the role of a consultant to administer the Behavioral Health Task Force as well as CIT training for the police.

**Application to Bridge Center:** The biggest outcome of the St. Tammany model that can be applied to the Bridge Center is the willingness and openness of the community to collaborate and hold each other accountable. The Behavioral Health Task Force incorporates city-government, non-profits, the Sheriff’s office, the Coroner’s office, the judicial system, and the local medical community into a well-organized operation with the common goal to aid persons with mental illness in St. Tammy parish. It is this drive that has allowed so much progress to be made in the area of mental health.

A similar connection is currently being created in Baton Rouge with the Behavioral Court process through aid from Hillar Moore and Judge Don Johnson, and with support from CAHSD. After visits to Judge Garcia’s court that occurred as a part of this study, it was decided that Judge Johnson would work with the City Court judges to begin a similar process. If this program is found to be successful, the Bridge Center can choose to help carry on the initiative and potentially expand its reach through ongoing collaboration.

The implementation of a Behavioral Health Court currently in process as well as the development of an effective model for community collaboration are opportunities for the Bridge Center to create early “wins”. By bringing the right people to the table, the Bridge Center can continue to bring new initiatives and opportunities to light and drive success in the Baton Rouge area.
THE BRIDGE CENTER MODEL

The Bridge Center concept was originally developed as an effort to decriminalize mental illness in Baton Rouge; meaning to divert persons with mental illness that have committed minor offenses away from incarceration and toward the behavioral health services they need. This kind of diversion is important in order to rehabilitate this population and reduce the likelihood of repeat offenses and prison recidivism rates, thus yielding a safer community while greatly reducing a public financial burden. While this goal is still at the heart of the Bridge Center mission, the organization’s scope has evolved in recent months due to a number of factors, including but not limited to a failed proposed tax measure in November 2016, the January 2016 executive order by Gov. John Bel Edwards to initiate Medicaid expansion, and the instability of key behavioral health-related service providers in the community that are currently relied upon by tens of thousands of Baton Rouge residents. The Bridge Center is envisioned to provide a “front door” for voluntarily admitted individuals seeking treatment, as well as an alternative destination for individuals with mental illness who are currently delivered to hospital EDs by law enforcement officers – a practice that has become a substantial burden on law enforcement resources while failing to yield long-term recovery benefits for these individuals.

The diagram below illustrates the Bridge Center components of a broader behavioral health care continuum, designed to fill needs where there are currently gaps and integrate with existing providers who are delivering quality critical crisis and wrap-around services. Ideally, the Bridge Center can grow to sustainably provide most or all of these services, and in some cases, coordinate with other effective community providers to deliver this care. The challenge lies in how to “stand up” the Bridge Center in the short term and chart a long-term course for delivering the full continuum.

THE BRIDGE CENTER CONTINUUM
A PHASED APPROACH

THE RESPONSIBILITY OF COLLABORATION

The Bridge Center Board of Directors is comprised of key community leaders in the greater Baton Rouge behavioral health arena who individually represent core pillars of the behavioral health continuum of care – from human services for the indigent and homeless assistance to hospitalization and medical care for offenders or incarcerated individuals. There is no more capable or well-equipped group of individuals to advance an agenda of creating a fairer Baton Rouge by diverting persons with mental illness away from endless cycles of ED visits and incarceration and towards the care they need – for their own good, and for the benefit of reducing the strain on the community created by the lack of appropriate crisis stabilization services. It has been proven – in communities such as San Antonio, Milwaukee, and St. Tammany Parish – that a fundamental step in solving for behavioral health issues in a community is establishing a focus on collaboration within any service delivery model. This level of collaboration must be intentional and regular, whereby key leaders, community stakeholders, and problem solvers convene on a regular basis to exchange and be transparent about data, look for ways to work together to create solutions, and serve as a visible force for positive change that moves the needle with regard to decriminalizing mental illness, even in the absence of significant funding sources beyond those that already exist in service to this population.

CAHSD currently hosts a monthly collaborative meeting where the community’s providers convene and guest speakers lead discussions on the latest trends and factors impacting the delivery of behavioral health care locally and nationally. This community and these conversations form a critical foundation for the kind of collaboration the Bridge Center should build on, especially in an environment where private sector providers do not always feel they are able to participate in conversations about solutions.

In cooperation with CAHSD, but as a separate initiative from the monthly collaborative, the Bridge Center should spearhead a group similar to what exists in St. Tammany or in San Antonio. With representatives from law enforcement and criminal justice, two of the region’s major health systems, and local public agencies and nonprofits with missions to serve populations struggling with mental illness, addiction, and homelessness, the Bridge Center Board of Directors offers an ideal cross-section of representation to lead a solution-oriented community conversation focused on mental illness while bringing other public, private, and non-governmental organizations to the table. Given the broad but interconnected needs for such a conversation, it is critical that a collaborative group be formalized, structured, and programmed in an intentional manner that helps to incrementally advance objectives along the full continuum of care. As such, it is recommended that the Bridge Center adopt a leadership position in establishing such a group that also relies heavily upon the actions and influence carried by the Bridge Center as an organization and the Bridge Center Board of Directors individually.

This collaborative endeavor, called the Behavioral Health Action Council (BHAC), should pursue key outcomes that include the following:

- Develop and plan for annual sets of priorities for the BHAC to address
- Lead the implementation of meaningful solutions where there are gaps in services and unmet needs by bringing leaders, providers, and decision makers to the table who can impact change
- Increase awareness of current needs and trends in the local and regional behavioral health space to empower the community to respond with solutions and connect service supply to community demand
- Maintain up-to-date risk stratification of populations in need of mental health services to allow community and providers to prioritize areas and individuals of greatest need
- Yield changes in public policy and practices to create an environment conducive to meeting the needs of behavioral health populations, including focusing on decreasing criminalization, equipping first responders with the appropriate training and tools to avert crisis with individuals with behavioral health issues and divert them from incarceration and/or the ED.
Support collaboration between hospitals, criminal justice system, and private and public service providers, as well as any other disparate stakeholders that have common or connected issues that can be improved through joint behavioral health-related initiatives.

Public awareness and education of the issues and impacts of unmet needs among Baton Rouge’s behavioral health population, including:
- Awareness of public safety implications, including the fact that law enforcement resources are currently spending significant portions of their shifts responding to behavioral health-related crises, often repeatedly with the same individuals, and are therefore less able to focus on public safety priorities and needs
- Clarification around inefficiencies in public spending that result from a system in need of improvement, including overcrowding in prisons
- Correction of the perspective that those who suffer from mental health issues are “other than”, when in fact they are among close family and friends

GOVERNANCE, STRUCTURE, AND PLANNING

The BHAC is recommended to be governed as a function of the Bridge Center Board of Directors, chaired by a member of Bridge Center leadership, possibly in conjunction with CAHSD leadership. While the Bridge Center will administer the BHAC, Bridge Center board members on the BHAC would have equal authority and voting rights to members that are not on the Bridge Center Board of Directors when it comes to actions and decisions of the council. Initial actions taken by the Bridge Center and involved stakeholders may include the following:

- Develop criteria for membership of the BHAC, which should be inclusive of both Bridge Center board members and external community stakeholders; these criteria could adapt over time and allow for new members as the BHAC learns of new needs or voices that can contribute
- Establish roles and responsibilities of BHAC officers
- Establish minimum commitment requirements for participation and related measures to ensure ongoing participation among BHAC members (including but not limited to public posting of meeting attendance on the Bridge Center website)
- Compose confidentiality documents prohibiting members from disclosing any patient information to which they are exposed in compliance with federal health care and patient privacy regulations
- Craft any additional governance measures or policies
- Recruit and obtain membership commitments

Once the initial composition of the BHAC has been established, it is recommended that the Bridge Center convene an organizational meeting and facilitate subsequent discussions among members to develop a strategic plan establishing the following:

- Mission and vision of the BHAC
- Strategic priorities focused around key behavioral health service delivery model components, including task forces that should be assembled, such as in the following areas:
  - Funding Sources
    - Maintenance of an updated record of Medicaid reimbursable services and opportunities on the continuum
    - Identification of funding opportunities and development of data-based cases for pursuing them
    - Assembly of teams of officials and providers to pursue specific, relevant opportunities
  - Technology and Data Management
    - Adoption of innovative front-line technologies
    - Tracking of behavioral health-related ED utilization
    - Tracking of behavioral health-related misdemeanor jail/prison admissions
    - Tracking of results of prison and inmate behavioral health screenings (state and local)
    - Monitoring of public funding impacts (e.g. cost of housing and medicating inmates with psychiatric needs)
    - Monitoring of prison recidivism rates among target populations and associated costs
- Tracking of results, good or bad, for any behavioral health treatment approaches implemented as a result of BHAC activities
- Gathering of ZIP code level data on target populations, including trends in homelessness and housing
  - Sequential Intercepts
    - Implementation and monitoring of jail diversion programs
    - Support for Crisis Intervention Team (CIT) training
    - Exploration and implementation of specialty courts
    - Collaboration and communication with law enforcement
  - Education and Advocacy
    - Development of communication and education campaigns aimed at raising awareness among a variety of audiences – including the general public, law enforcement, criminal justice, and providers – regarding behavioral health-related community issues and the tangible benefits of diversion and treatment, including cost savings to taxpayers and service providers
    - Support for training programs across various stakeholder groups that work with or come into contact with populations suffering from mental illness
    - Development and execution of an Accountability Agenda (draft Accountability Agenda included as Appendix B – a document to be signed by elected officials and candidates for office pledging to be a part of the solution to the community’s challenges in the behavioral health space
    - Creating understanding and establishing public positions on policy and regulatory issues – while as a 501(c)3, the Bridge Center is limited in its ability to advocate for specific policy initiatives, the BHAC can facilitate conversations around policy that lead to change
  - Health Care and Treatment
    - Management of the trauma-informed care component of BHAC meetings and resulting outcomes
    - Work towards community-based centralized providers database
    - Manage coordination and outreach with providers as needed for BHAC initiatives

Objectives, responsibilities, and action plans of strategic priority areas and related task forces, including task force membership and meeting cadence to support key objectives

BHAC COLLABORATION AGENDA
Consistency breeds success. One of the core elements of a successful community collaboration model is consistently assigning and facilitating results-driven action, related to both ongoing convening and influencing target outcomes. This is particularly true in the behavioral health landscape, which consists of a broad spectrum of stakeholders whose impact is critically important to the long-term viability of effective service delivery for this population but whose time and attention is a key resource constraint. As such, it is recommended that each BHAC meeting be held in a consistent, central location on the same day (e.g. first Monday of the month) and time each month, with every possible measure taken to increase the convenience of attendance for committee members who manage very busy schedules. To further reinforce the need for accountability among all stakeholders involved in such collaborative measures in serving this population, it is recommended that meeting agendas and minutes be captured and posted online for public consumption, with attendance noted prominently at the beginning of the documentation. Participants who cannot attend should send proxies, but attendance by the actual committee member should be strongly encouraged. An example BHAC meeting agenda is provided as Appendix A to this report featuring a structure designed to achieve the most meaningful outcomes associated with such a convening.

TRAUMA-INFORMED CARE
In Milwaukee, a group of law enforcement professionals, criminal justice professionals, and community service providers gather on a regular basis with a mission of working together to reduce violence through innovative interagency collaboration. The Milwaukee Homicide Review Commission meets regularly to exchange data on homicides and violent crimes with a case review process at the core of their agenda. By reviewing and analyzing specific homicide cases, participants are able to follow the events that led up to a homicide and identify where opportunities or intervention points may have been missed to prevent
the homicide. This review process results in recommendations ranging from micro-level strategies and tactics to macro-level policy changes, and the expertise and standing of those who serve on commission often leads to appropriate implementation of the recommendations. Through these and other successes, the commission has received the highest possible homicide reduction rating of “effective” from CrimeSolutions.gov (Milwaukee Homicide Review Commission, n.d.).

Trauma-informed care has become the standard for many organizations and behavioral health models – meaning workforces, peer counselors, and communities of care are learning to bring compassion and evidence-based treatments into their practices and policies, informed by the types of trauma that often exist at the root of behavioral health issues. By following a case review-driven approach to improving the Baton Rouge community’s delivery of care in a manner parallel to Milwaukee’s approach to violent crime, the Bridge Center can help create a trauma-informed ecosystem of behavioral health care as a function of the BHAC framework focused on accomplishing several key objectives:

- Keeps BHAC members and key stakeholders connected to the ground-level realities of behavioral health issues by introducing them to the stories of individuals suffering from a variety of ailments and moving through the current system
- Inspires solutions by presenting clear, real-life examples of the problems the committee is trying to solve
- Highlights ways to improve the system by illustrating where and how intervention opportunities were leveraged or missed
- Spurs action and accountability on the part of leaders and decision makers

Within the context of BHAC meetings, this component represents a private session among BHAC members with access granted only to those who have signed non-disclosure agreements to be compliant with privacy regulations. It is recommended that the proposed BHAC Health Care and Treatment Task Force should bear responsibility for planning trauma-informed care sessions at the beginning of each BHAC meeting, including developing annual plans for presentations by area service providers involving patients whose situations – bad or good – could have been greatly improved with a more effective community-based system for behavioral health care.

The role of the BHAC in these sessions is to distill these individual cases into goals or statements of need that exist community-wide, and to develop and assign action items where possible in direct response to these needs. The needs and action items established in these sessions and assigned to task forces should be reported on by the BHAC Health Care and Treatment Task Force in the subsequent public session to reinforce public accountability related to key action items ranging from targeted communications to supporting policy changes in the form of new legislation.

DATA SHARING AND TREND ANALYSIS

One of the core benefits of the public BHAC sessions – recommended to be open to media, outside providers, and the general public – involves the structured manner in which macro-level behavioral health service data and key metrics can be shared, analyzed, and utilized to make targeted changes within the continuum. Key objectives associated with data sharing through the overarching proposed BHAC framework include the following:

- Provide BHAC members, community leaders, the provider community, the media, and the general public with up to date information on local and national trends borne out by data from different key focus areas
- Create and maintain transparency about success metrics and progress of diversion efforts for both accountability and public education
- Create a data-driven environment where key stakeholders in the behavioral health care community can stay informed and collaborate to create solutions
- Hold BHAC task forces accountable relative to accomplishing action items while providing a platform to identify successes and seek input and assistance on ongoing efforts or areas of concern
- Create opportunity space for private providers to participate in collaborative discussions, problem solving, and data sharing
Any such data-sharing sessions should include active participation among representatives from the Bridge Center, the Capital Area Human Services District, area health systems, law enforcement agencies, the court system, corrections, state agencies, the Capital Area Alliance for the Homeless, private providers, and other keepers of key datasets. It is recommended that formal data-sharing agreements be established between participating agencies to define what data will be shared and the manner in which data redaction may occur to protect individual patient privacy. Additionally, any such data-sharing process must include electronic sharing of reports and other supporting data or metrics whereby it is recommended the Bridge Center maintain and publish on its website as part of the official record. While it is easier to get data transparency from public organizations, many people are currently getting treatment and/or support from private providers. It is recommended that the Bridge Center work with the private provider community to define secure and useful ways to obtain and share as much data as possible related to the populations they treat.

The following list is an example but not all-inclusive list of datasets that can be shared and discussed during BHAC meetings:

- Capital Area Human Services District: Behavioral health and addiction population data (including coverage numbers)
- Bridge Center: Jail diversion program numbers, Crisis Intervention statistics, detox numbers, numbers along active components of continuum
- Health Systems: psych consults, psych beds utilization, ED utilization
- Law Enforcement, First Responders (Baton Rouge Police Department, Sheriff’s Office, EMTs): CIT numbers, behavioral health-related responses
- Courts: Specialty court outcomes
- Corrections: behavioral health-related admissions, report on month’s behavioral health screenings
- Capital Area Alliance for the Homeless: Trends and numbers in homelessness
- Coroner’s Office: Orders of Protective Custody and Coroner Emergency Certificate issues

This data sharing will allow stakeholders to observe trends and changes over time, identify areas where efforts are having an impact vs. need to be increased, and give data providers a chance to highlight the factors they see in the data that need to be brought to the attention of BHAC members or specific leaders within the behavioral health care arena.

**A CONSOLIDATED SYSTEM**

According to CAHSD, since the implementation of Medicaid expansion by Gov. Edwards in January 2016, the percentage of the population in the Capital Area in need of behavioral health services that maintain some form of coverage – be it from Medicare, Medicaid, or private carriers – has grown to 90%, with the percentage of indigence at roughly 10%. This increase in coverage is an incentive for the market to grow certain behavioral health services, although recent federal tax legislation has repealed components of the ACA and the Bridge Center will need to monitor long-term impacts of this action on Medicaid and related coverage trends. In recent years, state and locally supported options for comprehensive behavioral health crisis and stabilization services have grown scarcer while the possibility of a private-market solution has been entertained and explored in depth, including by members of the Bridge Center Board of Directors. Unfortunately, these explorations have not yielded a solution to date that would address the full spectrum of services; instead, proposals by private providers have focused on solutions to only those components of care that would yield profits primarily through reimbursement opportunities (e.g. medical detoxification), as opposed to components not currently reimbursable by Medicaid (e.g. sobering), and therefore would not represent profit centers for a private sector health care provider.

For a mission-driven organization like the Bridge Center, the benefits of consolidating services in a central or coordinated service delivery environment are clear – the profitable components can help to subsidize and stabilize the loss centers, and the overall outcomes of a comprehensive system will be improved by the broader, consolidated approach to the continuum. Key to the Bridge Center’s approach is to serve as a connector between agencies that are already providing quality services to populations with mental illness; as such, standing up the organization will require threading a needle where it is providing critical services that are financially sustainable while working within the market’s capacity to support both the Bridge Center
and other existing providers. To be successful, the Bridge Center must initiate a population health strategy and services driven by a reimbursable and sustainable anchor component that will stabilize the organization while mitigating the risks of taking on less-profitable components. The phased approach below illustrates the manner in which this progression should occur – from start-up phases to those in which the Bridge Center is fully operational.
LAUNCHING THE BRIDGE CENTER IN PHASES

**Phase 1**

**Behavioral Health Advisory Committee (BHAC)**
- Trauma-informed Care
- Data Sharing
- Task Forces
  - Funding
  - Technology and Data Management
  - Sequential Intercepts
  - Education and Advocacy
  - Health Care and Treatment

**Crisis Intervention**
**Stabilization Services**
- Pre-Trial Release Program
- Triage
- Detox Services
- Sobering

**Funding**
- Reimbursements
- Fees for Services Contracts
- Possible MCO Contracts
- City-Parish Funding
- LINCCA Match
- Grants (e.g. Community Benefit Grants)

**Phase 2**

**Continued from Phase 1**
- BHAC
- Crisis Intervention
- Stabilization Services

**Additional Stabilization Services**
- Mobile Assessment
- Behavioral Health Respite (staffed for short-term Acute Psychiatric Care)
- Care Management

**For Consideration**
- "Back Door" intake and triage for involuntary admission

**Funding**
- New Tax Measure
- Reimbursements
- Fees for Services
- MCO Contracts
- City-Parish Funding
- LINCCA Match
- Grants (e.g. Community Benefit Grants)

**Phase 3**

**Continued from Phase 2**
- BHAC
- Crisis Intervention
- Stabilization Services

**Service Extensions/Partnerships**
- Transportation
- Housing
- Employment Programs
- Other Social Supports

**Funding**
- Tax Measure
- Reimbursements
- Fees for Services
- MCO Contracts
- City-Parish Funding
- LINCCA Match
- Grants (e.g. Community Benefit Grants)

In this phased scenario, detoxification serves the role of the anchor service that stabilizes Bridge Center operations while leadership works to implement the BHAC, pre-trial release services currently funded by City-Parish government, and the resolution of financial sustainability issues surrounding telephonic and chat/messaging-based crisis intervention services in East Baton Rouge Parish currently provided by CIC.

**PHASE 1: ANCHOR SERVICES**

**SERVICE FRAMEWORK**

- **Pre-Trial Release Program** – The Bridge Center began its Pre-Trial Release Program through funding from the MacArthur Foundation in 2017, and will maintain it through City-Parish funding in 2018. It is expected that continued funding will be available via City-Parish budget allocations in future years based on an ongoing analysis of service-related outcomes and success metrics, and pending funding availability.

- **BHAC** – As outlined in this report, implementation of the BHAC requires a commitment of time among key community stakeholders but can serve a critical role in leveraging existing partners and facilities toward the overall continuum of care.

- **24-Hour Crisis Intervention Services** – Currently, CIC provides critical phone, chat, and text message crisis response and counseling services for individuals with a variety of crisis-driven needs. The CIC crisis line, known more broadly as THE PHONE, has been a mainstay in Baton Rouge since its beginnings as a crisis and emotional support line on the campus of Louisiana State University in 1970. The crisis intervention model employed by operators of THE PHONE is nationally recognized for its effectiveness and it has been used to train generations of social workers pursuing degrees at...
LSU and related careers upon graduation. THE PHONE carries significant brand recognition across the community, built over the course of nearly 50 years, and CIC also provides fee-for-service crisis and care management services through individual contractual agreements supported by the CIC contact center and staff. As detailed in an analysis of CIC operations performed by Emergent Method as part of this effort, CIC operations are currently unsustainable, primarily due to negative cash flow circumstances surrounding operations of THE PHONE and a lack of alternative revenue streams to offset losses associated with these core services. While existing fee-for-service contracts help to marginally offset losses associated with THE PHONE, annual operations for call center services still represent a negative annual cash flow scenario. This operational deficit was covered in prior years through an annual funding allocation from the Capital Area United Way (CAUW), but that funding has been decreased in recent years due to an overall reduction in CAUW resources.

There is no other resource in the Capital Region that provides comparable volumes of critical crisis intervention support services; as such, the Bridge Center Board of Directors has expressed a commitment, compelled by its mission, to support the ongoing sustainability of these services. Previously, in late 2016, the Bridge Center entered into a third-party contract with VIA LINK, a New Orleans-based vendor offering a variety of contact center-based services, including suicide prevention and crisis counseling. The goal of the engagement was to provide crisis intervention services similar to those offered by CIC – a funding decision that was made by severe concerns expressed by CIC leadership at the time regarding a lack of funding and capability to continue providing services in the Baton Rouge market. However, since then, CIC has continued to remain operational and, given the lack of substantial marketing applied toward the VIA LINK alternative crisis intervention service, maintains an outsized market share of crisis intervention call and utilization volume. Given the recent assessment of CIC’s ongoing viability in the absence of significant operational restructuring and identification of new funding sources, it is recommended that Bridge Center leadership either:

- Encourage CIC to take into account and independently implement the recommendations detailed in Emergent Method’s current state operational analysis and identify opportunities to partner and pursue joint funding, potentially through a future tax measure, or
- Maintain and expand upon current levels of engagement with VIA LINK while working with CIC leadership to transition THE PHONE and other CIC contact center services to the Bridge Center, with services powered by a third-party agreement with VIA LINK, while Bridge Center leadership works to establish a sustainable path forward for crisis intervention services.

Should the Bridge Center opt to move forward with subsuming CIC services, negotiations both with VIA LINK and CIC’s current fee-for-service clients will be paramount. According to CIC, incoming call volumes for 2017 were 18,248 (including both THE PHONE and fee-for-service-related calls), and text and chat messaging volume was 1,495. The cost for VIA LINK to take on services at a volume of 20,000 calls, text, and chats would be $404,135.74 – a figure that is substantially lower than the cost to operate the CIC contact center. If in fact the Bridge Center receives yearly incoming call/text/chat volumes close to 20,000, these cost savings would provide a tremendous contribution toward resolving current cash flow deficits associated with core crisis intervention service delivery.

Key operational considerations will include telephonically transferring any phone numbers that currently route clients to CIC’s contact center to VIA LINK for a seamless client experience. VIA LINK also maintains its own databases of resources so that clients seeking a variety of types of services can still be referred by contact center representatives based on the need and severity of the client’s situation. In addition, VIA LINK utilizes the same contact center and data management platform as CIC, iCarol, creating an opportunity for the seamless importing of CIC-developed resources data with minimal compatibility issues.

As previously mentioned, an important part of this transition process will be for Bridge Center and CIC leadership to immediately enter into renegotiated fee-for-service agreements based on current state conditions and execute new service contracts with the Bridge Center. This renegotiation process should involve improving or eliminating those service
In this scenario, the simplest route for this transition will be for CIC to dissolve, transfer its assets to the Bridge Center, and for CIC leadership to work with the Bridge Center in moving key services and assist with logistical aspects of the transition. Some of the assets the Bridge Center inherits from CIC, especially the facilities it owns for a combined appraised value of $910,000, should be leveraged for necessary office space or be liquidated or used as collateral to generate funds to cover start-up costs. Special consideration will need to be given to two key elements associated with CIC’s current state and environment and related assets: one of CIC’s two primary facilities was donated by a caring supporter of the organization, and the memorial garden on CIC grounds that has been built by individuals grieving for lost loved ones and carries important value for them.

At the time of the CIC study, the organization employed nine core staff members. The full CIC team is comprised of full-time, part-time, hourly, and contract employees, some of whom plan to step away or minimize their roles prior to any organizational transition taking place, but many of whom provide key contributions in delivering CIC’s services and offer capabilities that can be incorporated into VIA LINK and/or Bridge Center operations moving forward. Contact center employees who are not a part of the core staff are employed through the services of a temp agency, allowing them to receive benefits in a manner that is affordable for CIC. Members of the core CIC team, to a certain extent, all currently report to the executive director, with the exception of clinical team members who require oversight from a clinical director with the proper licenses to oversee their work and supervise their professional development and licensure.

In addition to operating a crisis contact center, CIC currently provides a host of critical related services that do not fit in the Bridge Center continuum, including trauma response counselling, resource database management, support groups, and crisis management training. As part of transitioning crisis intervention services to Bridge Center via a third-party agreement with VIA LINK, it will be imperative for the Bridge Center to identify community providers that can take on and ensure continuity of services not included within the transition. Even services that are less utilized by Baton Rouge residents have a degree of loyal utilization and importance to those individuals who are served. With the dissolution of CIC, there will otherwise be a gap in the community with regard to these important services that many rely on for coping with loss and crisis.

“Front Door” Intake and Medical Triage – A physical location of the Bridge Center is recommended to be established in this first phase, providing the capacity for proper delivery of behavioral health care services. As described in the recommendations of this report, the Baton Rouge General Mid-City Campus is an ideal candidate for a number of reasons, including the fact that the closed ED space is built to handle intake and triage. At the Bridge Center, careful consideration should be given for how clients are taken into the facility, as ultimately some will be coming to the center voluntarily, and others involuntarily. For Phase 1, focusing first on voluntary intake will allow for lower startup costs, coupled with provision of security, as the facility will need to accommodate individuals who have been transported by law enforcement officers and should not require officers to stay with them until they are admitted. Triage nurses will see patients in any intake scenario, whereby they will provide a health screening to ensure they can be treated at the Bridge Center and, if they can, determine which bed and service is most appropriate. In Phase 2, plans should include secure “Back Door” intake for individuals who are under law enforcement custody and should be separated from voluntary clients.

Detoxification Services – Addiction and abuse of drugs and/or alcohol often co-occur with mental illness, and frequently are partially to blame for acute episodes of crisis for individuals with mental health concerns. For this reason, detoxification services are core to the Bridge Center continuum and may be sustainably delivered in a variety of ways depending on the client’s needs given funding and resources available to support such service delivery.

Despite such demonstrated needs and resource availability in Baton Rouge, there is a concerning gap in terms of capacity and the local market supply to meet demand. The Baton Rouge Detoxification Center (BR Detox) has provided such
services for years; however, the organization has been non-operational for months. According to BR Detox staff and board members, the organization has not collected Medicaid reimbursements since 2016, one of several key management and structural considerations that have contributed to BR Detox’s non-operational status. Historically, the organization has been licensed for 48 beds – serving a mix of patients requiring medical detox and residential treatment, as well as persons with HIV/AIDS. When fully operational and occupied, data provided by the organization indicates BR Detox operates with a net monthly profit of $250,000; however, the financial picture is complex. In 2018, BR Detox is slated to receive an allocation of $312,000 from the City-Parish via a line item in the City-Parish general fund budget; the organization also has $462,075.70 in unexpended funds for a 2016-2019 federal contract related to treating HIV/AIDS that is administered by the City-Parish Office of Community Development. While the bed count for detox versus HIV/AIDS treatment is unclear, BR Detox has stated that the organization has an average waitlist of 200 people, even when all 48 beds are fully occupied. In addition, organizational leadership has stated that BR Detox reaches a monthly cash flow break-even point at 24 filled beds, even with monthly expenses totaling $150,000.

Given the lack of appropriate resources with operational facilities to support the delivery of critical detox services, and the manner in which these services can be sustainably delivered by serving as a profit center to offset known losses associated with services such as crisis intervention support, it is recommended that the Bridge Center explore standing up a facility with detox services available as a primary offering as part of Phase I operations, with medical detoxification services provided. Medical detox is a medical service reimbursable by Medicaid and staffed by RNs, licensed social workers, and certified drug and alcohol counselors, with access to consulting physicians and/or psychiatrists. Treatment involves both stabilization and treatment planning and offers the opportunity to involve family in filling support functions. The typical stay for medical detox is often 4-10 days, but no more than 12. In some cases, stays are even shorter. Other private providers in the Baton Rouge market are moving to possibly offer medical detox, so this market condition is worth consideration in planning. The Bridge Center could opt to partner with other detox providers for this service. That said, the provision of medical detox and the associated reimbursements are included in financial modeling for this report.

Other types of detox exist and should be explored by Bridge Center leadership for potential incorporation into Phase I or future phases of Bridge Center operations. An early role for Bridge Center leadership will be to study the viability of social and/or ambulatory detox and implement these services if they prove to be sustainable:

- **Social Model Detoxification** – Social detox involves careful monitoring of the patient through a residential inpatient setting. The patient is not administered medication, but is assisted through the detox process with counseling and therapy. It can be effective in instances when life-threatening withdrawal symptoms are not an issue.

- **Ambulatory Detoxification** – Similar to social and/or medical detox, ambulatory offers a more cost-effective version not based on an inpatient model. Patients still come in and receive the treatment they need and are monitored, but do not remain in the facility.

■ **Sobering Services** – Pending funding approval from the Louisiana Department of Health for Medicaid reimbursements, it is recommended that the Bridge Center offer limited sobering beds for individuals who are under the influence of alcohol and/or drugs, but are not at risk of experiencing harmful withdrawal symptoms. Sobering does not require a medical approach, but provides a safe place for individuals to sober up. These individuals should not generally be at the center for more than 12 hours, but if they exhibit signs of withdrawal, they can be shifted to medical detox.

**FINANCIAL CONSIDERATIONS**

In this Phase 1 of Bridge Center operations, the focus should be placed on implementing services that are reimbursable while still capitalizing on other funding sources that can support the Bridge Center’s non-reimbursable services and administrative needs, thereby creating an inevitable and complex braiding of revenue streams with a number of variables.
REIMBURSEMENT ADMINISTRATION

The administration of reimbursements from Medicaid and other carriers requires deep expertise and carries significant operational and administrative responsibilities. Fortunately, in response to the demand created by smaller health care providers that require external support for this administrative function, a number of third-party vendors have entered into the local Baton Rouge market whose expertise can fill the necessary void that such functions will require if assumed by the Bridge Center. For the purposes of this analysis, Emergent Method consulted with a local market provider to establish true market conditions for services that would be required in fulfilling such functions for the Bridge Center. This provider charges a flat rate of 5% of successful reimbursements for its services, which include:

- Billing (of carriers and for unpaid patient copays)
- Coding
- Compliance (to ensure records are properly maintained for optimal reimbursement)
- Follow up
- Denials management

However, prior to being eligible for reimbursement, the Bridge Center will need to become credentialed as a facility, a process that takes up to 90 days and results in contracts with 12 major carriers, including private providers and MCOs.

In order to achieve this credentialing, the Bridge Center must have, at a minimum, one medical doctor (MD) on staff – one that is ideally a licensed psychiatrist. All providers on staff at the time of credentialing will be included in any resulting contracts for service delivery and reimbursement at no additional charge. The cost for this initial credentialing with the local provider consulted as part of this planning effort is $5,295. Each additional credentialed provider that joins the facility after the initial credentialing process can be added to contracts for $149. In the event that new hires are not independently credentialed, the cost to credential them for the facility (including adding them to contracts) is $395 per staff member.

In order to practice and be eligible for reimbursements, the following provider positions must be credentialed:

- Psychiatrists/MDs
- Registered Nurses (RN)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
- Licensed Professional Counselors (LPC)
- Licensed Clinical Social Workers (LCSW)
- Certified Alcohol and Drug Counselors (CADC)

Finally, setting up appropriate Medicaid reimbursement processes and reimbursement coding in general is an exercise that requires deep expertise. While reimbursement rates have been selected for the purposes of building pro forma financials to guide the Bridge Center into Phase 1 operations, it is recommended that Bridge Center leadership research and select an appropriate reimbursement model based on the center’s mission, business model, services, provider and employee job descriptions, and workflows. Many organizations have also negotiated reimbursements with carriers based on day rates, as opposed to treatment, provider, and time increment specific coding. This simplified approach can benefit both parties by incentivizing better long-term results for client populations and empowering providers to be adaptive and client-centered in their care models.
ADDITIONAL FUNDING SUPPORT

In addition to billing for Medicaid reimbursements associated with the delivery of recommended Phase 1 services, Bridge Center leadership must work diligently on diversifying and pursuing external revenue streams, even for Phase 1. Key opportunities for such support as part of Phase 1 start-up operations include the following.

- **Local Government Funding** – Over time, it is expected that there will be additional opportunities for the Bridge Center to identify and leverage funding sources, whether dedicated in the form of pass-through state or federal grants or allocated via local government budgetary line items, as Bridge Center outcomes are measured and a clear return on investment for taxpayers can be demonstrated through and associated with historical numbers. In the short term, however, there are two key opportunities the Bridge Center should work to secure, steward responsibly, and sustain, both of which are included in the pro formas included as Appendix B to this report.
  - Pre-Trial Release Program: The Bridge Center was recently allocated $260,000 in 2018 funding by the City-Parish to support the expansion of the Bridge Center’s jail diversion program, the start-up phase for which was funded by the MacArthur Foundation and the Baton Rouge Area Foundation. This represents a budgetary line item that should be cultivated and secured in future City-Parish budgets with clear data to demonstrate the impact and return-on-investment of such a funding allocation.
  - Medical Detoxification Services: In 2018, BR Detox received a City-Parish general fund budgetary allocation of $312,000, which is consistent with annual budgetary allocations BR Detox has received in prior years from the City-Parish to support related service delivery. If the Bridge Center is able to commence operations and successfully deliver detox services, while BR Detox remains nonoperational, the Bridge Center could pursue the reallocation of these designated funds from BR Detox to the Bridge Center in 2018, an action that would require executive action by the Mayor-President and Metro Council concurrence in the form of a majority vote.

- **Low Income Needy Care Collaboration Agreements (LINCCA)** – The LINCCA program allows for a 2.5x multiplier match for health care service delivery when the source of funding is a non-federal public agency and the recipient is a hospital. While competitive in nature, this mechanism could represent a significant opportunity for the Bridge Center to broaden the impact of funds received from a local government entity like the City-Parish. It is recommended that a key component of Bridge Center startup operations entail working with legal expertise to design the mechanism for receiving this match, including setting up an agreement with an area health system so that eligible public funds could flow through to provide services for Bridge Center clients in a manner that is consistent with LINCCA program policies and match stipulations.

- **Hospital Community Impact Grants** – On average in 2017, Ochsner’s Baton Rouge ED conducts more than 80 behavioral health-related consults per month, the Baton Rouge General conducts 140-150, and Our Lady of the Lake conducts an estimated 1,000 per month according to staff from each of the health systems. The Bridge Center’s potential to reduce the number of ED visits – even in Phase 1, given the co-occurrence of substance and alcohol abuse with behavioral health issues – represents a strong case for hospitals providing funding for the Bridge Center via community impact grants.

- **MCO contracts** – Louisiana’s MCOs are already working with organizations similar to the Bridge Center to provide funding that effectively prevents members from repeating cycles of crisis, ED visits, and extended inpatient behavioral health situations. It is recommended that another core component of the Bridge Center’s Phase 1 startup operations involves meeting with all MCOs to discuss Bridge Center service offerings and develop targeted agreements, potentially as flat fees, for the diversion of Health Plan members.
PRO FORMAS

The financial dashboard view below of the Bridge Center’s Phase 1 operations represents one fiscal year of operations, with dollar figures based on annual costs. Given the variability associated with start-up operations of any new business enterprise, some costs are not granularly defined and instead exist as part of a larger cost bucket (e.g., the 25% infrastructure line item). These costs may include but are not limited to:

- Facility and provider credentialing and contracts with Medicaid, Medicare, and insurance carriers
- Reimbursement model design
- Legal consultations to set up agreements for LINCCA, MCOs, crisis intervention contracts, and any other legal needs
- Startup marketing and outreach to make key audiences aware of Bridge Center services
- HR and recruitment efforts for building up clinical and administrative staff
- Campaign expenses for generating public support for a potential future tax measure

Embedded in the build out of this Phase 1 budget are several assumptions regarding what the Bridge Center will and will not be able to accomplish and provide. These assumptions, listed below, can be altered in the Appendix C: Bridge Center Financial Pro Formas as they are disproven or evolve:

- Staffing models are consistent with HMA report, but adjusted salary numbers are incorporated
- Sobering is not currently reimbursable, but the potential for reimbursement should be discussed with Medicaid officials
- The Bridge Center is not able to capture the $312,000 currently allocated by the City-Parish to BR Detox (these funds represent an opportunity for exploration, and could be leveraged for a LINCCA match, for combined potential of $780,000)
- The Phase 1 model represents approximately half the number of beds from the HMA model; as such, some numbers were reduced by 50% based on their HMA budget counterparts
- The Phase 1 model represents approximately 1/3 the number of FTEs from the HMA model; given this, some overhead numbers represent 1/3 of their HMA budget counterparts
- Bridge Center subsumes CIC contact center services via a contract with VIA LINK at the 20,000 call/text/chat level previously quoted to the Bridge Center
THE BRIDGE CENTER PHASE 1 FINANCIAL DASHBOARD

The table below outlines all Phase 1 services and overhead costs rolled up into a single dashboard. The individual service lines are detailed in the pages that follow and in Appendix 3. In the budget below, which represents both conservative and realistic scenarios, there is a shortfall of $1,633,288 – a gap that will need to be filled through liquidation of assets or a multi-pronged approach to increasing revenues and decreasing costs following the recommendations of this report.

<table>
<thead>
<tr>
<th>Pre-trial Release Program</th>
<th>Crisis Intervention</th>
<th>5 Medical Detox Beds</th>
<th>12 Sobering Beds</th>
<th>Non-Service Line Admin / Overhead</th>
<th>Total Phase 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL NON-SERVICE LINE REVENUE</strong></td>
<td>260,000</td>
<td>539,314</td>
<td>525,263</td>
<td></td>
<td>799,314</td>
</tr>
<tr>
<td><strong>MEDICAID REIMBURSEMENTS</strong></td>
<td></td>
<td></td>
<td>525,263</td>
<td></td>
<td>525,263</td>
</tr>
<tr>
<td><strong>TOTAL REVENUE</strong></td>
<td>260,000</td>
<td>539,314</td>
<td>525,263</td>
<td></td>
<td>1,324,576</td>
</tr>
<tr>
<td><strong>TOTAL DIRECT PERSONNEL EXPENSE</strong></td>
<td>230,000</td>
<td>421,984</td>
<td>327,056</td>
<td>566,530</td>
<td>1,545,570</td>
</tr>
<tr>
<td><strong>TOTAL NON-PERSONNEL EXPENSE</strong></td>
<td>30,000</td>
<td>404,136</td>
<td>26,263</td>
<td>541,150</td>
<td>1,001,549</td>
</tr>
<tr>
<td><strong>INFRASTRUCTURE @ 25% OF TOTAL ANNUAL EXPENSES</strong></td>
<td></td>
<td>112,062</td>
<td>81,764</td>
<td>276,920</td>
<td>470,746</td>
</tr>
<tr>
<td><strong>TOTAL EXPENSES</strong></td>
<td>260,000</td>
<td>404,136</td>
<td>560,308</td>
<td>436,083</td>
<td>1,384,600</td>
</tr>
<tr>
<td><strong>PROJECTED NET</strong></td>
<td>0</td>
<td>135,178</td>
<td>(35,046)</td>
<td>117</td>
<td>(1,384,600)</td>
</tr>
</tbody>
</table>

PRE-TRIAL RELEASE PROGRAM

The following table reflects information provided by the Bridge Center for how funds for the Bridge Center Pre-Trial Release program will be allocated. These public funds are not eligible for LINCCA matching as LINCCA cannot be used to treat incarcerated individuals.

<table>
<thead>
<tr>
<th>Pre-trial Release Program</th>
<th>CITY-PARISH FUNDING</th>
<th>TOTAL REVENUE</th>
<th>SALARIES AND CONSULTING FEES</th>
<th>TRAVEL/MEETINGS/OUTREACH</th>
<th>PROGRAM ADMINISTRATIVE COSTS</th>
<th>TOTAL EXPENSES</th>
<th>PROJECTED NET</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROJECTED NET</strong></td>
<td>0</td>
<td>260,000</td>
<td>230,000</td>
<td>10,000</td>
<td>20,000</td>
<td>260,000</td>
<td>0</td>
</tr>
</tbody>
</table>
CRISIS INTERVENTION
Projections for crisis intervention services are based on two factors: the quote provided by VIA LINK for fielding 20,000 incoming calls, texts, or chats annually and revenues based on current fee-for-services contracts. To increase the latter, it will be critical to transition and renegotiate contracts carefully to improve this financial model, particularly for those contracts that are currently profitable to the organization and can help to subsidize other loss-generating activities within the Bridge Center’s operations. Please note that if crisis intervention contact center utilization volumes increase beyond 20,000, the cost for VIA LINK’s services will increase as well, and this is a possibility that should be considered in planning.

<table>
<thead>
<tr>
<th>Crisis Intervention</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTACT CENTER FEE-FOR-SERVICES</td>
<td>539,314</td>
</tr>
<tr>
<td>TOTAL REVENUE</td>
<td>539,314</td>
</tr>
<tr>
<td>VIA LINK SERVICES FOR 20,000 CALLS</td>
<td>404,136</td>
</tr>
<tr>
<td>TOTAL EXPENSES</td>
<td>404,136</td>
</tr>
<tr>
<td>PROJECTED NET</td>
<td>135,178</td>
</tr>
</tbody>
</table>

In a scenario where CIC continues to run its own services independently from the Bridge Center, the crisis intervention component and related services would be neutral, or non-existent in financial modeling for the Bridge Center.

MEDICAL DETOX
Detox services are a potentially strong structural anchor for the Bridge Center business model, theoretically covering most costs through reimbursements alone. To improve the numbers below, the Bridge Center should explore ways to take on the existing budget support provided by the City-Parish intended for the non-operational BR Detox organization, and potentially leverage those public funds for a LINCCA match. Adding beds could increase net revenues as well, but the Bridge Center should start conservatively and adapt over time to meet demand. In addition, the Bridge Center should explore the possibility of providing outpatient and/or social detoxification as described in the Services Framework section above.

<table>
<thead>
<tr>
<th>Medical Detox</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>REIMBURSEMENTS</td>
<td>525,263</td>
</tr>
<tr>
<td>TOTAL REVENUE</td>
<td>525,263</td>
</tr>
<tr>
<td>RN STAFFING</td>
<td>224,509</td>
</tr>
<tr>
<td>CADC STAFFING</td>
<td>53,020</td>
</tr>
<tr>
<td>NP STAFFING</td>
<td>123,239</td>
</tr>
<tr>
<td>CONSULTING PHYSICIAN</td>
<td>21,216</td>
</tr>
<tr>
<td>CLAIMS PROCESSING (5% OF REIMBURSEMENTS)</td>
<td>26,263</td>
</tr>
<tr>
<td>INFRASTRUCTURE AT 25%</td>
<td>112,062</td>
</tr>
<tr>
<td>TOTAL EXPENSES</td>
<td>560,308</td>
</tr>
<tr>
<td>PROJECTED NET</td>
<td>(35,046)</td>
</tr>
</tbody>
</table>
SOBERING BEDS
The projections below assume 12 sobering beds and are included in the Phase 1 financial projections as a placeholder. As recommended in this report, an early task for Bridge Center leadership will be to discuss with state Medicaid the potential for reimbursement of sobering services. For now, sobering services are included based purely on an estimate of expenses. If reimbursement is an option and can cover these costs, sobering should be included in Phase 1; if not, sobering as a service of the Bridge Center should be set aside until funding becomes available.

<table>
<thead>
<tr>
<th>Sobering Beds</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL REVENUE</td>
<td>N/A</td>
</tr>
<tr>
<td>RN STAFFING</td>
<td>224,509</td>
</tr>
<tr>
<td>MA STAFFING</td>
<td>102,548</td>
</tr>
<tr>
<td>INFRASTRUCTURE AT 25%</td>
<td>81,764</td>
</tr>
<tr>
<td>TOTAL EXPENSES</td>
<td>408,820</td>
</tr>
<tr>
<td>PROJECTED NET</td>
<td>(408,820)</td>
</tr>
</tbody>
</table>

TRIAGE
It will require 4.2 full-time employees (FTEs) in the RN role to maintain triage 24 hours per day, 7 days per week. This staffing level may include a combination of part-time staff or staff that also spend a portion of their time working in one or more of the other services lines. The average salary plus benefits number used to quantify the cost of an RN is $74,836, bringing the total cost for staffing triage to $314,312. This number, represented under “Service Direct Personnel Expense” in the Phase 1 Financial Dashboard is substantially higher than in the original HMA study, which estimated these same expenses at $168,750. As not every client who walks into the Bridge Center will necessarily have a medical issue, it is possible there were assumptions in the HMA figure that some triage could be performed by non-RN staff, or perhaps that during slow times of the day or week, that RNs could double as both triage staff and staff for other service lines at the same time. Regardless, given these data, the figure below represents a conservative expense estimate for triage staffing.

<table>
<thead>
<tr>
<th>Triage Staffing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL REVENUE</td>
<td>N/A</td>
</tr>
<tr>
<td>TRIAGE PERSONNEL</td>
<td>314,312</td>
</tr>
<tr>
<td>TOTAL EXPENSES</td>
<td>314,312</td>
</tr>
<tr>
<td>PROJECTED NET</td>
<td>(314,312)</td>
</tr>
</tbody>
</table>

INFRASTRUCTURE
The 25% infrastructure expense is a key but currently vague assumption given how early actions within start-up operations will drive potentially significant cost centers such as facility and other needs. Thus, this line item is projected at 25%, a carry-over from the HMA study, to serve as a conservative general catch all for a number of ancillary services and needs. These needs may include but are not limited to risk management, data collection, quality improvement, HR, recruitment, credentialing, accounting, registration, marketing, and tax proposition campaign expenses (year one).
ADDITIONAL PHASES

PHASE 2 TAX MEASURE

As previously stated, there will inevitably be a need for public support in subsequent phases of the Bridge Center. This assumption is particularly true if the organization is to broaden its services to complete the continuum of care as outlined in the fully proposed Bridge Center model. This includes adding the following Phase 2 services:

- **Mobile Assessment Team (MAT)** – As envisioned by HMA, the MAT would be a two-person team, likely an RN and a social worker, able to respond to law enforcement, assess the level of service intervention needed for the individual in question, and direct and ensure transport of the individual to the appropriate service provider. CAHSD has also worked to provide and build out mobile assessment services in Baton Rouge and should be a partner in discussions and planning for a Bridge Center role in this area. To that end, CAHSD has brought to the table a potential private provider for these services, which would alleviate the need for the Bridge Center to fulfill this component of the continuum. For this reason, mobile assessment has been left out of calculations for future Bridge Center funding needs.

- **Behavioral Health Respite (staffed for short-term Acute Psychiatric Care)** – Among their suite of services for individuals with mental illness, the Mental Health Association for Greater Baton Rouge (MHA) currently provides mental health respite via The Alliance House Drop-In Center. Bridge Center behavioral health respite services would provide a deeper level of respite, typically involving stays of 23 to 72 hours, for individuals in crisis and potentially in need of other Bridge Center services such as detoxification for co-occurring substance abuse and psychiatric stabilization. Individuals in need of longer-term inpatient acute psychiatric care would be referred to other providers with a focus on inpatient behavioral health services.

- **Care Management** – The Bridge Center care management model would extend services and monitoring beyond the individuals stay with a duration and level of service based on need. The purpose of care management would be to prevent Bridge Center clients from continuing to cycle in and out of the behavioral health and criminal justice systems, delivering the care they need at home to stay on a course of treatment and recovery.

In a changing landscape, the financial needs and opportunities are similarly volatile for Bridge Center operations. The unknowns regarding the future of Medicaid expansion, what Medicaid may be able to cover, whether MCOs will be open to creative thinking around payment models, and the potential for Bridge Center to leverage LINCCA matches as a core component of its business model are all key variables that may change or fluctuate based on the direction in which the health care and corresponding state or federal policy environment moves in the coming years.

Given this expected volatility, financial models for a Phase 2 tax measure are based on a series of assumptions that may be adjusted based on evolving realities:

- The full suite of services to be provided by the Bridge Center will be consistent with the HMA model, excluding mobile assessment, adding the Pre-Trial Release Program, and considering the potential addition of crisis intervention services.
- Staffing models are consistent with the HMA model, but new salary numbers are incorporated.
- As with the Phase 1 financial projections, sobering expenses are included, but with no reimbursements.
- As with the Phase 1 financial projections, the Bridge Center is not able to capture the $312,000 currently allocated by the City-Parish to BR Detox and leverage it for a LINCCA match.
- With the success of a new tax measure, current City-Parish funding for the Pre-Trial Release Program would go away, and would therefore need to be covered by tax revenues.

The variations in numbers for the public funding need identified below are dictated by the two possible scenarios for sustaining crisis intervention services.
Prior to finalizing any such projections relative to a proposed tax proposition, Bridge Center leadership will need to do diligence around transferring CIC services and homing in on accurate numbers for some uncertain expenses and revenues, such as facility rental costs, and additional reimbursement opportunities. These types of needs are included in the recommendations of this report. In each of these scenarios as listed, the public ask would be reduced from the first attempt by a fair amount. This savings as well as the Bridge Center’s efforts to stand up and/or preserve services in advance of going back to the ballot will provide a strong case for trusting the organization’s ability to be good stewards and act in a fiscally responsible, mission-driven manner.

PHASE 3

Once the Bridge Center successfully establishes a stable source of funding and extends services to cover the full Bridge Center continuum, the organization will have the opportunity to focus on developing partnerships and potentially investing itself in service extensions that help lead to the long-term recovery and stability of populations suffering from mental illness. These services include housing, transportation, and connections to employment – three quality-of-life factors that can deal devastating blows when not met. The Bridge Center can also help connect clients to other social needs services, including nutrition, financial management, and preventative health organizations. Former clients can even ultimately become part of peer-based treatment solutions at organizations throughout Baton Rouge, helping other individuals overcome some of the same ailments they have survived themselves. Finally, in Phase 3, the Bridge Center can focus on enhancing its data resources and relationships with providers of primary care, extended inpatient care, and other health supports its clients will be using as they continue their journeys beyond the walls of the Bridge Center.

CONCLUSION

Throughout the work leading up to this report a few key themes persisted:

- The need for behavioral health services in the Baton Rouge area is great, and improvements in this space will benefit the community by improving safety, being more efficient with public funds, and providing the appropriate care for those among the community in need.
- The approach to addressing these needs should be comprehensive, with a goal of covering the full continuum of care, as the model is only as strong as its weakest link.
- The solution is not simple, and will require commitment and collaboration from individuals, organizations, and providers across the community.
- Comprehensive behavioral health service provision is not a money maker, and while the Bridge Center and other community providers should work hard to utilize strong business models, a full-continuum solution will require public support to be sustained.

While voters narrowly rejected the initial Bridge Center tax proposition, the organization now has the opportunity to show that giving up is not and has never been an option with regard to the behavioral health crisis the Baton Rouge community is facing, and that it has continued to perform the diligence needed to stand up services and do it with a mind for fiscal responsibility. Understandably, voters were not eager to increase taxes on a ballot that immediately followed the Louisiana floods of 2016, but while much work and continued investigation remains to be done to execute the recommendations of this report, the Bridge Center has proven it can find ways to have impact with existing resources and to plan for responsible stewardship of future resources. While the list below is a repeat of some of the recommendations spread throughout this report, the following factors represent a consolidated set of potential opportunities for the Bridge Center to further minimize funding gaps.
Offset financial needs through higher revenues from:

- Increasing volumes of reimbursable services
- Establishing a reimbursement model for some Phase 2 additional services
- Developing value-based contracts with MCO's for per-day reimbursements that cover a comprehensive approach to
diversion and behavioral health care as opposed to focusing on specific services
- Reconfiguring and renegotiating contracts related to crisis intervention services
- Planning for and pursuing LINCCA matches for future public funds
- Securing funding from hospitals through community impact grants or through in-kind support from the Baton Rouge
  General in the form of a free or discounted facility cost
- Securing funds from other outside sources such as The Substance Abuse and Mental Health Services Administration
  (SAMHSA), foundations with a focus on behavioral health, and/or future funds available for solutions dealing with the
  national opioid crisis

Partner with other organizations and providers, such as CAHSD and MHA, to provide some core services outside of the
Bridge Center (note: outsourcing services can save on expense, but may also represent reductions in revenues,
depending on the service)

The recommendations of this study, as well as those from the HMA study, and ongoing collaboration with organizations and
existing providers in the community, all represent the ongoing heavy lifting needed to successfully launch the Bridge Center
and service the needs of Baton Rouge. It will be up to Bridge Center leadership to identify and dedicate the right resources –
both financial and human – to continue making progress. In addition, the support of the behavioral health services community
and the Baton Rouge community at large will be paramount in achieving solutions that have real positive impact. It is a
community problem, and therefore requires a community solution.
REFERENCES


Mental Health America of Los Angeles. (n.d.). About Us. Retrieved from Mental Health America of Los Angeles: http://www.mhala.org/about/


APPENDICES

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# APPENDIX A: BHAC AGENDA

## BEHAVIORAL HEALTH ADVISORY COUNCIL MONTHLY MEETING AGENDA

**Date**

**Location**

<table>
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<tr>
<th>ITEM #</th>
<th>ITEM NAME</th>
<th>OWNER</th>
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<tbody>
<tr>
<td></td>
<td><strong>Trauma-Informed Care Session (1 hour)</strong></td>
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<tr>
<td>I.</td>
<td>Welcome, introduction of provider presenters (10 minutes)</td>
<td>Health Care and Treatment Task Force Chair</td>
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<tr>
<td>II.</td>
<td>Presentation by providers (30 minutes)</td>
<td>Provider representative(s)</td>
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<td>III.</td>
<td>Group discussion and takeaways (20 minutes)</td>
<td>Health Care and Treatment Task Force Chair</td>
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## Data Sharing and Task Force Reporting (1.5 hours)

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<th>ITEM #</th>
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<tr>
<td></td>
<td><strong>Data Sharing</strong></td>
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<td>Capital Area Human Services District: Behavioral health and addiction population data (including coverage numbers)</td>
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<td>Bridge Center: Jail diversion program numbers, Crisis Intervention statistics, detox numbers, numbers along active components of continuum</td>
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<td></td>
<td>Health Systems: psych consults, psych beds utilization, ED utilization</td>
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<td></td>
<td>Law Enforcement, First Responders (Baton Rouge Police Department, Sheriff’s Office, EMTs): CIT numbers, behavioral health-related responses</td>
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<td>Courts: Specialty court outcomes</td>
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<td>Corrections: behavioral health-related admissions, report on month’s behavioral health screenings</td>
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<td>Capital Area Alliance for the Homeless: Trends and numbers in homelessness</td>
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<td>Coroner’s Office: Orders of Protective Custody and Coroner Emergency Certificates issues</td>
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<td></td>
<td>Other organizations with relevant datasets to share</td>
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<tr>
<td>II.</td>
<td>Task Force Reports on current initiatives and action items according to the strategic plan</td>
<td>BHAC Chair</td>
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<td></td>
<td>Diversion funding</td>
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<td>Technology and Data Tracking</td>
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<td>Sequential Intercept</td>
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<td>Education and Advocacy</td>
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<td>Health Care and Treatment</td>
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<td></td>
<td>- To include update and outcomes of Trauma-Informed Care Session</td>
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<td>III.</td>
<td>Task Force Chairs</td>
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<td>Other task force reports</td>
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<td>IV.</td>
<td>New Business</td>
<td>BHAC Chair</td>
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<tr>
<td>V.</td>
<td>Public Input – Opportunity for providers, general citizens, media, or others in attendance to comment or ask questions</td>
<td>Education and Advocacy Chair</td>
</tr>
<tr>
<td>VI.</td>
<td>Adjournment</td>
<td>BHAC Chair</td>
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**ADDITIONAL NOTES ON MEETING FLOW**

Following the data sharing portion, BHAC task forces will have allotted times to report on their progress, according to action plans and milestones laid out through the committee’s strategic planning process. This open format for task force reporting will both keep the community apprised of BHAC’s progress and help avoid future political, legal, and financial “land mines” that could occur if the BHAC was acting behind closed doors.

Following task force reports and any new business, BHAC meeting attendees (e.g. other providers, the media, and the general public) will be given a time to ask questions, share knowledge, and offer services in the spirit of collaboration. This segment of the meeting should be facilitated by the chair of the Education and Advocacy Task Force, and speaking opportunities should be limited to a reasonable amount of time (e.g. three minutes).

Throughout the meeting, the secretary of the BHAC should be tracking minutes – including agenda, attendance, data sets, and subcommittee progress reporting – and action items. Following the meeting, action items should be reconciled with any notes taken by committee members, and should then be distributed along with meeting minutes to the full committee. After approval at the subsequent meeting, minutes and action items should be posted and publicly accessible online, possibly on the Bridge Center website.
APPENDIX B: DRAFT ACCOUNTABILITY AGENDA

2017-2018 MENTAL HEALTH AGENDA

The Bridge Center for Hope, a 501(c)3 not-for-profit organization, was formed in 2016 to create and manage programs for people with mental illness and substance abuse problems in East Baton Rouge Parish. The primary focus of The Bridge Center is to identify systems, processes, and structures that can be used to divert these individuals away from the criminal justice system and hospital Emergency Departments (EDs) and toward receiving the proper treatment and care they so desperately need. The Bridge Center’s efforts are led by a dedicated volunteer Board of Directors representing all facets of the mental health continuum of care – from criminal justice and homelessness to health systems and local government agencies.

THE CHALLENGE

There is a distinct need for collaboration and solutions that can aid those suffering from mental illness or substance abuse problems by keeping these individuals off the streets; out of jail and away from costly, extended, detrimental, and unnecessary incarceration; and diverting those in crisis situations away from costly visits to EDs and toward practical treatment options.

While treating the mentally ill with the dignity they deserve has been and will continue to be the priority in caring for this population, the reality is that there is a significant cost to our community, taxpayers, and society by refusing to acknowledge the problem and embrace potential solutions.

- Louisiana has the highest per-capita rate of incarceration of any state in the U.S. or any country in the world, with 847 persons per 100,000 state residents who are imprisoned – a rate that is 114% higher than the national average.¹
- In Louisiana, we incarcerate people with severe mental illness 4.6 times more than we treat them at the hospital.²
- It costs East Baton Rouge Parish taxpayers more than $6 million per year to move prisoners in and out of the parish throughout the year to avoid overcrowding of our parish prison and local detention facilities.³

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• As taxpayers, we spend on average $24 per day on each inmate housed in East Baton Rouge Parish; transporting these inmates to surrounding parishes for holding adds $1.29 per inmate, per day to these costs, in addition to those costs associated with prison medical care that may or may not be the appropriate type of specific treatment prisoners need for the illnesses that afflict them.\(^5\)

• The nationwide opioid epidemic is further contributing to issues involving substance abuse, including overdoses resulting in death, incarceration, and other societal costs; opioid-related deaths and overdoses in Louisiana have steadily climbed from 155 deaths in 2012 to 305 last year.\(^6\)

• At just one East Baton Rouge Parish health system’s ED, we see an average of 33 consults per day for psychiatric patients – approximately 1,000 per month. Simply put, our local health systems are not equipped to handle such a volume of psychiatric care, which requires very specific types of expertise, assessments and treatment.

• As the primary alternative to prison for housing mentally ill persons in times of crisis, the ED is very costly to the community and ill-equipped to treat and house these individuals for longer-term care; the result is congested EDs and hospitals that are over capacity for their inpatient psychiatric beds and with limited options for diverting individuals to the appropriate providers in order to receive the respite and care they need.

PUBLIC POLICY SOLUTIONS

Together, we can connect those who cannot care for themselves to the appropriate community-based providers they need – while greatly reducing nonessential spending of taxpayer dollars – through effective community-based collaboration among service providers and stakeholder agencies, efficient utilization of tax dollars and public resources, and effective diversion. The Bridge Center is focused on serving as a resource unlike any our community has ever seen, constantly working to identify acute service-related needs and address gaps in caring for this population. As an elected official in or representing the residents of East Baton Rouge Parish, we are asking for your support to take the steps needed to care for those members of our community who are suffering from mental illness. We ask for your commitment to work with us to identify solutions that can reduce taxpayer spending in caring for this population while providing more efficient, coordinated, cost-effective care. This commitment is not to blindly support future tax measures or the introduction of additional tax dollars into our local service landscape; rather, it is a commitment to work hand-in-hand with The Bridge Center and the many providers, stakeholders, and advocates that serve or represent this element of our community, focused around the following key priorities.

1. Take the necessary steps to meet the current and future demand for mental health and substance abuse treatment services for patients and their families
2. Support the resourcing of existing government agencies, staff, and programs focused on serving adults and children with mental health problems
3. Identify and advocate for the development of innovative programs and services not currently provided in the Baton Rouge area, such as effective pre-trial diversion programs that provide opportunities and appropriate care for low-level, mentally ill offenders

4. Commit to working with area healthcare facilities, public sector agencies, and educational institutions to identify and address hiring needs to support more effective and efficient mental health programs in the criminal justice or healthcare systems
5. Serve as a visible and vocal presence in the Baton Rouge community to reduce the stigma associated with seeking treatment for behavioral health issues, empowering those who need treatment to seek help
6. Provide access to and share relevant data with other agencies, while protecting any sensitive or personal information, to facilitate the development and management of an integrated system for providing coordinated services to those with behavioral health issues in Baton Rouge
7. Exchange research, strategies, and educational resources among mental and behavioral health agencies and stakeholder groups to better understand local trends and national best practices that can be utilized to inform service delivery or diversion strategies in Baton Rouge
8. Identify and pursue grant-related funding sources to support coordinated diversion and treatment strategies for the mentally ill in Baton Rouge
9. Work to improve the delivery of more effective and coordinated wraparound services such as housing, transportation, and job placement for those with a mental illness emerging from the local criminal justice or healthcare system and reduce recidivism among this population
10. Collaborate with The Bridge Center and other Baton Rouge area stakeholders as necessary to identify solutions that can address acute areas of need across the mental health continuum of care

We recognize that some of these priorities may not be universally applicable to the office you hold, or seek to hold, and your individual purview. By signing this mental health agenda, you pledge to take the applicable and related next steps to advance these priorities on behalf of the Baton Rouge community, using the presence, stature, and scope of your office or that which you seek to serve those living with a mental illness or substance abuse issue in East Baton Rouge Parish through ongoing collaboration with The Bridge Center and the various stakeholders that similar serve this critical population.

________________________
Signature

________________________
Print Name

________________________
Date
APPENDIX C: BRIDGE CENTER FINANCIAL PRO FORMAS
Included as attachment with the filename EM_Bridge-Center-Financial-Pro-Formas_02-2018.xlsx

APPENDIX D: CRISIS INTERVENTION CENTER CURRENT STATE ANALYSIS
Included as attachment with the filename EM_CIC-Current-State-Analysis_11-2017.xlsx