COMMUNITY TRIAGE CENTER

POLICY COMMITTEE | TUESDAY, AUGUST 21, 2017 | 1:00 P.M. – 3:00 P.M.D

ATTENDEES

Phyllis Ahrends – NAMI
Matt Burns – Sioux Falls Police Department
Sharon Chontos – Sage Project Consultants
Christine Erickson – City Council
Robin Huether – Sanford Health
Mike Milstead – Minnehaha Sheriff's Office
Lori Popkes – Avera Health
Erin Srstka – Minnehaha County
Jon Tveidt - xxx
Kari Benz – Minnehaha County
Chad Campbell – Bishop Dudley Hospitality House
Alicia Collura – Sioux Falls City Health
Kim Hansen – Southeastern Behavioral Health
Dean Karsky – Minnehaha County Commission
Betty Oldenkamp – Lutheran Social Services
Suzanne Smith – Augustana University
Gary Tuschen – Carroll Institute

WELCOME

Kari Benz, Minnehaha County, welcomed the Community Triage Policy Committee. Two significant accomplishments were accomplished since the last Policy Committee meeting. First, Committee members visited four model Community Triage Center (CTC) sites and had the benefit of asking CTC leaders and staff in-depth questions. Second, the Sequential Intercept Mapping (SIM) training was held at the end of June. A significant amount of data has been collected; however, we are still missing important data sets to inform the business plan and financial models.

COMMUNITY TRIAGE CENTER BASELINE DATA

Suzanne Smith, Augustana University, provided a preliminary data presentation based on data collected as of August 21, 2017. The data has been organized by the SIM format. Refer to PowerPoint file – ***Minnehaha Triage Baseline 20170823*** that accompanies these minutes. We extend a special thank you to Suzanne for authoring the summary below.

Intercept 0: Community Services (Slides 2 – 10)

The purpose of this set of baseline measures is to assess the demand of people who are looking for help. Thus far, the Helpline Center and Carroll Institute provided data. The 0perations Committee should consider the experiences of downtown healthcare and human services providers (shelters as well as Community Outreach, Center of Hope, Destiny Clinic, etc.) as well.

The Helpline Center receives an average of 25 mental health needs identified per day (statewide). Although this is a measure of community-based demand for access or navigation, not all would be triage candidates. It is not anticipated a CTC would reduce this number; it may increase as awareness of service availability increases.

The Carroll Institute serves ~2,000 clients annually. They cooperate with Southeastern Behavioral Health, especially for medication management for Arch Halfway House clients and Lutheran Social Services (LSS) clients for psychology services. The Arch has 87 beds (24 female and 63 male). The female wait list is estimated to the end of September and the male wait list is December. The average length of stay is 60 days.

In FY2017, the Carroll Institute received the vast majority (83%) of its referrals to the Arch from the courts or criminal justice. In June and July, Arch residents were detained 33 times (could include people detained multiple times). Usually a probation or parole violation is reported by Arch staff. On average, there are three or four ER/ambulance visits per month from the Arch usually due to anxiety mistaken for heart problem or to get medical clearance after using controlled substances.

Of the Arch client discharges, 42% were successful (FY16). New Horizons provides short-term housing for individuals held on IVCs while they await an open treatment spot. In 2015, there were 145 admissions and 63 admissions in 2016. There were six repeats (~10%) in 2016. In 2015, New Horizons had 149 discharges, with about 34% bound for inpatient treatment, 30% for outpatient treatment, and 18% to Slip/Slot, a combination intensive outpatient / low-intensity residential program. The remaining discharges were either terminated (14%) or had their IVCs dropped (4%).

Intercept 1: Law Enforcement (Slides 11 – 20)

Data collected under Intercept 1 included: a) Calls for Service; b) Mobile Crisis Team; c) Arrests and Charges; and d) Detox and Sobering Center.

Calls for Service: Of the 127,547 total calls for service, the Sioux Falls Police Department responded to 104,226 and the Minnehaha County Sheriff's Office responded to 23,321. They have been combined for this analysis. This is an average of 15 calls per hour or 350 per day. Disorderly subjects: more than 1 call per hour or 34 per day. Most of the calls were resolved on site.

Calls can have multiple outcomes (e.g., 4,534 calls have both "Necessary Action Taken" and Arrest, Jail, Citation, Detox, or McKennan as an outcome). In the table on Slide 14, counts represent calls for service, not people: one call could result in the same or different outcomes for several people. For example, a call could result in two people arrested and one lodged at McKennan. The outcomes Lodged at Jail and Arrest have been combined because they appear to be inconsistently used alone or in combination: 5,857 calls are coded Arrest and Lodged at Jail; an additional 4,632 are coded Lodged at Jail, and 4,656 are coded Arrest. Of those coded Lodged at Jail but not Arrest, 3,318 are 24/7 violations or warrant service.

Mobile Crisis Team. Of calls taken, 461 came from the Sioux Falls Police Department and 22 from the Minnehaha County Sheriff's Office. On average, the Mobile Crisis Team spent just under one hour (57.6 minutes) per call. The Mobile Crisis Team declines calls if there is no probable cause for a mental health hold, if the consumer is too violent or weapons are involved, if the consumer is too impaired (i.e., intoxicated) to speak to the team, if the consumer possibly overdosed and needs medical attention, and if a parent or guardian is not present to give authorization for the team to speak to an adolescent.

Arrests and Charges. In 2016, 15,145 calls (11.87%) resulted in arrest. The table on Slide 16 indicates the types of calls that resulted in the most arrests. Note, however, that call type is based on caller report and does not necessarily correspond to arrest charges. As above, arrest totals indicate a call outcome of "Arrest" or "Lodged at Jail." In most cases (about 85% of the time), only one arrest was made. About 10% of the time, two arrests were made. Three or more arrests were made in less than 5% of all calls resulting in arrest. The vast majority of the most common calls do not result in arrest—with the exception of 24/7 violations and narcotics violation.

Once an arrest has been made, law enforcement has very little discretion over whether someone is booked into jail. Post-arrest diversion would depend on judicial decision at initial appearance. Nevertheless, current arrest patterns provide a baseline for measuring the effects of pre-arrest diversion efforts and triage services. They also give an indication of the number and types of cases that might have been candidates for pre-arrest diversion to triage if the arresting officer had that option available.

19% of arrests include drug charges; 79% of those had only drug charges.
89% of shoplifting arrests had no other charges.
82% of trespassing arrests had no other charges.

Altogether, the 6 charges on Slide 18 were the ONLY charges in 43% of arrests made in 2016.

Detox and Sobering Service. The Detox unit admitted 241 individuals in 2016 and included 165 people held on IVCs. Average length of stay is about 6 days. The total bookings in the Sobering Center was 2,621 in 2016. The average length of stay was 9.7 hours.

Intercept 2 and 3: Initial Detention and Jail (Slides 21 – 29)

Data collected under Intercept 2 and 3 included: a) bookings and b) mental health and substance abuse.

In 2016, Minnehaha County had a total of 17,454 bookings. This total, and the analysis of jail bookings, excludes Detox and Sobering Center bookings. Individuals can have multiple bookings, so numbers should not be interpreted to represent numbers of individuals.

Data are based on self-reported history of mental health (MH) or substance use disorders (SUD) recorded during intake screening. Everyone booked into jail must have a medical screening within two hours. That medical screening consists of both a medical background and mental health screening. In this report, data on mental health and substance use disorders are based on self-report, not the full screening results. A new law enacted July 1, 2017 requires jails use a validated screening tool.

In 2016, the jail medical staff conducted a point-in-time count of people in jail with serious mental illness (SMI) on a single day. They found that 6% of people in jail on that day had been diagnosed with SMI. Anecdotally, jail medical staff have observed that proportion stays fairly steady. Rates of self-reported mental health or substance use disorders were slightly higher among the sentenced than unsentenced population, but fairly consistent across legal statuses.

Compared to the general jail population, bookings with self-reported mental health or substance use disorders are slightly more likely to face a felony charge or a violent charge or to have violated probation (indicating repeat offenders). Nevertheless, the majority (86.7%) of bookings with self-reported mental health or substance use disorders were booked on misdemeanors only (66.9%) or on non-violent charges (86.7%).

Bookings with self-reported mental health or substance use disorders had longer average (mean) length of stay compared to those without: 331 hours (14 days) compared to 180 hours (7.5 days).

While bookings with self-reported mental health or substance abuse disorders made up 24.1% of all bookings, they accounted for 37.1% of all jail bed days.

The length of stay distribution is skewed right: most bookings have relatively short stays, but a few having very long stays, driving up the mean. To put this in perspective, half of all bookings in 2016 had a length of stay of 27 hours or less.

Average length of stay varies by legal status, with longer stays for sentenced bookings. However, unsentenced bookings have the highest relative disparity in length of stay: among unsentenced bookings, those with self-reported mental health or substance use disorders have an average length of stay more than twice that of other unsentenced bookings.

The next steps for this set of data are to:

- Improve data quality with universal mental health screening at intake
- Data matching to identify at booking people known to community-based behavioral health providers
- Criminogenic risk assessment tool

Intercept 4 and 5 will not be discussed at this meeting.

Super Utilizers (Slides 31 – 35)

In 2016, Minnehaha County booked 9,533 people, resulting in 20,169 bookings. Mean number of bookings was 2.12 with a standard deviation of 3.78 bookings. The top 5% of individuals comprised 490 individuals who had 6 or more bookings each, collectively accounting for 5,698 bookings (28.3%) [of which 3,723, or 65%, were Sobering Center bookings]. The top 1% of individuals—102 people—had 12 or more bookings each, collectively accounting for 2,817 bookings (14.0%) [of which 1,670, or 59%, were Sobering Center bookings]. The maximum number of bookings for any individual was 143.

In 2016, Minnehaha County booked 782 people in Detox or the Sobering Center, resulting in 2,708 bookings. Mean number of bookings was 3.46 with a standard deviation of 8.91 bookings. The top 5% of individuals comprised 20 individuals who had 16 or more bookings each, collectively accounting for 1,311 bookings (48.4%). The top 1% of individuals—7 people—had 41 or more bookings each, collectively accounting for 578 bookings (21.3%). The maximum number of bookings for any individual was 139.

For the analysis on Slide 33, Sobering Center and Detox bookings are excluded because they use a different intake process and have inconsistent data on self-reported mental health and substance use status. Sensitivity analysis showed that excluding these bookings did not substantively change results (but universal screening would yield more consistent data).

If Sobering Center and Detox are *excluded*, there were 9,203 people booked in 2016, resulting in 17,461 bookings. Mean number of bookings was 1.9 with a standard deviation of 1.8 bookings. The top 5% of individuals comprised 638 people who had 5 or more bookings each, collectively accounting for 4,551 bookings (25.6%). The top 1% of individuals—123 people—had 9 or more bookings each, collectively accounting for 1,481 bookings (8.0%). The maximum number of bookings for any individual was 32.

Overall, the top 5% of super utilizers (those with 5 or more bookings) occupied a total of 36,782 jail bed days, or 100 beds per day. The top 1% of super utilizers (123 people with 9 or more bookings each) occupied a total of 8,500 jail bed days, or 23 beds per day.

Rates of self-reported mental health and substance use disorders increase with the number of bookings: people with more frequent bookings are more likely to self-report mental health or substance use problems. For example, about 70% of people with 5 or more bookings self-reported mental health or substance use disorders.

People who self-report either mental health or substance use problems are 2.14 times as likely to have multiple bookings (2+) as those who do not. Those who report substance abuse alone are 1.87 times as likely to have multiple bookings, and those who report mental health problems alone are 1.26 times as likely to have multiple bookings. People who report both mental health and substance use problems are 2.18 times as likely to have multiple bookings.

People who self-report either mental health or substance use problems are 5.74 times as likely to be frequent flyers (5+ bookings). Those who report substance abuse alone are 3.28 times as likely to be frequent flyers, but those who report mental health problems alone just as likely to be frequent flyers as those who do not. Because data are based on self-report, this might be due to underreporting of mental health problems among frequent flyers, or it might be due to higher rates of co-occurring disorders among frequent flyers, resulting in a smaller proportion with mental health problems alone. People who report both mental health and substance use problems are 5.43 times as likely to be frequent flyers.

Costs and Capacity (Slides 36 – 42)

This section presents the estimated cost of jailing super utilizers in 2016. It should be noted that new policies or services are unlikely to eliminate these costs, but could shift and reduce costs by decreasing either the number of bookings or length of stay in jail of the target population.

Almost all of the 1% self-report behavioral health problems. Approximately 70% of the top 5% self-report behavioral health problems.

Jail costs are estimated at $95 per day. Super utilizers account for between $713k and $3.5M annually and 21 to 101 beds per day. The estimates below should be considered maximum case volume estimates. They are based on the following assumptions:

- All current Detox and Sobering Center admissions would be diverted to the triage center.
- All Minnehaha County unsentenced bookings on nonviolent charges with self-reported mental health or substance use disorders would have been referred to triage instead of arrested if the arresting officer had the option. In 2016, the total number of bookings that might have been eligible for pre-arrest diversion to a triage center was 3,641. Of those, 985 were from outside Minnehaha County or were serving out a sentence and therefore were considered ineligible for triage in the estimates that follow. For this report, violent charges were defined following guidelines established for implementing the Laura and John Arnold Foundation (LJAF) pretrial risk assessment tool. The guidelines were adapted for use in South Dakota and aligned with state statute in consultation with Minnehaha and Pennington county judges, lawyers, and law enforcement officials. Of 17,461 total bookings, 2,059 included violent charges, and 542 of those self-reported mental health or substance use disorders. Those 542 bookings were excluded from triage daily case volume estimates. However, they were included in all other tables.
- All SFPD and Sheriff's Office calls for service that resulted in lodging at a hospital would have been referred to triage.
- Overall case flow is not reduced by removing super utilizers from circulation (they're picked up just as often, but brought to triage instead of jail).

Demographics (Slides 43 – 48)

MCT serves more women compared to arrests. Carroll Institute serves a similar proportion of men compared to arrests.

Do post-arrest programs miss women who need services? How can triage reach women?

- Nationally, men exhibit higher rates of substance abuse, so this could just be a difference between MH/SUD needs.
- Nationally (in 2012), 69.3% of persons arrested were white, 28.1% were black, and the remaining 2.6% were of other races.
- MCT race demographics more closely mirror general population of Sioux Falls.

The highest age group that are arrested are individuals in their 20s. MCT and Carroll Institute's majority of clients are in their 30s and 40s.

Preliminary Takeaways (Slides 49 – 50)

The data will inform:

- Target population: super utilizers of jail/ED, or people who are off the radar
    - People IN the system now, or people NEW to the system
        - Currently: 30s and 40s, male, ½ white, ¼ American Indian, 1/5 black
        - Possibly new: young people (teens and 20s), women
        - Reminder: private providers not shown
- Point of intervention / sources of referral (law enforcement, courts, community providers, walk-ins?)
- Services: diversion (sobering center), assessment, engagement with treatment, navigation (peers), wraparound services and long-term stability (case management, housing, etc.)?
    - Challenge with super utilizers: engagement

- Statewide epi data: compared to national, low community penetration for MH care, but also high perceived access to services
- Think: length of stay & follow-up care (where to go after triage?)

SEQUENTIAL INTERCEPT MAPPING (SIM)

Erin expressed gratitude to Policy and Operations Committee members who attended the SIM training at the end of June. The attendance demonstrated community support. Approximately 45 people participated. The draft report will be completed in September. Erin also expressed gratitude to the facilitators, Judge xxx xxx, from Dade County, Florida.

Minnehaha County will initially focus on Intercept 0. We are the first U.S. county to address Intercept 0 first. Intercept 0 will focus how e can do MORE on the 'front end" and do our best to have collective impact "BEFORE" individuals (a) start becoming involved with the legal system; or (b) have more intensive intervention for those that have already been involved with the legal system and high recidivism is not a pattern.

Peer navigators released that involving those that have life experience and first-hand experience in having, coping with, and addressing the same types of struggles and hurdles is critical piece to our strategies.

The Policy and Operations Committee will cross-walk the Intercept and the baseline data summarized by the Augustana Research Institute. We believe there will be an opportunity improve every Intercept. One strategy we may want to consider is using peer navigators.

In summary, we had amazing discussion and participation by all. Our trainers were very impressed with our level of commitment, desire for collaborative efforts, and openness to change.

SITE VISITS

Refer to ***Site Visit Report*** accompanying these minutes for more details on the site visit findings.

In second quarter 2017, the Community Triage Center (CTC) Policy Committee members visited four sites that represent successful models of addressing mental illness and substance abuse. Dade County, Bexar County, Las Vegas, and Salt Lake City have designed systems that not only treat individuals with behavioral health issues, but also helps them assimilate back into the community. The Policy Community members wrote a report of findings which is summarized in this report. Members recommended the Committee consider funding, communication, integration, and location.

Funding is the first issue to be addressed in establishing a CTC. A Key theme that surfaced in each report was that funding be addressed and solidified early in the planning process. Most Triage Centers received funding from city, county, and state governments. In addition, the members noted local health providers provided funding or in-kind staff at each site. The model CTC sites realized cost savings of city, county, and state agencies, and health care providers due to the decrease in resources of diverting individuals with behavioral health issues to the CTC. Thus, the Committee members recommended cost savings should be reinvested into the CTC to increase operational capacity and efficiency. However, it was noted that funding should be diverse to decrease dependency on any one provider. For example, one individual expressed concern over whether the state would be likely to get involved in funding the CTC. It is imperative that alternative funding mechanisms are discussed. A few of the more popular solutions were the "Civil Citation" used in Dade County, the reinvestment of organizational savings, collaboration or integration of existing organizations, and re-vising the current budget. Along with funding, operational revenues were a concern and thus the billing process must be established. For example, the CTC in Las Vegas worked with the state to add billable codes to the Medicaid System.

Inter-agency communication and integration was the second re-occurring theme. Committee members recommended establishing partnerships with law enforcement to create special mental health training and/or units, local health care providers, the judiciaries, EMS, Social Services, and other behavioral health providers. For communicative purposes, a cloud based software platform (such as an ERP) will be necessary to allow for the complete flow of information and thereby improving case management. Along with funding, communication and integration will be vital to the success of the program.

Lastly, the issue of **location** seems to be very important. For example, Dade County positioned its CTC in the jail itself to screen incoming arrestees and identify mental health or drug issues. Other CTC's were strategically placed in highly populated areas of the target population, such as in Las Vegas's homeless communities. One important note is that successfully establishing the Minnehaha County CTC as a "one-stop shop" or comprehensive care hub to allow for ease of use would be beneficial. It may be worthwhile to discuss bringing together current health providers in the area under one roof which thereby makes it easier to communicate and provide for a wide variety of cases.

The Policy Committee members summarized the site visit model they visited. The following are highlights:

Miami-Dade

- Funding: County and city (savings from avoiding incarceration), hospitals/health care facilities, civil citation process, health trust (primarily health). Note - they kept savings within the departments.
- Location: No brick and mortar
- Target Population: Those taken into custody
- Services/Process: Screening, referral to existing agencies within the community
    - *In boarding*
    - *Arrest and booking*
    - *Units: specialized based on needs*
    - *Decision: charged or treatment*
- Partnerships: Mayor, state level, healthcare, mental health services
- Length of Stay: Depends on where they were diverted to
- Staff: Law enforcement, psychiatrists, interns, peer navigators
- Measures: Days in jail, success measures, crime statistics, treatment effectiveness

Las Vegas

- Funding: County, city, state, and hospitals (NV had expanded Medicaid), billing insurance and Medicaid. They divided expenses by regions that hospitals served.
- Location: Among homeless population
- Target Audience: Homeless, meth/opiate, and alcohol. They are just starting with mental health services as co-existing conditions to substance abuse. No one was under arrest. Alternative to incarceration. They were not crowding the ERs. Clients could also self-report as well as referred to by law enforcement.
- Services/Process: Sobering and Detox Center. They use a EMS Procedure Card.
- Partnerships: Defined through Memorandums of Understanding
- Length of Stay: 3 – 5 days average; however, it has decreased now. Model is to have them in house for about 3 days and then refer them to where they need to be or back home
- Staff: Nursing techs, RNs (daytime), counselors
- Beds: 40 beds (may not be large enough for a community of that size)

Bexar County, TX

- Funding: 100 different sources (contracts – state, grants). They were very assertive in finding funding including legislative (state and national).
- Location: One place – centrally located – with wraparound services.
- Target Audience: Mental health, substance use disorder. Clients are not in custody; they are there by free will.
- Services/Process: Sobering center, crisis stabilization, mental health, and chemical dependency programming, meth clinic. They offer continuity of care and case management.
- Partnership: Haven for Hope: law enforcement (10 specialized officers)
- Length of Stay: Short-term and Long-term
- Staff: Psychiatrists, social workers, housing specialists, peer navigators, many volunteers, mobile crisis team, EMTs, internships
- Needs: Lack of housing; shelter – ballooned to over 2,000; 900 slept outside for 9 months. There is a long wait before shelter programming.

Salt Lake City

- Funding: City, county, state, hospitals, college
- Location: scattered through community. They offer a full continuum of care.
  - Facility: Placed offices in exterior of building to take advantage of views. Huge cafeteria – college students, clients, cultural food, "magic window", drop down computers in the hallways, doors could not be blocked, full beds, home-like setting.
  - Off-campus programs: Step-down unit, crisis unit, mobile crisis (peer coach), referral line
- Target Population: Primarily mental health but also co-existing substance use disorder
- Services: Mobile crisis team, medical detox, inpatient beds
- Partnerships: Extraordinary Inter-governmental collaboration
- Length of Stay: Short-term and Long-term (7 – 10 days)
- Staff: Specialized staff – RNs, psychiatric social workers, substance abuse counselors, peer navigators, psychiatrists. They did a good job in recruitment and retention strategies, partnership with higher education
- Notes: They have seen very good results. They are not being afraid to take risks and are open to change.

Minnehaha County Design Take-Aways

- What do you want to include or consider in business model?
  - *Funding: Public and private partnerships, health trust (investigate)*
  - *Location: Clearing house model – one stop shop (x211 model)*
  - *Services: Mental health service, substance use disorders, continuum of care between partner agencies, case management*
  - *Process: Self-referral, streamlined arrest, booking, referral (Miami Dade), EMS procedure card (Las Vegas)*
  - *Staff: Peer navigators, law enforcement, medical, internship, residency, formalized relationships with higher education*
  - *What can we do with our current resources?*
  - *What can we do with our current laws?*
- Las Vegas – funding model, EMS procedure card,

Overall, the Policy Committee members summarized they believed a Community Triage Center is achievable and may provide a valuable service to the community. The main concerns were funding, inter-agency communication and relationships, and location. However, the sites visited illuminated numerous ways to overcome these issues; thus, if the CTC program is to be pursued, the next step will be to data collection on prominent community needs and reaching out to local medical and behavioral health care and law enforcement, whom will play important roles in creating a CTC in Minnehaha County.

Action Items

- ✓ Provide data to Suzanne Smith. Do you want to call this out in minutes? Get unidentified data and gain agreements for identifiable data and share identifiable data.
    - Avera Health
    - Sanford Health
    - Southeastern Behavioral Health
- ✓ Determine the process to set up health trust.
- ✓ Ask Las Vegas CTC what services are they able to bill. (Erin Srstka)
- ✓ Keep in touch with Rapid City as they are modeling their CTC after Bexar County model. (Erin Srstka, Kari Benz)
- ✓ Reach out to Stepping Up staff to inquire what similar sized cities are doing. (Erin Srstka)

The next meeting will be in November after the data report has been completed. Sharon Chontos will send a Doodle Poll to set date the week of August 28.