Behavioral Health Crisis Response Stakeholder Coalition

9-8-8 Implementation Planning Meeting #2
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

- 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)

- Lifeline Crisis Center
  - Janet Kittams
  - Taylor Funke
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**
  - **Teresa 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**

- **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)

**Determine “How” to make it work**

- **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
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  
Chief Don Hedrick, SD Police Chiefs Association  
Staci Ackerman, SD Sheriffs Association  
Thomas Otten, Avera  
Dave Kinser, RCPD  
Jeremy Johnson, HSC

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

<table>
<thead>
<tr>
<th>Diversity &amp; Geographical Considerations</th>
<th>Lived Experience</th>
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<tbody>
<tr>
<td>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:</td>
<td>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:</td>
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<tr>
<td>Tosa Two Heart, GPTLHB</td>
<td>Tara Johanneson</td>
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<td>Tessia Johnston, DSS</td>
<td>Penny Kelley</td>
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<td>Amy Iversen-Pollreisz, Capital Area</td>
<td>Rosanne Summerside</td>
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<tr>
<td>Erik Muckey, Lost &amp; Found</td>
<td>Taylor Funke, Helpline Center</td>
</tr>
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<td>Terry Dosch, Council of Community BH</td>
<td>Jana Boocock, DSS</td>
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<td>Ellen Durkin</td>
<td>Matthew Glanzer</td>
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<td>Deb Griffith, HSA &amp; Watertown LOVE</td>
<td>Kelli Rumpza, Human Service Agency</td>
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<tr>
<td>Carissa Weddell</td>
<td>Kiley Hump, DOH</td>
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<td>Wendy Giebenk, NAMI</td>
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Handling Mental Health Crisis TODAY

Roundtable Discussion

Call Center Role
• Helpline Center

Receiving Facilities
• Open discussion among providers

911 Dispatch
• Representative PSAPs

Mobile Crisis Response
• Kris Graham and Kim Hansen (Sioux Falls)

Law Enforcement Response
• Dave Kinser (Rapid City)
**Public Safety Answering Points**

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<th>County</th>
<th>Address</th>
<th>Phone Numbers</th>
<th>E-Mail Address</th>
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<tbody>
<tr>
<td><em>Bon Homme County 911 (SO)</em></td>
<td>Amanda Boden&lt;br&gt;PO Box 1, 300 W 18th Ave.&lt;br&gt;Tyndall, SD 57066-0001&lt;br&gt;P: 605.589.3942  F: 605-589-4209&lt;br&gt;E: <a href="mailto:amandajboden@gmail.com">amandajboden@gmail.com</a></td>
<td></td>
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<tr>
<td><em>Brookings Police Department</em></td>
<td>JoLynn Longville&lt;br&gt;307 3rd Avenue&lt;br&gt;Brookings, SD 57006&lt;br&gt;P: 605.692.2113  F: 605.692.5320&lt;br&gt;E: <a href="mailto:jlongville@brookingspolice.org">jlongville@brookingspolice.org</a></td>
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<tr>
<td><em>Brown County Communications</em></td>
<td>Kent Jones&lt;br&gt;124 S 1st Street&lt;br&gt;Aberdeen, SD 57401&lt;br&gt;P: 605.626.4000  F: 605.626.4003&lt;br&gt;After 5pm: 605.626.7911&lt;br&gt;E: <a href="mailto:Kent.Jones@browncounty.sd.gov">Kent.Jones@browncounty.sd.gov</a></td>
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<tr>
<td><em>Butte County Dispatch Center (SO)</em></td>
<td>Vicki Greenwood&lt;br&gt;839 5th Avenue, Ste. 5&lt;br&gt;Belle Fourche, SD 57717&lt;br&gt;P: 605.892.2737  F: 605-892-2738&lt;br&gt;E: <a href="mailto:vicki.greenwood@buttesd.org">vicki.greenwood@buttesd.org</a></td>
<td></td>
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<tr>
<td><em>Central South Dakota Communications</em></td>
<td>Cindy Gross&lt;br&gt;1302 E HWY 14, Suite 9&lt;br&gt;Pierre, SD 57501&lt;br&gt;P: 605.773.7410  F: 605.773.7424&lt;br&gt;E: <a href="mailto:Cindy.Gross@ci.pierre.sd.us">Cindy.Gross@ci.pierre.sd.us</a></td>
<td></td>
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<tr>
<td><em>Charles Mix County 911 (SO)</em></td>
<td>Sheriff Randy Thaler&lt;br&gt;PO Box 610&lt;br&gt;215 S 6th Avenue&lt;br&gt;Lake Andes, SD 57356&lt;br&gt;P: 605.487.7625  F: 605.487.7198&lt;br&gt;E: <a href="mailto:171a@cme.coop">171a@cme.coop</a></td>
<td></td>
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<tr>
<td><em>Clay Area Emergency Services Communication Center</em></td>
<td>Ryan Anderson&lt;br&gt;15 Washington Street&lt;br&gt;Vermillion, SD 57069&lt;br&gt;P: 605.677.7070  F: 605.677.7165&lt;br&gt;E: <a href="mailto:randerson@claycomm.org">randerson@claycomm.org</a></td>
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<tr>
<td><em>Custer County Communications Ctr</em></td>
<td>Michelle Lyon&lt;br&gt;420 Mount Rushmore Road&lt;br&gt;Custer, SD 57730&lt;br&gt;P: 605.673.8146  F: 605.673.3765&lt;br&gt;After 5pm: 605.673.8176&lt;br&gt;E: <a href="mailto:mboehrs@custercountysd.com">mboehrs@custercountysd.com</a></td>
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<tr>
<td><em>Fall River County Sheriff's Office</em></td>
<td>Dave Weishaupl&lt;br&gt;906 N River Street&lt;br&gt;Hot Springs, SD 57747&lt;br&gt;P: 605.745.4444  F: 605.745.7591&lt;br&gt;E: <a href="mailto:dave.w@frcounty.org">dave.w@frcounty.org</a></td>
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<tr>
<td><em>Huron Police Department DPS</em></td>
<td>Lisa McWethy&lt;br&gt;239 Wisconsin Avenue SW&lt;br&gt;PO Box 1369&lt;br&gt;Huron, SD 57350&lt;br&gt;P: 605.353.8550  F: 605.353.8554&lt;br&gt;E: <a href="mailto:lsam@huronpolice.com">lsam@huronpolice.com</a></td>
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<tr>
<td><em>Lake County 911 Communications</em></td>
<td>April Denholm&lt;br&gt;219 NE 1st Street&lt;br&gt;Madison, SD 57042&lt;br&gt;P: 605.256.7620  F: 605.256.7160&lt;br&gt;E: <a href="mailto:lake911@lakelake.s.gov">lake911@lakelake.s.gov</a>&lt;br&gt;E: <a href="mailto:dispatch@lakelake.s.gov">dispatch@lakelake.s.gov</a></td>
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<tr>
<td><em>Lawrence County Sheriff's Office</em></td>
<td>Jamie Pesicka Olson&lt;br&gt;PO Box 405, 80 Sherman St. Ste #1&lt;br&gt;Deadwood, SD 57732&lt;br&gt;P: 605.578.4464  F: 605.578.3913&lt;br&gt;After 5pm: 605.578.2230&lt;br&gt;E: <a href="mailto:jpesicka@lawrence.sd.us">jpesicka@lawrence.sd.us</a></td>
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<tr>
<td><em>Lincoln County Communications</em></td>
<td>Todd Baldwin&lt;br&gt;128 North Main Street&lt;br&gt;Canton, SD 57013&lt;br&gt;P: 605.764.2664  F: 605.764.2767&lt;br&gt;E: <a href="mailto:lccc@lincolncountysd.org">lccc@lincolncountysd.org</a></td>
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<tr>
<td><em>Marshall County 911</em></td>
<td>Deb Skonberg&lt;br&gt;911 Vander Horck, PO Box 9&lt;br&gt;Britton, SD 57430&lt;br&gt;P: 605.448.5181  F: 605.448.5927&lt;br&gt;E: <a href="mailto:skonbergd02@yahoo.com">skonbergd02@yahoo.com</a></td>
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<tr>
<td><em>Meade County Telecom (SO)</em></td>
<td>Scott Johnson&lt;br&gt;1400 Main Street&lt;br&gt;Hurricanes, SD 57785&lt;br&gt;P: 605.347.2681  F: 605.347.6824&lt;br&gt;E: <a href="mailto:sjohnson@meadecounty.org">sjohnson@meadecounty.org</a></td>
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<tr>
<td>Metro Communications Agency</td>
<td>Miner County Dispatch</td>
<td>Mitchell Regional 911</td>
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<tr>
<td>Scott McMahon</td>
<td>Cora Schwader</td>
<td>Dawn Niehoff</td>
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<tr>
<td>500 N Minnesota Avenue</td>
<td>PO Box 366, 400 N Main</td>
<td>201 West 1st Avenue</td>
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<tr>
<td>Sioux Falls, SD 57104</td>
<td>Howard, SD 57349-0366</td>
<td>Mitchell, SD 57301</td>
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<tr>
<td>E: <a href="mailto:smcmahon@911metro.org">smcmahon@911metro.org</a></td>
<td>E: <a href="mailto:minerdispatch@alliancecom.net">minerdispatch@alliancecom.net</a></td>
<td>E: <a href="mailto:dawnn@mitcheldios.com">dawnn@mitcheldios.com</a></td>
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<tr>
<th>Moody County 911</th>
<th>North Central Regional E911 Center</th>
<th>Pennington County 911</th>
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<tbody>
<tr>
<td>Terry Albers</td>
<td>Tammie Fischer</td>
<td>Kevin Karley</td>
</tr>
<tr>
<td>108 E Pipestone Avenue</td>
<td>110 1st Ave. East</td>
<td>130 Kansas City St, Ste 110</td>
</tr>
<tr>
<td>Flandreau, SD 57028</td>
<td>Mobridge, SD 57601</td>
<td>PO Box 6100</td>
</tr>
<tr>
<td>P: 605.997.3251</td>
<td>P: 605.845.5000 F: 605.845.2034</td>
<td>Rapid City, SD 57701</td>
</tr>
<tr>
<td>After 5pm: 605.997.2423</td>
<td>E: <a href="mailto:tammie.fischer@mobridgepolice.org">tammie.fischer@mobridgepolice.org</a></td>
<td>P: 605.394.2192 F: 605.394.6795</td>
</tr>
<tr>
<td>E: <a href="mailto:mcem@moodycounty.net">mcem@moodycounty.net</a></td>
<td></td>
<td>E: <a href="mailto:kevin.karley@pennco.org">kevin.karley@pennco.org</a></td>
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<thead>
<tr>
<th>Roberts County Sheriff’s Office</th>
<th>Spearfish Police Department</th>
<th>Spink County Sheriff’s Office</th>
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<tbody>
<tr>
<td>Janessa Guy</td>
<td>Jude Warner</td>
<td>Amy Hearnen</td>
</tr>
<tr>
<td>11924 BIA HWY 700, Box 937</td>
<td>225 W Illinois Street</td>
<td>210 East 7th Avenue</td>
</tr>
<tr>
<td>Sisseton, SD 57262</td>
<td>Spearfish, SD 57783</td>
<td>Redfield, SD 57469</td>
</tr>
<tr>
<td>E: <a href="mailto:911@robertsco.org">911@robertsco.org</a></td>
<td>E: <a href="mailto:judith.warner@cityofspearfish.com">judith.warner@cityofspearfish.com</a></td>
<td>E: <a href="mailto:571@midconetwork.com">571@midconetwork.com</a></td>
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<tr>
<th>Union County Sheriff’s Office</th>
<th>Watertown Police Department</th>
<th>Winner Police Department</th>
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<tbody>
<tr>
<td>Sara Beatty</td>
<td>Ryan Remmers</td>
<td>Deb Bice</td>
</tr>
<tr>
<td>209 East Main Street, Ste. 250</td>
<td>128 North Maple</td>
<td>217 East 3rd Street</td>
</tr>
<tr>
<td>Elk Point, SD 57025</td>
<td>Watertown, SD 57201-3653</td>
<td>Winner, SD 57580-0691</td>
</tr>
<tr>
<td>E: <a href="mailto:Sara.Beaty@unioncountysd.org">Sara.Beaty@unioncountysd.org</a></td>
<td>F: 605.882.5246</td>
<td>E: <a href="mailto:wincomsd@goldenwest.net">wincomsd@goldenwest.net</a></td>
</tr>
<tr>
<td></td>
<td>E: <a href="mailto:memem@watertownpolice.com">memem@watertownpolice.com</a></td>
<td>E: <a href="mailto:911dispatch@gwtc.net">911dispatch@gwtc.net</a></td>
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<tr>
<th>Yankton Police Department</th>
<th>State 9-1-1 Coordinator</th>
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<tbody>
<tr>
<td>Julia Hussein</td>
<td>Maria King</td>
<td></td>
</tr>
<tr>
<td>410 Walnut St., Suite 102</td>
<td>Department of Public Safety</td>
<td></td>
</tr>
<tr>
<td>Yankton, SD 57078</td>
<td>118 W Capitol Avenue</td>
<td></td>
</tr>
<tr>
<td>P: 605.668.5210 F: 605.668.5203</td>
<td>Pierre, SD 57501</td>
<td></td>
</tr>
<tr>
<td>E: <a href="mailto:jhussein@cityofyankton.org">jhussein@cityofyankton.org</a></td>
<td>P: 605.773.3264 F: 605.773.3018</td>
<td>E: <a href="mailto:Maria.King@state.sd.us">Maria.King@state.sd.us</a></td>
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**TRIBAL PSAPs**

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<tr>
<th>BIA Law Enforcement Ctr Crow Creek</th>
<th>Cheyenne River Tribe 911</th>
<th>Ogala Sioux Tribe - DPS</th>
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<tbody>
<tr>
<td>Andrew Lepkowski</td>
<td>Lieutenant Joe Brings Plenty</td>
<td>Eula Yellow Boy</td>
</tr>
<tr>
<td>PO Box 110, 125 Wizi Street</td>
<td>PO Box 590, 2105 D Street</td>
<td>PO Box 300</td>
</tr>
<tr>
<td>Fort Thompson, SD 57339-0110</td>
<td>Eagle Butte, SD 57625</td>
<td>977 Horse Thief Road</td>
</tr>
<tr>
<td>P: 605.245.2351 F: 605.245.2159</td>
<td>P: 964.4567 F: 964.1023</td>
<td>Pine Ridge, SD 57770</td>
</tr>
<tr>
<td>E: <a href="mailto:Andrew.Lepkowski@bia.gov">Andrew.Lepkowski@bia.gov</a></td>
<td>E: <a href="mailto:Jessica.LeBeau@CRSTPD.com">Jessica.LeBeau@CRSTPD.com</a></td>
<td>P: 867.5111 F: 867-5936</td>
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<tr>
<th>Rosebud Tribal Police Department</th>
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<tr>
<td>Sylvia Wright</td>
<td></td>
<td></td>
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<tr>
<td>1 Fairground Road</td>
<td></td>
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<tr>
<td>Rosebud, SD 57570</td>
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<tr>
<td>P: 605.856-2365 F: 605.747.5010</td>
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<td></td>
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<tr>
<td>E: <a href="mailto:sylvia.wright@rstjustice.org">sylvia.wright@rstjustice.org</a></td>
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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.
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 also have a law enforcement response for situations outside of providing medical interventions*
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
**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. |
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<td>Responding personnel trained in CIT and de-escalation strategies</td>
<td>• SD-reality will likely not include each community with their own crisis response team, so having CIT-trained law enforcement will bridge that gap.</td>
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<td>Timely response that focuses on crisis stabilization first, then transfer to appropriate facilities only if needed</td>
<td>• Follow-up and follow-through; assurances that connections are indeed made, and services are indeed delivered.</td>
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| 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 |
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<tr>
<td>Messaging that is culturally sensitive and inclusive</td>
<td>• Lived experience is vital to ensure messaging is viewed as genuine.</td>
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<td>Create understanding about what 988 “looks like” in each community</td>
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<td>Seamless connection between 988 and 911 dispatch and call handling</td>
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<tr>
<td>Cross-training to ensure all emergency response professionals are as equipped as possible to handle these cases and refer to their appropriate regional resources</td>
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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.
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**
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

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
OUR PEOPLE

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Telephone: (212) 519-7514
dbergman@healthmanagement.com

Health Management Associates

David Bergman
Lee Repasch
Anh Pham

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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)
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:

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<td>Public Health</td>
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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.
1. Project Overview/Timeline
2. Progress to date
3. Next Steps
4. Questions
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. 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
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
NEXT STEPS

- Interview South Dakota Stakeholders
- Interview States
- Collect Information from Vendors
- Review/Discuss Findings
ANY QUESTIONS?
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 collecting 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.
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?
  o Language
  o Gender
  o Specific cultural/racial/ethnic/other identity expertise?
    ▪ If so, please identify:
  o Geography
  o Age (children, adult)
  o Other (please name)

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

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

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

• Do you use any electronic systems to manage your capacity?
  o If no, how do you monitor capacity and/or anticipate availability?
  o If yes, what is the system/platform name?
  o 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?
  o Do you track what happens to those consumers?
    ▪ If yes, please provide detail

• How often does your capacity change?
South Dakota Electronic Behavioral Health Registry
Organization Interview Guide

- 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?
Welcome and Introductions
Thank you for your willingness to join us for this interview. Let’s start with introductions.

Interviewees/Participants

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<th>Interviewee/Participant Name</th>
<th>Department/Division/Business Unit</th>
<th>Role</th>
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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)

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<th>Topic area</th>
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<td>Reporting and analysis</td>
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Fiscal Modeling
Project Overview

Guidehouse
988 Fiscal Planning
Grant Research Project

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

May 25, 2021

This deliverable was prepared by Guidehouse Inc. for the sole use and benefit of, and pursuant to a client relationship exclusively with the South Dakota Department of Social Services, Division of Behavioral Health (‘Client’). The work presented in this deliverable represents Guidehouse’s professional judgement based on the information available at the time this report was prepared. The information in this deliverable may not be relied upon by anyone other than Client. Accordingly, Guidehouse disclaims any contractual or other responsibility to others based on their access to or use of the deliverable.
Agenda

1. Introduction to Guidehouse
2. Project Tasks
3. Questions
Introduction to Guidehouse
PwC’s legacy public sector consulting practice became Guidehouse LLP in 2018, offering robust public health, financial services, technology, and strategy consulting services.

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*

**Veronica Ross-Cuevas**  
*Project Manager*

**Peter Joyce**  
*Project Consultant*

**Dr. Marguerite Clarkson**  
*Subject Matter Expert*

**Lynda Zeller**  
*Subject Matter Expert*

**Kappy Madenwald**  
*Subject Matter Expert*

---

**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** 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** 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. 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** 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** 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
Overview

Successful Implementation of 988

Coordination  Capacity  Funding  Communication
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
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:
  o Executive Summary
  o Summary of Research for funding strategies used and/or proposed to support 988 in states comparable to South Dakota
  o Recommendations to fund and sustain 988 services in the State
  o Summary of sustainable funding sources to support 988 services in the State including funding of crisis services and public messaging of 988 services
  o 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
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:
  o Summary of Existing Crisis Services Capacity and Identified Gaps
  o Identification and description of best practice models for the continuum of behavioral health services nationally
  o 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

May
- Summarize Existing Crisis Services Capacity and Identify Gaps
- Participate in Stakeholder Coalition Meetings

June
- Research 988 Funding Strategies in Comparable States
- Identify National Best Practice Models for the Continuum of Behavioral Health Services

July
- Identify Potential Options for Sustaining Capacity and Funding for Behavioral Health Crisis Services
- Deliver Final Report

August
- 988 Funding Options
- Deliver Final Report

*Exact timeframes to be confirmed with DBH*
Questions?
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

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<th>Level 1: MINIMAL</th>
<th>Level 2: BASIC</th>
<th>Level 3: PROGRESSING</th>
<th>Level 4: CLOSE</th>
<th>Level 5: FULLY INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>None or Very Limited Availability</td>
<td>Some Availability, Limited to Urban</td>
<td>Adequate Access, Some Availability</td>
<td>Statewide Access but Reliant on ED</td>
<td>Real-Time Access, Value Mgmt</td>
</tr>
<tr>
<td>Call Center Hub</td>
<td>Mobile Outreach</td>
<td>Sub-acute Stabilization</td>
<td>Crisis Now System</td>
<td>Level 5: System Also Conforms to 4 Modern Principles</td>
</tr>
<tr>
<td>Level 5: System Also Conforms to 4 Modern Principles</td>
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<tr>
<td>Priority Focus on Safety/Security</td>
<td>Inside Care Best Practice, e.g., Systematic Screening, Safety Planning and Follow-up</td>
<td>Limited Status/County Support</td>
<td>Significant Rate for Police</td>
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</tbody>
</table>

## How Does Your Crisis System Flow

1. **Community Crisis Flow**
   - 200 persons in crisis per 100,000 persons in your community on a monthly basis.
   - Greater Phoenix
   - 4m
   - Divide by 100k and multiply by 200
   - 8,000
   - Monthly Crisis Flow

2. **LOCUS Levels of Care**
   - Stratified Crisis Need
   - Clinically Matched Care
   - Call Center Hub
   - Mobile Crisis
   - Sub-Acute

3. **Dimension**
   - Risk of Harm
   - Functioning
   - Co-Morbidity
   - Environment
   - Treatment History
   - Engagement

4. **The typical LOCUS distribution for community crisis flow**

5. **What do they look like clinically?**

6. **Do you have the crisis continuous capacity to meet the need?**

---

[Images of flowcharts and tables demonstrating the crisis system rating and flow.]
Meets Level 1 Criteria  Meets Level 2 Criteria  Meets Level 3 Criteria  Meets Level 4 Criteria

Trauma-Informed Recovery

HOMEWORK | Complete Crisis Now Assessment Tool

Call Center Hub
Receive BH Crisis Calls

Mobile Outreach
Priority Focus on Safety / Call Abandonment Rate Under 20%
Staff Trained in Zero Suicide / Providers
Warm Hand-off to BH Crisis

Locally operated 24/7 Call Center in Place to Receive least part of the State at Least 8 hours Per Day in at Needed

Mobile Teams Connect to Assessments
Mobile Teams Complete Operation

Crisis Now Scoring Tool (Call Center Hub)

Crisis Now Scoring Tool (Mobile Outreach)

Crisis Now Scoring Tool (Crisis Receiving Center)

Crisis Now Scoring Tool (Crisis Now System)

Crisis Now Scoring Tool (Summary)

Score the assessment tool, and identify our current state

Summary Notes:
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