Behavioral Health Crisis Response Stakeholder Coalition

9-8-8 Implementation Planning Meeting #2

South Dakota Department of Social Services

Stakeholder Coalition members:

Roundtable introductions of coalition members

- Department of Social Services
  - **Laura Ringling**
  - **Tiffany Wolfgang**
  - **Bre Baltzer**
  - **Tessia Johnston**
- Contracted Project Supports
  - **Nick Oyen**
  - **Rachel Oelmann**
- Individuals with lived experience
  - **Tara Johanneson**
  - **Rosanne Summerside**
  - **Matthew Glanzer**
  - **Penny Kelly**
- Lifeline Crisis Center
  - **Janet Kittams**
  - **Taylor Funke**
- State Suicide Prevention Coordinators
  - **Jana Boocock** (DSS)
  - **Kiley Hump** (DOH)
- Providers of crisis respite / stabilization services
  - **Thomas Otten** (Avera)
  - **Katherine Sullivan** (Monument Health)
  - **Jeremy Johnson** (Human Services Center)
  - **Teri Corrigan** (Behavior Management Systems)
- Mobile crisis service providers
  - **Kris Graham** (Southeastern Behavioral Health Care)
  - **Amy Iversen-Pollreisz** (Capital Area Counseling Service)

Introductions

Roundtable introductions of coalition members

- Law Enforcement
  - **Staci Ackerman** (SD Sheriffs Association)
  - **Don Hedrick** (SD Police Chiefs Association)
  - **Dave Kinser** (Rapid City PD)
- 911 Leaders
  - **Maria King** (Statewide 911 Coordinator)
- Peer support service providers
  - **Wendy Giebink** (NAMI)
- Mental health and suicide prevention advocacy
  - **Kelli Rumpza** (Human Service Agency)
- Other Stakeholders
  - **Tosa Two Heart** (Great Plains Tribal Leader's Health Board)
  - **Terry Dosch** (Council of Community BH Directors)
  - **Chairman Peter Lengkeek** (Crow Creek Sioux Tribe)
- Technical Assistance Providers
  - **Terresa Humphries-Wadsworth** (Educational Development Center on behalf of Vibrant Emotional Health)

Eight Core Planning Considerations

Overview | BHCRSC Coalition Charter in Summary

- **Background**
  - Nationwide
  - Will be launched by July 2022
  - Transition from current 10-digit crisis number towards 9-8-8
  - All states were awarded funds to support implementation planning for their specific state and response systems in place
  - South Dakota has one Lifeline Center – Helpline Center (some states of multiple Lifeline Centers)
  - Will require implementation of statewide chat and text services in addition to hotline
  - Planning template is forthcoming to guide the work of this coalition

- **Mission & Vision**
  - Coalition is a required activity of the implementation planning grant funding
  - Coalition formed to guide and inform the development of the 9-8-8 statewide implementation plan
  - Three key tasks:
    - Develop plans to address coordination, capacity, funding, and communication strategies to launch 9-8-8
    - Plan for long-term improvement of in-state answer rates for 9-8-8 calls
    - Provide initial considerations for expanded crisis center services and systems to support real-time inventory and dispatch

Eight Core Planning Considerations

Overview | BHCRSC Coalition Charter in Summary

1. Ensuring statewide coverage for 9-8-8 calls, chats, and texts
2. Funding structure for Lifeline Centers
3. Capacity building for Lifeline Centers
4. State/Territory support of Lifeline's operational, clinical and performance standards for centers answering 9-8-8
5. Identification of key stakeholders for 9-8-8 roll out
6. Ensure there are systems in place to maintain local resource and referral listings
7. Ensure ability to provide follow-up services to 9-8-8 users according to Lifeline best practices
8. Alignment with national initiatives around public messaging for 9-8-8

BHCRSC Workgroup Roles & Key Priorities

Determine "what" is needed to best support South Dakotans

Determine "How" to make it work

Lived Experience

Marketing and public awareness (#8)

Follow-up services (#7)

Ideal mobile crisis response (#4)

Diversity / Geographical Considerations

Marketing and public awareness (#8)

Follow-up services (#7)

Ideal mobile crisis response (#4)

Crisis Response

Dispatch / coordination of mobile crisis response (#4)

Real-time bed availability (#4)

Follow-up services (#7)

9-1-1 / 9-8-8 Intercommunication

24/7 coverage for calls, chats, and texts with no geographical gaps (#1)

Current/future call volume handling (#3)

Operational standards & performance metrics (#4)

Reciprocal transfers between 9-1-1 / 9-8-8 (#4)

State Team / Lifeline Center

Statewide 24/7 Coverage (#1), Funding (#2) – In Progress

90% in-state answer rate (#3), Coalition (#5), Local resource listing (#6) - Completed

BHCRSC Workgroup Structure & Membership

Workgroup Membership

Crisis Response

This work group provides the coalition with leadership in the fields of crisis response. This group will take the lead in determining the best practices in immediate mobile crisis response and crisis stabilization in South Dakota. Members of this group include:

Bre Baltzer, DSS
Teri Corrigan, BMS
Kris Graham, SEBH
Katherine Sullivan, Monument
Thomas Otten, Avera
Dave Kinser, RCPD
Jeremy Johnson, HSC
Chief Don Hedrick, SD Police Chiefs Association
Staci Ackerman, SD Sheriffs Association

911 / 988 Intercommunication

This work group provides the coalition with operational expertise with crisis calls. This group will take the lead in recommending how 911 and 988 can partner together to best serve South Dakotans with a mental health or suicide crisis. Members of this group include:

Maria King, Statewide 911 Coordinator
Amy Chase, Metro Communications (Sioux Falls 911)
LeAnn Benthin (Watertown PD / 911)
Janet Kittams, Helpline Center
Stephanie Olson (Pennington Co. 911)
Tiffany Wolfgang, DSS

BHCRSC Workgroup Structure & Membership

Workgroup Membership

Diversity & Geographical Considerations

This work group provides the coalition with the crucially import perspective of diversity and geographical considerations. This group will take the lead in determining the important elements that are needed to best support the diversity across South Dakota in a crisis response system. Members of this group include:

Tosa Two Heart, GPTLHB
Tessia Johnston, DSS
Amy Iversen-Pollreisz, Capital Area
Erik Muckey, Lost & Found
Terry Dosch, Council of Community BH
Ellen Durkin
Deb Griffith, HSA & Watertown LOVE
Carissa Weddell

Lived Experience

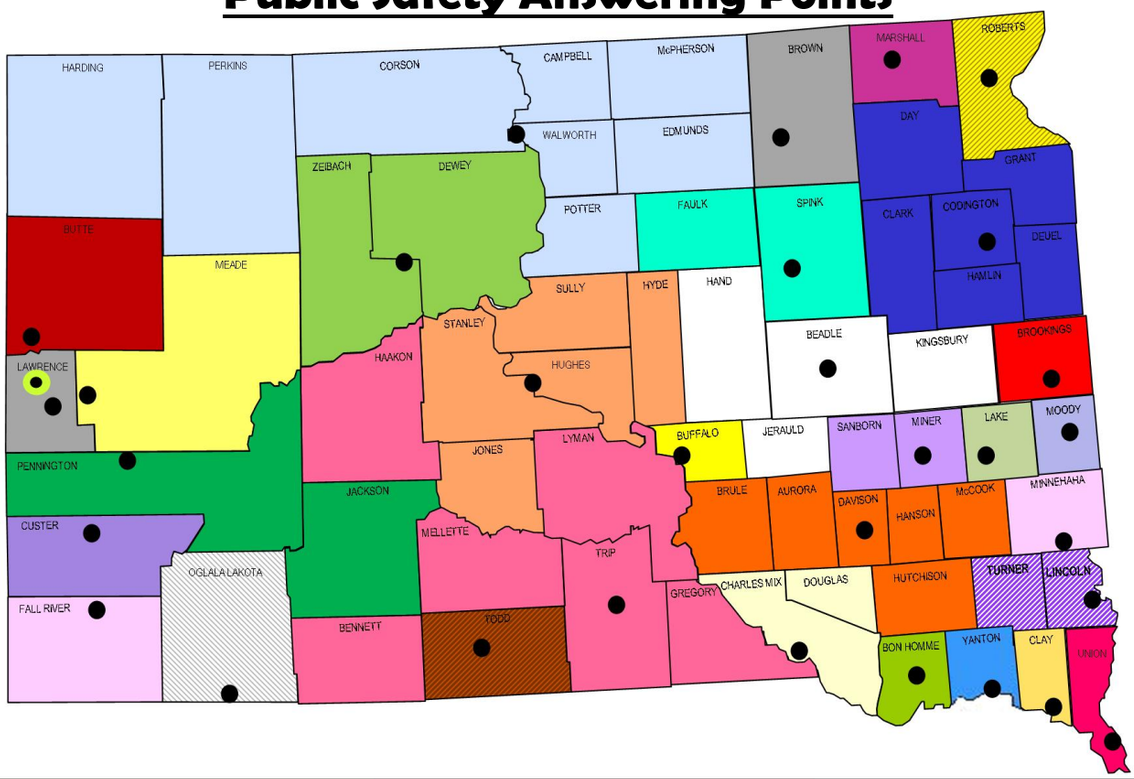
This work group provides the coalition with the crucially import perspective of individuals with lived experience of suicide thoughts, attempts and loss directly or through a family member. This group will take the lead in determining what are the critical elements of a crisis response system to ensure that it can best serve South Dakotans in crisis. Members of this group include:

Tara Johanneson
Penny Kelley
Rosanne Summerside
Taylor Funke, Helpline Center
Jana Boocock, DSS
Matthew Glanzer
Kelli Rumpza, Human Service Agency
Kiley Hump, DOH
Wendy Giebenk, NAMI

Handling Mental Health Crisis TODAY

Roundtable Discussion

Public Safety Answering Points



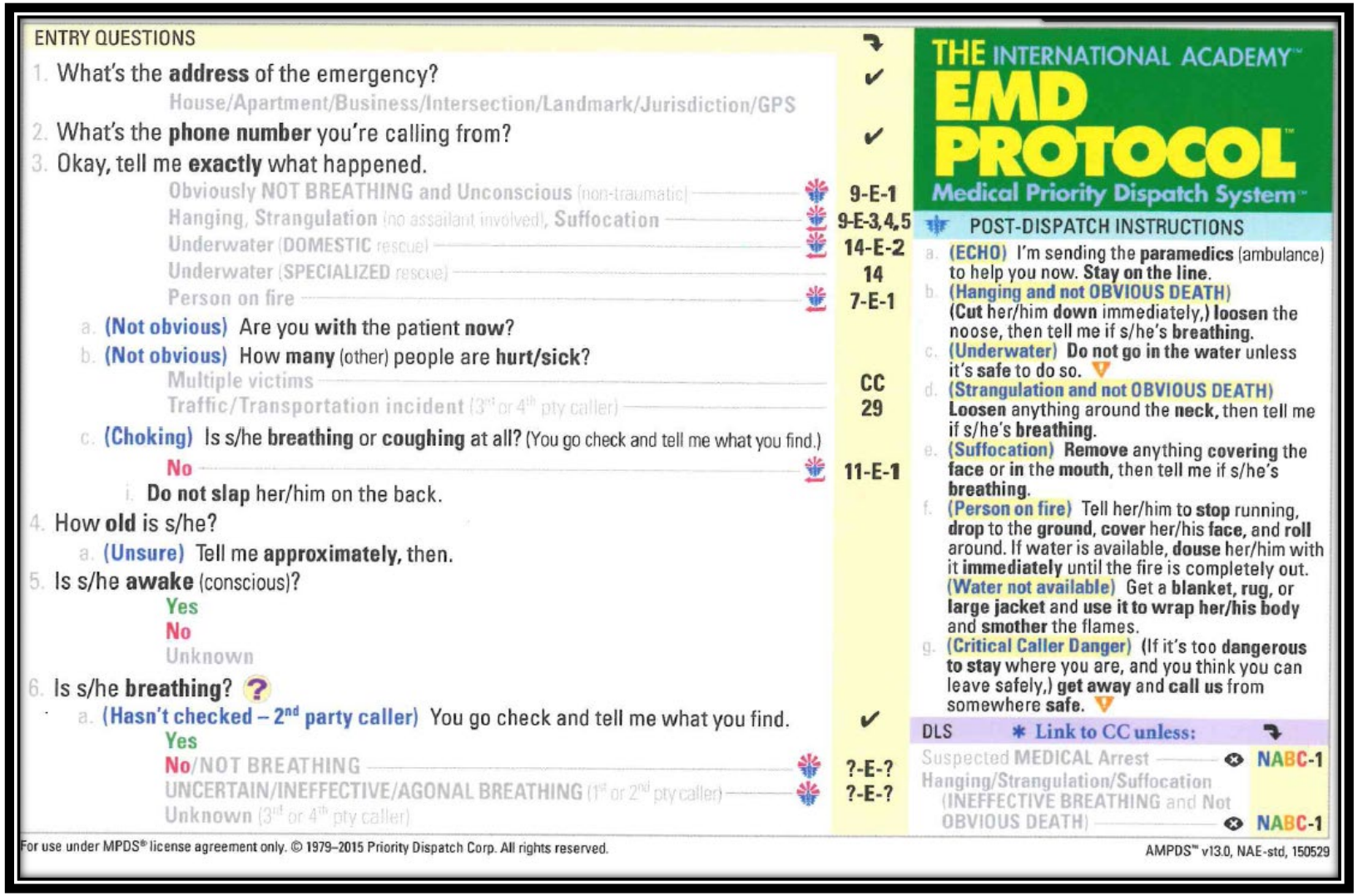
Bon Homme County 911 (SO) Amanda Boden PO Box 1, 300 W 18th Ave. Tyndall, SD 57066-0001 P: 605.589.3942 F: 605-589-4209 E: amandajboden@gmail.com	**Brookings Police Department** JoLynn Longville 307 3rd Avenue Brookings, SD 57006 P: 605.692.2113 F: 605.692.5320 E: jlongville@brookingsleo.org	**Brown County Communications** Kent Jones 124 S 1st Street Aberdeen, SD 57401 P: 605.626.4000 F: 605.626.4003 After 5pm: 605.626.7911 E: Kent.Jones@browncounty.sd.gov
Butte County Dispatch Center (SO) Vicki Greenwood 839 5th Avenue, Ste. 5 Belle Fourche, SD 57717 P: 605.892.2737 F: 605-892-2738 E: vicki.greenwood@buttesd.org	**Central South Dakota Communications** Cindy Gross 1302 E HWY 14, Suite 9 Pierre, SD 57501 P: 605.773.7410 F: 605.773.7424 E: Cindy.Gross@ci.pierre.sd.us	**Charles Mix County 911 (SO)** Sheriff Randy Thaler PO Box 610 215 S 6th Avenue Lake Andes, SD 57356 P: 605.487.7625 F: 605.487.7198 E: 171a@cme.coop
Clay Area Emergency Services Communication Center Ryan Anderson 15 Washington Street Vermillion, SD 57069 P: 605.677.7070 F: 605.677.7165 E: randerson@claycomm.org	**Custer County Communications Ctr** Michelle Lyon 420 Mount Rushmore Road Custer, SD 57730 P: 605.673.8146 F: 605.673.3765 After 5pm: 605.673.8176 E: mboehrs@custercountysd.com	**Fall River County Sheriff's Office** Dave Weishaupl 906 N River Street Hot Springs, SD 57747 P: 605.745.4444 F: 605.745.7591 E: dave.w@frcounty.org
Huron Police Department DPS Lisa McWethy 239 Wisconsin Avenue SW PO Box 1369 Huron, SD 57350 P: 605.353.8550 F: 605.353.8554 E: lisam@huronpolice.com	**Lake County 911 Communications** April Denholm 219 NE 1st Street Madison, SD 57042 P: 605.256.7620 F: 605.256.7160 E: lake911@lake.sd.gov dispatch@lake.sd.gov	**Lawrence County Sheriff's Office** Jamie Pesicka Olson PO Box 405, 80 Sherman St. Ste #1 Deadwood, SD 57732 P: 605.578.4464 F: 605.578.3913 After 5pm: 605.578.2230 E: jpesicka@lawrence.sd.us
Lincoln County Communications Todd Baldwin 128 North Main Street Canton, SD 57013 P: 605.764.2664 F: 605.764.2767 E: lccc@lincolncountysd.org	**Marshall County 911** Deb Skonberg 911 Vander Horck, PO Box 9 Britton, SD 57430 P: 605.448.5181 F: 605.448.5927 E: skonbergd02@yahoo.com	**Meade County Telecom (SO)** Scott Johnson 1400 Main Street Sturgis, SD 57785 P: 605.347.2681 F: 605.347.6824 E: sjohnson@meadecounty.org

Updated May 2021

Metro Communications Agency Scott McMahon 500 N Minnesota Avenue Sioux Falls, SD 57104 P: 605.367.7222 F: 605.367.7854 E: smcmahon@911metro.org	**Miner County Dispatch** Cora Schwader PO Box 366, 400 N Main Howard, SD 57349-0366 P: 605.772.4501 F: 605.772.4148 E: minerdispatch@alliancecom.net	**Mitchell Regional 911** Dawn Niehoff 201 West 1st Avenue Mitchell, SD 57301 P: 605.995.8400 E: dawnn@mitchelldps.com
Moody County 911 Terry Albers 108 E Pipestone Avenue Flandreau, SD 57028 P: 605.997.3251 After 5pm: 605.997.2423 E: mcem@moodycounty.net	**North Central Regional E911 Center** Tammie Fischer 110 1st Ave. East Mobridge, SD 57601 P: 605.845.5000 F: 605.845.2034 E: tammie.fischer@mobridgepolice.org	**Pennington County 911** Kevin Karley 130 Kansas City St, Ste 110 PO Box 6160 Rapid City, SD 57701 P: 605.394.2192 F: 605.394.6795 E: kevin.karley@pennco.org
Roberts County Sheriff's Office Janessa Guy 11924 BIA HWY 700, Box 937 Sisseton, SD 57262 P: 605.698.7667 F: 605.698.7386 E: 911@robertsco.org	**Spearfish Police Department** Jude Warner 225 W Illinois Street Spearfish, SD 57783 P: 605.642.1300 F: 605.642.1315 E: Judith.warner@cityofspearfish.com	**Spink County Sheriff's Office** Amy Hearnen 210 East 7th Avenue Redfield, SD 57469 P: 605.472.4595 F: 605.472.4599 E: 571@midconetwork.com
Union County Sheriff's Office Sara Beatty 209 East Main Street, Ste. 250 Elk Point, SD 57025 P: 605.356.2679 F: 605.356.3356 E: Sara.Beatty@unioncountysd.org	**Watertown Police Department** Ryan Remmers 128 North Maple Watertown, SD 57201-3653 P: 605.882.6210 (DL 5621) F: 605.882.5246 E: rremmers@watertownpd.com	**Winner Police Department** Deb Bice 217 East 3rd Street Winner, SD 57580-0691 P: 605.842.3324 F: 605.842.0415 E: wincomsd@goldenwest.net 911dispatch@gwtc.net
Yankton Police Department Julia Hussein 410 Walnut St., Suite 102 Yankton, SD 57078 P: 605.668.5210 F: 605.668.5203 E: jhussein@cityofyankton.org		
	State 9-1-1 Coordinator Maria King Department of Public Safety 118 W Capitol Avenue Pierre, SD 57501 P: 605.773.3264 F: 605.773.3018 E: Maria.King@state.sd.us	
TRIBAL PSAPs		
BIA Law Enforcement Ctr Crow Creek Andrew Lepkowski PO Box 110, 125 Wizi Street Fort Thompson, SD 57339-0110 P: 605.245.2351 F: 605.245.2159 E: Andrew.Lepkowski@bia.gov	**Cheyenne River Tribe 911** Lieutenant Joe Brings Plenty PO Box 590, 2105 D Street Eagle Butte, SD 57625 P: 605.964.4567 F: 605.964.1023 E: Jessica.LeBeau@CRSTPD.com	**Oglala Sioux Tribe - DPS** Eula Yellow Boy PO Box 300 977 Horse Thief Road Pine Ridge, SD 57770 P: 605.867.5111 F: 605-867-5936 E: Eyellowboy@ostdps.org
Rosebud Tribal Police Department Sylvia Wright 1 Fairground Road Rosebud, SD 57570 P: 605.856-2365 F: 605.747.5010 E: daisy.wright@rstjustice.org		

Any report of a suicidal subject, even 3rd/4th party reports, ***must*** be handled using Emergency Medical Dispatch (EMD)

EMD is also initiated with 211 employees reporting a suicidal caller.



ENTRY QUESTIONS

1. What's the **address** of the emergency? ✔
   House/Apartment/Business/Intersection/Landmark/Jurisdiction/GPS
2. What's the **phone number** you're calling from? ✔
3. Okay, tell me **exactly** what happened.
   - Obviously NOT BREATHING and Unconscious (non-traumatic) — 9-E-1
   - Hanging, Strangulation (no assailant involved), Suffocation — 9-E-3,4,5
   - Underwater (DOMESTIC rescue) — 14-E-2
   - Underwater (SPECIALIZED rescue) — 14
   - Person on fire — 7-E-1

   a. **(Not obvious)** Are you **with** the patient **now**?

   b. **(Not obvious)** How **many** (other) people are **hurt/sick**?
   - Multiple victims — CC
   - Traffic/Transportation incident (3rd or 4th pty caller) — 29

   c. **(Choking)** Is s/he **breathing** or **coughing** at all? (You go check and tell me what you find.)
   - No — 11-E-1

   i. **Do not slap** her/him on the back.
4. How **old** is s/he?

   a. **(Unsure)** Tell me **approximately**, then.
5. Is s/he **awake** (conscious)?
   - Yes
   - No
   - Unknown
6. Is s/he **breathing**? ?

   a. **(Hasn't checked – 2nd party caller)** You go check and tell me what you find. ✔
   - Yes
   - No/NOT BREATHING — ?-E-?
   - UNCERTAIN/INEFFECTIVE/AGONAL BREATHING (1st or 2nd pty caller) — ?-E-?
   - Unknown (3rd or 4th pty caller)

THE INTERNATIONAL ACADEMY™
EMD PROTOCOL™
Medical Priority Dispatch System™

POST-DISPATCH INSTRUCTIONS

a. **(ECHO)** I'm sending the **paramedics** (ambulance) to help you now. **Stay on the line.**

b. **(Hanging and not OBVIOUS DEATH)** **(Cut** her/him **down** immediately,) **loosen** the noose, then tell me if s/he's **breathing.**

c. **(Underwater)** **Do not go in the water** unless it's **safe** to do so.

d. **(Strangulation and not OBVIOUS DEATH)** **Loosen** anything around the **neck,** then tell me if s/he's **breathing.**

e. **(Suffocation)** **Remove** anything **covering** the **face** or **in** the **mouth,** then tell me if s/he's **breathing.**

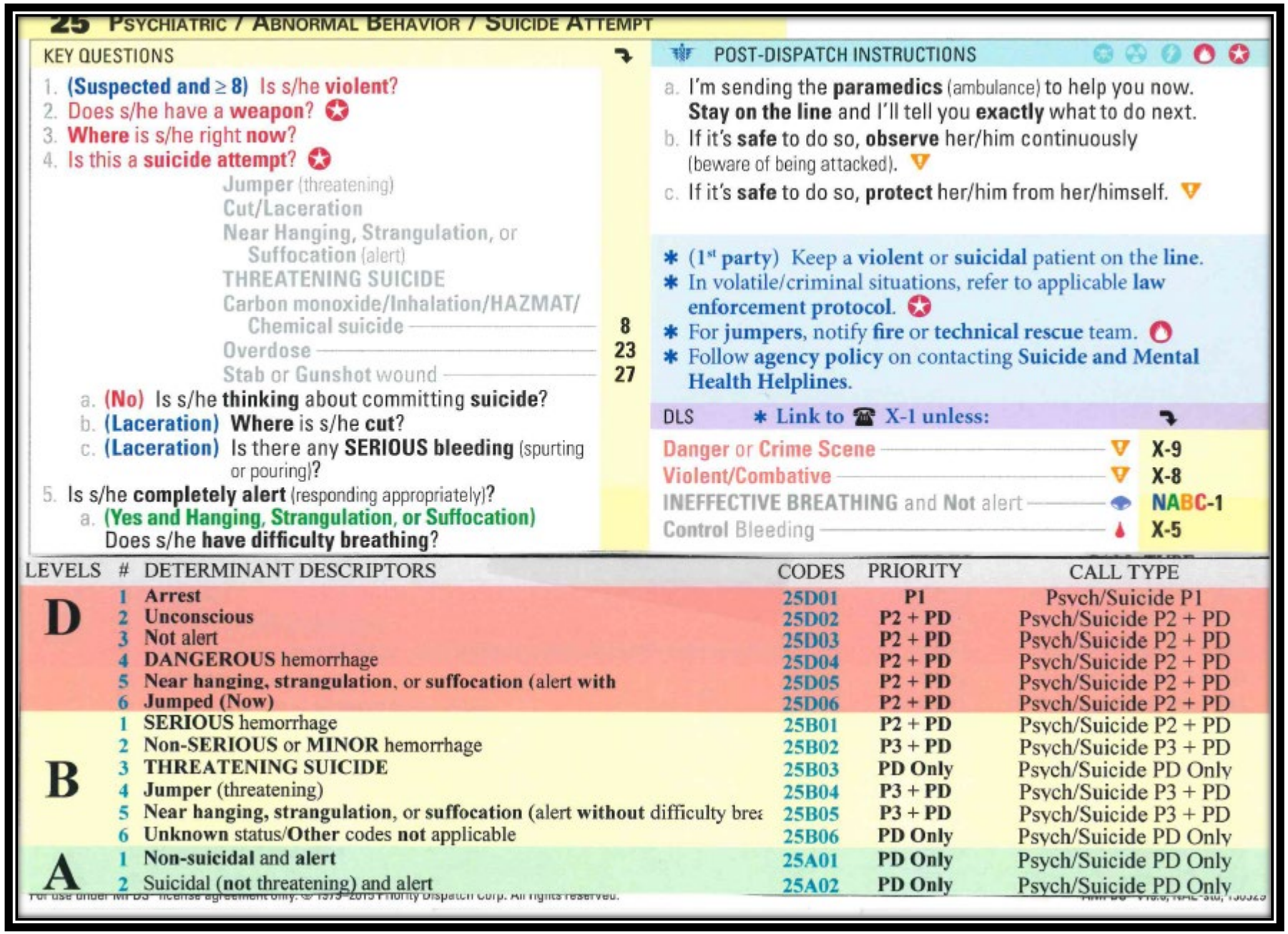
f. **(Person on fire)** Tell her/him to **stop** running, **drop** to the **ground, cover** her/his **face,** and **roll** around. If water is available, **douse** her/him with it **immediately** until the fire is completely out. **(Water not available)** Get a **blanket, rug,** or **large jacket** and **use it to wrap her/his body** and **smother** the flames.

g. **(Critical Caller Danger)** **(If it's too dangerous to stay** where you are, and you think you can leave safely,) **get away** and **call us** from somewhere **safe.**

DLS * Link to CC unless:

- Suspected MEDICAL Arrest — NABC-1
- Hanging/Strangulation/Suffocation (INEFFECTIVE BREATHING and Not OBVIOUS DEATH) — NABC-1

AMPDS™ v13.0, NAE-std, 150529



25 PSYCHIATRIC / ABNORMAL BEHAVIOR / SUICIDE ATTEMPT

KEY QUESTIONS

1. **(Suspected and ≥ 8)** Is s/he **violent?**
2. Does s/he have a **weapon?**
3. **Where** is s/he right **now?**
4. Is this a **suicide attempt?**

Jumper (threatening)
Cut/Laceration
Near Hanging, Strangulation, or Suffocation (alert)
THREATENING SUICIDE
Carbon monoxide/Inhalation/HAZMAT/Chemical suicide — 8
Overdose — 23
Stab or Gunshot wound — 27

   a. **(No)** Is s/he **thinking** about committing **suicide?**
   b. **(Laceration)** **Where** is s/he **cut?**
   c. **(Laceration)** Is there any **SERIOUS bleeding** (spurting or pouring)?

5. Is s/he **completely alert** (responding appropriately)?
   a. **(Yes and Hanging, Strangulation, or Suffocation)** Does s/he **have difficulty breathing?**

POST-DISPATCH INSTRUCTIONS

a. I'm sending the **paramedics** (ambulance) to help you now. **Stay on the line** and I'll tell you **exactly** what to do next.
b. If it's **safe** to do so, **observe** her/him continuously (beware of being attacked).
c. If it's **safe** to do so, **protect** her/him from her/himself.

* (1st party) Keep a **violent** or **suicidal** patient on the **line.**
* In volatile/criminal situations, refer to applicable **law enforcement protocol.**
* For **jumpers,** notify **fire** or **technical rescue** team.
* Follow **agency policy** on contacting **Suicide and Mental Health Helplines.**

DLS ✱ Link to ☎ X-1 unless:

Danger or Crime Scene — X-9
Violent/Combative — X-8
INEFFECTIVE BREATHING and Not alert — NABC-1
Control Bleeding — X-5

LEVELS	#	DETERMINANT DESCRIPTORS	CODES	PRIORITY	CALL TYPE
D	1	**Arrest**	25D01	P1	Psych/Suicide P1
	2	**Unconscious**	25D02	P2 + PD	Psych/Suicide P2 + PD
	3	**Not alert**	25D03	P2 + PD	Psych/Suicide P2 + PD
	4	**DANGEROUS** hemorrhage	25D04	P2 + PD	Psych/Suicide P2 + PD
	5	**Near hanging, strangulation,** or **suffocation** (alert **with**	25D05	P2 + PD	Psych/Suicide P2 + PD
	6	**Jumped (Now)**	25D06	P2 + PD	Psych/Suicide P2 + PD
B	1	**SERIOUS** hemorrhage	25B01	P2 + PD	Psych/Suicide P2 + PD
	2	**Non-SERIOUS** or **MINOR** hemorrhage	25B02	P3 + PD	Psych/Suicide P3 + PD
	3	**THREATENING SUICIDE**	25B03	PD Only	Psych/Suicide PD Only
	4	**Jumper** (threatening)	25B04	P3 + PD	Psych/Suicide P3 + PD
	5	**Near hanging, strangulation,** or **suffocation** (alert **without** difficulty brea	25B05	P3 + PD	Psych/Suicide P3 + PD
	6	**Unknown** status/**Other** codes **not** applicable	25B06	PD Only	Psych/Suicide PD Only
A	1	**Non-suicidal** and **alert**	25A01	PD Only	Psych/Suicide PD Only
	2	Suicidal (**not** threatening) and alert	25A02	PD Only	Psych/Suicide PD Only

Fire and Ambulance must standby for law enforcement to secure the scene on all suicide attempts, suicide threats with a gun or a knife, and all violent or disruptive psychiatric subjects.

Law Enforcement may ask to page the Mobile Crisis Team (MCT) after utilizing flow charts to assess the needs of the individual. These determine whether the subject needs to be placed on a hold at Avera Behavioral Health or if they can meet with a qualified mental health professional using the MCT program.

The MCT can either respond directly to the residence or law enforcement may transport the individual to the Crisis Care Center (CCC) for an assessment with a mental health professional.

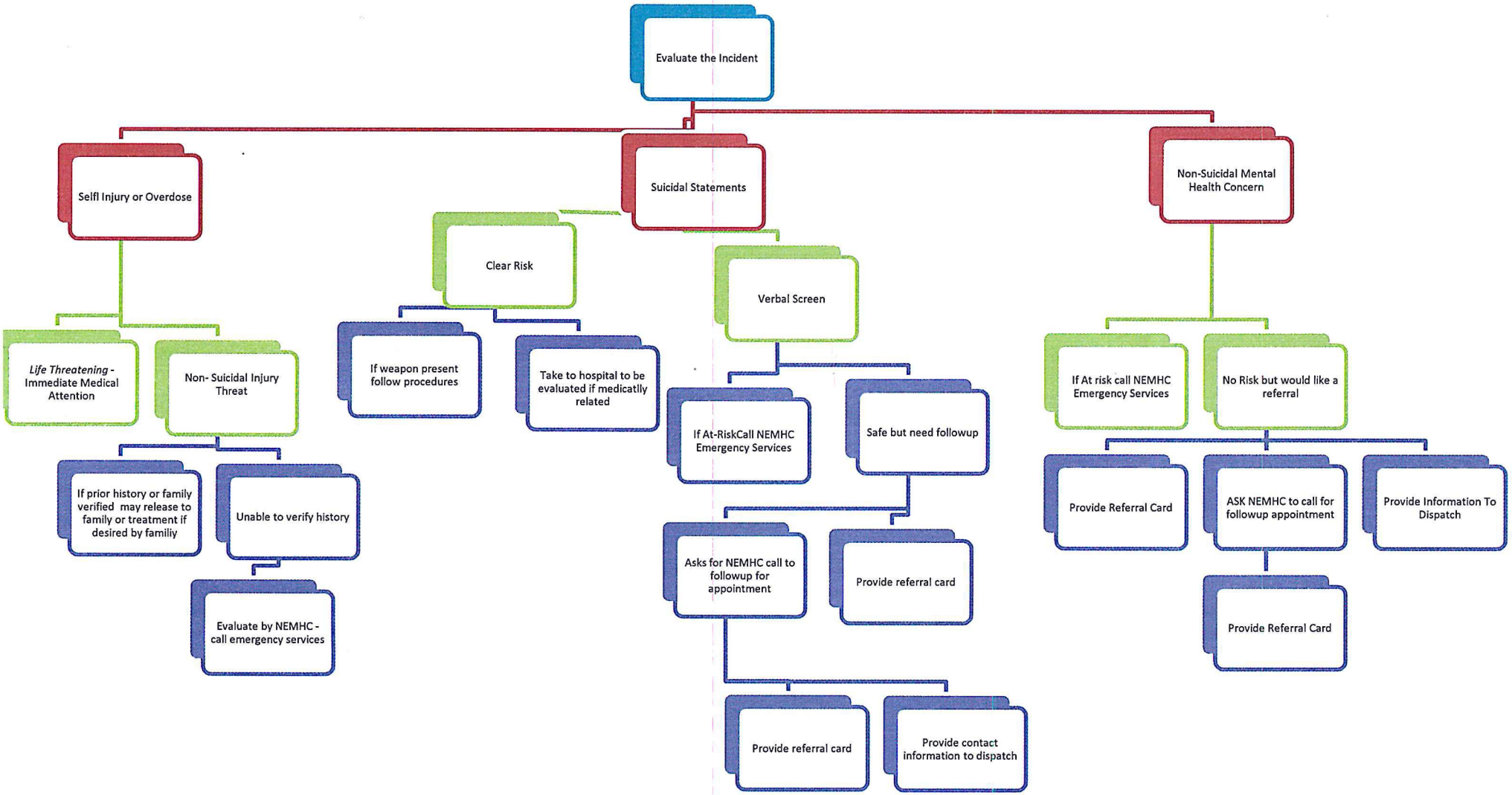
Priority 1 (P1) = Lights and Sirens
Law Enforcement, Fire Dept, Ambulance

Priority 2 (P2) = Lights and Sirens
Fire Dept, Ambulance

Priority 3 (P3) = Flow of Traffic
Ambulance

**P3 and P2 calls may <u>also</u> have a law enforcement response for situations outside of providing medical interventions*

Aberdeen Police Department Screening Process for Mental Health Needs



Jan 15th training

Feb 1st Start Date

Recap:
Workgroup Discussions to Date

Nick Oyen and Rachel Oelmann, Project Supports

Key Discussions

- Review of Ideal Mobile Crisis Response – Vision
- Supporting Framework for the Ideal Mobile Crisis Response
- Available or Emerging Resources
- Key Issues Identified to Date (Big Rocks to Overcome)
- Open Questions that Remain

Workgroup Updates

- Lived Experience
- Diversity / Geographical Considerations
- 911 / 9-8-8 Intercommunication
- Crisis Response Systems

Combined Notes & Themes
Workgroup Meetings Round #1

Ideal Mobile Crisis Response – Vision

Co-responder multi-disciplinary team model, which includes qualified mental health professionals in crisis response situations	• Parents / loved ones are hesitant to call 911, for fear of escalation • Current options for a response in many areas are limited to emergency departments and/or law enforcement facilities • Care for loved ones and/or parents • In person option always preferred, but inclusive of technology to account for rural and frontier response is reasonable.
Responding personnel trained in CIT and de-escalation strategies	• SD-reality will likely not include each community with their own crisis response team, so having CIT-trained law enforcement will bridge that gap.
Timely response that focuses on crisis stabilization first, then transfer to appropriate facilities only if needed	• Follow-up and follow-through; assurances that connections are indeed made, and services are indeed delivered.
Serve as an access point to the full continuum of behavioral health care	• Assessment for the appropriate level of response • Patients enter crisis care at the most appropriate, least restrictive facility first • Integration of step-down plans that navigate patients from higher levels of care to lower levels of care post-crisis • Preservation of autonomy and personal choice • Community buy-in for responsive, appropriate levels of care
Access to community-based resources whenever feasible	• Creation of “Safe Spaces” within communities • Access to mental health first-aid trained individuals
Call center response as robust and as easy to remember as 911	• Dispatch functionality consistent with 911 • Supporting decision tree for who handles what calls • At minimum co-coordinated, but ideally co-located with specialized dispatchers
Comprehensive follow-up care available to individuals and loved ones	• Integration of case management supports, peer recovery supports, care coordination, and related services to aid in patient navigation • Inclusion of spiritual and cultural resources that reflect the individual

Supporting Framework for the Ideal Mobile Crisis Response

Clear communication to the public on roles and responsibilities during a crisis response	• Need to "debunk" the process / map out what happens • Emphasis on inclusion of qualified mental health professionals as part of the response • Include parameters for when calls escalate to higher levels of response (e.g. involving law enforcement) • Messaging that evokes emotion with recognizable imagery, that relates to all – people need to recognize themselves in these services, and know they are being served by someone who gets their perspective • Emphasis on confidentiality and autonomy
Messaging that is culturally sensitive and inclusive	• Lived experience is vital to ensure messaging is viewed as genuine.
Create understanding about what 988 "looks like" in each community	
Seamless connection between 988 and 911 dispatch and call handling	
Cross-training to ensure all emergency response professionals are as equipped as possible to handle these cases and refer to their appropriate regional resources	

Available or Emerging Resources

- Department of Health is launching a rapid expansion of community health workers as a resource statewide; assessing feasibility of incorporating this type of trained workforce into crisis response is something to consider.
- Department of Social Services is working to define and expand access to peer support workers for both mental health and substance use; assessing alignment of this workforce role with the crisis response model is another thing to consider.
- Sioux Falls-based community triage center (The Link) is opening June 1, adding to Rapid City-based capacity provided by the Care Campus.
- Expansion of Zero Suicide principles statewide, including emphasis on CAMS (Clinical Assessment and Management of Suicidality) Training to support evidence-based clinical interventions and appropriate follow-up care.
- Existing regional network of community mental health centers that have emergency services available.
- Expansion of two additional appropriate regional facilities, to be identified, in partnership with Department of Social Services.

Key Issues Identified to Date (Big Rocks to Overcome)

- Accessibility to 988 or 911 in areas of our state that do not have access to internet, or where cell service is inadequate
- Intercommunication and interoperability between 988 and 911
    - 33 individual PSAPs (Public Safety Answering Points) across SD, 28 of which operate on the same network.
    - Coding of cases and appropriate response is defined at the local level.
    - Geolocation is presently not available for 988 (pending FCC review and hopeful approval); geolocation is central to appropriate 911 response, making this piece a critical control point moving forward for referrals between these answering points.
- Ability to share information about a case is not well defined, and may require legislative action to streamline.
- Need to enhance crisis stabilization services closer to home
- Transportation supports and logistics for individuals in crisis, both to and from receiving facilities, with specific focus on college campuses
- Follow-up care
    - is provided for those calling NSPL now, but the degree to which that can happen is greatly influenced by the information shared if that NSPL call is escalated to an emergency response.
    - is not universally provided through other access points.
    - should take into account the needs of the reporter / third-party / loved one.
    - should have the ability to transition to long-term case management and/or health coaching as appropriate to provide a support system, particularly for individuals who have little to no control of their situation.

Open Questions

- Is it required that law enforcement is part of a response team currently?
- Does statute address follow-up care for mobile crisis response teams now?

TRAUMA INFORMED POLICING TRAINING

- 2020 RCPD created a 8 hour Trauma Informed Policing training program that included historical trauma and Adverse Childhood Experience Training for all staff and has been brought to the community for training
- 2021 RCPD Handle With Care Implementation and Advanced ACEs training.
- 2021 CIT and Co-responder development.

CO-RESPONSE AND TRAUMA

- The RCPD is entering a new chapter of our trauma informed response by establishing a co-responder model
- Pursuing funding to stand up a unit of clinicians, EMT's and, Officers
- CIT driven response, currently have 58% of our agency trained in CIT, with all new officers being CIT certified before they hit the street.
- The strategic focus of our CIT programming is to enhance our trauma informed response both internally and externally. We brought on a full time wellness coordinator to enhance our CIT efforts, and to build officer resilience and wellness by understanding trauma to build emotional intelligence through recognizing trauma and crisis through an internal and external awareness.
- The future growth of our community response it to develop a collaborative co-responders that are responding in tandem with the police and EMS services in Rapid City. We have formed a committee (Fire/EMS, Police, Sheriff, Behavior Management Systems, Great Plains Tribal Chairman's Health Board Behavioral Health, Dispatch, Native Community Response Team) to create this co-responder model that will also for the foundation elements for our Community Crisis Committee, which will also oversee the community CIT training and coordinated case management.
- **Law Enforcement Training in Collaborative Crisis Response**

OFFICER WELLNESS & PEER SUPPORT

- 2016 Peer Support Team: The RPCD formally established and trained an in-house group of peers and mental health professionals capable of providing one-on-one support, referrals, stress awareness/reduction help, small group defusings and debriefings.
- 2016 IACP One Mind Campaign Pledge: the RCPD took the IACP 3 year pledge and completed the requirements within 6 months – the RCPD has clearly defined and sustainable partnership with the Crisis Care Center and Behavior Management Systems in Rapid City; 58% of our sworn officers ranks are Crisis Intervention Team (CIT) trained; and 100% of sworn officer ranks have been certified in Mental Health First Aid for Public Safety (MHFA), which was taught by BMS.
- 20 member peer support team with informal peer leaders from all ranks and roles in the PD
- 6 month wellness coordinator pilot program
- Full-time wellness coordinator
- On staff Psychologist

COORDINATED YOUTH OUTREACH

COORDINATED YOUTH OUTREACH

1. RCPD Youth Outreach Team—1 Youth and Family Support Navigator; 3 officers
    1. Co-location with LSS and CHS Youth Outreach Case Managers
    2. Primary focus will be to address youth exposure to trauma and victimization
    3. Care Bags and Hotel Placements.
    4. Work with CWOY at great plains

2. Handle with Care Initiative—RCAS/RCPD partnership to support youth exposed to traumatic events in the community and to provide a trauma-informed response that may have difficulty managing their exposure to trauma

3. Safe Place Initiative—RCPD is participating in the community planning process to bring the Safe Place Initiative to Rapid City. The effort focuses on providing a network of locations in the community where youth can go when they feel unsafe during all hours of the day

Electronic Registry Project Overview

HMA

South Dakota Department of Social Services

Strong Families - South Dakota's Foundation and Our Future

HEALTH MANAGEMENT ASSOCIATES

Electronic Behavioral Health Services Registry Research Project

Stakeholder Meeting
May 25, 2021

OUR PEOPLE

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HEALTH MANAGEMENT ASSOCIATES

David Bergman

Lee Repasch

Anh Pham

Innovators with unmatched real-world experience

OUR COLLEAGUES ARE FORMER:

- State Medicaid directors, mental health commissioners and budget officers
- CEO, COO, CFO and other hospital, health system and state-based health insurance marketplace leaders
- Managed care executives
- Physicians and other clinicians who have run health centers and integrated systems of care–many still practice medicine
- Policy advisors to governors and other elected officials
- Senior officials from the Centers for Medicare & Medicaid Services (CMS) and the Office of Management & Budget (OMB)

WHAT WE DO

Health Management Associates has successfully tackled a wide variety of public healthcare projects, from developing complete healthcare delivery systems to translating complex data into useful insights. Whether your project has run into a snag in the final stages or hasn't even gotten off the ground, we can provide the expertise and guidance to help you make it a success.

Our areas of expertise include:

- + **Analytics**
- + **Behavioral Health**
- + **Clinical Services**
- + **Community Strategies**
- + **Correctional Health**
- + **Government Programs and The Uninsured**
- + **Healthcare Delivery Development and Redesign**
- + **Healthcare IT Advisory Services**
- + **Investment Services**
- + **Long-Term Services and Supports**
- + **Managed Care**
- + **Opioid Crisis Response**
- + **Pharmacy**
- + **Public Health**

OUR REACH

With over **20 offices** and more than **200 multidisciplinary consultants coast to coast**, our expertise, our services, and our team are always within client reach.

Some of the brightest minds in publicly funded healthcare. Working for you.

AGENDA

1. Project Overview/Timeline
2. Progress to date
3. Next Steps
4. Questions

1 PROJECT OVERVIEW

Establish and expand the use of a comprehensive, electronic **behavioral health services registry.**

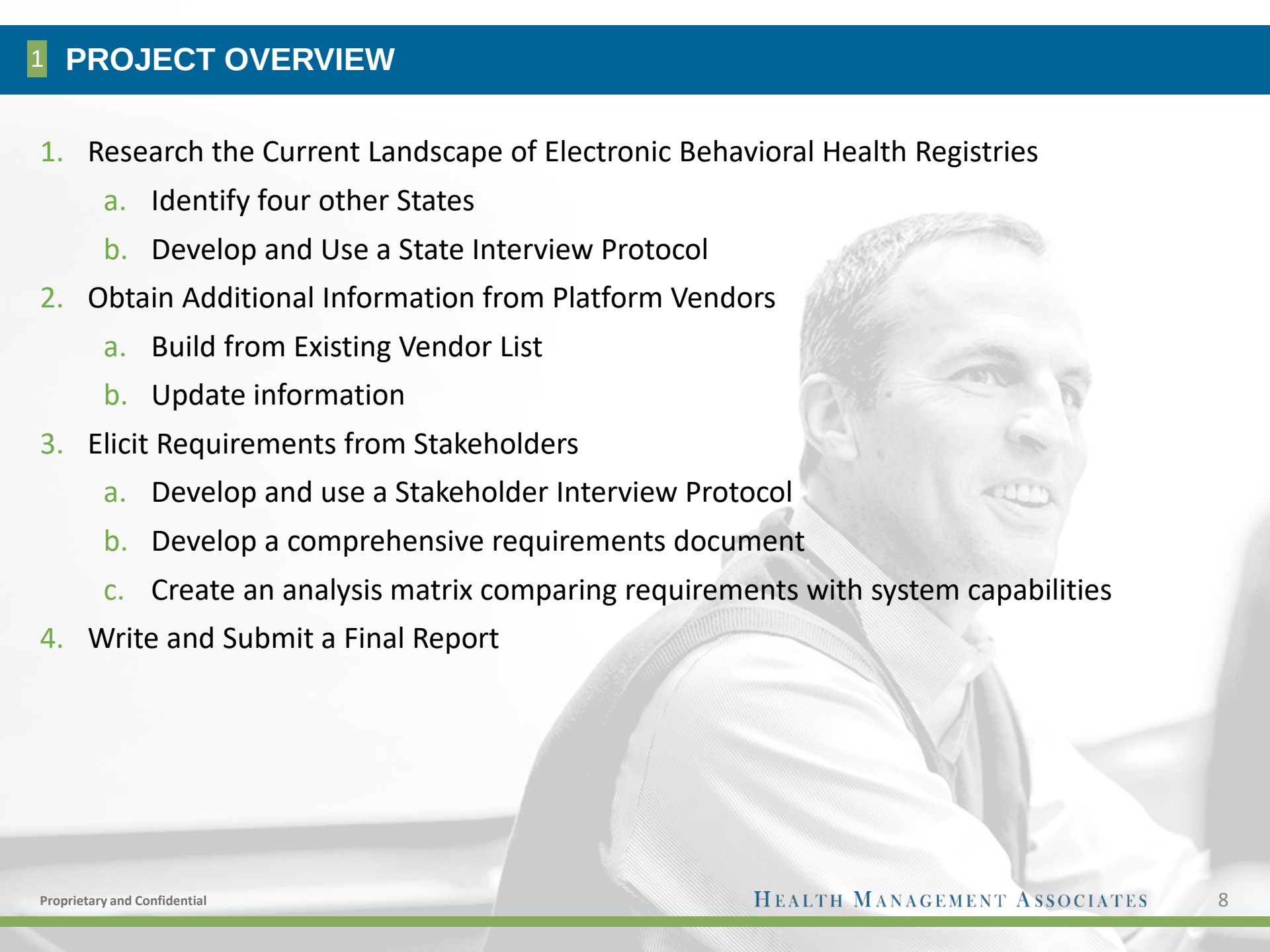
Goal is to collect and display **capacity information** for a comprehensive range of publicly and privately funded **behavioral health service** providers in the State. These providers include, but are not limited to:

- Crisis services
- Mobile crisis services
- Outpatient mental health and substance use disorder services
- Residential mental health and substance use disorder services
- Supportive and recovery housing
- Others to be determined

Review costs, capabilities; develop sustainability plan

1 PROJECT OVERVIEW

1. Research the Current Landscape of Electronic Behavioral Health Registries
    a. Identify four other States
    b. Develop and Use a State Interview Protocol
2. Obtain Additional Information from Platform Vendors
    a. Build from Existing Vendor List
    b. Update information
3. Elicit Requirements from Stakeholders
    a. Develop and use a Stakeholder Interview Protocol
    b. Develop a comprehensive requirements document
    c. Create an analysis matrix comparing requirements with system capabilities
4. Write and Submit a Final Report



2 PROGRESS TO DATE

- Background Info:
  - High level overview of "Bed Boards" in other States
  - Review of systems/providers in South Dakota
- Research and select four States with BH registries:
  - Iowa
  - Nebraska
  - Oklahoma
  - Vermont
- South Dakota Stakeholders
  - Review and categorize stakeholders
  - Develop interview protocol
  - Collect information on how a system will be used, by whom, basic requirements
- Vendor Exploration
  - Five Points
  - Open Beds
  - Netsmart's MyAvatar
  - Developed by MN

3 NEXT STEPS

- ❑ Interview South Dakota Stakeholders
- ❑ Interview States
- ❑ Collect Information from Vendors
- ❑ Review/Discuss Findings


ANY
QUESTIONS?

South Dakota Department of Social Services

South Dakota Electronic Behavioral Health Registry
Organization Interview Guide

Bed Board Registry Interview Protocol:

Intro/background

The South Dakota Department of Social Services, Division of Behavioral Health (DBH) has received funding to explore use of an electronic behavioral health services registry that will collect and display capacity information for a comprehensive range of publicly and privately funded behavioral health service providers in the State. These providers include, but are not limited to:

- Crisis services
- Mobile crisis services
- Outpatient mental health and substance use disorder services
- Residential mental health and substance use disorder services
- Supportive and recovery housing

DBH has contracted with HMA to assist in colleting information on how best to use capacity/resource tools by interviewing stakeholders in South Dakota and reviewing use of these tools in other states. In collaboration with DBH, we have identified you and your organization as a key stakeholder that can provide valuable insights about how a tool like this could best be deployed in the State, and how it might be used by your organization and others like it.

Your response to the questions and this conversation are intended to inform the development of the basic requirements we will use to evaluate different technology options. In addition to talking to you and other stakeholders, we will also be talking to other states about the platforms they are using and their experiences. We will use this information along with an evaluation of the technology vendors to make a recommendation to DBH on how best to deploy this capability in South Dakota.

South Dakota Electronic Behavioral Health Registry
Organization Interview Guide

Basic Information

- Name of Interviewee
- Title
- Role
- Organization
- What services does your organization provide?
- How would you characterize the role you or your organization might serve with regard to a resource guide?
    - We have BH capacity
    - We are seeking BH services
    - Both
    - Other:
        - *Please describe*

Service capacity

- What services does your organization provide?
    - Behavioral Health (BH)
        - General approach:
            - Low acuity
            - Serious Mental Illness
            - Children with Serious Emotional Disturbance
            - Both
            - Other
        - BH IP
        - BH Crisis/ER
        - BH Mobile Crisis
        - BH Treatment
        - BH Peer
        - Specific Programs:
            - *Name Programs*
    - Substance Use Disorder (SUD)
        - General:
            - Alcohol
            - Opioid Use Disorder (OUD)
            - Other Drug
            - Combination
            - Other (name)
        - SUD IP
        - SUD Detox
        - SUD OP Treatment
        - SUD Peer
        - Specific Programs:
            - *Name Programs*

- What payers/insurance do you accept?
    - Medicaid
    - Medicare
    - Commercial
    - Individual
    - Self-pay/uninsured
    - Other (e.g., Tricare)

- Do you partner with any other systems or payers (e.g., VA, IHS) to provide services?

- Are there any special attributes of the populations you provide services to?
    - Language
    - Gender
    - Specific cultural/racial/ethnic/other identity expertise?
        - If so, please identify:
    - Geography
    - Age (children, adult)
    - Other (please name)

- How many units of service do you provide by program/resource?
    - Monthly
        - Number of Services
        - Unique served individuals
    - Annually
        - Number of Services
        - Unique served individuals

- At what percentage of full capacity do you usually operate?

- Do you receive referrals from other agencies?
    - If yes, who refers to you, and how often do referrals come in?

- Do you use any electronic systems to manage your capacity?
    - If no, how do you monitor capacity and/or anticipate availability?
    - If yes, what is the system/platform name?
    - If yes, is this platform capable of sharing information with other systems?

- Do individuals or organizations outside your agency have trouble identifying when you do/don't have capacity? How do they know?

- Are there any groups you would want to make sure have access to information on your available capacity?

- Conversely, are there any groups you would want prohibited from accessing information on your available capacity?

- What do you do when you receive a referral, but you do not have capacity to provide care?
    - Do you track what happens to those consumers?
        - If yes, please provide detail

- How often does your capacity change?

- How often would a capacity resource need to be updated to be reasonably current?
    - By shift?
    - Daily?
    - Weekly?

- Are there any reasons you might not accept a referral, even if you have an available resource?
    - Language
    - Diagnosis (comorbid medical conditions, HIV, etc.)
    - Gender (e.g. DV)
    - Service limitations (e.g. threat of violence, use of restraints, etc.)
    - Reimbursement/Payer
    - Age (child, adult)

- How would you prefer to be contacted about the potential for available capacity? (e.g., phone, email, electronically)

- Do you currently collaborate with the South Dakota Helpline Center (988)?

Seeking Capacity

- What BH/SUD/Crisis services have you looked for in the last year?
- What BH/SUD/Crisis services are you most often looking for?
- What BH/SUD/Crisis services are hardest for you to find available when you need them?
- What process do you currently use to identify an available resource/capacity?
- What challenges do you have in identifying available capacity?
- Do you maintain any kind of personal or organizational resource directory?
    - How effective is it?
    - How did you compile it?
    - When was it last updated/how frequently do you update it?
- When seeking a resource, what information, if available, would be most useful to you?
- What might discourage you from using a specific information source?
    - User Experience/usability?
    - Unreliable information?
    - Incomplete information?
    - Irrelevant information?
- What do you do once you find capacity? How do you connect the consumer with the service provider?
- What do you do when you cannot find the right service?
    - How often does this happen?
    - Does it tend to happen for a particular kind of service?
- How pervasive is this problem?
    - Are you aware of other organizations that have the same issue in seeking services?
- Are there any other resource directories you use to identify capacity?
    - If yes, what do you use them for? Could they be expanded to include the BH/SUD resources you are seeking?

South Dakota Electronic Behavioral Health Registry
State Interview Guide

State:
Date:

Welcome and Introductions

Thank you for your willingness to join us for this interview. Let's start with introductions.

Interviewees/Participants

	Interviewee/ Participant Name	Department/Division/ Business Unit	Role
1			
2			
3			
4			
5			

Why Are We Here?

South Dakota has engaged Health Management Associates (HMA) to support the State of South Dakota Division of Behavioral Health planning efforts to establish and expand comprehensive, electronic behavioral health services registry to document the existence and availability of behavioral health services across the State. As part of this process, we have identified several states with solutions of interest to South Dakota. We are conducting a round of interviews with these select states to gain a better understanding of their current behavioral health registry system, including the pros, cons, and high level costs. If possible, we would also ask if you can conduct a short demo of your registry. We have attached a write up outlining our current understanding of your platform, which we will discuss during the interview.

Today's Discussion

We plan to discuss the following:

1. **Current IT Solution**: Is the attached platform description correct? Fields include website, year created, registry owner/operator, mandatory/voluntary, how the system updates, primary users, services covered, served populations, key operational features, and system vendor.
    a. **Access**: who in your state has access to the system and what is their role?
    b. **Changes**: currently, are you planning or implementing any major changes to the system? Adding new users/facilities?
    c. **Onboarding**: how do you onboard users to the system? Do you allow consumers seeking services or the general public to directly access the system?
    d. **Education**: do you educate users/consumers about how to seek the appropriate service or level of service / differentiate between the services available via the platform? How do you help users to use the system appropriately? How to triage services using the system?
    e. **System integration**: do you currently or are you planning to integrate your system with 988 or any other systems? If so, can you tell us more about this?

f. **O&M**: Does the state or a vendor maintain the system (e.g., upgrades, data migration, etc.)? Does the state (or a vendor) work with users of the system?

2. **Registry Updates**: does the state monitor user updates? Does the state work directly with users to ensure updates are being done appropriately/in accordance with any contractual obligations (in shifts or daily)?
3. **Usage**: how do you measure volume with your system (e.g. referrals, patients, entities, beds)? Are there any other metrics you use to understand utilization?
4. **Costs**: what are the high level costs of the system regarding design, development, and implementation (DDI), and operations and maintenance (O&M)? What were the cost methodologies used (e.g., per user, scheduled O&M).
5. **System funding**: how do you fund the system? Does the state charge system users any fees?
6. **Activity drivers**: what are the factors that result in more or less work, more or less time spent, more manual work arounds, and for whom? Does the platform require inconsistent activities/processes or is it fairly routine to work with?
7. **Process and system pain points:** what are the top five process and information system issues you deal with currently that have an adverse impact on your ability to get the work done the way it should be done (timely, without errors, without too many handoffs or rework).
8. **Process and system strengths:** what are the top five strengths of your system (in terms of ease of use, etc.)
9. **Reporting and Analysis:** how do you use your platform to collect, aggregate, and analyze program data? What are the barriers to report development using your current platform?
10. **Demo:** can you provide a short demo of your platform?

Documentation of discussion with interviewees/participants (for HMA team use only)

#	Topic area	Interviewee input/response/feedback and other observations
1	Current IT Solution	
2	Registry Updates	
3	Usage	
4	Costs	

#	Topic area	Interviewee input/response/feedback and other observations
5	System Funding	
6	Activity drivers	
7	Process and system pain points	
8	Process and system strengths	
9	Reporting and analysis	

Fiscal Modeling Project Overview

Guidehouse

Guidehouse

988 Fiscal Planning Grant Research Project

State of South Dakota
Department of Social Services
Division of Behavioral Health

South Dakota Department of Social Services
Strong Families - South Dakota's Foundation and Our Future

May 25, 2021

Agenda

1. Introduction to Guidehouse
2. Project Tasks
3. Questions

Introduction to Guidehouse

Guidehouse: A Synergy of Legacies

PwC's legacy public sector consulting practice became Guidehouse LLP in 2018, offering robust public health, financial services, technology, and strategy consulting services.

Guidehouse

NAVIGANT

Navigant was incorporated in 1999 as a diverse consulting services firm specializing in healthcare, energy, and legal consulting services.

Team Members

Jeffrey Meyers, JD, MA
Engagement Director

Jeff will be responsible for the successful delivery and completion of all services required under this contract. Jeff will also oversee required research and the preparation of the draft and final report deliverables to DBH and will serve as a point of contact for DBH.

Veronica Ross-Cuevas
Project Manager

Veronica will maintain day-to-day project responsibilities, including coordinating team members, tracking against workplan and timelines, and coordinating project tasks with the DBH project team. Veronica will also lead all regular status updates DBH and serve as the primary contact for DBH.

Peter Joyce
Project Consultant

Peter will serve as the primary resource for developing project deliverables under the leadership of the Project Director. Peter will also be available to the DBH team for project-related inquiries and support tasks.

Dr. Marguerite Clarkson
Subject Matter Expert

Dr. Clarkson will serve as a subject matter expert on suicide response, prevention, and communications throughout the engagement. She will also review and provide subject matter input on the draft and final report.

Lynda Zeller
Subject Matter Expert

Lynda will serve as a subject matter expert on SAMHSA block grant and other funding and will support research into funding options and cost modeling for the 988 program. As the leader of the single state authority in Michigan for all SAMHSA – funded programs, she has vast experience with federal funding for behavioral health.

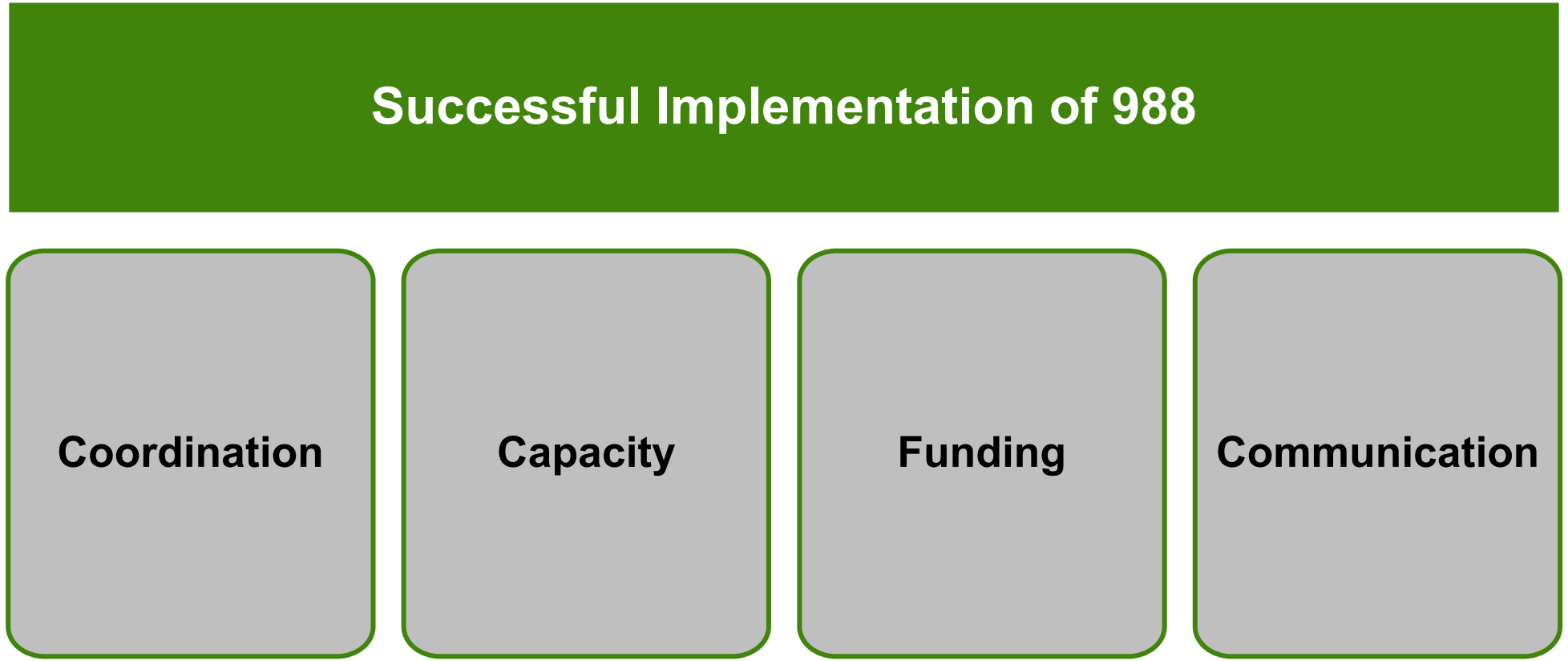
Kappy Madenwald
Subject Matter Expert

Kappy will serve as a subject matter expert on behavioral health crisis systems of care throughout the engagement. She will assist in the evaluation of current crisis response systems and building of effective treatment systems.

Project Tasks

Guidehouse

Overview



Task 1. 988 Funding Options Research

a. Research 988 Funding Strategies in Comparable States

Objective:

- Research state strategies for funding 988 services in states comparable to South Dakota

Activities:

- Conduct desk review of selected state data on funding options, existing hotline and communications resources, provider participation and capacity, short and long-term financial needs of 988 to foster sustainability for South Dakota
- Conduct review of South Dakota data and other data relevant to cost modeling
- In consultation with DBH, conduct potential brief interviews of other state officials to confirm their approach to 988 design and funding

Deliverables:

- Collection and documentation of all research findings
- Interim detailed summary of other state strategies and approaches for funding, communications, infrastructure requirements for 988, as well as interim findings

Task 1. 988 Funding Options Research (Continued)

b. Participate in Stakeholder Coalition Meetings

Objective:
- Support DBH's stakeholder engagement process

Activities:
- Prepare updates on project status for each meeting
- Attend (virtually) and present updates at each Stakeholder Coalition Meeting

Deliverables:
- Written and oral presentations / slides focusing on status updates

Task 1. 988 Funding Options Research (Continued)

c. Deliver and Communicate Final Report

Objective:
- Deliver report consisting of all required elements

Activities:
- Prepare and, if requested, present Final Report to DBH

Deliverables:
- Final Report including:
  - Executive Summary
  - Summary of Research for funding strategies used and/or proposed to support 988 in states comparable to South Dakota
  - Recommendations to fund and sustain 988 services in the State
  - Summary of sustainable funding sources to support 988 services in the State including funding of crisis services and public messaging of 988 services
  - Projected program costs for recommended strategies including a five-year financial pro forma

Task 2. Crises Services Research

a. Summarize Existing Crisis Services Capacity and Identify Gaps

Objective:
- Map out current state of crisis services that will underlie DBH's options for supporting implementation of the 988 system

Activities:
- Desk review of key documents* related to crisis service capacity
- Conduct research on publicly available information related to crisis service capacity in South Dakota

Task 2. Crises Services Research (Continued)

b. Identify and Describe Best Practice Models for the Continuum of Behavioral Health Services Nationally

Objective:

- Identify and describe nationally accepted best practices for implementation of services tied to crisis call centers and hotlines

Activities:

- Analyze best practice models developed by SAMHSA, National Association of State Mental Health Program Directors (NASMHPD), and comparable states to implement behavioral health crisis services

c. Identify Potential Options for Sustaining Capacity and Funding for Behavioral Health Crisis Services

Objective:

- Sustain South Dakota's behavioral health services system capacity after implementation of the 988 system

Activities:

- Identify options for South Dakota to increase capacity for and delivery of behavioral health services expected to increase with implementation of the 988 system

Task 2. Crises Services Research (Continued)

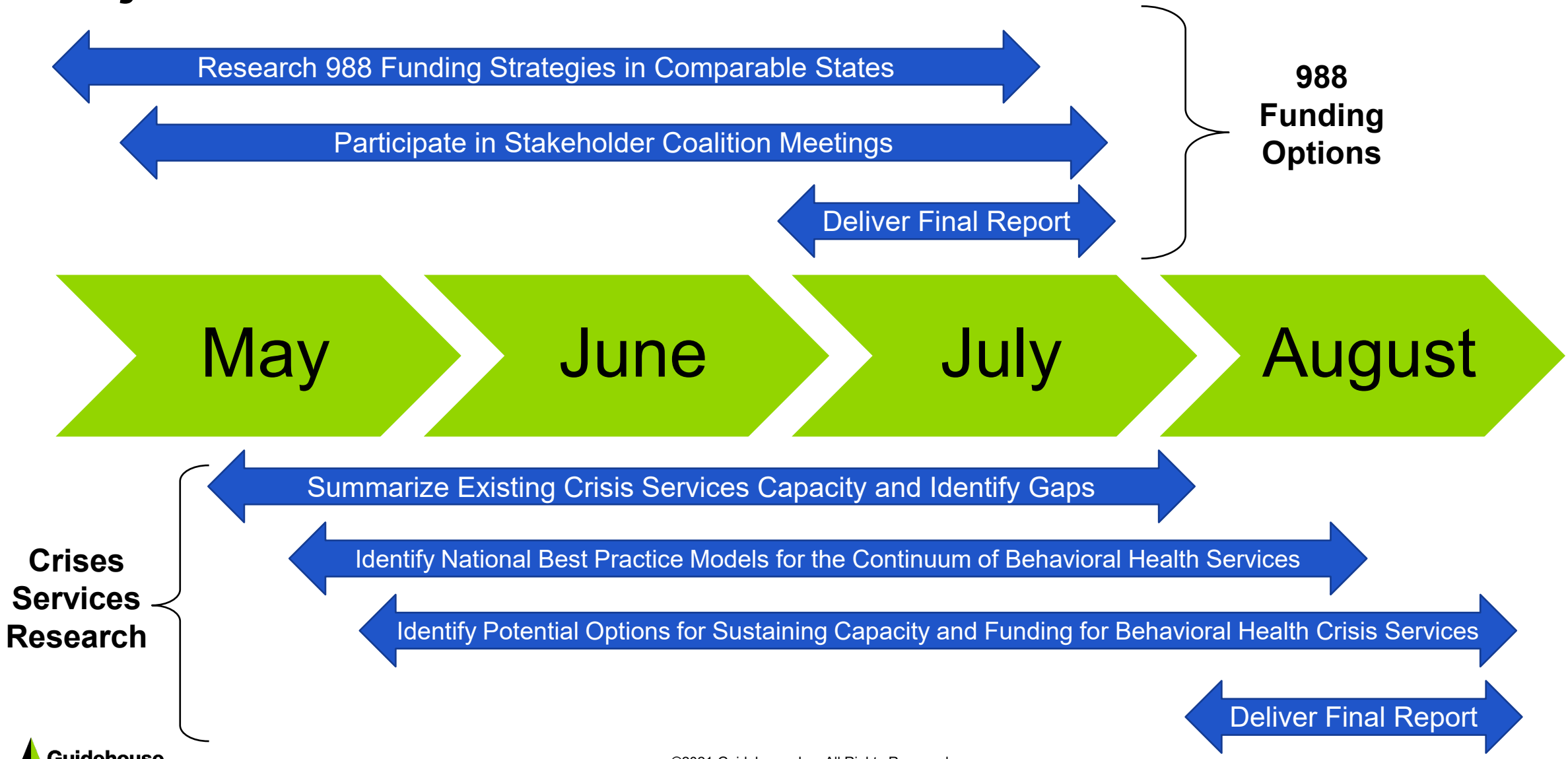
d. Deliver Final Report

Objective:
- Deliver report consisting of all required elements

Activities:
- Prepare final report for DBH

Deliverables:
- Final Report (~10-15 pages) including:
  - Summary of Existing Crisis Services Capacity and Identified Gaps
  - Identification and description of best practice models for the continuum of behavioral health services nationally
  - Identification of potential options for South Dakota to continue to assure capacity for and fund behavioral health crisis services that are anticipated to be tied to the implementation of the 988 Suicide Prevention Hotline

Project Overview and Timeframe



Guidehouse

**Exact timeframes to be confirmed with DBH*

Questions?

Guidehouse

Contact

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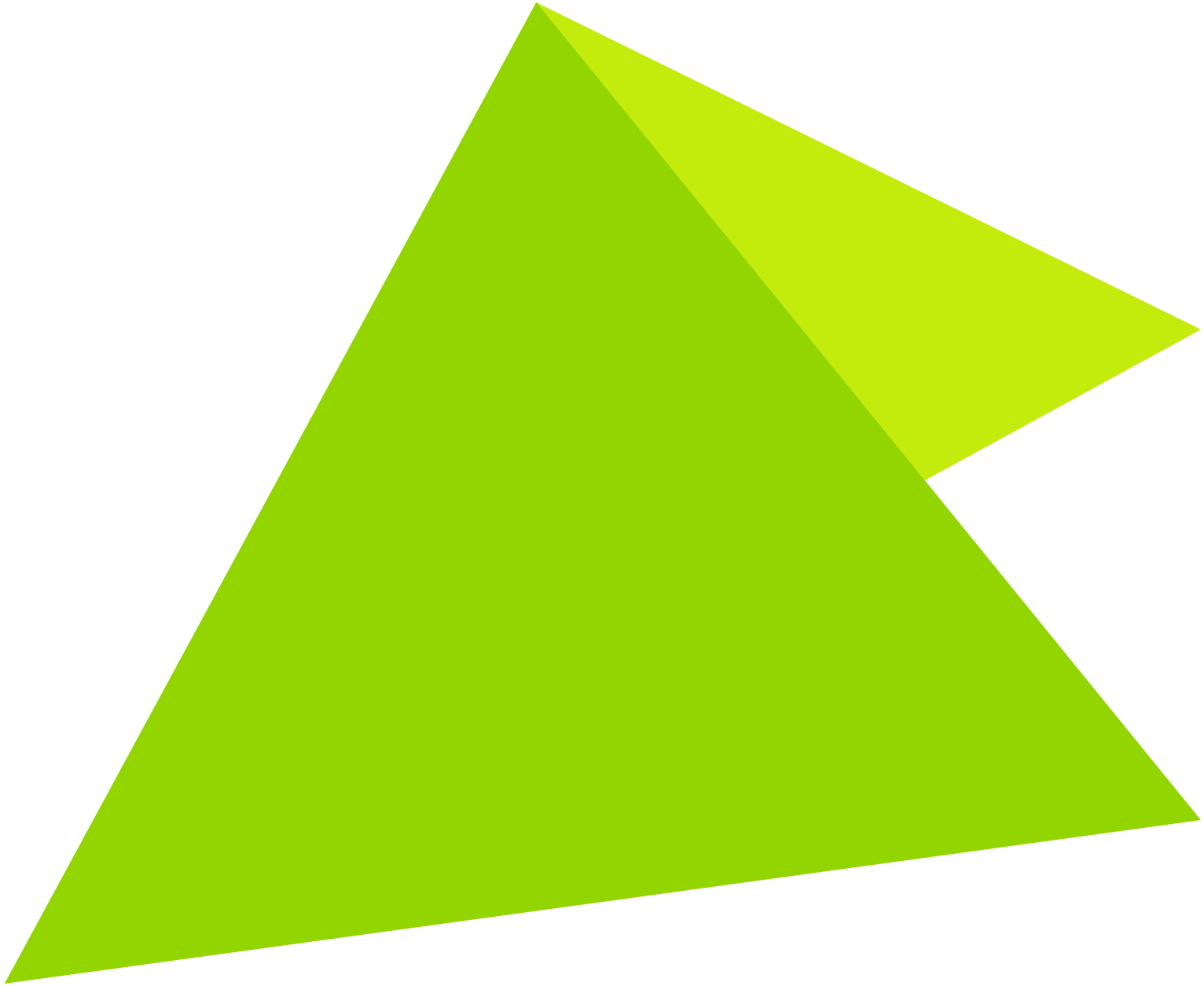


Guidehouse

Handling Mental Health Crisis
FUTURE STATE

Facilitated by Tiffany Wolfgang

Crisis Now Guidance

Facilitated by Tiffany Wolfgang

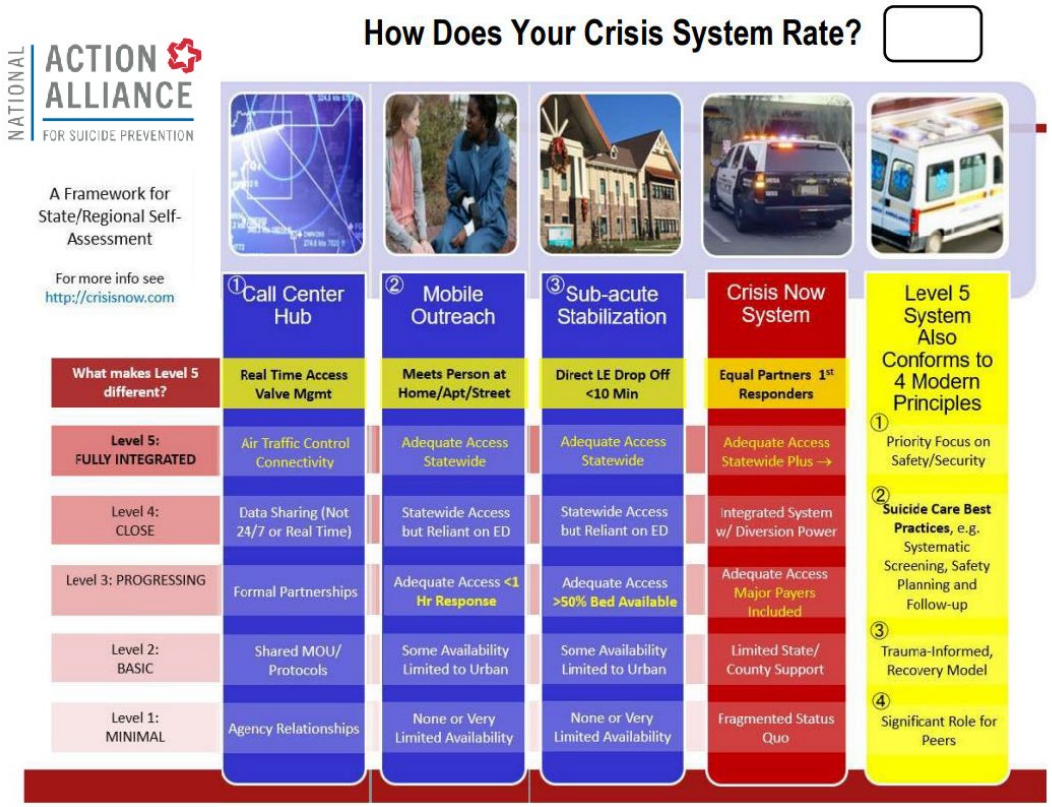
- It's Been A Bad Day

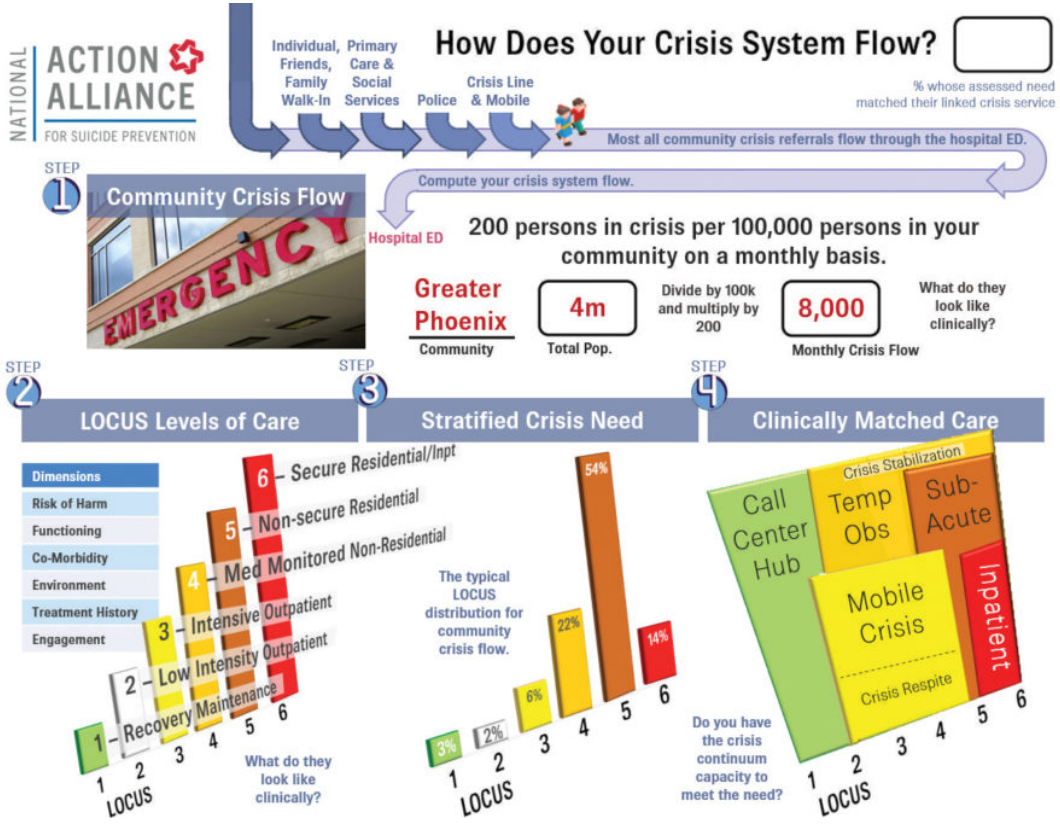
- Crisis Now: Transforming Crisis Services in Arizona

Crisis Now Guidance

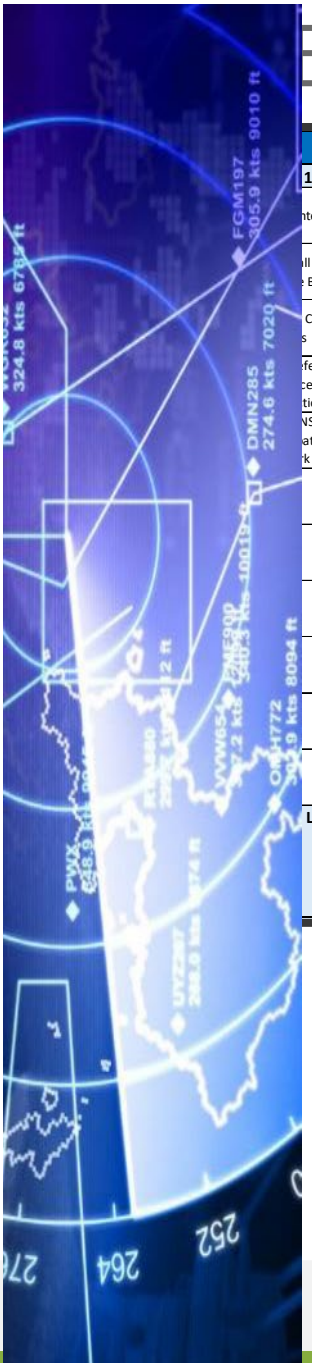
Facilitated by Tiffany Wolfgang

How Does Your Crisis System Rate





EWORK | Complete Crisis Now Assessment Tool



Crisis Now Scoring Tool (Call Center Hub)

	Level 1 (Minimal)	Level 2 (Basic)	Level 3 (Progressing)	Level 4 (Close)	Level 5 (Full)
	nter Exists	☐ Meets Level 1 Criteria	☐ Meets Level 2 Criteria	☐ Meets Level 3 Criteria	☐ Meets Level 4 Critieria

Crisis Now Scoring Tool (Mobile Outreach)

	Level 1 (Minimal)	Level 2 (Basic)	Level 3 (Progressing)	Level 4 (Close)	Level 5 (Full)
Mobile Outreach	☐ Mobile Teams are in Place for part of the State	☐ Meets Level 1 Criteria	☐ Meets Level 2 Criteria	☐ Meets Level 3 Criteria	☐ Meets Level 4 Critieria
	☐ Mobile Teams are Operating at Least 8 least part	Mobile Teams are Available	Mobile Teams are Available	Formal Data Sharing in Place	Real-Time Performance
	☐ Mobile Te Calls With Operation				
	☐ Mobile Te Communi Assessme				
	☐ Mobile Te Additiona Needed				
	Assessed L				

Crisis Now Scoring Tool (Crisis Receiving Center)

	Level 1 (Minimal)	Level 2 (Basic)	Level 3 (Progressing)	Level 4 (Close)	Level 5 (Full)
Crisis Receiving Center	☐ Sub-Acute Stabilization is in Place for Part of the State	☐ Meets Level 1 Criteria	☐ Meets Level 2 Criteria	☐ Meets Level 3 Criteria	☐ Meets Level 4 Critieria
	☐ Have 24/7 Access to Psychiatrists or Master's Level Clinicians	☐ Some Form of Facility-Based Crisis is Available Throughout the State	☐ Crisis Beds / Chairs Available at a Ratio of at Least 3 per 100,000 Census	☐ Formal Data Sharing with Sub-Acute Stabilization and All Crisis Providers	☐ Real-Time Performance Outcomes Dashboards Throughout Crisis System
	☐ In Counties with Sub-Acute Stabilization, at L Chair per 100,000	Crisis Beds / Chairs Available	Offers Crisis Stabilization /	Crisis Beds / Chairs Available	Crisis Beds / Chairs Available
	Assessed Level =				

Crisis Now Scoring Tool (Crisis Now System)

	Level 1 (Minimal)	Level 2 (Basic)	Level 3 (Progressing)	Level 4 (Close)	Level 5 (Full)
Crisis Now System	☐ System Includes at Least Level 1 Implementation in All Areas of Crisis Now	☐ System Includes at Least Level 2 Implementation in All Areas of Crisis Now	☐ Meets Level 2 Criteria	☐ System Includes at Least Level 3 Implementation in All Areas of Crisis Now	☐ System Includes at Least Level 3 Implementation in All Areas of Crisis Now
	☐ Some Implementation of at Least 2 Crisis Now Modern Principles	☐ Some Implementation of at Least 3 Crisis Now Modern Principles	☐ Some Implementation of all 4 Crisis Now Modern Principles	☐ Substantial Implementation of all 4 Crisis Now Modern Principles	☐ Full Implementation of all 4 Crisis Now Modern Principles
	The 4 Crisis Now Modern Principles Are:	**1** Priority Focus on Safety / Security	**2** Suicide Care Best Practices (Systematic Screening, Safety Planning and Follow-Up)	**3** Trauma-Informed Recovery Model	**4** Significant Role of Peers
	Assessed Level =	**Justification of Rating:**			

Crisis Now Scoring Tool (Summary)

Call Center Hub Score	**Summary Notes:**
Mobile Outreach Score	
Sub-Acute Stabilization Score	
Crisis Now System Score	
Overall Crisis Now Score	

Score the assessment tool, and identify our current state

Closing Remarks & Next Steps

Facilitated by Nick Oyen and Rachel Oelmann

- Coalition Meetings
  - **June 24** (in person – Oacoma / Cedar Shores; 10 am to 3 pm CT)
  - **July 21** (1-5 pm CT)
  - **August 26** (9-Noon CT)
- Workgroup Meetings
  - Prep for June meeting
  - Score the assessment tool
- Homework for June Meeting
  - Read the SAMHSA Best Practice document

Thank You