Kurt Salmon

Safe Haven Implementation Strategy

Final Report Package

July 2016

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Executive Summary

Executive Summary

Background:

The current state of mental healthcare in the US is a result of a confluence of the deinstitutionalization that happened in the 1960s, combined with inadequate and under-funded community-based mental health care programs and the significant stigma that has historically been associated with the disease. This has forced the criminal justice system and hospital emergency departments to be the "backstop" for people with serious mental illness, and neither are well equipped to deal these crisis situations or manage these illnesses on an ongoing basis.

Louisiana, and St. Tammany Parish, are in a similar position as many communities across the country. The Parish sees ~2,160 annual ED visits related to behavioral health and has ~65% of inmates with a substance use disorder. As a result, St. Tammany Parish has been proactively pursuing opportunities to address the behavioral health needs of its community over the past several years:

- 2010: St. Tammany Parish (STP) Government formed suicide crisis committee
- 2011: VOA Crisis Response Team funded by STP Public Health Millage
- 2012: SouthEast Louisiana Hospital closes: President Pat Brister directs formation of STP Behavioral Health Task Force (BHTF) in response to hospital closure and increased demands for behavioral health resources
- 2013-14: BHTF collaborates with LPHI and National Council on 18 month grant and system redesign: $259,500
- 2015: BHTF presents proposed plan for BH system redesign to STP Government
- 2015: 293 acres SELH site purchased by Parish; 75 acres retained as a wetlands mitigation bank; Southern 85 acres with 62,000 square feet of building space will serve as location for Safe Haven (a facility focused on serving the needs of the behavioral health population)
- 2016: STP government hires consultant, Kurt Salmon, to provide Safe Haven master facility planning, economic impact and implementation strategy

Executive Summary

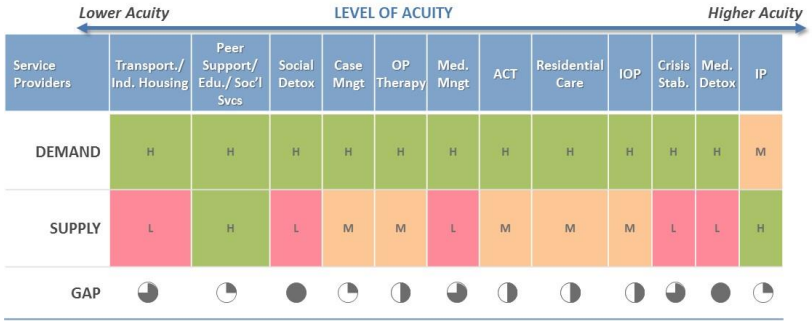
Findings/Recommendations:

Kurt Salmon's engagement with St. Tammany Parish Government provided leadership with:

- An assessment of the behavioral health needs of the community
- An analysis of community stakeholders and collaboration opportunities
- Information on innovative behavioral health delivery models and technologies
- Vision and goals for Safe Haven
- A master facility plan and economic implications of the proposed strategy
- A Safe Haven implementation plan, including a timeline and roadmap

Key Findings and Recommendations from the engagement include:

- Needs Assessment: Based on qualitative quantitative information from interviews and data analysis, the team found there are strong tailwinds for behavioral health development in the community, there are concerns from stakeholders regarding funding and branding of the facility, there is overutilization of EDs and jails by individuals with behavioral health conditions, and the behavioral health system in STP is fragmented.
  - A detailed gap analysis found the major services that will need to be the anchor programs at Safe Haven:



- **Anchor Programs** to address major gaps: Medication Management, Social Detox, Medical Detox, Crises Stabilization
- **Additional Services**: Transportation, Peer Support, Case Management, OP Therapy, Residential Care, IOP

Executive Summary

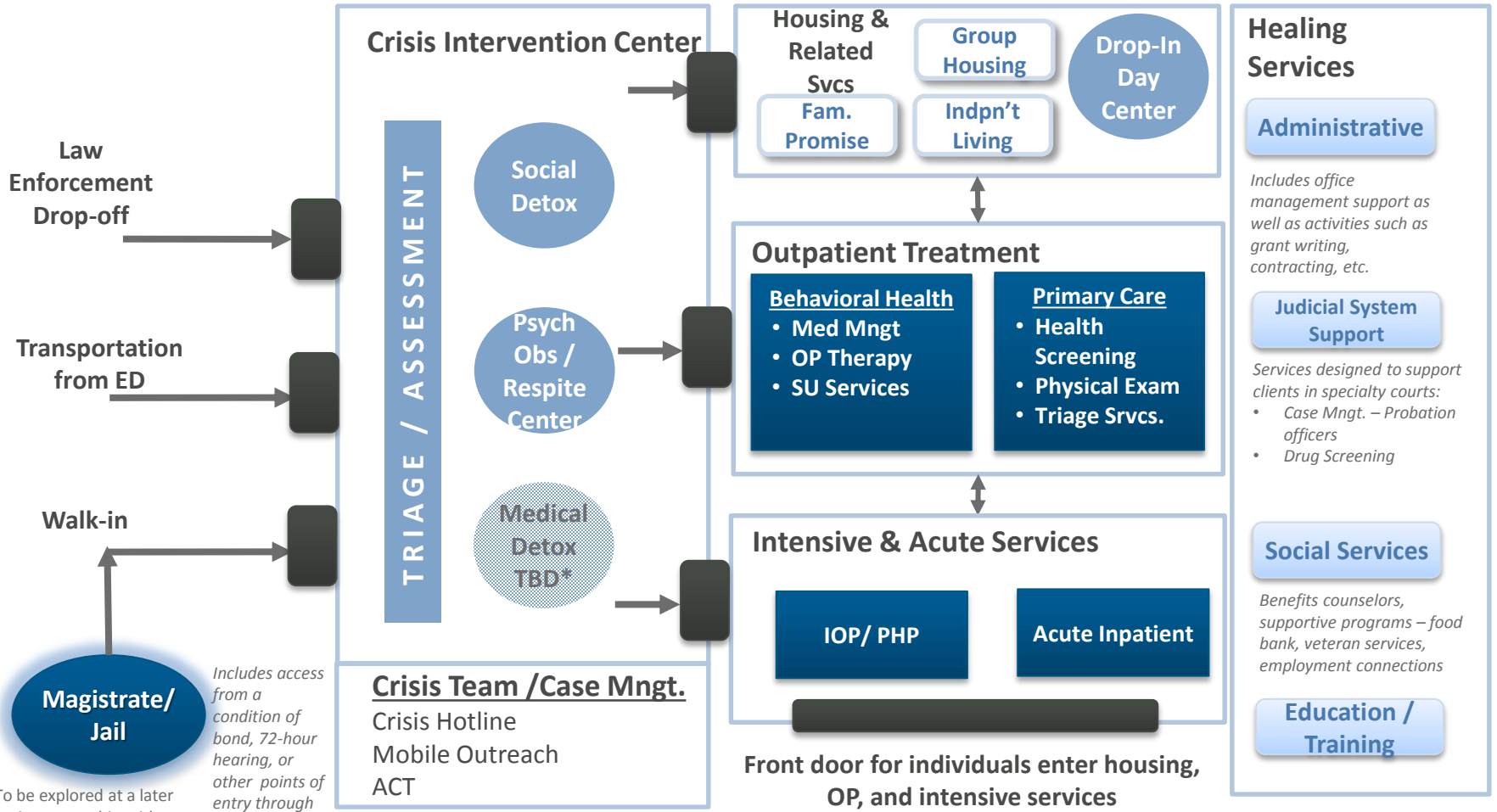
Findings/Recommendations (cont'd):

- Safe Haven Vision and Goals: In order to properly meet the needs of the community, the planning team determined the preferred direction of the facility will be a "Healing Campus" and developed the following:
  - Vision: *Safe Haven will provide a collaborative healing environment for the behavioral health continuum by creating a high-quality, coordinated, sustainable and humane network of care anchored in St. Tammany Parish.*
  - Goals: In order to achieve the vision, 7 goals were developed by the planning team:
    1. *Organizational Framework*: Create an organizational framework and governing body to effectively coordinate and develop services for the community
    2. *ED Diversion*: Support meaningful programs to ensure patients receive care in the most appropriate setting to foster recovery
    3. *Jail Diversion*: Support meaningful programs at all points of diversion to decriminalize behavioral health and ensure people receive respectful and humane care during times of need
    4. *Access*: Enhance access to high quality behavioral health services and fill service gaps in the community
    5. *Information Management*: Develop infrastructure and processes to enhance data capture and information sharing to better coordinate care and demonstrate outcomes
    6. *Financial*: Create a financially-sustainable service to the community
    7. *Healing Environment*: Offer supportive services to create an environment of recovery for individuals with behavioral health and social support needs

Executive Summary

Findings/Recommendations (cont'd):

› Behavioral Health System of Care: The following model was developed to meet the vision and goals



* To be explored at a later date in partnership with other communities

Executive Summary

Findings/Recommendations (cont'd):

- Master Facility Plan: Based on the needs assessment, vision and goals, and model, a master facility plan was developed with Phase 1, located in Wing A of the campus facility, to include space for triage/assessment, social detox, psych obs/respite care, crises tem/case management, outpatient treatment, social services, education/training, judicial system support, and administrative support. Phase 2, which would be located in Wing D of the campus, could provide space for growth and additional services if and when needed.
  - A total of 25,500 square feet in Wing A will be remediated and/or renovated to house:

Program / Department	Key Components
Check-in / Triage / Waiting	2-4 Triage Rooms, Check-in Desk, Security, Waiting, Staff Workstations, Case Management
Social Detox	3-6 beds (mattresses on the floor), office, EMT desk
Psych Obs / Respite Center	6-8 beds (combination of private and semi-private), offices, support
Common Areas Supporting Beds	Nursing Station, Day Room, Dining, Storage
Primary Care / Other OP Services, Social Services, Education / Training	4-6 exam rooms, Therapy, Offices, Meeting / Conference Rooms etc.

Executive Summary

Findings/Recommendations (cont'd):

› Implementation: The following timeline for capital spend and implementation key milestones will be worked towards by the Safe Haven team.

Implementation Timeline

Fiscal Year	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Capital Estimate		$4.3mm	$1.4mm								

Safe Haven Campus Phasing

- **Safe Haven Planning**
- **Remediation and Renovation of Wing A (75% in 2017, 25% in 2018)**
- **Phase 1 Services - Crisis Intervention and Healing Services - fully operational and running (50% brought online in 2018)**
- **Phase 2 Expansion into other Wings can be explored**

★ NAMI Drop-In Center Group operational 6/30/17

★ Family Promise Day Center 12/31/17

★ 100% of Phase 1 Services Operational at end of 2019

Process

Project Objectives

The engagement provided leadership with the following:

- Assessment of the behavioral health needs of the community
- Analysis of community stakeholders and collaboration opportunities
- Information on innovative behavioral health delivery models and technologies
- A Safe Haven vision and goals
- A master facility plan and economic implications of the proposed strategy
- The Safe Haven implementation plan, including a timeline and roadmap

1. Future plan Phase 1 will be focused on the vacant ~62K square foot building on the former Southeast Louisiana Hospital Campus

Approach

The engagement lasted 6 months, which included a kick off meeting and subsequent meetings with the Safe Haven Task Force and Core Team.

Work Step 1

Comprehensive Needs Assessment

- Data Collection
- Community Needs Analysis
- Capacity Assessment
- Confirmation of Best Practices
- Gap Analysis

Task Force Kick Off (2/1)
Interviews (2/2, 2/3)
Task Force SC #1 (3/7)

Work Step 2

Stakeholder Analysis

- Identify Stakeholders
- Engagement Assessment
- Determine Value of Collaboration

Bexar County/CHCS Tour
Midtown Community Health Tour
Core Team Work Session #1 (4/12)

Work Step 3

Implementation Strategy

- Vision and Goal Confirmation
- Strategy Development
- Facility and Economic Implications
- Implementation Planning

Task Force SC #2(5/9)
Task Force SC #3 (6/13)
Town Hall (6/21)

January	February	March	April	May	June

Background

The engagement leveraged previous work by the Louisiana Public Health Institute (LPHI) and St. Tammany Parish Government.

LPHI Findings

- Long wait times greatly limits access to timely services and lead to ED or jail as last resort
- Over utilization of law enforcement, emergency certificates, EDs, and jail for individuals in BH crisis
- A lack of confidence in alternative services has led to few individuals in crisis being diverted from the ED and subsequent inpatient placement
- EDs see repeat frequent flyers in BH crisis
- Lack of coordination and information sharing between BH providers
- Large gaps in data reporting to monitor the BH system's effectiveness over time

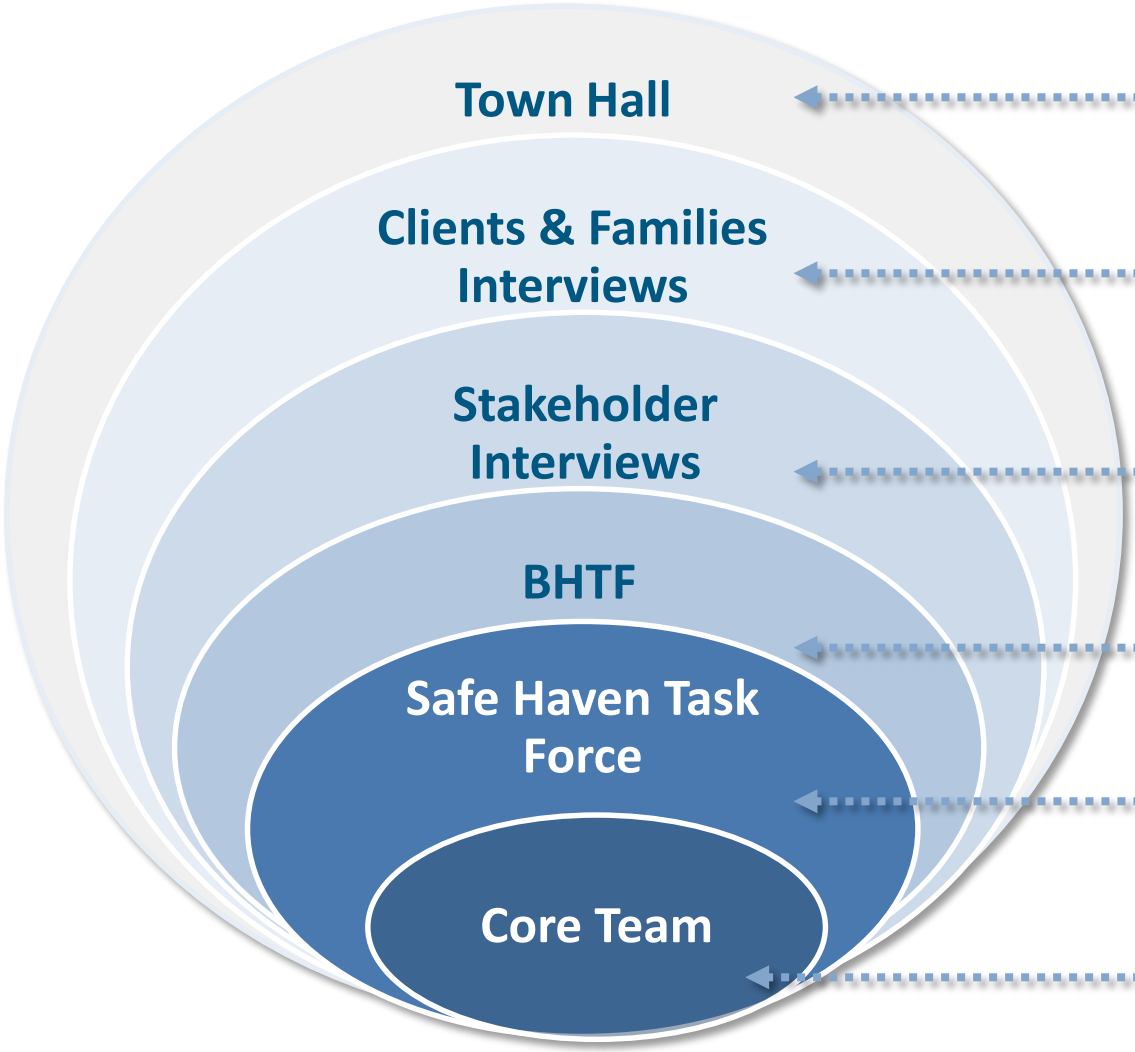
LPHI Recommendations

1. Enhance community-based behavioral health services
2. Transform utilization of emergency services
3. Enhance crisis service continuum
4. Enhance education, advocacy, and training
5. Enhance social services

Understanding of St. Tammany Parish Gov't's Situation

- Seeks programming for vacant 62k square foot building at Southeast Louisiana Hospital campus
- Safe Haven to focus on:
  - ED diversion
  - Jail diversion
- Haven for Hope in San Antonio is a best practice model

Major Activities of the Engagement



- **Town Hall** — Key findings and outputs for direction of Safe Haven Campus to be shared with community
- **Clients & Families Interviews** — Interviews with ~20 clients and families of individuals who utilized BH services in the community
- **Stakeholder Interviews** — 60+ interviews with provider organizations, government officials, law enforcement, first responders, and criminal justice system representatives
- **BHTF** — Information on the planning process and project status was shared with BHTF
- **Safe Haven Task Force** — 25+ member group; group of leaders responsible for project guidance and direction
- **Core Team** — Subset of Task Force: Kelly Rabalais, Angel Byrum, Anne Pablovich, Jan Robert, Richard Kramer, Nick Richard, Judge Peter Garcia

Key Stakeholders

The project process engaged with 80+ Key Stakeholders, including patients and families, from St. Tammany and the surrounding community including representatives from the following organizations and others.

Information Gathering

Safe Haven Fact Finding Table of Contents

Interviews

Safe Haven Project Interviewees

Kurt Salmon conducted interviews from February 1st – February 3rd and subsequent interviews as part of the assessment to gain key insights from a broad range of stakeholders.

Safe Haven Project Interviewees				
Shaun Armantrout	LaVondra Dobbs	Susan Johanssen	Kevin Pearson	Kathy Stuart
Dr. Sue Austin	Jack Donahue	Richard Kramer	Dr. Charles Preston	Judge Rick Swartz
Ty Bartel	David Doss	Teresa Krutzfeldt	Kelly Rabalais	Rebecca Thees
Martha Benson	Stephanie Dupepe	Melissa Landrum	Nick Richard	Vincent Trabona
Andrea Blaiser	Rachel Edelman	Dr. Schoener LaPrairie	Jan Robert	Dr. Leanne Truehart
Tim Brady	Celeste Falconer	Tony LeMon	Katie Saintcross	Dr. Will Wainwright
Pat Brister	Reid Falconer	Trilby Lenfant	Lynette Savoie	Melanie Watkins
Gina Campo	Trey Folse	Leslie Long	Denis Schexnaydre	Bernice Williams
David Carmouche	Judge Peter Garcia	Craig Marinello	Scott Simon	Damon Wilson
Terry Cederholm	Celeste Graham	Dwain Meche	Ronnie Simpson	Angie Wood
Vera Clay	Cindy Gutowski	Dr. Robert Mercadel	Collin Sims	Darlene Young
Greg Cromer	Marie Hammons	Dave Morel	Randy Smith	Mark Zelden
Margaret Cruz	Shannon Hattier	Wharton Muller	Jeanelle Stein	
Bill Davis	Dr. Head-Dunham	Fred Oswald	Jack Strain	
Marty Dean	Taylor Jacobsen	Anne Pablovich	Adrienne Stroble	

Interview Findings

Theme	Key Takeaways	Considerations for Safe Haven Strategic Plan
Strong Tailwinds for Behavioral Health Development	› The Behavioral Health Task Force has brought **Stakeholders to the table** › There is overall support from the community, given the **impact of mental health and substance abuse** has had on many families (particularly with opioids) › There is **political support** at the Local, State, and Federal level and Safe Haven is seen as a potential model for the rest of the nation	› The community and the organizations that work with the BH population are **eager to better serve this patient population**
Concerns Raised	› Funding is a major concern. There is a lack of appetite for tax increases and the current situation with the State's general fund mean **budget cuts are inevitable** › Branding for the Safe Haven campus is important. The perception and stigma of a Behavioral Health campus needs to be taken into account.	› **Alternative funding sources** may need to be explored to help support operations › **A phased approach** may be required to achieve the vision for Safe Haven given the current financial situation with the State › **Branding and messaging** needs to be incorporated into the planning process

Interview Findings *(cont'd)*

Theme	Key Takeaways	Considerations for Safe Haven Strategic Plan
Access to Care	› **Improving access** for patients, especially the Medicaid and indigent populations, is a priority › There are limited BH resources and in **some cases**, such as medical detox and pediatric inpatient care, there are **no services** in St. Tammany › **Lack of access to follow-up outpatient services** after individuals leave the ED, jail or inpatient setting causes a number of "frequent flyers" › Without insurance, substance abuse coverage is limited. › There are services available through the school system and Medicaid for adolescents and teenagers, however, **extended services** for parents and family are equally important › Many patients do not seek available services because of **lack of transportation** › Residential services, such as NAMI, provide a good venue for individuals to have **access to BH service through transportation or proximity** › Recent **funding reductions** have caused reductions in much-needed services (e.g., VOA Case Management)	› Safe Haven will need to ensure services for the underserved but find funding mechanisms to ensure **long-term viability** › **Services that are not found** within the community (detox, outpatient mental health – medication management) and **require a local presence** should be prioritized › Given the location of the Safe Haven campus and that many of these individuals do not have transportation, **creative solutions will be needed** (St. Tammany Parish provides some transportation services and could be incorporated if appropriately structured) › A **solution for the lack of psychiatrist** in the market will likely need to be considered to ensure access to the full continuum of care

Interview Findings *(cont'd)*

Theme	Key Takeaways	Considerations for Safe Haven Strategic Plan
Fragmented BH System	› There is a **willingness for collaboration** among the different organizations, however; there are **limited incentives** for coordination › The Behavioral Health Task Force is seen as a positive step to **improve communication and data sharing** › Some fragmentation is caused by a lack of coordination between entities in the **transition of patients** › **Case management services** are viewed as a must to improve care coordination, patient transitions, and preventive services › **Awareness** is lacking in the community of certain services that could be better utilized (e.g., community social services) › **Geographic dispersion of services and transportation issues** has added to the fragmentation of services and issues with patient coordination › Collaboration with the Bayou Health Plans has yet to be tested	› The Safe Haven campus has the opportunity to **further integrate** existing organizations that orbit this patient population › The Safe Haven campus should consider a structure that encourages **enhanced communication and coordination, joint planning, data sharing, and potentially shared support services** › **Coordination** and access to **case management services** will be essential in a **high functioning BH network** › There may be an opportunity to assemble a **clinically integrated BH network** to contract with the Bayou Health Plans to develop value-based reimbursement mechanisms

Interview Findings *(cont'd)*

Theme	Key Takeaways	Considerations for Safe Haven Strategic Plan
Over Utilization of EDs and Jails	› Over time, the jail feels it has become a "psych ward" given the high percentage of inmates with BH needs › Many feel the high incarceration rates in the Parish are a result of the **lack of access to appropriate care for people in crisis** › BH cases are **resource intensive** for the police force who are usually first responders along with EMT › The mobile crisis intervention initiative has not reached its potential due to it being mostly standard procedure for the **police to drop off a patient at an ED because of liability concerns** › Arrest to arraignment period is 4-6 weeks and **pre-trial screening** would help reduce time in jail › The problem solving courts have **shown success** in reducing recidivism for offenders that meet the program criteria. There may be an opportunity to expand these programs with the support of the DA's office › Inability to prescribe certain medications in jail can make **treating patients with BH conditions more difficult**	› Safe Haven may serve as a central location for **jail and ED diversion** › **Security and liability concerns** from the police and public will need to be addressed if patients are being diverted from jails › Consideration should be given to providing **space for a behavioral health court** if jail diversion is a focus › Safe Haven will need to meet laws and requirements if patients are transitioned from the police force › **Transportation** of individuals being diverted from jail or EDs, as well as being transported between jail and facility, must be **appropriately coordinated**

Data Collection

Data Collection

At the onset of the engagement, Kurt Salmon issued a detailed data request to a number of Stakeholders in the community:

- However, there is limited behavioral health data available in the community but as Safe Haven evolves, more robust data collection will be part of key strategies to demonstrate outcomes
- In addition to data collected from the community, Kurt Salmon also used national benchmarks, national and regional incidence rates, and experience to make estimates and projections for planning purposes
- The following are data items collected during the process:

Collected Data Items	
Behavioral Health Task Force Dashboard Access	22nd JDC Adult Drug Court program statistics
Behavioral Health Initiative Funding from STPG	Louisiana Regional Probation Information
STPSO Medical Department 2015 Statistics	Behavioral Health Task Force "Cost of Behavioral Health Patients to IP Pysch Hospitals" and "Cost of Behavioral Health Patients to Hospital Emergency Departments" estimates
Northlake Behavioral Health Inpatient Volumes	Data on Serious Mental Illness in the Past Year among Persons Aged 18 or Older, by State and Substate Regions: Percentages, Annual Averages Based on 2010, 2011, and 2012
St. Tammany Parish Hospital 2015 ED BH transfers and encounters by diagnosis	Data on Any Mental Illness in the Past Year among Persons Aged 18 or Older, by State and Substate Regions: Percentages, Annual Averages Based on 2010, 2011, and 2012 NSDUHs

Best Practice Review

Facility Tours Table of Contents

Facility Tours Overview

Facility Tours Overview

Kurt Salmon and members of the Safe Haven Core Team conducted behavioral health facility tours to gain a deeper insight regarding best practices, keys to success, lessons learned, and facility implications of other national models.

Bexar County

THE CENTER FOR HEALTH CARE SERVICES
Mental Health & Substance Abuse Solutions

Haven for Hope

San Antonio, TX

- Saved taxpayers over $50mm since 2003
- Diverted more than 100k people from jail or ERs
- Reduced homelessness by 85%

Midtown Community Mental Health

ESKENAZI HEALTH

Indianapolis, IN

- Serves 16k to 17k unique patients per year; equates to about 50k visit per year
- Large portion of Medicaid (33%) and Uninsured (37%) clients

Bexar County, TX

Bexar County Overview

On March 15th, 2016 St. Tammany Parish Government (Kelly Rabalais) and Kurt Salmon toured The Center for Health Care Services (CHCS) and Haven for Hope facilities in Bexar County, San Antonio. The facilities and programs have shown success:

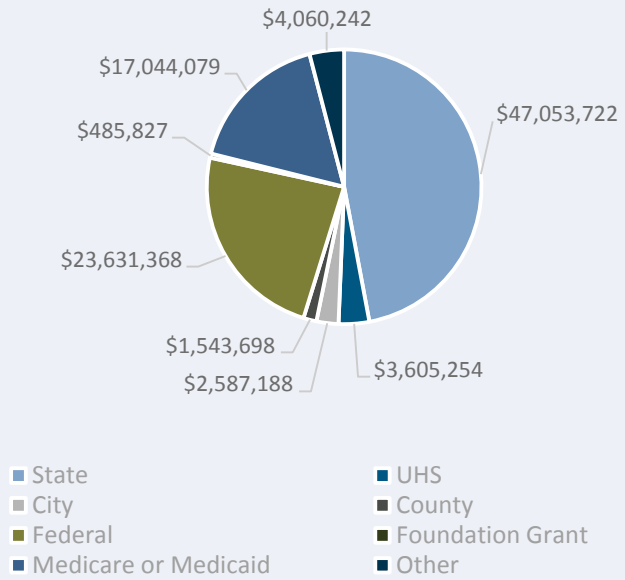
- **Internationally Acclaimed Jail/ER Diversion Strategies. Since inception in 2003, programs have:**
  - Saved taxpayers over $50mm
  - Diverted more than 100k people from jail or ERs
  - A 50% decrease in ED frequent fliers
  - Trained 40K law enforcement officers in 40 hour CIT training model (100% of the police force)
  - The cost of booking is $1,700 more than jail diversion ($2,000+ vs. $300)
  - Trained over 250 school district police and admin in Children's Crises Intervention Training
  - Reduced overcrowding in Bexar County jail from over-capacity to 800 empty beds
  - A 6.6% recidivism rate for offenders that have engaged in their programs
  - Officers can drop patients off and be back out in the community in 15 minutes
- **Treatment for Mental Illness and Substance Abuse**. In 2014, CHCS:
  - Delivered 750K services to 36K patients across 30 locations in Bexar County
- **Reducing Homelessness**. Through a system of transformation and restoration, programs have:
  - Reduced homelessness in Bexar County by 85%

Keys to Success

Based on the team's tour of The Center for Health Care Services and Haven for Hope Campus, there were a number of keys to success with lessons and implications for Safe Haven's development:

Category	Key to Success	Description	Implications for Safe Haven
Organizational Alignment	Buy in from range of Stakeholders	• Included SA Police Department, Sheriff's Office, County office of Mental Health Services, Judicial Department, and the community hospital (UHS) • Another key stakeholder were religious groups who helped spread awareness and raise funds	*As Safe Haven continues to build partnerships, identifying partners with the ability to promote awareness and raise funds will prove valuable.*
	Authority for BH Committee members	• Representatives from agencies at BH Committee meetings were given authority to commit resources to programs	*Safe Haven is in a similar situation with a large amount of support from Stakeholders. Asking for representatives to have authority may help identify the most committed entities to make forward progress.*
	Early wins	• On opening, there were immediate resources for law enforcement to confidently drop off individuals • The ability to have responding officer quickly back on the street was a key selling point	*Safe Haven campus will need to focus on success for first interactions with law enforcement to gain confidence.*
	Proper training for boots on the ground	• 100% of SA police force attend 40-hour CIT training • Mixed agencies in training creates friendly competition and a level of serious and focus from attendees (e.g. courts, 911, ED staff, chaplains, fire department)	*Safe Haven's diversion success will start with properly-trained "boots on the ground."*

Keys to Success (cont'd)

Category	Key to Success	Description	Implications for Safe Haven
Financials	Start-up Funding	• Limited start-up funds ($550,000), billed for services covering 25% - 30% of cost (through Medicaid Administration Claims – MAC) • Had to prove efficacy before justice system committed funding	*Managing data and outcomes is critical to the financial success of Safe Haven.*
	Diversified sources of funding	• There is a total of 100 different funding sources • The below is a CHCS Funding Source Breakout by major categories: 	*Diversification of funding will take resources and time for fundraising efforts. There are a few items to note from the Bexar County campus funding sources:* • *State sources account for 47% of total funds, which includes funding from the criminal justice system* • *The San Antonio community hospital, UHS, commits 4% of funding, and further talks are taking place with other hospitals in the region, as well as with payors* • *Medicare or Medicaid reimbursements only account for 17% of funding, indicating funds from operations will not cover services needed for the total population being served*

Keys to Success (cont'd)

Category	Key to Success	Description	Implications for Safe Haven
Operations	Integrated care and care continuation	• Provides a "one-stop shop" of behavioral health and medical care needs • In cases of minor medical emergencies, key is to have medical and behavioral clearance in the same location as services – increased value of service to police force because allowed them to get back on the streets faster • Co-location of various services allows for transitions between services and continuation of care	*A campus-centric model with a wide-enough array of medical and behavioral health services at the Safe Haven campus may provide most value for key stakeholders.*
	Innovative delivery models	• Telemedicine is leveraged for practitioners to provide psychiatric consult services to satellite locations in the Crisis Care Center • CHCS contracts with third-party telemedicine vendor	*With a shortage of certain providers, such as psychiatrists, Safe Haven should look at innovative models which have proven success, such as telemedicine consultations.*
	Information technology infrastructure	• Data collection from the very beginning was key to show success in care delivery, diversion, and cost savings • Participating agencies provide robust data to CHCS • Analytics and dashboards help provide leadership identify early trends in changes in outcomes, utilization of services, etc.	*There has been some success in initial efforts for data collection by the Behavioral Health Task Force. These initiatives should be pushed further as showing measured outcomes will be important for stakeholder buy-in and further future development.*
	Facilities	• Efficient use of space with ~60K SQFT	*County's BH needs can be served in a relatively small facility*

Indianapolis, IN

Midtown Community Mental Health Overview

History and Mission: Midtown Community Mental Health is part of Eskenazi Health, a large integrated delivery system that is the safety net provider for Marion County. It was Indiana's first community mental health center and its primary mission is to serve persons with serious mental illness and chronic addiction, as well as seriously emotionally disturbed children and their families. Serves all ages, from children to seniors.

ESKENAZI HEALTH

Midtown Community Mental Health

Services: Midtown has attempted to provide the full continuum of mental health services given the significant needs of the community it serves, even though funding is limited. Services include:

Acute Stabilization / Crisis Unit	Outpatient Art Groups	Prevention and Recovery for Early Psychosis (PARC)	Youth Svcs	Police Outreach
Addiction / Detox	Assertive Comm. Treatment (ACT)	Supported Employment	Inpatient Psychiatric Unit	Jail Reentry
Adult Community Based	Drop in Program	Residential Svcs – Group Home, Transitional Homeless Center	Telehealth (pilot)	

Delivery Model: Both integration into primary care and primary care integration into mental health (the later for patients with severe mental health issues). Staff includes social workers, clinical nurse specialists, and psychiatrists

Population Served: Serve about 16k to 17k unique patients per year, which equates to about 50k visit per year (7-8K patients are chronic). A large portion of clients are Medicaid and Uninsured individuals (33% Medicaid and 37% Uninsured for all Eskenazi OP encounters)

› Eskenazi serves mostly Marion County, with population of ~1mm

Keys to Success

Based on the team's tour of Eskenazi Health Midtown Community Mental Health Center, there were a number of keys to success with lessons and implications for Safe Haven's development:

Category	Key to Success	Description	Implications for Safe Haven
Organizational Alignment	Part of larger health system	• Midtown CMH is part of Eskenazi Health and was the first community mental health center in Indiana • Both Eskenazi Health and Midtown CMH organized under the Health and Hospital Corporation of Marion County	*Midtown CMH has inherent scale, array of services, and negotiating power as part of a larger system. Safe Haven can aim to achieve scale and negotiating power through clinical integration of BH providers in the community.*
	Diversified Advisory Board	• Board make-up consists of a number of key stakeholders. Members include: physician from the FQHC, judge from the community court, local professor, financial consultant, and consumer representation.	*Safe Haven has a large amount of support from a range of key stakeholders. While a Safe Haven Board for decision making is being proposed, an Advisory Board can also be implemented in future phases as Safe Haven grows.*
Financial	Grant Funding	• Despite support from a large system, grants have funded many initiatives • $8.3mm SAMHSA grant to implement SBIRT in 10 clinics and 5 Midtown sites • $1.9mm SAMHSA grant to implement primacy care	*Safe Haven will need to continue focus on diversification of funding, including grant writing, which will take resources and time.*

Keys to Success (cont'd)

Category	Key to Success	Description	Implications for Safe Haven
Operations	Integrated care is more than just co-location	• Primary care physicians need to be prepared to have BH integrated with services • Two different cultures coming together (e.g., PC calls patients and BH calls clients) • Integration is greater than just co-location and must also involve integration of reporting and EMRs • Relationships between physicians and BH providers took time to develop • SAMHSA's 6 levels of integration cited as a useful resource	*As many providers will come together under the Safe Haven campus, there will likely be an adjustment curve for cooperation and coordination. Safe Haven will need to focus on properly aligning incentives and providing infrastructure for proper integration.*
	Outpatient focus can be dependent on staff	• Midtown CMH originally had staffed a crisis respite service with staff rotating on an IP unit, and resulted in the crisis respite center being very similar to an IP model • Changed staff leadership to individuals with an OP background and focus, resulting in desired model	*While the Safe Haven Board will most likely not be making staffing decisions, Safe Haven operators will need to be responsible for desired care environment, metrics and outcomes (e.g., decreased ED utilization).*
	Phased approach	• Similar to Bexar County, the evolution of services at Midtown CMH was a phased approach, with dvlpmn't of most critical services needed at the time • E.g., in 1994 the Central State Hospital closed and Midtown expanded a PHP, sub-acute program, and mobile and residential care capacity	*Safe Haven will focus on immediate needs and early wins before expanding to provide a wider array of services at the campus.*
	Information technology	• Midtown CMH is in process of integrating electronic records with larger system records	*Information Management will be a Goal for Safe Haven*

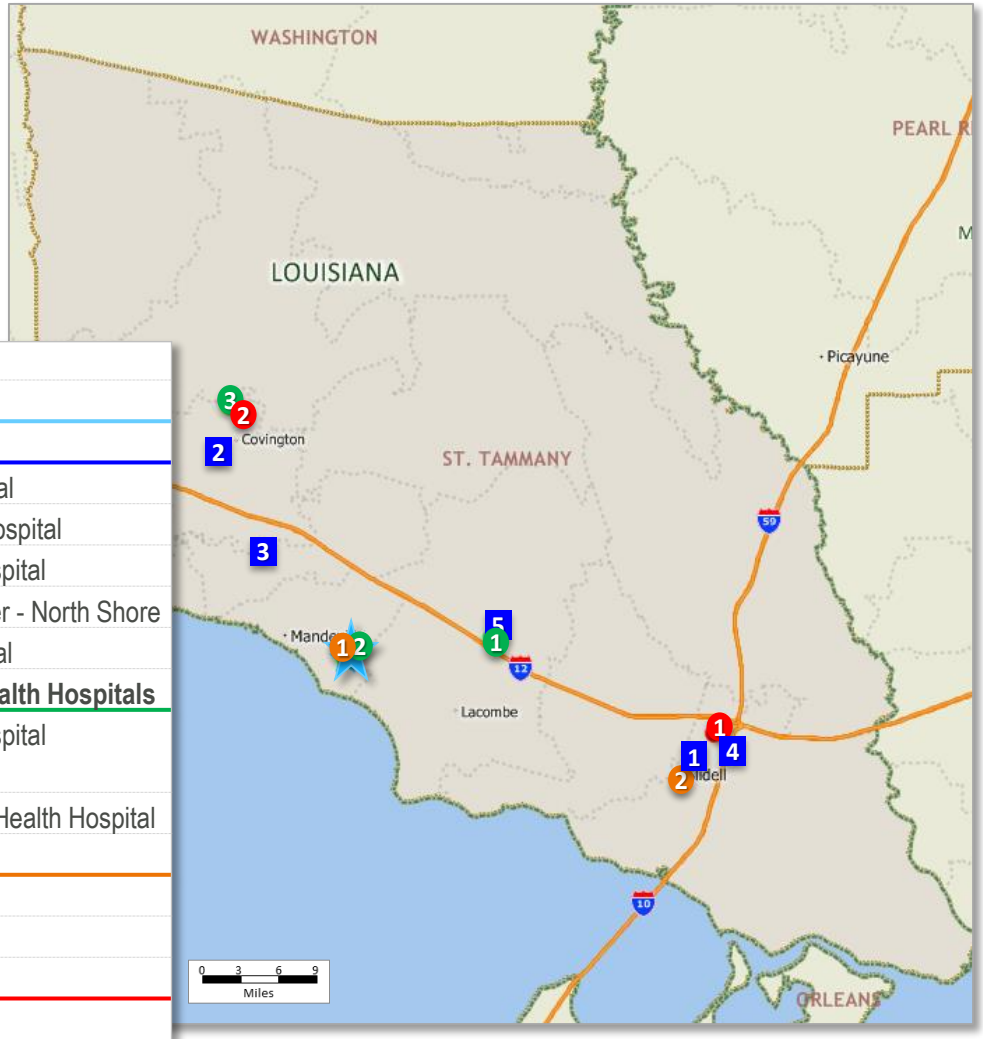
Needs Assessment

Needs Assessment Table of Contents

Population and Demographics

Market Study: Service Area

- The defined service area will be St. Tammany Parish, with potential to expand in later phases of development
  - A number of behavioral health, and emergency rooms, center around Slidell and Covington with fewer access points in Mandeville
  - There is a need for expansion of services outside of the current bi-modal distribution
- The Safe Haven campus is centrally located
  - This is positive for select services that should not be duplicated in the Parish; however, for other services there will likely need to be more convenient access points in Covington and Slidell



#	Location Name
	Safe Haven Campus
	Hospitals
1	Slidell Memorial Hospital
2	St. Tammany Parish Hospital
3	Lakeview Regional Hospital
4	Ochsner Medical Center - North Shore
5	Louisiana Heart Hospital
	Private Behavioral Health Hospitals
1	Beacon Behavioral Hospital
2	Northlake Behavioral
3	Greenbrier Behavioral Health Hospital
	FPHSA Locations
1	Mandeville Location
2	Slidell Location
	STCHC Locations
1	Slidell Location
2	Covington Location

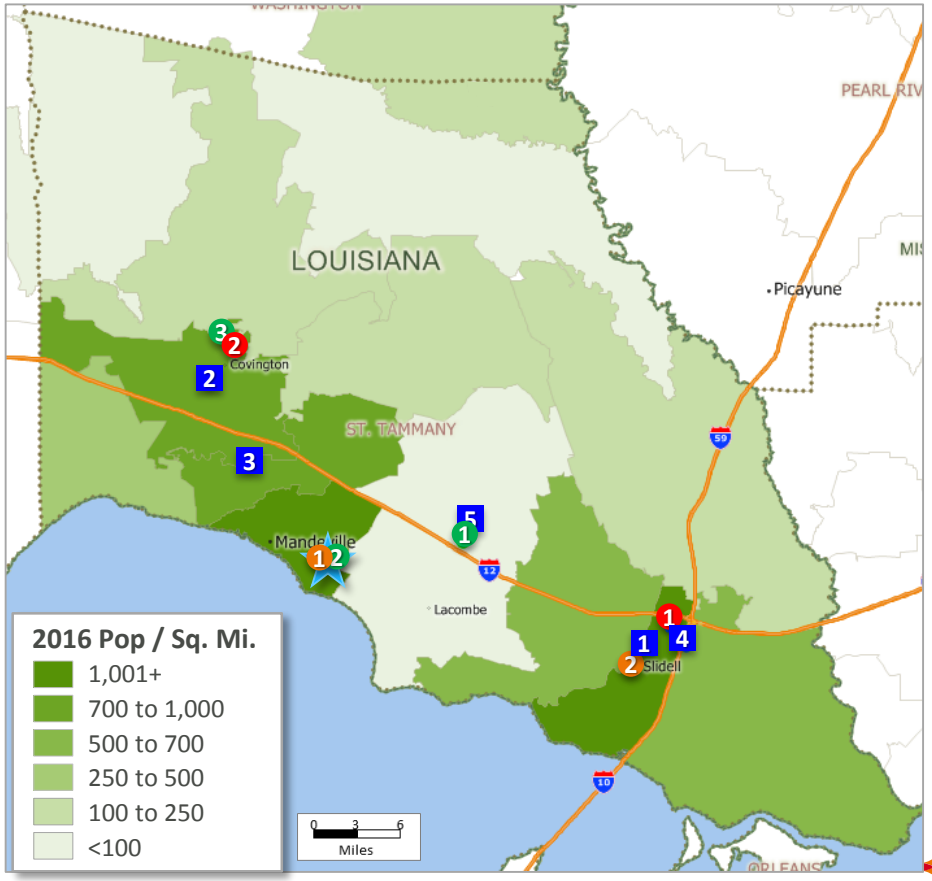
Population Density & Growth

- St. Tammany Parish's population is growing at a faster rate than the rest of Louisiana (0.9% annual growth vs. 0.5%)
- Most of the growth is occurring in/around existing population centers in Mandeville, Slidell, and Covington

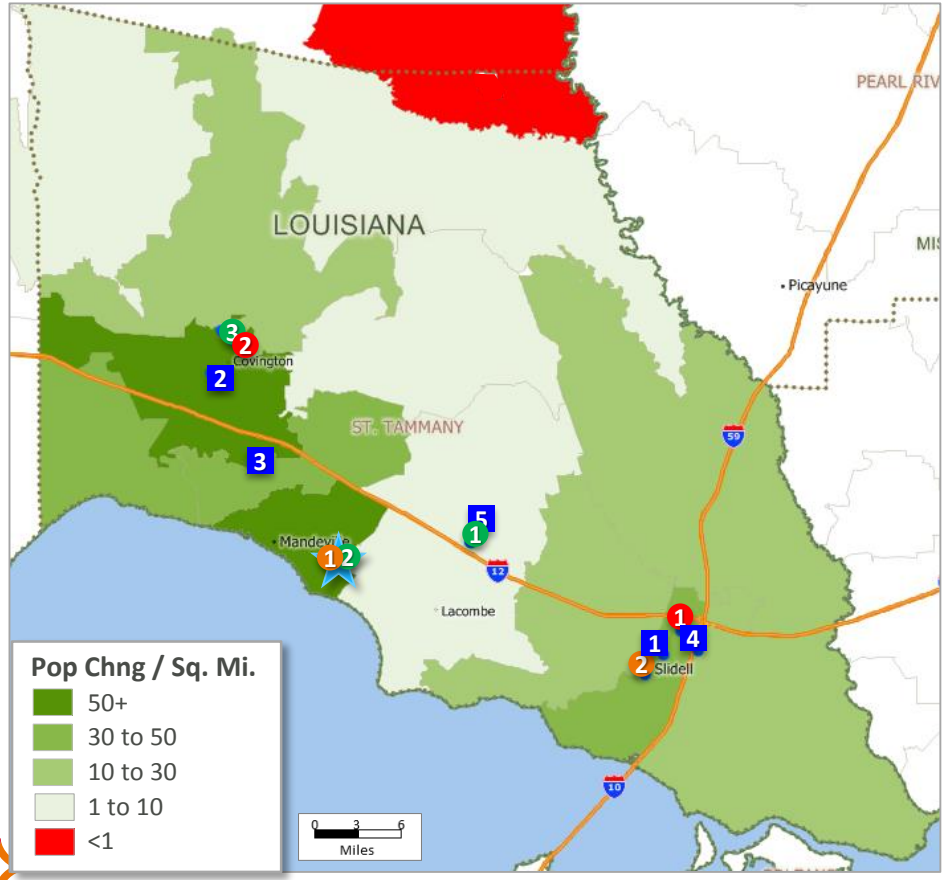
Total Population & Expected Growth Rate

	2016	2021	'16-'21 CAGR
St. Tammany	269K	282K	0.9%
Rest of Louisiana	4,417K	4,538K	0.5%

2016 Population / Sq. Mi.

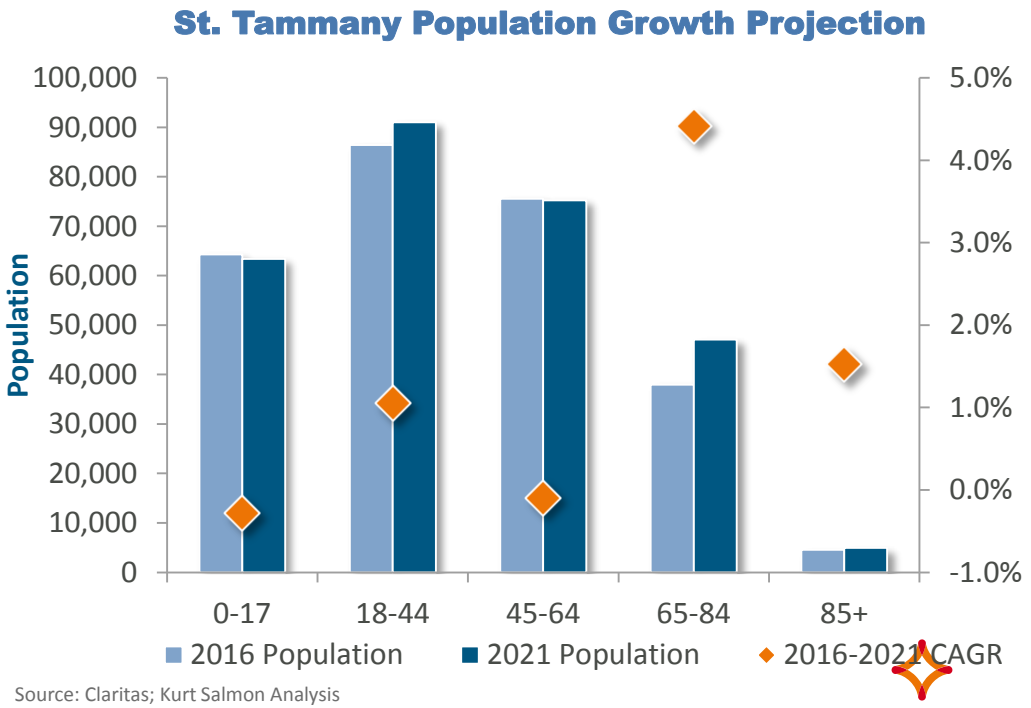


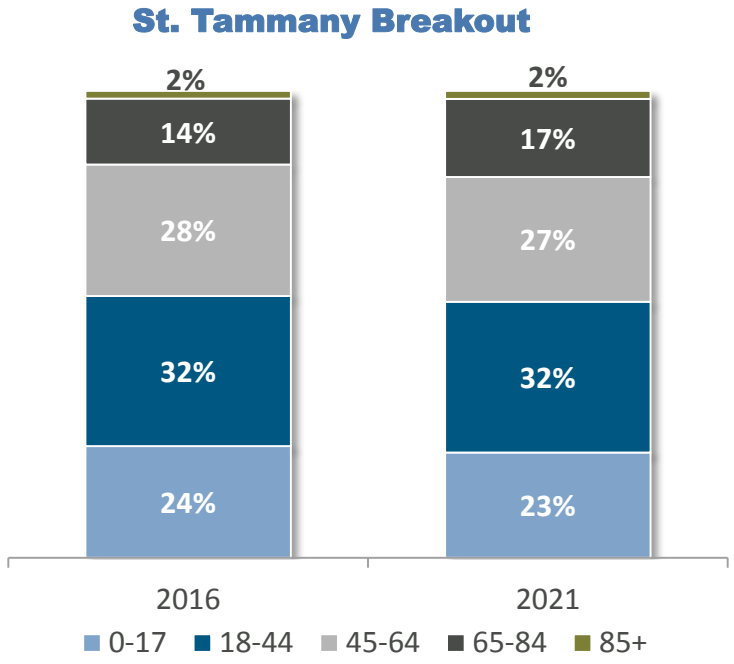
2016-2021 Population Change / Sq. Mi



Demographics

- The 65-84 cohort is growing 2.9x faster than the next fastest cohort, the 85+
  - Surprisingly, the 45-64 age cohort is expected to decline by 0.1% per year over the next 5 years
- As the 65-84 age cohort grows at a high rate, its share of total population will increase from 14% to 17%
- The aging population will increase utilization of all healthcare services in the Parish, furthering the impetus to care for behavioral health needs in the most appropriate environment





Source: Claritas; Kurt Salmon Analysis

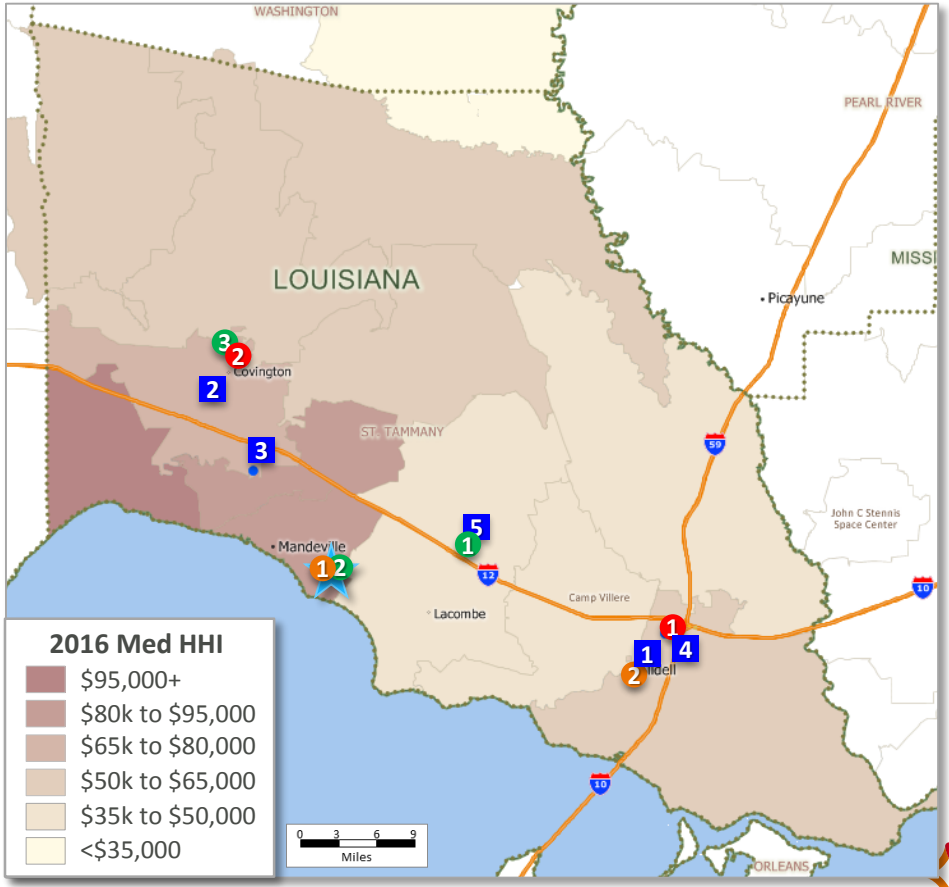
Median Household Income & Change

- St. Tammany has a higher Median Household Income than the State and is expected to grow at a faster annual pace (1.9% vs. 1.6%)
- Median household income is highest around and just west of Mandeville, with high expected growth east of Mandeville

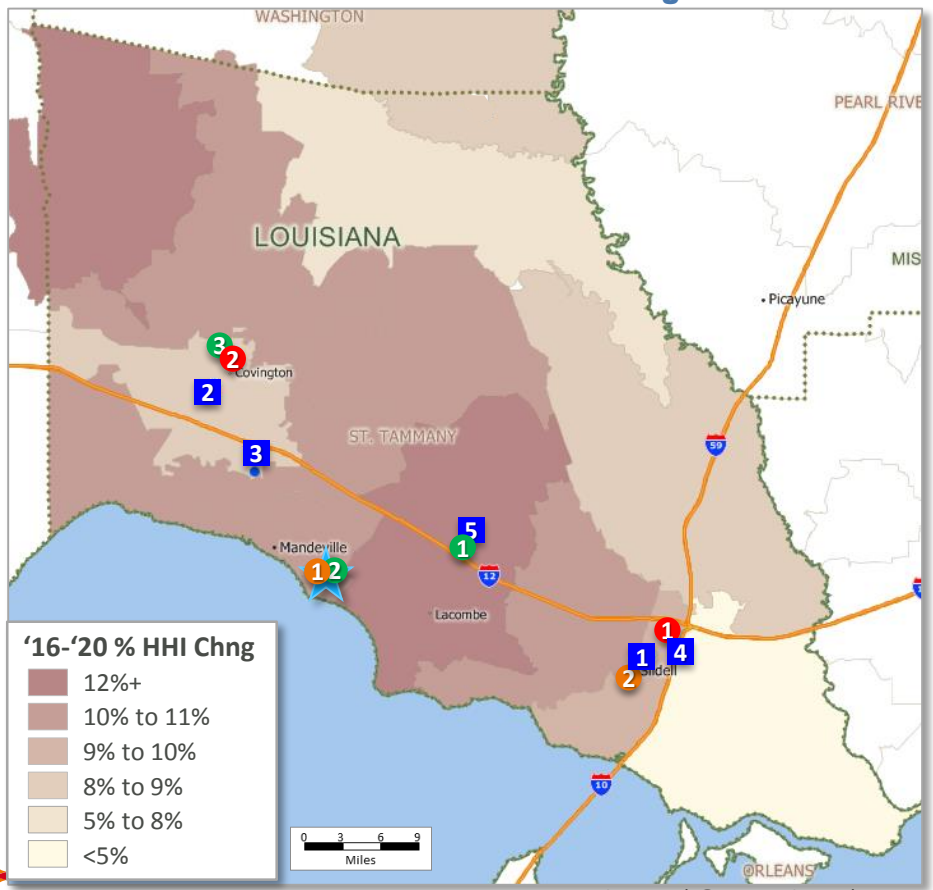
Median Household Income and Estimated Change

	2016	2021	'16-'21 CAGR
St. Tammany	$63,197	$69,460	1.9%
Rest of Louisiana	$47,957	$51,490	1.6%

2016 Household Income



2016-2021 Household Income Change as a %



Source: Claritas; Kurt Salmon Analysis

Gap Analysis

Utilization and Supply of Services

› Based on data and qualitative findings, there is varying utilization and supply by type of service provider

Service Provider	Utilization and Supply Summary
IP BH Hospitals	› 3 for-profit IP BH hospitals (Northlake, Greenbrier, Beacon) all running at full capacity › Patients from the Parish account for 20% of Northlake's volumes and 60% of Greenbrier's › Ample capacity for geri-pscyh IP needs; alternatively, there is a lack of children IP psych beds in the Parish
Emergency Departments	› Emergency departments see long boarding periods for patients with BH needs (up to a week in some cases) › Lack of discharge options to the appropriate environment leads to "frequent flyers" › Most EDs do not have rounding psychiatrists to evaluate patients with psychiatric concerns
Emergency Services	› VOA crisis intervention team and services have decreased due to budget cuts (1 FTE counselor down from 4) › Many times crisis stabilization is occurring in the ED vs. the field given liability concerns › VIA LINK 211 is a shared resource providing a 24/7 crisis intervention hotline, but is an underused resource
Community Centers	› FPHSA and STCHC (FQHC) employ psychiatrists, APRNs, and social workers for mental health needs › Residential care for substance abuse is available through Fontainebleau (24 beds for males, 12 beds for females) › There are no detox units in the Parish
Social Services	› Community social services are at capacity › Housing and residential services have been successful in addressing psycho-social needs and stabilizing individuals before the point of crisis › Funding shortfall is affecting most social services; there are cases where services may be competing for the same grants
Criminal Justice System	› Police force BH training has had some early success › The Behavioral Health Court has shown reductions in recidivism (<10% recidivism[1] for clients completing the program vs. ~50% for total release in St. Tammany Parish[2]) › Courts contract with FPHSA for 250 slots per year; also contracts with Truth 180 for treatment services with success › Jail has 1 FT psychiatrist, 1 social worker, and 5 suicide units with large number of inmates with BH conditions
Government	› Coroner's office has 1 full-time and 3 part-time psychiatrists; OPCs have been steady over the past few years, ~ 240/year
School System	› Employs 2 social workers for screening purposes › While children may have coverage for BH services, families many times do not, leading to a fragmentation of services

Source: Behavioral Health Task Force Dashboard; Interview Findings; Kurt Salmon Analysis
Data provided by 22nd JDC Adult Drug Court; 2010 Regional Probation Information

Gap Analysis

› Based on utilization and supply findings, there are large gaps in detox services, medication management, and crises stabilization

Lower Acuity — LEVEL OF ACUITY — *Higher Acuity*

Service Providers	Transport./ Ind. Housing	Peer Support/ Edu./ Soc'l Svcs	Social Detox	Case Mngt	OP Therapy	Med. Mngt	ACT	Residential Care	IOP	Crisis Stab.	Med. Detox	IP
DEMAND	H	H	H	H	H	H	H	H	H	H	H	M
SUPPLY	L	H	L	M	M	L	M	M	M	L	L	H
GAP	◕	◔	●	◔	◑	◕	◑	◑	◑	◕	●	◔

Legend:
- High Demand or Supply
- Medium Demand or Supply
- Low Demand or Supply

Small Gap ○ ◔ ◑ ◕ ● Large Gap

Source: Kurt Salmon Analysis based on research, data, and interview findings

Scope of Services in the Community

› There are a number of providers treating BH conditions at different points on the care continuum

Lower Acuity — LEVEL OF ACUITY — *Higher Acuity*

Service Providers	Transport./ Ind. Housing	Peer Support/ Edu./ Soc'l svcs	Social Detox	Case Mngt	OP Therapy	Med. Mngt	ACT	Residential Care[2]	IOP	Crisis Int./Stab.	Med. Detox	IP
BH IP Hospital				X	X	X			X			X
EDs						X				X	X	
ViaLink/ 211		X								X		
VOA and Acadian				X						X		
FPHSA[1]		X		X	X	X		X	X			
STCHC/ FQHC		X		X	X	X						
Priv. Psychiatrist					X	X						
Priv. Psychologist				X	X							
NAMI		X						X				
Fam. Promise	X	X										
Cath. Charities		X		X	X							
Fam. Pres. Srvc.				X	X		X					
Symphonia				X	X		X					
YSB		X							X			
School		X		X	X							
Jail			X[3]	X[3]	X[3]	X[3]				X[3]		

Legend:
- Mostly Comm Patients
- Mostly Comm-Medicaid
- Mostly Medicaid/Indigent
- Meets need but not in appropriate environment

Source: Kurt Salmon Analysis

1. Includes Fontainebleau Bleu Services; 2. Includes Group Home services; 3. Appropriate for violent and high-risk inmates

Gaps in Care

› There are a number of gaps in services of which Safe Haven will want to consider in planning scope of services

Lower Acuity — LEVEL OF ACUITY — *Higher Acuity*

Service Providers	Transport./ Ind. Housing	Peer Support/ Edu./ Soc'l svcs	Social Detox	Case Mngt	OP Therapy	Med. Mngt	ACT	Residential Care[2]	IOP	Crisis Int./Stab.	Med. Detox	IP
BH IP Hospital				X	X	X			X			X
EDs						**X**				X	**X**	
ViaLink/ 211		X								X		
VOA and Acadian				X						X		
FPHSA[1]		X		X	X	X		X	X			
STCHC/ FQHC		X		X	X	X						
Priv. Psychiatrist					X	X						
Priv. Psychologist				X	X							
NAMI		X						X				
Fam. Promise	X	X										
Cath. Charities		X		X	X							
Fam. Pres. Srvc.				X	X		X					
Symphonia				X	X		X					
YSB		X							X			
School		X		X	X							
Jail			**X[3]**	**X[3]**	**X[3]**	**X[3]**				**X[3]**		

Legend:
- Mostly Comm Patients
- Mostly Comm-Medicaid
- Mostly Medicaid/Indigent
- Meets need but not in appropriate environment
- Gaps in Services

Source: Kurt Salmon Analysis

1. Includes Fontainebleau Bleu Services; 2. Includes Group Home services; 3. Appropriate for violent and high-risk inmates

Overlapping Services

› There are a number of overlaps in services Safe Haven could help coordinate to create a more efficient system

Lower Acuity — LEVEL OF ACUITY — *Higher Acuity*

Service Providers	Transport./ Ind. Housing	Peer Support/ Edu./ Soc'l svcs	Social Detox	Case Mngt	OP Therapy	Med. Mngt	ACT	Residential Care[2]	IOP	Crisis Int./Stab.	Med. Detox	IP
BH IP Hospital				X	X	X			X			X
EDs						**X**				X	**X**	
ViaLink/ 211		X								X		
VOA and Acadian				X						X		
FPHSA[1]		X		X	X	X		X	X			
STCHC/ FQHC		X		X	X	X						
Priv. Psychiatrist					X	X						
Priv. Psychologist				X	X							
NAMI		X						X				
Fam. Promise	X	X										
Cath. Charities		X		X	X							
Fam. Pres. Srvc.				X	X		X					
Symphonia				X	X		X					
YSB		X							X			
School		X		X	X							
Jail			**X[3]**	**X[3]**	**X[3]**	**X[3]**				**X[3]**		

Legend:
- Mostly Comm Patients
- Mostly Comm-Medicaid
- Mostly Medicaid/Indigent
- Meets need but not in appropriate environment
- Overlapping Services

Source: Kurt Salmon Analysis

1. Includes Fontainebleau Bleu Services; 2. Includes Group Home services; 3. Appropriate for violent and high-risk inmates

Gap Analysis Implications for Safe Haven

› Safe Haven could aim to anchor the major gaps while acting as a central location to coordinate other services on the campus

Anchors	Considerations
Medication Management	Innovative delivery methods and/or pooled contracts with consulting psychiatrists should be explored given the limited psychiatrists, and cost of psychiatrists, in the community
Social Detox	• A major need in the Parish • Intake process will need to be carefully planned if diverting from ED or jail
Medical Detox	
Crises Stabilization	Intake process will need to be carefully planned if diverting from ED or jail
Additional Services	**Considerations**
Transportation	Transportation to the Mandeville-based campus should be evaluated given the bi-modal distribution of services and residents between Covington and Slidell
Peer Support/ Edu./ Soc'l svcs	• All these services are currently found in the community in varying supply • Centralization of services at Safe Haven Campus can help increase efficiencies and savings through shared resources • Safe Haven Campus centralization can increase coordination of services and help address fragmented nature of behavioral health care in the Parish
Case Management	
OP Therapy	
ACT	
Residential Care	
IOP	

Source: Claritas; Kurt Salmon Analysis

Safe Haven Vision and Goals

Safe Haven Vision and Goals Table of Contents

Vision and Goals

Preferred Direction

- Based on interview findings, stakeholders envision various levels of commitment and ideas for the Safe Haven Campus.
- The Task Force concluded that all of the levels should be included in the plan (although some phasing may be necessary)

"Fill the Gap"

- Fill the gap of unmet BH needs in St. Tammany Parish
- Change the portal of entry for BH patients in crisis
- Ensure patients in crisis or in need of detox are being cared for in the most appropriate setting
- Primarily serves Medicaid and indigent populations and others in BH crisis

"Coordinate the BH Continuum"

- Provide the continuum of BH and psycho-social services
- Create a prominent and single entry portal for BH patients
- Nexus of collaboration/ coordination of BH and social services in the community
- Provide space that collocates organizations that provide for this patient population and enhances collaboration

"Healing Campus"

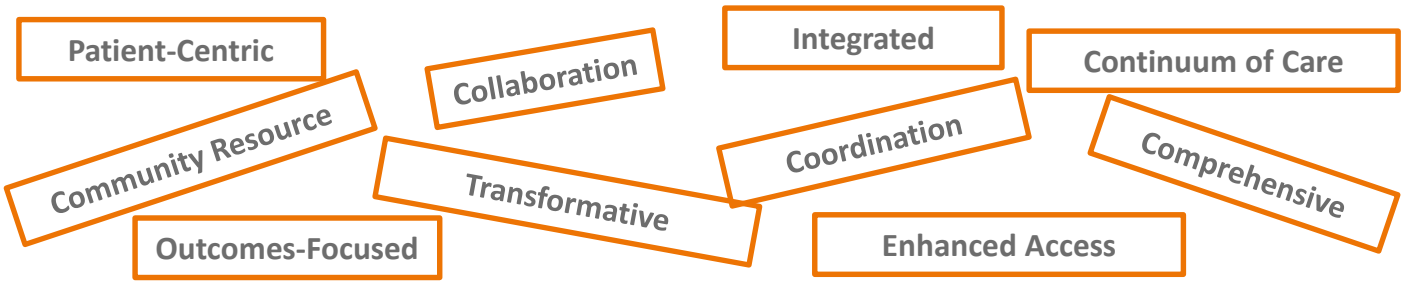
- Community resource beyond behavioral health (e.g. Farmer's market); broader vision including Pelican Park
- Mix of public and private services through collaboration (private psychiatrist and other HC providers)
- Utilized by all St. Tammany Parish residents
- Epicenter of Behavioral Health and Medical Health integration for some residents

Visioning: Strategic Plan Framework

The team developed the Safe Haven Vision, Goals, and Tactics with a structured framework

Vision Statement

Key Visioning Elements



Safe Haven Proposed Vision Statement

Safe Haven will provide a collaborative healing environment for the behavioral health continuum by creating a high-quality, coordinated, sustainable and humane network of care anchored in St. Tammany Parish.

Goals

› The following goals were developed based on key tenets, direction, and vision for Safe Haven.

Goals	Description
1. **Organizational Framework**:	Create an organizational framework and governing body to effectively coordinate and develop services for the community
2. **ED Diversion**:	Support meaningful programs to ensure patients receive care in the most appropriate setting to foster recovery
3. **Jail Diversion**:	Support meaningful programs at all points of diversion to decriminalize behavioral health and ensure people receive respectful and humane care during times of need
4. **Access**:	Enhance access to high quality behavioral health services and fill service gaps in the community
5. **Information Management**:	Develop infrastructure and processes to enhance data capture and information sharing to better coordinate care and demonstrate outcomes
6. **Financial**:	Create a financially-sustainable service to the community
7. **Healing Environment**:	Offer supportive services to create an environment of recovery for individuals with behavioral health and social support needs

Anticipated Outcomes

Organizational Framework	Create foundation to ***coordinate*** behavioral health ***services in the community***
ED Diversion	Reduce the ***$3.2mm***[1] annual costs to EDs for ***2,160*** BH visits
Jail Diversion	Create annual savings through decriminalization of BH (e.g., savings can range from ***$3.3mm - $6.9mm***[2] based on Bexar County scale)
Access	Create earlier access to produce savings of ***$1.8mm***[1] in avoidable IP psychiatric admissions
Information Management	Share standardized information between providers to ***better serve the patient***
Financial	Create ***sustainable*** behavioral health ***services for the community***
Healing Environment	***Enhance access*** to housing and social support services for ***vulnerable individuals***

1. Provided by BHTF in February 2016: Found on "Cost of Behavioral Health Patients to Hospital Emergency Departments" and "Cost of Behavioral Health Patients to IP Psych Hospitals" tables
2. Based on 7K individuals diverted at Bexar County with a population of 1.8mm

Detailed Strategies

Goal #1: Organizational Framework

Goal: Create an organizational framework and governing body to effectively coordinate and develop services for the community

Draft Strawman Strategies for Discussion

1.1 **Governance Model**– Develop a shared governance model inclusive of the Safe Haven tenants to make decisions about the campus, ensure collaboration, and monitor performance.

1.2 **Service Coordination** – Centralize care and case management services to standardize care plan development, create efficiencies and streamline communication between providers across the care continuum.

1.3 **Clinical Integration** – Develop a clinically integrated entity with the ability to jointly contract to provide reimbursement for innovative care models and ensure incentives are aligned across the Safe Haven providers.

1.4 **Shared Services** – Over time create savings through centralizing administrative and support services where possible.

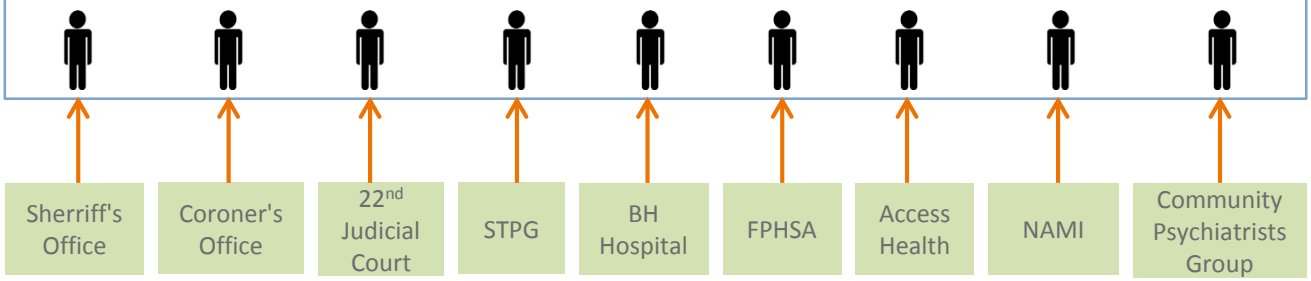
Governance Structure

- A governance structure is needed to ensure decisions regarding services to be offered on the campus, determine site operators, and monitor performance. The Board will also provide recommendations on budget and capital expenditures.
  - The community-based Behavioral Health Task Force will remain intact and provide a forum for all stakeholders to engage in ways to improve the BH system

Illustrative example

Safe Haven Governance Board

- Representative(s) from the most highly-aligned stakeholders will act on the Safe Haven Board



Decision Making

- Decide on continuing or discounting services at the campus
- Establish guidelines for contracts with operators
- Monitor performance
- Provide recommendations on budget decisions and capital expenditures

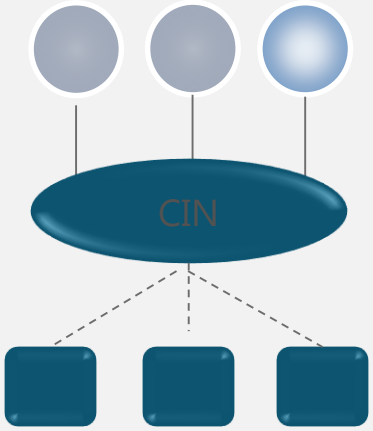
Safe Haven Campus Operators

Clinical Integration Strategy

Due to shifting regulations, financial reimbursement models, and patient preferences, healthcare providers are making a number of build/buy/partner decisions to adapt to this new landscape

- Providers in Louisiana are moving towards a Clinically Integrated Network (CIN) strategy led by Ochsner Health's efforts
- Safe Haven has an opportunity to develop clinically integrated mental health services that can add value to a larger CIN network because of the broad span of care continuum services on the Safe Campus but can also contract directly with payors such as the Bayou Health Plans

Clinically Integrated Network



Multiple Systems create a clinically integrated contracting vehicle comprised of hospitals and physicians.

CIN enters into contracts with Payers (or direct contracts with employers) for value-based reimbursement

Key Components:

Care Protocols
Patient Registries
Care Coordination
IT Integration
Joint risk-based contracting

Goal #2: ED Diversion

Goal: Support meaningful programs to ensure patients receive care in the most appropriate setting to foster recovery

Draft Strawman Strategies for Discussion

2.1 **Training –** Promote Crisis Intervention Team (CIT) training programs for all first responders, such as police force, EMTs, emergency room personnel, and 911 operators.

2.2 **Crisis Intervention –** Promote programs for crisis intervention professionals to integrate with community first responders (police force and EMTs).

- Standardize assessment and care model with medical clearance in the field
- Mental Health Unit within the Sheriff's Department

2.3 **Crisis Stabilization –**Create a crisis stabilization program at the Safe Haven campus, that provides 24/7 access to behavioral health support in the least restrictive environment for individuals in crisis.

Goal #3: Jail Diversion

Goal: Support meaningful programs, such as the specialty courts, to decriminalize behavioral health and ensure people receive respectful and humane care during times of need

Draft Strawman Strategies for Discussion

3.1 **Training –** Promote Crisis Intervention Team (CIT) training programs for all first responders, such as police force, EMTs, and emergency hotline operators.

3.2 **Criminal Justice System Integration –** Closely integrate Safe Haven campus with the criminal justice system, including the District Attorney's Office and the Judicial System (including the Specialty Courts).

- Standardize assessment tool across crisis intervention (mobile unit, Safe Haven triage and assessment, pre-trial, jail, specialty courts, etc.)
- Provide a centralized location for clients in specialty courts to receive services
  - Locate specialty court probation officers on the Safe Haven campus
  - Consider locating specialty court and magistrate functions on the Safe Haven campus in later phases

3.3 **Police Turnaround** – Ensure everything is in place for law enforcement to comfortably drop off patients efficiently at Safe Haven ("One-Stop Shop") including medical and behavioral health assessments by appropriate clinical professionals.

Goal #4: Access

Goal: Enhance access to high quality behavioral health services and fill service gaps in the community

Draft Strawman Strategies for Discussion

4.1 **Transportation –** Examine innovative transportation models (e.g., ride sharing) for patients that have transportation needs.

4.2 **Operational Performance Review –** Review operational performance on the shared board and hold agencies accountable for meeting established benchmarks.

4.3 **Integrated Primary Care Delivery Model –** Provide integrated medical and behavioral health care.

4.4 **Medical Detox** – Create access to medical detox services for St. Tammany parish residents either on the Safe Haven campus or through collaboration with other organizations.

4.5 **Innovative Delivery Models –** Explore innovative delivery models, such as telemedicine, to increase access for services with limited supply of providers (e.g., psychiatry, counseling).

4.6 **Psychiatry Medical Group** – Explore the potential to consolidate public funding for psychiatrists in the Parish to help financially support the creation of a psychiatry medical group at the Safe Haven campus.

Goal #5: Information Management

Goal: Develop infrastructure and processes to enhance data capture and information sharing to better coordinate care and demonstrate outcomes

Draft Strawman Strategies for Discussion

5.1 **Information Technology Infrastructure -** Invest in technology infrastructure to allow for accurate capture of data, enhanced data sharing, and analytics and reporting capabilities while ensuring all privacy laws and the protection of individuals' rights are upheld.

5.2 **Identify Metrics -** Identify meaningful outcome metrics to be tracked through a shared dashboard between agencies.

5.3 **Stakeholder Reports -** Develop standard annual reports to show outcomes and results (e.g., increased quality of care, cost savings, etc.) with key stakeholders.

Goal #6: Financial

Goal: Create a financially-sustainable service to the community

Draft Strawman Strategies for Discussion

6.1 **Financial Commitments -** Secure ongoing financial commitments from public and private organizations that will benefit from the services provided.

6.2 **Philanthropic Fund Raising -** Develop fund raising activities (e.g., yearly gala, sporting event, etc.) and sponsorships (e.g., Platinum, Gold, or Silver Donors) with the private sector and community members.

6.3 **Grant Fund Raising** – Centralize grant writing and focus on both individual and collaborative grants for the Safe Haven providers.

6.4 **Social Services** – Provide support for clients to access social services at Safe Haven including helping individuals navigate forms and applications for available coverage.

6.5 **Contract with Payors –** Collaborate with payors using the Safe Haven clinically integrated network to develop innovative funding mechanisms for the services provided.

Goal #7: Healing Environment

Goal: Offer supportive services to create an environment of recovery for individuals with behavioral health and social support needs

Draft Strawman Strategies for Discussion

7.1 **Wrap Around Supportive Services –** Support programs that provide wrap-around services for Safe Haven clients and providers including administrative services, community social services, education/training programs, and transportation programs.

7.2 **Housing Services –** Support programs that offer housing services for individuals with behavioral health needs.

Safe Haven Model

Safe Haven Model Table of Contents

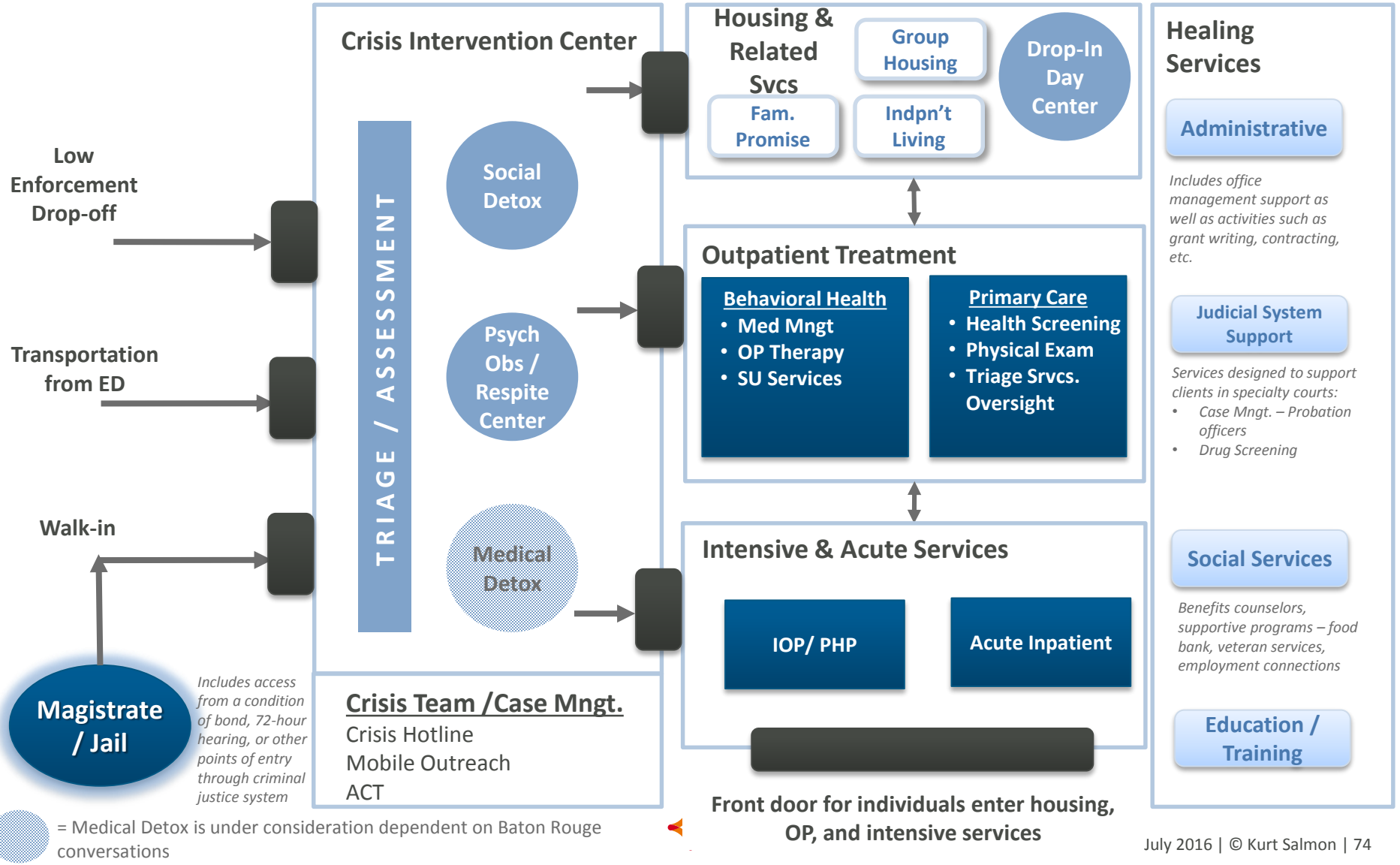
Safe Haven Model

Safe Haven Model Services Approach

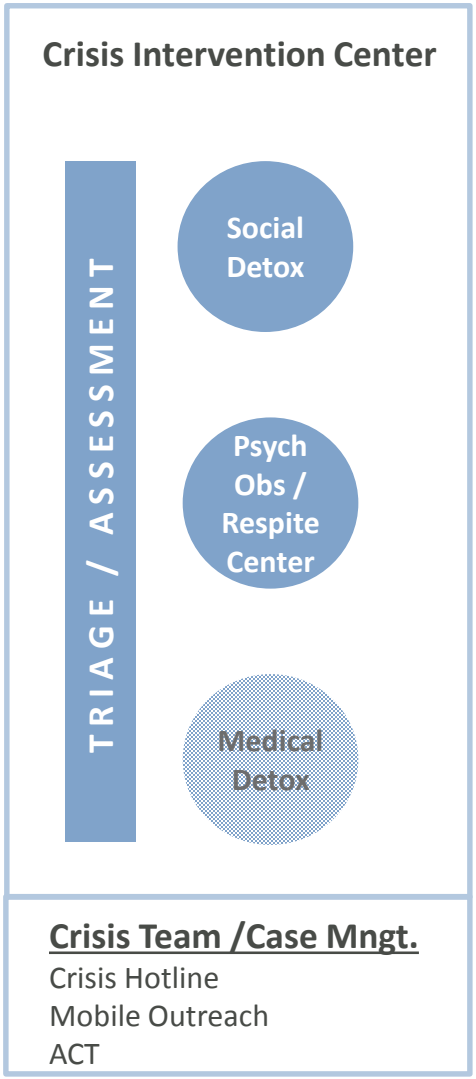
The following process was used in determining the scope of services at Safe Haven and complementary facility needs and size

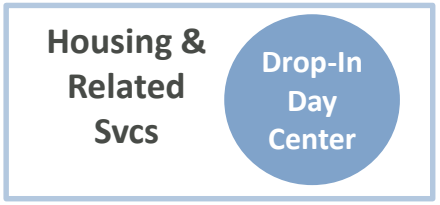
Step in Process	Inputs
1. Define Services	• Interviews • Market Study • Gap analysis and community needs assessment • Core Team Work Sessions
2. Estimate Patients Served	• Service area population and population growth • Population incidence rates by mental illness (MI) / substance use (SU) and severity and homeless with MI/SU • Population use rates of services
3. Determine Facility Needs	• Triangulate population use rates and incidence rates to facility need ranges • Facility dimensions and characteristics • Determine optimal facility layout

Safe Haven Model



Services Definition





Drop-In Day Center – Peer- run program for psycho-social rehabilitation, no medical support, NOT 24/7 operation; currently under development by NAMI

Triage / Assessment – First stop for many Safe Haven Clients; 24/7 Medical Clearance and Initial Behavioral Health evaluation (LCSW) to determine appropriate Safe Haven service

Social Detox – 24/7 Voluntary Sobering Unit staffed by EMT, Peer Counselors, PA-C on-site but not medically monitored, < 12 hr. stay

Psych Obs / Respite Center – Medically monitored, observation unit, access to psychiatric evaluation 24/7 supported by telehealth, patients have access to prescriber, 48-72 hr length of stay, can be walk in or referred by triage

Medical Detox * - Medically monitored detox center, 5-7 day length of stay, staffed by PA, APN, LVN, CAN

Centralized Crisis and Case Management Office– Enhances collaboration between entities, crisis hotline representatives can more easily direct to services at Safe Haven, Case Managers will know if patients enter Safe Haven

* Medical Detox is under consideration dependent on Baton Rouge conversations

Sizing

Safe Haven Sizing Approach

The following process was used in determining the scope of services at Safe Haven and complementary facility needs and size

Step in Process	Inputs
1. Define Services	• Interviews • Market Study • Gap analysis and community needs assessment • Core Team Work Sessions
2. Estimate Patients Served	• Service area population and population growth • Population incidence rates by mental illness (MI) / substance use (SU) and severity and homeless with MI/SU • Population use rates of services
3. Determine Facility Needs	• Triangulate population use rates and incidence rates to facility need ranges • Facility dimensions and characteristics • Determine optimal facility layout

Facility Need Approach

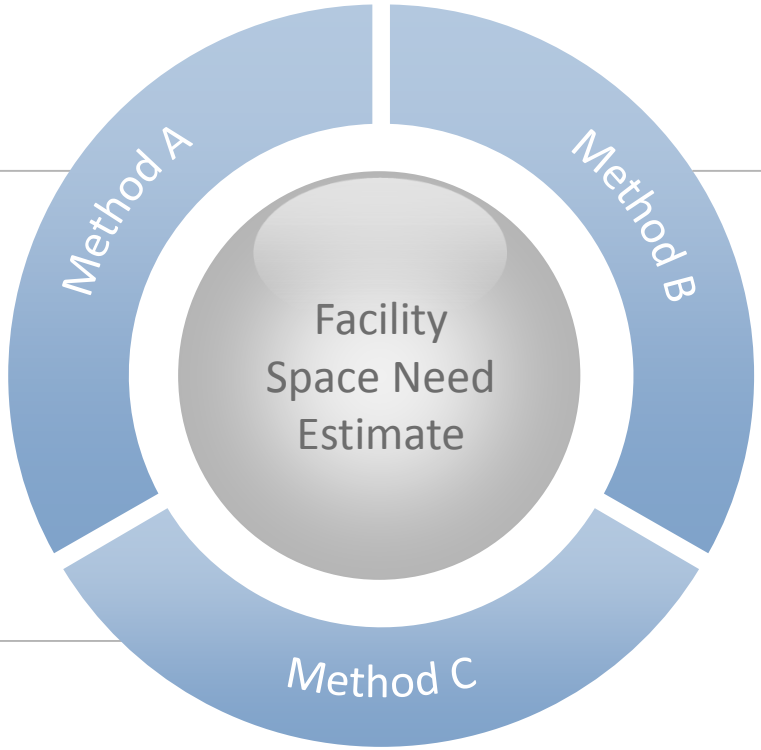
Kurt Salmon used a three-pronged approach to triangulate the facility need range at Safe Haven for Core Services (Social Detox, Psych Obs/Respite, Medical Detox)

Assets to Population Benchmarks

Applied average peer facility benchmarks to population ratios to St. Tammany population based on experience at Center for Health Care Services and Midtown Community Mental Health

Incidence Rates

Applied national rates for MI, SU, and homelessness with MI to St. Tammany population to understand total patients that may be served by Safe Haven (in appendix)



ED Utilization Estimates

Estimated St. Tammany Parish avoidable ED volumes due to mental health and substance abuse-related conditions

Facility Needs

Asset needs by service have been estimated based on peer facility asset to population benchmarks and compared against St. Tammany Parish ED volumes which may have been diverted

A Service	2021 St. Tammany Parish Population[1]	Peer benchmarks per 100K Pop.	Facility Needs[2]
Social Detox	281,767	1.1[3]	3 - 4 beds
Psych Obs / Respite Care	281,767	2.7[4]	6 – 8 beds
Medical Detox	726,809[5]	1.3[6]	8-10 beds

B Service	(a) National ED Adult Use Rate[7]	(b)Total ED Volumes that Involve a BH Diagnoses[8]	(c) % with Diagnosis as Mood Disorder or Anxiety[8]	Avoidable ED Visits in St. Tammany Parish (pop*a*b*c)		Throughput	Facility Needs[2] (Avoidable ED Visits * Throughput in days / 365)
Triage/Assessment	18%	12.5%	68.8%		4,360	12 visits/day	2 - 3 exam rooms
Psych Obs/ Respite Center				30%	1,308	48 hours	7 beds

1 Claritas population estimates 2016-2021
2 Facility needs range to allow for flexibility in client flows during busy hours and seasonal upticks
3 Based on 20 beds/spots for population of 1.8mm in Bexar County
4 Based on average of psych obs needs of 10 units for population of 923K at Eskenazi and psych Obs of 16 beds for pop. of 1.8mm in Bexar County plus 16 beds for sub-acute crisis respite and population of 923K at Eskenazi
5 Includes both St. Tammany Parish and East Baton Rouge population
6 Based on 24 bed unit with a population of 1.8mm at Bexar County
7 Reasons for Emergency Room Use Among U.S. Adults, Aged 18–64: National Health Interview Survey
8 Mental Health and Substance Abuse-Related Emergency Department Visits among Adults

Patient Estimates Approach

› Based on national incidence and use rates, individuals with behavioral health needs have been estimated for St. Tammany Parish

Condition	2021 St. Tammany Parish Population[1]	Incidence Rate	% that Seek Care	% Served by Safe Haven	Clients to be Served by Safe Haven
Severe Mental Illness (SMI)	281,767	4.1%[3]	62.9%[5]	100%	7,264
Any Mental Illness (AMI) Excluding SMI	281,767	14.0%[3]	41.0%[5]	100%	16,168
Illicit Drug AND Alcohol Abuse	*281,767*	-	*0.4%[6]*	*100%*	*1,127*
Illicit Drug OR Alcohol Abuse	*281,767*	-	*1.1%[6]*	*100%*	*3,098*
Illicit Drug AND/OR Alcohol Abuse	-	-	-	-	4,225
Homeless with Mental Illness or Substance Use	143[2]	46%[4]	-	100%	66

1 Claritas population estimates 2016-2021
2 Includes Slidell Sheltered and Unsheltered Individuals; provided by NAMI
3 SAMHSA 2014 Study: Figure 39. http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.htm#idtextanchor074
4 NAMI; Incidence of Homeless with MI and/or SU: https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers
5 NAMI: https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers
6 RESULTS FROM THE 2014 NATIONAL SURVEY ON DRUG USE AND HEALTH: DETAILED TABLES; Table 5.21B

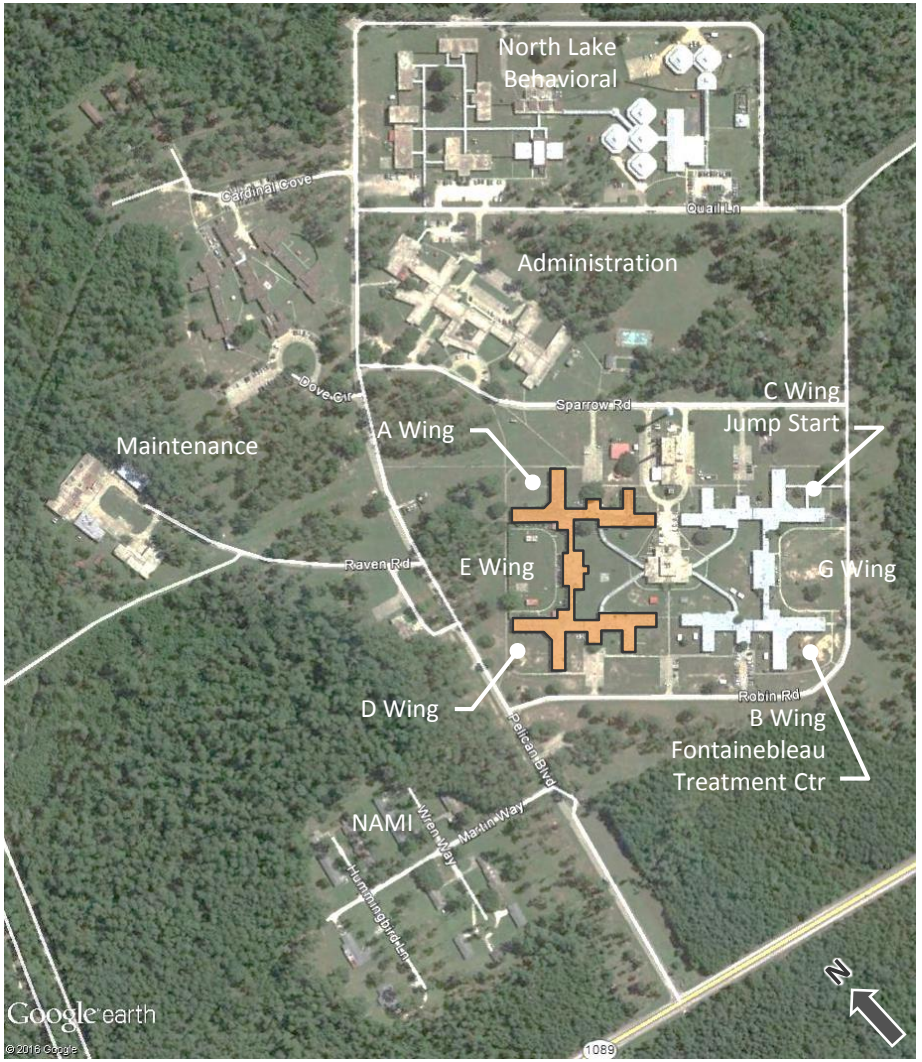
Master Facility Plan

Master Facility Plan Table of Contents

Facility Options

Safe Haven Campus Overview

- With Northlake Hospital to the north, NAMI residences to the south, Jump Start, and Fontainebleau Treatment Center "next door," the Safe Haven campus provides an opportunity to create a comprehensive, "one stop" for BH services in the St. Tammany Parish
  - ~296 acre property
    - 100 acres transferred to Pelican Park to accommodate bypass road and park expansion
    - Area north of Sparrow Road has been sold to North Lake Behavioral Health System (Meridian)
  - The A, E, and D wings are vacant and are good candidates for the proposed Crisis Intervention Center and potentially other services
  - As the scope of services is finalized and facility options are developed, it would be important to investigate the space in the available wings and confirm next steps to get it ready for re-use:
    - Opportunities to modify current layout to best fit the Crisis Intervention Center and other potential future uses
    - Remediation and renovation needed to bring wings A, E, and D "online" over time
    - Central Plant capacity needed to adequately accommodate new services
  - It is recommended that a high-level engineering assessment be completed to understand the order-of-magnitude capital implications to re-use all or a portion of available space in wings A, E, and D



Source: Parish Government, News Articles, Kurt Salmon review

Key Drivers for Facility Development

The following are facility planning drivers that serve as a guide to developing options for the Crisis Intervention Center:

a) Create a facility solution that will enable Parish Government to achieve its vision of creating a comprehensive Behavioral Health service portfolio for its citizens

b) Provide a financially viable solution while adequately addressing the behavioral health needs in the Parish

c) Maximize use of existing assets

d) Enhance accessibility and convenience for patients and families

e) Provide flexibility and expandability

Approach and Sizing

The order-of-magnitude scale for the Crisis Intervention Center is estimated based on potential demand and available space on the Safe Haven Campus:

a) Sizing for the Crisis Intervention Center is based on the following:
   - Facilities tour of Haven for Hope Campus in San Antonio
   - Facilities tour of Midtown Community Mental Health in Indianapolis
   - Kurt Salmon experience with similar programs

b) The actual scale of the programs in the facility options are dictated by the existing layout and square footage available on the Safe Haven campus

Program / Department	Key Components	Order of Magnitude Space Allocations
Check-in / Triage / Waiting	2-4 Triage Rooms, Check-in Desk, Security, Waiting, Staff Workstations, Case Management	2,000 – 2,500 DGSF
Social Detox	3-6 beds (mattresses on the floor), office, EMT desk	500 – 800 DGSF
Psych Obs / Respite Center	6-8 beds (combination of private and semi-private), offices, support	3,000 – 3,500 DGSF
Medical Detox*	8-10 beds (combination of private and semi-private), offices, support	3,500 – 4,000 DGSF
Common Areas Supporting Beds	Nursing Station, Day Room, Dining, Storage	1,500 – 2,000 DGSF
Primary Care / Other OP Services, Social Services, Education / Training	4-6 exam rooms, Therapy, Offices, Meeting / Conference Rooms etc.	8,000 – 9,000 DGSF
TOTAL		**18,500 – 21,800 DGSF**

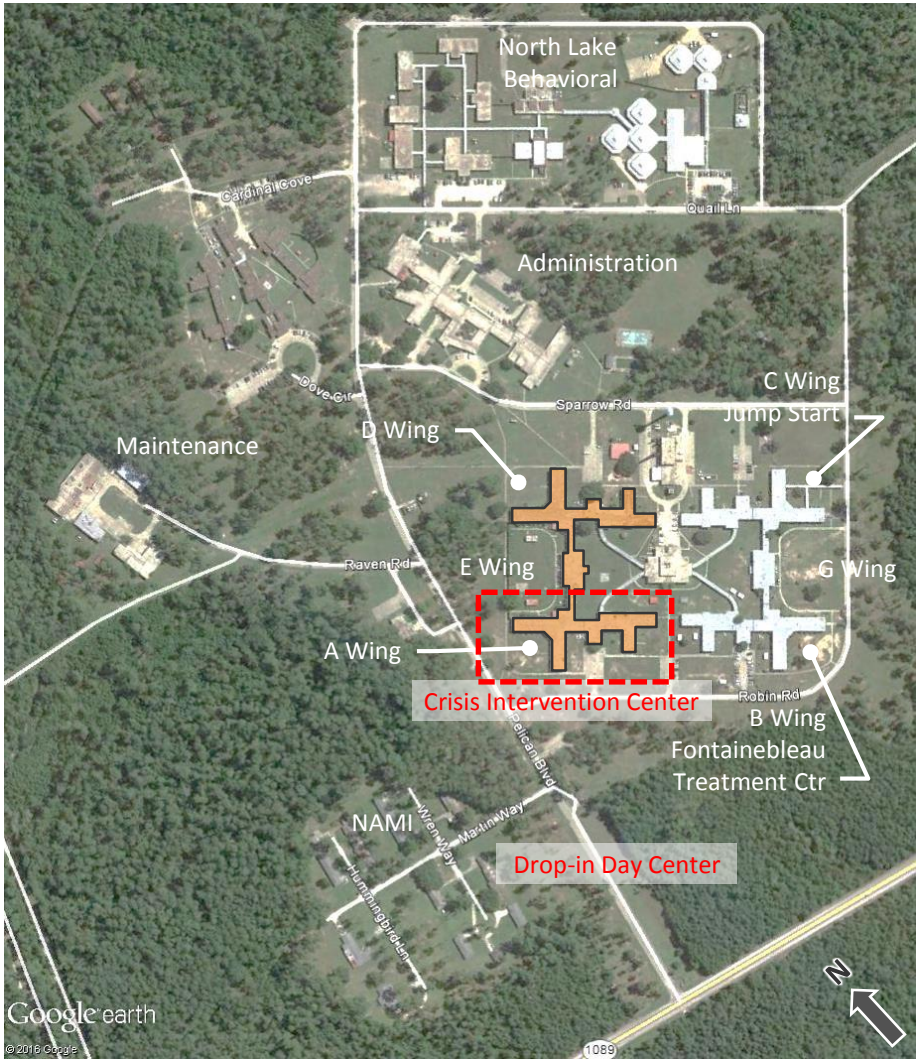
*Possible Future Expansion
DGSF = Departmental Gross Square Feet

Distribution of Services

The A Wing represents a more desirable location for the Crisis Intervention Center

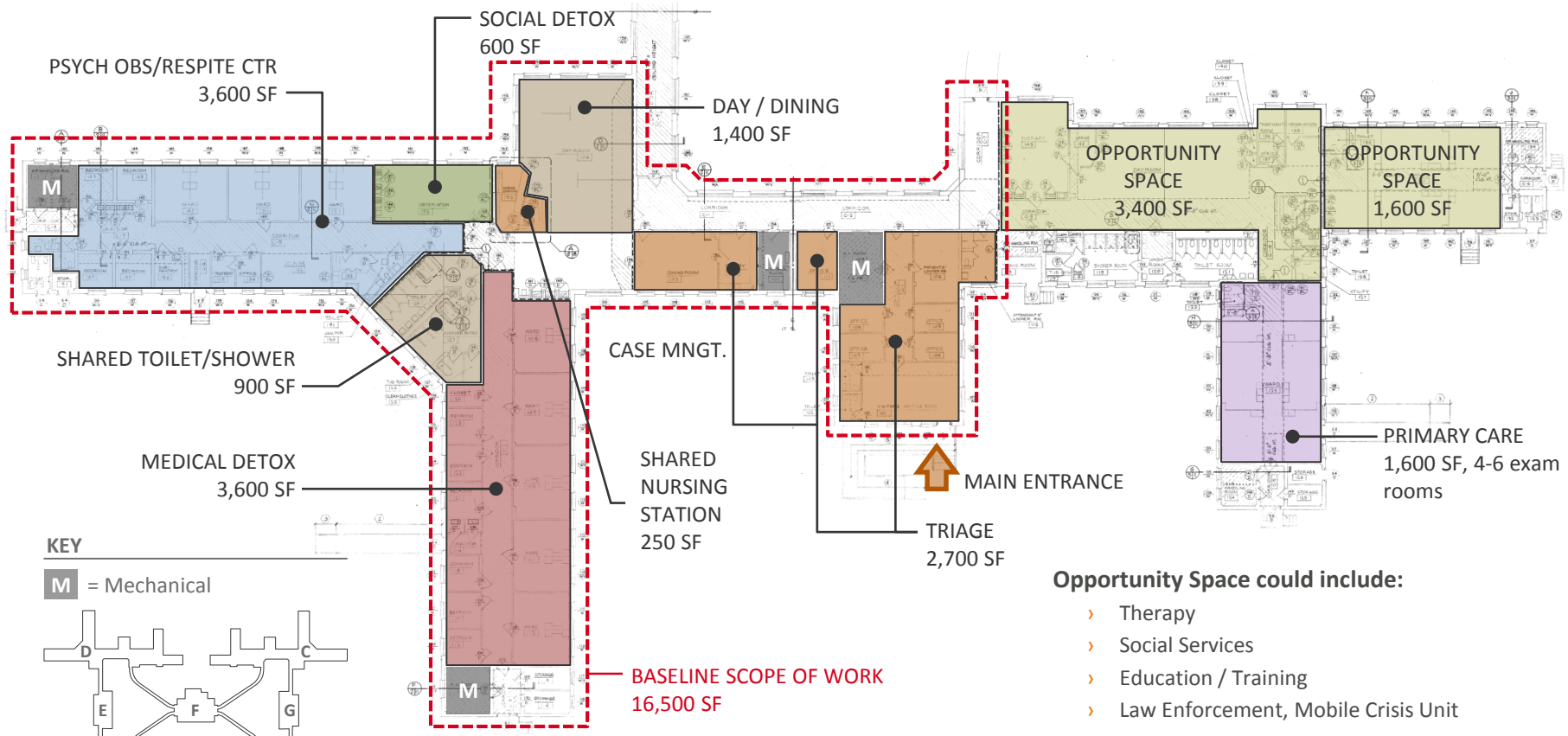
- More visible from the main entrance to the campus
- Easily accessible from Pelican Blvd.

It is assumed that the Drop-in Day Center will be located at the NAMI residences



With Medical Detox

"Core" services will need about 16,000 – 17,000 BGSF (building gross square feet) of space and remaining 8,000 – 9,000 BGSF could be used for wrap-around and primary care services



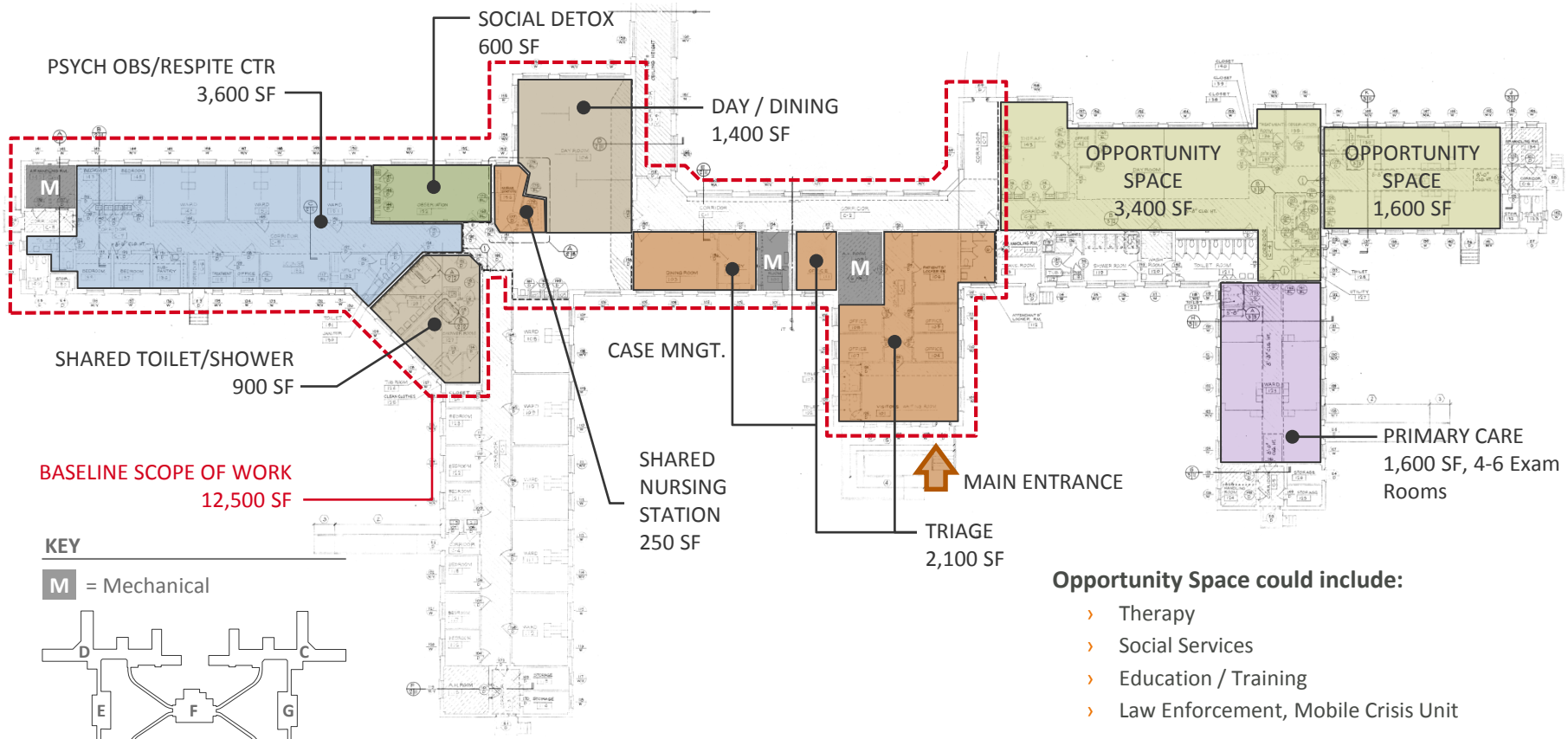
Opportunity Space could include:

- Therapy
- Social Services
- Education / Training
- Law Enforcement, Mobile Crisis Unit

Without Medical Detox: Alternative I

"Core" services will need about 12,000 – 13,000 BGSF (building gross square feet) of space and remaining 8,000 – 9,000 BGSF could be used for wrap-around and primary care services

› About 4,000 – 5,000 BGSF could remain un-programmed under this option or could provide a path to future expansion

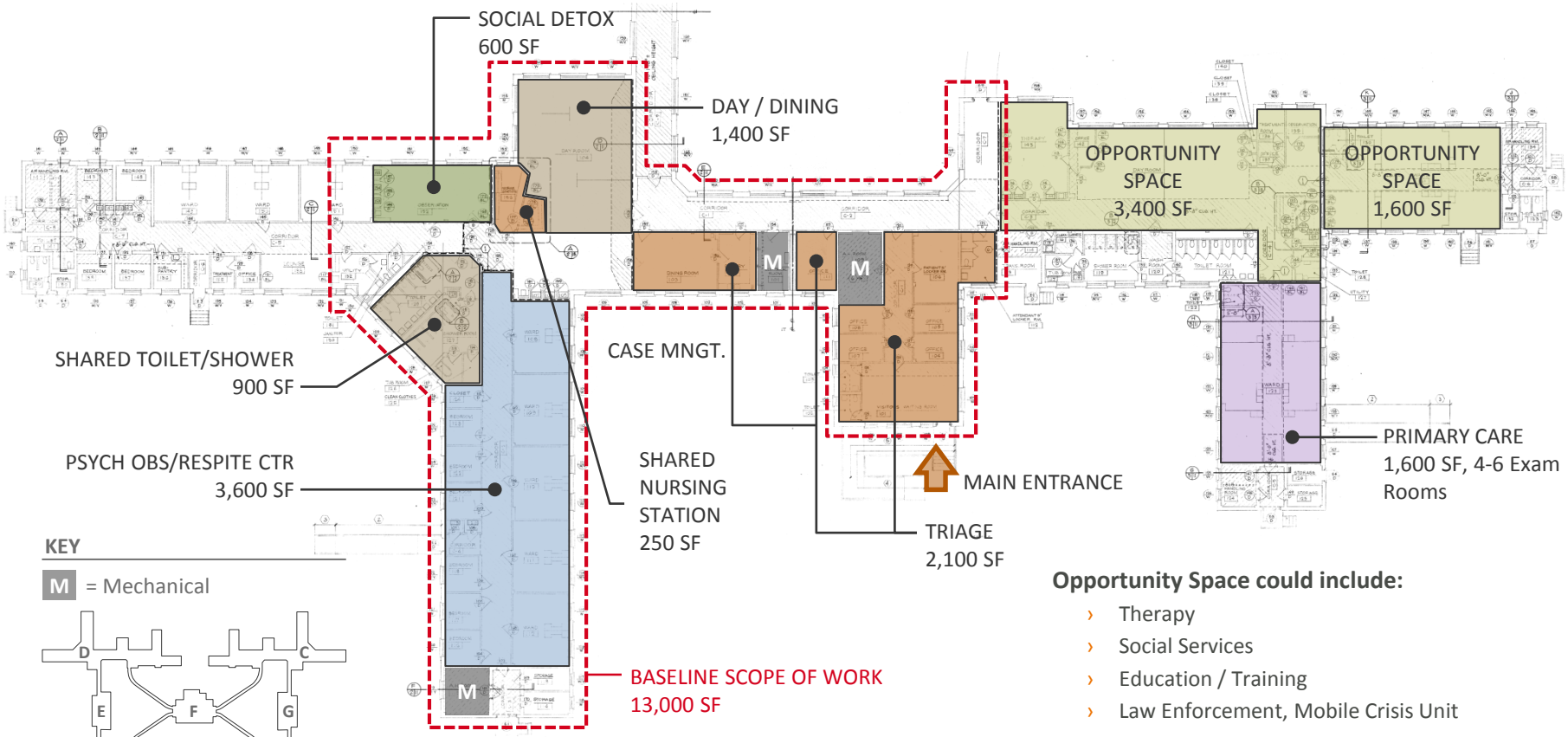


Opportunity Space could include:

› Therapy
› Social Services
› Education / Training
› Law Enforcement, Mobile Crisis Unit

Without Medical Detox: Alternative II

"Core" services will need about 13,000 BGSF (building gross square feet) of space and remaining 8,000 – 9,000 BGSF could be used for wrap-around and primary care services



Opportunity Space could include:

- Therapy
- Social Services
- Education / Training
- Law Enforcement, Mobile Crisis Unit

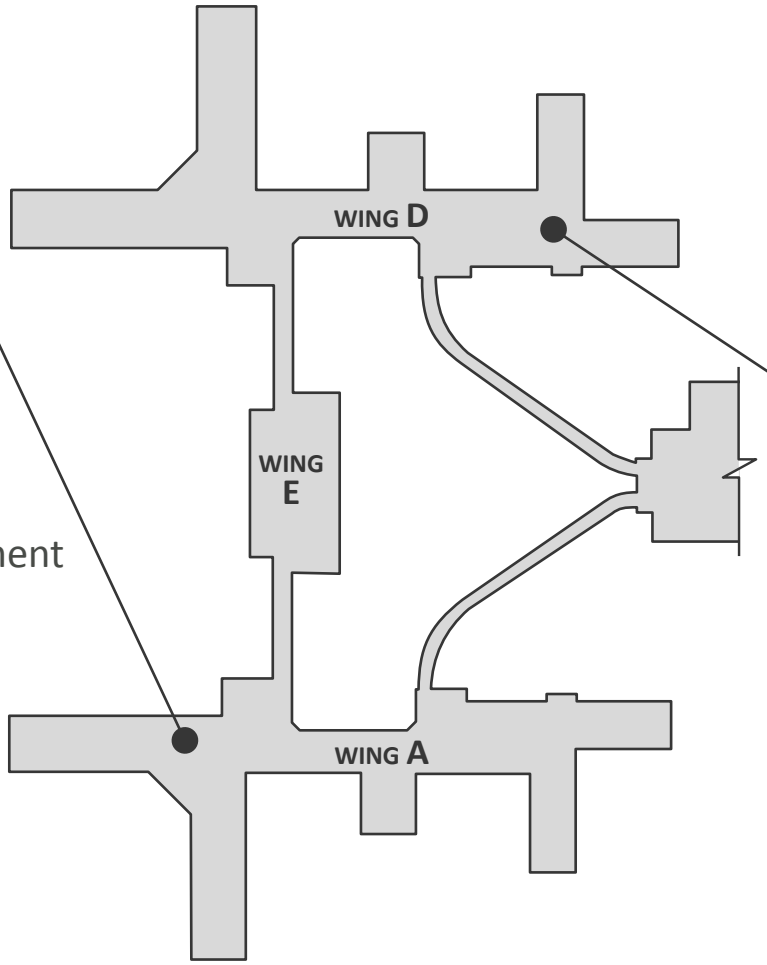
Master Facility Plan

Rendering

Site Map

Phase I (Wing A)

- Triage / Assessment
- Social Detox
- Psych Obs / Respite Center
- Crisis Team / Case Management
- Outpatient Treatment
- Social Services
- Education / Training
- Judicial System Support
- Administrative Support
- Medical Detox *



Phase II (Wing D)

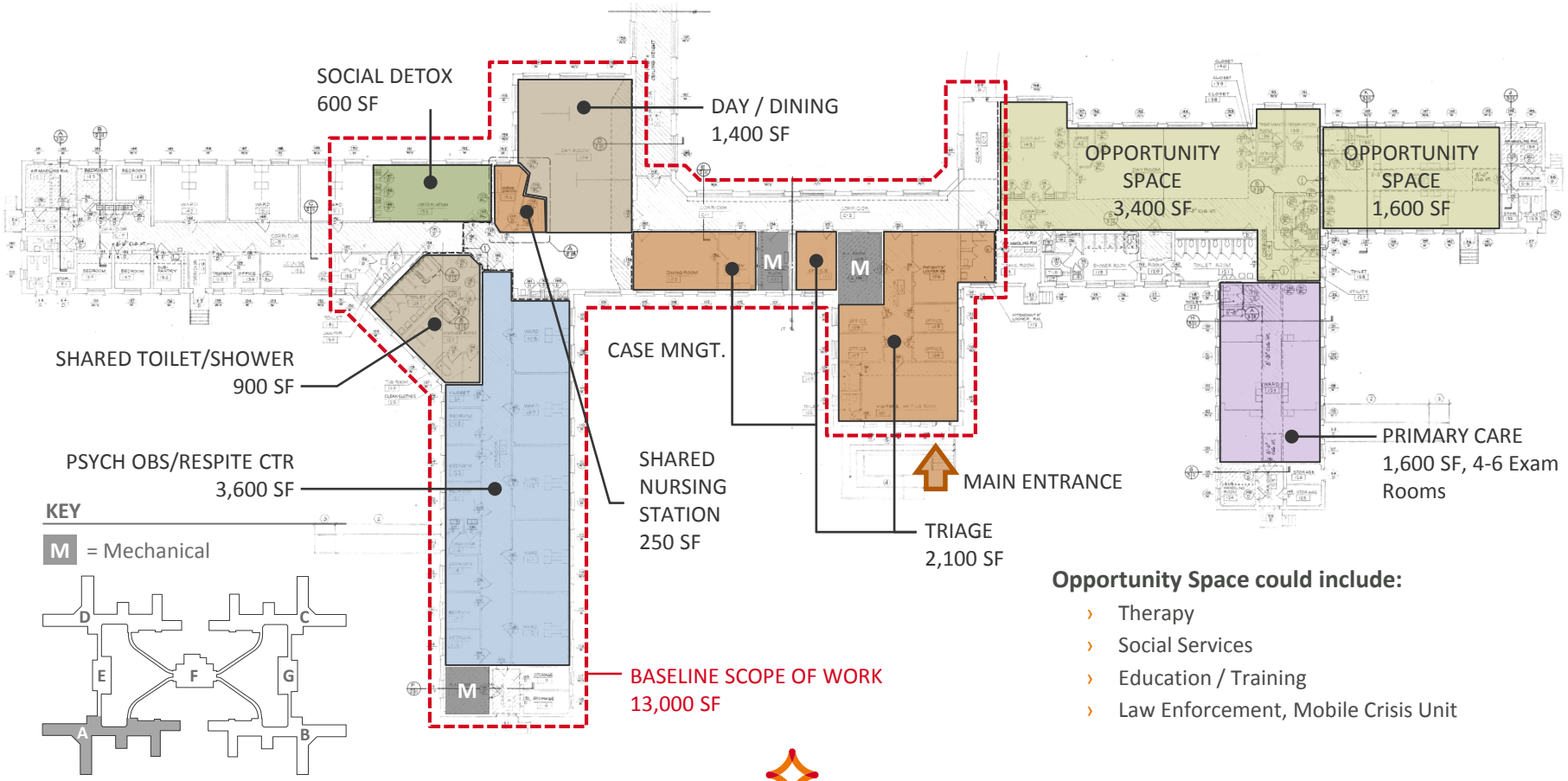
- Space to accommodate growth and additional services

*Optional – to be explored in the future in partnership with other community providers

Master Plan

The Crisis Intervention Center services will need 13,000 BGSF and remaining space could be used for wrap-around and primary care services.

› Total of 25,500 square feet in Wing A



Opportunity Space could include:

- Therapy
- Social Services
- Education / Training
- Law Enforcement, Mobile Crisis Unit

Financial Implications

Capital Investment and Implementation Timeline

A preliminary timeline has been developed regarding capital spending and opening.

› The total estimated capital expenditure spend of $5.7mm is assumed to be split by 75% in 2017 and the remaining 25% in 2018

Implementation Timeline

Fiscal Year	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Capital Estimate		$4.3mm	$1.4mm								

Safe Haven Campus Phasing

- **Safe Haven Planning**
- **Remediation and Renovation of Wing A (75% in 2017, 25% in 2018)**
- **Phase 1 Services - Crisis Intervention and Healing Services - fully operational and running (50% brought online in 2018)**
- **Phase 2 Expansion into other Wings can be explored**

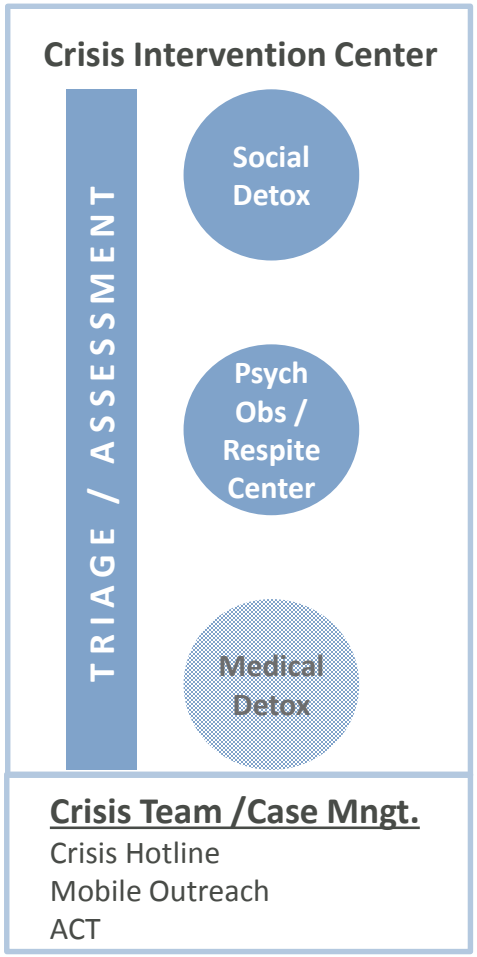
★ NAMI Drop-In Center Group operational 6/30/17

★ Family Promise Day Center 12/31/17

★ 100% of Phase 1 Services Operational at end of 2019

Core Services Included in Financials

The following Core Services have been evaluated in the financial estimates. Logic for exclusion of the other Defined Services is provided.



- **Judicial System Support:** Estimates only include cost of space. More detailed expense estimates, such as additional case managers or judicial administrative support, are not included as financial structures are already in place.
- **Housing & Related Svcs**: Estimates not included as services will be run by NAMI. Operational and financial structure are already in place.
- **Outpatient Treatment**: There will be components of behavioral health services and primary care services in the Triage/Assessment area, but larger primary care clinic operations are not considered in the financial estimates.
- **Intensive & Acute Services**: Estimates not included as assumed to be operated by Northlake who is already in place.

Financial Framework

The following inputs estimate operating costs for all core services at the Campus, regardless of whether services are already being offered by operators. Not all operating costs will ultimately be carried by STPG.

Fund Inflows (Drivers)
Philanthropy (as % of Costs)
Grants (as % of Costs)
Reimbursement (as % of Costs)
Parish Funds (as % of Costs)
Other[1] (as % of Costs)

Operating Costs (Drivers)
Triage (FTEs, salary, fringe, inflation)
Social Detox (FTEs, salary, fringe, inflation)
Psych / Obs (FTEs, salary, fringe, inflation)
Case Management (FTEs, salary, fringe, infl.)
Social Srvcs (FTEs, salary, fringe, inflation)
Admin. (FTEs, salary, fringe, inflation)
IT Maint. (FTEs, salary, fringe, inflation)
Security (FTEs, salary, fringe, inflation)
Client Support, Infrastructure, Other (% of total Personnel Costs)

Capital Expenditure (Drivers)
Remediation (cost per sq. ft, total sq. ft., inflation)
Renovation (cost per sq. ft, total sq. ft., inflation)

Safe Haven Campus Operating Budget (10 Year)
Revenue based on % of Costs
Operating Costs rolled up by service, administrative, supplies, and other
Capital Expenditure by Year

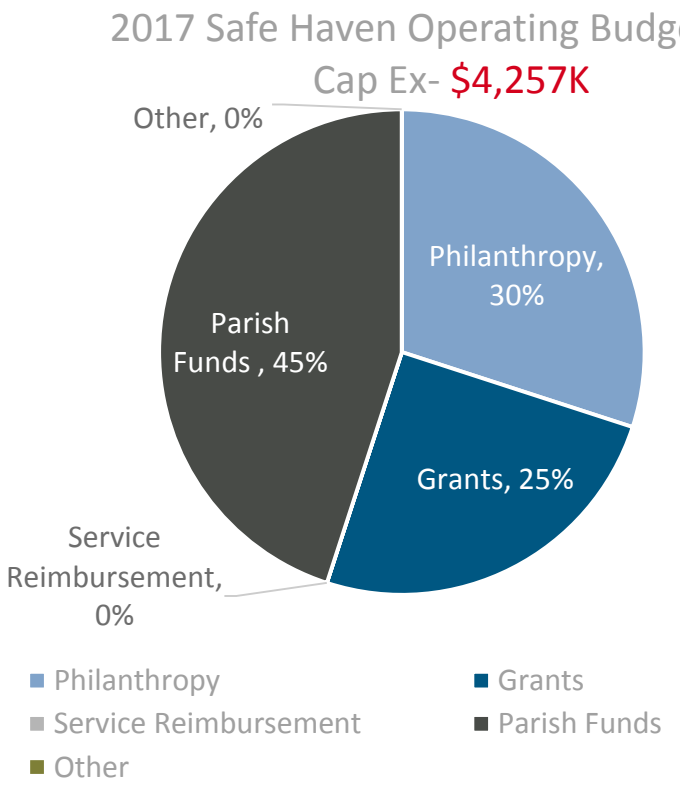
1. Other revenue includes Federal funds, State funds, and/or contributions from other community stakeholders (e.g., local hospitals)

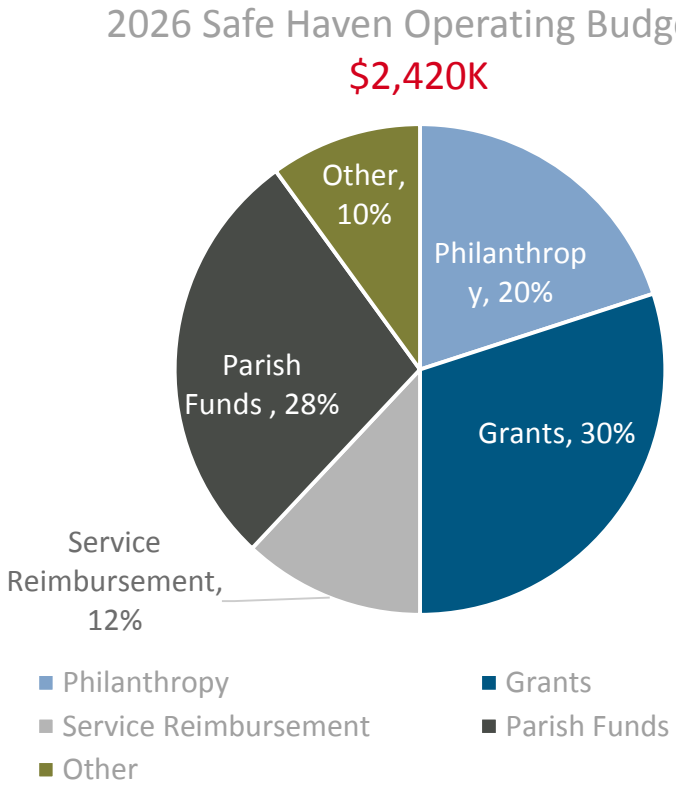
Key Fund Inflows Assumptions

Line Item	Baseline Assumption	Notes
Philanthropy	› **2017 (Year 1)**: 30% of Total Costs › **2026 (Year 10)**: 20% of Total Costs	› Will need higher percentage in early years before operations can contribute more to funding
Grants	› **2017 (Year 1)**: 25% of Total Costs › **2026 (Year 10)**: 30% of Total Costs	› Can aim to increase further as grant writing is shared and consolidated between service providers
Reimbursement	› **2017 (Year 1)**: 0% of Total Costs › **2026 (Year 10)**: 12% of Total Costs	› 2026 is lower than the Bexar County ~17% of funds; LA will have Medicaid Expansion but pared by not having Medical Detox › Year 1 is a conservative assumption as there most likely be reimbursable services offered immediately
Parish Funds	› **2017 (Year 1)**: 45% of Total Costs › **2026 (Year 10)**: 28% of Total Costs	› Includes Millage, redirected funds, and any already allocated capital
Other	› **2017 (Year 1)**: 0% of Total Costs › **2026 (Year 10)**: 10% of Total Costs	› Includes Federal funds, State funds, and/or contributions from other community stakeholders (e.g., local hospitals)

Evolution of Funding Sources

Over time, the funding sources will shift as clinical services stabilize and are able to demonstrate outcomes for additional contributions from other key stakeholders (Bayou Health plans, local hospitals, governmental agencies, etc.)





Assumptions and Outputs

Key Operating Expense Assumptions

Line Item	Baseline Assumption*	Notes
Triage / Assessment	› FTE: 1 **LCSW;** Salary: $53,578 › FTE: 2 **PA**; Salary: $81,707	› PA can rotate with Psych Obs / Respite Care
Social Detox	› FTE: 2 **EMT**; Salary: $32,720 › FTE: 1 **Peer Counselor**; Salary: $30,000	› EMT can support Triage/Assessment as needed
Psych Obs/Respite Care	› FTE: 2 **LCSW**; Salary: $53,578 › FTE: 1 **PA**; Salary: $81,707 › FTE: 0.5 **Psychiatrist**; Salary: $174,332	› LCSW can support with Triage / Assessment as needed (night shift) › PA can rotate with Triage / Assessment › Psychiatrist need assumes some ability to leverage telehealth when needed
Medical Detox	› Not included	› Will not be located at Safe Haven at this time
Crisis Team/Case Management	› FTE: 2 **Case Managers**; Salary: $72,852	› Case manager count should be explored further. VOA had 4 FTEs in the past
Social Services	› FTE: 2 **Community Social Workers (MSW)**; Salary: $49,907	

- Note: All salary information from Salary.com Median Salary for Mandeville, LA. Costs inflated at a 2% rate per year. Fringe of 25% added to all salaries.

Key Operating Expense Assumptions (cont'd)

Line Item	Baseline Assumption*	Notes
Education/Training	› Not included	› Assume to be coordinated and handled by NAMI › Did not make estimates as NAMI most likely has exact costs for services
Administrative Support	› FTE: **1 Admin. Assistant**; Salary: $44,393 › **Grant Writing**: Unknown	› Grant writing to be shared with STPG resources already in place and capacity of current resources for additional tasks should be explored
IT Maintenance	› FTE: 1 **IT Generalist**; Salary: $45,269	› Outsourcing options should be explored
Security	› FTE: 3 **Security Guards**; Salary: $29,369	› Will provide 24 hour coverage
Client Support	› **5%** of Total Personnel Expenses	› Includes food and transportation › Based on proxy from other behavioral health facilities

- Note: All salary information from Salary.com Median Salary for Mandeville, LA. Costs inflated at a 2% rate per year. Fringe of 25% added to all salaries.

Key Operating Expense Assumptions (cont'd)

Line Item	Baseline Assumption*	Notes
Other Operating Expenses	› **17%** of Total Personnel Expenses	› Includes utilities, insurance, repairs and travel, supplies, and maintenance expenses › Conservative estimate Proxy estimate based on publicly-traded behavioral health providers (Acadia Healthcare)
Operating Infrastructure	› **35%** of Total Personnel Expenses	› Includes management, marketing, data collection, accounting/billing, licensing, office supplies, etc.

- Note: All salary information from Salary.com Median Salary for Mandeville, LA. Costs inflated at a 2% rate per year. Fringe of 25% added to all salaries.

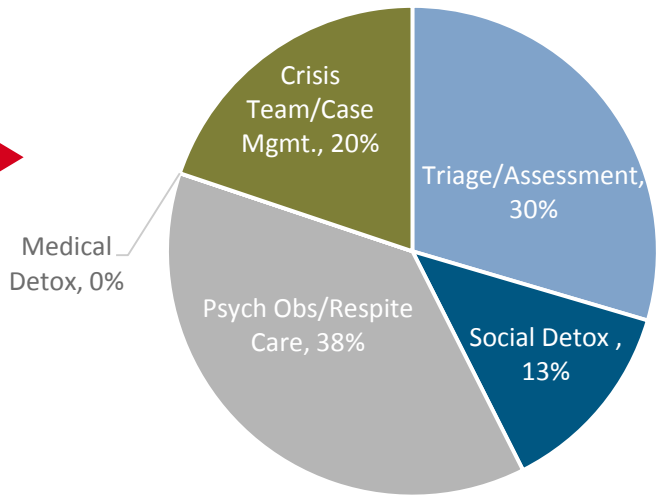
Operating Financial Estimates

The following is the output of estimated operating costs for Safe Haven Campus. As expected, higher acuity services will account for a larger percentage of total program costs.

Safe Haven 2026 Estimated Operating Expenses

BUDGET in $ '000s	2026	% of Total Operating Expenses
OPERATING EXPENSES		
Program Costs[1]	1,119	46%
Social Services	152	6%
Education/Training	-	0%
Administrative	68	3%
IT Maintenance	69	3%
Security	134	6%
Client Support	77	3%
Other[2]	262	11%
Operating Infrastructure[3]	540	22%
Total Operating Expenses	$2,420	100%

Safe Haven 2026 Estimated Breakout of Program Costs



1. Crisis Intervention Center and Crisis Team / Case Management
2. Other costs include utilities, insurance, repairs, supplies, and maintenance
3. Includes management, marketing, data collection, accounting/billing, licensing, office supplies, etc.

Assumptions and Outputs

Key Capital Expenditure Assumptions

Line Item	Baseline Assumption*	Notes
Remediation	› **$50** cost per square foot › **25,500** square footage of remediation › 75% spent in 2017, 25% in 2018	› Total Wing A to be remediated
Renovation	› **$200** cost per square foot › **22,000** square footage of remediation › 75% spent in 2017, 25% in 2018	› Includes Core Services, Primary Care, and Opportunity Space › Space that had been allocated for Medical Detox not included in renovation

Total Capital Expense: $5,676,188

* Costs inflated at a 2% rate per year

Implementation Planning

Implementation Planning Table of Contents

Strategy Prioritization and Implementation Approach

Elements Considered in the Prioritization of Strategies

Kurt Salmon's recommended prioritization is based on four elements:

- Generate Quick Win: How can we continue momentum of ongoing initiatives?
- Building Strong Foundation: What is critical to Safe Haven's long term success that needs to begin right away? Ensure we set up for a sustainable system long-term. Thoughtful about funding sources long-term-wean off of government support as we build our services.
- Addresses Immediate Need of Key Stakeholder: What activities are needed to address urgent community need or to keep key stakeholders engaged?
- Resources Required/Available: What resources are immediately available to support implementation? How can we ensure that resources are appropriately balanced based on availability?

Strategy Prioritization

	Quick Win	Build Strong Foundation	Address Immediate Need	Resources Required/Avail.
Goal #1: Organizational Framework		✓		✓
Goal #2: ED Diversion	✓	✓	✓	
Goal #3: Jail Diversion	✓	✓	✓	✓
Goal #4: Access	✓	✓	✓	
Goal #5: Information Management		✓		✓
Goal #6: Financial		✓	✓	✓
Goal #7: Healing Environment	✓	✓	✓	✓

Strategy Prioritization

		Strategy for Execution	FY17	FY 18	FY 19	FY 20
1	Organizational Framework	1.1 Governance Model 1.2 Service Coordination 1.3 Clinical Integration 1.4 Shared Services				
2	ED Diversion	2.1 Training 2.2 Crisis Intervention 2.3 Crisis Stabilization				
3	Jail Diversion	3.1 Training 3.2 Criminal Justice System Integration 3.3 Police Turnaround/ Social Detox				
4	Access	4.1 Transportation 4.2 Operational Performance Review 4.3 Int. Primary Care Model 4.4 Medical Detox 4.5 Innovative Delivery Models 4.6 Psychiatry Medical Group				
5	Information Management	5.1 Identify Metrics 5.2 Information Technology Infrastructure 5.3 Stakeholder Reports				
6	Financial	6.1 Financial Commitments 6.2 Philanthropic Fund Raising 6.3 Grant Fund Raising 6.4 Social Services 6.5 Contract with Payors				
7	Healing Environment	7.1 Wrap Around Supportive Services 7.2 Housing Services				

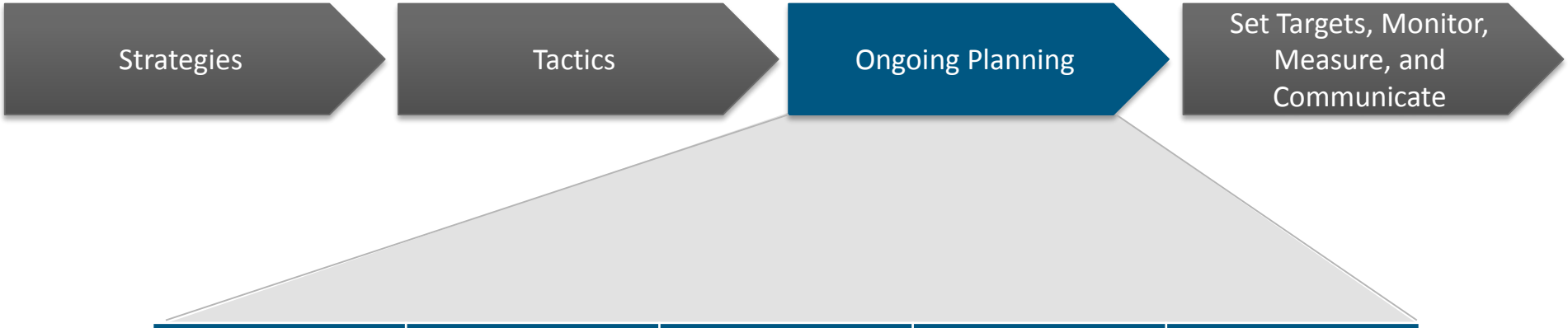
Post-Strategic Planning Process

After defining specific tactics, the Core Team will need to identify champions to lead the implementation of each strategy

Strategies	Tactics	Ongoing Planning	Set Targets, Monitor, Measure, and Communicate
› We have completed articulating the strategies that will form the plan	› A list of tactics supporting each strategy has initially been developed based on feedback provided by the Task Force and the Core Team › These tactics will be further reviewed and updated as each strategy is supported with a firm business plan	› Identify a champion for each strategy › Establish an ongoing planning process for the champion to engage key stakeholders › Define milestones › Determine metrics to track › Create implementation calendars	› Check in with champions regularly (e.g., quarterly) › Determine impacts achieved › Communicate successes to sustain engagement and create trust

Implementation Planning: Ongoing Planning

The Core Team will identify specific champions to lead the implementation of each strategy



Form a subcommittee	Champion assigns owners	Set milestones	Regular Reporting	Integrated Communication
ID Initiatives, barriers, additional tactics	Champion may designate owners to manage the implementation of specific tasks	Identify the key dependencies and establish a plan to reach milestones	Establish a process and timeline for reporting on progress on tactics and milestones	Define how and when progress and milestones will be communicated across missions

Illustrative Tactical Planning

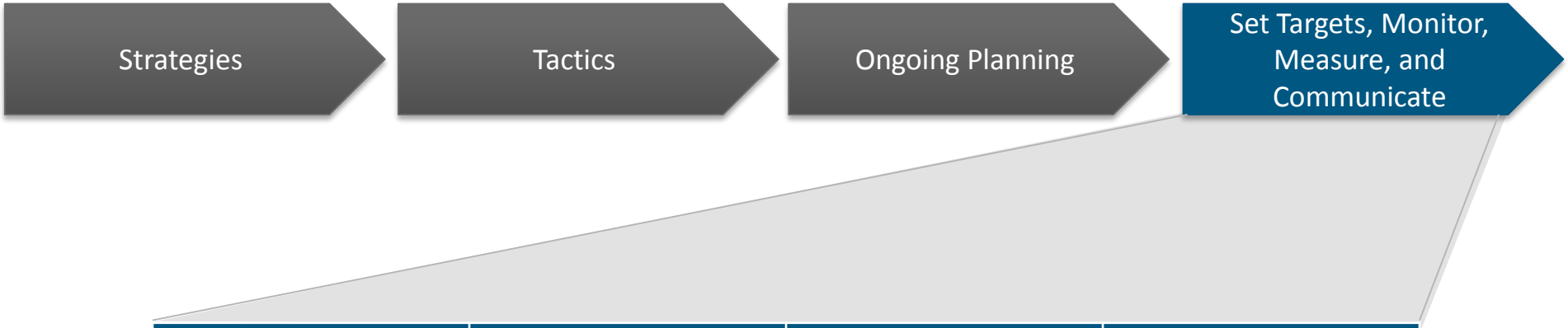
ILLUSTRATIVE

Strategy 5.2: Information Technology Infrastructure - Invest in technology infrastructure to allow for accurate capture of data, enhanced data sharing, and analytics and reporting capabilities while ensuring all privacy laws and the protection of individuals' rights are upheld.

Illustrative Tactics	2017	2018	2019	2020	Sponsor	Key Milestone
Identify key individual responsible for oversight of IT infrastructure plan	X				J. Robert, K. Rabalais	Appointment of responsibility by Jan. 2017
Develop a precise budget and implementation plan for IT infrastructure and operator	X				TBD	Develop business plan by June 2017
Secure funding sources to support infrastructure development and ongoing operations		X			K. Rabalais	Allocate funding sources by Jan. 2018

Monitor, Measure & Communicate

Once all champions have been identified, business plans associated with tactic(s) will be formed, with set timeline targets, metrics, resources. Communication vehicles and platforms must be identified to track and communicate progress and outcomes



Plan Implementation	Set Accountability	Establish Check-ins	Determine reporting forum(s)
Each champion or strategy owner is responsible for forming a clear plan for implementation of strategy	Set key metrics for each of the tactics to measure performance against	Define regular periods to report on progress (e.g., quarterly updates)	Set up town halls, quarterly meetings, etc. to report on progress and receive feedback

Detailed Tactics

Detailed Tactics

Post-Strategic Planning Process

Strategy 1.1: Governance Model

Develop a shared governance model inclusive of the Safe Haven operators to make decisions about the campus, ensure collaboration, and monitor performance.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Confirm 'Collaborate' and 'Empower' stakeholders needed for engagement and operations at the Safe Haven campus.		X							K. Rabalais	Communicate with all identified service operators their expected level of participation at Safe Haven by Oct. 2017.
Create Safe Haven Board Governance Board to include 8-10 members of Safe Haven operators and key stakeholders	X								K. Rabalais	Appoint all Board Members by Jan. 2017.
Ensure good working relationship with 'Empower' and 'Collaborate' stakeholders with regular communication on a monthly basis	X								K. Rabalais	Jan. 2017 and ongoing
Establish a charter for the Safe Haven Governance Board outlining the roles and responsibilities of members, meeting cadence, authority, etc.	X								K. Rabalais	Jan. 2017
Identify a Director for the Safe Haven campus	X								K. Rabalais/ Safe Haven Board	Appointment by June 2017

Post-Strategic Planning Process

Strategy 1.2: Service Coordination

Centralize care and case management services to standardize care plan development, create efficiencies and streamline communication between providers across the care continuum.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Engage case management service operators in a discussion regarding goals of Safe Haven and collaboration opportunities by co-locating services.	X								K. Rabalais/ J. Robert	Develop agreement with case management operator's services at Safe Haven campus by Jan. 2017.
Form sub-committee of Behavioral Health Task Force to standardize assessment and processes for behavioral health case management for all behavioral health clients in the Parish.		X							K. Rabalais/ J. Robert	Jan. 2018
Identify case management operators to be located on the Safe Haven Campus based on agreed upon shared objectives/performance metrics.	X								J. Robert	June 2017
Establish case management services on Safe Haven Campus			X						J. Robert	Jan. 2018

Post-Strategic Planning Process

Strategy 1.3: Clinical Integration

Develop a clinically integrated entity with the ability to jointly contract to provide reimbursement for innovative care models and ensure incentives are aligned across the Safe Haven providers.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Form subcommittee responsible for oversight of clinically-integrated network (CIN) development			X						Safe Haven Board	Subcommittee formed with a chair by June 2018
Determine partners to be included in CIN, draft goals, determine IT interoperability and clinical alignment strategies, and coordinated services to go to market (e.g. management of defined patient populations)					X				Subcommittee Chair	Finalize proposed offerings by April 2019.
Approach a Louisiana Clinically Integrated Network for Partnership opportunities							X		Subcommittee Chair	Open conversations with CIN and with a payor in LA to offer behavioral health services for the network by Jan 2020.

Detailed Tactics

Post-Strategic Planning Process

Strategy 1.4: Shared Services

Over time create savings through centralizing administrative and support services where possible.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Determine available current STPG resources to commit to administrative responsibilities at Safe Haven Campus.	X								K. Rabalais	Budget resources to Safe Haven by June 2017.
Determine needed additional administrative resources for Safe Haven.		X							K. Rabalais	Create a business plan by December 2017 to fund those services over a 5-year period
As services move on-campus, determine if there are opportunities for shared services – accounting, billing, community outreach, development, etc.			X						J. Robert	Determine shared services opportunities by June 2018.

Detailed Tactics

Post-Strategic Planning Process

Strategy 2.1: Training

Promote Crisis Intervention Team (CIT) training programs for all first responders, such as police force, EMTs, emergency room personnel, and 911 operators.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Identify a champion to lead the coordination of CIT training in the community to ensure cross agency participation, consistent curriculum development, etc.	X								K. Rabalais/ Safe Haven Task Force	Identify lead by Oct. 2016
Support grant-writing and coordination efforts for CIT training in the community	X								J. Robert	Identify funding source by Jan. 2017
Work with stakeholders to identify top priority agencies, or subsets thereof, to attend training	X								J. Robert	First training booked by Jan. 2017
Determine training timeline to align with key milestones of Safe Haven development	X								J. Robert	Timeline developed by March 2017
Allocate space for monthly CIT training sessions			X						J. Robert / Judge Garcia	Space available by Jan. 2018 (or earlier)

Detailed Tactics

Post-Strategic Planning Process

Strategy 2.2: Crisis Intervention

Promote programs for crisis intervention professionals to integrate with community first responders (police force and EMTs).

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Standardize assessment and care model with medical clearance in the field	X								K. Rabalais/ Safe Haven Board	Finalize and distribute standardized care plan to all BH by June 2017.
Evaluate integrating a Mental Health Unit within the Sheriff's Department		X							J. Robert / Sheriff Elect	Develop an implementation plan for integration by December 2017.

Detailed Tactics

Post-Strategic Planning Process

Strategy 2.3: Crisis Stabilization

Create a crisis stabilization program at the Safe Haven campus, that provides 24/7 access to behavioral health support in the least restrictive environment for individuals in crisis.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Engage engineering firm to confirm estimates for infrastructure and remediation upgrades	X								B. Crouch	Complete assessment by Dec. 2016
Conduct remediation and renovation of Wing A of Safe Haven	X								B. Crouch	Complete renovations by March 2018
Issue RFP and select operators for the 1) Triage & Assessment Center and Psych Obs/ Respite Center and 2) Social Detox program › Operators should be selected before renovations for their specific space is complete to ensure appropriate FFE is in place		X							K. Rabalais/ Safe Haven Board	Complete by Jan 2018
Open Safe Haven Phase 1 with Crisis Intervention Center			X						K. Rabalais	Open Safe Haven Campus by June 2018

Post-Strategic Planning Process

Strategy 3.1: Training

Promote Crisis Intervention Team (CIT) training programs for all first responders, such as police force, EMTs, emergency room personnel, and 911 operators.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Identify a champion to lead the coordination of CIT training in the community to ensure cross agency participation, consistent curriculum development, etc.		X							K. Rabalais/ Safe Haven Task Force	Identify lead by Oct. 2016
Support grant-writing and coordination efforts for CIT training in the community	X								J. Robert	Identify funding source by Jan. 2017
Work with stakeholders to identify top priority agencies, or subsets thereof, to attend training	X								J. Robert	First training booked by Jan. 2017
Determine training timeline to align with key milestones of Safe Haven development	X								J. Robert	Timeline developed by March 2017
Allocate space for monthly CIT training sessions			X		X				J. Robert / Judge Garcia	Space available by Jan. 2018 (or earlier)

Post-Strategic Planning Process

Strategy 3.2: Criminal Justice System Integration

Closely integrate Safe Haven campus with the criminal justice system, including the District Attorney's Office and the 22nd Judicial Court (including the Specialty Courts).

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Standardize assessment tool across crisis intervention (mobile unit, Safe Haven triage and assessment, pre-trial, jail, specialty courts, etc.).			X						J. Robert/ Safe Haven Board	Finalize by March 2017
Train behavioral health professionals, key staff at emergency rooms, first responders, law enforcement and judicial system representatives in assessment tool and process.			X						J. Robert/ Safe Haven Board	Training completed by Jan. 2018
Locate specialty court probation officers on the Safe Haven campus						X			Judge Garcia	December 2019
Consider locating specialty court and magistrate functions on the Safe Haven campus in later phases.								X	Judge Garcia	Determine whether locating court functions at Safe Haven is appropriate by Jan 2020.

Post-Strategic Planning Process

Strategy 3.3: Police Turnaround

Ensure everything is in place for law enforcement to comfortably drop off patients efficiently at Safe Haven ("One-Stop Shop") including medical and behavioral health assessments by appropriate clinical professionals.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Identify a champion to lead a sub-committee of the Safe Haven Task Force/ Governing Board to determine requirements for law enforcement drop off and design process for first responders		X							K. Rabalais	Identify champion by Oct 2016
Convene sub-committee of law enforcement and first responders to determine requirements for drop off to be included in RFP for future operator and policy manual	X								Sheriff Dept. Rep. / Champion	Requirements and process defined by June 2017 (when RFPs will be issued)
Train law enforcement and first responders on services available at Safe Haven		X	X						Sheriff Dept. Rep. / Champion	Six month period prior to opening Safe Haven
Open Safe Haven Phase 1 with Crisis Intervention Center [detailed steps in Strategy 2.3] 24/7 Triage & Assessment is most critical to have up and running first			X						K. Rabalais	Open Safe Haven Campus by June 2018.

Post-Strategic Planning Process

Strategy 4.1: Transportation

Examine innovative transportation models (e.g., ride sharing) for patients that have transportation needs.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Determine available STPG transportation services that may be able to service the Safe Haven Campus.	X								K. Rabalais	Determine whether current resources are available and budget those resources to Safe Haven by June 2017.
Survey key stakeholder agencies to identify opportunities to share transportation resources	X								K. Rabalais	June 2017
Explore innovative options through law enforcement or other means to supplement available transportation	X								K. Rabalais	June 2017
Determine needed additional transportation resources for Safe Haven.			X						K. Rabalais	Determine additional transportation services needed and create a business plan by December 2017 to fund those services over a 5-year period

Post-Strategic Planning Process

Strategy 4.2: Operational Performance Review

Review operational performance on the Safe Haven Governance Board and hold agencies accountable for meeting established benchmarks.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Form subcommittee responsible for oversight and development of key operating metrics to be met by Safe Haven service operators			X						Safe Haven Board	Subcommittee formed with a chair by June 2018
Set quarterly meetings for operational performance review				X					Subcommittee Chair	Conduct first operational review in Dec 2018.

Post-Strategic Planning Process

Strategy 4.3: Integrated Primary Care Delivery Model

Provide integrated medical and behavioral health care.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Meet with Access Health and FPHSA to determine whether they are willing to relocate or open a new clinic at Safe Haven			X						K. Rabalais	Meetings by June 2018
Determine if funding is available for a new clinic at Safe Haven				X					K. Rabalais	Funding availability by Sept. 2018
Determine if one agency, or both in partnership, can operate an integrated primary care/ behavioral health clinic at Safe Haven				X					K. Rabalais	Issue RFP by Dec. 2018
Allocate space for primary care physicians on Safe Haven Campus					X				K. Rabalais / R. Kramer	Have primacy care providers holding clinic sessions on Safe Haven Campus on by June 2019

Post-Strategic Planning Process

Strategy 4.4: Medical Detox

Create access to medical detox services for St. Tammany parish residents either on the Safe Haven campus or through collaboration with other organizations.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Continue dialogue with BRAF's planning team and Greenbrier to evaluate partnerships for Medical Detox	X								K. Rabalais/ R. Kramer	Dec. 2016
Identify potential funding source for Medical Detox start-up; consider providing funding for 2-3 beds of treatment for St. Tammany parish residents			X						K. Rabalais	Jan. 2018
Create referral pipeline between Social Detox and available Medical Detox facilities in surrounding area			X						Social Detox operator	June 2018
Evaluate whether Medical Detox will be developed at the Safe Haven campus							X		Safe Haven Board	Determine by Jan. 2020

Post-Strategic Planning Process

Strategy 4.5: Innovative Delivery Models

Explore innovative delivery models, such as telemedicine, to increase access for services with limited supply of providers (e.g., psychiatry, counseling).

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Identify grant opportunities to explore telemedicine to support Safe Haven services		X							J. Robert	Identify opportunities by Dec. 2017
Evaluate telemedicine services and application to Safe Haven			X						J. Robert/ Psych Obs operator	Determine telemedicine needs and create a business plan by December 2018 to fund those services over a 5-year period.
After business plan is evaluated, implement telemedicine services either through partnering with an existing service or developing in-house (TBD in business plan)					X				J. Robert/ Psych Obs operator	Service established by June 2019

Post-Strategic Planning Process

Strategy 4.6: Psychiatry Medical Group

Explore the potential to consolidate public funding for psychiatrists in the Parish to help financially support the creation of a psychiatry medical group at the Safe Haven campus.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Form subcommittee responsible for exploring and developing a Psychiatry Medical Group model						X			Dr. Preston/ Safe Haven Board	Subcommittee formed with a chair by Jan 2019
Determine feasibility of a Psychiatry Medical Group.							X		Subcommittee Chair	Develop a business plan by June 2020

Detailed Tactics

Post-Strategic Planning Process

Strategy 5.1: Identify Metrics

Identify meaningful outcome metrics to be tracked through a shared dashboard between agencies.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Determine key metrics that will be tracked to show impact of Safe Haven Services to all community stakeholders	X								J. Robert / K. Rabalais	Key metrics agreed upon by Dec. 2016.
Evaluate current data collection process by BH providers and all first responders and then develop operating procedures to allow for the collection and sharing of relevant information	X								J. Robert / K. Rabalais	Identify data collection gaps of all BH providers by June 2017
Secure funding sources to support dashboard development (in tangent with Strategy 5.2 involving infrastructure)			X						K. Rabalais	Allocate funding sources by Jan. 2018

Post-Strategic Planning Process

Strategy 5.2: Information Technology Infrastructure
Invest in technology infrastructure to allow for accurate capture of data, enhanced data sharing, and analytics and reporting capabilities while ensuring all privacy laws and the protection of individuals' rights are upheld.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Identify key individual responsible for oversight of IT infrastructure plan	X								J. Robert, K. Rabalais	Appointment by Dec. 2016
Determine IT needs based on desired data collection and connectivity designed through the assessment tool and process development in Strategy 2.2 and 3.2	X								J. Robert	Needs analysis by June 2017
Explore Behavioral Health IT best practices – › Behavioral Health Information Network of Arizona › http://www.integration.samhsa.gov/operations-administration/hie	X								J. Robert	June 2017
Explore the potential for collaborative development with BRAF or at the state-level	X								J. Robert/ K. Rabalais	June 2017
Develop a precise budget and implementation plan for IT infrastructure and operator	X								TBD	Develop business plan by June 2017
Secure funding sources to support infrastructure development and ongoing operations	X								J. Robert, K. Rabalais	Appointment by Dec. 2016

Detailed Tactics

Post-Strategic Planning Process

Strategy 5.3: Stakeholder Reports

Develop standard annual reports to show outcomes and results (e.g., increased quality of care, cost savings, etc.) with key stakeholders.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Identify audience of annual reports	X								K. Rabalais	June 2017 so reports can be tailored accordingly
Determine process of creating annual reports			X						K. Rabalais	Determine individuals who will be creating the annual reports and have sample reports created by Dec. 2017
Begin to distribute annual reports once data collection process is solidified.			X							Issue annual report for year ending 2017 in Spring of 2018

Post-Strategic Planning Process

Strategy 6.1: Financial Commitments

Secure ongoing financial commitments from public and private organizations that will benefit from the services provided.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Determine short, medium, and long term funding targets from community organizations, including community hospitals	X								K. Rabalais	Have list of segmented (short, medium, long term) targets by Jan. 2017.
Create contracts with committed public and private organizations	X								K. Rabalais	Begin securing funds from identified targets, with first commitment targeted by June 2017.

Post-Strategic Planning Process

Strategy 6.2: Philanthropic Fund Raising

Develop fund raising activities (e.g., yearly gala, sporting event, etc.) and sponsorships (e.g., Platinum, Gold, or Silver Donors) with the private sector and community members.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Identify key individual responsible for oversight of philanthropic fundraising	X								K. Rabalais	Appointment by Jan. 2017
Develop a philanthropic Safe Haven fund raising strategy with key events	X								TBD	Develop fundraising plan by June 2017

Post-Strategic Planning Process

Strategy 6.3: Grant Fund Raising

Centralize grant writing and focus on both individual and collaborative grants for the Safe Haven providers.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Determine available current STPG resources to commit to grant fundraising at Safe Haven Campus.	X								K. Rabalais	Determine whether current resources are available for grant fund raising activities at Safe Haven and budget those resources to Safe Haven by June 2017.
Determine needed additional grant fundraising resources for Safe Haven.		X							K. Rabalais	Determine additional grant fund raising resources needed and create a business plan by December 2017 to fund those services over a 5-year period

Post-Strategic Planning Process

Strategy 6.4: Social Services

Provide support for clients to access social services at Safe Haven including helping individuals navigate forms and applications for available coverage.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Work with the Behavioral Health Task Force to determine the most relevant agencies or non-profits to be located on the campus to meet the needs of their patients (Medicaid enrollment, housing assistance, LA CAFÉ, Food Pantry, etc.). Focus organizations on those that can help patients get signed but for insurance coverage.			X						K. Rabalais/ Safe Haven Director	List of target organizations identified by March 2018
Meet with prioritized organizations to gauge interest in locating on the campus			X						K. Rabalais/ Safe Haven Director	June 2018
Determine space needs and allocate space for social services on the campus				X					K. Rabalais/ Safe Haven Director	Organizations on campus by Dec. 2018

Post-Strategic Planning Process

Strategy 6.5: Contract with Payors

Collaborate with payors using the Safe Haven clinically integrated network to develop innovative funding mechanisms for the services provided.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Form subcommittee responsible for oversight of clinically-integrated network (CIN) development [Strategy 1.3]			X						Safe Haven Board	Subcommittee formed with a chair by June 2018
Identify Medicaid patients being served at Safe Haven, determine cost of care incurred and develop a proposal for managing these patients				X					Subcommittee	By Dec. 2018
Approach payors with proposal to manage the behavioral health of a defined population					X				Safe Haven Director/ Subcommittee	By June 2019

Post-Strategic Planning Process

Strategy 7.1: Wrap Around Supportive Services

Support programs that provide wrap-around services for Safe Haven clients and providers including administrative services, community social services, education/training programs, and transportation programs.

Illustrative Tactics	2017 Jan-Jun	2017 Jul-Dec	2018 Jan-Jun	2018 Jul-Dec	2019 Jan-Jun	2019 Jul-Dec	2020 Jan-Jun	2020 Jul-Dec	Sponsor	Key Milestone
Work with the Behavioral Health Task Force to determine the most relevant agencies or non-profits to be located on the campus to meet the needs of their patients (Medicaid enrollment, housing assistance, LA CAFÉ, Food Pantry, etc.). Focus organizations on those that can help patients get signed but for insurance coverage.			X						K. Rabalais/ Safe Haven Director	List of target organizations identified by March 2018
Meet with prioritized organizations to gauge interest in locating on the campus			X						K. Rabalais/ Safe Haven Director	June 2018
Determine space needs and allocate space for social services on the campus					X				K. Rabalais/ Safe Haven Director	Organizations on campus by Dec. 2018

Appendix

National and Regional Context

National and Regional Context:

Key Behavioral Health Trends

	Trend	Description
1	**Historical Trends**	BH has not been as high a priority for health systems or local governments in the past, but has increasingly become a focus due to the effects from public facilities closures, legislation, public outcry, and payment reform.
2	**National and Regional Legislation/Policy**	Mental Health Parity, ACA, Medicaid expansion have all been tailwinds for coverage of BH services, but will increase pressure on already-strained providers.
3	**Reimbursement Shifts**	Changing reimbursement models, specifically value-based payment mechanisms, will drive BH integration. Additionally, the shift to Managed Medicaid in LA creates an increased opportunity to change the payment mechanism.
4	**Innovative Delivery Models**	As the demand for mental health services continues to increase across the country, public and private entities are rolling out non-traditional approaches to delivery care to those in need.
5	**New Entrants**	Technology advancements and shifting reimbursement has created a rise in new market entrants. For-profit organizations continue to emerge across the spectrum of the mental health continuum.
6	**National Dialogue**	National headlines are encouraging the conversation around behavioral health and is reducing associated stigma.

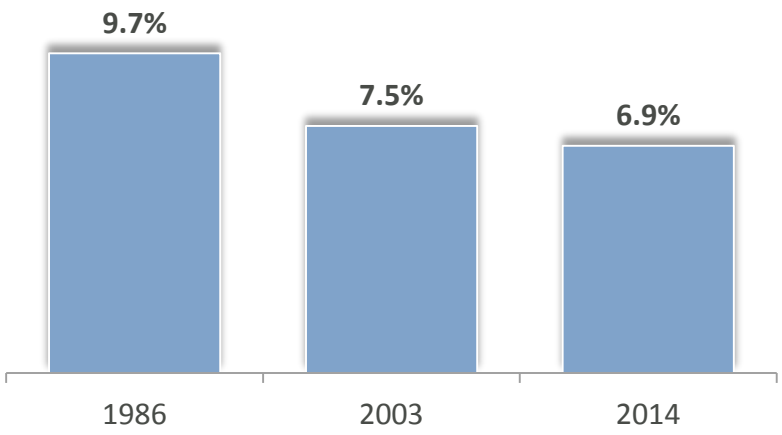
National and Regional Context:

Historical Trends

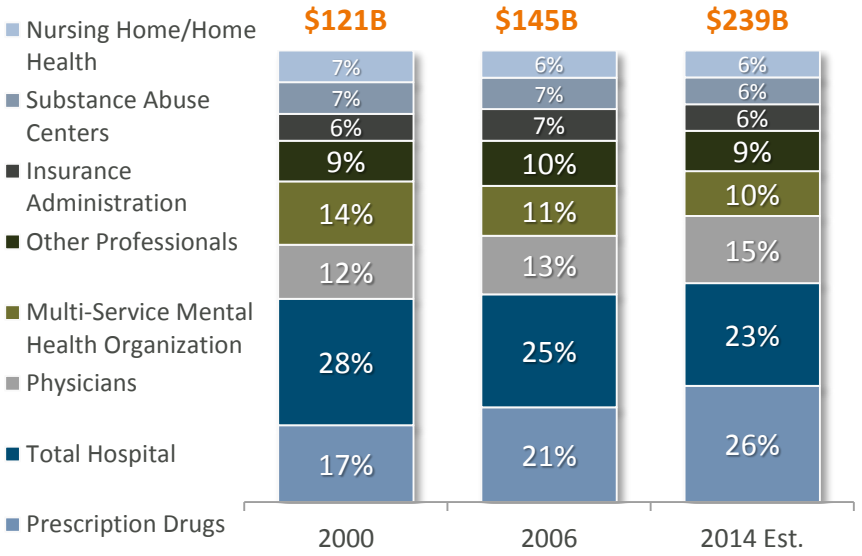
The U.S. has historically de-emphasized funding for mental health care:

- Mental health (MH) expenditures grew 6.4% annually from 2003 - 2014, compared to a 7.2% annual growth rate for total health expenditures[1]
  - Louisiana cut 0.5% of State MH Budget from 2009-2012, but ranks 43 of 51 in MH spend/capita[2]
  - Medicaid inpatient per diem rates in LA are less than half of what providers are receiving in many other states
- Public payors account for approximately 58% of all mental health spending[1]
  - As a result of the recession in 2009, states cut $4.35B in public mental-health spending over 3 years[3]

Mental Health and Substance Abuse (MHSA) Expenditures as % of Total Health Care Expenditures[1]



Mental Health and Substance Abuse (MHSA) Expenditures in the U.S. by Provider[1]



1. National Expenditures for MHSA; US Dept. of Health and Human Services
2. National Alliance on Mental Health, include Washington DC
3. National Alliance on Mental Illness, March 2011 Report

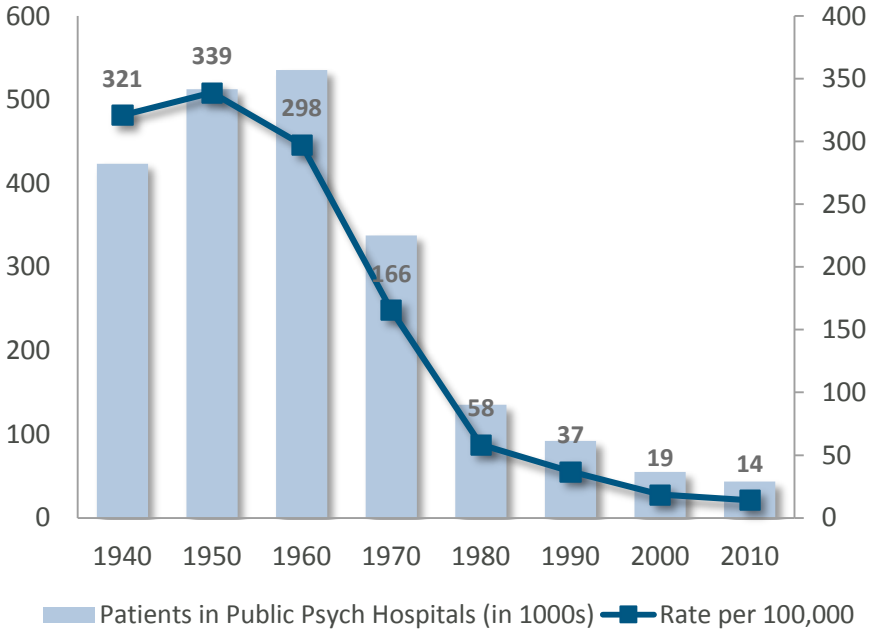
National and Regional Context:

Historical Trends

The use and access of public psychiatric hospital beds, which typically act as safety nets for at-risk community members, have been in decline:

- The number of inpatient discharges per 1,000 population has declined from 58 per 1,000, to 14 per 1,000
- Beds counts have decreased by 13% from 2005 – 2010 and have continued to decrease since 2010

Trends in Public Psych Hospital Patient Counts[1]



Trends in Public Psych Hospital Beds[1]

Public Psychiatric Beds[1]	2005	2010	% Change	Beds per 100,000 Population	
				2010	1850
Number of Beds (Nat'l)	49,907	43,318	-13%	14.1	14.1
Louisiana	903	914	-1%	19.9	-

Consequences[1]

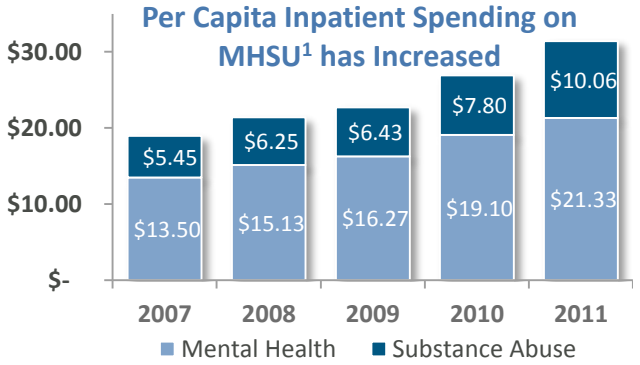
Increased:

- Strains on EDs
- Demand on police force
- Mentally ill individuals in jails and prisons
- Acts of violence, including homicide, by the mentally ill
- Number of mentally ill homeless

1. Treatment Advocacy Center- http://tacreports.org/tables

National and Regional Context:

National and Regional Legislation/Policy

Legislation	Description	Impact
Mental Health Parity Laws	**Original Parity 1996 (MHPA):** › Lifetime and annual dollar limits for mental health have to be equivalent to other health services › Applied only to commercial plans Under 2008 and 2010 Updates (MHPAEA): › **Parity expanded to substance use**	
ACA	The **Affordable Care Act (ACA)** increased the number of patients with **behavioral health coverage,** while supporting mechanisms aimed at the development of **emerging care models** and improved patient care management incentives › Plans on exchanges must offer MHSU as part of 10 essential benefits › Proliferation of innovation funding to address behavioral health (e.g., $50mm of funding was announced in 2013 to help Community Health Centers hire/add BH professionals and employ team-based models of care[2])	› Access to psychiatric services already limited › Increased demand will place greater strain on existing capabilities › Evolution of care models will be needed (i.e., inclusion of a broader range of mental health professionals, integration with primary care)

1. Healthcare Cost Institute, 2013
2. http://www.hhs.gov/about/news/2013/12/10/hhs-announces-affordable-care-act-mental-health-services-funding.html

National and Regional Context:

National and Regional Legislation/Policy

Legislation	Description	Impact
Medicaid Expansion	For states that agree to expand Medicaid, plans must: › Provide "essential health benefits" package that includes MHSU services › Benefits must be at **parity based Mental Health Parity of 2008** (MHPAEA) 1/12/2016, Gov. Edwards signed executive order to expand Medicaid in Louisiana and aims to expand coverage by 7/1/16	› Potential to receive funding for historically large, indigent population and potentially fund additional access › Existing healthcare providers may be willing to extend the scope and scale of their BH service offering › Provisions allow for better coordination of Medicaid services with MH services and housing programs aimed at homeless › Promotes early screening and intervention › Increased funding for community based programs › ~398K adults are expected to enroll in Louisiana due to Medicaid expansion[1]

1. Center for Budget and Policy Priorities; Note: estimates have ranged from 300k to 400K

National and Regional Context:

National and Regional Legislation/Policy

Legislation	Description	Impact
Medicaid Behavioral Health Carve Out[1]	Magellan had been managed care provider: › Explored plans for **Home Based Community Services** in which Northlake was proposing a **crises stabilization facility (CSF)** › 5 Bayou Health plans would assume carve out in 2016	› Home Based Community Services will continue to be explored by Bayou Health plans › CSF proposal will continue to be pursued with new Medicaid Bayou Health plans
Bipartisan Mental Health Reform Act[2]	Introduced by Senators Bill Cassidy, (R-LA) and Chis Murphy, (D-CT) aimed to: › Create a new **assistant secretary** to oversee mental health › Establish grants to improve **integration** of physical and mental health and for **early intervention** › Promote Assisted Outpatient Treatment (AOT)	TBD

1. "Transforming the St. Tammany Behavioral Health System", 2014 Report
2. Introduced on 8/4//1205, http://thehill.com/policy/healthcare/250245-senators-unveil-bipartisan-mental-health-bill

National and Regional Context:

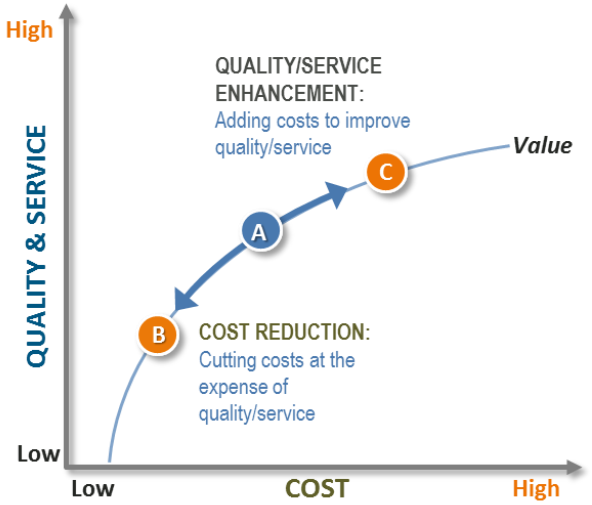
Reimbursement Shifts

The Affordable Care Act is accelerating the shift away from fee-for-service and towards **value-based reimbursement:**

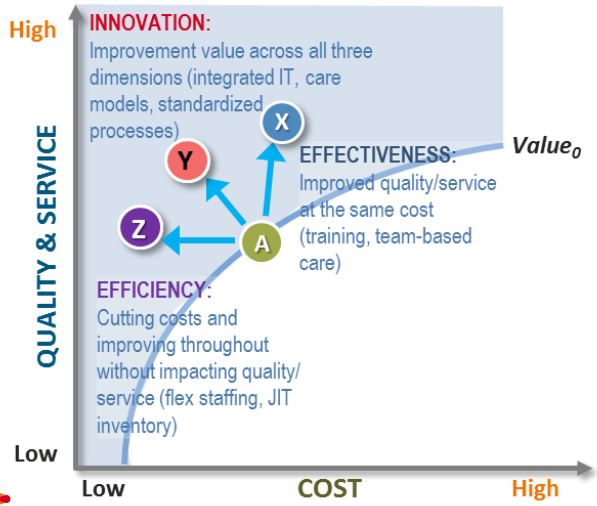
› As providers seek to shift the value curve, they are pursuing care models that feature integration with primary care, greater coordination across the care continuum, and community-oriented services that were not historically incentivized under a FFS model

$$\text{Value (V)} = \frac{\text{Quality (Q) x Service (S)}}{\text{Cost (C)}}$$

TRADITIONAL THINKING



FUTURE EMPHASIS

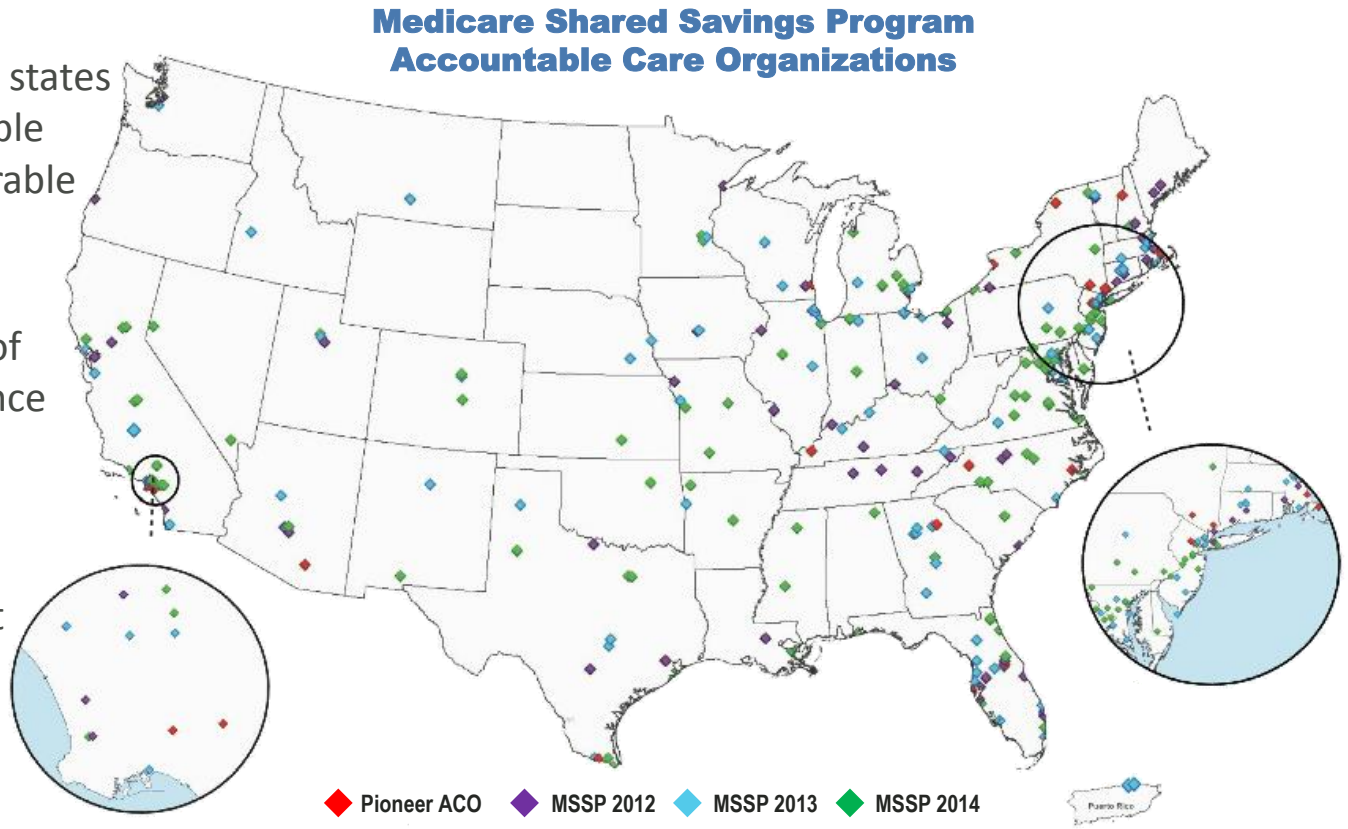


National and Regional Context:

Reimbursement Shifts

Health systems in LA may be behind other health systems in getting behind innovative models that thrive under value-based care but not fee-for-service.

- Louisiana ranks 49th of 51 states (including D.C.) for avoidable hospital use among vulnerable populations[1]
- 26% of patients admitted for screening and history of mental health and substance abuse were readmitted within 30-days to US hospitals in 2010[2]
  - This was the 9th highest source of 30-day readmissions to US hospitals in 2010



Sources:
1. Commonwealth Fund, September 2013 (2009 data)
2. Kaiser Family Foundation, Map- The Advisory Board, January 2013

National and Regional Context:

Reimbursement Shifts

The behavioral health population is becoming increasingly important to reducing costs.

› Medical expenditures for conditions affecting different body systems are 2X-4X higher in patients with co-morbid mental illness than those without co-morbidities

Total Per Member per Month costs by Medical Condition and Mental Health/ Substance Use Comorbidity, Commercial Population 2012

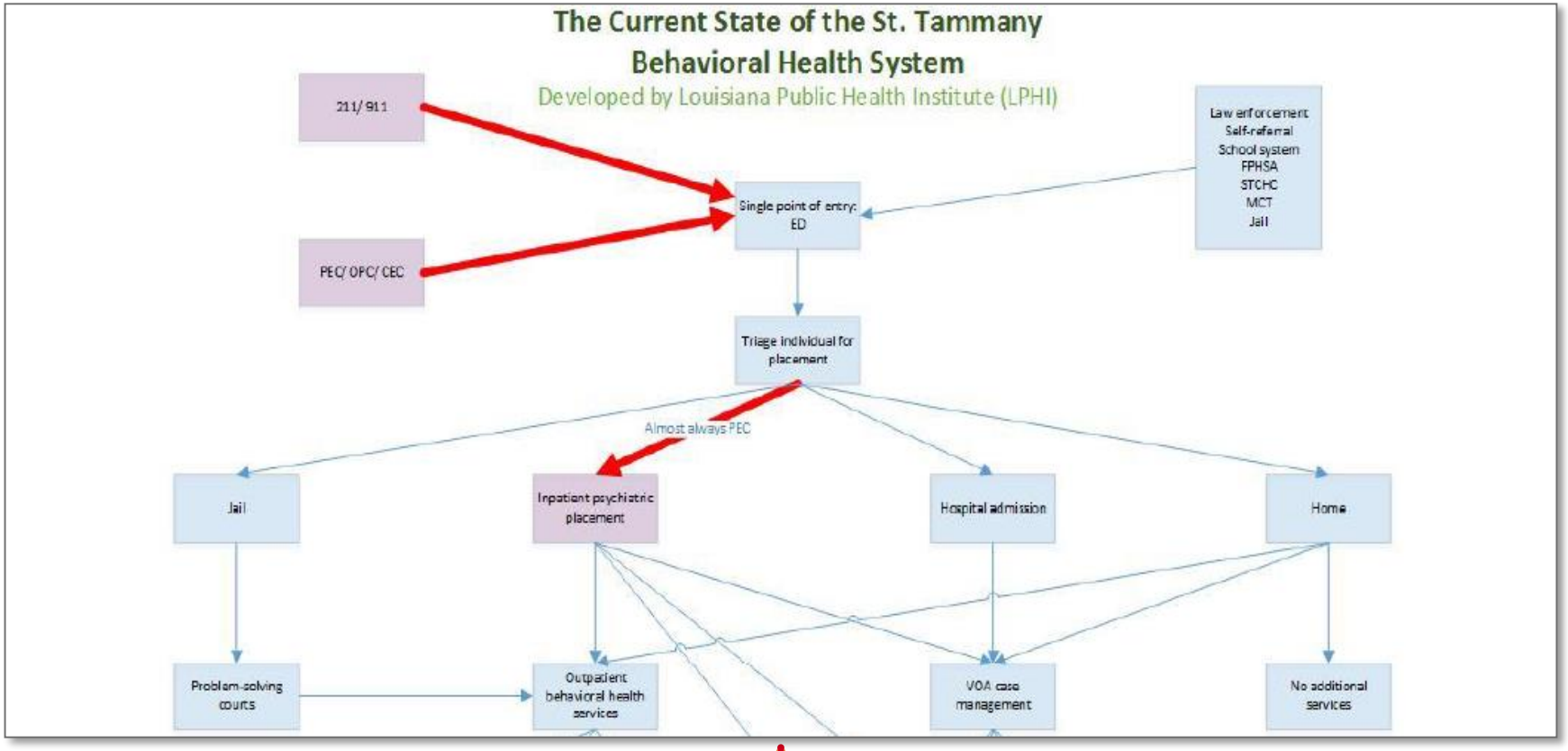
Body System (Condition)	No MH/ Substance Use Disorder	MH/Substance Use Disorder	Cost Differential
Benign/In-situ/ Uncertain Neoplasm	$686	$1,580	2.3x
Cardio-Respiratory Arrest	$4,798	$5,134	1.1x
Cerebro-Vascular	$2,052	$3,299	1.6x
Cognitive Disorders	$2,319	$3,552	1.5x
Diabetes	$1,066	$2,368	2.2x
Ears, Nose, and Throat	$488	$1,455	3.0x
Eyes	$587	$1,625	2.8x
Gastrointestinal	$843	$1,932	2.3x
Genital System	$662	$1,538	2.3x
Heart	$1,023	$2,134	2.1x
Hematological	$1,419	$3,003	2.1x
Liver	$1,328	$2,564	1.9x
Lung	$737	$1,912	2.6x
Malignant Neoplasm	$1,913	$3,185	1.7x
Musculoskeletal and Connective Tissue	$693	$1,624	2.3x
Neurological	$1,476	$2,365	1.6x
Nutritional and Metabolic	$815	$1,923	2.4x
Pregnancy-Related	$1,147	$1,669	1.5x
Skin and Subcutaneous	$598	$1,771	3.0x
Urinary System	$1,079	$2,395	2.2x
Vascular	$1,808	$3,375	1.9x
Total	**$382**	**$1,301**	**3.4x**

Source: Milliman American Psychiatric Association Report, August 2013

National and Regional Context:

Innovative Delivery Models

Behavioral health and physical health providers have typically operated in silos. Accessing behavioral health services through the ED, as seen in St. Tammany, is reflective of national trends and has been driving costs and straining resources.



Source: "Transforming the St. Tammany Behavioral Health System", 2014 Report

National and Regional Context:

Innovative Delivery Models – Care Delivery Integration

Integrating mental health and primary care has shown proven benefits.

Program	Goals	Structure/Process	Services
Cherokee Health System (Knoxville, TX)[1]	› A community health center that was granted status as a Federally Qualified Health Center › Receives Medicaid capitated rate	› Integrated behavioral health and primary care › Integrated record system › Co-location of services allows for informal collaboration	› Integrated services at 22 sites › Services include: – Primary care – Specialized programs for serious mental illness – Case management for chronic BH and physical conditions – Day programs – Substance abuse services

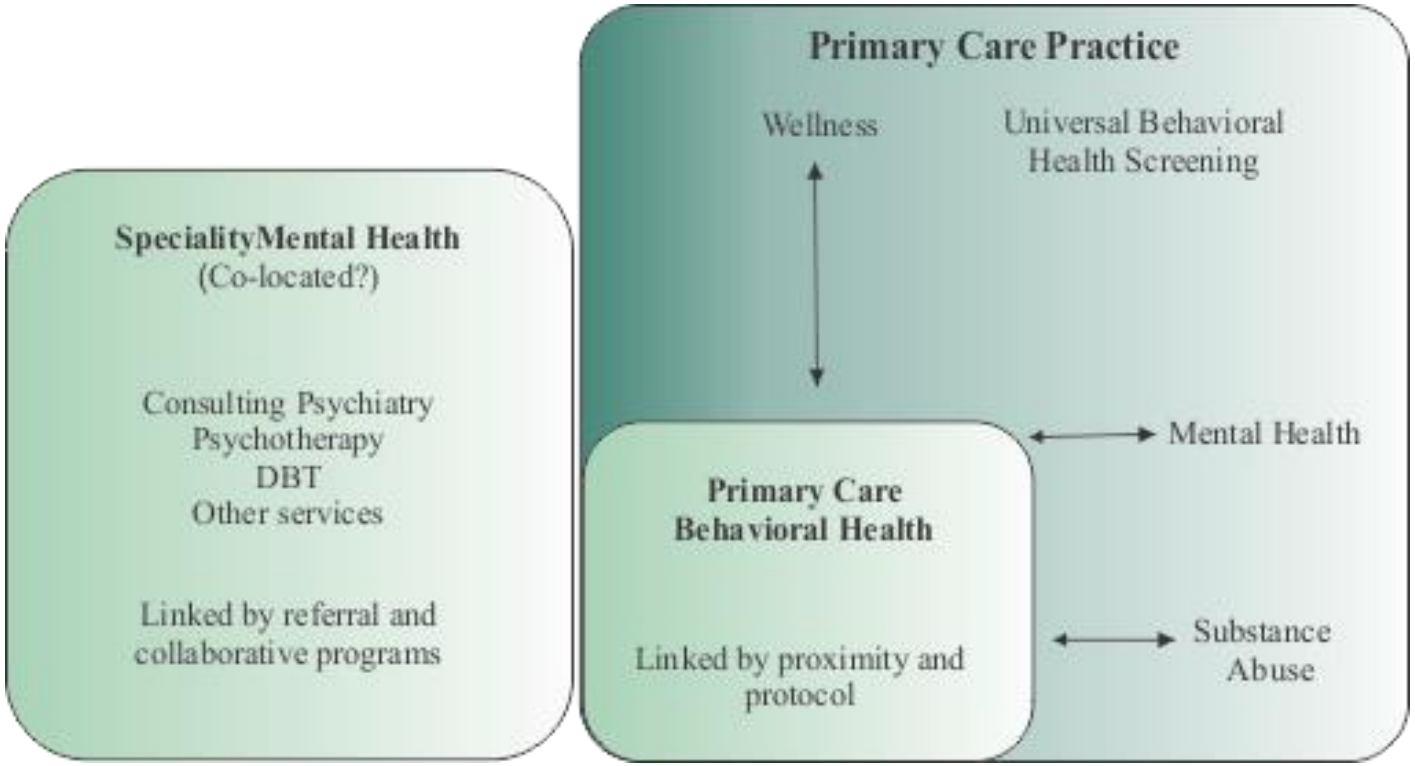
1. "Evolving Models of Behavioral Health Integration in Primary Care", Millibank

National and Regional Context:

Innovative Delivery Models – Care Delivery Integration

In a fully-integrated primary care model, behavioral health and primary care are co-located with consultation from specialty mental health providers.

Fully Integrated Primary Care Structure[1]



1. Center for Integrated Primary Care, UMass Medical School

National and Regional Context:

Innovative Delivery Models – Care Continuum Integration

There are a number of innovative models which promote emergency room and jail diversion.

Program	Goals	Structure/Process	Services
Haven for Hope initiative (Bexar County, TX)[1]	› Address homelessness › Reduce ER visits and incarcerations of mentally ill	› Law enforcement brings non-violent offenders directly to Haven for Hope Campus	› The Courtyard: Shelter Program › Transformational Campus – Substance abuse rehab – Legal services – Social worker aid – Job search and housing search assistance
Los Angeles Police Department's Mental Evaluation Unit (Los Angeles, CA)[2]	› Reduce ER visits and incarcerations of mentally ill	› Half of unit are clinicians › Triage desk for other LAPD units › Estimated to save city and county $10mm per year	› Appropriate encounters are redirected to private facilities with open beds (identified by clinician) › Case Assessment Management Program (CAMP) provides management for complex and chronic cases

1. www.havenforhope.org
2. http://www.scpr.org/news/2015/03/09/50245/police-and-the-mentally-ill-lapd-unit-praised-as-m/

National and Regional Context:

New Entrants

In addition to innovative delivery models, there have also been new entrants in behavioral health. While most focus on servicing payors, employers, and directly to consumers, local governments should explore partnership opportunities with these new entrants.

1. Telemedicine has become more standard and over the past two years has raised over $500mm in funding[1,2]
   - Funding of behavioral health-focused digital health applications has dramatically increased, with 2015 seeing over $70mm invested in nascent firms[1,2]

Telemedicine	Digital Health Applications			Medical Adherence
TELADOC	LYRA	Ginger.io	talkspace	AdhereTech
2015 Funding: $270mm (IPO) **Services:** Over 1,100 board certified physicians; treats BH conditions ranging from anxiety to smoking cessation; $40 per visit News: Recently acquired BetterHealth to expand BH capabilities **Clients:** Payors , employers, direct to consumer	**2015 Funding:** $35mm **Services:** Analytics and screening to identify and connect BH patients w/providers **Clients:** Payors and employers	**2015 Funding:** $20mm **Services:** App provides coaching, self-care tools, and connection to licensed therapist **Clients:** Payors and direct to consumer	**2015 Funding:** $13mm **Services:** Connects patients with independent therapists **Clients:** Employers and direct to consumer	**2014 Funding:** $2mm **Services:** "Smart pillbox" to monitor prescription adherence **Targeted Clients:** Payors, PBMs, pharma

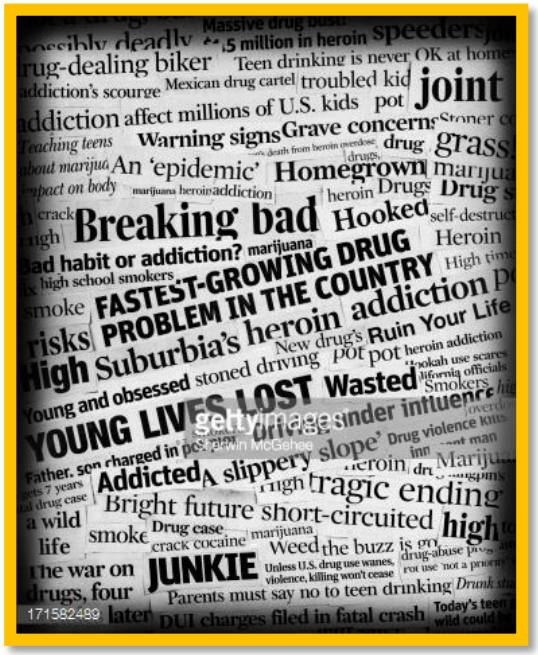
1. Rockhealth.com
2. StartUp Health.

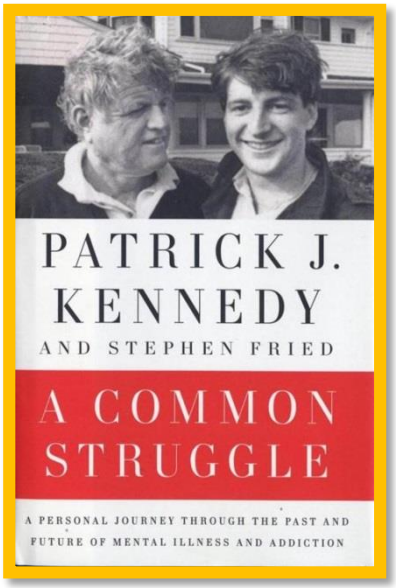
National and Regional Context:

National Dialogue

Over the past few years, mental health and substance abuse has become common in the national dialogue, leading to reduced stigma and a search for solutions.

› In response to repeated acts of gun violence, the Obama Administration's Executive Actions on Gun Control includes $500mm to increase access to mental health





Summary

The national and regional trends all have implications for St. Tammany Parish and the Safe Haven project:

- Lack of inpatient capacity, due to historical declines in funding and a shift to providing "non-institutional care", will require St. Tammany Parish to innovate in providing care delivery
- National and State legislation / policy will increase access to services for community members and St. Tammany Parish will need to design new models of delivery in order to meet the increased demand
- Shifts towards value-based reimbursement will encourage both public and private providers in St. Tammany Parish to integrate behavioral health services into the continuum of care
- Innovative delivery models that target ER and jail diversion will be best practice cases as the Safe Haven campus is developed and implemented
- New entrants to healthcare delivery, including telemedicine and digital health providers, could allow St. Tammany to address behavioral health needs of the community through increased efficiency, innovation, and/or effectiveness
- The national dialogue about mental health and substance abuse provides the Parish with an opportunity that it has not had historically to develop a long-term solution for the community