SOUTH DAKOTA
COUNCIL OF COMMUNITY BEHAVIORAL HEALTH, Inc.
PO Box 532
Pierre, South Dakota 57501-0532

September 16, 2020

Representative Kevin Jensen
c/o South Dakota Legislative Research Council
500 East Capitol Avenue
Pierre, South Dakota 57501

Dear Representative Jensen:

This is provided to communicate further input in follow-up to the testimony that I provided on behalf of the South Dakota Council of Community Behavioral Health during the August 4, 2020 meeting of the "Mental Health Services Delivery" Legislative Task Force. Specifically this follow-up is response to questions raised pertaining to implementation of SB4, An Act to provide for the designation of an appropriate regional facility by the Department of Social Services.

During our discourse, Representative Reed inquired about the level of interest among Community Mental Health Centers (CMHCs) towards establishing/operating appropriate regional facilities (ARFs), as defined in SB 4. I responded that several CMHCs are interested in implementing an ARF in their regions of the state provided that doing so is feasible and supported. CMHCs that have expressed such interest include:

1. Lewis & Clark Behavioral Health Services (LCBHS), Yankton, SD. LCBHS actually established the ARF model on an emergency pilot basis, working in conjunction with the Department of Social Services in the aftermath of the tornadic destruction in the greater Sioux Falls area during September 2019. Beds in LCBHS's high intensity inpatient Substance Use Disorder treatment facility were used for this to ease the demand for acute inpatient mental health hospitalization during a time of diminished resources. They would be interested in maintaining this capacity under the new law.

2. Behavior Management Systems (BMS), Rapid City, SD. BMS, operates an eight bed, less than 24 hour Crisis Care Center at the Care Campus in Rapid City in collaboration with Pennington County Sheriff's office, Pennington County Health and Human Services, and Rapid City Police Department. The Crisis Care Center (CCC), was opened in 2011 through a collaborative effort of community stakeholders and partners, to support individuals, 7 days a week, 24 hours a day, who are 18 years of age or older, through an immediate crisis, develop a safety plan, and develop a plan for follow up in the community. CCC provides assessment, observation, and stabilization phases in a safe environment for less than 24 hours. BMS would explore transitioning this model to a Crisis Stabilization Unit/Appropriate Regional Facility, if it is supportable.

3. Human Service Agency (HSA), Watertown, SD. HSA is willing to implement an ARF on an "as needed" basis utilizing space at Serenity Hills in Watertown. Serenity Hills is an intensive residential treatment program for individuals with dual mental illness and addiction diagnoses. HSA currently reserves space at Serenity Hills for use for crisis stabilization working in conjunction with local stakeholders.

4. Capital Area Counseling Service (CACS), Pierre, SD. CACS working in collaboration with the Pierre/Fort Pierre Mental Health Task Force presently supports local Mobile Crisis Response programming. Conceptually, if sufficient regulatory flexibility is accorded, space in its new structure could be allocated to support ARF services on an "as needed" basis.

5. In addition, although they wouldn't seek to take lead on ARF implementation within their regions, Northeastern Mental Health Center (NEMHC), Aberdeen, SD and Southeastern Behavioral HealthCare (SEBH), Sioux Falls, SD anticipate fulfilling a supporting role if ARFs are established there.

In addition, Senator Steinhauer inquired about barriers that could potentially block the way of effective implementation of SB 4 and steps that should be followed to assure success. I have contemplated these questions and offer the following perspective.

1. Care standards and operational requirements. The capacity requirements enumerated in Section 1, Subsections (1) through (5), were derived from the Commission on Accreditation of Rehabilitation Facilities' (CARF) standards for residential crisis stabilization services. These programs are organized and staffed to provide the availability of overnight residential services 24 hours a day, 7 days a week for a limited duration to stabilize psychiatric or behavioral symptoms, evaluate treatment needs, and develop plans to meet the needs of the person served. It is a level of care less than inpatient. It is also important to recognize that crisis stabilization is not a residential service alone. While the residential component is important, the service allows a Qualified Mental Health Professional to work through a crisis and develop a safety plan that allows a person to return home over a period of hours, not days. Focus is on marshaling of family and other supports, and the development of a safety plan that allows the individual to return home as quickly as possible. The care standards and operational requirements that are adopted in rule should take this continuum of care and programming into account. While there must be provisions for quality and safety, the operational requirements should be flexible. For example, requirement to maintain full in-place operational capacity at all times will prove unfeasible in less populated areas of the state. The ability to meet capacity requirements on an "on-call" basis will be critical from a practical standpoint.

2. Reimbursement. Reimbursement rates must be modeled based on the continuum of services necessary to stabilize an individual in crisis, including non-residential services, and not solely on per diem or bed days. Rate structure should recognize that in many

cases, individuals that will be served at an ARF will not be held overnight; in most cases it may be a matter of hours. Rate modeling should include and bear upon potential cost avoidance (including costs related to involuntary commitment Board of Mental Illness processes, legal fees, protective custody/incarceration, emergency department medical fees, transportation costs, admission fees and actual inpatient hospitalization, etc.).

3. Long-term funding. The availability of continuous and long-term funding represents perhaps the greatest potential obstacle. Successful implementation will hinge on the commitment of "up-front" funding and a re-investment of realized savings to sustain services over time. Potential cost avoidance is shared between the counties and the State and is probably skewed in the direction of the counties. However, county costs have steadily mounted over time and have increased dramatically over the past decade. For the ARF model to be feasible and supportable at the local level, the State will need to do the "heavy lift" in terms of funding these services.

I am hopeful that you will find this summary useful as the task force deliberates on recommendations.

Please contact me if I may provide further information or if additional detail is requested. I may be reached by calling 605-224-0123. My e-mail address is tladosch@dakota2k.net.

Respectfully yours,

Terrance L. Dosch
Executive Director