

Community Triage Center

CONCEPTUAL PLAN

CTC Policy and Operations Committee

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Glossary

The following terms, acronyms or identifiers are used throughout this plan.

2-1-1	A free and confidential service that helps people find the local resources they need. Managed by the Helpline Center in South Dakota.
ARSD	Administrative Rules in South Dakota that are officially promulgated agency regulations that have the force and effect of law. Passed by the state legislature.
Addiction Counselor	Any individual who meets the standards established by BAPP and is recognized as a licensed addiction counselor or certified addiction counselor, by BAPP.
Addiction Counselor Trainee	Any individual who meets the standards established, and is recognized, by BAPP.
Admission	The point in an individual's relationship with an agency or program when the intake services is complete, and the individual is eligible to receive and accept services.
Agency	Any facility seeking or holding accreditation through the Department of Social Services as provided in SDCL subdivision 34-20A-2(1);

ASAM Criteria	American Society of Addiction Medicine (ASAM) is the Nation's leading addiction medicine society representing physicians, clinicians and other professionals. The ASAM criteria is most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.
ASAM Criteria Level 3.2	Level 3.2D" or "Clinically-managed residential detoxification program," an accredited short-term residential program providing services listed in chapter 67:61:17 through the supervised withdrawal from alcohol or other drugs for a person not having a known serious physical or immediate psychiatric complication.
ASAM Criteria Level 3.7	Level 3.7" or "Medically-monitored intensive inpatient treatment program," an accredited residential treatment program providing services listed in chapter 67:61:18 to a client in a structured environment.
Board of Directors	The entity legally responsible for the overall operation and management of an agency.
BAPP	Board of Addiction and Prevention Professionals
CD	Chemical dependency
Client	An individual receiving alcohol, other drug, or gambling treatment services from an accredited agency.
CNA	A certified nursing assistant (CNA) helps patients or clients with healthcare needs under the supervision of a Registered Nurse (RN)
Continued Service Criteria	Criteria to describe the clinical severity and degree of resolution of a client's alcohol or other drug problem and indicate the intensity of the services needed in determining continuing care.
Continuing Care	The provision of a treatment plan and organizational structure that will ensure a client receives the care needed at the time, particularly at the point of discharge or transfer from the current level of care. The treatment program is flexible and tailored to the shifting needs of the client and level of treatment acceptance or adherence.
Co-occurring Disorder	A mental health condition in combination with any of the following: substance use problem, trauma issues, problem gambling, medical issues, or developmental disabilities.

Detox	A facility that provides 24-hour supervision observation and support for clients who are intoxicated and/or experiencing withdrawal symptoms.
Detoxification	The medical treatment of an alcoholic or drug addict involving abstinence from drink or drugs until the bloodstream is free of toxins.
EC	Emergency Commitment. In order for a person to be committed under the emergency commitment statute, SDCL § 34-20A-63, the applicant must allege the person, whose commitment is being sought, is an intoxicated person who: a) has threatened, attempted, or inflicted physical harm on him or herself or on another or is likely to inflict physical harm on him or herself or on another unless committed; or b) is incapacitated by the effects of alcohol or drugs; or c) is pregnant and using alcohol or drugs.
EMS	Emergency Medical Services
ER	Emergency Room
Evidence-Based Practice	A treatment or intervention that research has proved to be effective.
Group Counseling	The face-to-face interaction between an addiction counselor or addiction counselor-trainee and two or more clients for a specific therapeutic purpose, not to exceed 15 clients unless otherwise dictated by the evidence-based practice used.
Individual Counseling	The face-to-face interaction between an addiction counselor or counselor-trainee and an individual client for a specific therapeutic purpose.
Intern	A college student gaining supervised practical experience.
IVC	Involuntary Commitment. South Dakota state law allows a person to proceed with an involuntary commitment for the treatment of another person with a serious mental illness or who has a substance abuse disorder. A person with mental illness can be involuntarily committed if they meet the statutory criteria as stated in <u>SDCL 27A-1-2</u> . A person with a substance abuse disorder can be involuntarily committed if they meet the statutory criteria as stated in <u>SDCL 34-20A-63</u>
HIPAA	Health Insurance Portability and Accountability Act is United States legislation that provides data privacy and security provisions for safeguarding medical information.
ICM	Intensive case management
LPN	Licensed practical nurse

MAT	Medication-assisted treatment
MIS	Management Information Systems is a system designed to collect, store, and report treatment and treatment outcome data
Medical Director	The person responsible for providing care and oversight of medical care to a client in an accredited agency.
Mental Disorder	A substantial organic or psychiatric disorder of thought, mood, perception, orientation, or memory as specified within the DSM-5 criteria or coding found in § 67:16:01:26. Intellectual disability, epilepsy, other developmental disability, alcohol or substance abuse, or brief periods of intoxication, or criminal behavior do not, alone, constitute mental illness.
Nonresidential Program	An accredited program that provides alcohol and other drug abuse treatment and prevention services on a less than 24-hour-a-day basis and do not provide housing for clients; a nonresidential program includes prevention programs, early intervention programs, outpatient treatment programs, intensive outpatient programs, and some day treatment programs.
PBT	A preliminary breath test (PBT) is considered a field sobriety test. The purpose of this test is to determine if the officer has probable cause to make a DUI arrest.
PC	Protective Custody. Protective custody procedure (duty of detaining officer, no arrest or record): Any law enforcement officer, in detaining a person pursuant to § 34-20A-55 and in taking him/her to an approved SUD treatment facility, for emergency commitment is taking him/her into protective custody and shall make every reasonable effort to protect his/her health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect themselves. Protective custody under this section is not an arrest. No entry or other record may be made to indicate that the person has been arrested or charged with a crime. (34-20A-56)
Physician	A person licensed in accordance with the provisions of SDCL chapter 36-4 and qualified to provide medical and other health services under this chapter.
Prevention Program	An accredited program providing services listed in chapter 67:61:11 through a planned and recurring sequence of multiple, structured activities to inform, educate, impart skills, deliver services, and provide appropriate referrals for other services, through the practice and application of recognized prevention strategies.
Program	An organized system and specific level of services offered by an agency designed to address the treatment needs of a client.

Recovery	A process of change through which an individual achieves improved health, wellness and quality of life.
RN	A licensed registered nurse
Residential Program	An accredited program that provides housing and food services in addition to alcohol and other drug abuse treatment services on a 24-hour, 7-day-per-week basis; residential programs may include day treatment programs, clinically managed residential detoxification programs, medically-monitored intensive inpatient treatment programs for adolescents, medically-monitored intensive inpatient treatment programs for adults, or clinically-managed low-intensity residential treatment programs.
SD DSS	South Dakota Department of Social Services
SD UJS	South Dakota Unified Judicial System
Services	Direct or indirect contact between a client or a group of clients and agency staff for the purpose of diagnosis, evaluation, treatment, consultation, or other necessary direct assistance in providing comprehensive treatment
SIM	Sequential Intercept Mapping is an interactive tool for developing criminal justice-mental health partnerships used by communities to assess their resources, gaps and opportunities at each of five “intercept points.” The mapping exercise aims to identify potential opportunities for diversion, or alternative justice and behavioral health interventions for persons with mental illness and co-occurring disorders, within each of the five intercepts.
Sobering Center	A safe place for intoxicated individuals until they are no longer intoxicated.
SUD	Substance Use Disorder also known as drug use disorder, is a condition in which the use of one or more substances leads to a clinically significant.
Transfer	Movement of the client from one level of service to another.
Treatment Plan	A written, individualized, and comprehensive plan based on information obtained from the integrated assessment and includes treatment goals or objectives for primary problems that indicate a need for treatment services and is designed to improve a client's condition;
Volunteer	An individual who provides unpaid assistance to an agency or program.
Work Therapy	A therapeutic task based on the client's physical abilities, interest level, and proficiency used to habilitate or rehabilitate a client.

Executive Summary

The primary purpose of the **Community Triage Center (CTC)** planning project is to investigate the feasibility and develop a conceptual plan for a voluntary, mid-level care alternative for those with substance/alcohol abuse as well as those with mental illness who are not violent in behavior. The target population are individuals in a mental health and/or substance use disorder crisis, regardless of socio-economic background. The partnership collaborative, led by Minnehaha County, aims to create a front-line service for a population that needs treatment provided with respect, dignity, and understanding.

The first phase of the CTC project was to bring the strategic community partners together to determine if a triage center would be appropriate for our community. In order to inform the conceptual plan, data was collected and analyzed to determine need, a sequential intercept mapping model was defined to determine interventions, and model community sites visited to identify operational best practices.

The purpose of this conceptual plan is to provide information to the Policy Committee to determine a Go / No Go decision for the Phase 2 Pilot and to investigate a Phase 3 scale up model.

Guiding Principles

Five principles will guide the Community Triage Center and key partners as they implement the Pilot Recommendation.

- **Client-Centered Care Plans.** Establish client-centered, strength-focused care plans that identify a discharge strategy and support services. Clients may return to the CTC for support groups, education, case management, and/or appointments with a psychiatrist until a long-term provider has an opening.
- **Data-Driven Solutions.** Recommend solutions that are driven by data, research, and best practices.
- **Justice System Alternative.** Create an alternative to the justice system for the community to utilize as a response to individuals in a behavioral health related crisis. Specific decision points include a pre-arrest, arrest, pretrial release, and reentry.
- **Emergency Room Alternative.** Create an alternative to emergency rooms so they have greater capacity to address life-threatening medical emergencies, such as heart attacks, diabetes issues, strokes, etc.
- **Demonstrate Success.** Show that a collaborative approach is an effective, efficient strategy to provide optimal outcomes for those in our community with intensive needs while being fiscally and programmatically cutting edge.

Pilot Recommendation

The proposed recommendation is to execute a staged pilot process by first relocating the detox center to a community setting and adding behavioral health services. If this model is successful, the second stage would add medical services. ***The committees identified the IVC, EC, and PC processes will need to be vetted and action plan in place before pilot is launched.***

Stage 1: Relocation of Detox Facility and addition of behavioral health moderate crisis referrals

- Current Sobering Center and Detox, law enforcement, family and friend referrals, and self-referrals without physical ailment.

- Among other requirements, space to allow co-location or office sharing with community partners will be considered for providing services and warm hand-offs.
- Emergency Room (ER) walk-ins include only those whose primary diagnosis is a behavioral health issue and who were discharged to home/self-care, detox, law/jail/court, or admitted to Behavioral Health.
- During Stage 1, data collection and research will be completed to substantiate advancement to Stage 2.

Stage 2: Based on the CTC and hospital ER data collected during Stage 1, continue Stage 1 activities and consider a medical drop-off option.

- The target audience will be current Sobering Center and Detox clients plus law enforcement referrals, walk-ins with or without physical ailment, and possibly EMS drop-off.
- Room will be added for community partners for providing outreach, supportive services, and warm hand-offs.
- ER walk-ins and EMS arrivals may include those discharged to home/self-care, detox, law/jail/court, or admitted to Behavioral Health.

The pilot project has the following assumptions which are further explained and justified in the conceptual plan and attachments. The committees had several suggestions to the assumptions which will be addressed in the next phases.

- **Location and Space.** For the purposes of budgeting, a 10,000-square foot building was assumed to calculate lease, taxes, utilities, and insurance. Location criteria must include but not be limited to expansion possibilities, access to transportation, and access to community partners. If the building has a larger footprint, the pro forma will be recalculated assuming the actual square footage.
- **Clients and Bed Capacity.** Based on data analysis described below, a range of 5,306 – 9,109 clients will be seen per year. The CTC will have 22 beds, the same as the current Detox (8) and Sobering Center (14) combined.
- **ASAM 3.2-WM.** The CTC will apply to be accredited as Level 3.2-WM Clinically Managed Residential Withdrawal Management, sometimes referred to as “social setting detoxification” or “social detox.” This level provides 24-hour supervision, observation, and support for clients who are intoxicated or experiencing withdrawal and is characterized by its emphasis on peer and social support rather than medical and nursing care. It addresses the needs of clients whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support, but for whom the full resources of a Level 3.7-WM, Medically Monitored Inpatient Withdrawal Management service are unnecessary.
- **Services.** Services will include detoxification, observation center, mental health, basic medical care (treatment of minor injuries), referral, and case management.
- **Operations.** Clients will be assessed by trained staff upon arrival. Once assessed, clients will be assigned to one of the following levels.
 - **Intake and Assessment.** The CTC staff will interview client to complete intake form(s). All clients will have vitals taken. Depending on presenting symptoms, the clients will be assessed using the chemical dependency and/or mental health assessments. The staff will determine if they should be referred to a) Observation Center; b) Stabilization Beds and Detox Unit; c) a community partner; d) hospital; or e) home.

- **Observation Center/Unit.** A room(s) will be set up for individuals to stabilize and for further observation and assessment. Clients will be in this level for less than 24 hours., after which they will be released to home, a community partner, or the Detox Unit.
 - **Mental health and detox unit / ASAM 3.2WM.** Individuals will be in this no less than 24 hours and no more than 5 days. Services will include but not be limited to medical screening exam, detox management, medication management, mental health counseling, and chemical dependency counseling. Following discharge, they will be released to home or to a community partner.
- **Budget.** The budget was based on the Detox / Observation Center budget. Budget assumptions are captured below. Annual expenses will be approximately \$1,200,000 - \$1,400,000 for Stage 1. As the CTC is further defined, the budget will be updated. The same level of revenue, \$600,000, was modeled in both stages.
 - **Pilot Time Period.** An evaluation including performance indicators will be conducted every six months. Medical services will be added/increased if the data demonstrates a compelling need and if approved by the community advisory board.
 - Trigger to move to Phase 2 – at least 12 months.

Refer to Attachment 1 and 2 for Stage 1 and 2 flow charts.

Research and Data Analysis

Target Population Data Analysis

Augustana University Research Institute, led by Director Suzanne Smith, was contracted to analyze behavioral health, emergency room, and law enforcement data to inform the number and range of clients the CTC can expect to see during the pilot and scaled up models.

Detox and Sobering Center

In both stages, the 2016 observed number of admissions and length of stay for Detox and the Sobering Center were carried forward, assuming these remain constant when housed under the CTC.

Law enforcement referrals

The estimated number of law enforcement referrals is based on 2016 arrests by the Sioux Falls Police Department (SFPD) and Minnehaha County Sheriff's Office (SO) and 2016 bookings in the Minnehaha County Jail. In 2016, the SFPD and SO made 1,691 adult arrests in which the only charges were disorderly conduct, liquor law violations, trespassing, or curfew, loitering, or vagrancy violations. These accounted for 17.8% of all arrests, and were used as the base for calculating law enforcement referrals, assuming only non-violent, Class 2 Misdemeanors would be eligible for referral to the CTC.

The law enforcement referral estimate assumes 20% of the 1,691 arrests (338) would be referred to CTC, based off the observed rates of self-reported mental health or substance use disorders among unsentenced bookings (23.3%) and misdemeanor bookings (21.2%) in 2016.

Length of stay for law enforcement referrals to CTC are assumed to be the same as the observed Sobering Center length of stay in 2016 (9.7 hours).

Walk-ins

The estimated number of walk-ins is based on 2016 ER encounters at Avera McKennan and Sanford for whom the primary, secondary, or tertiary diagnosis was behavioral-health related. Together, the two ERs saw 3,915 walk-ins who met this criterion. At this time, case-level data was not available for both ERs, so observed proportions of encounters with various means of arrival, dispositions, and primary diagnoses have been extrapolated.

Stage 1 assumes that ER walk-ins would be redirected to the CTC if their primary diagnosis is behavioral health issue (56.5% of walk-ins), and disposition is home/self-care (81.5%), detox (5.7%), law/jail/court (4.9%), or Behavioral Health (2.7%). Overall, 2,106 (53.8%) walk-ins met criteria for inclusion in Stage 1.

Stage 2 assumes that ER walk-ins would be redirected to the CTC if their primary, secondary, or tertiary diagnosis is behavioral health issue (100% of walk-ins), and disposition is home/self-care (81.5%), detox (5.7%), law/jail/court (4.9%), or Behavioral Health (2.7%). Overall, 3,703 (94.6%) walk-ins met criteria for inclusion in Stage 2.

The estimated length of stay (6.4 hours) is based on the average of observed ER encounter length of stay (3 hours) and Sobering Center length of stay (9.7 hours).

EMS referrals

For **Stage 2**, the estimated number of EMS referrals is based on the number of EMS arrivals to the Avera McKennan and Sanford ERs in 2016 for whom the primary, secondary, or tertiary diagnosis was a behavioral health issue. In 2016, the two ERs together saw 2,325 EMS arrivals that met that initial criteria. Stage 2 assumes EMS arrivals would be redirected to the CTC if the disposition was home/self-care (53.7%), detox (29.6%), law/jail/court (9.0%), or Behavioral Health (3.1%). In total, 2,206 (94.9%) EMS arrivals met these criteria.

The estimated length of stay (6.4 hours) is based on the average of observed ER encounter length of stay (3 hours) and Sobering Center length of stay (9.7 hours).

Stage 1: Current Sobering Center and Detox plus law enforcement referrals and walk-ins without physical ailment (based on 2016 data)

Source	Annual Admissions	Daily Admissions	Length of Stay (hours)	Average Daily Beds Occupied
Detox	241	0.7	155	4.3
Sobering Center	2621	7.2	9.7	2.9
Law enforcement referrals	338	0.9	9.7	0.4
Walk-ins	2106	5.7	6.4	1.5
TOTAL:	5,306			9.1

Stage 2: Current Sobering Center and Detox plus law enforcement referrals, walk-ins with or without physical ailment, and maximum possible ER redirects (based on 2016 data)

Source	Annual Admissions	Daily Admissions	Length of Stay (hours)	Average Daily Beds Occupied
Detox	241	0.7	155	4.3
Sobering Center	2621	7.2	9.7	2.9
Law enforcement referrals	338	0.9	9.7	0.4
Walk-ins	3703	10.0	6.4	2.7
EMS referrals	2206	5.9	6.4	1.6
TOTAL:	9,109			11.9

The proposed triage center represents a new model of care, and length of stay may differ from what is currently observed in emergency departments, detox, and the Sobering Center. Length of stay and capacity estimates can be updated pending decisions about operations.

Refer to Attachment 3: Data Summary. The summary includes the quantitative data, SIM mapping, and site visits. The summary was provided to the Operations Committee to inform recommendations. Also refer to CTC Baseline Data accompanying this report.

Sequential Intercept Model

In July 2017, a Sequential Intercept Model mapping workshop was held which hosted close to 40 participants, two facilitators, and keynote speaker and guest facilitator, Judge Steve Leifman. SIM is a model SAMHSA supports with the purpose of identifying service gaps and opportunities for people with mental/behavioral health issues to utilize at specific decision points of the criminal justice system. SIM workshop acts as a strategic planning process specifically regarding the decision points where people with behavioral health symptomologies or diagnosis can intercept with the criminal justice system. This planning process is one piece of qualitative data to utilize to inform this plan as well as other areas and opportunities for improvement. The workshop had three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and cooccurring disorders flow through the criminal justice system along six distinct intercept points: (0) Mobile Crisis Outreach Teams/Co-Response, (1) Law Enforcement and Emergency Services, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections/Community Support.
2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.
3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.

Based on the mapping, the following four recommendations were made for Minnehaha County.

1. Examine the feasibility and need for alternatives to detention and pre-adjudication diversion options for people with mental disorders at Intercept 2.
2. Expand the utilization of Peer Support Specialists across the Intercepts.
3. Increase trauma training for justice involved personnel.
4. Improve cross-system data collection and integration to identify high-user populations, justify expansion of programs, and measure program outcomes.

Refer to Attachment 4 - SIM Summary.

Model Triage Center Site Visits

Policy Committee members visited four communities that have implemented a triage model to divert non-medical and non-violent clients from jail and emergency departments: Bexar County (Texas), Las Vegas, Miami, and Salt Lake City. The visits illuminated numerous ways to overcome barriers and operational best practices. The primary insights the Policy Committee took away from the visits were:

- **Target Population.** Mental health, substance use disorder, and co-occurring conditions. Non-violent. No significant acute medical issues.
- **Services Observation.** Unit/ Center, Detox, Stabilization Beds
- **Length of Stay.**
 - *Observation Unit:* Up to but no longer than 24 hours from the time of admission.
 - *Stabilization Unit (Mental Health only):* 3 – 5 days average; upon admission and throughout an individual's stay, a care plan would be established. At discharge, appropriate supports have been established, follow up appointments made, and additional referrals to appropriate providers identified.
 - *Detox Unit:* Length of stay varies
- **Location.** The main focus in regard to location needs to be accessibility. Being centrally located for easy access would be ideal along with being located on a bus route.

In addition, there were operational best practices, such as an EMS procedure card, the Committee members recommended be considered in the conceptual plan. **Refer to Attachment 3- Data Summary** for a summary of the quantitative data, SIM mapping, and site visits.

Conceptual Plan

Target Population

The target population are individuals in a mental health and/or substance use disorder crisis, without significant physical illness or injury, and regardless of socio-economic background.

In Stage 1, the clients would arrive via walk in, private transportation, police, or hospital referral. In Stage 2, clients would arrive in the same means as Stage 1 as well as ambulance.

Law enforcement cases where the subject appears to have a substance use disorder or behavioral health issue , and would otherwise be subject to arrest for non-violent, Class 2 Misdemeanors (such as disorderly conduct, liquor law violations, trespassing, or curfew, loitering, or vagrancy violations), would be diverted to the CTC based on officer discretion in cases.

Regulations

The CTC would be managed under South Dakota Administrative Rules 67:61 Substance Use Disorders. The ARSD 67:61 can be found at <http://sdlegislature.gov/rules/DisplayRule.aspx?Rule=67:61>

Services

Clients would be assessed, receive care until stabilized, and then referred to community providers or back home depending on their status. Case managers and peer navigators would follow up with clients to ensure they are following their treatment and prescribed interventions.

The Operations Team recommended the CTC should prepare for and apply for ASAM 3.2-WM accreditation from SD DSS as the chemical dependency target audience meets the Level 3.2-WM criteria. The pilot project evaluation will determine if Level 3.7-WM is warranted for Phase 2 – Scale-up.

Refer to Attachment 5 - Dimensional Admission Criteria Decision Rules; Attachment 6 - Level 3.2-WM: Clinically Managed Residential Withdrawal Management, Attachment 7 - Level 3.2D Review Tool and Attachment 8 – Chemical Dependency Review Tool for further requirements.

- **Detox Unit.** A facility that provides 24-hour supervision observation and support for clients who are intoxicated and/or experiencing withdrawal symptoms.
- **Observation (Sobering) Unit.** A safe place for intoxicated individuals until they are no longer intoxicated.
- **Stabilization Unit (Mental Health).**
 - Screening / Assessment
 - Crisis intervention
 - Safe beds
 - Prescription management
- **Basic Medical Care.** Treatment of MINOR injuries (i.e., simple lacerations, wound care)
- **Referral.**
 - Housing
 - CD Treatment
 - Work Training
 - Financial Education
 - Cultural Support
 - Transportation
- **Case Management.** 3 – 5 days average and then refer to community service provider or home.

Operations

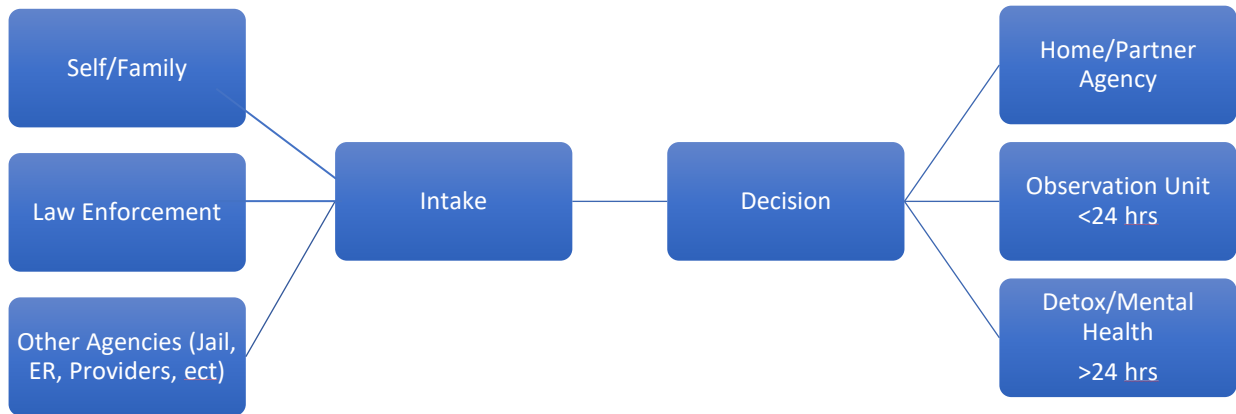
Two stages were outlined for the pilot project.

Stage 1: Relocation of Detox Facility and include behavioral health moderate crisis referrals

- Current Sobering Center and Detox, law enforcement referrals, and walk-ins without physical ailment.
- Among other requirements, space to allow co-location or office sharing with community partners will be considered for providing services and warm hand-offs.
- Emergency Room (ER) walk-ins include only those whose primary diagnosis is a behavioral health issue and who were discharged to home/self-care, detox, law/jail/court, or admitted to Behavioral Health.
- During Stage 1 data collection and research will be completed to substantiate advancement to Stage 2.

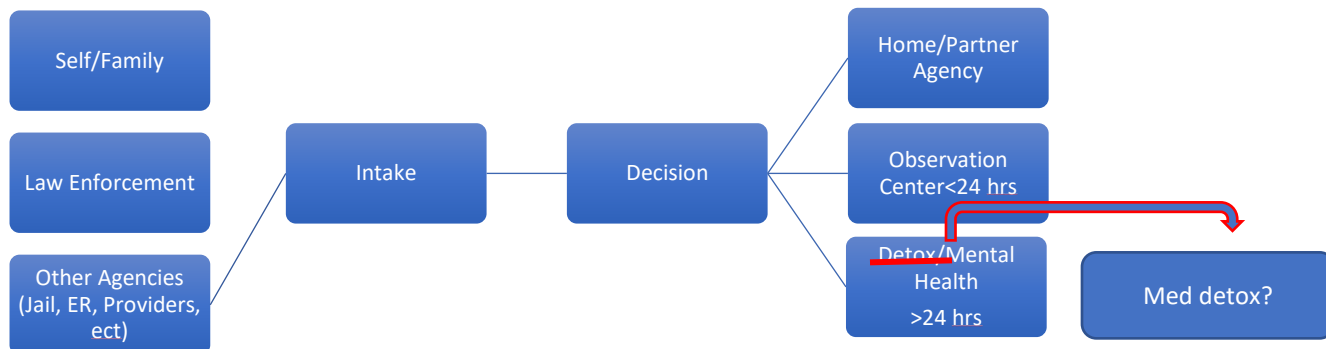
Currently, individuals who are experiencing a mental health or substance abuse crisis arrive at the emergency room department, Detox Facility, or the Sobering Center. Once the CTC is operational, individuals in crisis can be

routed to the CTC through self-referral, law enforcement, and other agencies (jail, ER, and SUD providers). The CTC staff will complete the intake information and decide to send the individual to the Detox Unit, Observation Unit, Stabilization Unit or provide a warm hand-off to a partner agency. If stabilized, the patient may be sent home.



Stage 2: Based on the CTC and hospital ER data collected during Stage 1, continue Stage 1 activities and consider a medical drop off option.

The target audience will be current Sobering Center and Detox clients plus law enforcement referrals, walk-ins with or without physical ailment, and possibly EMS drop-off. Room will be added for vendors for providing outreach, supportive services, and warm hand-offs. ER walk-ins and EMS arrivals may include those discharged to home/self-care, detox, law/jail/court, or admitted to Behavioral Health.



Stabilization and Detox unit / ASAM 3.2WM. Individuals will be in this unit less than 24 hours. Services will include but not be limited to medical screening exam, detox management, medication management, mental health counseling, and chemical dependency counseling. They will be released to home or to a community partner.

Notes:

1. The CTC will not be applying for an ASAM Level 3.7 Medical Detox during the pilot phase. During the pilot project, the team will assess if an ASAM 3.7 is warranted for the scale-up phase.
 - Involuntary Commitments (IVC) **The committees identified the IVC, EC, and PC processes will need to be vetted and action plan in place before pilot is launched.**
 - Grounds for an EC/admission to 3.2D (or WM) exist (This would mean admission to Detox- If grounds do not exist, the IVC process is handled outside of Detox in the same matter as follows.)
 - A petition for an Involuntary Committal has been filed: any responsible person can file a petition
 - An attorney is assigned to represent the petitioner.
 - A hearing is scheduled.
 - A Chemical Dependency Assessment is scheduled by the petitioning attorney with a Licensed Addictions Counselor; If the client refuses the assessment, the hearing stands.
 - The counselor makes recommendations as part of the assessment and sends a certificate indicating recommendations to the petitioning attorney.
 - A Stipulations and Agreement document is drafted by the petitioning attorney.
 - Stipulations and Agreement are then presented for the individual and the petitioner to sign. If the individual has representation, the stipulations are presented through their representation.
 - If the individual and the petitioner sign in agreement the hearing is canceled, and the judge signs the agreement to which it then becomes an official Involuntary committal for treatment/Order Upon Stipulations. The individual has a limited amount of time to begin and complete the agreed stipulations. If they do not comply with the Order Upon Stipulations, they are in violation of the order.
 - If the individual and/or the petitioner do not agree to the Stipulations and Agreement, the hearing remains scheduled to which the Judge will makes a decision based on the material presented.
- 2- Based on data collected and legal statutes, we will consider having a secure portion or protective hold of the CTC to restrict movement and cannot leave until he/she is stabilized.

Staff

Staff Positions*	Stage 1 Stage: Some Medical FTEs	Stage 2 Stage: Medical FTEs
PA/NP	0	1
Director	1	1
Lead Counselor	1	1
Counselor	1	1
Mental Health Counselor	1	1
Med Asst/EMT/Detox Tech – FT	5	5
Med Asst/EMT/Detox Tech – PT	0.75	0.75
Chemical Dependency Counselor - PT	0.25	0.25
RN	1.5	5.5
LPN	4	0

*This is just an estimate, when actual operations and provider are selected this may change.

Refer to Attachment 9 - Job Descriptions.

Note: In the pilot stages, peer navigation is not forecasted; however, would be considered for Phase 2 – Scale-up.

CTC Phases

The CTC project will be managed through the following phases with a go/no go decision between each phase.

Phase 1 | Research | February 2017 – March 2018

During Phase 1, members of the Policy Committee traveled to model Community Triage Centers in Bexar County (Texas), Las Vegas (Nevada), Miami (Florida), and Salt Lake City (Utah). Augustana University Research Institute analyzed behavioral health, emergency room, and law enforcement data to inform the range of client numbers and services the CTC can expect to see during the pilot and scaled up modes. The Policy Committee and Operation Committee members also participated in a Sequential Intercept Model mapping session that highlighted systemic recommendations for all key stakeholders. The work resulted in the data report, Minnehaha County Community Triage Center conceptual plan and a draft three year pro forma. In addition, the Criminal Justice and Mental Health Summit will be held March 28 – 29 at Augustana University.

Phase 2 | CTC Pilot Project Plan | March 2018 – 2019

The Policy Committee will address the following but not limited to:

- a) Governing Board
- b) Partnership MOUs and/or Interagency Agreements
- c) Funding
- d) Location (room for expansion, bus access, easily accessible, access to community partners, etc.)
- e) Operations (including chemical dependency assessments)
- f) Length of contract
- g) Data agreements with aggregate and non-aggregate data
- h) Mental health tools and administrative rules
- i) Referral process for IVC, EC, and PCs
- j) Security skill set considerations, CTC budget impact and impact to jail budget
- k) Role of mobile crisis team
- l) EMS/911 regulations recommendations
- m) Requirements to move to Scale Up
- n) Pilot CTC RFP
- o) Other issues as identified

Phase 3 | CTC Pilot Project | 2019

During Phase 3, the pilot project (Stage 1) will be implemented and evaluated. Note the proposed evaluation plan below. During the pilot project, questions regarding medical services required at the CTC will be addressed. At the end of Phase 3, the Committees will determine if the pilot project should be scaled up. If so, the project will proceed to Phase 4. Identify the funding and location to support the RFP.

Stage 1: Relocation of Detox Facility and include behavioral health moderate crisis referrals

- Current Sobering Center and Detox, law enforcement, family and friend referrals, and self-referrals without physical ailment.
- Among other requirements, space to allow co-location or office sharing with community partners will be considered for providing services and warm hand-offs.
- Emergency Room (ER) walk-ins include only those whose primary diagnosis is a behavioral health issue and who were discharged to home/self-care, detox, law/jail/court, or admitted to Behavioral Health.
- During Stage 1, data collection and research will be completed to substantiate advancement to Stage 2.

Phase 4 | Scale-Up Planning | 2020

As data is produced and analyzed, the timing of scale-up will be determined based on need. During Phase 4, the Committees and stakeholders will outline the scale-up CTC model including the decision to include medical services. A sustainability plan, pro forma, and MOUs will be developed. Based on pilot project experience and research, legislative bills will be drafted and circulated for feedback for the 2020 legislative session.

Stage 2: Based on the CTC and hospital ER data collected during Stage 1, continue Stage 1 activities and consider a medical drop off option.

The target audience will be current Sobering Center and Detox clients plus law enforcement referrals, walk-ins with or without physical ailment, and possibly EMS drop-off. Room will be added for vendors for providing outreach, supportive services, and warm hand-offs. ER walk-ins and EMS arrivals may include those discharged to home/self-care, detox, law/jail/court, or admitted to Behavioral Health.

Phase 5 | Scale-Up | 2020 Forward

During Phase 5, a scale up model will be implemented and evaluated. The data collection scope of work from Phase 1 will be repeated highlighting changes.

Phase 6 | Rural Community Outreach | Timeline To Be Determined

During Phase 6, rural community outreach via video conferencing / tele-health technology to rural communities will be offered. Based on need and funding, outreach services can be implemented earlier.

The CTC objectives were driven by the following sources:

- MacArthur Foundation; Safety and Justice Challenge <http://www.safetyandjusticechallenge.org/>
- Sequential Intercept Mapping <https://www.prainc.com/what-exactly-is-a-sequential-intercept-mapping/>
- Step Up Together
- Data Driven Justice Initiative <http://www.naco.org/resources/programs-and-services/data-driven-justice>

Performance Indicators and Evaluation

The CTC pilot will be evaluated every six months. The evaluation methods may be adjusted to conform with grant or funder requirements.

Performance Indicators

The following rubric captures an example of measures to establish baseline performance and could be used to monitor forward progress of this conceptual plan. All indicators will be assessed every six months unless otherwise noted. **Note the performance indicators are subject to change based on research.**

Indicator	Baseline 2016	Pilot 2019	Scale Up 2020
Jail super-utilizers (5+ bookings) as percentage of all individuals booked			
Percentage of unsentenced jail bookings with mental health or substance use disorder			
Percentage ER encounters where primary diagnosis is behavioral health issue			
Disorderly Conduct arrests/Arrest indicator(s)			
Call reason indicator			

Evaluation Methods

As we learn more from models from other locations, we will modify the evaluation design. The evaluation methods will include but not be limited to the following:

[1] Logic Model. A draft logic model has been developed as part of this proposal so as to guide the overall evaluation strategy. The logic model methodology was based on [The Logic Model Guidebook](#) (Wyatt Knowlton, 2013). Also referred to as a program matrix, logic models are tools that can be used to evaluate the effectiveness of a program, examining logical relationships between resources (inputs), activities, outputs, and desired outcomes. Theoretically, the logic model allows the evaluator and program managers to causally assess the “if-then” relationship between elements of a program; for example, if certain resources are available, then certain program activities can happen, and if those activities are implemented successfully then certain outcomes can be expected. The logic model will be reviewed during initial planning conversations with the project team and adjusted to reflect accurate assumptions as needed. **Refer to Attachment 10 – Phase 1 CTC Logic Model.**

[2] Client Statistics. The Director will be responsible for tracking the statistics which will include but not be limited to the following:

- Age, race, gender
- Number of clients referred from each source
- Number of clients using each service
- Ratio of filled beds versus capacity
- Referrals accepted/denied by each client
- Number of clients that would qualify for ASAM level of care (ASAM)
- Number of arrests per client in the 6 months (or 1 year) prior to and following CTC intake
- Number of ER encounters in the 6 months (or 1 year) prior to and following CTC intake
- Justice system involvement

The participants will be de-identified to protect client confidentiality.

[3] Level 3.2D Review Tool. The SD DSS uses a Level 3.2 review tool to assess facilities. The CTC will self-assess using the same tool to ensure processes and procedures are in place. *Refer to Attachment 7: Level 3.2D Review Tool.*

[4] Chemical Dependency Review Tool. The SD DSS uses a chemical dependency review tool to assess facilities. The CTC will self-assess using the same tool to ensure processes and procedures are in place. *Refer to Attachment 8: Chemical Dependency Review Tool Review Tool.*

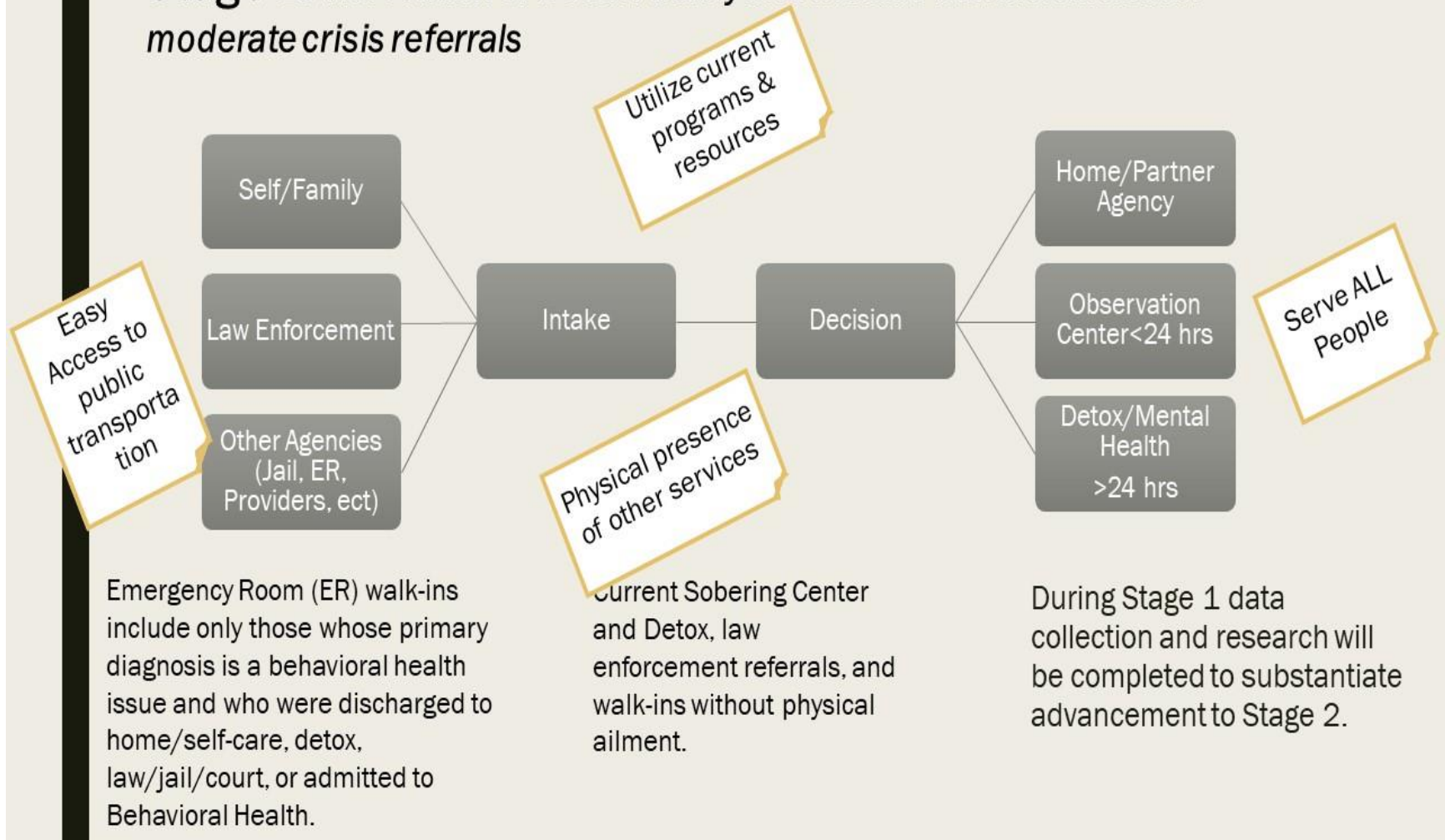
[5] Client Satisfaction Survey. A literature search will be conducted to identify survey instruments used for similar programs that have demonstrated validity and reliability. The survey will assess satisfaction with the CTC personnel, resource and support services, and suggestions for improvement.

[6] Longitudinal Client Outcomes. The Director will reach out to the program client alumni during the pilot period to document their current status, influence of resources in the ability to manage behavioral health, suggestions for improvement, and satisfaction of overall programming.

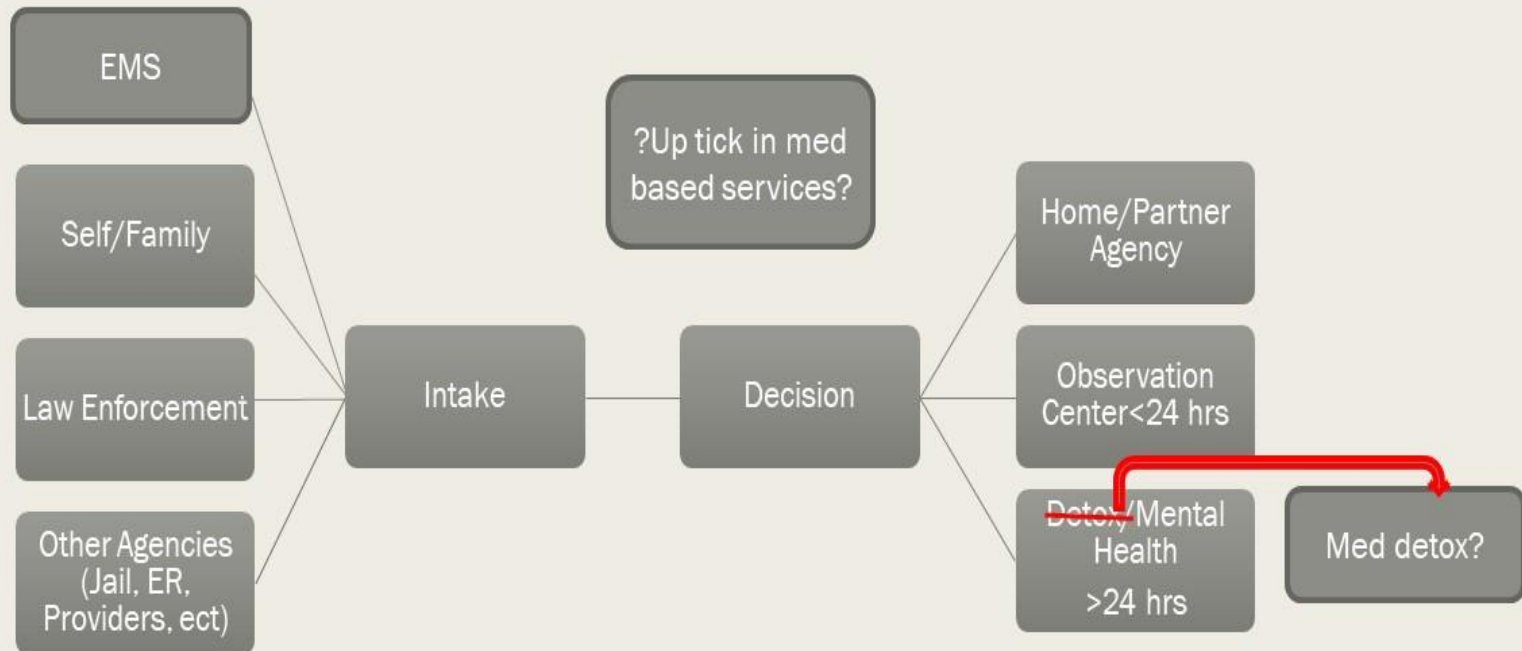
[7] Partner Satisfaction Interviews. The Director will track services and support referred to each partner and if those services were provided. A gap analysis will be tracked. The Director will interview each partner to assess strengths and areas of improvement. This feedback will inform the process map [8] method described below. An action plan will be developed and followed up.

[8] Process map. The initial processes of assessing, treating, and referring clients will be mapped. At each six-month meeting, the process map will be updated to see what steps have been changed or optimized based on experience.

Stage 1: Relocation of Detox Facility and include behavioral health moderate crisis referrals



Stage 2: Stage 1 PLUS EMS drop off & additional medical services as data indicates



Emergency Room (ER) walk-ins include only those whose primary diagnosis is a behavioral health issue and who were discharged to ...

Current Sobering Center and Detox, law enforcement referrals, and walk-ins without physical ailment.

Collect data.



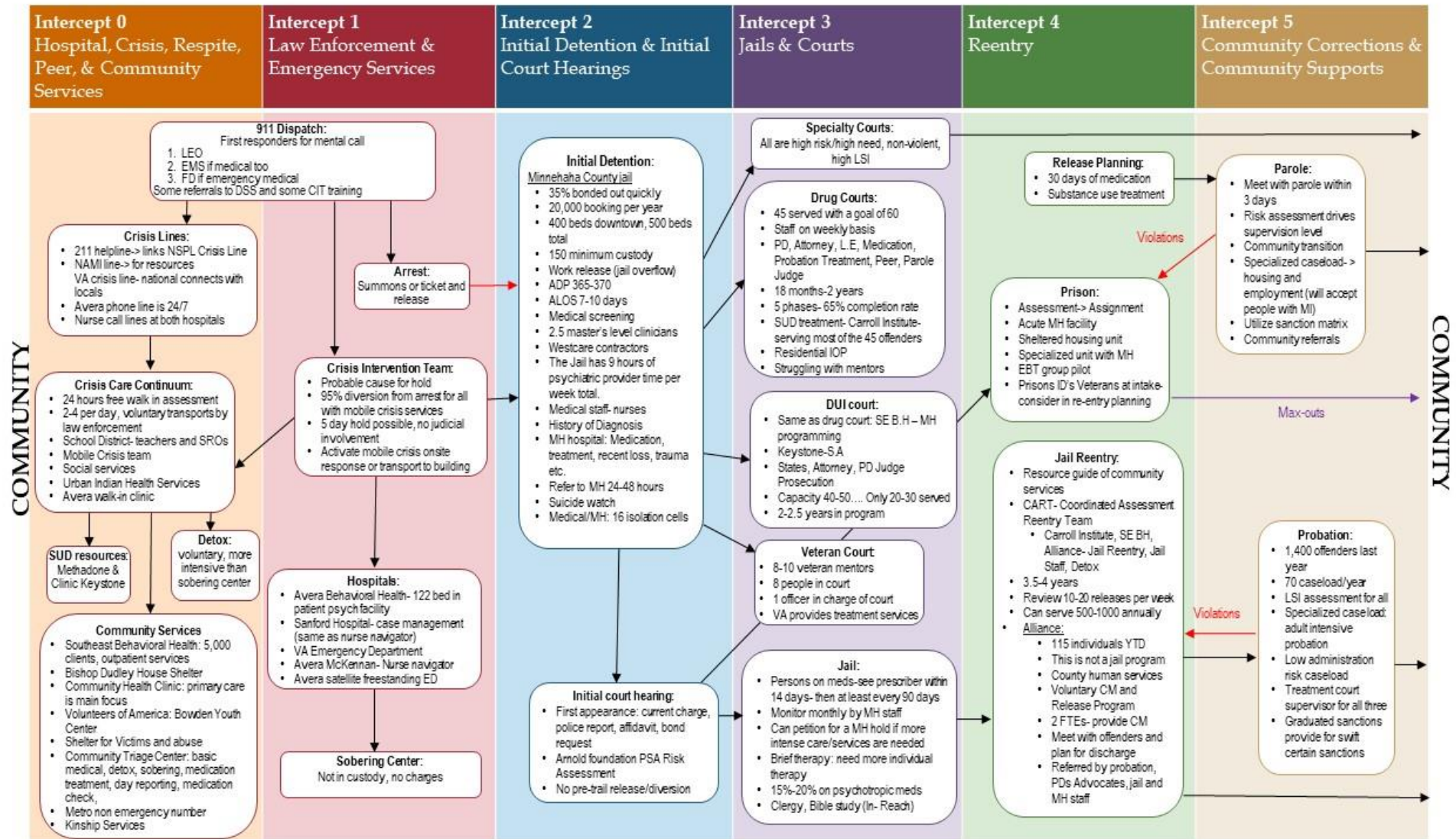
Additional Medical Services, EMS drop off, and other amendments based on data.

ATTACHMENT 3 | Data Summary

Operations Task	Preliminary Quantitative	SIM	Site Visit	Policy Committee Direction
Target population And Services	<p>6,364 hospital emergency department (ED) behavioral health encounters (excludes admitted patients)</p> <ul style="list-style-type: none"> • Diagnosis: <ul style="list-style-type: none"> ○ 2,024 substance abuse: alcohol ○ 556 substance abuse: drugs • Mode of arrival: <ul style="list-style-type: none"> ○ 3,929 walk in ○ 2,341 EMS + 73 law enforcement • Disposition after ED: <ul style="list-style-type: none"> ○ 4,722 home ○ 593 jail ○ 556 detox • Average length of stay: 190 minutes • 32% uninsured, 14% Medicaid, 18% Medicare, 31% private insurance <p>572 calls to Mobile Crisis Team</p> <ul style="list-style-type: none"> • 85 declined • 417 remained home • 30 voluntary admission to behavioral health • 14 detox/other placement • 26 involuntary hold <p>Detox</p> <ul style="list-style-type: none"> • 797 or 241 clients? • Average daily census: 4.25 • Average length of stay: about 6 days <p>Sobering Center</p> <ul style="list-style-type: none"> • 2,621 bookings • Average length of stay: 9.7 hours <p>Arrests and bookings</p> <ul style="list-style-type: none"> • 446 jail super utilizers w/ self-reported behavioral health problems (top 5%) 	<p>GAPS:</p> <p>There is a need for a location such as the planned Crisis Triage Center that will provide basic medical services, detox, mental health services, and sobering.</p> <p>Mobile Crisis Teams must be activated by law enforcement rather than the general public.</p> <p>Peer services are needed in more Intercept 0 agencies and programs.</p> <p>Clients go directly from Emergency Medical Services Unit (EMT) to law enforcement when in crisis.</p> <p>Lack of publicizing and communicating to the public on how to access crisis services without calling 911 or involving law enforcement.</p> <p>People over-utilize the emergency department</p>	<p>Focus on Mental Health, Substance Use, and co-Occurring</p> <p>Peer navigators</p> <p>Sobering Center and Medical Detox availability</p> <p>Mental Health services</p> <p>Crisis Stabilization</p> <p>Full continuum of care from crisis call line to mobile crisis overnight to on-going</p>	<p>Both Mental Health and Substance Use focus</p> <p>Create wish list</p> <p>Identify priorities (if there are any)</p>

	<ul style="list-style-type: none"> ○ 5+ bookings each, average 62 days/year in jail • 2,656 non-violent jail bookings self-reported behavioral health problems • Overall, 4,201 (24%) of bookings report behavioral health problems <ul style="list-style-type: none"> ○ 1,942 (11%) SUD alone ○ 1,465 (8.4%) mental health problems alone ○ 794 (4.5%) report both <p>Arrest demographics:</p> <ul style="list-style-type: none"> • 70% male • 51% white, 26% Native American, 17% black • Median age 27 years; 25% under 18 (ED encounters median age 40 with 5% under 18) <p>Of 11,240 arrests in 2016, the following categories accounted for all charges in 1,902 (16.9%) arrests:</p> <ul style="list-style-type: none"> • Curfew/Loitering/Vagrancy Violations • Disorderly Conduct • Law Violations • Trespassing <p>Of those 1,902 arrests, 1,612 (84.8%) had a single charge, and 226 (11.9%) had two charges. None had more than five charges, and none had any charges outside of the categories above.</p>	<p>because they don't know how to access crisis care services.</p> <p>Clients have difficulty accessing services if English is not their primary language.</p> <p>Funding is an issue that may determine whether clients access services on their own or not.</p> <p>Some people don't access services voluntarily because the involuntary commitment process will require the county to pay for services.</p> <p>Data is not being collected on CIT trained officers and responses to calls.</p>		
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ATTACHMENT 4 | Sequential Intercept Summary



ATTACHMENT 5 | Dimensional Admission Criteria Decisions Rules

<p>Level 1 – WM Ambulatory Withdrawal Management without Extended On-site Monitoring</p>	<p>The patient is experiencing at least mild signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent.</p>	<p>The patient is assessed as being a minimal risk of severe withdrawal syndrome and can be safely managed at his level.</p>
<p>Level 2 – WM Ambulatory Withdrawal Management with Extended On-site Monitoring</p>	<p>The patient is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptom; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent.</p>	<p>The patient is assessed as being at moderate risk of severe withdrawal syndrome outside the program setting; is free of severe physical and psychiatric complications; and would safely respond to several hours of monitoring, medication, and treatment.</p>
<p>Level 3.2 – WM Clinically Managed Residential Withdrawal Management</p>	<p>The patient is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent.</p>	<p>The patient is assessed as not being at risk of severe withdrawal syndrome, and moderate withdrawal is safely management at this level of service.</p>
<p>Level 3.7 – WM Medically Monitored Inpatient Withdrawal Management</p>	<p>The patient is experiencing signs and symptoms of severe withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that a severe withdrawal syndrome is imminent.</p>	<p>The severe withdrawal syndrome is assessed as management at this level of service.</p>
<p>Level 4 – WM Medically Managed Intensive Inpatient Withdrawal Management</p>	<p>The patient is experiencing signs and symptoms of severe withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive condition) that a severe withdrawal syndrome is imminent.</p>	

Source: Mee-Lee, M.D., David. **The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions**. American Society of Addition Medicine, Inc. The Change Companies. Chevy Chase, MD. 2013

ATTACHMENT 6 | Level 3.2-WM: Clinically Managed Residential Withdrawal Management

The text below is from Tab 4 Level of Care Placement, Chapter 6: Addressing Withdrawal Management

Level 3.2-WM Clinically Managed Residential Withdrawal Management (sometimes referred to as “social setting detoxification” or “social detox.”) is an organized service that may be delivered by appropriately trained staff, who provide 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal. This level is characterized by its emphasis on peer and social support rather than medical and nursing care. This level provides care for patients whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support; however, the full resources of a Level 3.7-WM, Medically Monitored Inpatient Withdrawal Management service are not necessary.

Some programs are staffed to supervise self-administered medications for the management of withdrawal. All programs at this level rely on established clinical protocols to identify patients who are in need of medical services beyond the capacity of the facility and to transfer such patients to more appropriate levels of care.

EXAMPLES OF SERVICE DELIVERY

Social setting withdrawal management program.

SUPPORT SYSTEMS

In Level 3.2-WM withdrawal management, support systems feature:

- a. Availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems.
- b. Since Level 3.2-WM is managed by clinicians, not medical or nursing staff, protocols are in place should a patient’s condition deteriorate and appear to need medical or nursing interventions. These protocols are used to determine the nature of the medical or nursing interventions that may be required. Protocols include under what conditions nursing and physician care is warranted and/or when transfer to a medically monitored facility or an acute care hospital is necessary. The protocols are developed and supported by a physician knowledgeable in addiction medicine.
- c. Affiliation with other levels of care.
- d. Ability to arrange for appropriated laboratory and toxicology tests.

STAFF

Level 3.2-WM social withdrawal management programs are staffed by appropriately credentialed personnel who are trained and competent to implement physician-approved protocols for patient observation and supervision, determination of appropriate level of care, and facilitation of the patient’s transition to continuing care.

Level 3.2-WM social withdrawal management is a clinically managed withdrawal management service designed explicitly to safely assist patients through withdrawal without the need for ready on-site access to medical and nursing personnel.

Medical evaluation and consultation is available 24-hours a day, in accordance with treatment/transfer practice protocols and guidelines.

All clinicians who assess and treat patients are able to obtain and interpret information regarding the needs of these patients. Such knowledge includes the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the appropriate treatment and monitoring of those conditions and how to facilitate entry into ongoing care.

Facilities that supervise self-administered medications have appropriately licensed or credentialed staff and policies and procedures in accordance with state and federal law.

Staff assures that patients are taking medications according to physician prescription and legal requirements.

THERAPIES

Therapies offered by Level 3.2-WM withdrawal management programs include daily clinical services to assess and address the needs of each patient. Such clinical services may include appropriate medical services, individual and group therapies, and withdrawal support.

The following therapies are provided as clinically necessary, depending on the patient's progress through withdrawal management and his or her assessed needs in Dimensions 2 through 6:

- a. A range of cognitive, behavioral, medical, mental health, and other therapies are administered to the patient on an individual or group basis. These are designated to enhance the patient's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment.
- b. Interdisciplinary individualized assessment and treatment.
- c. Health education services.
- d. Services to families and significant others.

ASSESSMENT/TREATMENT PLAN REVIEW

In Level 3.2-WM withdrawal management programs, elements of the assessment and treatment plan review include:

- a. An addiction-focused history, obtained as part of the initial assessment and reviewed with a physician during the admission process.
- b. A physical examination by a physician, physician assist or nurse practitioner as part of the initial assessment, if self-administered withdrawal management medications are to be used.
- c. Sufficient biopsychosocial screening assessments to determine the level of care in which the patient should be placed and for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6.
- d. An individualized treatment plan, including problem identification in Dimensions 2 through 6 and development of treatment goals and measurable treatment objectives and activities designed to meet those objectives.
- e. Daily assessment of patient progress through withdrawal management and any treatment changes.
- f. Discharge/transfer planning, beginning at admission
- g. Referral arrangements, made as needed.

ASSESSMENT/TREATMENT PLAN REVIEW

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- a. An addiction-focused history, obtained as part of the initial assessment and reviewed with a physician during the admission process.

- b. A physical examination by a physician, physician assistant, or nurse practitioner as part of the initial assessment, if self-administered withdrawal management medications are to be used.
- c. Sufficient biopsychosocial screening assessments to determine the level of care in which the patient should be placed and for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6.
- d. An individualized treatment plan, including problem identification in Dimensions 2 through 6 and development of treatment goals and measurable treatment objectives and activities designed to meet those objectives.
- e. Daily assessment of patient progress through withdrawal management and any treatment changes.
- f. Discharge/transfer planning, beginning at admission.
- g. Referral arrangements, made as needed.

DOCUMENTATION

Documentation standards of Level 3.2-WM programs include progress notes in the patient record that clearly reflect implementation of the treatment plan and the patient's response to treatment, as well as subsequent amendments to the plan.

Withdrawal rating scale tables and flow sheets (which may include tabulation of vital signs) are used as needed.

Lengths of Service/Continued Service and Discharge Criteria

The patient continues in a Level 3.2-WM withdrawal management program until:

1. Withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or,
2. The patient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a more intensive level of withdrawal management service is indicate; or,
3. The patient is unable to complete withdrawal management at Level 3.2-WM despite an adequate trial. For example, he or she is experiencing increasing depression and suicidal impulses complicating cocaine withdrawal and indicating the need for transfer to a more intensive level of care or the addition of other clinical services (such as intensive counseling.

SOURCE: Source: Mee-Lee, M.D., David. **The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions.** American Society of Addition Medicine, Inc. The Change Companies. Chevy Chase, MD. 2013

ATTACHMENT 7 | Level 3.2D Review Tool

Initial Assessment & Planning 46:05:09:07, 46:05:18:03, 46:05:18:10 (5d) & (7)

- The client's current problems and needs;
- The client's emotional and physical state including screening for the presence of cognitive disability, mental illness, medical disorders, collateral information and prescribed medications;
- The clients drug and alcohol use including the types of substances used including prescribed or over the counter medications, age of first use, the amount used, the frequency of use, date of last use, the duration of use and the criteria met for diagnosis of abuse or dependence for each substance including nicotine and gambling;
- A statement of the intended course of action;
- Admission justification is documented in the file [ASAM Criteria];
- Refer the client to alcohol and drug abuse services pursuant to the initial assessment and the requirements of 42 U.S.C. and 45 C.F.R.;
- Referral to community programs that offer educational, vocational, social, mental health, employment, and legal services to persons who abuse alcohol or drugs and to the families;
- Client shall be interviewed and evaluated by a chemical dependency counselor or counselor trainee within 48 hours of admission.

Progress Notes 46:05:09:10 46 & 46:05:18:10

- The date, time met, and length of the counseling session and the behaviors, events, reports, or observations discussed;
- A summary of the client's feelings, and behavioral or attitudinal observations, which may include the client's statements during the session;
- The counselor's assessment of the client's involvement in the issues discussed and in the treatment process, and the client's actions and behaviors;
- The signature and credentials of the staff providing the service;
- Encourage the client to use alcohol and drug abuse programs for long range rehabilitation and note the specific action taken or plan developed to address unresolved issues to achieve identified goals.

Detox Admission Requirements 46:05:18:02

- Presence of bruises, lacerations, cuts or wounds;
- Medication the client is currently taking particularly sedative use and medication carried by the client or found on the client's person;
- Any history of diabetes, seizure disorders including epilepsy delirium tremens and any client history of convulsive therapies, e.g., electroconvulsive or insulin shock treatments and any history of exposure to tuberculosis and any current signs or symptoms of the disease;
- Any history of medical, psychological or psychiatric treatment and currently present symptoms of mental illness.

Continued Service 46:05:18:12

- The client meets the continued service criteria for the current level and is documented every 2 days;
- The progress and reasons for retaining the client at the present level of care;

- The individualized plan of action that addresses the reasons for retaining the individual in the present level of care to promote entry into a less restrictive environment.

Discharge Criteria 46:05:18:13

- The reason for discharge and diagnoses at discharge.

Other Information

- The grievance procedure shall be given to each client or the client's representative upon admission [46:05:07:05]
- Client orientation documented at the time of admission [46:05:09:02]
- The program shall provide daily to each client a minimum of 90 minutes of any combination of services [46:05:18:11]
- A tuberculin screening for the absence or presence of symptoms shall be conducted for each new client within 24 hours of the onset of services [45:15:18:02.01]

Detox Monitoring 46:05:18:07

- Blood pressure, pulse, and respiration at a frequency dependent on the degree of hypertension or hypotension, but at least three times in the first eight hours after admission and at least once every eight hours thereafter;
- Physical, mental, and emotional state, including presence of confusion, anxiety, depression, hallucinations, restlessness, sleep disturbances, tremors, ataxia, or excessive perspiration;
- Type and amount of fluid intake;
- Other appropriate medically related information.

SOURCE: South Dakota Department of Social Services

ATTACHMENT 8 | Chemical Dependency Review Tool

Governance

- The agency maintains an accounting system pursuant to generally accepted accounting principles and, if applicable, submits an annual entity-wide independent fiscal audit. [46:05:04:03]
- The CD agency posts the hours the agency is open to the general public in a prominent place on the premises [46:05:14:02, 46:05:15:02, 46:05:16:08, & 46:05:17:09]
- The board of directors meets at least quarterly and keeps minutes of all meetings which include at least the following: (1) date of meeting; (2) names of members attending; (3) topics discussed; (4) actions taken; (5) summary of the agency director's report; (6) fiscal reports; and (7) quality of care reports on a quarterly basis. [46:05:03:03]
- The agency may not deny any person equal access to its facilities or services on the basis of race, color, religion, gender, ancestry, national origin, mental or physical illness, or disability unless such illness or disability makes treatment offered by the agency non-beneficial or hazardous. [46:05:03:07]
- Each agency shall have a policies and procedures manual to establish compliance in accordance with the services provided including written fiscal management policies. [46:05:03:06 & 46:05:04:07]
- Each agency that provides Level II.1, II.5, III.2-D, III.7, or III.1 services that is not a governmental agency or federally recognized Indian tribe is incorporated as, or a part of, either a business corporation or a nonprofit corporation. [46:05:03:01]
- If the agency does not have a board, the quality of care review findings are reported directly to the agency director. [46:05:08:04]
- The agency has an up-to-date organizational chart indicating lines of authority from the board of directors or the agency director and for all job classifications. The organizational chart is made available to all staff members and the board of directors. [46:05:03:05]
- The CD agency has developed a formal line item budget indicating expected revenues and expenses before the beginning of the fiscal year. The agency director and the board approves the budget each fiscal year and documents approval in board meeting minutes. For an agency without a board, a copy of the annual budget is made available to the Division for review. [46:05:04:01]
- The CD and Prevention program conducts an annual tuberculin risk assessment to evaluate the risk for transmission of Mycobacterium tuberculosis within the agency utilizing the TB risk assessment worksheet developed by the Dept. of Health, and writes and implements a TB infection control plan and appropriate agency policies and procedures based on the results, with changes to the TB infection control plan and agency policies as needed. [46:05:05:02]
- The CD agency contacts the Division Director prior to any of the following changes: (1) change in agency director, medical director, or clinical supervisor; (2) reduction in services provided by the agency; and (3) the impending closure of the agency, to determine whether any changes in accreditation status are necessary. [46:05:02:13]

Program Services

- The agency establishes a sliding scale fee schedule for all services provided and submits it annually to the Division and any time there are changes. The program provides clients, referral sources, the public and the Division current information regarding fees charged including fee per unit of service. [46:05:04:06 & Contract Attachment]
- The agency gives the client/client's parent or guardian a written statement of the clients' rights and responsibilities/grievance upon admission/during the intake process and discusses with the client/client's

parent or guardian. The clients' rights/grievance statement is posted in a place accessible to clients. [46:05:07:01 & 46:05:07:05]

- The agency ensures counseling staff are on duty as required. [46:05:14:02, 46:05:15:02, 46:05:16:08, 46:05:17:09, 46:05:18:06, 46:05:19:07, 46:05:20:09 & 46:05:21:08]
- The CD agency collects outcome measures on each individual receiving treatment at time of admission and discharge. [46:05:06:02]
- The CD program has a written discharge policy including client behavior that constitutes reason for discharge at staff request, procedures to follow when a client leaves against medical or staff advice, prohibition against automatic discharge for non-prescribed substance use or displaying symptoms of mental or physical illness or referring for more intensive intervention as necessary. [46:05:07:06]
- The contracted CD program publicizes priority services for pregnant women and women with dependent children and IV drug users and maintains a record of the programming/outreach services. [Contract Attachment]
- The contracted CD program has a Limited English Proficiency (LEP) policy to ensure LEP individuals are provided with an opportunity to participate in and understand all provided services. [Contract Attachment]
- In a Level III.2-D facility, each staff member is under the direct supervision of an RN, LPN, or EMT. [46:05:18:06]
- In Level III.2-D, III.1, and III.7 facilities, a staff person is on duty at all times (when the agency is open for detox facilities) who is trained to respond to fires and natural disasters as well as administer emergency first aid and CPR. [46:05:18:06 & 46:05:19:07]
- The Level II.5 or higher CD agency has appropriate arrangements in place for medical emergencies (Level II.5: written agreement for emergency medical services with a licensed hospital or agreement with or employment of a physician to respond to medical emergencies; Level III.2-D: written affiliation for emergency, inpatient and ambulatory medical services with a licensed hospital including specifying in the agreement that the hospital consents to accept all transfers for prompt medical evaluation, and availability of a medical director; Level III.7: nursing staff are on-call 24 hrs./day 7 days/wk., the facility has a formal written agreement for the provision of emergency medical services with a licensed hospital serving the area in which the agency is located; Level III.1: nursing staff are on call 24 hrs./day 7 days/wk.). [46:05:17:08, 46:05:18:04, 46:05:18:06, 46:05:19:05, 46:05:19:06, 46:05:19:07 & 46:05:20:09]
- Agencies that provide gambling services, Level II.1, Level II.5, Level III.1, and Level III.7 provide a written directory complete with addresses and phone numbers of support services to give to clients and is available at all times to clients. [46:05:21:06, 46:05:16:06, 46:05:17:06, 46:05:19:12, & 46:05:20:06]

Personnel

- The agency provides orientation for all employees, interns and volunteers within 10 working days after employment. [46:05:05:01]
- CD program orientation includes at least the following items: (1) fire prevention and safety including location of all fire extinguishers in the facility, instruction in the operation and use of each type of fire extinguisher, and fire evacuation plan and agency's smoking policy; (2) confidentiality of all information about clients including a review of 42 CFR Part 2, and 45 CFR Parts 160 and 164; (3) the proper maintenance and handling of client case records; (4) the agency's philosophical approach to treatment and the agency's goals, including specific orientation regarding individuals with mental illness, developmental disabilities, substance abuse, gambling addiction or any combination thereof; (5) procedures to follow in medical emergencies or natural disasters; (6) specific job descriptions and

responsibilities of the employee; (7) the agency's policies and procedures manual; and (8) the agency's procedures for the reporting of cases of suspected child abuse or neglect. [46:05:05:01]

- The agency has a policy and procedure for checking the Medicaid exclusion list. Personnel records contain evidence the OIG list was checked.
- In a III.2D facility, all counseling staff and client supervisory staff are trained in emergency first aid and CPR and to respond to fires and natural disasters with personnel files containing current certificates verifying successful completion of training. [46:05:18:08]
- A CD agency employing mental health professionals has documentation of the additional training required in Contract Attachment.
- In CD agencies employing mental health professionals who facilitate integrated initial assessments that recommend a residential level of care, the assessments are reviewed and co-signed by an LAC or CAC. [Contract Attachment]
- Each agency shall establish and enforce policies and procedures for supervising agency employees, interns, and volunteers. [46:05:05:09]
- Trainees are supervised by CACs or LACs either within the agency or through a contractual/consultant basis from an outside party with the required qualifications [46:05:05:11 and Contract Attachment]
- Trainee supervision shall occur according to standards set in the BAPP Standards Manual. [Contract Attachment]
- The CD agency conducts quality of care reviews each quarter on at least 3 randomly selected closed case files for each Trainee to determine whether the file is in compliance. [46:05:08:01] The quality of care reviews are conducted by a CAC or LAC who was not the primary counselor for the specific client whose file is being reviewed. [46:05:08:02]
- The quality of care reviews document all problems identified in the review and include written recommendations for corrective action which are reviewed with the case counselor. Any corrective action taken is documented. [46:05:08:03]
- Staff providing gambling services are trained in crisis intervention. [46:05:21:08]
- All employees involved in the initial assessment or admission department of an agency providing Level III.2-D, Level III.7 or Level III.1 services receive annual TB skin tests. [46:05:05:02]
- New CD program employees receive a two-step method of Mantoux skin test to establish a baseline within 14 days of employment and two documented Mantoux skin tests are completed within a 12-month period from the date of hire. [46:05:05:02] (skin testing is not necessary if documentation is provided of a previous positive result)
- Any employees with a positive reaction to the Mantoux skin test obtained a medical evaluation and chest x-ray to determine the absence or presence of the active disease. [46:05:05:02]
- Any employees with a positive reaction to the Mantoux skin test are evaluated annually by a designated staff person with a record maintained of the absence or presence of the following symptoms: productive cough for a 2-3 week duration, unexplained night sweats, unexplained fevers, or unexplained weight loss. If an employee is identified to have one or more of these symptoms, the employee immediately consults a physician for a medical evaluation and chest x-ray to determine if the employee has active TB. [46:05:05:02]
- CD program personnel files are maintained for each employee, intern and volunteer and contain copies of the employee's qualifications, identification card, and all other health care licenses or certificates related to job duties; documentation of employee's orientation; any staff health clearances including the TB test results and clearances from a physician if an infectious disease requires absence from work; and

documentation of a criminal background check in programs providing services to children and adolescents. [46:05:05:08]

- The agency director's qualifications, authority and duties are defined in writing. The Director is knowledgeable of drug and alcohol services and Administrative Rules and possesses administrative skills. [46:05:03:04]

Case Record Management

- Each agency shall arrange for the safe storage of client case records for six years from closure. [46:05:09:05 & 46:05:09:03 (1-2)]
- The CD agency ensures that all entries in case records are legible, dated, and signed by the person making the entry with their credentials. The CD agency reviews all client case records for required content, uniformity of format and completeness of content. Agency policies detail the methods used, the frequency of the reviews, and the individuals responsible for the reviews. [46:05:09:03 (3-4)]

Dietary Services

- The residential program has established and implemented a written plan for meeting the basic nutritional needs of clients including three meals a day with snacks included in the overall dietary plan. [46:05:11:01]
- The residential program shall establish and implement a written plan for meeting any special dietetic needs of the client. [46:05:11:01]

Medication

- The agency has a policy relating to control, accountability and storage of client medication. [46:05:10:01(1)]
- The residential program stores client medications in a locked storage area. [46:05:10:01(3)]
- The residential program stores controlled drugs in a separate locked box or drawer in the medication storage area. [46:05:10:01(4)]
- The residential program stores poisons, disinfectants, and medications for external use separately from internal medications and apart from each other, each in a separate locked area. [46:05:10:01(5)]
- Identified biologicals and medications requiring refrigeration or other storage shall be stored appropriately. If stored in a refrigerator or freezer containing items other than medications, they are kept in a separate compartment with proper security. [46:05:10:01(6)]
- The residential program maintains medications in original containers and with proper labeling. [46:05:10:01:(7-9)]
- The residential program has a procedure for contacting pharmacies and physicians as soon as possible after admission to allow client access to necessary medication. [46:05:10:01(12)]
- At discharge following program physician approval, client medication is returned with documentation in client case record. [46:50:10:01(13)]
- A residential program has the telephone number of the regional poison control center, the local hospitals, and the agency administrator posted in all drug storage and preparation areas. [46:05:10:01(14)]

Emergency Kit

- The emergency kit is stored in a sealed emergency box and the agency maintains a complete and accurate inventory of contents every six months [46:05:10:02(1-2)].

- There are no more than five different controlled drugs, no more than five doses of an injectable Schedule II, III or IV drug, and no more than twelve doses of an oral Schedule III or IV drug stored in the emergency kit at one time. [46:05:10:02(3)]
- After first administration of an emergency kit medication, standing and verbal orders are verified in writing by the physician within 72 hours. [46:05:10:02(5)]

Receipt and Administration of Scheduled Drugs

- Client case records include entries for receipt and administration of Schedule II, III, and IV drugs. [46:05:10:03]

Medication Destruction

- The residential program uses an acceptable drug destruction process. [46:05:10:04]

Administration of Medications and Drugs

- The residential program has a policy regarding administration of Schedule II, III, and IV drugs as authorized by a licensed physician. [46:05:10:05]
- Only trained and qualified RNs, LPNs or UAPs administer medication and document/sign in the client case record. [46:05:10:05]
- The agency has a procedure for immediate reporting of drug reactions and medication errors to the responsible physician. [46:05:10:05]
- When medication errors occur, the responsible individual completes and signs an entry in the client case record and an incident report form. [46:05:10:05]

Staff Assistance with Medications

- For Level III.7 programs not employing RNs, LPNs, or UAPs, medications are made available to clients for self-administration with the instructions of a physician and under the supervision of staff who documents in the client case record. [46:05:10:06]
- Level III.1 programs which allow clients to possess and self administer identified prescription medications have a developed list specifically for the client in consultation with a physician which is reviewed at least annually. Any medication not identified on the list is administered under supervision. [46:05:10:06]

Environmental/Sanitation/Safety/Fire Prevention

- The agency has a health, safety, sanitation, and disaster plan that includes 1) specific procedures for responding to medical emergencies; 2) procedures for responding to fire and natural disasters including evacuation plans, training and regularly scheduled drills; 3) procedures to respond to communicable diseases; 4) procedures to ensure sanitation of all settings. [46:05:12:02]

SOURCE: South Dakota Department of Social Services

ATTACHMENT 9 | Job Descriptions

Title: Director

Position Summary: Person in this position will be responsible for providing the clinical and administrative programmatic leadership and oversight for the program. Responsible for the coordination of client care by collaborating with multidisciplinary professionals to provide and facilitate services. Essential Job Functions include those listed below.

Essential Job Functions:

- Provide clinical and administrative leadership and supervision to the program.
- Direct and supervise the work of all assigned support staff members.
- Participate in the interviewing, hiring and terminating of support staff members by providing advice and recommendations.
- Review each employee's job performance on a yearly basis (or more often if necessary). Make recommendations to the immediate supervisor regarding employee advancement and retention.
- Responsible for training and supervision of all support staff.
- Develop staff work schedule and assign daily responsibilities to ensure proper coverage for all shifts.
- Function as a liaison to key partners.
- Coordinate with external groups and agencies in promoting inter-organizational collaboration and facilitating placement of program graduates after program completion.
- Assist in grant planning and initiation of potential funding opportunities when required.
- Participate in design and implementation of research, such as program evaluation and outcome studies.
- Designate a representative to participate in a committee to recommend common data elements, formats and to cooperate on an electronic system of data transfer.
- Coordinate staff development, education and training activities.
- Attend partner meetings as required.
- Implement Quality Assurance and Utilization Review systems that monitor the effectiveness of the program services.
- Monitor compliance with all required standards, regulations, state and federal guidelines.
- Develop, implement and monitor procedures to meet agency policies and contract management including the preparation of comprehensive reports for funding or agency sources.
- Embrace and embody the mission, vision, guiding principles, clinical vision and goals.
- Perform any other duties as assigned.

Essential Qualifications:

- A minimum of two years' experience working in a substance abuse program with criminal justice populations.
- Management and administrative experience and capabilities.
- Experience in program implementation, monitoring and contract compliance and fiscal responsibility is required;
- Must possess knowledge of chemical dependency, substance abuse and personality dynamics of the substance abuser.
- Must possess knowledge of cognitive behavioral approach to treatment/care/services.

- Experience in staff supervision, hiring, evaluation and staff development.
- Knowledge of state and federal regulations.
- CPR Certification, first aid Certification and an annual tuberculosis test.

Education:

- Graduate degree, Criminal Justice, Social Work, Psychology, or a related field or equivalent experience and education combined consisting of substituting education with experience on a year to year basis; or
- Two years cumulative documented administrative experience demonstrating a history of administrative responsibility in substance abuse programs for the criminal justice population.

Working Conditions

- Work will be in residential behavioral health setting.

Physical Demands:

- The normal work routine involves no exposure to blood, body fluids, or tissues; however, exposure or potential exposure may be required as a condition of employment. Appropriate personal protective equipment will be readily available to every employee.
- Occasional lifting of more than 10 pounds.
- Sitting, standing, walking, reaching are performed in the normal course of the position.

SOURCE: WestCare

Title: Chemical Dependency Counselor

Position Summary: Person in this position will be responsible for the day-to-day assessment and treatment program functions, clinical staff supervision as qualified and assigned, and flow of program activities. Essential job functions include those listed below. Other duties may be assigned as needed.

Essential Job Functions:

- Responsible for managing the day-to-day functions of the detoxification program;
- Maintain ongoing communication between staff and management;
- Insure that all intakes, clinical documentation, discharge summaries, Community Re-entry Checklist, continued care plans, verifications and data system episodes, placements and discharges are accurate and completed in a timely manner;
- Insure WestCare is in compliance with 42 CFR part 2, and 45 CFR (HIPAA) regulations and other Federal, State and local policies, rules, and standards regarding the protection of paper and computer-based information and its transfer WestCare and any other program;
- Fill in for counselors during times they may be unavailable due to illness, training etc.;
- Provide daily, weekly and monthly reports as requested;
- Role model ethical and professional behaviors and standards;
- Provide new employee orientation for assessments and clinical documentation;
- Attend section head, case planning and MDT meetings as assigned;
- Meet routinely with team members to communicate program and client issues and needs;
- Engage in on-going professional development;
- Embrace and embody the mission, vision, guiding principles, clinical vision and goals of WestCare Foundation, and
- Perform other duties as assigned.

Essential Qualifications:

- Three (3) years counseling experience (preferred);
- Must be capable of obtaining and interpreting information regarding the client's bio-psychosocial spiritual needs, and is knowledgeable about the bio-psychosocial spiritual dimensions of alcohol and other drug disorders, including assessment of the client's stage of change;
- Must possess knowledge of chemical dependency, substance abuse and personality dynamics of the substance abuser including knowledge of cultural and criminal sub-cultures;
- Experience in training and evaluating employees including counselor abilities to facilitate and manage classroom environments and present information;
- Experience in developing schedules for groups and staffing schedules;
- Must possess excellent documentation and communication skills;
- Must have ability to obtain prison clearance; and
- CPR certification, First Aid Certification and an annual tuberculosis test.

Education:

- Licensed (or licensable) by the State of South Dakota as a clinical social worker, professional counselor, psychologist, addictions therapist, or other related professional and meets the licensing standards for clinical supervisor if supervisory duties are assigned.

- South Dakota license must have application on file within 30 days of hire.

Physical Demands:

- Occasional lifting of more than 10 pounds; and
- Sitting, standing, walking, reaching are performed in the normal course of the position.

Mental Demands:

- Requires the ability to collect and analyze complex numerical and written data and verbal information to reach logical conclusions;
- Requires the ability to work and cooperate with clients, co-workers, managers, the public and employees at all levels in order to exchange ideas, information, instructions and opinions;
- Requires the ability to work under stress and in emotionally charged situations;
- Requires the ability to defend oneself and clients in mentally/verbally abusive situations through the use of approved mental/verbal de-escalation techniques; and
- Requires the ability to work under time deadlines.

SOURCE: WestCare

Title: Detox Technician

Position Summary:

Detox Technician under the supervision of the Director and implements, assists and reinforces Policy and Procedure of the facility they are assigned to. They assist with new client intakes, especially with initial assessments and interviews. They assist with a variety of data entry and clerical tasks that support the function of the facility and client care. They assist with basic client care for patients, including hygiene, safety and security. They assist with documentation in the client record as delegated by supervising staff. They assist with the discharge of clients from the facility.

Essential Job Functions:

1. Able to perform detox duties that are specified by the State of South Dakota.
2. Assists in the initial admission assessment of each client.
3. Monitors status of patients and ensures that both medical and social needs are addressed.
4. Document and appropriately report health needs and/or status changes of the client to supervisors.
5. Monitors vital signs.
6. Recognizes and intervenes in emergent medical and psychological emergencies.
7. Reinforces personal hygiene activities by clients.
8. Schedules clients for medical and social appointments.
9. Maintains client files as needed.
10. Maintains adequate medical supplies for the Detox Center.
11. Flexibility to meet the scheduling and program needs.
12. Take call for emergencies as needed.
13. Embrace and embody the mission, vision, guiding principles, clinical vision and goals of WestCare Foundation.
14. Other relevant duties as assigned.

Essential Qualifications:

1. Prefer minimum of one (1) year experience in medical and/or detoxification treatment field.
2. Prefer mental health/Psych and/or substance abuse experience.
3. Must pass pre-employment drug screen, reference checks and physical.
4. Must pass a background check.

Education:

1. High School diploma or equivalent (GED).
2. Bachelor's Degree preferred in an associated area of emergency medical care.
3. Certified or able to obtain certification in Cardiopulmonary Resuscitation (BLS).
4. Certified or able to obtain certification in Automatic External Defibrillation (AED).

Working Conditions:

1. The Detox Technician will be stationed within the Minnehaha County Detention Detox Center.
2. Chance of doing a ride along with transportation.

Physical Demands:

1. Able to perform all physical tasks (bending, lifting, carrying, etc.).

SOURCE: Westcare

ATTACHMENT 10 | Phase 1 CTC Logic Model

PURPOSE: The primary purpose of the **Community Triage Center** planning project is to investigate the feasibility and develop a conceptual plan for a voluntary, mid-level care alternative for those with substance/alcohol abuse as well as those with mental illness who are not violent in behavior. The partnership collaborative, led by Minnehaha County, aims to create a front-line service for a population that need treatment provided with respect, dignity, and understanding.

LOGIC MODEL: The logic model will drive the program and evaluation design to ensure the inputs and activities result in the required outputs and outcomes. Formative evaluation results will guide programmatic interventions.

<p>Inputs</p>	<ul style="list-style-type: none"> ▪ Policy Committee representing the following organizations: Minnehaha County Human Resources, Minnehaha County Jail Mental Health and Detox Center, Sioux Falls Police Department, Sioux Falls Public Health Department, Unified Judicial System, Bishop Dudley Hospitality House, Carroll Institute, Lutheran Social Services, Southeastern Behavioral Health, Avera Health, Sanford Health, NAMI, and Lloyd Companies. ▪ Operations Committee representing the following organizations: Minnehaha County Human Resources, Minnehaha County Sheriff, Lincoln County Sheriff, Sioux Falls Police Department, Sioux Falls City Council, Sioux Falls Public Health Department, Unified Judicial System, Carroll Institute, Lutheran Social Services, Southeastern Behavioral Health, Tallgrass Recovery, Avera Health, Sanford Health. ▪ National promising practice models ▪ Grant funding for site visits, policy and operation committee meetings, training, research, and consultants ▪ In-kind labor and expenses
<p>Activities</p>	<ul style="list-style-type: none"> ▪ Develop a collaboration of health care, criminal justice, government, and social service agency leaders and operational managers to develop innovative solutions to address avenues of care for patients with behavioral health diagnosis. ▪ Build a database and collect baseline data. Build infrastructure for tracking data if the Committee decides to go forward with Community Triage Center to determine community impact. ▪ Receive education and training through formal training sessions. ▪ Attend on-site visits at cities implementing promising practice models. ▪ Develop an implementation plan. Decisions and deliverables include but are not limited to: target audience/patient profile, referral processes, services, staffing, location, financial model, gap identification and resolution, and length of stay.
<p>Outputs</p>	<ul style="list-style-type: none"> ▪ Number of agency and organizations contributing in planning ▪ Number and type of agreements ▪ Percent of policy members signing agreement to actively contribute in planning ▪ Number of policy committee meetings ▪ Percent of policy committee members attending meetings ▪ Number of operation committee meetings ▪ Percent of operation committee members attending meetings ▪ Number of site visits ▪ Percent of policy committee members attending site visits

	<ul style="list-style-type: none"> ▪ Number of training opportunities ▪ Percent of policy and operation committee members attending training opportunities ▪ Presentations regarding planning project ▪ Number of attendees at presentations ▪ Number and type of leveraged resources from outside the policy and operations committee ▪ Conceptual Plan ▪ Financial model ▪ Data plan ▪ Go / No go decision to move forward with Community Triage Center
<p>Outcomes</p>	<ul style="list-style-type: none"> ▪ Providing an alternative to the justice system for the community to utilize as a response to individuals in crisis. Specific decision points include at arrest, pretrial release, and reentry. ▪ Providing the emergency rooms to have more be availability for life threatening medical emergencies (heart attacks, diabetes issues, strokes, etc.) ▪ Providing the clients the opportunity to have a client-center, strength focused care plan established so upon discharge there is a strategy in place and supports established. The opportunity to return may be for groups or education, case management, and/or appointments with a psychiatrist until a long-term provider has an opening, etc. ▪ Providing the opportunity for our community to come together and have the CTC as a beacon of love and hope for all members of this city/county/community.
<p>Impact</p>	<ul style="list-style-type: none"> ▪ Pre-arrest diversion program ▪ Processes, procedures, and policies to deliver services to behavioral health patients ▪ Community database to inform decisions and strategies ▪ Greater collaboration among government, healthcare, and community partners to address problems within the community