COMMUNITY TRIAGE CENTER

POLICY COMMITTEE | THURSDAY, NOVEMBER 9, 2017 | 11:00 A.M. – 1:00 P.M.

ATTENDEES

Phyllis Ahrends – NAMI
Matt Burns – Sioux Falls Police Department
Sharon Chontos – Sage Project Consultants
Christine Erickson – City Council
Kim Hansen – Southeastern Behavioral Health
Dean Karsky – Minnehaha County Commission
Betty Oldenkamp – Lutheran Social Services
Lori Popkes – Avera Health
Traci Smith – Public Defender
Chris Thorkelson – Lloyd Companies
Jon Tveidt – UJS Court Services
Kari Benz – Minnehaha County
Chad Campbell – Bishop Dudley Hospitality House
Alicia Collura – Sioux Falls City Health Dept
Jill Franken – Sioux Falls City Health Dept
Monica Huber – Sanford Health
Mike Milstead – Minnehaha Sheriff's Office
Judge John Pekas – UJS Judge
Suzanne Smith – Augustana University
Erin Srstka – Minnehaha County
Gary Tuschen – Carroll Institute

WELCOME

Kari Benz, Minnehaha County, welcomed the Community Triage Center (CTC) Policy Committee. She expressed appreciation of the Committee members commitment to attend the meetings and provide support to the project outside meetings. Since the last meeting in August, Kari and Erin traveled to New Orleans to attend the McArthur Safety and Justice Challenge Innovation Site conference. There they picked up many best practices that will be shared with the Policy and Operations Committee.

Four Operations Committee meetings are scheduled in November and December. The Operations Committee will define the pilot project business plan. From the business plan, we will be able to develop a budget.

There will be a KSFY news story facilitated by Kelley Smith. KSFY will be doing a two-part story at 6 p.m. and 10 p.m. on Monday, November 13. Kelly traveled to Las Vegas triage center. She met with a client who is now a director. Gromer – will be interviewed.

COMMUNITY TRIAGE CENTER BASELINE DATA

Suzanne Smith, Augustana University, provided a presentation based on data collected as of November 8, 2017. The data has been organized by the SIM format. Criminal justice, behavioral health, and health care data were provided. Refer to PowerPoint file – ***Minnehaha Triage Baseline 20171109*** that accompanies these minutes. We extend a special thank you to Suzanne for authoring the summary below.

Intercept 0: Community Services (Slides 3 – 17)

The purpose of this set of baseline measures is to assess the demand of people who are looking for help. The following organizations provided data: Helpline Center, Lutheran Social Services, Southeastern Behavioral Health, Carroll Institute, Falls Community Health, Avera Emergency Room, and Sanford Emergency Room.

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.

Lutheran Social Services served 667 during 2016. Clients may receive more than on service, so clients per service sum to more than total number of clients.

Southeastern Behavioral Health serviced 5,000 clients annually. Their top referral sources were Department of Social Services, schools, self/family/friend, hospital/medical facilities, court/criminal justice, and Human Services Center.

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 one to two months and the male wait list three to four months. 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%).

Falls Community Health provides medication bridging for one month. During 2016, Falls Community Health had 1,998 encounters for behavioral health, 231 for chemical dependence, 871 for alcohol abuse, and 543 for drug abuse.

Avera and Sanford Emergency Rooms (combined) had 6,081 encounters for mental health, 2,542 for substance abuse, 2,024 for alcohol abuse, and 556 for drug abuse. These encounters represented approximately 832 days in the emergency rooms or 2.28 occupied beds per day.

The summary of the Intercept 0 data is summarized below:

Organization	Behavioral Health Clients Served (2016)
Helpline	> 9,000 calls statewide
Falls Community Health	500 to 1,000 behavioral health patients
Lutheran Social Services	667 counseling clients
Carroll Institute	2,000 clients
Southeastern Behavioral Health	5,000 clients
Hospital ERs	6,589 behavioral health encounters
Adults with SMI (est. 5% MSA)	9,156
Adults with SUD (est. 15% MSA)	27,468

Intercept 1: Law Enforcement (Slides 18 – 28)
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.

The summary of the Intercept 1 data is summarized below:

Organization	Instances (2016)
Calls for service	127,547 calls
Necessary action taken	79,114 calls
Arrests	15,145 calls
MCT calls	572 calls
Detox	241 clients
Sobering Center	2,621 bookings

Intercept 2 and 3: Initial Detention and Jail (Slides 31 – 38)

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, and the Sheriff reports screening will begin early in 2018. Screening will be conducted by correctional officers within 72 hours of booking, and results will be provided to judges.

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

Super Utilizers (Slides 39 – 45)

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 42, 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 46 – 55)

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. In 2016, the top 1% and self-reported behavioral health problem individuals account for 106 people with 5+ bookings, 71 total days in jail person (on average), 7,510 bed days annually, 21 beds per day, and $713k annually. In 2016, the top 5% and self-reported behavioral health problem individuals account for 446 people with 5+ bookings, 62 total days in jail person (on average), 27,710 bed days annually, 76 beds per day, and $2.6M annually.

The total charges at Avera and Sanford ER visits in 2016 for this population was $40M. The average charges per encounter was $6,076. Overall, about 32% of behavioral health ER visits are uninsured. Breakout by insurance type is currently available for only one hospital, where it was 14% Medicaid, 18% Medicare, and 31% private insurance.

Fifty-three percent (53%) of Falls Community Health clients are uninsured. Approximately 30% have Medicaid or CHIP, and 15 % have other third-party insurance.

Unless, the triage could provide care at lower costs, a triage center ma result in cost shifting and not cost saving. Hospital costs are based on observed ***charges*** for selected encounters (behavioral health related). Charges for uninsured and Medicaid patients have been estimated by extrapolating ratios of insurance status and charges from one hospital for which they were available.

Organization	Behavioral Health Cost Estimate (2016)
Jail (super users)	$700,000 to $2.6 million
Hospital ER (total)	$40 million
Uninsured (est.)	*$9.7 million*
Medicaid (est.)	*$6.1 million*

Suzanne ran three scenarios:

1. Maximum – 92 daily beds

   The potential demand estimate of 92 daily beds 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).
- Ten percent (10%) of behavioral health related ER visits that do not result in inpatient admission are redirected to the Triage center.

2. 72-hour average – 27 daily beds
   Twenty-seven (27) daily beds are assumed if length of stay is assumed to be 72 hours. Length of stay hospital redirects could be longer if Triage aims to engage in ongoing care (versus ER), and length of stay for criminal justice redirects (pre-arrest or pre-trial) could be shorter (if stabilized more quickly than max length of stay). However, detox clients may need a longer length of stay.

3. Minimum – 8 daily beds
   Assume hospital redirects could be longer if Triage aims to engage in ongoing care (versus ER), and length of stay for criminal justice redirects (pre-arrest or pre-trial) could be shorter (if stabilized more quickly than max length of stay). If we assume average length of stay is 155 hours, the beds required would be ~eight. Criminal justice redirects might be overestimated. It is assumed 10% of potentially eligible are redirected (pre-arrest or pre-trial) and they're stabilized in 12 hours

Note Waterloo, IA (about a third the size of Sioux Falls) launched a pilot crisis center with two beds and quickly expanded to ten beds. Most referrals came from medical providers/ER; very few came from criminal justice and law enforcement.

Demographics (Slides 56 – 60)

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

Twenty-three percent (23%) of Falls Community Health clients speak another language.

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. By comparison, ER median age for behavioral health-related encounters (calculated only for one hospital) is 40 with about 5% of encounters for patients under 18. Compared to arrests, population, and behavioral health providers, ER encounters are older.

Policy Questions (Slides 61 – 63)

Goals 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?)
  - Pre-arrest or pre-trial diversion

    - EMS protocol
- 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?)

Discussion of Data Slides

Sheriff Milstead validated there are super utilizers. The sobering center keeps individuals until their blood alcohol level is 1.0. When they are leave, they can become victimized. The detox center are for people who want help. The community triage center could keep individuals off the street so they will not be exposed and may be encouraged to get help. The Triage Center may be able to fill the gap of providing transitional beds to keep individual s off the street and have time to engage them to begin treatment. The Triage Center may also be able to provide case management especially for those individuals with co-occurring conditions.

Safe Home does not have enough room for the population described above. Safe Home is a 33-bed permanent housing solution for individuals that are medically stable.

Chad Campbell validated many of the target population would be classified as homeless. This population may not be ready to receive treatment; some have indicated they wish to die.

Other Data

Jeff Gromer, Warden of the Minnehaha County Jail pulled the following 2016 statistics:

- In 2016 the Jail conducted 2903 bookings for Protective Custody Holds (SDCL 34-20A-55) these are commonly the Sobering Center Holds.

- In 2016 there were 797 different individuals booked for Protective Custody Holds, the average is 3.64 Protective Custody Bookings per individual. The average is a little misleading since one particular individual was booked for Protective Custody holds 143 separate times. This person was booked into Jail on a Protective Custody hold 29 different times in June alone.

- 523 different people were booked in only one time. Leaving 274 that were booked multiple times for Protective Custody holds.

- 10 Separate individuals were booked for Protective Custody holds more than 40 times in 2016.

- The Summer months had a higher number of Protective Custody Bookings than the winter months.

  In 2016:
  523 different people were booked on Protective Custody Holds only 1 time
  178 different people were booked on Protective Custody Holds 2-5 times
  40 different people were booked on Protective Custody Holds 6-10 times
  27 different people were booked on Protective Custody Holds 11-20 times
  19 different people were booked on Protective Custody Holds 20-40 times
  10 different people were booked on Protective Custody Holds over 40 times

These numbers only count Jail Bookings for SDCL 34-20A-55, meaning that any of the people referenced above could have been to jail on other instances but charged with criminal violations, those bookings for criminal violations are not counted in this data.

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 final report will be completed in November.

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 we 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.

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. 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 draft report listed the following recommendations:

Recommendation 1: Examine the feasibility and need for alternatives to detention and pre-adjudication diversion options for people with mental disorders at Intercept 2.

Defendants with mental disorders who are remanded to pretrial detention often have worse public safety outcomes than defendants who are released to the community pending disposition of their criminal cases. Consider proportional responses based on the severity of a defendant's criminal risk and behavioral health treatment needs.

Recommendation 2: Expand the utilization of Peer Support Specialists across the Intercepts.

Peer support is particularly helpful in easing the traumatization of the corrections process and encouraging consumers to engage in treatment services. Settings that have successfully integrated peers include crisis evaluation centers, emergency rooms, jails, treatment courts, and reentry services.

Recommendation 3: Increase trauma training for justice involved personnel.

Trauma training that specifically targets personnel involved in criminal justice addresses the unique issues related to traumatization and its impact on recidivism. This may be helpful in changing cultural attitudes and lead to increased diversion efforts.

Recommendation 4: Improve data collections across Intercepts.

Improving cross system data collection and integration is key to identifying high user populations, justifying expansion of programs, and measuring program outcomes and success.

OPERATIONS COMMITTEE QUESTIONS

The Operations Committee will be meeting four times in November and December to develop a business plan for a pilot project. The Policy Committee provided the following aims:

- Decrease avoidable costs.
- Increase access.
- Improve processes.
- Decrease duplication of services.

- Serve the target audience.

Target audience

Who should be the pilot project target audience? The initial assessment is:

- Substance use disorder and non-medical emergency, non-violent
- Mental health need/situation (without SUD) and non-medical emergency, non-violent
- Mental health need/situation (with SUD or Co-occurring) and non-medical emergency, non-violent

How many beds should be in the pilot project?

One option would be to target 20 – 40 super utilizers. Another option is the 446 per year.

What should be the plan for youth?

The CTC will not be an option; however, we need to know where youth can receive services.

Services

What should be the pilot project services? The initial assessment is:

- Detox
- Sobering center (may leave sobering center in place – one of the CTC doors)

Operations

Outline 24/7 operations including but not limited to:

- Referral process
    - Walk-in
    - Law enforcement
    - First responders
    - Judicial system
- Assessment and Triage
- Care plan
- Follow up/Case Management

Outline case management operations.

Software operating system

What software operating system should be used?

- Look to partners systems. Software platform.
- ERP to manage:
    - Intake
    - Case management
    - Information flow between departments and partners
    - Other processes

Staffing

Outline staffing plan for pilot project.

- Sober Unit – now staffed with correctional officers
- Detox
- Mental Health
- Administration
- Medical
- Security

Funding and in-kind resources
What are the budget assumptions?

What are potential funding sources?

- State - check with state sources to make sure contracts remain the same
- City
- County
- Local Health Providers (define, if any)
- MacArthur Safety and Justice Challenge Innovation Site: $50,000
- SAMHSA Gains Center Sequential Intercept Mapping (SIM) Workshop: $21,000
- South Dakota Department of Social Services Behavioral Health Crisis Response Grant: $18,750 (Oct 2017)

Facility Requirements
What are the requirements of the facility?

What are pilot project location options?

What are options for a permanent location options if the pilot is successful?
Note: ~3 years, the Public Safety Building will be vacated.