SAN JUAN COUNTY, NM

Crisis Triage Center Business Plan

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Executive Summary and Recommendations

Executive Summary and Recommendations

RI International, Inc. (RI) contracted with San Juan County on August 2, 2023, to provide the consultation, research, and recommendations necessary to produce a Business Plan for the operation and sustainability of a Crisis Triage Center (CTC) for San Juan County. The Scope of Work (SOW) for this project was spelled out in a proposal submitted to the County on May 23, 2023, and this proposal was included as an addendum to the contract. RI is contracted to provide the consultation, research, and recommendations necessary to produce a Business Plan for the operation and sustainability of a Crisis Triage Center (CTC) within San Juan County. The CTC would operate as a crisis receiving facility that accepts all admissions for individuals experiencing a behavioral health (BH) related crisis and/or those individuals in crisis with an Intellectual or Developmental Disorder (IDD), including those with a substance use disorder (SUD). The CTC would operate as a key component of a crisis response system within San Juan County that would be based on the *Crisis Now* exceptional practice standard and the Substance Abuse and Mental Health Administration's (SAMHSA) *National Guidelines for Behavioral Health Crisis Care* (2020). The CTC under this framework would eventually have two distinctive facility-based crisis response services.

The first service is a 23-hour crisis receiving center, which would be a newly constructed CTC, and it would accept both voluntary and involuntary admissions. This unit would use recliners instead of beds to maximize capacity flow and create an environment conducive to dialog during the initial crisis engagement period. This component would act as a "psychiatric emergency department" and accept a large percentage of its admissions as diversions from the detention center and the emergency department. The average length of stay (ALOS) that is anticipated would initially be between seven (7) to (ten) 10 hours, but this amount of time would be expected to shorten as the crisis care continuum is optimized and matures.

Consistent with the *Crisis Now* model, but outside the initial SOW for this project, would be an additional CTC facility-based crisis service, a 16-bed short-term crisis stabilization unit that is also licensable within NM. This unit would serve approximately 30% of the persons admitted to the crisis receiving center who are not sufficiently stabilized within 23-hours. The ALOS would initially be expected to be around seven (7) to ten (10) days and eventually shorten to three (3) to five (5) days. These units have been identified by the Crisis Services Task Force of the National Action Alliance for Suicide Prevention as a nationwide best practice and were included in the *Crisis Now* model and subsequently in the *National Guidelines*. This additional crisis component should be considered as the next phase in San Juan County's establishment of a comprehensive BH crisis response system.

The first service proposed for the CTC is intended to provide an up to 23-hour safe and secure environment for individuals with serious BH conditions introduced into the system through protective custody by law enforcement officials pursuant to NMSA §43-1-10(2)-(4) referred by others, or self-referred, until they are triaged and stabilized. The purpose of this project is to provide guidance to the County regarding the establishment of the CTC to operate under high standards, as an integrated component of a BH crisis response system that reduces the inefficient use of law enforcement, the emergency department, and the County detention facility for individuals in a BH crisis.

A comprehensive and integrated crisis response system is the first line of defense in preventing tragedies of public and patient safety, civil rights, loss of life, and the waste of resources. Effective crisis care that saves lives and dollars requires a systemic approach. This Business Plan is designed to serve as a blueprint for San Juan County to build, implement, and operate the CTC with recliners, instead of beds, as the entry stage to a crisis response system. Recliners are utilized as opposed to beds, because the licensing

restrictions associated with the use of beds, requires that the CTC would have to go on diversionary status once all beds were occupied. This status would effectively close the CTC, until a bed became available. There are no such restrictions when operating a CTC with recliners. The CTC needs to be positioned to operate on a "no wrong door" basis, so that virtually anyone who presents for admission has immediate access. This Business Plan includes the proposed CTC design elements, its projected capacity and staffing needs; and the financing necessary to more than cover expenses.

In addition, this Plan projects the positive community-changing impact that will occur when services are aligned with *Crisis Now* and SAMHSA's *National Guidelines*. This Business Plan also demonstrates how this approach harnesses performance data, draws on the expertise of those with lived-experience, and incorporates evidence-based trauma responsive and Zero Suicide practices.

Utilizing an analysis of information collected and reviewed and analyzed from existing data sources and reports, this Business Plan has accomplished the following:

- Validated the gaps in services that had previously been identified in the *San Juan Gap Analysis Report of 2019.*
- Identified opportunities to include service demand, costs, feasibility, and funding resources.
- Identified opportunities to reduce overall costs associated with ED psychiatric boarding, law enforcement arrests, and booking and detention of individuals in crisis, when BH treatment is the preferred intervention.
- Identified areas for efficiency and effectiveness to better meet the needs of those in crisis at onset to decrease the need for more costly, and invasive levels of intervention later.
- Provided recommendations on how to align the CTC and crisis care continuum with the crisis response practice standards defined within the *Crisis Now* and the *National Guidelines*, while also optimizing crisis response resources and allocations.

Per the expectations of the County, RI has engaged in key stakeholder engagements that included representation from public safety, health, BH, housing and homeless services, and community advocates. The number of stakeholder engagements would have normally been more extensive. However, given the exhaustive number of stakeholder meetings and focus groups that were convened for the *2019 San Juan County Gap Analysis Report*, such a duplication of effort for this project was deemed unnecessary. Within each meeting convened for the purposes of this project, there was a discussion around the application of the BH crisis care best practices and key service components and standards. These stakeholder engagements also served as an opportunity for participants to have unanswered questions addressed and to share their respective perspectives on the planning for a crisis response system that includes the proposed CTC. These discussions also served to rally support for the CTC. A crisis response system is a complex and tiered structure comprised of crisis response services that support anyone, anywhere, and anytime. This system is designed to stabilize those whose safety and health are threatened by BH challenges, including mental illness, developmental disabilities, substance use, and/or overwhelming stressors and the associated services begin to guide them towards a path of recovery.

RI and the County convened meetings with twenty-two different (22) organizations and engaged a total of over fifty-seven (57) individuals. Below are the general themes that emerged from these stakeholder engagements:

- Support is evident for the Crisis Triage Center (CTC) to fill a recognized service gap in the County's BH care continuum.

- Adoption of a "no wrong door" approach for those accessing the CTC and the utilization of a heavy reliance on peer support were both favorably received.
- The CTC will serve as a major diversion from the ED and the County Detention Center.
- Recognition that both federal and state government policies and financing are facilitating the implementation of 988 crisis response systems to include the implementation of CTCs.
- Better coordination between crisis response services and other services needs to occur.
- The crisis response services provided to Hispanic and Navajo residents must be culturally appropriate, to which staff providing services will be sensitive to cultural needs.
- BH workforce challenges need to be addressed.

It was abundantly clear, within each meeting, that there exists a broad consensus and a sense of ownership around the building of BH service assets to better meet the needs of County residents. However, it was generally recognized there was much more work to do to better meet the BH needs of youth. San Juan County residents have access to NM's statewide 988 Crisis Call Center, but currently no facility-based crisis services are currently operational within the County.

To meet the County's expectation that RI conduct a comprehensive quantitative and qualitative analysis of current resources and conditions for crisis intervention and jail diversion, it was necessary to review existing data sources and reports. This Business Plan is not intended to replicate any of the resources that have been published (see below), but they have respectively been used to inform this project.

- Bureau of Justice Statistics. *Household Poverty and Nonfatal Violent Victimization*, 2008-2012. Accessed March 24, 2021. www.bjs.gov/index.cfm?ty=pbdetail&iid=5137
- Friedman, Joseph et al. "*Deaths of Despair and Indigenous Data Genocide*," The Lancet, January 26, 2023.
- *Healthiest Communities.* U.S. News & World Report (2022). Data gathered and analyzed by the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES). https://www.usnews.com/news/healthiest-communities/new-mexico/san-juan-county
- McIntyre, T., Velázquex. V., Feng, S., & Wertheimer, J. (2023, February). *More Than 1 in 9 People With Co-Occurring Mental Illness and Substance Use Disorders Are Arrested Annually*. The Pew Charitable Trusts.
- *New Mexico Health Care Workforce Committee: 2022 Annual Report*. Albuquerque NM: University of New Mexico Health Sciences Center, 2022.
- Nordstrom K, Berlin JS, Nash SS, Shah SB, Schmelzer NA, Worley LLM. *Boarding of Mentally Ill Patients in Emergency Departments*: American Psychiatric Association Resource Document. West J Emerg Med. 2019 Jul 22;20(5):690-695. doi: 10.5811/westjem.2019.6.42422. PMID: 31539324; PMCID: PMC6754202.
- *Prosperity Now SCORECARD* https://scorecard.prosperitynow.org/data-bylocation#tribe/990002430
- *San Juan County 2019 Behavioral Health Gap Analysis: Building Bridges.* Prepared by MAS Solutions, LLC in partnership with Ericson Consulting. May 2019.
- Teplin, Linda A. *Police Discretion and Mentally Ill Persons*. (NIJ Journal, July 2000).
- *The County Health Rankings and Roadmaps: Building a Culture of Health, County by County*. A program of the University of Wisconsin Population Health Institute (2023), https://www.countyhealthrankings.org/explore-health-rankings/new-mexico/data-and-resources.

- *2023 Community Health Needs Assessment: San Juan County, New Mexico.* Sponsored by San Juan Regional Medical Center and prepared by PRC Custom. April 2023
- *2016 Community Needs Assessment of San Juan County, New Mexico.* Sponsored by San Juan Regional Medical Center and prepared by the San Juan County Partnership, Inc. June 2016.
- *2022 NM Community Survey: San Juan County*. Prepared by the San Juan County Partnership, Inc.
- Walker ER, Druss BG. *Cumulative Burden of Comorbid Mental Disorders, Substance Use Disorders, Chronic Medical Conditions, and Poverty on Health among Adults in the United States*. Psychol Health Med. 2017;22(6):727-735.

This Business Plan builds on the conclusions of this previous body of work, along with other relevant data gathered throughout the process, and on the information gleaned from the various stakeholder engagements.

This information has been synthesized and used to inform the application of specific algorithms when calculating the capacity for the CTC and related components, that appear in the conclusion section of this Plan. Most specifically, this Business Plan addresses CTC costs, staffing requirements, facility size, and potential funding mechanisms, and associated system alignment issues, such as facility and provider licensing, Medicaid provider type regulations, and payment structures and rates. This Plan also assesses the overall cost of CTC implementation against the potential savings that are anticipated to accrue to the entire system. The intent is to offer a staged roadmap for how a high-fidelity CTC can be established and sustained within San Juan County. In addition, this Business Plan contains projections of the anticipated impact that the CTC will have on the entire crisis response system and other systems and suggests the crisis response redesign that will be required to both address this impact and to optimize the system.

Recommendations

Below is a summary of the recommendations for this Business Plan. For a full explanation of the conclusions and the recommendations that flow from those conclusions, please refer to the complete Business Plan. Each recommendation within the Plan has been organized within the context of the *Crisis Now* best practice model and SAMHSA's *National Guidelines for Behavioral Health Crisis Care* balanced against the needs and the strengths of the County. In addition, each recommendation, when appropriate, includes specific policy and operational details and resources that outline capacity needs, infrastructure, and cost estimates.

1. Crisis Response System Accountability

Ensure the partnership with Mental Wellness Resource Center (MWRC) is responsible and accountable for the oversight, resourcing, and administration of the County's BH crisis response system.

Without a clear designation of authority, the responsibility for leadership for BH crisis response services becomes diffuse, making it difficult for any one entity to be held accountable for the implementation and management of a crisis response system with high fidelity to SAMHSA's *National Guidelines for Behavioral Health Crisis Care.* This need becomes critical to facilitating the planning, financing, and monitoring of BH crisis service adequacy and quality that is relevant to the local community.

2. Crisis Response System Redesign

Design the San Juan County BH crisis response system to enhance client flow throughout the crisis care continuum.

The system, as it is implemented, should consistently provide immediate access to crisis care, by assuring the following:

- Do not require medical clearance prior to admission into the CTC and any facility-based crisis services, as that a nurse in the facility would do a physical health screening as part of the assessment process.
- Place the responsibility, on these same crisis facilities, for the placement of and transport to an appropriate higher level of care (LOC) when appropriate.
- Designate the Crisis Triage Center (CTC) as the "no wrong door" to crisis care.

3. Performance Expectations and Metrics

Establish performance expectations and metrics for each component of the crisis response system and the data systems to collect the information necessary to manage, analyze, and report on the performance of each component and on the system.

SAMHSA published in 2020 a *Crisis Service Best Practice Fidelity Review Tool*. The Fidelity Review Tool is designed to assist in the implementation of essential crisis service elements, and to assist with the delineation of performance expectations. This will be an important resource to San Juan County for establishing performance metrics for the CTC and the other components of the crisis response system.

In addition to monitoring fidelity to the *Crisis Service Best Practice Standards*, funders, system administrators and crisis service providers should continuously evaluate performance with shared data systems. System transparency and the regular monitoring of key performance indicators support continuous quality improvement. It is highly recommended that the crisis response system applies shared systems that offer real-time views of agreed-upon system and provider-level dashboards that can also be used to support alternative payment reimbursement approaches that focus on value.

4. Address Policy, Regulatory, and Administrative Barriers

Advocate for the elimination of barriers, by the State of New Mexico, that will potentially impede San Juan County's efforts to optimize its BH crisis response system, to include:

- Enforcement of Parity Laws by the NM Superintendent of Insurance, requiring NM's commercial health insurers to pay for BH crisis response services as these health insurance plans do for emergency medical response. This should not be the continued responsibility of NM taxpayers to assume crisis care costs for enrollees with commercial health insurance.
- Continued payment of crisis response services by the Single State Behavioral Health Authority, the Behavioral Health Services Division (BHSD) of the NM Department of Human Services, for those who remain uninsured.

- The passage of legislation by the NM Legislature to enact a phone surcharge to provide sustainable funding for NM's 988 crisis response services as authorized by The National Suicide Designation Act of 2020. **NASMHPD Releases Revised 988 Model Bill for 2024**
- A requirement by BHSD, that all funded service providers, update in real time, NM's Treatment Connections, a BH services registry hosted by Bamboo Health Solutions, https://www.treatmentconnection.com/ so that immediate access can be made to BH services in San Juan County and statewide.
- A requirement by BHSD, that the NM 988 Crisis Contact Center implement Global Positioning System (GPS) technology to replace the reliance on the use of area codes to determine the location of a person in crisis and to improve response times by identifying the nearest available mobile crisis response team to be deployed within San Juan County and statewide.

5. Crisis Triage Center (CTC) Startup and Operational Costs

Plan for the provision of financial support associated with CTC site preparation, and construction, along with equipment, start up, ramp up, and operating costs.

Without financial support for construction, equipment, start up, and ramp up costs associated with the establishment of the proposed CTC, it will be very challenging to build and operationalize the CTC. Without capital and initial financial operating assistance, these facilities will not be established. Therefore it is recommended and encouraged that San Juan County, private foundations, the San Juan Regional Medical Center, and Presbyterian Medical Services (PMS) should collaborate and explore all available financing options to support the capital and initial operating costs to build and operationalize this new facility.

6. Crisis Triage Center (CTC) Implementation

Establish and sustain an adult Crisis Triage Center with seven (7) recliners, instead of beds, to maximize capacity flexibility, client flow, and an environment that is conducive to meaningful engagement during the initial crisis triage period. These services would not require a referral.

The CTC will operate 24 hours a day, seven days a week, with stays of up to 23 hours and it will provide high acuity care under the "no wrong door" approach, admitting all those who present, whether voluntarily or involuntarily, to include those needing detoxification services or those with intellectual or developmental disabilities; and without requiring medical clearance in advance of admission. This facility will act as a "psychiatric emergency department," and accept a large percentage of its anticipated 2,200 admissions annually, as diversions from arrest and detention; and from the emergency department and psychiatric hospitalization. The anticipated admissions would incrementally increase from month one to approximately month nine of operations, when a fully optimized program should see the six (6) admissions a day. The CTC will have a multi-disciplinary staff to include medical staff, BH clinicians, and peer support specialists.

7. Combined Crisis Triage Center Crisis Stabilization Services Implementation

San Juan County should establish the CTC to combine operating with recliners and beds which is allowable under NM's CTC licensure standards. The addition of beds would enable the CTC to

serve the roughly 30% of CTC admissions that would not be sufficiently stabilized in under 23 hours. These services would not require a referral.

The capacity projections for this level of care (LOC) are seven (7) recliners and six (6) beds, serving 768 admissions annually. These individuals would have up to two weeks to be stabilized and would be expected to have an average length of stay (ALOS) of five (5) to seven (7) days. In addition, there would be economies of scale associated with the staffing of this combined CTC, that would also improve the CTC's efficiency and financial sustainability.

8. Rural Crisis Service Adaptations

Planning needs to occur with the more sparsely populated areas of San Juan County to create local crisis response solutions, where access to facility-based crisis services may prove challenging.

As with most urban areas in the country, crisis response services will tend to be concentrated in the County's largest city – Farmington. In addition, the implementation of satellite Community Calming Centers in rural areas, that are staffed by Certified Peer Support Workers, may be a viable rural adaptation.

9. Care Coordination

Adopt the usage of SYNCHRONYS, NM's designated Health Information Exchange (HIE), by San Juan County health and BH service providers to assure that there is meaningful care coordination across the crisis response system and with other adjacent service systems.

With the adoption of SYNCHRONYS, by providers within San Juan County, the tools necessary to enable collaborative service planning will be available. More than 138 provider organizations currently utilize SYNCHRONYS statewide, including San Juan Regional Medical Center and Presbyterian Medical Services (PMS).

10. Behavioral Health Workforce Development

San Juan County should adopt BH workforce development as a priority. Focus should be on attracting and supporting those from diverse backgrounds, to careers within BH. San Juan County should implement The National CLAS Standards, which are a set of fifteen (15) action steps intended to advance health equity, improve quality, and help eliminate health care disparities.

The web portal *Think Cultural Health, https://thinkculturalhealth.hhs.gov/* features information, continuing education opportunities, resources, and more for health and health care professionals to learn about culturally and linguistically appropriate services, or CLAS. Launched in 2004, Think Cultural Health is sponsored by the Office of Minority Health at the U.S. Department of Health and Human Services (HHS).

San Juan County should review the Annual Reports of the NM Health Care Workforce Committee of the University of New Mexico (UNM), which includes a set of recommendations that are presented each year to the State Legislature. This Report has extensive data statewide

and by county on the adequacy of each professional health care discipline, including those associated with BH.

These Reports will inform San Juan County on the status of its BH workforce that can serve as a benchmark against which workforce development initiatives can be measured. It also provides public policy recommendations which either the County can choose to implement or advocate for with the State Legislature.

11. Cost Offsets and Reinvestment Opportunities

When San Juan County's BH crisis response system is optimized, analyze the resulting cost offsets, and reinvest those cost offsets to further address the BH clinical and support service continuum and the social determinants of health.

It is anticipated that San Juan County will experience reductions in arrests, detention, ED, and hospital utilization; and therefore, the reinvestment of those savings can further buildout community-based services and supports. This requires providing intensive levels of community-based care, such as peer-run crisis respite, Assertive Community Treatment (ACT) teams, Intensive Outpatient (IOP), and supportive housing, supported education and employment to address the social determinants of health and system inequities. Ultimately, San Juan County like every other locality, must get upstream to prevent BH conditions and their effects, rather than always having to pay exorbitant costs to intervene later to treat these conditions. Therefore, it is urged that there be greater investments in primary prevention, such as the highly researched and evidence-based, PAX Good Behavior Game, which has been implemented in several NM school districts, including schools operated by the Indian Board of Education.

12. Peer Respite Centers and/or Community Calming Centers (CCC) Implementation

Establish Peer Respite Centers and/or Community Calming Centers as components within San Juan County's crisis response system. Peer respites are peer-run, voluntary, short-term (typically up to two weeks), overnight programs that provide community-based, non-clinical support for people experiencing or at risk of an acute BH crisis. CCCs are a scaled down version of a CTC which is intended to be a better fit for rural communities which have too sparse a population to justify the operational costs associated with operating a CTC.

Peer respites operate 24 hours per day in a homelike environment and can provide a "step-down" from facility-based crisis services or a step up from the community to mitigate the precipitation of a crisis. Peer navigation services are provided to assist with transition back to the community. Peer respites also allow users to take a break from stressful life circumstances, while building a community of peer support.

The CCC also operates 24/7, but it is intended to be an alternative to a CTC to meet the unique needs of those living in rural and frontier communities by leveraging local knowledge and resources and by utilizing telehealth options for professional services. This option potentially minimizes the travel barriers for those individuals needing higher acuity crisis services that probably will only be available in a more urban community such as Farmington.

Findings and Analyses

INTRODUCTION

RI International, Inc. (RI) contracted with San Juan County on August 2, 2023, to provide the consultation, research, and recommendations necessary to produce a Business Plan for the operation and sustainability of a Crisis Triage Center (CTC) for San Juan County. The Scope of Work (SOW) for this project was spelled out in a proposal submitted to the County on May 23, 2023, and this proposal was included as an addendum to the contract. RI is contracted to provide the consultation, research, and recommendations necessary to produce a Business Plan for the operation and sustainability of a Crisis Triage Center (CTC) within San Juan County. The CTC would operate as a crisis receiving facility that accepts all admissions for individuals experiencing a behavioral health (BH) related crisis and/or those individuals in crisis with an Intellectual or Developmental Disorder (IDD), including those with a substance use disorder (SUD). The CTC would operate as a key component of a crisis response system within San Juan County that would be based on the *Crisis Now* exceptional practice standard and the Substance Abuse and Mental Health Administration's (SAMHSA) *National Guidelines for Behavioral Health Crisis Care* (2020). The CTC under this framework would eventually have two distinctive facility-based crisis response services

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) defines a BH crisis stabilization service, as:

> "A direct service that assists with de-escalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery."

Like a physical health crisis, a mental health crisis can be devastating for individuals, families, and communities. While a crisis cannot be planned, we can plan how services are structured and organize them to best meet the needs of those individuals who experience a BH crisis. Too often that experience is met with delay, detainment and even denial of service in a manner that creates undue burden on the person, law enforcement, emergency departments and justice systems.

Given the ever-expanding inclusion of the term "crisis" by entities describing service offerings that do not truly function as "no-wrong-door" services, it is important to distinguish what crisis services are and what they are not. Crisis services are for anyone, anywhere and anytime without undergoing a prescreening process or medical clearance in advance of accessing them. Examples of emergency medical response services seen in communities around the country include: (1) 911 accepting all calls and dispatching support based on the assessed need of the caller; (2) law enforcement, fire or ambulance dispatched to wherever the need is in the community; and (3) hospital emergency departments serving everyone that comes through their doors from all referral sources.

Similarly, BH crisis response should include:

1. 988 crisis response contact centers that accept all calls, texts, and chats and triaging the contact based on the assessed need of the caller.

2. Mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments).
3. Facility-based crisis services that serve everyone that comes through the doors from all referral sources, including law enforcement.

A simple test regarding whether a service meets this standard definition of a crisis response service is to inquire whether there is any pre-screening of referrals by location, acuity, eligibility, or other exclusionary criteria; or any limitation of the service based on availability during certain days of the week or hours of the day. If pre-screening exists, the service may still represent an important part of a community's system of care, but the service is not representative of the SAMHSA's *National Guidelines for Behavioral Health Crisis Care*.

There appears to be general agreement, in San Juan County and elsewhere, that far too many persons with BH issues are arriving in hospital emergency departments (EDs) or are being charged and transported by law enforcement to detention facilities; and they are not being well served in either setting. In fact, criminal justice settings have been increasingly referred to as, "the de facto BH system," but where crisis is typically either absent or inadequate and where the setting can be re-traumatizing. Holding those with BH conditions in EDs has been termed "psychiatric boarding" and is a growing problem most everywhere. Long waits, often for hours or even days, in often-chaotic ED environments, may exacerbate symptoms and trigger trauma responses. In addition, "boarding' consumes hours of law enforcement officers' time, which they commonly refer to as, "wall time." To exacerbate this problem further, EDs typically do not have the appropriate BH personnel onboard to effectively engage and intervene when someone presents in a BH crisis.

Another unproductive dynamic involves BH crisis dispositions by EDs. These have become known as, "streeting." This occurs when those with presenting BH conditions are not appropriately assessed and triaged and, as a result, are discharged prematurely, usually without appropriate treatment and/or support. Well-trained CTC staff would therefore assess properly and thoroughly before making referrals. "Boarding" or "streeting" is damaging to not only those in crises, but also frequently the significant others who must endure these dynamics as well. From a cost standpoint, ineffective interventions in EDs or jails are poor uses of resources, and they exacerbate costs. They perpetuate the crisis response dynamic of the "revolving door" that saps the resources of health care, law enforcement, the judiciary, incarceration settings, and social services. The ED is an expensive setting and can result in unnecessary and costly admissions for public and private insurers. Likewise, costs associated with 911 dispatch, law enforcement, EMS, and the criminal justice system for those in crisis, are costs that could be better spent and with better outcomes using an adequately resourced BH crisis response system.

The underlying issues that impede the appropriate interventions for a person in a BH crisis are complex. For instance, many large service systems may be involved with someone who has complex needs. Each of these intervening service systems have their own respective missions, cultures, competencies, and entry points with rules for accessing services. The BH system has its own complexities and issues with having a dearth of intermediate and intensive community-based treatment options that serve people in their natural environments. Care for these individuals is left too often to EDs and hospitals at one end of the care continuum, and routine outpatient services on the other. There are significant legal issues that serve as barriers to accessing BH crisis care, including professional scope of practice laws, facility, and service licensing (including ambulance emergency destination restrictions), and protections for those in care, including medical clearance and "certifications for involuntary admissions." Financing of BH treatment services has its own set of challenges, since insurers (public and private) have their own systems, rules,

and payment rates that only reimburse certain services operated by only certain facility and provider types. And let's not forget, there are also those who are uninsured and require safety net funding to access services, dozens of payor sources, community discrimination and misinformation about what "people in crisis" look like, and mental health is not funded the same as medical care.

Per the expectations of San Juan County, RI engaged in key stakeholder meetings with members of the local community, including public safety, health care, behavioral health (BH) treatment providers, housing and homeless service providers, advocates, those with "lived experience," and other key parties and safety net services providers. In each meeting, there was a discussion around the application of the BH crisis care best practices and key service components and standards. These stakeholder engagements also served as an opportunity for participants to have unanswered questions addressed and to share their respective perspectives on the current crisis response system and the proposed Crisis Triage Center. These discussions also served to rally support for crisis response system development to include the CTC, utilizing national best practices as a guide. A crisis response system is a complex and tiered structure comprised of crisis response services that support anyone, anywhere, and anytime. This system is designed to stabilize those whose safety and health are threatened by BH challenges, including mental illness, developmental disabilities, substance use, and/or overwhelming stressors and then begin to guide them towards a path of recovery.

RI and the County convened meetings with twenty-two (22) different organizations and engaged a total of over fifty-seven (57) individuals. Below are the general themes that emerged from these stakeholder engagements:

- Support for the Crisis Triage Center (CTC) to fill a recognized service gap in the BH care continuum.
- Adoption of a "no wrong door" approach for those accessing the CTC and the utilization of a heavy reliance on peer, were both favorably received.
- An awareness of the need for the CTC to serve as a major diversion from the ED and the County Detention Center.
- Recognition that both federal and state government policies and financing are facilitating the implementation of 988 crisis response systems to include the implementation of CTCs.
- Better coordination between crisis response services and other services needs to occur.
- The crisis response services provided to Hispanic and Navajo residents must be culturally appropriate.
- BH workforce challenges need to be addressed.

It was abundantly clear, within each meeting, that there exists a broad consensus and a sense of pride regarding the behavioral health (BH) service assets within the County, except for intensive levels of community-based care for youth. San Juan County has access to NM's statewide 988 Crisis Call Center, but currently it does not provide facility-based crisis services. as outlined in SAMHSA's *National Guidelines for Behavioral Health Crisis Care.*

A comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. There is a better way. Effective crisis care that saves lives and dollars requires a systemic approach. This Business Plan is intended to guide San Juan County on estimating the crisis response system resource needs, the number of individuals who can be served within this response system, the cost of crisis services, the workforce demands of implementing crisis care, and the expected community-changing impact with the optimization of the crisis response system. This Plan will also demonstrate how this approach

harnesses data and technology, draws on the expertise of those with lived experience, and incorporates evidence-based suicide prevention practices. Perhaps the most potent element of all is human connection. To be authentic. To be compassionate. RI knows from experience that immediate access to help, hope and healing, does indeed save lives.

Utilizing an analysis of information collected during key stakeholder interviews, related to the utilization of emergency room care, police/fire intervention, arrest, and service waitlists, RI has accomplished the following:

- Identified gaps in services and opportunities for San Juan County to include demand, optimization, costs, feasibility, and funding mechanisms.
- Identified opportunities to reduce overall health care costs, psychiatric boarding, law enforcement resources dedicated to addressing BH crises and incarceration of individuals when BH treatment is the preferred intervention.
- Identified areas of overlap and opportunities for efficiency for how to most effectively and efficiency meet the needs of those in crisis on the front end to effectively decrease the need for higher more costly and invasive levels of intervention.
- Provided recommendations on how to align current practices with the crisis practice standard defined within national best practices while optimizing crisis resource design and allocations to meet the needs most efficiently in San Juan County.
- Presented a draft report to key stakeholders for community engagement and implementation planning before finalizing the final report.

RI operates a continuum of BH crisis and recovery services across the U.S. and in Australia. Included in this continuum are ten (10) Crisis Receiving Centers (CRC) that would be analogous to a psychiatric emergency level of care. RI is operating these facilities in Arizona, California, Delaware, Louisiana, New Mexico, North Carolina, Ohio, and Washington. RI is currently establishing additional facility-based crisis services in Maryland, Ohio, and Washington. All of RI's crisis response services operate in alignment with *SAMHSA's National Guidelines for Behavioral Health Crisis Care* and the proposed components and recommendations for San Juan County's crisis response system are framed by these guidelines.

San Juan County Background, Needs, and Strengths

SAN JUAN COUNTY BACKGROUND, NEEDS, AND STRENGTHS

According to San Juan County, the story of the region begins with ancestral people and the traditional and contemporary lands of the Diné (Navajo), Pueblos, Southern Ute, Ute Mountain Ute and Apache peoples and transitions with those who have subsequently migrated to the region. The San Juan Basin, home to ancient Puebloan ruins preserved in sites like Chaco Culture National Historical Park, bears witness to the area's earliest inhabitants who flourished around the 12th century. The region's recorded history with non-native settlers began in 1598 when Spain claimed part of present-day New Mexico as a kingdom within New Spain. In 1610, Santa Fe replaced Española as the capital city.

The territory was contested between France and Spain until 1850 when the U.S. New Mexico Territory was established. In 1863, the territory was divided, creating the familiar boundaries of southern Nevada, Arizona, and New Mexico. San Juan County was formed in 1887 when Rio Arriba County split, 25 years before New Mexico achieved statehood.

By the early 1900s, San Juan County was primarily agricultural. The arrival of the Denver and Rio Grande Railroad in 1905 established Aztec, the county seat, as a significant shipping point. A new chapter in the county's history began in 1921 with the drilling of the first gas well in Aztec, marking the start of the oil and gas industry.

The 1950s saw a population boom driven by oil and gas development, with Farmington's population surging by nearly 763% in just a decade. Today, while oil and gas remain important, the county's economy is diversifying through growth in retail and tourism. As of the 2020 U.S. Census Bureau estimate, San Juan County's population stands at 121,661. In 2010, the population was 130,209, which is approximately 11,000 more than the most recent Census. The area has been subject to boom or bust economic fluctuations due to the market volatility of oil and gas. The Census Bureau also reports that reservations (and off-reservation trust lands) comprise 63.4 percent of the County's land area: The Navajo Nation takes up 60.45% and the Ute Mountain Ute Tribe Reservation another 2.93%.

42.9% of the residents of San Juan County are Native American. The overwhelming majority of them, approximately 60,000 are Navajo. The Navajo Nation is an American Indian territory that covers over 17 million acres and encompasses portions of northeastern Arizona (AZ), northwestern NM, and southeastern Utah (UT). The Navajo Nation land in NM is the Eastern Region of the Nation and it is nicknamed the “Checkerboard,” because the federal government attempted to diversify Navajo lands with non-native lands. Thus, the Navajo lands in NM are intermingled with fee lands, owned by both Navajo and non-Navajo, and federal and state areas under various jurisdictions. Additionally, there are three recognized groups of Navajos living in NM outside of the regular reservation boundaries: the Ramah Navajo, the Alamo Navajo, and the Tohajiilee Navajo Reservations.

The Navajo Nation is the largest indigenous community in the United States. While it makes up just 1.7% of the total U.S. population, it makes up 10.6% of the NM population. According to the *Prosperity Now SCORECARD* https://scorecard.prosperitynow.org/data-by-location#tribe/990002430, within the Navajo Nation as a whole, 35.8% of the households have incomes below the federal poverty threshold, similar to the 35% of all NM households. According to the Health Resources and Services Administration (HRSA) for 2023, this is in comparison to 11.4% of all households nationally and 16.8% of those in NM.

According to U.S. News & World Report’s *Healthiest Community Index (2022*), San Juan County’s overall health score is 24 out of 100. On Public Safety, the score is 29 out of 100. The violent crime rate is 745.2

persons per 100k, compared to the national median of 204.5/100k. Yet the County expends $492 per capita on health and emergency services compared to the national median of $358; and it has a higher rate of public safety professionals in its population at 1%, compared to the national median of .73%. Its property crime is 36% lower than NM's, but it is 79.3% higher than the U.S. Its accidental death rate is 93.9 per 100k, which is higher than NM at 74.1 and the U.S. at 58.5. The vehicle crash fatality rate of 24.1/100k is less than half that of NM at 59.0/100k, but it is significantly more than the U.S. at 17.5/100k.

In terms of Population Health, San Juan County appears to fare better overall than it does on Public Safety. The County's overall population health score is 45 out of 100. The County has greater hospital bed availability than either the State or the U.S. and the same holds true for primary care. However, within that composite score on population health, there are some disturbing findings. Adults who are in poor or fair general health in the County are higher than either NM or the rest of the country; and its life expectancy is two years less than NM and a year and a half less than the U.S. In addition, its teen birth rate is higher than both NM and the U.S. Its smoking rate is 2.3% higher than the U.S. and 6.3% higher than NM.

The composite mental health score for the County is only 35 out of 100. The percentage of adult residents who report frequent mental distress is 18.5% compared to 15.1% for the State and 15.8% for the U.S. Even more concerning is that deaths of despair per 100k are 103.5 for the County compared to 78.7 for NM and 47.5 for the U.S. In 2015, a social theory was introduced into the U.S. that was termed, deaths of despair. It was speculated that rising rates of deaths among white Americans shared a common cause: rising. Now, nearly a decade after the theory was postulated, a flaw in this public-health concept has emerged. That midlife deaths were increasing only among white people, particularly men without college degrees, was the core conclusion from the theory. But a new analysis shows otherwise.

In an article published in The Lancet, data is provided showing that between 1999 and 2013, premature deaths among Native Americans increased by a far greater margin: nearly 30%. These deaths started at a much higher rate to begin with, and unfortunately the inequities have only deepened in recent years. It was found that as of 2020, Native Americans had a premature death rate double that of white Americans.

Many of the issues facing San Juan County and its indigenous population, are highly correlated with the incidence of poverty, which stands at 21.8%. This rate is higher than NM's at 18.6% and the U.S. at 13.6%. This problem is exacerbated by the following variables, which are all lower than the national median except for unemployment, which is higher:

- The unemployment rate of 3.7%.
- A low high school graduation rate of 77.1%.
- The population with an advanced degree is 7.6%.
- Per pupil expenditure is $11,252.

The County Health Rankings and Roadmaps: Building a Culture of Health, County by County is a program of the University of Wisconsin Population Health Institute (2023), and it further confirms these findings https://www.countyhealthrankings.org/explore-health-rankings/new-mexico/. San Juan County is ranked, among NM's 33 counties: 28th in Health Outcomes, 27th in Health Factors, 29th in Length of Life, 21st in Quality of Life, 29th in Health Behaviors, 27th in Clinical Care, 23rd in Social and Economic Factors, and 29th in Physical Environment. Another indication of the County's poverty level is the fact that 79% of the County's children are enrolled in free or reduced lunch programs. And in terms of its mental health status, San Juan County ranks 33rd in its suicide rate and it is expected to have 121 firearm deaths this year, making it the 4th highest county in the state; and 280 motor vehicle deaths which is the highest NM county ranking for 2023.

It is evident from these findings that San Juan County, despite its significant investments in public safety and healthcare, is not seeing a positive return on these investments. Poverty probably has a lot to do with this result. Poverty is a complex determinant of health caused by systemic factors that can persist for generations in families. Beginning before birth and continuing throughout an individual's life, poverty can significantly impact both health and BH. Mental illness, chronic health conditions, and substance use disorders are all more prevalent in populations with low income (Walker, 2017).

Over the last thirty (30) years, NM has consistently had among the highest alcohol-related death rates in the U.S., and it has had the highest alcohol-related death rate since 1997. The negative consequences of excessive alcohol use in NM are not limited to death, but also include domestic violence, crime, poverty, and unemployment, as well as, chronic liver disease, motor vehicle crashes and other injuries, mental illness, and a variety of other medical problems. Death rates from alcohol-related causes increase with age. New Mexico has the highest drug-induced death rate in the nation, and the consequences of drug use continue to burden NM communities, including those in San Juan County. At least 107,495 people died of drug overdoses in the U.S. between February 2022 and January 2023, more than double the 52,404 deaths in 2015. Of those, 42 deaths were in San Juan County and 996 in New Mexico. https://www.sfchronicle.com/projects/us-drug-overdose-deaths/?fips=35045

Violence is also more prevalent in areas with greater poverty. From 2008 to 2012, individuals in households at or below the poverty level experienced more than double the rate of violent victimization than individuals in high-income households. This pattern of victimization by violent behavior significantly impacts both the victim's and perpetrator's families. In the latter case, this appears to be attributable to the effects of incarceration (Bureau of Justice Statistics, 2021). The County's violent crime rate per 100K is almost double that of the U.S. and is significantly higher than the State.

In addition to national and state reporting related to BH, San Juan County has consistently been measuring the wellness status of its residents. The latest report, *2023 Community Health Needs Assessment: San Juan County, New Mexico, s*ponsored by the San Juan Regional Medical Center and prepared by PRC Custom, incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for the trending of data and comparing it to benchmark data at the state and national levels. This Report further validates many of the findings already presented.

As indicated earlier, the County does have a higher number of mental health (MH) providers (360:1) than NM overall (220:1), but the percentage of residents who report being treated in the last year for MH conditions is lower. There is no explanation offered within the Report regarding the causes of this differential, but the finding suggests that the service capacity in the County is not being efficiently utilized or managed. The Report also demonstrates that suicide deaths (35.4/100K) are almost triple the rate for the rest of the country and are 68.9% higher than for NM. However, residents of the County report less stress, less depression, while indicating only slightly poorer MH than the U.S.

When it comes to substance use disorders (SUD), the same phenomenon seems to be present. For example, alcohol-induced deaths for San Juan County are approximately seven (7) times the rate for the U.S. and more than double that for NM. This tragic reality is supported by the fact that cirrhosis deaths within the County are almost five (5) times the rate for the U.S. and almost double of that for NM. Yet only 7.3% of residents report excessive drinking compared to 14.1% for NM and 34.3% for the U.S. When it comes to unintentional drug overdoses, the County rate is like the rate for the U.S. and about 8% less than NM.

Unintentional injuries are the fourth leading of cause of deaths within the County and each category of these deaths correlates highly with SUDs:

- 36.8% poisoning & OD.
- 30.1% motor vehicle crashes.
- 19.1% falls.
- 4.3% drownings.

Since 94.2% of the informants, responding to the community survey, perceive mental illness to be a moderate to major problem within the County and 95.6% identify SUD to be a moderate to major problem as well, and since these perceptions are more than supported by the evidence, then it appears reasonable to conclude that having immediate access to a CTC that can assess and intervene to ameliorate acute crises associated with these conditions, is a requisite for this community.

In 2019, the County also conducted a *Behavioral Health Gap Analysis: Building Bridges***,** which was prepared by MAS Solutions, LLC in partnership with Ericson Consulting. The gap analysis team reviewed quantitative data from a variety of sources to complete its report and it hosted six (6) focus groups and completed interviews with more than sixty (60) key informants. The project entailed the identification of:

- Programs and/or program elements that are working effectively and present opportunities for enhancement.
- Weaknesses or gaps in categories of service that present opportunities for improvement.
- Specific populations that appear to be more or less likely to access the "right" services in the "right" way at the "right" time.
- The state of community collaboration.

This Gap Analysis indicated that,

> "San Juan County is not unlike other counties that are increasingly focused on addressing the adverse impacts of unaddressed and under-addressed behavioral health issues. These issues require attention at all stages of the continuum of care – from initial crisis response to crisis stabilization, to short- and intermediate-term solutions, to how to more effectively work with individuals that are incarcerated. Early intervention and diversion are certainly priority goals."

One of the many potential solutions proposed within the *Gap Analysis,* was for the County to consider, in the long-term, allocating the necessary resources to develop a comprehensive Crisis Triage Center (CTC). This recommendation came in 2019 and the long-term is upon us. This *Analysis* also proposed the establishment of at least one fully staffed co-responder Mobile Crisis Response Team (MCRT) involving a law enforcement officer and a BH clinician. This recommendation was made in advance of the release, in 2020, of SAMHSA's *National Guidelines for Behavioral Health Crisis Care*. The national 988 crisis response system, which was launched on July 16, 2022, is intended to serve as an alternative to the 911 emergency management system. Law enforcement involvement therefore should be limited to situations wherein public safety is at risk.

The SJC IMPACT Network began in 2021 with a group of eleven (11) jurisdictions to provide technical assistance to participating communities on issues related to the over-incarceration of individuals with BH conditions. The IMPACT Network communities engage in a peer-to-peer learning model to accelerate best and promising practices in BH reform and jail diversion, with a commitment to pursuing community-driven

solutions to reduce harm to populations overrepresented in, or disparately impacted by, the criminal legal system.

Over the past two years, these communities have participated in topical technical assistance meetings focused on BH data tracking and evaluation, equity within the intersection of the criminal legal system and BH, developing early diversion strategies, building a robust jail continuum of care, and other critical topics. The communities participating in the IMPACT Network focus on a variety of strategies to decrease inappropriate incarceration of people with BH needs.

San Juan County has worked closely with community stakeholders and cross-agency representatives through the Sequential Intercept Mapping (SIM) process, identifying gaps in services available to individuals with BH needs. As part of their post-SIM work, the County is identifying a system for data collection that will assist stakeholders in tracking needs.

Consistent with the work of SJC IMPACT, The SJC Sheriff's Office has committed, over the last three years, to Crisis Intervention Team (CIT) training for its deputies. In that time, a total of sixty-four (64) deputies completed Basic CIT training. The CIT program is a community partnership of law enforcement, mental health and addiction professionals, individuals who live with mental illness and/or addiction disorders, their families, and other partners to improve community responses to mental health crises. While CIT programs are known for CIT-trained officers, successful programs also focus on improving the crisis response system, advocating for needed services, and strengthening partnerships across the community.

CIT is a program that provides the foundation necessary to promote community and statewide solutions to assist individuals with BH conditions. The CIT Model reduces both discrimination and the need for further involvement with the criminal justice system. CIT provides a forum for effective problem-solving regarding the interaction between the criminal justice and BH care system and creates the context for sustainable change. Research shows that communities that prescribe to the CIT Program model have higher success rates in resolving crisis situations.

According to the Sheriff's Office, from January 1, 2020, to October 25, 2023, CIT deputies have encountered 469 individuals who were a suicide threat, 280 attempted suicide, and 33 of these attempts, resulted in death. The total number of calls that deputies responded to that were for BH issues was 1385. During the same timeframe, the Sheriff Office's BH Deputy, responded to another 1791 calls. In total, during this period approximately 3,176 individuals were encountered who had BH-related problems. Of these, at least 315 would have been appropriate for a CTC drop-off, had this option been available and would have been diversions from the ED. Deputies did make 1582 referrals to other BH service resources during this period.

The County Mental Wellness Resource Center located in Farmington is a direct result of the *Gap Analysis'* conclusion that a central location be created to assist in accessing services in a simpler and more collaborative manner. The goals of the Mental Wellness Resource Center are to provide:

- Up-to-date and adequate information on resource availability.
- Improved awareness and de-stigmatization of BH needs.
- Improved awareness of BH services and treatment availability.
- Increased suicide awareness and prevention efforts.
- Enhanced community awareness about BH.

Peer Mentors are available at the Center who understand how to navigate the area's service systems and are knowledgeable about the services offered. They are available by phone or in-person to assist with accessing needed services.

To further assist residents with accessing services, San Juan County published a Mental Wellness Resource Center Directory on June 23, 2023, which was funded by a grant from the NM Human Services Department, Behavioral Health Services Division (BHSD). This directory lists the BH provider organizations operating within the County and other basic need resources. It would be beneficial if the contents of the Directory were loaded into NM's *Treatment Connections*, operated by Bamboo Health, where service provider data would be automated and accessible 24/7. In addition, service providers would have the ability to update their respective data, as appropriate in real time.

Beginning in 2008, San Juan County Partnership, Inc. (SJCP) has administered the annual NM Community Survey (NMCS) in San Juan County to evaluate and plan prevention initiatives funded by BHSD's Office of Substance Abuse Prevention (OSAP) and other sources. In 2022, a total of 1336 surveys were collected from San Juan County residents. The NMCS asks about alcohol and prescription drug use, community attitudes and perceptions, and sources of alcohol and prescription painkillers. In 2022, SJCP also implemented the Opioid and Polysubstance modules to NMCS to learn more about painkiller misuse, polysubstance use, prescription pain medication concerns, and naloxone availability.

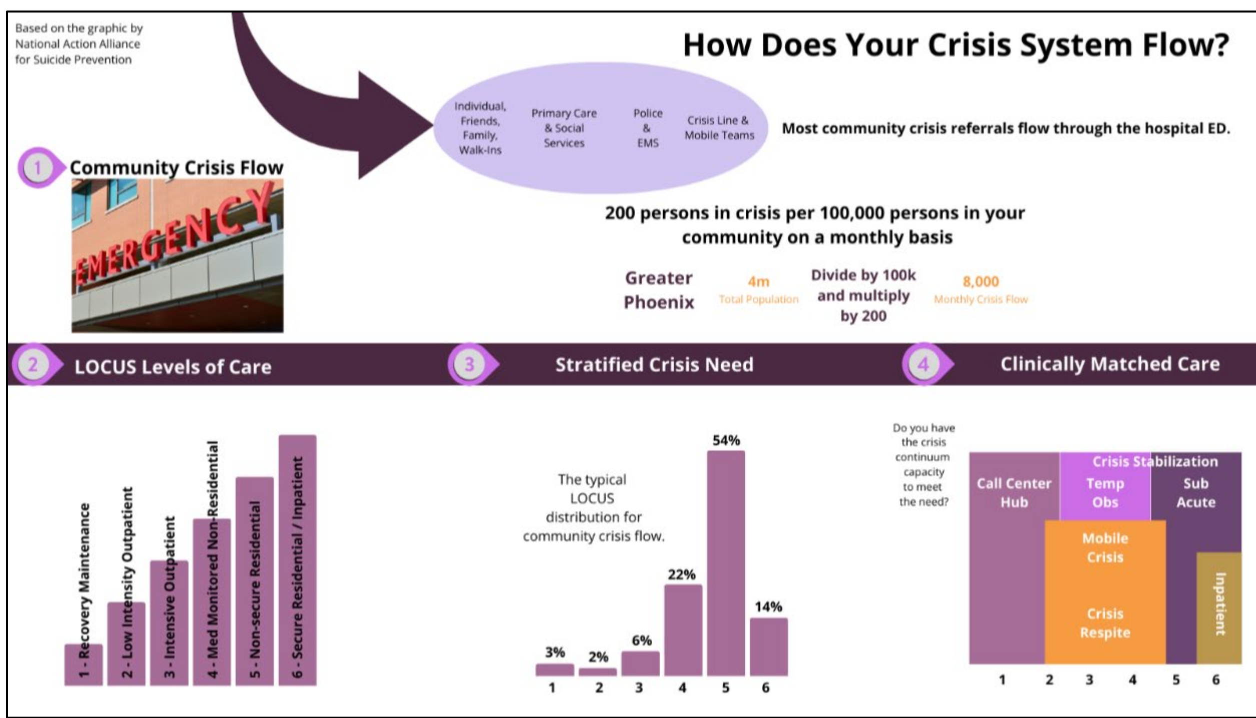
It is apparent that the County has sufficient needs assessment data collection and reporting that recurs on an ongoing basis. Three assets that could potentially be better utilized for this purpose could be the San Juan County Partnership, the San Juan County Mental Health Task Force, and San Juan College. SJCP is a non-profit community action organization that provides community planning activities and projects; the aim of the Task Force is to reduce the number of people with mental health disorders that require law enforcement intervention and to reduce the number of the people with mental health disorders in detention centers; and the mission of the College is to educate and empower individuals to thrive in an ever-changing world. With adequate planning and financing of these three pivotal organizational assets, potential synergies could be realized in implementing more of the solutions that were proposed in the *San Juan County 2019 Behavioral Health Gap Analysis: Building Bridges.*

SAMHSA'S National Guidelines for Behavioral Health Crisis Care

SAMHSA's National Guidelines for Behavioral Health Crisis Care

According to the paper published by the National Association of State Mental Program Directors (NASMHPD) and co-authored by RI's CEO, David W. Covington, LPC, MBA, *Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness*, August 2018, individuals in crisis often interface with the justice system, first responders, hospital emergency departments (EDs) and correctional facilities. These resources are essential to supporting a healthy community, but they are not designed to meet the unique needs of individuals experiencing a BH crisis.

The diagram below, from the National Action Alliance, represents an example of the Greater Phoenix community and its various routes to receive care for individuals experiencing a BH crisis:



It is estimated that for every 100,000 members of a representative population, 220 of those population members will experience a crisis that requires something more than a typical outpatient or phone intervention. Research has resulted in the utilization of data to stratify the service level needs of those individuals; and that data can be applied to design a cost-effective crisis response system.

Timely access to vital acute psychiatric inpatient (hospital) care is frequently unavailable for individuals experiencing the most significant BH crises. A decade of Level of Care Utilization System (LOCUS) assessment data, gathered in Georgia by mobile crisis teams, emergency departments and crisis facilities indicate that 14% of individuals experiencing a crisis who have reached these higher levels of care have a clinical need that aligns with inpatient care (LOCUS level 6). A majority (54%) of these individuals experiencing a BH crisis have needs that align better with services delivered within a crisis facility and 32% have lower-level needs that would benefit from interventions by a mobile crisis team (LOCUS levels 1-4). It is important to note that this LOCUS data set does not include an assessment of individuals who have

only contacted the 988 crisis contact center. Therefore, it is used to only stratify the clinical needs of those engaged by higher levels of care and is not being used to predict 988 resource needs.

As indicated above, it is expected that 220 individuals per 100,000 will experience a crisis that requires a service level more acute than can be accommodated by outpatient services or a phone intervention. If this ratio were applied to San Juan County (see Appendix D) with a population in 2023 of 125,043, it would be expected that 5,200 individuals would annually need crisis response services, with 2,200 of these requiring facility-based crisis services.

As portrayed earlier, a key element of a comprehensive BH crisis response system as delineated in the *National Guidelines* is:

1. **Crisis Observation and Stabilization Facilities**. These facility-based crisis services offer short-term BH crisis care for individuals who need support and observation. Design of these facility-based crisis services may vary, but ideally, they will include a medically staffed flexible observation and stabilization area with recliners, instead of beds, (usually limited to less than 23 hours of care); and operate under a "no wrong door" approach. The proposed CTC will operate as crisis observation service. Under this approach walk-ins, law enforcement, and other first responder referrals, are immediately accepted without requiring any form of medical clearance prior to admission. This approach also includes accepting both voluntary and involuntary admissions. Therefore, it is imperative that the facility is staffed and equipped to assure the health and safety of everyone within the facility. These centers are typically a high-speed assessment, observation, engagement, and stabilization service. Each admission receives the following services: a psychiatric evaluation by a Licensed Psychiatrist or Psychiatric Nurse Practitioner that includes a risk assessment and medication evaluation; a brief medical screening by a registered nurse to ensure that co-occurring medical issues are addressed; Substance Use Disorder (SUD) screening and assessment by a licensed clinician; a psychosocial assessment by a licensed clinician; crisis stabilization services utilizing a high engagement environment with a strong recovery focus and peer support model; and comprehensive discharge planning and community coordination of services.

   These observation and triage stabilization programs are typically paired with an acute short-term (2-5 day) facility-based crisis program with beds (either inpatient, respite or residential) to offer more than 23 hours of care without escalating to more costly acute inpatient options that would result in longer lengths of stay and higher per diem costs. This facility needs to be licensed to accept involuntary guests and have the licensed ability to offer seclusion and restraint services, if needed. This unit is intended to serve approximately 30% of those admitted to the 24/7 center with recliners, who were not sufficiently stabilized during the 23-hour observation stay.

   Both settings should be designed as inviting non-institutional environments that are enhanced by natural light, and hopeful and inspiring aesthetic features. Common security elements such as uniformed and armed security guards and razor wire fences are not features in these facilities. Program interventions are delivered by both professional (MD, PNP, RN, Clinician) and para-professional (certified peer support specialists) staffs designed to support ongoing recovery, and to engage in comprehensive discharge planning and community coordination of care. Equally important is that this interdisciplinary team creates and sustains an environmental milieu where all "guests" are treated with dignity and respect, are authentically and meaningfully engaged, and

when dysregulated, they are allowed the space, time, and support necessary to de-escalate. As a result, these stabilization settings, when appropriately staffed, can assure greater safety than normally expected in crisis settings. Seclusion and restraints are available, but rarely applied.

It should be noted that once these core components are in place and operating as intended, there are additional crisis systems service enhancements that can be made. These can include a Peer Navigator service, with a transportation capability that assists individuals who have accessed crisis services to subsequently navigate San Juan County's health and human services systems. Such navigation is necessary to provide access to the benefits and services that potentially further stabilize and improve one's quality of life, such as permanent supportive housing, supported employment or education.

Another option is a Peer Respite Center that is managed by and staffed with Peer Support Specialists. Crisis Respite is typically a short-term (two-week) residential environment that operates as a transition from crisis stabilization to the community, or as a step up from the community to prevent a potential crisis. Unfortunately, in NM such facilities are not recognized as a facility type nor do they have a payment mechanism. Other alternative models are being developed as communities become freer to innovate in meeting identified needs and garner a broader base of practice-based evidence.

An alternative in NM for facility-based crisis care is a Community Calming Center (CCC). A CCC operates 24/7 and is intended to operate in more rural communities where service demand would not be sufficient to support a CTC. The CCC can access medical professionals as appropriate via Telehealth, however it does not have the capability to serve those who are on an involuntary status. NM Medicaid has submitted a State Plan Amendment to the Centers for Medicare and Medicaid (CMS) to gain approval for coverage of CCCs under Medicaid. Upon approval, the Medical Assistance Division (MAD) of the Human Services Department (HSD), will publish the reimbursement rate for services provided at a CCC, within the next one to five years.

Communities that lack a crisis response service continuum pay the price in terms of the cost of law enforcement engagement in addressing BH crises, the expense of incarceration, the negative impact on the quality of life for individuals in the community, and ED and hospitalization costs. Those unable to access needed services in a timely manner endure the effects of psychiatric boarding (waiting in an ED for hours or days) and the exacerbation of symptoms and distress. For payers of healthcare, a lack of adequate crisis care translates into paying unnecessary ED bills that are estimated to cost between $1,200 and $2,260. In contrast, 96% of individuals directly referred to a crisis response provider do not require an ED visit. Additionally, acute psychiatric inpatient care often comes with a higher per diem rate and a longer average length of stay (ALOS) than crisis response facilities. The escalated expenses increase healthcare costs by an estimated 100% of the costs realized within a comprehensive crisis system.

The desired model is to connect individuals to a crisis response provider as quickly as possible using a systemic method that is analogous to the healthcare delivery system's approach to medical emergencies. This prototype can also be used as a tool to help frame reimbursement rates for these similar crisis response services in a manner consistent with parity expectations. The chart below demonstrates the differences between the 911 medical emergency response system in comparison to the traditional BH crisis response system. The final column illustrates

how an optimized crisis response system can operate on par to traditional medical emergency management systems. In so doing, those with BH conditions in crisis can be subject to life-saving interventions, rather than routinely being endangered and traumatized, or even worse, exposed to deadly force. The table below highlights how the BH crisis response systems are intended to be comparable to emergency medical response systems:

Medical Emergency Response versus a BH Crisis Response			
	Medical System	**BH Crisis System**	**National Guidelines**
Call Center	911	Crisis Line or 911	Crisis Line – 988 in 2022
Community Service	Ambulance / Fire	Police	Mobile Crisis Team (MCT)
Facility Option	Emergency Dept.	Emergency Dept. Arrest/detention	Acute Crisis Observation & Stabilization Facility
Facility Response	Always Yes	Wait for Assessment	Always Yes
Escalation Option	Specialty Unit (PRN)	Inpatient if Accepted	Crisis Facility or Acute (PRN)

The *Crisis Now Transforming Crisis Services: Business Case* suggests that a comprehensive crisis response system is affordable and within the reach of most communities. The cost of crisis response services can be further supported by the reinvestment of savings from the decreased spend on hospital-based services and incarceration/detention.

The escalating costs communities pay for not investing in a comprehensive crisis response system are unsustainable; manifesting as demands on law enforcement, other first responders, criminal justice systems, emergency departments, service providers of all types, and public and private payers. These escalating trends are pushing the limits of what is affordable and sustainable, while also resulting in adverse outcomes for those in need of care and the communities within which they reside. The impact on vulnerable and marginalized individuals, and their families, is devastating. Zero unnecessary admittance for BH conditions to emergency departments and jails (where only nuisance crimes have been committed) are attainable goals through the implementation of the *National Guidelines.*

Core Principles and Practices

There are several additional elements that must be systematically “baked into” excellent crisis response systems, in addition to the core structural elements. These essential principles and practices are:

- Embracing recovery.
- Significant role for peers.
- Trauma-informed and responsive care.
- Safer suicide care.
- Safety and security for staff and consumers.
- Crisis response partnerships with law enforcement.

Embracing Recovery

Crisis response providers must embrace the reality that individuals and families move beyond their BH challenges to lead happy, productive, and connected lives, each day. At the 2019 International Initiative for Mental Health Leadership (IIMHL) *Crisis Now* Summit, consumer Misha Kessler ended his description of his direct experiences with crisis response services, "Mental illness is [just] one part of my tapestry." The fact that recovery is possible and that it means not just the absence of symptoms, but also the development of meaning and purpose in life, has begun to transform mental health care (Anthony, 1993). The President's New Freedom Commission on Mental Health (Hogan, 2003) recommended that mental health care be "recovery-oriented" and enriched by person-centered approaches, a hopeful and empowering style, and increased availability of support by individuals with lived experience.

The significance of a recovery-oriented approach is critical for those in crisis, and thus for crisis response settings. In an outmoded, traditional model, crises typically reflect "something wrong" with the individual. Risk is seen as something to be contained, often by means of an involuntary commitment to an inpatient psychiatric unit. In worst-case scenarios, people end up restrained on emergency room gurneys or in jails. These actions in turn, are traumatizing to those who are subjected to them, and often they further reinforce the likelihood that the person will soon again recycle through this same revolving door of inadequate crisis interventions.

In a recovery-oriented approach to crisis care, the risks of harm to self or others are recognized, but the basic approach is fundamentally different. Crises are viewed as challenges that may present opportunities for growth. When crises are ameliorated in comfortable and familiar settings, people feel less alone and isolated with their feelings of anxiety, panic, depression, and frustration. This creates a sense of empowerment and belief in one's own recovery, and ability to respond effectively to future crises. The recovery-oriented approach to crisis care is integral to transforming a broken system.

Implementation Guidance

1. *Commit to a "no force first" approach regarding care that is characterized by engagement and collaboration.*
2. *Create engaging and supportive environments that are as free of barriers as much as possible. This would include eliminating Plexiglas from crisis stabilization facilities and minimal barriers between team members and those being served, to support stronger connections.*
3. *Ensure team members engage individuals in the care process during a crisis. Communicate clearly and frequently to those in care regarding all intervention options, and offer materials regarding any processes in writing, in the individual's preferred language whenever possible.*
4. *Ask the individual served about their preferences and do what can be done to align any actions to those preferences.*
5. *Work to convert those with an involuntary commitment to voluntary, as soon as practicable, so they become more invested in their own well-being and recovery.*

Significant Role for Peers

One specific, transformative element of recovery-oriented care is to engage the experience, capabilities, and compassion of those who have experienced BH crises. Integrating those "with lived experience" within the components of crisis care has repeatedly demonstrated that they "take all of [their] experiences; regardless of the pain and use them to transform [their] life into 'living hope' for others who want to recover" (Ashcraft, Zeeb, & Martin, 2007). This reality has been increasingly substantiated by studies investigating peer services and supports. This body of work has found support for a range of peer support benefits including strengthened hope, relationship, recovery, and self-advocacy skills, and improved community living skills (Landers & Zhou, 2011).

Utilizing peers, especially those who have experienced suicidality and suicide attempts, and learned from these experiences, can provide a safe, authentic, and respectful context within which the feelings of aloneness and burdensomeness, associated with suicidality, can be ameliorated. Peer intervention in the crisis response setting with suicidal individuals is particularly potent considering the reported 11%-50% range of attempters who refuse outpatient treatment or abandon outpatient treatment quickly following an ED referral (Kessler et al., 2005). Certified peer support workers (CPSW) can relate without judgment, can communicate hope in a time of great distress, and can model the fact that improvement and success are possible. This increases engagement, while reducing distress.

The role of peers—specifically survivors of suicide attempts, as well as survivors of suicide loss—was bolstered when the Action Alliance's Suicide Attempt Survivors Task Force released its groundbreaking report, *The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience*, in July 2014. The report describes the many ways in which learning from and capitalizing on lived experience can be accomplished.

Implementation Guidance

1. *Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible; including, but not limited to, gender, race, primary language, ethnicity, religion, veteran status, lived experiences and age considerations.*
2. *Develop support and supervision that aligns with the needs of the program's peer staff.*
3. *Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program. This would include peers who:*
    a. *Are available for connection with crisis line operations.*
    b. *Serve as one of two mobile team members.*
    c. *Are one of the first individuals to greet someone upon entrance to a crisis stabilization facility.*

Trauma-Informed Care

The great majority of individuals served with BH services have experienced significant interpersonal trauma. The adverse effects of child trauma may present well into adulthood, increasing the risk for post-traumatic stress disorder (PTSD), mental illness, substance use

disorders, and poor medical health (Finkelhor et al., 2005). Persons with a history of trauma or trauma exposure are more likely to engage in self-harm and suicide attempts; and their trauma experiences make them acutely sensitive to how care is provided to them. When crisis care involves a loss of freedom, noisy and crowded environments, and/or the use of force, there is an exacerbation of presenting symptoms. These situations can re-traumatize individuals at the worst possible time, leading to worsened increased agitation or withdrawal, and often followed a genuine reluctance to seek help in the future.

Alternatively, environments and interventions that are safe and calming can facilitate stabilization and healing. Therefore, trauma-informed care is an essential element of crisis treatment. In 2014, SAMHSA posited six (6) guiding principles for trauma-informed care:

1. Safety.
2. Trustworthiness and transparency.
3. Peer Support and mutual self-help.
4. Collaboration and mutuality.
5. Empowerment, voice, and choice.
6. Cultural, historical and gender issues.

These principles should inform treatment and recovery services. When these principles are applied to practice, they become self-evident to staff, consumers, and their significant others. The program's culture becomes transformed. All of those admitted to facility-based crisis services are screened for trauma exposure and its impact on overall well-being. Addressing the trauma that family and significant others have experienced is also a critical component that assists stabilization and reduces the possibility for further trauma or crisis.

Developing and maintaining a healthy therapeutic and supportive environment also requires support for staff, who may have a trauma history or may experience post-secondary trauma because of working with other trauma victims. An established resource for further understanding trauma-informed care is provided by SAMHSA (2014): *Trauma-Informed Care in Behavioral Health Services (TIP 57)*. Trauma-informed care is urgently important in crisis response settings because of the links between trauma and crisis and the associated vulnerability of people in crisis, especially those with trauma histories.

Implementation Guidance

1. *Incorporate trauma-informed care training into each team member's new employee orientation with refresher training delivered as needed.*
2. *Apply assessment tools that evaluate the level of trauma experienced by the individuals served by facility-based crisis services and create action steps based on those assessments.*

Zero Suicide/Suicide Safer Care

Crisis intervention programs have always focused on suicide prevention. This stands in contrast to other health care and BH services, where suicide prevention was not always positioned as a

core responsibility. Every crisis response provider in the nation must make two transformational commitments:

1. Adoption of suicide prevention as a core responsibility.
2. Eliminate the incidence of suicide among people under care. These changes were adopted and advanced in the revised *National Strategy for Suicide Prevention* (2012).

The National Action Alliance for Suicide Prevention created a set of evidence-based actions known as *Zero Suicide* or *Suicide Safer Care* that health care organizations can apply through an implementation toolkit developed by the Suicide Prevention Resource Center (SPRC) at the Education Development Center, Inc. (EDC). The following seven key elements of *Zero Suicide* or *Suicide Safer Care* are all applicable to crisis care:

- Leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care, which includes survivors of suicide attempts and suicide loss in leadership and planning roles.
- Develop a competent, confident, and caring work force.
- Systematically identify and assess suicide risk among people receiving care.
- Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs and that includes collaborative safety planning and reducing access to lethal means.
- Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.
- Provide continuous contact and support, especially after acute care.
- Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

See more at http://zerosuicide.sprc.org/about

It should be noted that the elements of zero suicide closely mirror the standards and guidelines of the National Suicide Prevention Lifeline (NSPL). NSPL has established suicide risk assessment standards, guidelines for callers at imminent risk, protocols for follow-up contact after the crisis encounter, while promoting collaborative safety planning, reducing access to lethal means, and incorporating the feedback of suicide loss and suicide attempt survivors.

Since comprehensive crisis response systems are the most urgently important clinical service for suicide prevention; and since most parts of the country do not have adequate crisis care, a national and state-level commitment to implementing comprehensive crisis response services is foundational to suicide prevention. It is anticipated that health authorities (i.e., payers, plans, state agencies, Medicaid, and Medicare) will increasingly require this as an expectation that best practices in suicide care.

Implementation Guidance

1. *Incorporate suicide risk screening, assessment and planning into the new employee orientation for all staff.*
2. *Assign the completion of Applied Suicide Intervention Services Training (ASIST) or similar training to all staff.*

3. *Incorporate suicide risk screening, assessment and planning into crisis care practices.*
4. *Automate the suicide risk screening, assessment and planning process, and associated escalation processes, within the electronic health record (EHR).*
5. *Commit to the goal of Zero Suicide as a crisis response system.*

Safety and Security

Safety for both guests and staff is a foundational element for all crisis response service settings. Crisis response settings are also on the front lines of assessing and managing suicidality, an issue with life and death consequences. While ensuring safety for people using crisis response services is paramount, the safety of staff is also a priority. People in crisis may have experienced violence or acted in violent ways, they may be intoxicated or delusional, and/or they may have been dropped-off by law enforcement and may present an elevated risk for violence.

Trauma-informed and recovery-oriented care is safe care. Nevertheless, much more than philosophy is involved. Keys to safety and security in crisis delivery settings include:

- Evidence-based crisis training for all staff.
- Role-specific staff training and appropriate staffing ratios to number of clients being served.
- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas "fishbowl" observation rooms and keypad-locked doors. This space must also be anti-ligature sensitive and contain safe rooms for people for whom violence may be imminent or who may find the crisis environment over-stimulating.
- Established policies and procedures emphasizing "no force first" prior to any implementation of safe physical restraint or seclusion procedures.
- Strong relationships with law enforcement and first responders.

Ongoing staff training is critical for maintaining both staff competence and confidence, and for producing improved outcomes for those served; and decreasing the risk for staff (Technical Assistance Collaborative (TAC), 2005). Nationally recognized best practices in crisis intervention such as *CPI* (Crisis Prevention Institute, Nonviolent Crisis Intervention Training) and *Therapeutic Options* (Therapeutic Options, Inc.) are highly effective and instrumental in their utilization of positive practices to minimize the need for physical interventions and re-traumatization of persons in crisis. Such approaches have contributed to a culture of safety for staff and guests in crisis care settings.

RI has implemented, Ukeru® which is a safe, comforting and restraint-free crisis management technique developed by and for BH caregivers and educators. Named for the Japanese word, "receive," this award-winning program helps people engage, sense, and feel, and then respond to what someone is trying to communicate through their actions. Ukeru has helped BH providers and schools reduce the use of restraint, seclusion, and injury, while lowering workers' compensation costs and employee turnover. In addition, RI relies on SafeClinch which is a group of restraint techniques that relies more on two to three people restraint holds, although it does teach individual/solo restraint techniques and personal safety as well. The SafeClinch Training System provides verbal de-escalation; restraint training; and proven instructional strategies. The program is customizable for a wide variety of organizations that deal with uncooperative behaviors and with people who have special needs.

Adequate staffing for the number and clinical needs of guests under care is foundational to safety. Access to enough qualified staff (clinicians, nurses, providers and peer support specialists) promotes timely crisis intervention and risk management for persons in crisis who are potentially dangerous to self or others (DHHS, 2006).

In Crisis Triage Centers (CTC) within NM, seclusion and/or restraint is now permitted. Though some practitioners view physical and/or pharmacological restraint and seclusion as safe interventions, they are often associated with increased injury to both guests and staff; and may ultimately re-traumatize individuals who have experienced physical and/or emotional trauma. Therefore, restraint and seclusion should be considered safety measures of last resort, not to be used as a threat of punishment, an alternative to appropriate staffing, as a technique for behavior management, or as a substitute for active engagement (TAC, 2005). RI views any use of seclusion and restraint as a treatment failure.

Crisis response providers must engage in person-centered planning and treatment, while assessing risk for violence and collaboratively develop de-escalation and safety plans for individuals served. The routine debriefing with staff and individuals involved in those interventions is necessary after a seclusion/restraint event to inform policies, procedures, and practices; thereby, reducing the probability of the future use of such interventions.

Following the tragic death of Washington State social worker Marty Smith in 2006, the Mental Health Division of the WA Department of Social and Health Services sponsored two safety summits. The legislature passed into law a bill (SHB 1456) relating to home visits by mental health professionals. These measures should be adopted as policy by every state or jurisdiction.

This statute stipulates that the keys to safety and security for home visits by mental health staff include:

- No mental health crisis outreach worker will be required to conduct home visits alone.
- Employers will equip mental health workers, who engage in home visits, with a communication device.
- Mental health workers dispatched on crisis outreach visits will have prompt access to any history of dangerousness or potential dangerousness on the client they are visiting, if available.

Ensuring safety for both consumers and staff is the very foundation of effective crisis care. While safety is urgently important in all health care, in crisis care, the perception of safety is also essential. The prominence and damaging effects of trauma and the fear that usually accompanies a psychological crisis can lead to dysregulation, resulting in potential agitation and aggression.

Implementation Guidance

1. *Commit to a "no force first" approach to care.*
2. *Monitor, report and review all incidents of seclusion and restraint with a goal of minimizing the use of these interventions.*

3. *Barriers do not equal safety. The key to safety is engagement and the empowerment of the individual served while in crisis.*
4. *Offer enough space in the physical environment to meet the needs of the population served. A lack of space can elevate anxiety for all.*
5. *Incorporate quiet spaces into the crisis facility for those who would benefit from time away from the milieu of the main stabilization area.*
6. *Engage team members and those served in discussions regarding how to enhance safety within the crisis setting, make safety truly "Job One."*

Law Enforcement and Crisis Response—An Essential Partnership

Law enforcement agencies have reported a significant increase in police contacts with people with BH conditions in recent years. Some involvement with BH crises is inevitable for police. As first responders, they are often the principal point of entry into emergency care for individuals experiencing a BH crisis.

Police officers are critical to mobile crisis services as well; by either providing support in potentially dangerous situations (Geller, Fisher, & McDermeit, 1995); or by serving as a referral source delivering "warm hand-offs" to facility-based crisis services. Research investigating law enforcement response to individuals with mental illness (Reuland, Schwarzfeld, & Draper, 2009) found police officers frequently:

- Encounter persons with mental illness at risk of harming themselves.
- Often spend a greater amount of time attempting to resolve situations involving people exhibiting mental health concerns.
- Address many incidents informally by talking to the individuals with mental illness.
- Encounter a small subset of "familiar faces."
- Often, transport individuals to an emergency medical facility where they may wait for extended periods for medical clearance or admission.

In many communities across the United States, the absence of sufficient and well-integrated BH crisis care has made local law enforcement the de facto BH mobile crisis response system. This is unacceptable and unsafe. The role of local law enforcement to address emergent public safety risk is essential and important. With responsive BH crisis care in place, collaboration with law enforcement, which will improve both public safety and produce better outcomes for those in crisis. Unfortunately, well-intentioned law enforcement responders to a crisis call can often escalate the situation just based on their presence. Police vehicles and armed officers can generate anxiety or agitation for far too many individuals in a crisis.

We now know a good deal about crisis care/law enforcement collaboration. Deane et al. (1999), reporting on partnerships between BH personnel and law enforcement, found the alliance between first responders and BH professionals helped to reduce unnecessary hospitalization or incarceration. Specialized responses to BH crises included specialized police response, police-based specialized BH response, and BH-based specialized BH response. These forms of collaboration share the common goal of diverting people with BH crises from criminal justice settings into BH treatment settings and were rated as "moderately effective" or "very effective" in addressing the needs of persons in crisis.

Specialized police responses involve police training by BH professionals to provide crisis intervention and to act as liaisons to the BH crisis system. The Memphis Crisis Intervention Team (CIT) model pioneered this approach. In CIT, training for law enforcement includes educating officers about mental illness, substance use disorders, psychiatric medications, and strategies for identifying and responding to a crisis (Tucker et al., 2008). Lord et al. (2011) found most officers involved volunteered to participate in the training.

Consistent with the findings above, CIT necessitates a strong partnership and close collaboration between the police officers and BH programs (e.g., availability of a crisis setting where police can drop off people experiencing a mental health crisis). CIT has been cited as a "Best Practice" model for law enforcement (Thompson & Borum, 2006). Crisis care programs should engage in ongoing dialogue with local law enforcement agencies to support continuous quality improvement and collaborative problem solving. Optimized crisis response systems report facilitating monthly meetings with aggregate data sharing as a part of their ongoing operations.

Strong partnerships between BH crisis care systems and law enforcement are essential for public safety, suicide prevention, connections to care, justice system diversion, and the elimination of psychiatric boarding in emergency departments. The absence of a comprehensive crisis response system has been the major "front line" cause of the criminalization of those with BH conditions, and a root cause of shootings and other incidents that have left too many people, including police officers, dead. Collaboration is the key to reversing these unacceptable trends.

Implementation Guidance

1. *Have local crisis providers actively participate in CIT training sessions.*
2. *Incorporate regular meetings between law enforcement and crisis providers into the schedule so that these partners can work to continuously improve their practices.*
3. *Include BH crisis provider and law enforcement partnerships in the training for both partner groups.*
4. *Share aggregate outcomes data, such as: numbers served, percentage stabilized and returned to the community, and connections to ongoing care.*

Methodology

METHODOLOGY

The over-arching purpose of this project was to create a CTC Business Plan and to align its operationalization to the practice standards for BH crises care as defined within the *National Guidelines*. In addition, the intention of this project is to optimize crisis resource design and allocations to meet local needs; and to find opportunities to reduce overall health care costs and those costs associated with psychiatric boarding, law enforcement interventions, and the incarceration. To implement and sustain a comprehensive BH crisis response system that is in fidelity to the *National Guidelines*, RI examined available information regarding NM's alignment of facility certification standards, Medicaid administrative rules and payment rates, and regulations governing involuntary placements.

Lastly, RI applied the pertinent data that was gleaned throughout the assessment process, to its algorithmic formulations to determine the general crisis capacity needs for the County. The results of these calculations were subsequently modified to accommodate the unique permutations of client flows within San Juan County's system and the impact on that flow with the operationalization of the proposed CTC. The results were then analyzed against current crisis service assets and strengths to develop a set of concrete recommendations on how to best develop and implement a staged approach to achieving these aims. RI implemented the following methodology and management plan to accomplish the scope of services in meeting the County's objectives for this project.

- **Pre-Planning:** Virtual stakeholder meetings were planned with the County to discuss the project schedule, scope of work, deliverables, and to receive input regarding BH crisis care within San Juan County and respond to questions.
- **Assessment:** RI initially gathered information on San Juan County's existing system in response to presenting crises, which included an examination of substantiated needs, an inventory of existing services, and an analysis of the gaps in the crisis services provided. This was completed through a review of existing publicly available records and data, but particularly the results of the *San Juan County 2019 Behavioral Health Gap Analysis: Building Bridges.* Each of these sources is listed in the Reference Appendix of this Report. Additionally, RI's consultant team conducted stakeholder meetings. These stakeholder engagements were determined and scheduled in consultation with the County, and included representatives from the following organizations:
- **Analysis and Draft Report, and Business Plan Development:** RI analyzed the assessment results to identify any additional service gaps and opportunities. This process was followed by an analysis of crisis response service demand, costs, feasibility, and a review of financing methodologies and rates. Subsequently, RI developed a draft Business Plan, balancing all these elements and reviewed it with the County Manager and the Manger's designated representatives.
- **Community Engagement:** RI engaged current and potential future stakeholders to rally support for the CTC. A community stakeholder forum was convened to further build consensus within the community. Invitees for this forum were determined by working with the County.
- **Final Business Plan:** This Business Plan is the project's final work product, which is intended to be a roadmap for the development and implementation of the CTC that builds on the current service assets within San Juan County, while maximizing system efficiencies whenever possible. This Business Plan contains all the substantive information acquired during the

project and it will be publicly shared by the County Manager, and it was presented to the County Commissioners. The Business Plan includes:

i. An overview of the project, lessons learned, and recommendations for the future.
ii. A brief description of San Juan County's crisis response system needs (facility-based crisis services, and other potential crisis care assets) with recommendations for projected service capacity.
iii. A recommended plan to best incorporate existing service assets into a developing crisis response system, which will include the implementation of a 24/7 CTC with recliners. This Business Plan addresses CTC costs, staffing requirements, facility size, and potential funding mechanisms. This Report also assesses the overall cost impact of the implementation of recommendations balanced with potential savings to the system.

- **Wrap-Up Meeting:** The goal of this meeting was to the review the Business Plan, answer questions and determine actionable next steps. This involved one (1) two-hour collaborative teleconference between representatives from San Juan County, and RI's consultant team.

Findings and Analyses

FINDINGS AND ANALYSES

San Juan County and its various service entities have done a commendable job of chronicling BH needs, inventorying related existing service capacity, completing gaps analyses; issuing recommendations for providing a more comprehensive response to better meet BH-related needs, and completing a sequential intercept-mapping (SIM) project. This body of work has included analyses and recommendations related to needed public policy to support crisis response service system enhancements. The following reports were reviewed in preparation of this Business Plan, and the relevant information from the respective findings and recommendations, have been integrated within this Plan:

- *Community Needs Assessment of San Juan County*. San Juan County Partnership, Inc. June 2016.
- *San Juan County 2019 Behavioral Health Gap Analysis: Building Bridges.* Prepared by MAS Solutions, LLC in partnership with Ericson Consulting. May 2019.
- *2022 New Mexico Community Survey San Juan County*. Prepared by Noah J Salvatore, Ph.D., Evaluator for the San Juan County Partnership, Inc.
- *2023 Community Health Needs Assessment: San Juan County, New Mexico.* Sponsored by San Juan Regional Medical Center and prepared by PRC Custom. April 2023.
- *Prosperity Now SCORECARD* https://scorecard.prosperitynow.org/data-by-location#tribe/990002430
- *Healthiest Community Index.* U.S. News and World Report. 2022. https://www.usnews.com/news/healthiest-communities/new-mexico/san-juan-county
- *San Juan County Mental Health Resource Center: Resource Directory.* Funded by a Grant from the NM Human Services department, Behavioral Health Services Division. June 30, 2023.
- *The County Health Rankings and Roadmaps: Building a Culture of Health, County by County.* University of Wisconsin Population Health Institute. 2023. https://www.countyhealthrankings.org/explore-health-rankings/new-mexico/data-and-resources

A Crisis Triage Center (CTC) in San Juan County was first proposed in the report, *San Juan County 2019 Behavioral Health Gap Analysis: Building Bridges.* Subsequently, the potential of establishing a CTC appeared to gain momentum. That momentum was reinforced by the findings from the *Sequential Intercept Model (SIM) Mapping Project*. While the idea for a CTC was not specifically addressed, developing a crisis care continuum was seen as a priority. SIM projects typically encourage the development of alternatives to detention and pre-adjudication diversion options for people with BH disorders.

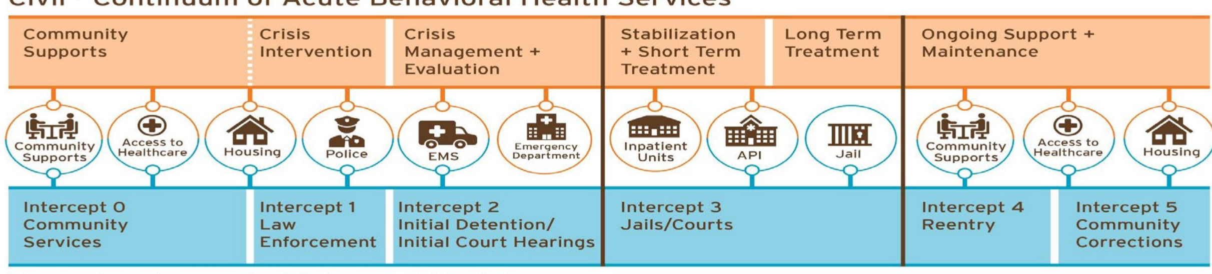
In direct response to this identified need, the San Juan County Manager solicited a proposal from RI to develop a Business Plan for CTC implementation. The County Manager was aware that RI had completed a similar project in 2019 for Dona Ana County, NM that led to the operationalization of the CTC that had been constructed in 2013. To move this initiative forward, RI responded with a proposal on May 23, 2023, and the County and RI executed a contract on August 2, 2023, for the completion of a CTC Business Plan.

As envisioned by the County, the CTC would:

- Operate as a 23-hour observation and crisis triage service with recliners that would operate under "no wrong door" on a 24/7 basis.

- Serve as a jail diversion by accepting and safely managing all referrals by law enforcement for individuals who are believed to have emergent and urgent BH-related issues.
- Assess and address the immediate BH need(s) of the individuals referred, to include medication-assisted detoxification, provide stabilization services, and link the individual with on-going services and supports.
- Admit individuals on a voluntary or involuntary basis for a period as determined by medical or BH professionals.
- Serve as a resource for individuals and families seeking assistance in dealing with BH-related issues.
- Address the disparate impact of the criminal justice system on those who are members of Black, Indigenous, and People of Color (BIPOC) communities.

In preparing the recommendations for this Report, the RI consultant team became firmly convinced that the CTC holds tremendous promise for San Juan County. Implementation of the CTC, along with the other recommendations of this Business Plan, has the potential of meeting the BH crisis-related recommendations from the reports previously cited and the needs identified by other sources. This perhaps can best be illustrated by the diagram below on the *Civil + Forensic Psychiatric Continuums of Care*. It illustrates the BH continuum of care in conjunction with the Forensic Sequential Intercept Model, which has been conducted in San Juan County. The CTC and the optimization of a crisis response system will provide a set of community based BH crisis intervention and stabilization facilities and services that effectively and efficiently meet the community needs associated with Intercept Levels 1, 2, and much of 3. Once established, the CTC will divert many of the individuals experiencing BH crises from EDs and the County Detention Center.



Each of the reports reviewed for this Business Plan has built the case using incidence, prevalence, utilization, and other data to substantiate the need for a CTC. Because of this archival of documented data, RI will not be replicating what already has been thoroughly documented.

San Juan County, of course, exists within a larger context – the State of New Mexico. In March of 2020, the University of New Mexico's School of Medicine published *The New Mexico Behavioral Health Needs Assessment 2020.* This needs assessment referenced The NM Department of Health's (NMDOH) Substance Abuse and Epidemiology Profile which describes the burden and epidemiology of various BH issues in the state. Deaths related to alcohol, drugs, and suicide are identified using vital records data. Between 2013 and 2017, 6,789 New Mexicans died from alcohol-related chronic disease, 2,470 died from drug overdose, and 2,335 died from suicide. NM's alcohol-related chronic disease mortality rate has been first, second or third in the nation for the past fifteen (15) years, and it is 1.5 to 2 times the national rate. It has also been increasing since 1990. The leading causes of alcohol-related chronic disease mortality

include chronic liver disease, alcohol dependence, alcohol abuse and liver cancer, hypertension, and stroke. NM had the seventeenth highest drug overdose morality rate in the U.S. in 2017 (which decreased from second in 2016). These deaths include intentional drug overdose, but 88% are caused by unintentional drug overdoses. The recent increase in unintentional drug overdose deaths is largely attributed to the rise in prescription drug use, which accounts for 57% (which is a decrease from 48% in 2016) of drug overdose deaths in NM. NM's suicide mortality rate has been 1.5 to 1.9 times higher than the national rate since 1981.

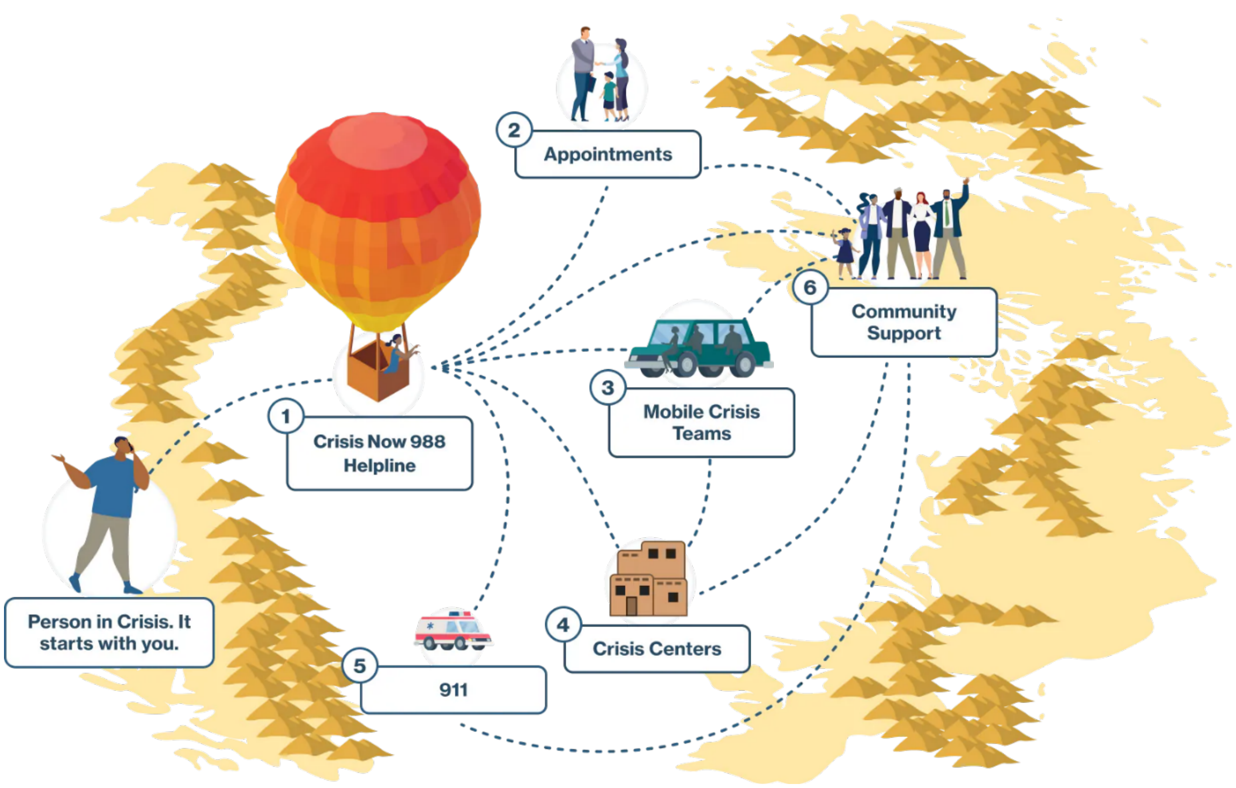
Based on SAMHSA's Unified Reporting System for 2018, public mental health system consumers in NM reported higher rates of improved functioning from treatment than the national average, among both children (75.5% vs. 73%), and adults (74.1% vs. 76.1%). According to recent NSDUH results, only 44.3% of NM adults 18 years or older with a mental illness received mental health treatment each year from 2013 to 2017. On a single day in 2017, 18,808 people were enrolled in substance use treatment in NM; 41.2% of these individuals were being treated for a substance use issue only, 18.4% for alcohol use only, and 40.4% for both an alcohol and a drug use issue. Treatment rates for substance abuse is far lower than for mental illness. Only 7.1% of NM individuals 12 years or older with alcohol dependence or abuse received treatment each year from 2014 to 2017, and only 9.1% of those with drug dependence or abuse received treatment. In 2013, 78% of NM's population had health insurance. However, this number has increased to 89% in 2017. In 2017, 230,230 NM residents under the age of 65 did not have health insurance. During this same timeframe for San Juan County, the health insurance coverage rate was 86% which was the State's second lowest county rate behind McKinley County at 82.6%.

Based on the June 2019 Health Resources and Services Administration's (HRSA) Health Professional Shortage Area data, 27.27% of the need for mental health care in the United States has been met, but only 12% of the NM population's need has been met, leaving 1,246,744 New Mexicans without adequate mental health care access.

According to authors, Kris Ericson, PhD, et al, in the background report for the 2022 Statewide Town Hall on Transforming Behavioral Health in New Mexico,

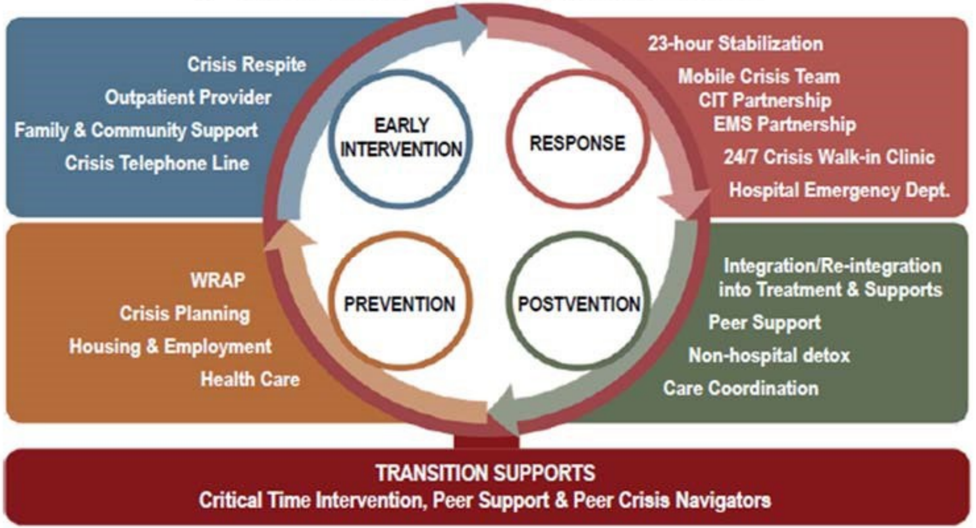
> "One thing that stands out as a treatment gap virtually everywhere in New Mexico is crisis triage … There has been some progress. But for most residents, behavioral health crisis support is only available via text or telephone or, on rare occasions, through presenting at a hospital emergency room."

San Juan County is in the beginning stages of building a BH crisis response system, as outlined in *SAMHSA's National Guidelines for Behavioral Health Crisis Care* and as depicted by the NM Human Services Department in the graphic below:



As indicated earlier in this document, NM designated the NM Crisis and Access Line (NMCAL) as the NM 988 Crisis Call Center on July 16, 2022. NM also has received a Centers for Medicare and Medicaid planning grant to establish Mobile Crisis Teams that will be largely paid for by Medicaid. Likewise, NM has licensing standards for CTCs and has a Medicaid payment mechanism currently in place for these facilities. San Juan Counties first major step is to establish a 23-hour Crisis Triage Center with recliners. This Business Plan is intended to be a roadmap to implement that 23-hour CTC with observation recliners that will offer 24/7 crisis care, dedicated law enforcement drop off, and fully integrated crisis response services for those with co-occurring MI and SUD. As this Business Plan has been developed, it has become increasingly clear that it would be advantageous if the planned CTC were built to also accommodate a crisis stabilization service with beds, for stays of to two weeks. There would also be significant economies of scale in operating both types of facility-based crisis services under one roof.

A depiction of SAMHSA's Continuum of Crisis Intervention Needs, which is more extensive than the NM graphic, is shown in the figure on the following page:



The point to be made here is that while the proposed CTC is a first step toward building San Juan County's crisis response system, it will by itself improve access for those in crisis, including under-served populations, and will increase diversion options. It will not, however, in and of itself, overcome the other identified system-wide issues, nor will it be able to sustain a "no wrong door" approach, without the full continuum of crisis-related services that are contained within the diagram above.

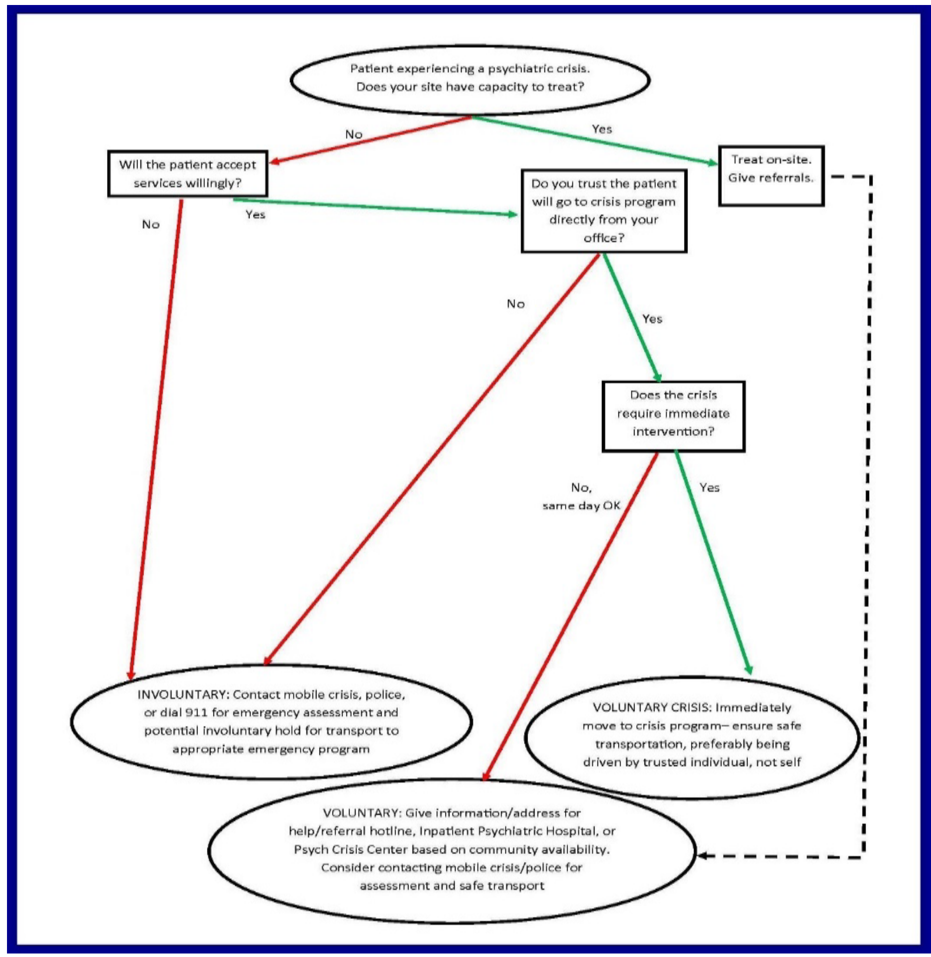
Simon, Beder and Manseau's report in the June 2018 edition of Psychiatric Times Journal identifies that "poverty is one of the most significant social determinants of health and mental health". There is likely a direct correlation between those seeking/receiving mental health emergency services and those living in poverty in San Juan County. In RI's experience, we would expect that as the CTC becomes operational and the overall crisis response system becomes further optimized, that there will be a disproportionate share of marginalized people in BH crisis care, but it is our contention that this should be viewed as a positive development. This increase in BIPOC participation in crisis care will be attributable to the fact that the barriers to BH crisis care access will increasingly cease to exist.

In addition, those most in need of crisis services will have immediate access to crisis care, via either call, text, or chat, intervention and support in their natural environments, or facility-based crisis services. With the CTC operating as the front door to facility-based crisis services, there will be no exclusionary criteria to deny crisis care; and with no medical clearance requirement in advance of admission, there will be no delays in accessing care. With the use of new technological tools, there will be meaningful care coordination resulting in better outcomes for those with BH conditions who also suffer health inequities. The proverbial revolving door dynamic of people repeatedly cycling through service systems will also end because of being supported and sustained in the community.

We now know that BH crisis intervention and stabilization, per se, is not a treatment service. When someone is experiencing a crisis, conducting a diagnostic assessment, and developing a treatment plan are inappropriate, but still required, and unwarranted in terms of addressing the immediate acute crisis need that is presented. Assessing imminent risk is, of course, key, but stabilizing a crisis is "a direct service

that assists with de-escalating the severity of a person's level of distress and/or need for urgent (or emergent) care, associated with a substance use or mental health disorder" (SAMHSA, 2014).

The figure below appears in *Understanding Crisis Services: What They Are and When to Access Them* (Zeller, 2020). Since a BH crisis can surface anywhere—in public, in the home or work environment, or in any number of clinical settings, this diagram focuses on the considerations when an apparent crisis arises when an individual is under a clinician's direct care. However, a similar process needs to be followed regardless of the setting within which the crisis occurs. Moreover, the process should be as safe, humane, expedient, easy to navigate, and accessible as possible; and without barriers associated with admission, eligibility, or authorization criteria or with an inability to pay.



With the implementation of the CTC and with the further optimization of the crisis response system, San Juan County and its residents will experience a crisis response system that is truly responsive by immediately responding to anyone, anywhere, and at any time who is experiencing a crisis. Nevertheless, as previously indicated, the CTC will be a key component of that system but will be dependent on an entire BH crisis response continuum of services. In particular, the initial 23-hour CTC will experience placement challenges, since approximately 30% of those admitted to the CTC will require a longer length of stay to sufficiently stabilize. Therefore, without simultaneously expanding the CTC to accommodate at least six (6) beds with stays extended for up to two weeks, the County will have no real placement options for

these individuals. This dynamic has the potential to force extended CTC stays beyond 23 hours, thereby forcing the CTC to go on diversionary status and be closed to additional admissions.

Facility-based Crisis Services

Since the Scope of Work for this project is specifically related to developing a CTC Business Plan, the next phase of analysis is focused on facility-based crisis services, beginning with a further delineation of why such facilities are so critical to communities in the U.S. and around the globe. Many individuals in crisis brought to hospital EDs for stabilization, report experiencing increased distress and worsening symptoms due to noise and crowding, limited privacy in the triage area, and being attended to by staff who had little experience with psychiatric disorders. All of this increases frustration and agitation (Clarke et al., 2007). Agar-Jacomb and Read (2009) found individuals who had received crisis services preferred going to a safe place, speaking with peers and trained professionals who could understand what they were experiencing, and interacting with people who offered respect and dignity to them as individuals, an experience they did not have at the hospital. In such an alternative setting, psychiatric crises could be de-escalated.

In its review of crisis services, SAMHSA (2014) defined crisis stabilization as:

> "A direct service that assists with de-escalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness.

Facility-based crisis services are usually provided in relatively small structures. The exception to this is when an entire spectrum of crisis services is provided under one roof. Often these facilities are more home-like than institutional. They are staffed with a mix of professionals and paraprofessionals. They may operate as part of a community mental health center, in affiliation with a hospital, or a stand-alone facility

operating by a non-profit provider organization. Crisis stabilization facilities function best when the facilities:

- Function as an integral part of a regional crisis system serving a whole population, rather than as an offering of a single provider.
- Operate in a home-like environment.
- Utilize peers as integral staff members.
- Have 24/7 access to psychiatrists and/or Master's-level BH clinicians.

In general, the evidence suggests a high proportion of people in crisis, who are evaluated for hospitalization, can safely be cared for in a crisis response facility, the outcomes for these individuals are at least as good as hospital care, and the cost of crisis care is substantially less than the costs of inpatient care. SAMHSA (2014) summarized the evidence on crisis stabilization facilities as follows:

> "The current literature generally supports that crisis residential care is as effective as other longer psychiatric inpatient care at improving symptoms and functioning. It also demonstrates that the satisfaction of these services is strong, and the overall costs for residential crisis services are less than traditional inpatient care. For the studies examined in this review, the populations range from late adolescence (aged 16 to 18 years) through adulthood. Regarding mental health and crisis residential, a recent systematic review examined the effectiveness of residential alternatives to hospital inpatient services for acute psychiatric conditions (Lloyd-Evans, et al., 2009). This review included randomized control trials or studies that provided specific quantitative comparisons of effectiveness of alternatives to standard acute inpatient care. The authors concluded that there is preliminary evidence to suggest residential alternatives may be as effective as and potentially less costly than standard inpatient units."

Home-like crisis facilities are a necessary core element of a crisis system of care. To maximize their usefulness, crisis facilities should function as part of an integrated crisis response system within the county. Access to the program should be facilitated through the Care Traffic Control Hub, which monitors the trajectory of crises throughout the service area. In this way, those that ultimately need the benefits associated with facility-based care can readily access it. Access is also readily available to first responders, such as law enforcement and EMS.

Safety, for both guests and staff, is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality, an issue with life and death consequences. Moreover, while ensuring safety for people using crisis services is paramount, the safety for staff cannot be compromised. People in crisis may have experienced violence or acted in violent ways, they may be intoxicated or delusional, and/or they may have been brought in by law enforcement, and thus may present at the facility at an elevated risk for violence. Trauma-informed and recovery-oriented care is safe care. Nevertheless, much more than philosophy is involved. It is understood that NM has addressed this issue by setting new parameters for crisis response services that are flexible and delivered in the least restrictive available setting while attending to intervention, de-escalation, and stabilization. The keys to safety and security in crisis response facilities include:

- Evidence-based crisis training for all staff.

- Role-specific staff training and appropriate staffing ratios to number of guests being served.
- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas “fishbowl” observation rooms and keypad-locked doors. This space must also be ligature resistant and contain safe rooms for people for whom violence may be imminent or find the common areas overly stimulating.
- Established policies and procedures emphasizing “no force first” prior to implementation of safe physical restraint or seclusion procedures.
- Pre-established criteria for crisis system entry.
- Strong relationships with law enforcement and first responders.

Ongoing staff training is critical for maintaining both staff competence and confidence and promotes improved outcomes for persons served and decreased risk for staff (Technical Assistance Collaborative, 2005). Nationally recognized best practices in crisis intervention such as CPI (Crisis Prevention Institute, Nonviolent Crisis Intervention Training) and Therapeutic Options (Therapeutic Options, Inc.) are highly effective and instrumental in their utilization of positive practices to minimize the need for physical interventions and re-traumatization of persons in crisis. RI has adopted Ukeru and SafeClinch to assure the safety of both staff and those admitted to crisis care, whom RI refers to as, “guests.”

Adequate staffing for the number and clinical needs of consumers under care is foundational to safety. Access to enough qualified staff (clinicians, nurses, providers, peer support professionals) promotes timely crisis intervention and risk management for persons in crisis who are potentially dangerous to self or others (DHHS, 2006).

If a CTC is to operate under a “no wrong door” approach, it is imperative that it be able to accommodate involuntary admissions, which is now permissible under NM statute and DOH regulations. Though some practitioners view physical and/or pharmacological restraint and seclusion as safe interventions, they are often associated with increased injury to both guests and staff; and often end up re-traumatizing individuals who have experienced physical and emotional trauma. Therefore, as indicated earlier in this document, restraint and seclusion are now considered safety measures of last resort, not to be used as a threat or act of punishment, alternative to staffing shortages or inadequacies, as a technique for behavior management, or a substitute for active treatment (Technical Assistance Collaborative, 2005).

The National Association of State Mental Health Program Directors (NASMHPD) (2006) has postulated a set of core strategies for mitigating the use of seclusion and restraint. These include employing BH leadership that sets seclusion and restraint reduction as a goal, oversight of all seclusion/restraint for performance improvement, and staff development and training in crisis intervention and de-escalation techniques.

Person-centered approaches and the use of assessment instruments to identify risk for violence are also critical in developing de-escalation and safety plans. Other recommendations include collaborating with the guest and his or her family in service planning, as well as debriefing staff and guests after a seclusion/restraint event, to inform policies, procedures, and practices to reduce the probability of repeat episodes that result in the use of such interventions. In the crisis response facilities that RI operates, every episode of seclusion and restraint is considered a treatment failure and therefore requires not only a debriefing, but intense scrutiny as a sentinel event. A sentinel event is typically a patient safety event that results in death, permanent harm, or severe temporary harm. While seclusion and restraint episodes do

not often result in death, seclusion and restraint are debilitating to both guests and practitioners involved in the event and can result in permanent harm.

Ensuring the safety of both guests and staff is the very foundation of effective crisis care. While safety is urgently important in all health care, in crisis care, maintaining a safe and welcoming environment is essential. The prominence and damaging effects of trauma and the fear that usually accompanies psychological crisis make safety truly "Job One" in all crisis settings.

Ashcraft (2006) and Heyland et al. (2013) describe an alternative crisis setting called "the living room," which uses the recovery model to support an individual's stabilization and return to active participation in the community. RI is the originator of this model. Key elements include a welcoming and accepting environment, which conveys hope, empowerment, choice, and higher purpose. Individuals in crisis are admitted as "guests" into a pleasant, home-like environment designed to promote a sense of safety and privacy. A team of "crisis competent" professionals, including peers with lived experience, engage with the guest. Risk assessment and management, treatment planning, and discharge goals are set. A peer support worker is assigned to each guest to discuss the guest's strengths and coping skills that can be used to reduce distress and empower the guest on his or her recovery journey.

Preferably, these facilities are available for direct drop-off by law enforcement and/or EMS. Since the last Legislative Session, this practice is now allowable in NM. This advanced practice can avoid the criminalization of crisis-induced behavior; and the associated costs and trauma resulting from hospitalization and/or incarceration. If it is determined, a guest continues to pose a safety threat to self or others, he or she may be subject to seclusion and restraint, but only as a last resort. Rarely, is a guest transferred to a more intensive level of care. Likewise, upon medical screening, roughly 4% on average require a medical transfer, which the facility manages with the expectation that the guest return upon the completion of medical intervention.

"No Wrong Door," has become the motto for these facilities since everyone that presents, whether a walk-in or a police drop-off, whether actively psychotic, violent on methamphetamines, or suicidal, is admitted. There is no need for medical clearance to be accepted. There is no "diversion," which seems to be a common practice among the EDs in many communities, when their respective capacities have been overwhelmed, often by BH crises. In addition, law enforcement is not called back to the facility after drop-off because the facility has been unsuccessful at de-escalation. The entire milieu of the facility is designed to assure that guests and staff are kept safe. This extends from the design of the facility, the staffing ratio, the teamwork culture, and the use of "milieu specialists" who are "bulked-up" peers who engage guests who are being challenged with self-regulation. They serve as an alternative to security guards whose mere presence can escalate situations.

The average length of stay of a CTC is only seven to ten (7-10) hours in an optimized crisis response system. Initially, it is anticipated to be at least ten to twelve hours (10-12) for San Juan County. This is again possible because of the milieu and the culture of this "living room" approach. The CTC has no beds, but recliners instead; and they are arranged to facilitate interaction with other guests and with staff. With seven (7) recliners instead of beds, the CTC is a high-speed assessment, observation, engagement, and stabilization service.

Each guest admitted receives the following services: a psychiatric evaluation by a Licensed Psychiatrist or Psychiatric Nurse Practitioner that includes a risk assessment and medication evaluation; a brief medical screening by a registered nurse to ensure that co-occurring medical issues are addressed; Substance Use Disorder (SUD) screening and Assessment by a licensed clinician; a psychosocial assessment by a licensed clinician; crisis stabilization services utilizing a high engagement environment with a strong recovery focus and peer support model; and a comprehensive discharge and coordination of care planning. Effective August 3, 2023, DHI issued an emergency amendment to 7.30.13 NMAC, Section 7, 9, and 29. Under Section 29 A. (3), CTCs offering 23 hours or less non-residential services; may have onsite medical professionals who have access to immediate support and supervision by an RN or a higher-level provider in accordance with Section 24-25-1 et al. NMSA 1978 New Mexico Telehealth Act.

Often within the same facility as the 24/7 CTC, a CTC with beds (also known as a CTC under NM licensure and allowable under the same roof) is a home-like environment that addresses BH crises in a community-based BH provider setting or in some instances, affiliated and operated by a hospital. These are bedded units and such a facility in San Juan County should accommodate at least six (6) beds that would be staffed by licensed and unlicensed peer support specialists, as well as clinical and non-clinical professionals. (SAMHSA, 2014; Mukherjee & Saxon, 2017). Services typically consist of assessment, diagnosis, abbreviated treatment planning, observation and engagement, support, individual and group therapy, skills training, prescribing, and monitoring of PRN 776psychotropic medications, referral, and linkage to community resources. Services are provided on a 24/7 basis to address immediate safety needs, to develop resiliency, and to create a plan to address the cyclical nature of BH challenges.

The National Alliance for Suicide Prevention (2016) considers Crisis Stabilization Centers to be a “core element” of BH crisis systems. Different from the Living Room Model and the 24/7 CTC, this type of CTC offers services to individuals who are unable to be stabilized in under 23 hours and whose conditions may be exacerbated by co-morbidity and complex social needs. In RI’s experience, these CTCs have an ALOS of 2-3 days, but stays of 5-7 days is probably the norm. This service is currently not available in San Juan County, but since the County plans on pursuing new construction for a 24/7 CTC, it would be wise to build this facility to accommodate future expansion and the addition of beds for stays of up to two weeks.

Many communities have only two basic options available to those in crisis, and they represent the lowest and highest end of the continuum: outpatient versus inpatient treatment. However, for those individuals who can best benefit from crisis care, outpatient services lack the intensity to meet their needs and inpatient psychiatric services tend to be too restrictive and overly clinically focused. The focus instead of crisis care should be on determining with the guest, what precipitated the crisis and how to best return this individual to his or her baseline functioning in the community. CTCs offer an alternative that is less costly, less intrusive, designed to feel like home, and reliant on peers for meaningful engagement.

Conclusions and Recommendations

Conclusions and Recommendations

Below is a summary of the recommendations for this Business Plan. For a full explanation of the conclusions and the recommendations that flow from those conclusions, please refer to the complete Business Plan. Each recommendation within the Plan has been organized within the context of the *Crisis Now* model and SAMHSA's *National Guidelines for Behavioral Health Crisis Care* balanced against the needs and the strengths of the County. In addition, each recommendation, when appropriate, includes specific policy and operational details and resources.

1. Crisis Response System Accountability

Establish a dedicated organizational entity within the San Juan County Department of Community Health and Social Services to be responsible and accountable for the oversight, resourcing, and administration of the County's behavioral health (BH) crisis response system.

Without a clear designation of authority, the responsibility for leadership for BH crisis services becomes diffuse, making it difficult for any one entity to be held accountable for the implementation and management of a crisis system with high fidelity to SAMHSA's *National Guidelines for Behavioral Health Crisis Care.* This need becomes critical to facilitating the planning, financing, and monitoring of BH crisis service adequacy and quality is relevant to the local community.

2. Crisis Response System Design

Design the San Juan County behavioral health crisis response system to optimize over time the client flow throughout the crisis care continuum.

The system, as it is implemented, should consistently provide immediate access to care.

- Do not require medical clearance prior to admission into the CTC and any facility-based crisis services.
- Place the responsibility, on these same crisis facilities, for the placement of and transport to, an appropriate higher level of care when appropriate.
- Designate the Crisis Triage Center (CTC) as the "no wrong door" to crisis care.

3. Performance Expectations and Metrics

Establish performance expectations and metrics for each component of the crisis response system and the data systems to collect information necessary to manage, analyze, and report on the performance of each component and the system.

SAMHSA published in 2020 a *Crisis Service Best Practice Fidelity Review Tool*. The Fidelity Review Tool is designed to assist in the implementation of essential crisis service elements, and to assist with the delineation of performance expectations. This will be an important

resource to San Juan County for establishing performance metrics for the CTC and the other components of the crisis response system.

23-hour CTCs should be expected to:

a. Accept all referrals without pre-screening.
b. Not require medical clearance prior to admission but assess for and support medical stability while in the CTC.
c. Design CTC services to address BH-related crisis issues.
d. Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges.
e. Staff (24/7/365) with a multi-disciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including:
    i. Psychiatrists or psychiatric nurse practitioners (telehealth may be used)
    ii. Nurses
    iii. Licensed and/or credential clinicians capable of completing assessments.
    iv. Peers with lived experience like those of the population served.
f. Offer walk-ins and dedicated first responder drop-off area.
g. Be structured in a manner that offers capacity to accept all referrals at least 90% of the time, with a no reject policy for first responders.
h. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated.
i. Function as a 23 hour or less stay crisis receiving and stabilization facility.
j. Incorporate some form of intensive stabilization beds into a partner program (could be within the same CTC or another facility) to support the flow for individuals who need additional stabilization services and supports.
k. Include beds within the real-time regional bed registry system to support efficient connection to needed resources.
l. Coordinate connection to ongoing care utilizing Synchronys, NM's HIE.

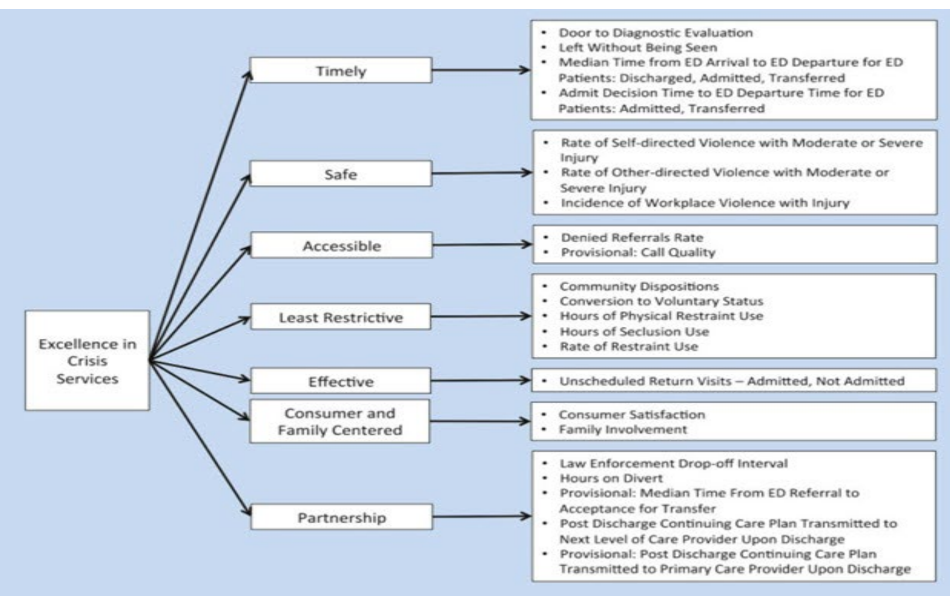
In addition to monitoring fidelity to the *Crisis Service Best Practice Standards*, funders, system administrators and crisis service providers should continuously evaluate performance with shared data systems. System transparency and the regular monitoring of key performance indicators support continuous quality improvement. It is highly recommended that the crisis response system applies shared systems that offer real-time views of agreed-upon system and provider-level dashboards that can also be used to support alternative payment reimbursement approaches that focus on value. Performance metrics should include the following:

- **23 Hour Crisis Triage Center:**
    - Number served (could be per recliner daily).
    - Percentage of referrals accepted (should be 100%).
    - Percentage of referrals from law enforcement (should be substantial to serve as hospital and jail diversion).
    - Law enforcement drop-off time (should be under 5 minutes).
    - Percentage of referrals from all first responders.
    - Average length of stay (throughput matters – allows for increased capacity within a limited resource).

- The percentage of discharges to the community (target high percentage of crises resolved with a transition home).
- The percentage of involuntary commitment referrals converted to voluntary (this is 75% in Maricopa County).
- The percentage that was not referred to the emergency department for medical issues/assessment (should target over 95% to divert from ED costs and boarding).
- Readmission rate.
- The percentage completing an outpatient follow-up visit after discharge.
- The total cost of care for crisis episode.
- Guest service satisfaction levels.
- The percentage of individuals reporting improvement in ability to manage future crises.

For further guidance on developing a framework for developing crisis performance, see Dr. Margie Balfour's journal article, *"Crisis Reliability Indicators Supporting Emergency Services (CRISES): A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatric Emergency Programs,"* Community Mental Health Journal, 2015, (available at: https://www.ncbi.nlm.nih.gov/pubmed/26420672) which includes the outcomes model below:

Crisis Reliability Indicators Supporting Emergency Services Framework



4. Address Policy, Regulatory, and Administrative Barriers

Advocate for the elimination of barriers that will potentially impede San Juan County's efforts to optimize its BH Crisis Response System, to include:

- Enforcement of Parity Laws by the NM Superintendent of Insurance, requiring NM's commercial health insurers to pay for BH crisis response as these health insurance plans do for emergency medical response. This should not be the continued responsibility of NM taxpayers to assume crisis care costs for enrollees with commercial health insurance.

- Continued payment of crisis response services by the Single State Behavioral Health Authority, the Behavioral Health Services Division (BHSD) of the NM Department of Human Services, for those who remain uninsured.
- The passage of legislation by the NM Legislature to enact a phone surcharge to provide sustainable funding for NM's 988 crisis response services as authorized by The National Suicide Designation Act of 2020.
- A requirement by BHSD, that all funded service providers, update in real time, NM's https://www.treatmentconnection.com/ so that immediate access can be made to BH services in San Juan County and statewide.

5. Crisis Triage Center (CTC) Startup and Operational Costs

Plan for the provision of financial support associated with the CTC site acquisition, and its construction, along with equipment, start-up and operating costs.

Without financial support for construction, equipment, and start-up costs associated with the establishment of the proposed CTC, it will be very challenging for providers to stand up these facilities. Most providers do not have the assets necessary to assume these costs and therefore, without capital and initial financial operating assistance, these facilities will most likely not be established. Therefore, San Juan County, private foundations, and local health systems should collaborate and explore all available financing options to support the capital and initial operating costs to standup this new facility.

Some states, like NM, have capital allocations available for constructing and equipping facilities that serve to benefit the well-being of residents. The method for accessing such funds is variable and often competitive. At the local level, where county and/or city governments have levy authority, dedicated measures have been passed to better meet local BH needs, including the construction of new facilities. Often these funds have been intended to overcome local gaps in services and to fund services and programs that are not funded by Medicaid. The County is urged to seek similar financing measures.

Some counties pass specific measures with allocations to provide social safety net funding to support the uninsured and to cover the cost associated with needs that are not included in health care benefits, including Medicaid. The method for accessing such funds is also variable and often competitive. At the local level, where jurisdictions have levy authority, dedicated measures have been passed to better meet local BH needs. Often these funds have been intended to overcome local gaps in services and to fund services and programs that are not funded by Medicaid. The capital, startup, and ramp up costs for establishing the CTC are delineated in the CTC implementation section, which follows.

6. Crisis Triage Center (CTC) Implementation

Establish and sustain an adult CTC with seven (7) recliners, instead of beds, to maximize capacity flexibility, client flow, and an environment that is conducive to meaningful engagement.

The CTC will operate 24/7, with stays of up to 23 hours and it will provide high acuity care under the "no wrong door" approach, admitting all those who present, whether voluntarily or involuntarily, to include those needing detoxification services or those with intellectual or developmental disabilities; and without requiring medical clearance in advance of admission. This facility will be accepting individuals into crisis care who have the same acuity level as those who commonly present to "psychiatric emergency departments," and accept a large percentage of its anticipated 7,085 admissions annually, as diversions from arrest and detention; and from emergency departments and psychiatric hospitalizations. As a result, the CTC will require a multi-disciplinary staff to include medical staff, behavioral health clinicians, and peer support specialists. It also requires a high staffing ratio to ensure clinically appropriate crisis care, while maintaining safety for both guests and staff. RI used its Crisis Resource Need Calculator to project the staffing capacity needs of the CTC and the entire crisis response system.

The innovative Crisis Resource Need Calculator offers an estimate of optimal crisis system resource allocations to meet the needs of the community. It also calculates the impact on healthcare costs associated with the incorporation of those resources. The calculator analyzes several data elements that includes population size, average length of stay in various system beds, escalation rates into higher levels of care, readmission rates, bed occupancy rates, and local costs for those resources. In communities in which these resources do not currently exist, figures from comparable communities can be used to support planning purposes.

The calculations are based on data gathered from several states and the *Crisis Now Business Case* that explains the rationale behind the model. A video can be seen on NASMHPD's web portal www.crisisnow.com, which delineates this methodology. Quality and availability of outpatient services also influences demand for a crisis response system so the Crisis Resource Need Calculator should be viewed as a guide in the design process. A valid assessment of system adequacy must include a look at the overall functioning of the existing system. Signs of insufficient resources will include, but are not limited to, psychiatric boarding in EDs and incarceration for misdemeanor offenses when connection to urgent care is the preferred intervention. The calculator's algorithms are built in part on an analysis of the distribution scores on over one million Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) score assignments.

The Crisis Resource Need Calculator demonstrates the cost savings that can be realized by implementing mobile crisis and facility-based crisis services within a given community. Using the calculator, the population for San Juan County for 2023 was estimated to be 125,043. The algorithms built into the Calculator will indicate that those with LOCUS level scores of five (5), 68% of them would be expected to be referred to inpatient care. The Calculator has also projected the number of psychiatric beds that would be needed, based on the inpatient ALOS of 7.5 for the County.

The average per diem inpatient rate of $1,464 for San Juan County was also included in the calculations which tabulates as a total inpatient spend. After applying an ED cost for the area per admission to an inpatient bed (medical clearance and assessment), the total estimated cost escalates further. For the 32% of individuals with LOCUS levels scores of 1-4, no cost or service is included in the calculations, since it is unlikely that any actual cost would be incurred. When facility-based crisis services are included in optimal ratios, total costs drop in the projections. This is despite engaging the entire appropriate LOCUS scored individuals.

This means that the more individuals who are served with programs that align better to their unique level of clinical need, will result in lowered costs by a calculated percentage. Additionally, alignment of clinical level need to the service delivered improves from a low of 14% to as high as 100% in an optimized crisis response system under the *National Guidelines*.

The algorithm also utilizes key crisis performance indicators from current community crisis response providers to predict the capacity needed to serve the expected number of crisis events that a community would experience over the course of a year. In utilizing this algorithm for San Juan County, it is important to note that not all used data points came from current service providers, since the County currently does not offer certain services whose data points could be used to inform the model. In these cases, the consultants used data points from high functioning crisis programs as a proxy. The final set of Calculator results for San Juan County appear in Appendix D, entitled San Juan County Crisis System Needs Analysis.

The Calculator projects that San Juan County can expect 5,200 BH crisis episodes per year. Out of these, 2,200 CTC admissions would be expected annually, if the CTC operates under "no wrong door," and accepts voluntary and involuntary admissions. In this scenario, the CTC would need seven (7) recliners. For construction purposes, the County should plan to construct a facility that at a minimum can accommodate ten (10) recliners. There are other relevant Calculator projections for County planning purposes that can be applied to the crisis response system but only those that are relevant to establishing the CTC have been elaborated upon here.

As indicated earlier, the Calculator projects that 8,555 people will be served in the CTC annually. 7,085 of these will be a mix of first responder drop-offs and community and self-referrals.

7. Community Collaborations

Continue to hone and establish community collaborations for the success of referral streams, resources for discharge, and overall positive regard for services.

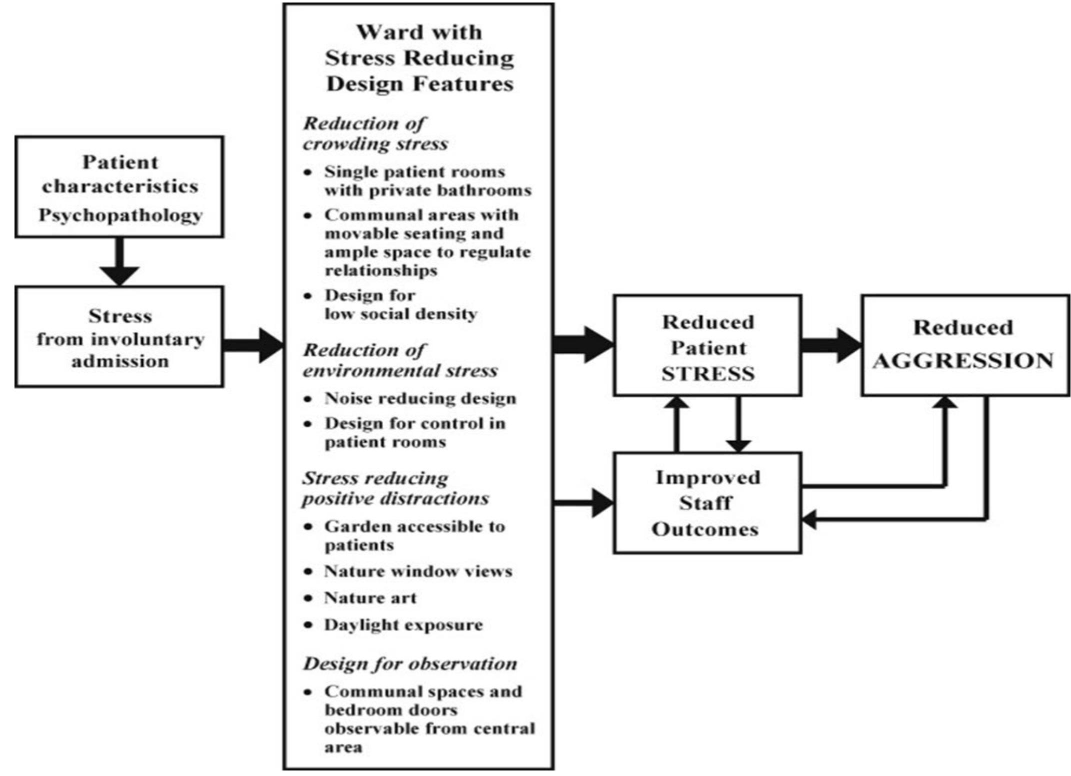
Robust community collaborations are vital for the success and sustainability of the crisis facility growth initiative in San Juan County. The established partnership with San Juan Regional Medical Center and their inpatient unit has already paved the way for a coordinated approach to crisis care, aligning resources and expertise. By fostering additional collaborations with local organizations, civic groups, and stakeholders, the program can further strengthen its reach, enhance service delivery, and ensure a comprehensive support system for individuals in crisis situations.

Facility Planning

While BH facilities have some of the same general needs as other medical facilities, they also require planning to assess and address their specialty needs. That is more valid now than ever, since we are moving toward more person-centered approaches to BH treatment and support. A controlled research project on a design conceptual model proposed that aggression in psychiatric facilities can be reduced by designing the physical environment with ten evidence-

based stress-reducing features. The model was first tested in a newer psychiatric hospital in Sweden. Data, on two clinical markers of aggressive behavior, compulsory injections and physical restraints, was subsequently compared with data from an older facility that had only one stress-reducing feature. Another hospital, with one feature which did not change during the study period, served as a control.

The proportion of patients requiring injections as a chemical restraint declined ($p < 0.0027$) in the new hospital compared to the old facility but did not change in the control hospital. Among patients who received such injections, the average number of injections declined marginally in the new hospital compared to the old facility but increased in the control hospital by 19%. The average number of physical restraints (among patients who received at least one) decreased 50% in the new hospital compared to the old. These findings suggest that designing better psychiatric buildings using well-reasoned theory and the best available evidence can reduce the major client and staff safety threat posed by aggressive behavior (Ulrich, 2018). These findings are portrayed in the diagram below:



The design elements, that were determined in this study to reduce violent behavior, are consistent with the principles of the *National Guidelines*, and are featured below:

- Single patient rooms with private bathrooms, which require patients to be continuously monitored, however, in the case of CTC, an open floor plan is optimal.
- Communal areas with movable seating, (but incapable of being weaponized) and ample space for building relationships.
- Design for low social density.
- Reduction of environmental stress.

- Noise reducing design.
- Design to foster personalization and control in patient rooms.
- Stress reducing positive distractions.
- Garden accessible to patients.
- Nature window views.
- Nature art.
- Daylight exposure.
- Design for observation of and engagement with patients.
- Good visibility of communal areas.

However, when it comes to facility standards for the CTC, RI follows those of The Joint Commission. When planning for new, altered, or renovated space, the applicable standard is EC.02.06.05. The Joint Commission expects organizations to assess building design and construction requirements based on local, state, and federal regulations and codes. The NM controlling authority for this issue is the Department of Health (DOH), Division of Health Improvement (DHI). When DHI is silent on a particular design criterion, The Joint Commission recognizes the 2022 Facility Guidelines Institute (FGI) Guidelines for Design and Construction of Hospitals for new construction and renovation.

FGI allows requirements at the time of construction to be used, so the edition of the FGI applicable at the time of construction would be used for existing construction. If the current requirements are stricter than the building codes at the time of construction, The Joint Commission would expect the organization to perform a gap analysis to validate that adequate patient and staff safety, and process integrity can be maintained. The Guidelines are available for purchase at: https://shop.fgiguidelines.org/products/list

San Juan County CTC will have space requirements of approximately 8,275 square feet. It will need to be a relatively open floor plan with no hallways to accommodate up to seven recliners (7) recliners, six (6) beds, an institutional kitchen, and an eating area. Additionally, the following spaces would need to be designed and incorporated into the building plans:

- 3 intake rooms
- 1 small lobby and reception space
- 2 quiet rooms
- 2 seclusion and restraint rooms
- 1 sally port
- Eating area and food storage
- 3 dayroom restrooms
- 1 sally port restroom
- 1 staff breakroom with staff lockers
- 1-2 family visitation areas
- 2-3 multi-purpose conference/training rooms
- 2-3 consultation rooms
- 1 nursing station/medication dispensary with sink, refrigeration, and OmniCell pharmacy unit
- IT closet

- Janitorial closet with roof access
- 3-4 staff offices
- Ample space to accommodate multiple washers and dryers
- Storage space for guest belongings and clothes pantry

The CTC building plans should be of professional quality, prepared and stamped by a licensed architect. The following plans are typical of the minimum required for all facilities in new construction:

- Site plan: showing the location of the building on a site/plot plan to determine surrounding conditions, driveways, all walks and steps, ramps, parking areas, handicapped and emergency vehicle spaces, accessible route to the main entrance, secure yard for clients, any permanent structures, including notes on construction materials used.
- Life safety and code compliance plan: noting applicable code requirements and compliance data, locations of rated firewalls, smoke partitions (if any), exit paths & distances, fire extinguishers locations. The design of the CTC should be to the specifications of a secure psychiatric facility and include anti-ligature features throughout.
- Floor plans: showing location use of each room and all other pertinent explanatory information addressing the requirements in applicable regulations.
- Dimensioned floor plan: showing all exterior and interior dimensions of all rooms, spaces, and corridors, etc.
- Exterior building elevations: noting all building heights, locations of exterior doors, and any operable and fixed windows (sill heights).
- Building and wall sections: showing at least one building or wall section showing an exterior and interior wall construction section including the material composition of the floor, walls, and ceiling/roof construction.
- Schedule sheets: room finish: noting all room finishes, (e.g., carpet, tile, gypsum board with paint, etc.); door schedule; noting door sizes/thickness, door types & ratings; window schedule, noting sizes, type and operation; skylight schedule, noting size, type.
- Special systems plan: location of fire extinguishers, heat and smoke detectors, nurse call systems, and operational elements of alarm system.
- Mechanical plans: noting location of heating units, furnaces, hot water heaters, and fuel type and source; all heating, ventilating and air conditioning/cooling systems including locations of fire dampers.
- Plumbing plan: noting all plumbing fixture locations, fixture types.
- Electrical plan: noting power and lighting layouts, exit lighting, emergency lighting fixtures, emergency power systems (if any), electrical panel information.
- Other plans: As necessary (i.e. phasing plan) to describe compliance with the other requirements in applicable regulations.

Site Selection

In meeting with San Juan County leadership, the RI consultant team learned that the County does own vacant real estate upon which the CTC could be built. Prime among the criteria for potential site selection is that it would have to be in the central area of Farmington and in proximity to other service providers and major highways, to facilitate referrals and responder drop-offs to the CTC. It should also be near public transportation to facilitate walk-ins into the CTC.

Project Management

The selected CTC management entity should be expected to present a project plan that clearly explains how it will manage and control all proposed implementation activities including timelines. It should explain how the management and administrative processes function to ensure that the appropriate levels of supervision are provided to monitor and oversee all proposed activities and the resulting timetable. When a provider organization is awarded a contract by the County to operate the CTC, it should forge a project implementation team. This team should be comprised of members that are representative of functional areas across the organization. This approach offers several benefits by focusing on integrating, aligning, and linking processes and organizational functions effectively to achieve the planned goals and objectives for the opening and ongoing operations of the CTC.

Collaborating with the County, at the outset to pinpoint the necessary requirements to implement the project correctly the first time will have a positive domino effect, with bottom line impact. The resulting deliverables will include a more efficient requirement gathering process, fewer plan modifications, improved staging of project milestones, heads-up planning that minimizes risk, and ultimately, timely project implementation. This will ensure that all work is properly performed, and that all milestones are met as proposed.

The CTC Statutory and Regulatory Environment

Over almost the last decade, NM has established a solid foundation upon which a CTC can operational and sustainable. The major milestones that have been achieved over that time span include:

- On January 1, 2014, NM launched Centennial Care, which expanded Medicaid and integrated behavioral health care into a new managed care benefit plan. Studies have subsequently shown that Medicaid expansion resulted in significant coverage gains and reductions in uninsured rates among the low-income population broadly and within specific vulnerable populations. This has meant that previously ineligible single adult males whose incomes follow below the federal poverty level, had health insurance coverage with the federal government paying 90% of the cost. This expansion allowed for the potential that those in need of BH crisis response services would have the health care coverage necessary to pay for such services.
- In 2017, the NM Legislature passed a bill authorizing the NM Department of Health (DOH) to promulgate licensing standards for residential CTCs. This Legislation was

amended in the following session, to include the licensing of CTCs with a 23-hour outpatient stabilization service.

- In 2018, the NM Behavioral Health Services Division (BHSD) and Medical Assistance Division (MAD) collaborated to increase reimbursement rates for a variety of BH services to incentivize building further intensive community based BH services such as Assertive Community Treatment (ACT) and Comprehensive Community Support Services (CCSS). This initiative has had the potential to implement crisis adjacent services, to become part of a more comprehensive crisis response system.
- Also in 2018, the state's MAD applied for and received a Medicaid 1115 Waiver from the Centers for Medicare and Medicaid Services (CMS) to allow for CTCs to become a benefit under Centennial Care, thereby allowing Medicaid to pay for the services rendered by a CTC.
- In 2019, Medicaid recognized the different types of CTCs as facility types and provided for an actuarially determined cost-based bundled payment mechanism for CTC services.
- In the 2023 Legislative Session, SB 310 was enacted which gave CTCs the authority to accept those on an involuntary status for admission and gave law enforcement the authority to transport individuals in crisis to a CTC.
- Effective August 3, 2023, DHI issued an emergency amendment to 7.30.13 NMAC, Section 7, 9, and 29 to comply with the new CTC provisions within SB 310. Under Section 29 A. (3), CTCs offering 23 hours or less non-residential services; may have onsite medical professionals who have access to immediate support and supervision by an RN or a higher-level provider in accordance with Section 24-25-1 et al. NMSA 1978 New Mexico Telehealth Act.

These NM policy developments make building a CTC not only possible, but once established also sustainable. Therefore, developing a comprehensive crisis response system that aligns with the best-practice *Crisis Now* and the *National Guidelines,* that includes the operation of a CTC is critical. The County is well positioned to provide better care for people with serious mental illness, substance use disorders, and intellectual and developmental disorders while improving health outcomes and realizing a positive return on investment.

Licensing and Application

Section 7.30.13 of the New Mexico Administrative Code (NMAC) under the NM Department of Health (DOH) specifies the licensure standards for Crisis Triage Centers. NMAC 7.30.13.6 outlines the objectives for this service:

- To establish minimum standards for licensing crisis triage centers that provide quality crisis stabilization services outside of a hospital setting.
- To ensure the provision of quality services which maintain or improve the health and quality of life to the clients.
- To monitor compliance under these regulations through surveys and to identify any facility areas which could be dangerous or harmful.

Under NMAC 7.30.13.9A. It stipulates that the licensure regulations apply to crisis triage centers (CTC) which are health facilities offering youth and adult outpatient and residential care services. A CTC provides stabilization of BH crises as outpatient stabilization or short-term residential stabilization in a residential rather than institutional setting, which may provide an alternative to hospitalization or incarceration. The CTC services may vary in array of services offered to meet the specific needs of different communities in NM. A CTC may provide limited detoxification services, but the CTC is differentiated from a detoxification center, because it is prohibited from treating individuals who require treatment beyond Level III.7-D: Medically Monitored Inpatient Detoxification. The CTC provides emergency BH triage and evaluation, and on a voluntary or involuntary basis. The CTC may serve individuals 14 years of age or older who meet admission criteria. The CTC offers services to manage individuals at high risk of suicide or intentional self-harm. The CTC is prohibited from refusing service to any individual who meets criteria for services.

The recognized type of CTC services relevant to this Business Plan is under NMAC 3.30.13.9B and is designated as a CTC structured for less than 23-hour stays providing only outpatient withdrawal management or other stabilization services. Under Item C., this section sets limitations on scope of services for an OP CTC as follows:

- The CTC will not provide detoxification services beyond Level III.7-D: Medically Monitored Inpatient Detoxification services.
- The CTC will not provide medical care not related to crisis triage intervention services beyond basic medical care of first aid and CPR.
- The CTC will not provide ongoing outpatient BH treatment.
- The CTC will not exceed the capacity for which the CTC is licensed.

The CTC management entity should seek to gain a temporary license which the licensing authority may, at its sole discretion, issue prior to the initial survey, or when the licensing authority finds partial compliance with these regulations. This can occur before clients are admitted, provided that the CTC has:

- Submitted a license application, with required supporting documents.
- Met all of the applicable life safety code requirements.
- Had its program, policies, and procedures reviewed and approved for compliance with the licensure regulations.

The issuance of a temporary license will allow the CTC to accept admissions and provide services within three months of the execution of a contract with the CTC management entity. The temporary license cannot exceed 120 days, during which time the CTC will have to correct any specified deficiencies and subsequently gain full licensure. The temporary license is contingent upon a finding that the applicant is qualified and in full compliance with life and safety code requirements; and upon an applicant’s statement that it is qualified and in full compliance with the licensure regulations and has requested an initial health survey from the licensing authority.

The first step in applying to DHI for CTC licensure requires the submission of a letter of intent (LOI) to open a CTC. The LOI must be submitted on letterhead and endorsed, by a person with authority to make legal decisions on behalf of the CTC. At a minimum, this LOI must include the following:

1. Name of CTC.
2. Name of the legal owner and the licensee and the type of legal entity under which the CTC is owned.
3. Name of the management company, if any.
4. Type of facility license requested.
5. Name and resume of the proposed administrator.
6. Anticipated number of residential and non-residential clients to be served.
7. Intended population and age range of the clients to be served.
8. Number of residential beds in the proposed CTC.
9. Physical address of CTC including building name or suite number.
10. Mailing address, if different from physical address.
11. Applicant's contact name(s), address, e-mail address, and telephone number(s).
12. Anticipated payers and sources of reimbursement.
13. List of all services intended to for provision at the CTC location that is requesting the license.

After a review by DHI of the LOI for general compliance with these regulations and verification that an application is appropriate under these regulations, the CTC management entity will be required to complete the CTC license application. It must be fully completed, dated, signed, and notarized accompanied by the required licensure fee. DOH reserves the right to require additional documentation to verify the identity of the applicant to verify whether any federal or state exclusions may apply. The CTC must also attach to the application a set of building plans that includes all the information required by these rules, accompanied by proof of zoning approvals by the applicable building authority.

The CTC building plans must be of professional quality, prepared and stamped by an Architect licensed by NM pursuant to Subsection B of Section 61-15-9 NMSA 1978. One copy of the building plans must be submitted and printed on substantial paper, measuring at least 24 inches by 36 inches, and drawn to an accurate scale of at least one-eighth inch to one (1) foot. The building plans for renovated or building additions to the existing building must include sufficient information to distinguish between new and existing construction, for DHI to make a compliance determination. The following plans are the minimum required for all facilities in new and /or renovated construction:

- Site plan: showing the location of the building on a site/plot plan to determine surrounding conditions, driveways, all walks and steps, ramps, parking areas, handicapped and emergency vehicle spaces, accessible route to the main entrance, secure yard for clients, any permanent structures, including notes on construction materials used.
- Life safety and code compliance plan: noting applicable code requirements and compliance data, locations of rated firewalls, smoke partitions (if any), exit paths and distances, fire extinguisher's locations.

- Floor plans: showing location use of each room and all other pertinent explanatory information addressing the requirements in applicable regulations.
- Dimensioned floor plan: showing all exterior and interior dimensions of all rooms, spaces, and corridors, etc.
- Exterior building elevations: noting all building heights, locations of exterior doors, and any operable and fixed windows (sill heights).
- Building and wall sections: showing at least one building or wall section showing an exterior and interior wall construction section including the material composition of the floor, walls, and ceiling/roof construction.
- Schedule sheets: room finish: noting all room finishes, (e.g., carpet, tile, gypsum board with paint, etc.); door schedule; noting door sizes/thickness, door types & ratings; window schedule, noting sizes, type and operation; skylight schedule, noting size, type.
- Special systems plan: location of fire extinguishers, heat and smoke detectors, nurse call systems, and operational elements of alarm system.
- Mechanical plans: noting location of heating units, furnaces, hot water heaters, and fuel type and source; all heating, ventilating and air conditioning/cooling systems including locations of fire dampers.
- Plumbing plan: noting all plumbing fixture locations, fixture types.
- Electrical plan: noting power and lighting layouts, exit lighting, emergency lighting fixtures, emergency power systems (if any), electrical panel information.
- Other plans: As necessary (i.e., phasing plan) to describe compliance with the other requirements in applicable regulations.

The CTC must receive initial life safety code approval and a temporary license from DHI prior to accepting or admitting any clients into the CTC. At minimum, additional documents are required, as part of the initial licensure process prior to the issuance of a temporary license, include, but are not limited to:

1. Building approvals required for the CTC to operate in the jurisdiction in which it is located, including but not limited to:
   a. Written zoning approval, building permit final approval, or certificates of occupancy from the appropriate authority (state, city, county, or municipality) for business occupancy; and
   b. Written fire marshal approvals from the fire safety authority having jurisdiction.
2. Environmental approvals if applicable or required, the CTC must provide written approval from the NM Environment Department for the following:
   a. Private water supply.
   b. Private waste or sewage disposal.
   c. Kitchen/food service.
   d. X-ray equipment (if any).
3. Board of pharmacy approval must be demonstrated by submitting a copy of CTC's drug permit issued by the State Board of Pharmacy.
4. A program description must be submitted with the license application, that is consistent with the licensure regulations which includes at a minimum, the following information:
   a. A list and description of all services and the scope of those services to be provided by the proposed CTC.

b. Projected number of clients to be served monthly, both residential and non-residential.
c. A list of staffing and personnel requirements and duties to be performed.
d. Proposed staffing plans for both residential and non-residential program.
e. Photocopies of written operating agreements with the following: treatment facilities for behavioral health and physical health care needs that are beyond the scope of the CTC.
f. Admission and discharge criteria. (See Appendix G)
g. An organizational structure diagram or chart including the administrator, governing body, clinical director, director of nursing, direct care staff, and other staff.

5. Policies and procedures: The CTC must submit with its license application a copy of the CTC's policies and procedures with a crosswalk to these regulations to show compliance.

Public Sources of Payment for Services

In 2021, the NM Human Services Department (HSD)/Behavioral Health Services Division (BHSD) and the Behavioral Health Collaborative (BHC) created a Behavioral Health Provider Toolkit for those interested in becoming a BH provider organization in NM. This toolkit, which is available at https://www.hsd.state.nm.us/wp-content/uploads/Behavioral-Health-Provider-Toolkit-REVISED-5.5.2021-1.pdf contains valuable information about the processes, documents, forms, links, and other resources to assist in establishing and sustaining a publicly funded BH provider organization or adding a new service.

NM BH programs and facilities operate under the oversight of the Behavioral Health Services Division (BHSD) of the Human Services Department (HSD), the Children, Youth and Families Department (CYFD), and the Department of Health (DOH). The BH services system has three major sources of public funding: Medicaid (includes managed care Medicaid and fee-for-service Medicaid), federal grants, and/or state general funds. The Behavioral Health Collaborative, which administers state general funds, is the payor of last resort for BH services for adults and children covered by Medicaid. When a Medicaid covered service is provided to a Medicaid eligible client, those services must be billed to Medicaid. Effective use of federal Medicaid funds allows the State greater opportunity to devote its own funds to NM priorities. The toolkit provides information on each of these funding sources and how to apply for funding.

Prior to becoming an eligible provider organization to qualify for reimbursement from Medicaid and non-Medicaid funding opportunities payer agreements, BH provider organizations must apply for and receive a ten-digit National Provider Identifier (NPI) number through the National Plan and Provider Enumeration System (NPPES) of the Centers for Medicare and Medicaid Services (CMS). The NPI is easy to obtain and update. To create or update an account, go to https://nppes.cms.hhs.gov/#/.

Most publicly funded BH providers intend to serve both Medicaid-eligible individuals and those who qualify for funding from non-Medicaid sources such as federal block grants, state general funds, or discretionary grants. To be reimbursed for eligible services delivered to eligible recipients from these different funding sources, providers must complete the respective licensing and credentialing processes.

Approval as a BH service provider can come from DOH, CYFD, and BHSD. Refer to the Behavioral Health Policy and Billing Manual for details on agency approvals. Here is the link to the current manual: https://www.hsd.state.nm.us/lookingforinformation/behavioral-health-policy-andbilling-manual/. The 2020 New Mexico Administrative Code (NMAC) 8.321.2 Specialized Behavioral Health Services and the Behavioral Health Manual list the following as eligible to provide BH professional services; each provider type must meet certain conditions as explained in the manual.

- Community Mental Health Center (CMHC)
- Federally Qualified Health Center (FQHC)
- Indian Health Services (IHS) hospital, clinic, or FQHC
- PL-93-638 tribal operated hospital, clinic, or FQHC
- CYFD facility
- Hospital and its outpatient facility
- Core Service Agency (CSA)
- CareLink NM Health Home (CLNM HH)
- Crisis Triage Center (licensed by DOH)
- Behavioral Health Agency (BHA) (some require Supervisory Certification)
- Opioid Treatment Program (OTP) (methadone clinic)
- Political Subdivision of the State of New Mexico
- Crisis Services Community Provider as a BHA

Medicaid Funding

Medicaid is the major payer of publicly funded BH services nationally. Therefore, Medicaid would normally be expected to be the major payer for services rendered by the CTC. This is particularly true in states that have chosen to expand Medicaid, which NM implemented in 2014. With Medicaid Forward being proposed by NM for implementation in 2024, The Urban Institute (2023) estimates that 710,000 nonelderly New Mexicans would be enrolled in traditional Medicaid and CHIP in 2024. If Medicaid Forward is implemented in 2024, it is estimated that between 407,000 and 542,000 New Mexicans would enroll in the new Medicaid Forward option, along with some additional enrollment in traditional Medicaid and CHIP, raising the share of nonelderly New Mexicans in Medicaid from 38.4% to between 62% and 70.1%. There would be between 130,000 and 142,000 fewer uninsured New Mexicans, and the uninsured rate would decline from 13.1% to between 6.1% and 5.4%. The proposal would substantially increase coverage at all income levels and among all racial and ethnic groups. Virtually all uninsured New Mexicans would be eligible for coverage, increasing the importance of efforts to enroll those who are eligible but uninsured and increasing the numbers of those who would have Medicaid coverage at the time of presentation to the CTC.

The first step for a new service provider to enroll as a Medicaid provider is to acquire a NM provider Medicaid Identification Number. Enrollment can be completed on the NM Medicaid Portal: https://nmmedicaid.portal.conduent.com/static/index.htm. After all the required application information has been submitted, enrollment should take approximately 7-10 business days to complete.

A key reference guide for use by BH providers is the NM Medicaid Behavioral Health Policy and Billing Manual (BH Manual). The BH Manual is a reference for the policies and processes related to BH for the administration of Medicaid BH services, as defined in NMAC, Section 8.321.2. The BH Manual also provides supplemental material as direction for the Medicaid Managed Care Organizations (MCOs). The BH Manual is developed by HSD, MAD, BHSD, and CYFD. The provisions of the BH Manual reflect the general operating policies and essential procedures specific to BH services, but are not all-inclusive, and may be amended or revoked at any time by HSD. If there is a conflict between the BH Manual and the NMAC rules, the NMAC rules supersede the Manual.

The BH Manual is updated on a regular basis. HSD reserves the right to change, modify or supersede any of its policies and procedures, with or without notice at any time. As policies are revised throughout the year, they are incorporated into the BH Manual. The BH Manual may be viewed or downloaded from MAD's home page, which is available at: www.hsd.state.nm.us. A summary list, of any policy revisions is also posted each year. It is the responsibility of all providers and entities affiliated with Medicaid to review, and be familiar with, the BH Manual and any amendments.

Medicaid General Provider Policies are contained in NMAC 8.302.1. Providers should review the details of this Rule prior to applying for permission to bill for Medicaid-funded services. To obtain a Medicaid Enrollment ID number for the CTC, the MAD 335 online application must be completed and submitted. It is available on the Medicaid Portal at https://nmmedicaid.portal.conduent.com/webportal/home. Conduent operates the Omnicaid system and the NM Medicaid Portal. These systems are utilized for provider enrollment and claims processing, and house Medicaid client eligibility and claim information. The steps to enroll as a provider differ between experienced providers and providers who are new to the NM BH system. Within the portal, there are significant resources to assist providers.

For the experienced NM BH service provider, the Conduent Provider Type and Specialties spreadsheet should be reviewed on the NM Medicaid Portal. This document can be found in the Provider Information section of the Portal, and includes information on provider type, specialty, needed licenses and approval letters. Experienced providers need to ensure that their registration with the Council for Affordable Quality Healthcare (CAQH) or National Provider Identifier (NPI) includes the organization's most current information. When a provider is re-enrolling in Medicaid, the Excel spreadsheet should be reviewed and Conduent should be contacted to provide organizational updates.

Provider credentialing by The Council for Affordable Quality Healthcare, Inc. (CAQH) is required by the state and all the Medicaid Managed Care Organizations (MCO). This is a data-collection and credentialing system that is used in all fifty (50) states. It is free-of-charge and reduces paperwork and the administrative burden associated with collecting and disseminating information. The CAQH process can take up to forty-five (45) days to complete. Experienced providers are typically already credentialed in the CAQH system and therefore records can be easily updated. If a service provider has never been credentialed within the CAQH system, CAQH registration can be made online: https://www.caqh.org/resources#.

Medicaid allows for consolidated basic applications for credentialing at all Managed Care Organizations (MCOs) in the NM Medicaid Managed Care system, although each MCO will have additional unique credentialing requirements in addition to the information submitted to CAQH. Each MCO requires that the CTC complete a roster of practitioners for each service(s) that is intended to be rendered. Rosters should be updated regularly to reflect changes in direct service personnel. Each MCO has its own detailed provider manual or handbook detailing complete rostering requirements. All MCOs use the same rostering form. The CTC will be required to execute a Provider Agreement with each MCO. As agents of Medicaid, the MCOs exercise contractually mandated oversight of all providers serving their enrolled members.

After becoming an approved Medicaid service provider, the last step prior to billing is the MCO enrollment process. Medicaid services cannot be billed prior to completion of this step. Enrolling with an MCO can take from two weeks up to three months. This step cannot be started until the Conduent, and state agency approvals are complete, and credentialing is completed through CAQH. Billing cannot begin until enrollment with the MCO system is complete. There have been three Medicaid MCOs operating under Centennial Care, which will no longer be NM's Medicaid Managed Care Plan effective June 30, 2023. It is recommended that service providers enroll in all three if CTC service is expected before July 1, 2024. If service is anticipated after that date, the CTC should be enrolling with the MCOs that will be active under Turquoise Care. Each MCO has a similar system that requires the same documentation that Conduent and the state agencies require.

- BlueCross BlueShield of New Mexico
  Provider portal: https://www.bcbsnm.com/provider/index.html
- Presbyterian Health Plan
  Provider portal: https://www.phs.org/providers/Pages/default.aspx
  Letter of Interest (online application): https://www.phs.org/providers/our-networks/healthplan/Pages/letter-of-interest.aspx
  Western Sky Community Care
  Provider portal: https://www.westernskycommunitycare.com/pro

Effective July 1, 2023, Turquoise Care will be launched as NM's new Medicaid Managed Care Plan, thereby replacing Centennial Care. If contract negotiations proceed as expected, two of the three previous MCOs will remain in place – BlueCross BlueShield and Presbyterian Health Plan. Western Sky Community Plan will cease operating as a Medicaid MCO. Two other MCOs, however, will be added to the mix – United Health Plan and Molina Health Care of NM, for a total of four MCOs comprising Turquoise Care. Open enrollment for the new MCOs is expected to begin in April 2024.

The Behavioral Health Fee Schedule, which is also published by MAD, has information on the provider types that can bill specific procedure codes, payment information, referring and rendering provider requirements, and information on billing units. The rates on the fee schedule are the base rate. Rates with MCOs may be negotiated, but negotiated rates should never be lower than what is on the fee schedule. The billing instruction delineated in the Fee Schedule for CTC specifies that CTC services are reimbursed through a provider specific cost-based bundled rate relative to type of services rendered. CTCs are classified within Medicaid

as a Behavioral Health Agency (BHA), specialty 246, provider type. Under this classification, a non-residential CTC should submit its Medicaid billing on a UB claim form utilizing revenue codes. The revenue code 0513 should be utilized if a Medicaid enrollee's stay has been less than 23 hours. In this instance, the type of bill to be used is 089X. The BH fee schedule is available at: https://www.hsd.state.nm.us/providers/fee-for-service/ under *Behavioral Health Fee Schedule*.

Medicaid Payment for Out-of-State Residents

Although most Medicaid enrollees obtain medical services within their state of residence, some enrollees seek care out-of-state under certain circumstances. Since San Juan County is situated within the Four Corners area which borders the states of NM, CO, UT, and AZ, it is expected that the anticipated CTC will be getting a segment of its admissions from outside NM. Current Medicaid regulations describe four situations in which states must provide out-of-state coverage:

1. A medical emergency.
2. The beneficiary's health would be endangered if required to travel to the state of residence.
3. Services or resources are more readily available in another state.
4. It is general practice for recipients in a particular locality to use medical resources in another state (42 CFR § 431.52).

Members of the Navajo Nation tend to have a high uninsurance rate for Medicaid. Therefore, those referred to the CTC may have to undergo an application for presumptive eligibility for Medicaid to pay for the services of the CTC. If a member of the Navajo Nation is actively enrolled in Medicaid, it will be under traditional fee-for-service (FFS), not Medicaid managed care.

States have broad flexibility to determine Medicaid payment rates for services provided out-of-state and the processes that providers must follow to enroll as an out-of-state Medicaid provider. Specifically, many states pay out-of-state providers at lower rates than in-state providers and require out-of-state providers to undergo provider screening and enrollment, even if the provider is already enrolled in Medicaid in NM. More information about Medicaid payment policies is available in Medicaid and CHIP Payment and Access Commission's (MACPAC) compendia of state payment policies for inpatient and outpatient services https://www.macpac.gov/.

State Non-Medicaid Funding

The federal government has delivered a significant amount of funding to states that can be used to advance crisis services; including American Rescue Plan, COVID Relief, SAMHSA Block Grant and other SAMHSA dollars. Many of these must be expended in the next year or two so there could be an opportunity to secure funding to establish a facility in San Juan County. County leaders might consider identifying a desired property, acquire architectural renderings

and project construction costs that could be used to formulate a request for funding to state officials.

Another essential step in advancing facility-based crisis care in New Mexico is to engage the Behavioral Health Services Division to initiate a rate-setting process through the Human Services Department's (HSD) Medical Assistance Division. The State engages actuaries to establish Interim crisis care fee-for-service rates based on the projected operations costs and utilization of the facility. After one year, rates are subject to adjustment by HSD based on actual costs and utilization experienced by the program. Medicaid managed care organizations in New Mexico are then required to contract for services at the rate established by HSD. Following the establishment of Medicaid a Medicaid reimbursement rate will be further collaboration with Behavioral Health Services to establish reimbursement rates for individuals who are not enrolled in Medicaid. A vendor agreement with Falling Colors is needed to secure reimbursement for these services. Our experience is that Falling Colors reimbursement is just under 80% of the rate paid New Mexico Medicaid MCOs.

Falling Colors, Inc. is the NM BH Collaborative's Administrative Service Organization (ASO) for non-Medicaid funded programs BH programs operated by BHSD, CYFD, and the Aging and Long-Term Services Department (ALTSD). The ASO operates an online system BHSDStar https://www.bhsdstar.org/ and it administers state General Revenue Funds (GRF), SAMHSA Block Grants for Mental Health and Substance Abuse, and various discretionary federal grant funds. The BHSDStar portal houses manuals, online training guides, specialty program documents, and registration materials for BH service providers. A Frequently Asked Questions (FAQ) document is provided, covering accounts, client registration, billing submission payment, support desk, vendor registration and general questions.

All vendors of non-Medicaid services (claims based or not) are required to register in the BHSDStar system. Recorded webinars provide detailed training on client registration, claims submission, and how to bill. As with Medicaid Provider Participation Agreements, all direct service staff must have an NPI (and, additionally, copies of licensure and certification documents). Once contracted to provide services, non-claims-based vendors can access the STAR Vendor Manual and claims-based providers can access the Quick Guide for Claims Submission, Claims User Manual, and Claims Billing Guide, all from the ASO's home page. CTCs should be billing for services provided to New Mexicans who are uninsured and ineligible for Medicaid.

County and Municipal Funding

There remain those in NM who are uninsured and require safety net funding to access crisis response services. Therefore, it is necessary for there to be additional financial supports, beyond state and federal funding, to sustain San Juan County's adoption of and ongoing support of its crisis response system, to include the CTC. The County should explore all available financing options to sustain the proposed system.

Some counties and cities pass specific measures with allocations to provide social safety net funding to support the uninsured and to cover the cost associated with needs that are not

included in commercial health care benefits, nor in Medicare. The means for accessing local funds are variable and often competitive. At the local level, where jurisdictions have levy authority, dedicated measures have been passed to better meet local BH needs. Often these funds have been intended to overcome local gaps in services and to fund services and programs that are not funded by Medicaid. San Juan County and its various jurisdictions are urged to seek similar financing measures.

Without financial support for the start-up costs associated with the establishment of a CTC, it will be very challenging for any provider organization to absorb these costs. Most provider organizations do not have the operating reserves or financing necessary to assume these costs. Therefore, without any initial financial operating assistance, the CTC will most likely not become operational. Therefore, the County along with local municipalities, private foundations, San Juan Regional Medical Center, and Presbyterian Medical Services (PMS) should collaborate and explore all available financing options to support the capital and initial operating costs to standup and sustain the CTC. These funds have also been used to overcome local gaps in other counties, to fund crisis services that are not funded by Medicaid, and to reimburse crisis services for those that do not have the health plan coverage for BH crisis services. San Juan County and its surrounding counties are urged to seek similar financing measures. If surrounding counties intend on accessing San Juan County's CTC, then it should be expected that these counties will pay for their respective residents who either do not have Medicaid or are ineligible for Medicaid.

Critical Incident Reporting

It is important for the CTC to work with its contracted Medicaid MCOs and/or Conduent, as appropriate, on reporting critical incidents, as appropriate, on reporting critical incidents. A critical incident is any serious or traumatic event that causes, or can cause, physical or mental harm or harm to the well-being of a person. Critical incidents are typically classified as abuse, neglect, or exploitation. Each NM State Department may have its own reporting protocols in addition. Anyone billing Medicaid, state, or federal funds received through the state, must report critical incidents. The Behavioral Health CIR Reporting Protocol and forms are located on the HSD website and can be found at: https://www.hsd.state.nm.us/providers/critical-incident-reporting/.

Staffing

The CTC must be staffed every hour of every day without exception, so that it will be equipped to accept any admission. To fulfill this commitment, a multi-disciplinary team is essential. It should be stressed, because of the high acuity of those being admitted, a high staff to client ratio is required along with the professional personnel necessary to manage the acuity levels of those admitted. Therefore, this is an expensive service to render. To be able to financially support this level of staffing for 24/7, there needs to be sufficient referrals into the CTC to generate an average occupancy rate of 85%. To achieve this this level of utilization requires a sufficient population base, and a collaborative working relationship with law enforcement, EMS, hospitals, BH providers, and the community. The staffing configuration for the proposed CTC to operate 24/7 is presented below for 26.25 full-time equivalents (FTE) that would operate in two (2) twelve (12) hour personnel shifts per day. The hourly rate that is provided

is based on actual NM salaries. The aim of this model is to have five (5) staff on the floor during the day and evening shifts, with a smaller number of staff available at night. Transportation staff are included for eight (8) hours a day. The overall composition of the staffing plan is presented below:

POSITION CONTROL		7 recliners	23 hour obs						
all linked to 24-7 SP tab		no beds	stabilization	Hours	160	160	160	480	
Position	**FTE**	**Rate**	**Comments**		**Month 1**	**Month 2**	**Month 3**	**Total**	
Admin Staff									
Program Director	1.00	$ 49.30	x		$ 7,888.00	$ 7,888.00	$ 7,888.00	$ 23,664.00	
Office Manager	1.00	$ 23.00	x		$ 3,680.00	$ 3,680.00	$ 3,680.00	$ 11,040.00	
Medical Director	0.10	$ 155.00	x						
Nurse Manager	0.50	$ 46.45	x		$ 3,716.00	$ 3,716.00	$ 3,716.00	$ 11,148.00	
Executive Admin Leadership	0.10	$ 72.00	x						
Executive Medical Leadership	0.05	$ 168.27	x						
Direct Staff									
NP / Psych Worked	0.70	$ 95.00	telehealth as needed		$ 10,640.00	$ 10,640.00	$ 10,640.00	$ 31,920.00	
Nurse RN	4.20	$ 42.95	on site		$ 28,862.40	$ 28,862.40	$ 28,862.40	$ 86,587.20	
TeleHealth Peer	1.50	$ 21.00	on site		$ 5,040.00	$ 5,040.00	$ 5,040.00	$ 15,120.00	
Shift Supervisor (Clinician)	4.20	$ 35.00	on site		$ 23,520.00	$ 23,520.00	$ 23,520.00	$ 70,560.00	
Peer Support Specialist I	4.20	$ 17.00	on site		$ 11,424.00	$ 11,424.00	$ 11,424.00	$ 34,272.00	
Milieu Specialist (Peer)	4.20	$ 21.00	on site		$ 14,112.00	$ 14,112.00	$ 14,112.00	$ 42,336.00	
Transportation Specialist (Peer)	2.10	$ 21.00	on site		$ 7,056.00	$ 7,056.00	$ 7,056.00	$ 21,168.00	
TOTALS	23.85				$ 115,938.40	$ 115,938.40	$ 115,938.40	$ 347,815.20	S&W
								$ 86,953.80	Benefits
		Salary & Wages	$ 1,865,613.97						
		Registry Services	$ 120,000.00					$ 434,769.00	SWB Start-Up
		Employee Benefits	$ 406,634.36						
			$ 2,392,248.33			People			
						10			
						Airfare	10,000.00		
						Hotel	13,000.00		
						Meals	7,900.00		
						Rental Car	2,000.00		
						Total	32,900.00	Start-UP Travel	

This intensive level of onsite professional staffing can now be mitigated in a CTC offering 23 hours or less non-residential services. The CTC may have onsite medical professionals who have access to immediate support and supervision by an RN or a higher-level provider in accordance with Section 24-25-1 et al. NMSA 1978 New Mexico Telehealth Act.

The staffing required doesn't change whether San Juan County elects to only operate a standalone 23-hour CTC with recliners or chooses to combine it with CTC with stabilization beds in Phase II, since involuntary admissions will be accepted. The staffing model that is presented above is based on the minimum staff necessary to manage aggressive behavior associated with high acuity level presentations in a CTC operating as a no wrong door crisis response facility. Thereby, the high staffing ratio proposed assures both client and staff safety with the two types of CTC operating under one roof. There are definite economies of scale to be realized by San Juan County in establishing a CTC with both recliners and beds.

Technology Needs

Electronic Health Record (EHR)

The CTC will need to negotiate and execute provider agreements with each payer. The CTC will need to determine who is eligible for any given health plan benefit, document financial eligibility, record clinical and demographic characteristics, generate appropriate invoices/claims and effectively bill appropriate third-party payers. CTC management will need to become well versed on the nuances of each benefit plan, to include its eligibility criteria and

member enrollment processes. The CTC should be expected to retain a Medicaid enrollment expertise to assist with eligibility determination and with enrollment of clients who are eligible for Medicaid, but who have not enrolled. The CTC should be expected to utilize the NM's web portal to check eligibility at the time of services and document the payer in the EHR.

Demographic information should be collected upon admission and entered into the EHR. Reverification of payer status should be determined within each episode of care. Billing should be completed at least weekly through a claims clearinghouse on a two-week lag timeframe to allow time for internal claim scrubs to occur and be corrected prior to billing, i.e., missing member ID. Internet resources such as Avidity can be used to identify other potential health insurance coverage. Primary insurance needs to be billed prior to Medicaid, when covered billing codes exist within a covered code set (S9484 and S9485). While there will be those that are admitted to the CTC with Medicare coverage, Medicare does not have a benefit plan that includes coverage for BH crisis services, except for coverage for professional services provided in a crisis stabilization facility with beds.

The CTC will benefit from utilizing an EHR that is specifically designed for organizations that provide BH treatment services in community-based, residential, and inpatient programs. Preferably, it should offer a recovery-focused suite of solutions that leverage real-time analytics and clinical decision support to drive decision-making. The ideal platform should streamline workflows, making client information quickly accessible with user-friendly dashboards. It should also offer a whole-person integrated care model with a comprehensive set of features that support all CTC clinical and management functions, from front desk staff and clinicians, to billing administrators and executive management. This level of functionality will result in improved operational, clinical, and financial workflows within the CTC.

The EHR clinical features should include supporting the scheduling and workflows for group appointments and treatments, detoxification, and any outpatient care; monitoring of treatment adherence while alerting clinicians to needed information; and supporting documentation for different treatment workflows such as crisis stays, and recovery supports. In terms of financial management, it should provide automated electronic remittance processing and efficient denial management workflow while managing complex billing requirements, intensive episodes of care, including wrap-around services and Medicare pharmacy billing. Particularly important in today's complex healthcare environment, it should support complex billing models, including value-based reimbursement payments, shadow billing, and non-profit grant funding. Operationally, it should track key performance indicators to measure meaningful use compliance, revenue and other organizational goals, while monitoring system status and optimization utilizing modeling tools.

The EHR should be used for all documentation of clinical care, service delivery, claim submission, and reporting. Any electronic documents should have discrete data capture fields that can be modified for contract requirements. Hardcopy client records need to be scanned into the system for ease of access and chart review. The EHR should also have batch transaction capability for transmission and reception for organizations that can accept HIPAA compliant 837 transactions. The EHR 837 templates should be created based on CMS and funder companion file requirements. It should also accommodate claims transmission through a payer portal, if preferred or required. In order for the CTC to sustain a high success rate in

clean claim submission and subsequent appropriate payment, the CTC will have to engage in the rigorous working of internal claim rejections, clearinghouse rejections, and 835 denials, as well as, vetting back-end reports for accurate contract amounts, etc. These denial reviews need to be completed on a daily, weekly, and monthly basis.

The EHR must secure storage of protected health information, as well as generate reports from the data to conduct continuous quality improvement analyses that should include:

- Referral outcomes.
- Average wait time to completion of critical assessment and treatment planning.
- Average transition time for law enforcement handoffs.
- Reason for referral.
- Average length of stay.
- Disposition at discharge.
- Involuntary to voluntary conversion percentage.
- Readmission percentage/recidivism rates.
- Linkage to community resources.
- Customer Satisfaction Survey.
- 72-hour follow-up calls to monitor stabilization and connection to care.
- Incidence of sentinel events.
- Incidence of seclusion/restraints, if applicable.

Most EHRs have a Report Library that contains a host of standardized reports often including those related to Client Management; Provider Practice; Scheduling; Billing Management; Diagnoses; Active Client List; Missing Progress Notes; Client Satisfaction, and Services by Client Demographics. However, reporting requirements should be considered a collaborative effort with contracted authorities and payers of service. Customized reporting requirements to multiple entities is possible via Secure File Transfer Protocol (SFTP) delivery. Any pre-determined templates can be built into an EHR for specific data capture and delivered on any delivery schedule. Specific forms and outcome reports can be customized for service recipients using an Application Designer who can further modify existing forms and reports based on the changing needs of customer(s). CTC management must possess the necessary competencies related to its EHR and its application to meet various performance measurement requirements.

Telehealth

Telehealth or tele-psych involves the use of mobile and web platforms that brings BH care directly to the person. By enabling the distribution of virtual clinical services, these capabilities can expand the reach of BH care during times of crisis. Improved care outcomes can be achieved with timely access to high-demand practitioners, such as psychiatry and after-hours access to physicians. It offers the potential to improve health outcomes and lower costs by allowing the CTC to access specialty and assessment expertise, often 24/7 that might not be otherwise available on-site, hence making this expertise available and affordable. In addition, telehealth provides the ability to follow-up with discharged clients and thereby facilitate ongoing care coordination.

The features commonly available with a telehealth platform are:

- Schedule initial intake or ongoing appointments with existing clients.
- Access and launch a telehealth session from the EHR.
- Document treatment and services, and seamlessly bill for services.
- Available on an Android or iOS device.
- Dedicated tablets can connect individuals with specialists for consultations and assessments.

Telehealth platforms now offer integration with an EHR, enabling the scheduling and launching of virtual appointments, creating dedicated virtual practices, while providing strict compliance with industry safety and security standards.

Technology Assisted Care (TAC)

The SAMHSA Treatment Improvement Protocol 60 (TIP), *Using Technology-Based Therapeutic Tools in Behavioral Health Services,* provides an overview of current technology-based assessments and interventions (including treatment, recovery support, relapse prevention, and prevention-focused interventions) targeting BH, and it summarizes the evidence base supporting the effectiveness of such interventions. It also examines opportunities for technology-assisted care (TAC) in the BH arena—particularly in improving early access to care, client engagement in and commitment to treatment and recovery, client education, specific treatment interventions, relapse prevention and recovery management, extended recovery, community engagement, MH promotion, and SUD prevention, among other areas.

This TIP addresses how BH service providers can use Web sites, telephone and telehealth resources, smartphones, and other portable devices and electronic media for education, outreach, and direct client services. It emphasizes use of TAC with clients who might not otherwise receive treatment or whose treatment might be impeded by physical disabilities, rural or remote geographic locations, and lack of transportation, employment constraints, or symptoms of mental illness. While this TIP emphasizes the use of TAC with those who might not seek treatment in conventional settings and/or who have personal preferences that limit access to conventional services, including crisis services, it has application to the full crisis care continuum.

In short, evidence-based TAC has the potential to reach more clients and help engage and retain them in services in a cost-effective manner. This TIP provides treatment and prevention staff in the BH arena with the resources they need to use various technologies in clinical practice; and to recognize the limits and ethical considerations involved in using them. It also provides BH program administrators with the need to integrate and expand the use of technologies in their systems of care. This TIP 60 is highly recommended as a resource for the implementation of the San Juan County CTC and in the further development of a more robust crisis continuum of care. However, more importantly, is the adoption and sound execution of an EHR, which will be critical to the operational success of the CTC.

Additional Technology

Below is a listing of additional technology that the CTC will require. The associated costs appear in the operating budget:

Server	Server computer, temperature monitor and software
	UPS
	Network switch
	Cables
	Rack and patch panel
	Wiring data/voice jacks each
Electronic Bed Board	Electronic Bed Board & cabling
Group Printer	Group printer
RSA Laptop	Laptop with bag, docking station, monitor, licenses, webcam & speakers
	Power strips & cables
Basic Laptop or Desktop	Laptop with bag
	Licenses
	Power strips & cables
Desktop	Desktop
	Licenses
	Power strips & cables
Billing	1 scanners
	add dual video card and one monitor
WIFI	Wireless Access Point
Security Camera System	Security Camera System

Legal and Accounting

CTC management will eventually face legal questions and challenges. The CTC will require legal counsel to mitigate risk and ensure legal and regulatory compliance. Below, are reasons why legal counsel should be retained by the CTC:

1. Corporate law and governance
   One of the biggest hurdles for nonprofits (NPO) generally is governance. A strong nonprofit business attorney can help ensure that the CTC corporate structure, practices, and procedures always remain in legal compliance.
2. Taxes
   Legal counsel will help ensure compliance with all regulations and requirements with regard to maintaining the CTC's nonprofit tax-exempt status.
3. Intellectual property
   The CTC may need to protect any intellectual property. NPO status does not; in and of itself protect any innovative ideas and practices. Legal counsel will help to protect intellectual property through trademark and copyright law.
4. Contracts
   As with intellectual property, a business attorney can help create concrete contracts to protect the CTC's interests whenever possible.
5. Employment
   The CTC will face many of the same labor and employment related issues that traditional businesses do, but with even more complications due to the CTC may make use of volunteers and interns. There are many ways to be in jeopardy when

utilizing unpaid labor. Legal counsel can help ensure that all hiring and labor practices are fair and legal.

6. Liability
   Because of the nature of its work, the CTC can be subject to malpractice allegations.
7. Fundraising
   A business attorney can assist to maintain legality in any fundraising practices. Missteps in fundraising can jeopardize the CTC's tax-exempt status.
8. Lobbying
   Nonprofits are not permitted, under law, to engage in lobbying. However, it is often necessary for a NPO to engage in advocacy. A business attorney can assist with limiting the any advocacy activities to operating only within prescribed legal parameters.

The bottom line is that there are numerous reasons why CTC management should utilize experienced legal counsel. It should have an attorney on its Board of Directors or retain an attorney who understands the intricacies of the CTC and BH-related legal matters.

Increased requests for transparency and accountability in financial reporting has NPO financial managers continually reviewing their programs and processes. In the age of digital communications, social media, and the 24-hour news cycle, perceived violations of public trust offer NPOs little chance to recover from financial mistakes. In the headlights of this increased focus on integrity and accountability are the chief financial officer, accounting staff, and finance director. They are each increasingly being asked to anticipate problems and suggest solutions, to articulate timely financial results and decisions, and to provide leadership in a dynamic health care provider marketplace.

Unfortunately, traditional accounting systems are ill equipped to help health care financial officers meet these challenges. Managing unique revenue streams such as donations, membership dues, program revenues, grants, and investment income requires accounting systems tailored to meet these needs. Operational systems that are not designed to automate these specific business processes and reporting needs, cost organizations time, energy, and effort. A solution that provides the highest levels of transparency and accountability is necessary to help CTC management make solid, strategic decisions and avoid violating the public's trust. A major solution toward that aim is for CTC management either to have an accountant on its Board of Directors or to retain one. Another solution is to have an accounting system that can generate the information necessary for the organization's finance team and accountant to manage the CTC's finances.

Quality Management

The Quality Management Program (QMP) for the CTC should extend beyond traditional Quality Assurance and instead embrace a Continuous Quality Improvement (CQI) process that involves monitoring and evaluating clinical, management, and support services provided to internal and external customers and identifies and assigns priority to problems and/or opportunities for improving departmental and overall organizational performance. The basic tenets of the QMP should include:

- Quality is every employee's job.
- A belief that optimal quality results from a close partnership between the provider of services and the participants.
- Quality problems that result in inefficiencies or substandard services frequently stem from faulty processes and systems, rather than individual performance.
- Accessible, reliable and current data is vital to organizational decision-making.
- Quality problems can be resolved, and service continually improved.
- Poor quality is costly.
- Education, training, and retraining are critical to quality, and to facilitating improvement in job performance.

The Director of the CTC should be designated with the responsibility for assuring the quality and effectiveness of care and services provided by its medical, professional, and support staff. The Director should actively and visibly support and lead Quality Management efforts by establishing priorities for the QMP consistent with the CTC's mission and directives; and by modeling his/her ongoing commitment to CQI. The responsibility of designing, planning, implementing, and evaluating the QMP should fall to the Quality and Compliance function, that works collaboratively with the Director and the management team in striving for excellence in all aspects of the organization's clinical, management and support services.

The QMP should define quality improvement targets and initiatives based on established priorities; reviewing and recommending indicators for measuring individual and organizational functions, processes, and outcomes; analysis and assessment of findings; identification and resolution of known or suspected opportunities for improvement; making recommendations for formulation of Performance Improvement Teams; and ensuring appropriate follow-through on quality improvement action items. The QMP should also plan for the review of statistical data and findings on Customer Satisfaction, Seclusion and Restraint, Qualitative Record Reviews, Utilization Management, Critical Incidents, Customer Complaints and Grievances, Risk Management, Periodic Cultural Assessments, and Health and Safety. The information reviewed and any recommendations regarding the QMP should be readily available to San Juan County, regulators, and payers.

Employees from all levels of the within the CTC should participate in teams created to improve a specific process or outcome, as appropriate. Teams may be Functional (created from within one department, work area, or discipline), or Cross Functional (members from two or more departments, work areas or disciplines which share ownership of the issue discussed). Representation of individuals from outside the organization who have special knowledge or expertise may participate as team members, as appropriate. All teams should have a designated Team Leader and Facilitator and utilize the **F**ind, **O**rganize, **C**larify, **U**nderstand, and **S**elect – **P**lan, **D**o, **C**heck, and **A**ct (FOCUS- PDCA) model, or a modified version of this model, for performance improvement activities. FOCUS-PDCA is a management method, developed in the healthcare industry that is used to improve processes.

The QMP should become operational through a Quality Management Work Plan, which includes an annual evaluation of QMP; Quality Management Plan and Work Plan; Utilization Management Program; Utilization Management Plan; Policies and Procedures and Forms; and The Joint Commission (TJC) Training and Education Program, or other accrediting body. In

addition, a quarterly evaluation, should be conducted, of Customer Satisfaction Surveys, Infection Control Report, Environment of Care Report, Quality Record Reviews, and Sentinel Event Report; and monthly, there should be an evaluation of the Patient Complaint and Grievance, and Seclusion and Restraint Reports.

The CTC 23-hour crisis observation and stabilization service should be expected to achieve the following expectations:

- Accept all referrals without pre-screening.
- Does not require medical clearance prior to admission, but will assess for and support medical stability while in the program.
- CTC services to address SMI, SUD, and IDD crisis-related conditions.
- Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges.
- Staff always (24/7/365) with a multi-disciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community.
- Offer walk-in and first responder drop-off options.
- Be structured in a manner that offers capacity to accept all referrals, with a no reject policy for first responders.
- Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated.
- Function as a 23 hour or less stay crisis receiving and stabilization facility.
- Offer a dedicated first responder drop-off area.
- Incorporate some form of intensive support beds into a partner program (could be own program or another provider) to support flow for individuals who need additional support.
- Have access in real-time to the bed registry system operated by the crisis call center hub to support efficient connection to needed resources.
- Coordinate connections to ongoing care.

For CTC performance metrics, see **Recommendation 3. Performance Expectations and Metrics**.

Competency in Serving Persons with Intellectual and Developmental Disabilities

Individuals with intellectual and developmental disabilities (PWIDD) are at high risk for co-occurring mental health conditions, with the incidence of psychiatric disorder estimated to be more than three times higher in the IDD population compared to the general population. One of the challenges in providing mental health services for these individuals in all age groups is in addressing their broader spectrum of unique needs. The vulnerabilities faced by these individuals are pronounced and can lead to catastrophic consequences, including, pronounced rates of victimization, lack of access to appropriate treatment with multiple transitions in care that can create regression, the potential for criminalization of behavior as an unfortunate result of miscommunication, and other challenges. Therefore, the CTC staff and all those that are part of the crisis response system must develop the requisite competence to serve PWIDD.

The National Association of State Mental Health Program Directors' (NASMHPD) Technical Assistance Coalition White Paper Assessment #7 from August 2017, entitled, *The Vital Role of Specialized Approaches: Persons with Intellectual and Developmental Disabilities in the Mental Health System,* makes several recommendations that would be beneficial for CTC management to consider, among them:

- Policymakers should work to develop cross-agency guidelines for greater intersystem collaboration, recognizing that PWIDD will and do appear in the mental health service system. The development of these collaborative efforts should include input from a variety of stakeholders and examine collaboration across all ages, including persons served in the child/adolescent, adult, and older adult sectors. Perspectives of persons served, their families, and representative advocacy organizations will be critical in the development of guidelines. Examples of important areas for these guidelines to address include:
    - Development of shared data to understand total numbers of individuals served across systems and those denied services because of overlapping issues, and the development of planning based on those data.
    - Development of approaches to handle requests for services for people that do not neatly fit into administrative lines for services and the development of approaches for reviewing individual cases where overlapping needs are present but are not being met.
- Foster leadership to develop methods through blended and braided funding streams for continuum of care services that address the dual need populations.
- Establish intersystem partnerships, such as with law enforcement and jail diversion programs, to include interventions for persons with both IDD and SMI.
- Establish mutual workforce development.
- Systemic data collection must be done to better identify population prevalence and needs across systems.
- Prioritize the ability to develop self-directed and person-centered care planning, focusing on PWIDD's strengths, capabilities, and potential to contribute to their community.
- Partner with IDD agencies overseeing services for these persons, and together there should be interagency outreach and collaboration with law enforcement, courts, and corrections to provide skilled de-escalation, diversion approaches, cross-discipline education, and linkages to services and guidance in developing greater supports to accommodate persons with disabilities in justice and forensic systems, as well as build bridges to programs reflecting alternatives to incarceration. Partner in cross-agency activities and policy development to strengthen appropriate services for the IDD population within corrections and offer strategies to advance improved conditions of confinement targeting this sub-population's needs.

Recommendations for practitioners include the following:

- Co-occurring challenges such as psychiatric disorders, other neurodevelopmental disorders, hearing loss, and other sensory challenges, are important to consider among the PWIDD population across the continuum of care and support services. There is much heterogeneity in the population, so generalizations and cookie-cutter approaches are risky.

- Rates of trauma and victimization are alarmingly high in PWIDD. Safeguards, self-scrutiny, and monitoring are of ongoing critical importance.
- All behavior reflects some type of communication. An individual's limited ability to verbally communicate anxiety, mood issues, or a psychotic disorder may manifest in aggression or externalizing behaviors, which can often result in missed diagnoses or opportunities for treatment. Always ask, "What is the communication or behavior trying to achieve?"
- Given the limited guidance on helpful medication strategies for PWIDD in the literature, the evidence for psychopharmacology should be case-specific, data- informed rather than anecdotal, coming from behavioral evidence and comprehensive contextual information (e.g., behavior tracking reports) for the specific individual.
- Gather information from all sources, especially direct service professionals, who can provide a wealth of information to inform program and planning. Peer partners, provider treatment networks, and an emphasis on environmental precipitants to behavioral challenges should be helpful.
- Secure access to current policy and regulatory guidance in your state governing the provision of services to persons with co-occurring IDD and MH conditions. The guidance would include coverage and reimbursement guidelines, as well as criteria for case reconciliation carried out by interagency health and human services bodies designed to parse eligibility, and clinical and financial responsibility, for complex cases crossing multiple agency lines.
- Current practitioners should update their skills in working with PWIDD through continuing educational activities. Trainees must be instructed in best practices in the appropriate biopsychosocial approach to psychiatric diagnosis and treatment of PWIDD.

This publication is available at https://www.nasmhpd.org/content/ta-coalition-assessment-working-papers-vital-role-specialized-approaches-persons. Another issue paper on this topic is, *Findings of Joint NASMHPD/NADD/NASDDDS Roundtables on Supporting Individuals with Co-Occurring Mental Health Support Needs and Intellectual/Developmental Disabilities* which can be accessed at https://www.nasmhpd.org/content/findings-joint-nasmhpdnaddnasddds-roundtables-supporting-individuals-co-occurring-mental-0 .

Utilization Management

The Level of Care Utilization System (LOCUS) was developed, for psychiatric and addiction services for adults, by the American Academy of Community Psychiatry to help guide level of care decisions. This tool is recommended for use by the CTC. It can be programmed into the Electronic Health Record (EHR), within which key assessment concepts and tools can be integrated. For example, SAMHSA's Suicide Risk Assessment Standards (SRAS) can be a tool available within the EHR, using the LOCUS methodology for determining the level of care assignment for any given admission. These software-driven clinical decision support tools should be integrated into the EHR and be reauthorized on an ongoing basis by the Medical Director. The Clinical Institute Withdrawal Assessment (CIWA) can also be integrated for use with individuals with severe SUD and potential withdrawal symptoms, along with elements of the Columbia Suicide Scale to assess for suicidality.

Capital, Startup, and Ramp-up Costs

Capital

It is recommended that the County engage a developer and/or general contractor that is working in NM to get cost estimates on the CTC site work, design/engineering, and construction. The capital cost estimate provided by Kidder Mathews- West Coast Commercial Real Estate Firm. A CTC with seven (7) recliners and (6) beds would require a facility of approximately 9,000 total square feet. An architect retained by San Juan County provided the capital cost estimates as follows:

- Estimated Site Work Costs:
    - This is dependent on several variables. For example, onsite utilities in place, etc.
    - Cost per SF, dependent on the parcel proposed site size.
- Estimated Construction Costs:
    - Shell Building (various based on current market value)
    - Tenant Improvements (Interior Buildout)
- Estimated Total Project Costs: +/-$323 per square foot.

This estimate does not include the space required to accommodate the Mental Health Resource Center (MHRC) which currently occupies 2400 square feet. The County plans to allow for an increase of 20% for potential growth of MHRC services, bringing the total to 2,880 square feet.

Startup

Costs associated with the startup of the CTC have to with the initial period following contract execution and/or facility occupancy permitting, for a provider organization to operate the CTC. This period of 60 days involves the recruitment, hiring, and onboarding/training of staff, while at the same time gaining State CTC certification and meeting other necessary requirements. Because there will be no services delivered during this period, there will be no revenue to offset these startup costs which equates to $838,425.

Ramp-up

The ramp-up period is the period from when the CTC becomes operational and begins accepting admissions until the CTC generates sufficient revenue to meet its expenses. During this time, the County must offset the expenses not covered by generated revenue. This can be done through legislation, grants, and other options the County deems fit. It is expected that the CTC will have a 35% occupancy rate in the first month of operation and it is anticipated to reach 85% by the ninth month. Without a resource to make up for the shortfall in revenue during the first eight months, a provider operating the CTC would take on a significant operating loss during the first year. Ramp-up funds are intended to compensate the CTC provider for these losses. In this circumstance, it appears that the County will be the CTC's primary funder and during the first year of operation, the CTC provider can be reimbursed for the services delivered, and the County could choose to cover the balance of expenses for this period only. For the first eight months of operation, the CTC would not have sufficient occupancy to meet expenses, therefore it would experience a shortfall of $981,237.84 during this ramp-up period.

Operating Expense Budget

Seven (7) Chairs/ Six (6) Beds

	Operational Budget		Start-Up Budget
REVENUE	3,566,483		
OPERATING EXPENSES			
Salary & Wages	1,994,392		267,961
Registry Services	120,000		
Employee Benefits	437,688	22%	66,990
Total Employee Expenses	**2,552,080**		**334,951**
Travel	6,000		1,000
Office Occupancy (Facility)	168,000		28,000
Client Occupancy	0		0
Program Services	82,900		13,817
Program Supplies	153,800		25,633
Office Supplies & Equipment	22,320		3,720
Insurance	76,518		12,753
Telephone	24,600		4,100
Other Expenses	13,200		2,200
Property Management (RI Properties)	0		0
Recovery Connections Line	0		0
Local Shared Services	0		0
Capital Expenditures	0		0
Net Operating Expenses, excluding Direct Allocations	**3,099,417**		**426,174**
Direct Allocation Expenses	188,119	6.1%	25,867
Operating Expenses, including Direct Allocations	**3,287,536**		**452,040**
Indirect Allocation Expenses	278,948	8.5%	36,161
Total Expenses	**3,566,483**		**488,201**
Net Income (Loss)	**0**	**0.0%**	**(488,201)**

Revenue	Start-Up	Operational Year 1	Operational Year 2
FFS (Medicaid)	$ -	$ 2,745,769.55	$ 3,339,376.73
County/Gap Fund	$ 900,583.55	$ 990,893.04	$ 609,735.88
Total Revenue	$ 900,583.55	$ 3,736,662.60	$ 3,949,112.61
Total Expenses	$ 900,583.55	$ 3,736,662.60	$ 3,949,112.61
Margin	$ -	$ -	$ -

.0

Seven (7) Chairs

	Operational		Start-Up
	Budget		Budget
REVENUE	3,548,893		1,014,283
OPERATING EXPENSES			
Salary & Wages	1,865,614		347,815
Registry Services	120,000		
Employee Benefits	406,634	22%	86,954
Total Employee Expenses	2,392,248		434,769
Travel	6,000		1,000
Office Occupancy (Facility)	168,000		28,000
Client Occupancy	0		0
Program Services	82,900		13,817
Program Supplies	153,800		25,633
Office Supplies & Equipment	166,982		363,175
Insurance	76,518		12,753
Telephone	24,600		4,100
Other Expenses	13,200		2,200
Net Operating Expenses, excluding Direct Allocations	3,084,248		885,446
Direct Allocation Expenses	187,062	6.1%	53,703
Operating Expenses, including Direct Allocations	3,271,310		939,150
Indirect Allocation Expenses	277,582	8.5%	75,133
Total Expenses	3,548,893		1,014,283

Revenue	Start-Up	Operational Year 1	Operational Year 2
FFS (Medicaid)	$ -	$ 1,225,035.65	$ 1,489,875.77
County/Gap Fund	$ 1,014,282.83	$ 2,323,857.18	$ 2,084,967.07
Total Revenue	$ 1,014,282.83	$ 3,548,892.83	$ 3,574,842.84
Total Expenses	$ 1,014,282.83	$ 3,548,892.83	$ 3,574,842.84
Margin	$ -	$ -	$ -

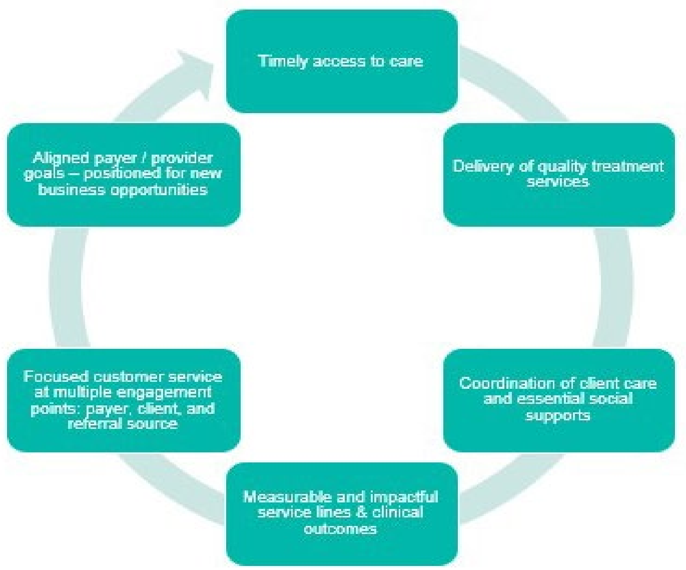
Revenue

The 23-hour CTC with recliners is expected to receive an actuarially determined Medicaid cost-based bundled episodic rate of reimbursement for a projected 2,200 episodes of crisis care annually, once at full services. The remaining 30% will be individuals who either remain uninsured, are enrolled in commercial health insurance or Medicare. There is not a CTC episode of care form of reimbursement unless specifically negotiated with each MCO. The CTC services for those who are uninsured can be billed to the ASO of the BH Collaborative.

The CTC portion of the facility that will be operating with beds will be reimbursed by Medicaid using an actuarially determined cost-based per diem. This crisis response component is expected to serve 768 individuals annually. The revenue assumptions for this CTC service are not unlike those for the 23-hour service, but with one exception. Medicare will reimburse for the professional services provided in this bedded unit. Due to this form of Medicare payment and the efficiencies that accrue from having both types of CTC under one-roof, it is anticipated that the combined facility will need to be operating for close to a year to determine real operating expenses and revenue. The County is advised in the interim to consult with its finance department, to determine the needed contingency funding to budget to cover potential liabilities associated with this bedded crisis stabilization unit.

Promotion

The key to the ongoing sustainability of the CTC is dependent on a steady flow of referrals and their successful stabilization and reintegration into the community. It is not dependent on competitive analysis, target market research, nor brand identity and positioning. Therefore, promoting the CTC requires a pragmatic approach that is typified by the Referral Development Planning Process that is diagrammed below:



If the CTC adheres to the *National Guidelines*, then the CTC will provide ongoing timely access to crisis response services, and it will be delivering consistently effective and efficient care.

However, the next three components of this process involve adopting what appeared earlier in this Business Plan regarding Level Five (5) of Care Coordination.

In this model, the highest level requires shared protocols for coordination and care management that are "baked into" electronic processes, not simply add-ons. For a crisis response system to provide Level five, "Close and Fully Integrated Care", it must implement an integrated suite of software applications that employ online, real-time, and 24/7 functionality, as indicated in the diagram below:

Level 1	Level 2	Level 3	Level 4	Level 5
MINIMAL	BASIC	BASIC	CLOSE	CLOSE
Agency Relationships	Shared MOU Protocols	Formal Partnerships	Data Sharing (Not 24/7 nor Real Time)	"Air Traffic Control" Connectivity

← CRISIS SYSTEM COMMUNITY COORDINATION & COLLABORATION CONTINUUM →

It would be ideal if NM's 988 crisis call center adopted the "Care Traffic Control" connectivity technology and practices as outlined in this Business Plan to achieve this level of care coordination. The County is strongly encouraged to collaborate with its BH and health care providers to adopt and maximize the care coordination functionality of NM's BH service registry - Treatment Connection: https://www.treatmentconnection.com/ and NM's Health Information Exchange (HIE) - SYNCRONYS: https://www.syncronys.org/.

7. Combined Crisis Triage Center Crisis Stabilization Services Implementation

San Juan County should establish the CTC to combine operating with recliners and beds which is allowable under NM's CTC licensure standards. The addition of beds would enable the CTC to serve the roughly 30% of CTC admissions that would not be sufficiently stabilized in under 23 hours.

The capacity projections for this level of care (LOC) are six (6) beds, serving 768 admissions annually once at 85% occupancy. In the first year of operations, it is expected to not reach 85% occupancy until month nine (9), with incremental growth starting around 40% occupancy. These individuals would have up to two weeks to be stabilized and would be expected to have an average length of stay (ALOS) of five (5) to seven (7) days. In addition, there would be economies of scale associated with the staffing of this combined CTC, that would also improve the CTC's financial sustainability.

8. Rural Crisis Service Adaptations

Planning needs to occur with the more sparsely populated areas of San Juan County to create local crisis response solutions, where access to facility-based crisis services may prove to be challenging.

As with most urban areas in the country, crisis response services will tend to be concentrated in the County's largest city – Farmington. In addition, the implementation of satellite

Community Calming Centers in rural areas, that are staffed by Certified Peer Support Workers, may be a viable rural adaptation.

The National Association of State Mental Health Program Directors (NASMHPD) issued a Technical Assistance Brief in 2020 entitled, *Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S.* This paper is divided into seven sections. The first five sections discuss the challenges and opportunities related to particular barriers to crisis service delivery in rural areas, including workforce, distance to travel and transportation, sustainability, and the use of technology and broadband access. These sections are followed by a section discussing the additional effects the COVID-19 pandemic was having on the delivery of BH crisis services in rural and frontier communities, and the implications each of these challenges and opportunities have had for policy makers. This publication should be considered a resource: https://nasmhpd.org/sites/default/files/2020paper10.pdf.

SMI Advisor, which is a clinical support system for serving those with serious mental illness, released the report, *Improving Behavioral Health Services for Individuals with SMI in Rural and Remote Communities.* This publication involved a partnership between SMI Advisor, NASMHPD, and the NASMHPD Research Institute (NRI), and it is designed to offer strategies and key lessons for developing, implementing, financing, and sustaining BH services for individuals who have SMI and live in rural and remote communities. A copy is available here: https://smiadviser.org/wp-content/uploads/2021/09/Improving-Behavioral-Health-Services-for-Individuals-with-SMI-in-Rural-and-Remote-Communities-Full-Report-September-2021.pdf

9. Care Coordination

Adopt the usage of SYNCHRONYS, NM's designated Health Information Exchange (HIE), by San Juan County health and BH service providers to assure that there is meaningful care coordination across the crisis response system and with other adjacent service systems.

With the adoption of SYNCHRONYS, by providers within San Juan County, the tools necessary to enable collaborative service planning will be available. More than 138 provider organizations currently utilize SYNCHRONYS statewide, including San Juan Regional Medical Center and Presbyterian Medical Services (PMS). https://www.syncronys.org/

The Agency for Healthcare Research (AHRQ), since 2011 has developed and updated what it terms, the *Care Coordination Measures Atlas*, which includes relevant research, a coaching manual, quality measures, and a safety net toolkit. According to AHRQ, "The main goal of care coordination is to meet a person's healthcare needs and preferences in the delivery of high-quality, high-value health care. This means that the patient's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide in the delivery of safe, appropriate, and effective care." *The Care Coordination Measures Atlas* contains a Care Coordination Measurement Framework that diagrams the key domains of care coordination that are important to facilitating meaningful care coordination and this

framework and its associated resources should assist with improving care coordination: https://www.ahrq.gov/ncepcr/care/coordination/atlas/chapter3.html.

10. Behavioral Health Workforce Development

San Juan County should adopt BH workforce development as a priority. Particular focus should be on attracting and supporting those from Black, Indigenous (with a specific focus on Navajo), and People of Color (BIPOC) and queer and trans BIPOC (QTBIPOC) populations, to careers within BH. San Juan County should implement The National CLAS Standards, which are a set of fifteen (15) action steps intended to advance health equity, improve quality, and help eliminate health care disparities.

The web portal *Think Cultural Health, https://thinkculturalhealth.hhs.gov/* features information, continuing education opportunities, resources, and more for health and health care professionals to learn about culturally and linguistically appropriate services, or CLAS. Launched in 2004, Think Cultural Health is sponsored by the Office of Minority Health at the U.S. Department of Health and Human Services (HHS).

San Juan County should review the Annual Reports of the NM Health Care Workforce Committee of the University of New Mexico (UNM), which includes a set of recommendations that are presented each year to the State Legislature. This Report has extensive data statewide and by county on the adequacy of each professional health care discipline, including those associated with BH.

These Reports will inform San Juan County on the status of its BH workforce that can serve as a benchmark against which workforce development initiatives can be measured. It also provides public policy recommendations which either the County can choose to implement or advocate for with the State Legislature. The Committee's 2023 Report can be accessed at https://digitalrepository.unm.edu/nmhc_workforce/11/.

11. Cost Offsets and Reinvestment Opportunities

When San Juan County's BH crisis response system is optimized, analyze the resulting cost offsets, and reinvest those cost offsets to further address the BH clinical and support service continuum and the social determinants of health.

It is anticipated that San Juan County will experience reductions in arrests, detention, ED, and hospital utilization; and therefore, the reinvestment of those savings can further buildout community-based services and supports. This requires providing intensive levels of community-based care, such as peer-run crisis respite, Assertive Community Treatment (ACT) teams, Intensive Outpatient (IOP), and supportive housing, supported education and employment to address the social determinants of health and system inequities. Ultimately, San Juan County like every other locality, must get upstream to prevent BH conditions and their effects in the first place, rather than always having to pay exorbitant costs on the back end to intervene to treat these conditions. Therefore, it is urged that there be greater investments in primary prevention, such as the highly researched and evidence-based, PAX

Good Behavior Game, which has been implemented in several NM school districts, including schools operated by the Indian Board of Education.

McKinsey & Company, in its publication in February of 2021 entitled, *Unlocking Whole Person Care through Behavioral Health,* stated,

> "Individuals with behavioral health conditions often face difficulty accessing treatment, high out-of-pocket costs, non-guideline-based care, and multiple forms of discrimination, leading to meaningful disparities in healthcare outcomes and affordability. In addition, in both government and commercially insured populations, around 60% of healthcare spend is attributable to the roughly 23% of the population diagnosed with behavioral health conditions."

McKinsey goes on to propose major strategies to address the overall lack of access to BH services. Among them, McKinsey recommends the expansion of community based BH crisis services which is among a set of actions to improve the quality of care and experience for those with BH conditions. Taken together, McKinsey projects an overall reduction in healthcare spending of $185 billion annually. To realize this saving requires an additional incremental investment of $65 billion which overtime will result in three (3) times the return on investment (ROI). https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/unlocking-whole-person-care-through-behavioral-health

The actions delineated in this Business Plan will increase access to crisis care, provide guideline-based crisis care, and reduce health inequities, while at the same time San Juan County is making increasing investments in BH, that include the establishment of the CTC. These investments will result in a positive return that can be re-invested to improve the BH system overall.

In optimizing San Juan County's crisis response system, there is the potential for a fifty percent (50%) reduction in healthcare spending related to ED and psychiatric inpatient utilization, according to the Crisis Resource System Calculator. This translates to a potential annual saving of $14 million, while serving more people annually. How many more individuals cannot be calculated without knowing the number of ED episodes of care monthly for those with BH conditions and the number of monthly psychiatric inpatient episodes of care.

In terms of the potential diversion impact of an optimized crisis response system on the San Juan County Detention Center, if it is assumed that 60% of the annual anticipated CTC admissions of 2200 are police drop-offs, it would be expected that up to 1,320 individuals annually would be diverted from County detention.

12. Peer Respite Center Implementation

Establish a peer respite center as a component within San Juan County's crisis response system. Peer respite centers are peer-run, voluntary, short-term (typically up to two weeks),

overnight programs that provide community-based, non-clinical support for people experiencing or at risk of an acute BH crisis.

Peer respite centers operate 24 hours per day in a homelike environment and can provide a "step-down" from facility-based crisis response services, where peer navigation services are provided to assist with transition back to the community. Peer respite centers also allow users to take a break from stressful life circumstances, while building a community of peers.

Peer respite centers are designed as psychiatric hospital diversion programs to support individuals experiencing or at-risk of a BH crisis. The premise behind peer respite centers is that psychiatric emergency services can be avoided, if less coercive or intrusive supports are available in the community. Peer respites engage guests in mutual, trusting relationships with CPSWs. Peer support involves a process of mutual help based on the principles of respect and shared responsibility. Peer support includes interactions in which individuals help themselves and others through fostering relationships and engaging in advocacy to empower people to participate in their communities.

All individuals associated with program management in these facilities have "lived experience" associated with BH conditions and are engaged in active recovery. The peer respite center either is typically operated by a peer-run organization or has an advisory group with 51% or more of its members having "lived experience." Within NM, there is no licensure or certification for peer respite centers nor a method of payment. Likewise, NM does not have a peer-run organization that is operating that could take on the management of peer respite center.

The web portal, at the link below, was created by Live & Learn, Inc. to provide the public access to resources about peer respites in the United States. The resources available include the criteria and definition of a Peer Respite, the Peer Respite Directory (updated in 2018), and the *Guidebook for Peer Support Program Self-Evaluation*, and reports from the Peer Respite Essential Features Surveys, which document nationwide trends in organizational characteristics and policies. This resource now serves as an archive for work that was completed prior to 2019, and it hosts a repository of research on peer respite programs. https://www.peerrespite.com/

13. Continuing consultation and collaboration with the Navajo Nation

San Juan County should continue consultation and collaboration with the Navajo Nation to assure that all BH crisis response services, including the CTC, are culturally humble and appropriate.

With 42.9% of the residents of San Juan County being Native American and the overwhelming majority of these being Navajo, approximately 60,000; and with 60.45% of the land within San Juan comprised of Navajo Nation land, it is imperative that the Navajo Nation be at the table in planning and operating BH crisis response services. Equally crucial is that these services contribute positively to the initiation of recovery to begin to ameliorate decades of intergenerational trauma and the ongoing effects of poverty, which are double the rates for NM and triple the rates for the U.S. A recent Tribal Summit on Pathways to Recovery stressed "that a connection to culture, supports treatment and recovery by reinforcing social justice

through one's indigenous identity, traditional learning, cultural healing, and environmental safeguards…Tribes draw strength from these traditions and their resilience is reinforced through culture, shared values, spirituality, and a strong sense of identity, responsibility, and accountability."
https://www.samhsa.gov/blog/pathways-recovery-highlighting-tribal-recovery-efforts?utm_source=SAMHSA&utm_campaign=d4f9df762aEMAIL_CAMPAIGN_2023_12_12_08_05&utm_medium=email&utm_term=0_-d4f9df762a-%5BLIST_EMAIL_ID%5D

The therapeutic literature provides only a handful of concrete examples for integrating indigenous traditional healing into mainstream therapeutic services within clinical settings. In an attempt to overcome this knowledge gap, a qualitative study involving the Native American diaspora in American cities, engaged with researchers and concluded that traditional healing that is integrated into clinical settings should entail the following four components: 1) ceremony to enact the healing, 2) education to relearn traditional practices, 3) culture keepers to guide traditional practices, and 4) community cohesion to protect against potentially exploitative culture keepers and ceremony participants (Hartmann, 2012).

"In addition to identifying these key components, this study also uncovered four important sources of tension that arose in planning the integration of traditional healing into clinical settings." These four dynamics appear to be between traditional healing protocols and the realities of impoverished urban living, multitribal representation and relational consistency with culture keepers, enthusiasm for traditional healing and uncertainty about who is trustworthy, and the integrity of traditional healing and the appeal of alternative medicine. The authors of the study stress that how each of these is resolved will likely depend on individual community needs, conditions, and health objectives. As such, the responsibility lies with Tribal communities and their external health care partners to ensure that each tension is resolved in a manner that brings maximal benefit to Tribal members. The Navajo Nation and San Juan County can potentially apply these learnings as the BH crisis response system is being planned, developed, and implemented.

Appendices

Appendix A: Stakeholder Engagement

The input, questions and comments from the stakeholder sessions can be grouped into the following general categories: Need, Operations, and System Impact.

Need

- A recognition that San Juan County is diverse and not well-resourced for meeting behavioral health services, particularly for youth.
- There is concern about access to CTC services in rural sections of the County and how people outside of Farmington may access the CTC and how services will be paid for those living outside of the County.
- Questions were raised about how the CTC would be responsive to the needs of indigenous populations, especially those of the Navajo Nation.
- General expression and recognition that a CTC could result in fewer inpatient admissions and use of the Emergency Departments for BH needs/crises.
- The construct of “No Wrong Door” was well received. Too frequently people attempt to access care and are rejected, without sufficient connection to the “right” resource.
- Law enforcement personnel (LE) were very receptive to having the CTC operate as a designated drop-off point for those in a BH crisis, as a facility with a no refusal policy for admissions presented by LE and a streamlined process for receiving these admissions resulting in LE getting back to performing their public-safety mission in under five minutes.
- The CTC would serve as an important resource to ensure stabilization through a crisis and reduce use of the ED, inpatient psychiatric care, and detention.
- A local CTC would greatly reduce the use of law enforcement by making long transports out of county for crisis care.
- Several stakeholders, including LE, expressed frustration at not receiving an appropriate response at the ED for someone seeking crisis care. It is hoped that access to a CTC will be a more expedient and responsive service.
- There is a frequent need for people who may be referred to a Homeless Shelter or sobering services who require a BH assessment/intervention and stabilization prior to integrating into these environments. There is hope that the CTC will be an appropriate first step into accessing these services.
- There is a lot of community support and interest in establishing the CTC as a point of entry to needed services. It was stressed that collaboration between the CTC and MHRC will facilitate both admissions, as well as discharges to the community.
- Several comments were made about the need for a similar CTC level of care for children and youth. It was suggested that the CTC could be a resource for transition age youth (18 to 24).
- Need to locate the CTC near or accessible to public transportation. It needs to be centrally located in the county to be readily accessible by Farmington and Bloomfield PDs and the Sheriff.
- Several positive comments were shared about the CTC serving individuals with mental illness, substance use and co-occurring disorders.
- It would be positive if the CTC reduced the number of jail bookings for people experiencing a BH crisis.

Operations

- Questions about accepting and serving people who are unhoused (on the street or in a shelter) and how they will be connected to community resources upon stabilization and release.
- Some service providers are reluctant to call law enforcement out of concern about possibly escalating a situation or it results in an arrest. They want to know what resources and processes will be available so that people can access a CTC without law enforcement engagement? Multiple questions and comments were offered about accepting people without law enforcement engagement or transportation. They want CTC to be able to accept referrals and admissions at all hours and on a voluntary and involuntary basis.
- Concerns were expressed about the possibility of people cycling through the CTC frequently and not engaging in follow-up community services. This was expressed several times along with the recognition there are any number of "known" people who make "inappropriate" use of services.
- Several positive comments were made about the significant role of Certified Peer Support Workers (CPSW) at the CTC.
- The perception was shared that there is not an adequate labor pool of people with "lived experience" who are trained and certified as Peer support Workers to become part of the CTC staff.
- It was noted that several programs have had significant difficulty recruiting and retaining professional BH staff. Concern that this labor shortage will impact CTC hiring and operations.
- Several questions were expressed about how the CTC would coordinate with the hospital and the ED; how it would accept referrals from EDs for people who do not require a hospital admission; and for those transferring from the CTC due to medical needs or who are so acute they do need a hospital admission.
- Several questions were asked about the use of and access to virtual technology at the CTC. This could be useful for some court hearings, connections with family members, and even possibly as part of a welcome message for individuals reluctant to come to the facility.
- There were many questions about how large the CTC would be, how many recliners, how many beds and how it would be staffed given a fluctuating census and where would it be located.
- For people who are served at the CTC but also receiving services in the community, the need was stressed for meaningful care coordination.

System Impact

- The following question was asked several times, "Will the CTC reduce the number of people with significant BH needs currently being booked into the County Jail?"
- It was expressed that there are individuals with misdemeanor offenses that are released from the Jail who could benefit from services through a CTC.
- There were several concerns about what happens when people are stabilized and ready to leave the CTC. There were concerns expressed regarding the limited choices for community placement and for supportive housing.
- There were some questions about what service provider would operate and manage the CTC? And, how the CTC would relate with the network of existing providers?
- It was suggested that it would be important to gain buy-in for the CTC from the hospital and ED.
- It was also suggested that there be a process for on-going and regular communication with key stakeholders as CTC progresses and continues once it is operational.

- Several individuals asked for the opportunity to review and comment on a draft report/plan before it is finalized and adopted.
- There were questions raised about how services would be paid for, for CTC admissions of residents from surrounding counties and even states.

THE FOLLOWING ORGANIZATIONS HAVE CONTRIBUTED TO THIS PROJECT:

- BlueCross/BlueShield NM
- City of Aztec Police Department
- City of Bloomfield Police Department
- City of Farmington Police department
- Farmington Daily Times
- Law Offices of the Public defender's Office
- Presbyterian Medical Services (PMS)
- San Juan College
- San Juan County Adult Detention Center
- San Juan County Commissioners
- San Juan County Emergency Medical Services (EMS)
- San Juan County Health and Wellness Center
- San Juan County Manager's Office
- San Juan County Regional Medical Center (SJCRMC)
- San Juan County Mental Health Task Force
- San Juan County Partnership, Inc.
- San Juan County Sheriff's Office
- San Juan County United Way
- San Juan Safe Communities Initiative (SJSCI)
- Sasha's Rainbow of Hope
- Senator Martin Heinrich's Office
- The Arc of San Juan County, Inc.

Appendix B: Acronyms

ACT	Assertive Community Treatment
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AHCCCS	Arizona Healthcare Cost Containment System
AHRQ	Agency for Healthcare Research and Quality
ALOS	Average Length of Stay
ALTSD	Aging and Long Term Services Department
ASO	Administrative Services Organization
ASL	American Sign Language
BH	Behavioral Health
BHA	Behavioral Health Agency
BHC	Behavioral Health Collaborative
BHRC	Behavioral Health Resource Center
BHL	Behavioral Health Link
BHSD	Behavioral Health Services Division
BIPOC	Black, Indigenous, and People of Color
CAQH	Council for Affordable Quality Healthcare
CASA	Court Appointed Special Advocates
CCBHC	Certified Community Behavioral Health Center
CCC	Community Calming Centers
CCSS	Comprehensive Community Support Service
CFR	Code of Federal Regulations
CIP	Crisis Intervention Program
CIT	Crisis Intervention Team
CLAS	Culturally and Linguistically Appropriate Services
CIWA	Clinical Institute on Withdrawal Assessment
CLNM	Care Link New Mexico
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid
CPI	Crisis Prevention Institute
CQI	Continuous Quality Improvement
CPSW	Certified Peer Support Worker
CRISES	Crisis Reliability Indicators Supporting Emergency Services
CRC	Crisis Receiving Center
CSG	Council of State Governments
CSA	Core Service Agency
CTC	Crisis Triage Center
CYFD	Children, Youth, and Families Department
DHI	Division of Health Improvement
DOH	Department of Health
ECC	Emergency Contact Center
ED	Emergency Department
EDC	Educational Development Corporation, Inc.
EHR	Electronic Health Record
EMS	Emergency Medical Services
EMT	Emergency Medical Technician

FCC	Federal Communications Commission
FAQ	Frequently Asked Questions
FFS	Fee-for-Service
FGI	Facility Guidelines Institute
FMAP	Federal Medical Assistance Percentages
FOCUS-PDCA	Find, Organize, Clarify, Understand, Select - Plan, Do, Check, and Act
FPD	Farmington Police Department
FQHC	Federally Qualified Health Center
FTE	Full Time Equivalent
GPS	Global Positioning System
HHS	U.S. Department of Health and Human Services
HIE	Health Information Exchange
HIPAA	Health Information Portability and Accountability Act
HRA	Health Resource and Services Administration
HSD	Human Services Department
IHS	Indian Health Service
IIMHL	International Initiative for Mental Health Leadership
IP	Inpatient
IPS	Individual Placement and Supports
IOP	Intensive Outpatient Program
KFF	Kaiser Family Foundation
LOC	Level of Care
LOI	Letter of Intent
IMD	Institute of Mental Disease
LOCUS	Level of Care Utilization System
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, and Other
MAD	Medical Assistance Division
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MCT	Mobile Crisis Team
MH	Mental Health
MHPAEA	Mental Health Parity and Addiction Equity Act
MOU	Memorandum of Understanding
MRSS	Mobile Response and Stabilization Service
NASMHPD	National Association of State Mental Health Program Directors
NENA	National Emergency Number Association
NMAC	New Mexico Administrative Code
NMCAL	New Mexico Crisis and Access Line
NMCS	New Mexico Community Survey
NMSA	New Mexico Statutes Annotated
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration
NSPL	National Suicide and Prevention Lifeline
NTSB	National Transportation Safety Board
NPO	Non-Profit Organization
OP	Outpatient
OSAP	Office of Substance Abuse Prevention
OUD	Opioid Use Disorder

PHP	Partial Hospitalization Program
PHS	Permanent Supportive Housing
PMHC	Police-Mental Health Collaboration
PMS	Presbyterian Medical Center
PSAP	Public Safety Answering Point
PSH	Permanent Supportive Housing
PTSD	Post-Traumatic Stress Disorder
PWIDD	Person With an Intellectual or Developmental Disorder
QMP	Quality Management Plan
RI	RI International
RSA	Recovery Services Administrator
SAMHSA	Substance Abuse and Mental Health Services Administration
SE	Supported Education
SFTP	Secure File Transfer Protocol
SJC	San Juan College
SIM	Sequential Intercept Mapping
SJCCA	San Juan County Communications Authority
SJCP	San Juan County Community Partnership, Inc.
SMI	Severe Mental Illness
SOW	Scope of Work
SPRC	Suicide Prevention Resource Center
SRAS	Suicide Risk Assessment Standards
SUD	Substance Use Disorders
TAC	Technology Assisted Care
TIP	Treatment Improvement Protocol
UM	Utilization Management
UNM	University of New Mexico
UPS	Universal Power Supply

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Appendix D: San Juan County Crisis System Needs Analysis

San Juan County Crisis System Needs Analysis

Presented by:
Wayne Lindstrom, PhD
VP, Business Development and Consulting

SAN JUAN COUNTY NEW MEXICO SINCE 1887

Overview of Capacity Modeling

The innovative **Crisis Resource Need Calculator** offers optimal crisis resource allocations to meet the needs of each community. It enables communities to understand the potential healthcare cost associated with delivering care for all individuals requiring BH crisis care.

The algorithm uses current data from the area(s) being assessed as well as key crisis performance indicators from exemplar service providers to predict the capacity needed to serve the expected number of crisis events over the course of a year.

This document will share the **output** of the calculator including potential capacity needs and potential differences in current and future state. It will also share the **inputs** used for calculations of **San Juan County.**

The calculations are based on data gathered from several states and the *Crisis Now Business Case*. A video delineating the methodology can be seen on NASMHPD's www.crisisnow.com.

Data Points

Below are the integrated data points provided by the **Crisis Resource Need Calculator**.

Data Point	Data
Population	125,043
ALOS of Acute Inpatient (Days)	7.5
Acute Bed Occupancy Rate	90%
Avg Cost of Acute Bed/Day	$1,464
Escalation Rate of Subacute to Acute	25%
ALOS of Subacute (Days)	2.5
Subacute Bed Occupancy Rate	90%
Avg Cost of Short-Term Psych Bed/Day	$1,464
Escalation Rate of Chair to Subacute	35%
ALOS Crisis Observation Chair (Days)	0.8
Crisis Chair Occupancy Rate	70%
Avg Cost Per Crisis Chair/Episode	$835
Escalation of Mobile Team to Chair	30%
Cost per Mobile Team	$270,000
Mobile Team time on Scene (Hrs)	1.25

Population & Demographics

Population Coverage

125k

San Juan Co.

Housing Units Occupied

85%

Graduate 5.5%
Bachelor's 8%
Associates 12%
Some College 28%
HS, No College 31%
Some High School 11%
No High School 4.2%

Ethnicity

Native American 40%
White 52%

Age

0-17 29%
18-29 15%
30-44 18%
45-64 24%
65+ 14%

CRISIS NOW ACADEMY

Estimated Annual Behavioral Health Episodes & Costs

Below is a breakdown of annual estimated costs and estimated crisis episodes in a complete crisis care system for **San Juan County**.

$14 million

Acute Inpt
EDs
Short Term Beds
Crisis Chairs
Mobile Teams

15,000,000
10,000,000
5,000,000
0

5,200 Episodes

Acute Inpt
EDs
Short Term Beds
Crisis Chairs
Mobile Teams

6,000
4,000
2,000
0

CRISIS NOW ACADEMY

Mobile Team Capacity Predictions

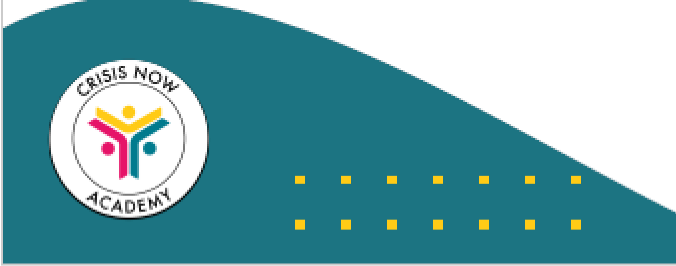
2 Mobile Teams
(assuming 40-hour work week)

serving

2,200 people
annually

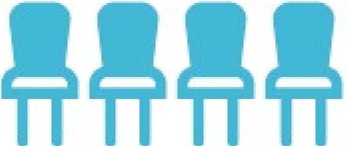
with a cost prediction of

$459k



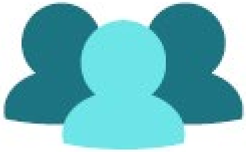
Crisis Chair Capacity Predictions

7 Crisis Chairs



serving

2,200 people
annually

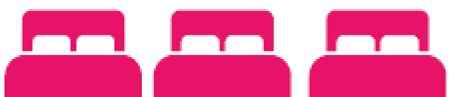


with a cost prediction of

$3.2 million
Annually

Short Term Bed Capacity Predictions

6 Short Term Beds



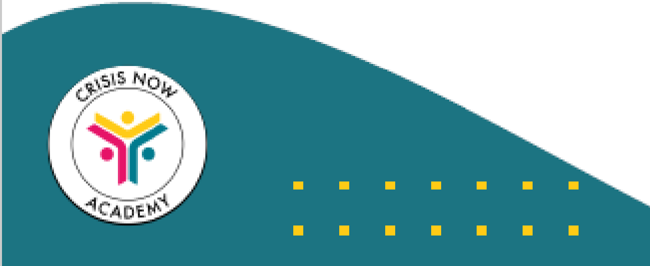
serving

768 Adults
annually

with a cost prediction of

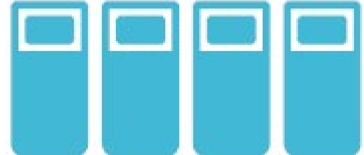
$403k

Annually



Acute Inpatient Capacity Predictions

15 acute beds



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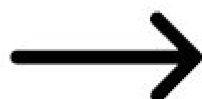
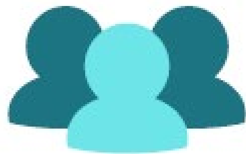


675 Adults
annually



with a cost prediction of

$7.4 million
Annually

Limitations of Capacity Modeling

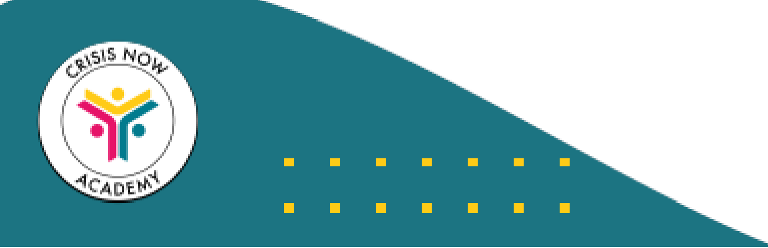
Capacity modeling is a predictive practice to estimate the behavioral health needs of a community. It involves the translation of data gathered from other communities and transposing it to the New Mexico population. As with all predictive models incorporating data, there may not be a perfect correlation to New Mexico actuals.

Additionally, the capacity model above represents a fully aligned system to SAMSHA's *National Guidelines for Behavioral Health Crisis Care (2020).* It takes into account the building of an integrated system working together to ensure that people access services at any point and are able to be connected with the right level of care. This means that creating one element of the system in absence of the others would skew capacity for that element up or down.

Capacity model predicts the actual needs for the community, not necessarily the utilization. Some communities have systems that are underutilized for a variety of reasons. These reasons include poor system performance, poor awareness, regulatory challenges, poor site placement, and others. Capacity recommendations should be taken as the upper limit of need.

The Capacity Model is based on current data elements from San Juan County. We would anticipate that these data elements will begin to change in the coming years (i.e. population increases, average length of stay decreases, escalation rate changes). Capacity Modeling should be done at least annually to align with changes in data elements.

Stakeholders also need to be aware that it takes time to align utilization with capacity predictions. It may take a year or more to align actual usage with predicted capacity. This process is sped up through good community outreach but still can take longer than anticipated.



Appendix E: Crisis Triage Center Implementation Plan

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Category	Task	Staff Responsible	Start Date	Finish Date
01. Initial Preparations	1.1 Identify Implementation Team of key staff from Finance, HR, Clinical, Communications, IT, QI, Facilities Mgt, Risk Mgt, Billing & Administration			
01. Initial Preparations	1.2 Meet with stakeholders, including Funder, community supporters, schools, probation and parole, youth services, police, ED's housing and other providers announcing program and introducing it into the community			
01. Initial Preparations	1.3 Contract Completion- Final negotiations completing including start-up, ramp-up and annual budget 1.3.a Letter of Intent? 1.3.b Bridge Contract?			
01. Initial Preparations	1.4 Any additional contractors (i.e., MCO's or TPL)			
02. Program Site: Review and Selection	2. Identify and choose location			
02. Program Site: Review and Selection	2.1 Identify and choose architect			
02. Program Site: Review and Selection	2.1.1 Include costs: • Architect • Consultant Costs • Licensing/Application Fees • Build-out/up fit costs of facility			
02. Program Site: Review and Selection	2.1.2 Negotiate and finalize lease (preferable to have realtor to support this effort)			
02. Program Site: Review and Selection	2.2 Review site and approvals to move forward			
02. Program Site: Review and Selection	2.3 Funder review site and approves to move forward			
02. Program Site: Review and Selection	2.4 Finalize lease and terms			
02. Program Site: Review and Selection	2.5 Sign lease			
03. Program Site: Renovations	3. Meet with architect to design space			
03. Program Site: Renovations	3.1 Plan renovations to compliance			
03. Program Site: Renovations	3.1.a. Furniture plan			
03. Program Site: Renovations	3.2 Finalize plan for renovation / submit for permit process			
03. Program Site: Renovations	3.3 Request bids from contractors			
03. Program Site: Renovations	3.4 Select contractors			
03. Program Site: Renovations	3.5 Determine Completion Date			
03. Program Site: Renovations	3.6 Schedule work: **obtain timeline**			
03. Program Site: Renovations	3.7 Schedule licensing inspections (review plans)			
03. Program Site: Renovations	3.8 Com Room <MDF/Server Room> include in buildout of facility			
04. Program	4.1 Create working program description to guide process and notify team of needs			

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Category	Task	Staff Responsible	Start Date	Finish Date
04. Program	4.2 Meet with funder to review program requirements			
04. Program	4.3 Eligibility Requirements			
05. Human Resources: All	5.1 Identify HR needs, credentials, requirements, processes, etc. and plan for start up including start date for new hires			
05. Human Resources: General	5.2 Approval of job descriptions with accurate requirements and duties			
05. Human Resources: Recruiting	5.3 Review Staffing Plan/Budget to determine staffing pattern and staff needs			
05. Human Resources: Recruiting	5.4 Determine any Medical Director needs and fill plan (Shared, Individual, Physician Group, etc.)			
05. Human Resources: Recruiting	5.5 Determine any Provider needs and fill plan (Shared In house, Agency, etc.)			
05. Human Resources: Recruiting	5.6 Peer Employment Training RECRUITING (If applicable): Prepare PET advertising/postings to generate qualified leads/candidates for PET classes to create Peer candidate pool (only if hiring *post* PET class)			
05. Human Resources: Recruiting	5.7 Determine, prepare and post internal/external posting/advertising to recruit qualified staff/candidates			
05. Human Resources: Recruiting	5.8 Collect, Screen and Process applications			
05. Human Resources: Recruiting	5.9 Receive, Screen & Interview applicants, determine hires and advise HR/Recruiting			
05. Human Resources: Recruiting	5.10 Hire staff (offers to be made minimum 2-3 WEEKS prior to employee start date) inc. all onboarding processes. Include ALL paperwork (including onboarding, state/county-specific forms, authorized driver, ROI, etc.)			
05. Human Resources: Recruiting	5.11. Any needs state-specific needs required for staff?			
06. Orientation and Training	6.1 Determine start date & schedule for PET& NEO as needed			
06. Orientation and Training	6.2 On-Site Orientation			
06. Orientation and Training	6.3 Roles & Responsibilities of each position			
06. Orientation and Training	6.4 Process & Procedure Review			
06. Orientation and Training	6.5 Licensing Shadowing @ other locations			
06. Orientation and Training	6.6 CPI/ Therapeutic Options Training / Ukeru			
06. Orientation and Training	6.7 CPR/ First Aid/ AED			
06. Orientation and Training	6.8 Motivational Interviewing			
06. Orientation and Training	6.9 Person Centered Thinking			
06. Orientation and Training	6.10 Relias Training			
06. Orientation and Training	6.11 Quality & Compliance Trainings			
06. Orientation and Training	6.12 HR Trainings			
07. Risk Management	7.1 Review program, site and staff for all insurance, health & safety, workers comp, etc.			

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Category	Task	Staff Responsible	Start Date	Finish Date
08. CBO	8.1 Obtain NPI Number			
08. CBO	8.2 Obtain Medicaid ID			
08. CBO	8.3 Obtain Contract and Fee Schedule			
08. CBO	8.4 Coordinate with IT to program new fiscal, billing and program codes per contract			
08. CBO	8.5. Create billing capacity to bill Medicare and TPL			
08. CBO	8.6 Review and delineate contract deliverables, including reporting requirements			
08. CBO	8.7 Identify reporting & billing requirements.			
08. CBO	8.8 Verify Billing Functionality			
08. CBO	8.9 Netsmart and RCM Billing and Software Training			
08. CBO	8.10 TPL Required?			
09. Fiscal Systems	9.1 Review Start Up Budget			
09. Fiscal Systems	9.1.a Ramp-up budget (if needed)			
09. Fiscal Systems	9.2 Review Operations Budget			
09. Fiscal Systems	9.3 Assign Department Numbers			
09. Fiscal Systems	9.4 Notify HR/Payroll and relevant departments of new #s			
09. Fiscal Systems	9.5 Create Account Numbers/Budget Input			
09. Fiscal Systems	9.6 Establish Accounts Receivable			
09. Fiscal Systems	9.7 Insurance Allocation (internal)			
09. Fiscal Systems	9.8 Establish any specific billing report format for distribution to funder			
09. Fiscal Systems	9.9. Finalize Budgets			
10. Purchasing	10.1 Identify & review Equipment needs list, including copiers, fax machines, computers, printers, cell phones, medical equipment, etc.			
10. Purchasing	10.2 Identify, order and purchase cell phone and MiFi needs			
10. Purchasing	10.3 Purchase all furniture and decorations: Identify delivery date			
10. Purchasing	10.3. a. Install furniture upon building completion date			
10. Purchasing	10.4 Identify and review office supply items including, pens, paper, staplers, calendars, dry erase boards, etc.			
10. Purchasing	10.5 Purchase furnishings and office supplies			
10. Purchasing	10.6 Identify & review Program Supply needs list including therapeutic and recreational activities, books on mental illness, recovery, wellness and personal items, etc.			
10. Purchasing	10.7 Purchase supplies			
10. Purchasing	10.8 Medical Purchases			
10. Purchasing	10.9 Design and Purchase Signage			
10. Purchasing	10.10 Coordinate with home-like decorations			
11. Vendors	11. Utilities, etc.			
11. Vendors	11.1 Set up contracts for vendor services			
11. Vendors	11.2. Cleaning / Janitorial			
11. Vendors	11.3. Linens			
11. Vendors	11.4 Food (In house kitchen or catered?)			
11. Vendors	11.5 Speciality Supplies (kitchen, medical room, etc.)			
11. Vendors	11.6 Transportation Vendor (if needed)			
11. Vendors	11.7 Medications			
12. Medical	12.1. Formulary			
12. Medical	12.2. Prescription Pads			

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Category	Task	Staff Responsible	Start Date	Finish Date
13. Information Technology: Requirements	13.1 Assess site for IT configuration			
13. Information Technology: Requirements	13.1.1 Install Data Lines: Private Port- T1 / DSL / Cable			
13. Information Technology: Requirements	13.2 Identify location of data and phone drops			
13. Information Technology: Requirements	13.3 Identify any connectivity issues relating to facility			
13. Information Technology: Requirements	13.4 Identify and order computer equipment: Laptops, Workstations			
13. Information Technology: Requirements	13.5 CCTV or other video needs			
13. Information Technology: Requirements	13.6 Identify and order network peripherals: Fax/Scanners/Printers, Switches, Firewall, Router			
13. Information Technology: Requirements	13.7 Identify and order Phone requirements			
13. Information Technology: Requirements	13.8 Setup EHR structure			
13. Information Technology: Requirements	13.9 Confirm EHR meets program needs for tracking, EMR and Connection to Care, etc.			
14.EHR	14.1 Setup EHR structure			
14.EHR	14.2 Confirm EHR meets program needs			
14.EHR	14.3 Create Workflows for EHR			
14.EHR	14.3.1 Initial New Site EHR Orientation			
14.EHR	14.4 Identifying Reporting Requirements			
14.EHR	14.5 Identify what data available and required through EHR to capture necessary data and create reports			
14.EHR	14.6 EHR Training			
15. Software	15.1. Clinical Document Training			
16. QI Plan	16.1 Formulate QI Plan according to proposal, evidence-based practices and projected outcomes			
16. QI Plan	16.2 Official Program Description			
16. QI Plan	16.3 Implement Building, Vehicle & Fire Safety Inspections			
16. QI Plan	16.4 Implement Incident Reporting and Tracking			
16. QI Plan	16.5 Implement Complaint & Grievance Tracking			
16. QI Plan	16.6 Identify QI Indicators with staff			
17. Quality Improvement Plan	17.1 Identify Outcome Measures			
17. Quality Improvement Plan	17.2 Include Compliance Plan into operations			
17. Quality Improvement Plan	17.3 Plan audits, compliance reviews & inspections			
17. Quality Improvement Plan	17.4 Plan Satisfaction Surveys			
17. Quality Improvement Plan	17.5 Ensure HIPAA program compliance			
18. Medical Records	18.1 Determine what information must be captured in the medical record including preferences and expectations			
18. Medical Records	18.2 Determine at what point the information must be captured i.e. initial contact or during face-to-face visit.			
18. Medical Records	18.3 Develop policies and procedures for medical record by job requirement.			
18. Medical Records	18.4 Implement tracking for requests to release records			

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Category	Task	Staff Responsible	Start Date	Finish Date
19. Program Site: Credentialing	19.1 CLIA Waiver			
19. Program Site: Credentialing	19.1.1 Submit CLIA application.			
19. Program Site: Credentialing	19.1.2 Receive CLIA Fee Coupon – pay fee.			
19. Program Site: Credentialing	19.1.3 Receive CLIA Waiver Certificate.			
19. Program Site: Credentialing	19.2 Complete Facility DEA registration online.			
19. Program Site: Credentialing	19.3 Receive Facility DEA number.			
19. Program Site: Credentialing	19.3.1 Receive controlled substance registration.			
19. Program Site: Credentialing	19.4 Obtain Medicare Certification			
19. Program Site: Credentialing	19.5 Determine Optum Facility Credentialing and Site Visit Requirements			
19. Program Site: Credentialing	19.6 Submit Programmatic Licensing Application			
20. Develop P&Ps, Forms and Chart	20.1 Review with all applicable standards including accreditation requirements as needed for compliance			
20. Develop P&Ps, Forms and Chart	20.2 Transfer applicable, existing policies, procedures and forms to new program or create anew as needed			
20. Develop P&Ps, Forms and Chart	20.3 Submit policies, procedures and forms for internal review			
20. Develop P&Ps, Forms and Chart	20.4 Finalize Policy and Procedure Manual			
21. Program Documents	21.1 Institute building & fire safety inspections			
21. Program Documents	21.2 Obtain Certificate of Occupancy			
22. Promote & Develop Marketing Plan	22.1 Attend Provider meetings			
22. Promote & Develop Marketing Plan	22.2 Re-Identify key provider agencies including inpatient units, emergency services, drug and alcohol programs, advocacy groups, case management services, housing agencies, adult foster care programs, primary care physicians, outpatient clinics, etc			
22. Promote & Develop Marketing Plan	22.3 Hold meetings with key provider agencies to facilitate coordination of services			
22. Promote & Develop Marketing Plan	22.4 Schedule Open House (invitations, invite police & fire)			
22. Promote & Develop Marketing Plan	22.4.1 Create invitation			
22. Promote & Develop Marketing Plan	22.4.2 Send invitations			
22. Promote & Develop Marketing Plan	22.5 Hold Open House (internal/external)			
23. GO LIVE	**GO LIVE**	**Entire Team**		

Master Purchase List

Description	FF&E STARTUP	Quantity	Unit cost	Total	Comments
Technology					
Server	Server computer, temperature monitor and software				
	UPS				
	Network switch				
	Cables				
	Rack and patch panel				
Group Printer	Group printer				
	Desktop printer				
Admin Laptops	Laptop with bag, docking station, monitor, licenses, webcam & speakers				
	Power strips & cables				
Staff Laptop or Desktop	Laptop with bag				
	Licenses				
	Power strips & cables				
Staff Tablets	Tablet				
	Screen Protector				
Guest Tablets	Tablet				
	Screen Protector				
Law Enforcement Entrance Tablets	Tablet				
	Screen Protector				
	Mobile Work Stations				
Staff Communication	Walkie talkie communications				
	Cellphones				
	MIFI				
	TV 55"				
	TV Mount				
	TV 60" Screen Cover				
	Projectors				
Carts	Linen, Carts				
	Supply, Carts				
Medical Supplies	Phlebotomy, Chair				
	Diagnostic Set (Ophthalmoscope/Otoscope) Portable & Wall mounted				
	Lab Instrumentation (Glucose & POCT)				
	Stools, Exam				
	Exam/Treatment, Table				
	Automated Med stations (I.e. Pyxis)				
	ECG				
	Vital signs monitor				
	Cup Dispenser				
	PPE Dispenser and Glove Box				
	PPE & Food Supplies				
	Sharps Receptacles, Wall- Mounted				
	Breathalyzers				
	Roll Stands, Monitor				
	Safe				
	Mini Refrigerator				
	Mobile Stand-On Scale				
	Regular Scale				
	Wheelchair				
	Mobile Patient Lift				
Activity Supplies	Gym Equipment (yoga mats, basketballs, etc)				
	Internal Activity Items (Adults)				
	Internal Activity Items (Children)				
	Respite Room Supplies				
Supplies	Office Supplies (clipboards, copy paper, pens, etc)				
	Laundry Supplies				
	Guest Hygiene Supplies				
Building Needs	Hand Sanitizer Dispenser				
	Kitchen Supplies				
	Wire Rack				
	Bin Storage System				
	Safe petty cash				
	Hot box				
	Washer & Dryer				
	Staff Breakroom #1				
	Staff Breakroom #2				
	Police Breakroom				
	Ice machine				
Safety Supplies	Wands				
	Ukeru Supplies				
	Sales Tax				
	TOTAL EQUIPMENT & FURNISHINGS:				

Master Staffing Plan by Service

Total # FTE From CM	Position	Intake / Triage # FTE	24/7 MHUC Urgent Care # FTE	23 hour Obs 40 recliners # FTE	CTC 16 beds # FTE	Family Resource Center # FTE	Shared Sta # FTE	TOTAL FTE	$ per hour	Plus 9% for 2024 Start (3 yrs @ 3%)	8 or 12 hour shifts (24/7 only)	Comments
	Chief Medical Officer											
	Program Director											
	Program Supervisor											
	Clinical Supervisor											
	Support Services Manager											
	Support Services Coordinator											
	Nursing Director											
	Authorization Specialist											
	Billing Specialist III											
	Medical Director											
	Nurse Manager											
	Vice President OH											
	Billing Manager											
	State Director											
	Provider Manager											
	Peer Manager											
	Nurse Practioner											
	Nurse - RN											
	Nurse - LPN											
	Shift Supervisor / Clinician											
	MHP											
	Team Lead											
	Peer Support Specialist											
	Milieu Specialist											
	Familly Resource Lead											
	Community Liaison											
	Customer Service Specialist											
	Admit / Discharge Coordinator											
	Facility Navigators											
	Food Services Manager											
	Food Services Assistant											
	Transportation Specialist / Peer											
0	TOTAL FTE:											

Facility Implementation Plan

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Completed?	Update/Notes
1.1	Initial Preparations	Identify who from each support department should be on the Implementation Team from Finance, HR, Clinical, Communications, IT, QC, EHR, Facilities Mgt, Risk Mgt, Billing & Administration					
1.2	Initial Preparations	Meet with stakeholders, including Funder, community supporters, schools, probation and parole, youth services, police, ED's housing and other providers announcing program and introducing it into the community					
1.3	Initial Preparations	Contract Completion with Funder- Final negotiations completing including start-up, ramp-up and annual budget Letter of Intent? Bridge Contract?					
1.4	Initial Preparations	Identify Additional MCOs for contracting					
		Care Source					
		Buckeye (Centene)					
		Optum					
		Molina					
		Anthem (Paramount)					
2.1	Program Site: Review and Selection	Identify and choose location					
2.2	Program Site: Review and Selection	Negotiate lease agreement and terms with Funder					
2.3	Program Site: Review and Selection	Review site, walkthrough, and approvals to move forward					
2.4	Program Site: Review and Selection	Finalize lease and terms					
2.5	Program Site: Review and Selection	Sign lease					
3.1	Program Site: Renovations	Furniture plan					Furnishings will be decided upon once floor plan reviewed and approved Furniture order completed.

Facility Implementation Plan

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Completed?	Update/Notes
4.1	Program	Review Regulations for each service					
4.1	Program	Create working facility description to guide process and notify team of high-level needs					
4.2	Program	Meet with funder to review program requirements					
4.3	Program	Eligibility Requirements					
5.1	Human Resources: All	Identify HR needs, credentials, requirements, processes, etc. and plan for start up including start date for new hires					
5.2	Human Resources: General	Approval of job descriptions with accurate requirements and duties					
5.3	Human Resources: Recruiting	Review Staffing Plan/Budget to determine staffing pattern and staff needs					Look for detailed staffing plan in each tab pursuant to that tab's room/service
5.4	Human Resources: Recruiting	Determine any Medical Director needs and fill plan (Shared, Individual, Physician Group, etc.)					
5.5	Human Resources: Recruiting	Determine any Provider needs and fill plan (Shared In house, Agency, etc.)					
5.6	Human Resources: Recruiting	Peer Employment Training RECRUITING (If applicable): Prepare PET advertising/postings to generate qualified leads/candidates for PET classes to create Peer candidate pool (only if hiring *post* PET class)					
5.7	Human Resources: Recruiting	Determine, prepare and post internal/external posting/advertising to recruit qualified staff/candidates					
5.8	Human Resources: Recruiting	Collect, Screen and Process applications					
5.9	Human Resources: Recruiting	Receive, Screen & Interview applicants, determine hires and advise HR/Recruiting					

Facility Implementation Plan

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Completed?	Update/Notes
5.10	Human Resources: Recruiting	Hire staff (offers to be made minimum 3 WEEKS prior to employee start date) inc. all onboarding processes. Include ALL paperwork (including onboarding, state/county-specific forms, authorized driver, ROI, etc.)					
5.11	Human Resources: Recruiting	Any state-specific needs required for staff?					
6.1	Orientation and Training	Determine start date & schedule for PET & NEO as needed					
6.2	Orientation and Training	On-Site Orientation					
6.3	Orientation and Training	Roles & Responsibilities of each position					
6.4	Orientation and Training	Process & Procedure Review					
6.5	Orientation and Training	Licensing Shadowing @ other locations					
6.6	Orientation and Training	CPI/ Therapeutic Options Training/Ukeru/Safe Clinch					
6.7	Orientation and Training	CPR/ 1st Aid/ AED/NARCAN					
6.8	Orientation and Training	Motivational Interviewing					
6.9	Orientation and Training	Person Centered Thinking					
6.10	Orientation and Training	Relias Training					
6.11	Orientation and Training	Quality & Compliance Trainings					
6.12	Orientation and Training	HR Trainings					
7.1	Risk Management	Review program, site and staff for all insurance, health & safety, workers comp, etc.					
8.1	CBO	Obtain NPI Number					
8.2	CBO	Obtain Medicaid ID					
8.3	CBO	Obtain Contract and Fee Schedule					
8.4	CBO	Coordinate with IT to program new fiscal, billing and program codes per contract					
8.5	CBO	Create billing capacity to bill Medicare and TPL					
8.6	CBO	Review and delineate contract deliverables, including reporting requirements					
8.7	CBO	Identify reporting & billing requirements.					
8.8	CBO	Verify Billing Functionality					

Facility Implementation Plan

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Completed?	Update/Notes
8.9	CBO	Netsmart and RCM Billing and Software Training					
8.10	CBO	Third Party Liability Payments					
9.1	Fiscal Systems	Review Start Up Budget					
9.2	Fiscal Systems	Ramp-up budget (if needed)					
9.3	Fiscal Systems	Review Operations Budget					
9.4	Fiscal Systems	Assign Department Numbers					
9.5	Fiscal Systems	Notify HR/Payroll and relevant departments of new #s					
9.6	Fiscal Systems	Create Account Numbers/Budget Input					
9.7	Fiscal Systems	Establish Accounts Receivable					
9.8	Fiscal Systems	Insurance Allocation (internal)					
9.9	Fiscal Systems	Establish any specific billing report format for distribution to funder					
9.10	Fiscal Systems	Finalize Budgets					
10.1	Purchasing	Identify & review Equipment needs list, including copiers, fax machines, computers, printers, cell phones, medical equipment, etc.					
10.2	Purchasing	Identify, order and purchase cell phone and MiFi needs					
10.3	Purchasing	Purchase all furniture and decorations: Identify delivery date					
10.4	Purchasing	Install furniture upon building completion date					
10.5	Purchasing	Identify and review office supply items including, pens, paper, staplers, calendars, dry erase boards, etc.					
10.6	Purchasing	Purchase furnishings and office supplies					
10.7	Purchasing	Identify & review Program Supply needs list including therapeutic and recreational activities, books on mental illness, recovery, wellness and personal items, etc.					
10.8	Purchasing	Purchase supplies					
10.9	Purchasing	Medical Purchases					
10.10	Purchasing	Create and deploy Medical Go bags for each service and unit					
10.11	Purchasing	Design and Purchase Signage					
11.1	Vendors	Utilities, etc.					
11.2	Vendors	Set up contracts for vendor services					

Facility Implementation Plan

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Completed?	Update/Notes
11.3	Vendors	Cleaning / Janitorial					
11.4	Vendors	Linens					
11.5	Vendors	Food (In house kitchen or catered?)					
11.6	Vendors	Speciality Supplies (kitchen, medical room, etc.)					
11.7	Vendors	Transportation Vendor (if needed)					
11.8	Vendors	Medications					
12.1	Medical	Formulary					
12.2	Medical	Stock Formulary on each unit					
12.3	Medical	Prescription Pads					
13.1	Information Technology: Requirements	Assess site for IT configuration					
13.2	Information Technology: Requirements	Install Data Lines: Private Port- T1 / DSL / Cable					
13.3	Information Technology: Requirements	Identify location of data and phone drops					
13.4	Information Technology: Requirements	Identify any connectivity issues relating to facility					
13.5	Information Technology: Requirements	Identify and order computer equipment: Laptops, Workstations					
13.6	Information Technology: Requirements	CCTV or other video needs					
13.7	Information Technology: Requirements	Identify and order network peripherals: Fax/Scanners/Printers, Switches, Firewall, Router					
13.8	Information Technology: Requirements	Identify and order Phone requirements					
14.1	EHR	Setup EHR structure					
14.2	EHR	Confirm EHR meets program needs for tracking, EMR and Connection to Care, etc.					
14.3	EHR	Confirm EHR meets program needs					
14.4	EHR	Create Workflows for EHR					

Facility Implementation Plan

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Completed?	Update/Notes
14.5	EHR	Initial New Site EHR Orientation					
14.6	EHR	Identifying Reporting Requirements					
14.7	EHR	Identify what data available and required through EHR to capture necessary data and create reports					
14.8	EHR	EHR Training					
15.1	Software	Clinical Document Training					
16.1	QC Plan	Formulate QC Plan according to proposal, evidence-based practices and projected outcomes					
16.2	QC Plan	Official Program Description					
16.3	QC Plan	Implement Building, Vehicle & Fire Safety Inspections					Monthly environmental safety check will be completed upon building being finished, prior to opening, and then to continue monthly
16.4	QC Plan	Create Disaster Go Bag for each service and location					
16.5	QC Plan	Implement Incident Reporting and Tracking					
16.6	QC Plan	Implement Complaint & Grievance Tracking					
16.7	QC Plan	Submit Provider contract deliverables and documentation standards					
17.1	Quality Improvement Plan	Identify Outcome Measures					
17.2	Quality Improvement Plan	Include Compliance Plan into operations					
17.3	Quality Improvement Plan	Plan audits, compliance reviews & inspections					
17.4	Quality Improvement Plan	Plan Satisfaction Surveys					
17.5	Quality Improvement Plan	Ensure HIPAA program compliance					
18.1	Medical Records	Determine what information must be captured in the medical record including preferences and expectations					
18.2	Medical Records	Determine at what point the information must be captured i.e. initial contact or during face-to-face visit.					
18.3	Medical Records	Develop procedures for medical record by job requirement.					
18.4	Medical Records	Implement tracking for requests to release records					
19.1	Program Site: Credentialing	CLIA Waiver					
19.2	Program Site: Credentialing	Submit CLIA application.					
19.3	Program Site: Credentialing	Receive CLIA Fee Coupon – pay fee.					
19.4	Program Site: Credentialing	Receive CLIA Waiver Certificate.					
19.5	Program Site: Credentialing	Complete Facility DEA registration online.					
19.6	Program Site: Credentialing	Receive Facility DEA number.					
19.7	Program Site: Credentialing	Receive controlled substance registration.					
19.8	Program Site: Credentialing	Obtain Medicare Certification					
19.9	Program Site: Credentialing	Submit Programmatic Licensing Application					
20.1	Develop P&Ps, Forms and Chart	Review with all applicable standards including accreditation requirements as needed for compliance					
20.2	Develop P&Ps, Forms and Chart	Transfer applicable, existing policies, procedures and forms to new program or create anew as needed					
20.3	Develop P&Ps, Forms and Chart	Create P&P related to fire and disaster plans, drills, and evacuation					
20.4	Develop P&Ps, Forms and Chart	Submit policies, procedures and forms for internal review					
20.5	Develop P&Ps, Forms and Chart	Finalize Policy and Procedure Manual					
21.1	Program Documents	Institute building & fire safety inspections					

Administration

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
1.1	Initial Preparations	Identify key administrative staff required				
1.2	Initial Preparations	Identify their hire dates				
1.3	Initial Preparations	Identify their training plan a schedule				
2.1	Human Resources: All	Identify HR needs, credentials, requirements, processes, etc. and plan for start up including start date for new hires				
2.2	Human Resources: General	Approval of job descriptions with accurate requirements and duties				
2.3	Human Resources: Recruiting	Review Staffing Plan/Budget to determine staffing pattern and staff needs				
2.4	Human Resources: Recruiting	Determine, prepare and post internal/external posting/advertising to recruit qualified staff/candidates				
2.5	Human Resources: Recruiting	Collect, Screen and Process applications				
2.6	Human Resources: Recruiting	Receive, Screen & Interview applicants, determine hires and advise HR/Recruiting				
2.7	Human Resources: Recruiting	Hire staff (offers to be made minimum 3 WEEKS prior to employee start date) inc. all onboarding processes. Include ALL paperwork (including onboarding, state/county-specific forms, authorized driver, ROI, etc.)				
2.8	Human Resources: Recruiting	Any needs state-specific needs required for staff?				
3.1	Orientation and Training	Determine start date & schedule for PET& NEO as needed				
3.2	Orientation and Training	Employee HR Orientation, Benefits				
3.3	Orientation and Training	Roles & Responsibilities of each position				
3.4	Orientation and Training	Process & Procedure Review				

Administration

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
3.5	Orientation and Training	Licensing Shadowing @ other locations				
3.6	Orientation and Training	CPI/ Therapeutic Options Training/Ukeru/ Safe Clinch				
3.7	Orientation and Training	CPR/ 1st Aid/ AED/NARCAN				
3.8	Orientation and Training	Motivational Interviewing				
3.9	Orientation and Training	Person Centered Thinking				
3.10	Orientation and Training	Relias Training				
3.11	Orientation and Training	Quality & Compliance Trainings, QI Plan, Safety Manual				
3.12	Orientation and Training	HR Trainings (ADP, Payroll, Leadership, Management, Performance Management, Policies, Performance Evaluations, Disciplinary Actions, Supervision Expectations)				
3.13	Orientation and Training	Vendor Experience and Interactions, Contract Review				
3.14	Orientation and Training	AP Training and Invoice Submission				
3.15	Orientation and Training	Orientation to the Crisis Facility and features				
3.16	Orientation and Training	EHR Training and Workflow				
3.17	Orientation and Training	P&P review, Workflow Development				
4.1	Purchasing	Identify & review Equipment needs list, including copiers, fax machines, computers, printers				
4.2	Purchasing	Identify, order and purchase cell phone and MiFi needs				
4.3	Purchasing	Purchase all furniture and decorations: Identify delivery date				

Administration

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
4.4	Purchasing	Install furniture upon building completion date				
4.5	Purchasing	Identify and review office supply items including, pens, paper, staplers, calendars, dry erase boards, etc.				
4.6	Purchasing	Purchase furnishings and office supplies				
4.7	Purchasing	Design and Purchase Signage for office doors				
5.1	Admin Vendors Set Up	Adobe				
5.2	Admin Vendors Set Up	Beanworks				
5.3	Admin Vendors Set Up	Stampli				
5.4	Admin Vendors Set Up	E fax				
6.1	Information Technology: Requirements	Identify and order computer equipment: Laptops, Workstations				
6.2	Information Technology: Requirements	Identify and order Phone requirements				

Clinical Administration

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
1.1	Initial Preparations	Determine BIlling Needs for Each Service				
1.2	Initial Preparations	Determine regulations and billable coding for each service				
1.3	Initial Preparations	Determine billable codes for urgent care				
1.4	Initial Preparations	Determine billable codes for triage and assessment/law enforcement				
1.5	Initial Preparations	Determine billable codes for observation units				
1.6	Initial Preparations	Determine billable codes for inpatient				
1.7	Initial Preparations	Determine credentialing needs and expectations. Solidify Needs for Medicaid Presuptive Eligibility				
1.8	Initial Preparations	Review any applicable regulations related to services				
1.9	Initial Preparations	Identify Billing manager to be hired with administration				
2.1	Program	Create working program description to guide process and notify team of needs				
3.1	Human Resources	Identify Staff needed for services/link to Centralized RCM Team				
3.2	Human Resources: All	Identify HR needs, credentials, requirements, processes, etc. and plan for start up including start date for new hires				
3.3	Human Resources: General	Approval of job descriptions with accurate requirements and duties				
3.4	Human Resources: Recruiting	Review Staffing Plan/Budget to determine staffing pattern and staff needs				
3.5	Human Resources: Recruiting	Determine, prepare and post internal/external posting/advertising to recruit qualified staff/candidates				
3.6	Human Resources: Recruiting	Collect, Screen and Process applications				
3.7	Human Resources: Recruiting	Receive, Screen & Interview applicants, determine hires and advise HR/Recruiting				
3.8	Human Resources: Recruiting	Hire staff (offers to be made minimum 3 WEEKS prior to employee start date) inc. all onboarding processes. Include ALL paperwork (including onboarding, state/county-specific forms, authorized driver, ROI, etc.)				
3.9	Human Resources: Recruiting	Any needs state-specific needs required for staff?				
4.1	Orientation and Training	Determine start date & schedule for NEO as needed				
4.2	Orientation and Training	On-Site Orientation, facilities, services, ammenities				
4.3	Orientation and Training	Roles & Responsibilities of each position				
4.4	Orientation and Training	Process & Procedure Review				
4.5	Orientation and Training	Licensing Shadowing at other Provider locations/Provider Implementation team mentorship				

Clinical Administration

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
4.6	Orientation and Training	CPR/ 1st Aid/ AED/NARCAN				
4.7	Orientation and Training	Quality & Compliance Trainings				
4.8	Orientation and Training	HR Trainings/Benefits				
5.1	CBO	Review/Obtain NPI Numbers				
5.2	CBO	Obtain Medicaid ID				
5.3	CBO	Obtain Contract and Fee Schedule				
5.4	CBO	Coordinate with IT to program new fiscal, billing and program codes per contract				
5.5	CBO	Create billing capacity to bill Medicare and TPL				
5.6	CBO	Review and delineate contract deliverables, including reporting requirements				
5.7	CBO	Identify reporting & billing requirements.				
5.8	CBO	Verify Billing Functionality				
5.9	CBO	Netsmart and RCM Billing and Software Training				
5.10	CBO	Third Party Liability				
6.1	Purchasing	Identify & review Equipment needs list, including copiers, fax machines, computers, printers, cell phones, medical equipment, etc.				
6.2	Purchasing	Identify, order and purchase cell phone and MiFi needs				
6.3	Purchasing	Identify and review office supply items including, pens, paper, staplers, calendars, dry erase boards, etc.				
6.4	Purchasing	Purchase office supplies				
7.1	Vendors Utilized	Utilities, etc.				
7.2	Vendors Utilized	Cleaning / Janitorial				
8.1	Information Technology: Requirements	Identify and order computer equipment: Laptops, Workstations				
8.2	Information Technology: Requirements	Identify and order Phone requirements				
8.3	Information Technology: Requirements	Setup EHR Billing structure				
9.1	EHR	EHR Training				
9.2	EHR	Review what data is available and required through EHR to capture necessary data and create reports				
10.1	Software	Clinical Document Training and Review				
11.1	Quality Improvement Plan	Review Official Program Description				
11.2	Quality Improvement Plan	Identify Outcome Measures and percentage expectations for Billing				
11.3	Quality Improvement Plan	Plan audits, compliance reviews & inspections				
12.1	Medical Records	Determine what information must be captured in the medical record including preferences and expectations				
13.1	Program Site: Staff Credentialing	Finalize staff credentialing				
13.2	Program Site: Staffing Credentialing	Submit staff credentialing				

Public and Customer Service

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
1.1	Initial Preparations	Finalize Scope of Second Customer Service Desk and Facility Navigation				
1.2	Initial Preparations	Determine how utilization will be tracked				
2.1	Program Site	Review Furniture plan for Spaces				
3.1	Program	Create working description to guide process and notify team of needs				
3.2	Program	Meet with funder to review space requirements				
4.1	Human Resources: General	Identify key staffing for this space and role				
4.2	Human Resources: All	Identify HR needs, credentials, requirements, processes, etc. and plan for start up including start date for new hires				
4.3	Human Resources: General	Approval of job descriptions with accurate requirements and duties				
4.4	Human Resources: Recruiting	Review Staffing Plan/Budget to determine staffing pattern and staff needs				
4.5	Human Resources: Recruiting	Peer Employment Training RECRUITING (If applicable): Prepare PET advertising/postings to generate qualified leads/candidates for PET classes to create Peer candidate pool (only if hiring *post* PET class)				
4.6	Human Resources: Recruiting	Determine, prepare and post internal/external posting/advertising to recruit qualified staff/candidates				
4.7	Human Resources: Recruiting	Collect, Screen and Process applications				
4.8	Human Resources: Recruiting	Receive, Screen & Interview applicants, determine hires and advise HR/Recruiting				
4.9	Human Resources: Recruiting	Hire staff (offers to be made minimum 3 WEEKS prior to employee start date) inc. all onboarding processes. Include ALL paperwork (including onboarding, state/county-specific forms, authorized driver, ROI, etc.)				
4.1	Human Resources: Recruiting	Any needs state-specific needs required for staff?				
5.1	Orientation and Training	Determine start date & schedule for PET& NEO as needed				
5.2	Orientation and Training	On-Site Orientation				
5.3	Orientation and Training	Roles & Responsibilities of each position				

Public and Customer Service

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
5.4	Orientation and Training	Process & Procedure Review				
5.5	Orientation and Training	Licensing Shadowing @ other locations				
5.6	Orientation and Training	CPI/ Therapeutic Options Training/Ukeru/Safe Clinch				
5.7	Orientation and Training	CPR/ 1st Aid/ AED/NARCAN				
5.8	Orientation and Training	Motivational Interviewing				
5.9	Orientation and Training	6Person Centered Thinking				
5.10	Orientation and Training	Relias Training				
5.11	Orientation and Training	Quality & Compliance Trainings				
5.12	Orientation and Training	HR Trainings				
6.1	Risk Management	Review program, site and staff for all insurance, health & safety, workers comp, etc.				
7.1	Purchasing	Identify & review Equipment needs list, including copiers, fax machines, computers, printers, cell phones, medical equipment, etc.				
7.2	Purchasing	Identify, order and purchase cell phone and MiFi needs				
7.3	Purchasing	Identify and review office supply items including, pens, paper, staplers, calendars, dry erase boards, etc.				
7.4	Purchasing	Purchase furnishings and office supplies				
8.1	Vendors Utlized in Space	Utilities, etc.				
8.2	Vendors Utilized in Space	Cleaning / Janitorial				
9.1	Information Technology: Requirements	Identify and order computer equipment: Laptops, Workstations				
9.2	Information Technology: Requirements	Identify and order Phone requirements				
10.1	Develop P&Ps, Forms and Chart	Review with all applicable standards and research any evidence based practices including accreditation requirements as needed for compliance				
10.2	Develop P&Ps, Forms and Chart	Transfer applicable, existing policies, procedures and forms to new program or create anew as needed				
10.3	Develop P&Ps, Forms and Chart	Submit policies, procedures and forms for internal review				
10.4	Develop P&Ps, Forms and Chart	Finalize Policy and Procedure Manual				

Triage & Law Enforcement

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
1.1	Initial Preparations	Determine Scope of Practice for Triage and Law Enforcement Area				
1.2	Initial Preparations	Review Furniture Plan, Review Equipment Purchase List,				
2.1	Program	Create working service description to guide process and notify team of needs				
2.2	Program	Meet with funder to review program requirements				
2.3	Program	Eligibility Requirements				
3.1	Human Resources	Identify Staff needed for services				
3.2	Human Resources: All	Identify HR needs, credentials, requirements, processes, etc. and plan for start up including start date for new hires				
3.3	Human Resources: General	Approval of job descriptions with accurate requirements and duties				
3.4	Human Resources: Recruiting	Review Staffing Plan/Budget to determine staffing pattern and staff needs				
3.5	Human Resources: Recruiting	Determine any Provider needs and fill plan (Shared In house, Agency, etc.)				
3.6	Human Resources: Recruiting	Peer Employment Training RECRUITING (If applicable): Prepare PET advertising/postings to generate qualified leads/candidates for PET classes to create Peer candidate pool (only if hiring _post_ PET class)				
3.7	Human Resources: Recruiting	Determine, prepare and post internal/external posting/advertising to recruit qualified staff/candidates				
3.8	Human Resources: Recruiting	Collect, Screen and Process applications				
3.9	Human Resources: Recruiting	Receive, Screen & Interview applicants, determine hires and advise HR/Recruiting				
3.10	Human Resources: Recruiting	Hire staff (offers to be made minimum 2-3 WEEKS prior to employee start date) inc. all onboarding processes. Include ALL paperwork (including onboarding, state/county-specific forms, authorized driver, ROI, etc.)				
3.11	Human Resources: Recruiting	Any needs state-specific needs required for staff?				
4.1	Orientation and Training	Determine start date & schedule for PET& NEO as needed				
4.2	Orientation and Training	On-Site Orientation, facilities, services, ammenities				
4.3	Orientation and Training	Roles & Responsibilities of each position				
4.4	Orientation and Training	Process & Procedure Review				
4.5	Orientation and Training	Licensing Shadowing at other Provider locations/Provider Implementation team mentorship				
4.6	Orientation and Training	CPI/ Therapeutic Options Training/UKERU/Safe Clinch				
4.7	Orientation and Training	CPR/ 1st Aid/ AED/NARCAN				

Triage & Law Enforcement

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
4.8	Orientation and Training	Motivational Interviewing				
4.9	Orientation and Training	Person Centered Thinking				
4.10	Orientation and Training	Relias Training				
4.11	Orientation and Training	Quality & Compliance Trainings				
4.12	Orientation and Training	HR Trainings				
5.1	Risk Management	Review program, site and staff for all insurance, health & safety, workers comp, etc.				
6.1	Fiscal Systems	Review Start Up Budget				
6.2	Fiscal Systems	Ramp-up budget (if needed)				
6.3	Fiscal Systems	Review Operations Budget				
6.4	Fiscal Systems	Assign Department Numbers-This will be a shared department between observation units				
6.5	Fiscal Systems	Notify HR/Payroll and relevant departments of new #s				
6.6	Fiscal Systems	Create Account Numbers/Budget Input				
6.7	Fiscal Systems	Establish Accounts Receivable				
6.8	Fiscal Systems	Insurance Allocation (internal)				
6.9	Fiscal Systems	Establish any specific billing report format for distribution to funder				
6.10	Fiscal Systems	Finalize Budgets				
7.1	Purchasing	Identify & review Equipment needs list, including copiers, fax machines, computers, printers, cell phones, medical equipment, etc.				
7.2	Purchasing	Identify, order and purchase cell phone and MiFi needs				
7.3	Purchasing	Identify and review office supply items including, pens, paper, staplers, calendars, dry erase boards, etc.				
7.4	Purchasing	Purchase furnishings and office supplies				
7.5	Purchasing	Purchase supplies				
7.6	Purchasing	Medical Supplies				
7.7	Purchasing	Medical Purchases				
7.8	Purchasing	Design and Purchase Signage				
8.1	Vendors Utilized	Utilities, etc.				
8.2	Vendors Utilized	Cleaning / Janitorial				
8.3	Vendors Utilized	Linens				
8.4	Vendors Utilized	Food (In house kitchen)				
9.1	Information Technology: Requirements	Identify and order computer equipment: Laptops, Workstations				
9.2	Information Technology: Requirements	Identify and order network peripherals: Fax/Scanners/Printers, Switches, Firewall, Router				

Triage & Law Enforcement

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
9.3	Information Technology: Requirements	Identify and order Phone requirements				
9.4	Information Technology: Requirements	Setup EHR structure				
9.5	Information Technology: Requirements	Confirm EHR meets program needs for tracking, EMR and Connection to Care, etc.				
10.1	EHR	Setup EHR structure				
10.2	EHR	Confirm EHR meets program needs				
10.3	EHR	Create Workflows for EHR				
10.4	EHR	Initial New Site EHR Orientation				
10.5	EHR	Identifying Reporting Requirements				
10.6	EHR	Identify what data available and required through EHR to capture necessary data and create reports				
10.7	EHR	EHR Training				
11.1	Software	Clinical Document Training				
12.1	Quality Improvement Plan	Formulate QI Plan according to proposal, evidence-based practices and projected outcomes				
12.2	Quality Improvement Plan	Official Service Description				
12.3	Quality Improvement Plan	Implement Incident Reporting and Tracking				
12.4	Quality Improvement Plan	Implement Complaint & Grievance Tracking				
12.5	Quality Improvement Plan	Identify QI Indicators with staff				
12.6	Quality Improvement Plan	Identify Outcome Measures				
12.7	Quality Improvement Plan	Include Compliance Plan into operations				
12.8	Quality Improvement Plan	Plan audits, compliance reviews & inspections				
12.9	Quality Improvement Plan	Plan Satisfaction Surveys				
12.10	Quality Improvement Plan	Ensure HIPAA program compliance				
13.1	Medical Records	Determine what information must be captured in the medical record including preferences and expectations				
13.2	Medical Records	Determine at what point the information must be captured i.e. initial contact or during face-to-face visit.				
13.3	Medical Records	Develop policies and procedures for medical record by job requirement.				
13.4	Medical Records	Implement tracking for requests to release records				
14.1	Develop P&Ps, Forms and Chart	Review with all applicable standards including accreditation requirements as needed for				
14.2	Develop P&Ps, Forms and Chart	Procedures must incorporate law enforcement entrance, processes, guest property, hot room, how determine to observation unit, and on to utilize in house medical services if medical needs are identified.				
14.3	Develop P&Ps, Forms and Chart	Transfer applicable, existing policies, procedures and forms to new program or create anew as needed				
14.4	Develop P&Ps, Forms and Chart	Submit policies, procedures and forms for internal review				
14.5	Develop P&Ps, Forms and Chart	Finalize Policy and Procedure Manual				

Kitchen & Nutrition

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
1.1	Initial Preparations	Determine Scope of Practice for Kitchen and Nutrition				
1.2	Initial Preparations	Determine Health standards credentialing requirements				
1.3	Initial Preparations	Consult with a dietician around Licensingint Commission rules of Nourish spaces				
1.4	Initial Preparations	Approval and Licensing of Commerical Kitchen				
1.5	Initial Preparations	Determine nutrition needs for daily scheduled meals and snacks, meals and snacks for admissions, and as needed Nourish areas for guests for family resource center, urgent care, observation units, and inpatient.				
1.6	Initial Preparations	Determine scope of providing nutrition for staff, staff breakrooms, respite, lactation rooms.				
1.7	Initial Preparations	Review and Finalize Kitchen and Nutrition of Services with Funder				
1.8	Initial Preparations	Determine Kitchen Equipment Needs and Supplies				
1.9	Initial Preparations	Identify Food Services Manager will be hired with administration				
2.1	Program	Create working program description to guide process and notify team of needs				
3.1	Human Resources	Identify Staff needed for services				
4.1	Human Resources: All	Identify HR needs, credentials, requirements, processes, etc. and plan for start up including start date for new hires				
4.2	Human Resources: General	Approval of job descriptions with accurate requirements and duties				
4.3	Human Resources: Recruiting	Review Staffing Plan/Budget to determine staffing pattern and staff needs				
4.4	Human Resources: Recruiting	Determine, prepare and post internal/external posting/advertising to recruit qualified staff/candidates				
4.5	Human Resources: Recruiting	Collect, Screen and Process applications				
4.6	Human Resources: Recruiting	Receive, Screen & Interview applicants, determine hires and advise HR/Recruiting				
4.7	Human Resources: Recruiting	Hire staff (offers to be made minimum 3 WEEKS prior to employee start date) inc. all onboarding processes. Include ALL paperwork (including onboarding, state/county-specific forms, authorized driver, ROI, etc.)				
4.8	Human Resources: Recruiting	Any needs state-specific needs required for staff?				
5.1	Orientation and Training	Determine start date & schedule for PET& NEO as needed				
5.2	Orientation and Training	On-Site Orientation, facilities, services, ammenities				

Kitchen & Nutrition

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
5.3	Orientation and Training	Roles & Responsibilities of each position				
5.4	Orientation and Training	Process & Procedure Review				
5.5	Orientation and Training	Licensing Shadowing at other Provider locations/Provider Implementation team mentorship				
5.6	Orientation and Training	CPI/ Therapeutic Options Training				
5.7	Orientation and Training	CPR/ 1st Aid/ AED/NARCAN				
5.8	Orientation and Training	Person Centered Thinking				
5.9	Orientation and Training	Relias Training				
5.10	Orientation and Training	Quality & Compliance Trainings				
5.11	Orientation and Training	HR Trainings				
6.1	Risk Management	Review program, site and staff for all insurance, health & safety, workers comp, etc.				
7.1	Fiscal Systems	Review Start Up Budget				
7.2	Fiscal Systems	Ramp-up budget (if needed)				
7.3	Fiscal Systems	Review Operations Budget				
7.4	Fiscal Systems	Assign Department Numbers-Shared Cost Center				
7.5	Fiscal Systems	Notify HR/Payroll and relevant departments of new #s				
7.6	Fiscal Systems	Create Account Numbers/Budget Input				
7.7	Fiscal Systems	Establish Accounts Receivable				
7.8	Fiscal Systems	Insurance Allocation (internal)				
7.9	Fiscal Systems	Finalize Budgets- Shared between services				
8.1	Purchasing	Identify & review Equipment needs list, including copiers, fax machines, computers, printers, cell phones, medical equipment, etc.				
8.2	Purchasing	Identify, order and purchase cell phone and MiFi needs				
8.3	Purchasing	Identify and review office supply items including, pens, paper, staplers, calendars, dry erase boards, etc.				

Kitchen & Nutrition

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
8.4	Purchasing	Purchase office supplies				
8.5	Purchasing	Identify Kichen Supplies				
8.6	Purchasing	Make Kitchen Purchases				
8.7	Purchasing	Design and Purchase Signage if needed				
9.1	Vendors Utilized	Utilities, etc.				
9.3	Vendors Utilized	Cleaning / Janitorial				
9.5	Vendors Utilized	Food (In house kitchen)				
10.1	Information Technology: Requirements	Identify and order computer equipment: Laptops, Workstations				
10.2	Information Technology: Requirements	Identify and order Phone requirements				
11.1	QI Plan	Formulate QI Plan according to proposal, evidence-based practices and projected outcomes				
11.2	QI Plan	Identify QI Indicators with staff				
13.1	Quality Improvement Plan	Identify Outcome Measures				
13.2	Quality Improvement Plan	Include Compliance Plan into operations				
13.3	Quality Improvement Plan	Plan audits, compliance reviews & inspections				
14.1	Program Site: Credentialing	Determine credentialing for full medical services				
15.1	Kitchen Site: Credentialing	Submit for Kitchen licensing				
16.1	Develop P&Ps, Forms, and Chart	Determine meeting cadence to develop P&Ps				
17.1	Develop P&Ps, Forms and Chart	Review with all applicable standards including health standard requirements as needed for compliance				
17.2	Develop P&Ps, Forms and Chart	Transfer applicable, existing policies, procedures and forms to new program or create anew as needed				
17.3	Develop P&Ps, Forms and Chart	Submit policies, procedures and forms for internal review				
17.4	Develop P&Ps, Forms and Chart	Finalize Policy and Procedure Manual for kitchen				

CTC Beds

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
1.1	Initial Preparations	Review Furniture Plan, Review Equipment Purchase List,				
1.2	Initial Preparations	Determine Licensing Needs for an inpatient unit				
1.3	Initial Preparations	Review Service Regulations for an Inpatient Unit				
1.4	Initial Preparations	Obtain clear guidance from expert on how "court room services" work and what is expected.				
2.1	Program	Create working program description to guide process and notify team of needs				
2.2	Program	Meet with funder to review program requirements				
2.3	Program	Eligibility Requirements				
3.1	Human Resources	Identify Staff needed for services				
3.2	Human Resources: All	Identify HR needs, credentials, requirements, processes, etc. and plan for start up including start date for new hires				
3.3	Human Resources: General	Approval of job descriptions with accurate requirements and duties				
3.4	Human Resources: Recruiting	Review Staffing Plan/Budget to determine staffing pattern and staff needs				
3.5	Human Resources: Recruiting	Determine any Provider needs and fill plan				
3.6	Human Resources: Recruiting	Peer Employment Training RECRUITING (If applicable): Prepare PET advertising/postings to generate qualified leads/candidates for PET classes to create Peer candidate pool (only if hiring *post* PET class)				
3.7	Human Resources: Recruiting	Determine, prepare and post internal/external posting/advertising to recruit qualified staff/candidates				
3.8	Human Resources: Recruiting	Collect, Screen and Process applications				
3.9	Human Resources: Recruiting	Receive, Screen & Interview applicants, determine hires and advise HR/Recruiting				
3.10	Human Resources: Recruiting	Hire staff (offers to be made minimum 3 WEEKS prior to employee start date) inc. all onboarding processes. Include ALL paperwork (including onboarding, state/county-specific forms, authorized driver, ROI, etc.)				
3.11	Human Resources: Recruiting	Any needs state-specific needs required for staff?				
4.1	Orientation and Training	Determine start date & schedule for PET& NEO as needed				
4.2	Orientation and Training	On-Site Orientation, facilities, services, ammenities				
4.3	Orientation and Training	Roles & Responsibilities of each position				
4.4	Orientation and Training	Process & Procedure Review				
4.5	Orientation and Training	Licensing Shadowing at other Provider locations/Provider Implementation team mentorship				
4.6	Orientation and Training	CPI/ Therapeutic Options Training/UKERU/Safe Clinch				
4.7	Orientation and Training	CPR/ 1st Aid/ AED/NARCAN				
4.8	Orientation and Training	Motivational Interviewing				
4.9	Orientation and Training	Person Centered Thinking				
4.10	Orientation and Training	Relias Training				
4.11	Orientation and Training	Quality & Compliance Trainings				
4.12	Orientation and Training	HR Trainings				
5.1	Risk Management	Review program, site and staff for all insurance, health & safety, workers comp, etc.				
6.1	CBO	Obtain NPI Number				
6.2	CBO	Obtain Medicaid ID				
6.3	CBO	Review Contract and Fee Schedule				

CTC Beds

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
6.4	CBO	Coordinate with IT to program new fiscal, billing and program codes per contract				
6.5	CBO	Create billing capacity to bill Medicare and TPL				
6.6	CBO	Review and delineate contract deliverables, including reporting requirements				
6.7	CBO	Identify reporting & billing requirements.				
6.8	CBO	Verify Billing Functionality				
6.9	CBO	Netsmart and RCM Billing and Software Training				
6.10	CBO	TPL Required?				
7.1	Fiscal Systems	Review Start Up Budget				
7.2	Fiscal Systems	Ramp-up budget (if needed)				
7.3	Fiscal Systems	Review Operations Budget				
7.4	Fiscal Systems	Assign Department Numbers				
7.5	Fiscal Systems	Notify HR/Payroll and relevant departments of new #s				
7.6	Fiscal Systems	Create Account Numbers/Budget Input				
7.7	Fiscal Systems	Establish Accounts Receivable				
7.8	Fiscal Systems	Insurance Allocation (internal)				
7.9	Fiscal Systems	Establish any specific billing report format for distribution to funder				
7.10	Fiscal Systems	Finalize Budgets				
8.1	Purchasing	Identify & review Equipment needs list, including copiers, fax machines, computers, printers, cell phones, medical equipment, etc.				
8.2	Purchasing	Identify, order and purchase cell phone and MiFi needs				
8.3	Purchasing	Identify and review office supply items including, pens, paper, staplers, calendars, dry erase boards, etc.				
8.4	Purchasing	Purchase furnishings and office supplies				
8.5	Purchasing	Purchase supplies				
8.6	Purchasing	Medical Supplies				
8.7	Purchasing	Medical Purchases				
8.8	Purchasing	Design and Purchase Signage				
9.1	Vendors Utilized	Utilities, etc.				
9.2	Vendors Utilized	Cleaning / Janitorial				
9.3	Vendors Utilized	Linens				
9.4	Vendors Utilized	Food (In house kitchen)				
9.5	Vendors Utilized	Transportation Vendor (if needed)				
9.6	Vendors Utilized	Medications/Pharmacy				
10.1	Medical	Formulary				
10.2	Medical	Prescription Pads				
11.1	Information Technology: Requirements	Identify and order computer equipment: Laptops, Workstations				
11.2	Information Technology: Requirements	Identify and order network peripherals: Fax/Scanners/Printers, Switches, Firewall, Router				

CTC Beds

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
11.3	Information Technology: Requirements	Identify and order Phone requirements				
11.4	Information Technology: Requirements	Setup EHR structure				
11.5	Information Technology: Requirements	Confirm EHR meets program needs for tracking, EMR and Connection to Care, etc.				
12.1	EHR	Setup EHR structure				
12.2	EHR	Confirm EHR meets program needs				
12.3	EHR	Create Workflows for EHR				
12.4	EHR	Initial New Site EHR Orientation				
12.5	EHR	Identifying Reporting Requirements				
12.6	EHR	Identify what data available and required through EHR to capture necessary data and create reports				
12.7	EHR	EHR Training				
13.1	Software	Clinical Document Training				
13.2	Quality Improvement Plan	Formulate QI Plan according to proposal, evidence-based practices and projected outcomes				
13.3	Quality Improvement Plan	Official Program Description				
13.4	Quality Improvement Plan	Implement Incident Reporting and Tracking				
13.5	Quality Improvement Plan	Implement Complaint & Grievance Tracking				
13.6	Quality Improvement Plan	Identify QI Indicators with staff				
13.7	Quality Improvement Plan	Identify Outcome Measures				
13.8	Quality Improvement Plan	Include Compliance Plan into operations				
13.9	Quality Improvement Plan	Plan audits, compliance reviews & inspections				
13.10	Quality Improvement Plan	Plan Satisfaction Surveys				
13.11	Quality Improvement Plan	Ensure HIPAA program compliance				
14.1	Medical Records	Determine what information must be captured in the medical record including preferences and expectations				
14.2	Medical Records	Determine at what point the information must be captured i.e. initial contact or during face-to-face visit.				
14.3	Medical Records	Develop policies and procedures for medical record by job requirement.				
14.4	Medical Records	Implement tracking for requests to release records				
15.1	Program Site: Credentialing	CLIA Waiver				
15.2	Program Site: Credentialing	Submit CLIA application.				
15.3	Program Site: Credentialing	Receive CLIA Fee Coupon – pay fee.				
15.4	Program Site: Credentialing	Receive CLIA Waiver Certificate.				
15.5	Program Site: Credentialing	Complete Facility DEA registration online.				
15.6	Program Site: Credentialing	Receive Facility DEA number.				
15.7	Program Site: Credentialing	Receive controlled substance registration.				
15.8	Program Site: Credentialing	Obtain Medicare Certification				
15.9	Program Site: Credentialing	Determine Facility Credentialing and Site Visit Requirements				
15.10	Program Site: Credentialing	Submit Programmatic Licensing Application				
16.1	Develop P&Ps, Forms and Chart	Review with all applicable standards including accreditation requirements as needed for compliance				
16.2	Develop P&Ps, Forms and Chart	Transfer applicable, existing policies, procedures and forms to new program or create anew as needed				
16.3	Develop P&Ps, Forms and Chart	Submit policies, procedures and forms for internal review				
16.4	Develop P&Ps, Forms and Chart	Finalize Policy and Procedure Manual				

Observation Unit

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
1.1	Initial Preparations	Review Furniture Plan, Review Equipment Purchase List,				
2.1	Program	Create working program description to guide process and notify team of needs				
2.2	Program	Meet with funder to review program requirements				
2.3	Program	Eligibility Requirements				
3.1	Human Resources	Identify Staff needed for services				
3.2	Human Resources: All	Identify HR needs, credentials, requirements, processes, etc. and plan for start up including start date for new hires				
3.3	Human Resources: General	Approval of job descriptions with accurate requirements and duties				
3.4	Human Resources: Recruiting	Review Staffing Plan/Budget to determine staffing pattern and staff needs				
3.5	Human Resources: Recruiting	Determine any Provider needs and fill plan (Shared In house, Agency, etc.)				
3.6	Human Resources: Recruiting	Peer Employment Training RECRUITING (If applicable): Prepare PET advertising/postings to generate qualified leads/candidates for PET classes to create Peer candidate pool (only if hiring *post* PET class)				
3.7	Human Resources: Recruiting	Determine, prepare and post internal/external posting/advertising to recruit qualified staff/candidates				
3.8	Human Resources: Recruiting	Collect, Screen and Process applications				
3.9	Human Resources: Recruiting	Receive, Screen & Interview applicants, determine hires and advise HR/Recruiting				
3.10	Human Resources: Recruiting	Hire staff (offers to be made minimum 3 WEEKS prior to employee start date) inc. all onboarding processes. Include ALL paperwork (including onboarding, state/county-specific forms, authorized driver, ROI, etc.)				
3.11	Human Resources: Recruiting	Any needs state-specific needs required for staff?				
4.1	Orientenation and Training	Determine start date & schedule for PET& NEO as needed				
4.2	Orientenation and Training	On-Site Orientation, facilities, services, ammenities				
4.3	Orientenation and Training	Roles & Responsibilities of each position				
4.4	Orientenation and Training	Process & Procedure Review				
4.5	Orientenation and Training	Licensing Shadowing at other Provider locations/Provider Implementation team mentorship				
4.6	Orientenation and Training	CPI/ Therapeutic Options Training/UKERU/Safe Clinch				
4.7	Orientenation and Training	CPR/ 1st Aid/ AED/NARCAN				
4.8	Orientenation and Training	Motivational Interviewing				
4.9	Orientenation and Training	Person Centered Thinking				
4.10	Orientenation and Training	Relias Training				
4.11	Orientenation and Training	Quality & Compliance Trainings				
4.12	Orientenation and Training	HR Trainings				
5.1	Risk Management	Review program, site and staff for all insurance, health & safety, workers comp, etc.				
6.1	CBO	Obtain NPI Number				
6.2	CBO	Obtain Medicaid ID				
6.3	CBO	Review Contract and Fee Schedule				

Observation Unit

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
6.4	CBO	Coordinate with IT to program new fiscal, billing and program codes per contract				
6.5	CBO	Create billing capacity to bill Medicare and TPL				
6.6	CBO	Review and delineate contract deliverables, including reporting requirements				
6.7	CBO	Identify reporting & billing requirements.				
6.8	CBO	Verify Billing Functionality				
6.9	CBO	Netsmart and RCM Billing and Software Training				
6.10	CBO	TPL Required?				
7.1	Fiscal Systems	Review Start Up Budget				
7.2	Fiscal Systems	Ramp-up budget (if needed)				
7.3	Fiscal Systems	Review Operations Budget				
7.4	Fiscal Systems	Assign Department Numbers				
7.5	Fiscal Systems	Notify HR/Payroll and relevant departments of new #s				
7.6	Fiscal Systems	Create Account Numbers/Budget Input				
7.7	Fiscal Systems	Establish Accounts Receivable				
7.8	Fiscal Systems	Insurance Allocation (internal)				
7.9	Fiscal Systems	Establish any specific billing report format for distribution to funder				
7.10	Fiscal Systems	Finalize Budgets				
8.1	Purchasing	Identify & review Equipment needs list, including copiers, fax machines, computers, printers, cell phones, medical equipment, etc.				
8.2	Purchasing	Identify, order and purchase cell phone and MiFi needs				
8.3	Purchasing	Identify and review office supply items including, pens, paper, staplers, calendars, dry erase boards, etc.				
8.4	Purchasing	Purchase furnishings and office supplies				
8.5	Purchasing	Purchase supplies				
8.6	Purchasing	Medical Supplies				
8.7	Purchasing	Medical Purchases				
8.8	Purchasing	Design and Purchase Signage				
9.1	Vendors Utilized	Utilities, etc.				
9.2	Vendors Utilized	Cleaning / Janitorial				
9.3	Vendors Utilized	Linens				
9.4	Vendors Utilized	Food (In house kitchen)				
9.5	Vendors Utilized	Transportation Vendor (if needed)				
9.6	Vendors Utilized	Medications/Pharmacy				
10.1	Medical	Formulary				
10.2	Medical	Prescription Pads				
10.3	Information Technology: Requirements	Identify and order computer equipment: Laptops, Workstations				
10.4	Information Technology: Requirements	Identify and order network peripherals: Fax/Scanners/Printers, Switches, Firewall, Router				
10.5	Information Technology: Requirements	Identify and order Phone requirements				
10.6	Information Technology: Requirements	Setup EHR structure				
10.7	Information Technology: Requirements	Confirm EHR meets program needs for tracking, EMR and Connection to Care, etc.				
11.1	EHR	Setup EHR structure				
11.2	EHR	Confirm EHR meets program needs				
11.3	EHR	Create Workflows for EHR				
11.4	EHR	Initial New Site EHR Orientation				
11.5	EHR	Identifying Reporting Requirements				
11.6	EHR	Identify what data available and required through EHR to capture necessary data and create reports				
11.7	EHR	EHR Training				

Observation Unit

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
12.1	Software	Clinical Document Training				
13.1	Quality Improvement Plan	Formulate QI Plan according to proposal, evidence-based practices and projected outcomes				
13.2	Quality Improvement Plan	Official Program Description				
13.3	Quality Improvement Plan	Implement Incident Reporting and Tracking				
13.4	Quality Improvement Plan	Implement Complaint & Grievance Tracking				
13.5	Quality Improvement Plan	Identify QI Indicators with staff				
13.6	Quality Improvement Plan	Identify Outcome Measures				
13.7	Quality Improvement Plan	Include Compliance Plan into operations				
13.8	Quality Improvement Plan	Plan audits, compliance reviews & inspections				
13.9	Quality Improvement Plan	Plan Satisfaction Surveys				
13.10	Quality Improvement Plan	Ensure HIPAA program compliance				
14.1	Medical Records	Determine what information must be captured in the medical record including preferences and expectations				
14.2	Medical Records	Determine at what point the information must be captured i.e. initial contact or during face-to-face visit.				
14.3	Medical Records	Develop policies and procedures for medical record by job requirement.				
14.4	Medical Records	Implement tracking for requests to release records				
15.1	Program Site: Credentialing	CLIA Waiver				
15.2	Program Site: Credentialing	Submit CLIA application.				
15.3	Program Site: Credentialing	Receive CLIA Fee Coupon – pay fee.				
15.4	Program Site: Credentialing	Receive CLIA Waiver Certificate.				
15.5	Program Site: Credentialing	Complete Facility DEA registration online.				
15.6	Program Site: Credentialing	Receive Facility DEA number.				
15.7	Program Site: Credentialing	Receive controlled substance registration.				
15.8	Program Site: Credentialing	Obtain Medicare Certification				
15.9	Program Site: Credentialing	Determine Facility Credentialing and Site Visit Requirements				
15.10	Program Site: Credentialing	Submit Programmatic Licensing Application				
16.1	Develop P&Ps, Forms and Chart	Review with all applicable standards including accreditation requirements as needed for compliance				
16.2	Develop P&Ps, Forms and Chart	Transfer applicable, existing policies, procedures and forms to new program or create anew as needed				
16.3	Develop P&Ps, Forms and Chart	Submit policies, procedures and forms for internal review				
16.4	Develop P&Ps, Forms and Chart	Finalize Policy and Procedure Manual				

Vendors

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
1.1	Initial Preparations	Determine Vendors List				
1.2	Initial Preparations	Determine which vendors will be provided by funder (Funder)				
1.3	Initial Preparations	Prepare to contract for vendors that Provider is responsible				
1.4	Initial Preparations	Involve AP for contract reviews and Provider protocol review for securing vendors				
1.5	Initial Preparations	Obtain 3 vendors contracts for each service				
1.6	Initial Preparations	Obtain most recent reviews of each potential vendor				
2.1	Fiscal Systems	Review Start Up Budget				
2.2	Fiscal Systems	Ramp-up budget (if needed)				
2.3	Fiscal Systems	Review Operations Budget				
2.4	Fiscal Systems	Finalize Budgets				
3.1	Vendors	Utilities, trash, power, internet, water, etc.				
3.2	Vendors	Cleaning / Janitorial				
3.3	Vendors	Linens				
3.4	Vendors	Medical Supply Vendor				
3.5	Vendors	BioHazard Waste				
3.6	Vendors	Speciality Supplies				
3.7	Vendors	Nerds Onsite				
3.8	Vendors	Language Line				
3.9	Vendors	E-Fax				
3.10	Vendors	Transportation Vendor				
3.11	Vendors	Shred It				
3.12	Vendors	Labortory				
3.13	Vendors	Pest Control				
3.14	Vendors	Portable X-Ray Imaging				
4.1	Final	Determine and select vendor for each service				
4.2	FInal	Review and Negotiate contracts				
4.3	Final	Execute Contracts and Submit to AP with W9				

Pharmacy

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
1.1	Initial Preparations	Determine Scope of Practice for Pharmacy				
1.2	Initial Preparations	Consult Pharmacist to determine scope				
1.3	Initial Preparations	Need to determine if approval and licensing is needed from board of phramacy				
1.4	Initial Preparations	Apply for the "address change" of the existing license on Central Ave/ 1 license covers all medication rooms				
1.5	Initial Preparations	Review Scope of Practice with Funder				Determine extrnal vendors or Inhouse provided supply/ clinic and pharmacy license or clinic/pharmacy license
1.6	Initial Preparations	Research Pharmacy Vendors, if applicable				Pharmacy Vendors to consider
1.7	Initial Preparations	Determine P&P for Pharmacy				
1.8	Initial Preparations	Determine contact, delivery schedule for discharge medications, storage options for internal use				
1.9	Initial Preparations	Review and Finalize Formulary				
1.10	Initial Preparations	Involve AP for contract reviews and Provider protocol review for securing vendors				
1.11	Initial Preparations	Obtain 3 vendors contracts for each service				
1.12	Initial Preparations	Obtain most recent reviews of each potential vendor				
2.1	Fiscal Systems	Review Start Up Budget				
2.2	Fiscal Systems	Ramp-up budget (if needed)				
2.3	Fiscal Systems	Review Operations Budget				
2.4	Fiscal Systems	Finalize Budgets				
3.1	Final	Determine and select vendor for each service				
3.2	FInal	Review and Negotiate contracts				
3.3	Final	Execute Contracts and Submit to AP with W9				

Medical Services

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
1.1	Initial Preparations	Determine Scope of PRactice for Medical Serices within Urgent Care				
1.1	Initial Preparations	Meet with Potential Medical Providers within Community to assist with shaping Scope				
1.1	Initial Preparations	Pull Provider data on the Top 10 reasons guests are sent out for medical treatment				
1.1	Initial Preparations	Request data from Funder on data from previous provider on medical concerns of guests				
1.1	Initial Preparations	Finalize Urgent Care Behavioral Health and Medical Scope of Services Internally within facility				
1.1	Initial Preparations	Review and Finalize Urgent Care Behavioral Health and Medical Scope of Services with Funder				
1.1	Initial Preparations	Determine Medical Equipment Needs and Supplies				
1.1	Initial Preparations	Determine contracted provider for medical services for urgent care				
1.1	Initial Preparations	Negotiate Scope of Medical Services				
1.1	Initial Preparations	Review Medical Supply and Equipment list				
2.1	Human Resources	Identify Staff needed for medical services				
2.2	Human Resources: All	Identify HR needs, credentials, requirements, processes, etc. and plan for start up including start date for new hires				
2.3	Human Resources: General	Approval of job descriptions with accurate requirements and duties				
2.4	Human Resources: Recruiting	Review Staffing Plan/Budget to determine staffing pattern and staff needs				
2.5	Human Resources: Recruiting	Determine any Provider needs and fill plan				
2.6	Human Resources: Recruiting	Peer Employment Training RECRUITING (If applicable): Prepare PET advertising/postings to generate qualified leads/candidates for PET classes to create Peer candidate pool (only if hiring *post* PET class)				
2.7	Human Resources: Recruiting	Determine, prepare and post internal/external posting/advertising to recruit qualified staff/candidates				
2.8	Human Resources: Recruiting	Collect, Screen and Process applications				
2.9	Human Resources: Recruiting	Receive, Screen & Interview applicants, determine hires and advise HR/Recruiting				
2.10	Human Resources: Recruiting	Hire staff (offers to be made minimum 2-3 WEEKS prior to employee start date) inc. all onboarding processes. Include ALL paperwork (including onboarding, state/county-specific forms, authorized driver, ROI, etc.)				
2.11	Human Resources: Recruiting	Any needs state-specific needs required for staff?				
3.1	Orientation and Training	Determine start date & schedule for PET& NEO as needed				
3.2	Orientation and Training	On-Site Orientation, facilities, services, ammenities				
3.3	Orientation and Training	Roles & Responsibilities of each position				
3.4	Orientation and Training	Process & Procedure Review				
3.5	Orientation and Training	Licensing Shadowing at other Provider locations/Provider Implementation team mentorship				
3.6	Orientation and Training	CPI/ Therapeutic Options Training/UKERU				
3.7	Orientation and Training	CPR/ 1st Aid/ AED/NARCAN				
3.8	Orientation and Training	Motivational Interviewing				
3.9	Orientation and Training	Person Centered Thinking				
3.10	Orientation and Training	Relias Training				
3.11	Orientation and Training	Quality & Compliance Trainings				
3.12	Orientation and Training	HR Trainings				
4.1	Risk Management	Review program, site and staff for all insurance, health & safety, workers comp, etc.				
5.1	CBO	Review and determine billing ability for medical services				
5.2	CBO	Obtain Contract and Fee Schedule if appropriate				
5.3	CBO	Coordinate with IT to program new fiscal, billing and program codes per contract				

Medical Services

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
5.4	CBO	Create billing capacity to bill Medicare and TPL				
5.5	CBO	Review and delineate contract deliverables, including reporting requirements				
5.6	CBO	Identify reporting & billing requirements.				
5.7	CBO	Verify Billing Functionality				
5.8	CBO	Netsmart and RCM Billing and Software Training				
5.9	CBO	TPL Required?				
6.1	EHR	Setup EHR structure				
6.2	EHR	Confirm EHR meets program needs				
6.3	EHR	Create Workflows for EHR				
6.4	EHR	Initial New Site EHR Orientation				
6.5	EHR	Identifying Reporting Requirements				
6.6	EHR	Identify what data available and required through EHR to capture necessary data and create reports				
6.7	EHR	EHR Training				
7.1	Software	Clinical Document Training from medical aspect				
8.1	Quality Improvement Plan	Formulate QI Plan according to proposal, evidence-based practices and projected outcomes				
8.2	Quality Improvement Plan	Official Program Description				
8.3	Quality Improvement Plan	Identify QI Indicators with staff				
8.4	Quality Improvement Plan	Identify Outcome Measures				
8.5	Quality Improvement Plan	Include Compliance Plan into operations				
8.6	Quality Improvement Plan	Plan audits, compliance reviews & inspections				
8.7	Quality Improvement Plan	Ensure HIPAA program compliance				
9.1	Medical Records	Determine at what point the information must be captured i.e. initial contact or during face-to-face visit.				
9.2	Medical Records	Develop policies and procedures for medical record by job requirement.				
9.3	Medical Records	Implement tracking for requests to release records				
10.1	Develop P&Ps, Forms, and Chart	Collaborate with contracted medical provider for P&Ps				
10.2	Develop P&Ps, Forms, and Chart	Determine meeting cadence to develop P&Ps				
10.3	Develop P&Ps, Forms, and Chart	Review with all applicable standards including accreditation requirements as needed for compliance				
10.4	Develop P&Ps, Forms, and Chart	Transfer applicable, existing policies, procedures and forms to new program or create anew as needed				
10.5	Develop P&Ps, Forms, and Chart	Submit policies, procedures and forms for internal review				
10.6	Develop P&Ps, Forms, and Chart	Finalize Policy and Procedure Manual				
11.1	Vendors	Research Medical Venders				
11.2	Vendors	Involve AP for contract reviews and Provider protocol review for securing vendors				
11.3	Vendors	Obtain 3 vendors contracts for each service				
11.4	Vendors	Obtain most recent reviews of each potential vendor				
12.1	Fiscal Systems	Review Start Up Budget				
12.2	Fiscal Systems	Ramp-up budget (if needed)				
12.3	Fiscal Systems	Review Operations Budget				
12.4	Fiscal Systems	Finalize Budgets				
13.1	Final	Determine and select vendor for each service				
13.2	FInal	Review and Negotiate contracts				
13.3	Final	Execute Contracts and Submit to AP with W9				

Facilities & Maintenance

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
1.1	Initial Preparations	Determine scope of Facility and Maintenance, hours of operation				
1.2	Initial Preparations	Determine collaboration between Funder and Provider				
1.3	Initial Preparations	Determine Protocol for reporting building maintenance issues				
1.4	Initial Preparations	Determine Protocol for reporting challenges with facility services				
1.5	Initial Preparations	Initial building meeting cadence for first 6 months of services				
1.6	Initial Preparations	Discuss how maintenance can be completed on active units				

Staff Only Areas

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
1.1	Initial Preparations	Indentify overall supports and encouragement of staff only areas				
1.2	Initial Preparations	Review break policy				
1.3	Initial Preparations	Review Food and Nutrition				
1.4	Initial Preparations	Employee Support Activities				
2.1	Fiscal Systems	Review Start Up Budget				
2.2	Fiscal Systems	Ramp-up budget (if needed)				
2.3	Fiscal Systems	Review Operations Budget				
3.1	Purchasing	For Respite, Lactation Rooms, Workrooms, Staff Bathrooms, and Breakrooms				
3.2	Purchasing	Purchase all decorations: Identify delivery date				
3.3	Purchasing	Identify and review office supply items including, pens, paper, staplers, calendars, dry erase boards, etc.				
3.4	Purchasing	Purchase furnishings, decorations, and office supplies				
3.5	Purchasing	Identify & review Staffing Supply needs list including therapeutic and wellness activities, etc.				
3.6	Purchasing	Purchase supplies				
3.7	Purchasing	Design and Purchase Signage				
3.8	Purchasing	Coordinate with home-like decorations				
4.1	Vendors	Utilities, etc.				
4.2	Vendors	Cleaning / Janitorial				
4.3	Vendors	Food (In house kitchen or catered?)				
4.4	Vendors	Speciality Supplies (kitchen, medical room, etc.)				
5.1	Promote & Develop Wellness Plan	Promote Staff Wellness Plan				
6.1	Promote & Develop Marketing Plan	Marketing Staff Wellness Plan				

Guest Recreation Spaces

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
1.1	Fiscal Systems	Review Start Up Budget				
1.2	Fiscal Systems	Ramp-up budget (if needed)				
1.3	Fiscal Systems	Review Operations Budget				
1.4	Fiscal Systems	Determine budget capabilities for external therapist support- art therapist, yoga instructor, recreational therapist, etc.				
2.1	Purchasing	For Activity storage rooms on each unit and for each program. Movement Room				
2.2	Purchasing	Identify & review Staffing Supply needs list including therapeutic and recreational activities, books on mental illness, recovery, wellness and personal items, etc.				
2.3	Purchasing	Purchase supplies				
2.4	Purchasing	Design and Purchase Signage, if needed				
3.1	Program	Determine daily schedule for each unit and schedule				
4.1	Pomote & Develop Marketing Plan	Determine internal plan for promoting recreational activities				

Community Provider Workroom

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
	01. Initial Preparations	Identify Scope of Practice				
	01. Initial Preparations	Determine Hours of Operation				
	01. Initial Preparations	Determine internal P&P for use				
	01. Initial Preparations	Determine how to provide details of use to community				

Post Launch

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
	01. Initial Preparations	Review and determine positives and lessons learned				
	01. Initial Preparations	Review and determine staged and phased plan based on volume				
	01. Initial Preparations	Review and determine what is working and what is not working				
	01. Initial Preparations	Submit contracting details to MCOS				
	01. Initial Preparations	Submit for Licensingint Commission Review				

Contracting

ID	Category	Task	Staff Responsible	Tentitive	Progression	Projection	Update/Notes
1.1	Facilities Preparations	**Licensure/Accreditation requirement**:Obtain Needed information from licensing and accreditation team		New Implementation	Ongoing; weekly check ins	Q FY	
2.1	Program	**Scope of Work**: Review working program description to guide process and notify team of needs		New Implementation	Ongoing; weekly check ins	Q FY	
3.1	Initial Preparations	**Queue New Implementation:**Key staff are Director of RCM, Director of Payor Relations, Director of Credentialing. Follow contracting protocols and		Pending Certificate of Occupancy	Based on completion of contruction/ build out	Q FY	
3.2	Initial Preparations	**Licensure/Accreditation requirement**: Before contracting can be started for the crisis facility, the appropriate licensure and credentials must be completed for each service		Pending Certificate of Occupancy	Based on completion of contruction/ build out	Q FY	
3.3	Initial Preparations	**Identify Scope of Work:** Contracting will be for Urgent Care, 23 Hour observation 1, 23 hour observation 2, and inpatient unit		Pending State License	Provider Type/ Taxonomy codes	Q FY	
3.4	Initial Preparations	**Submit Intent to Enroll/ Enrollment Forms**: Contracting takes at minimum 180 days to complete		Submission of Enrollment	Approx.90 to 120 days	Q FY	
3.5	Initial Preparations	State Medicaid: ODM		Submission of Enrollment	Approx.90 to 120 days	Q FY	
3.6	Initial Preparations	Medicare:+Advantage Plans		Submission of Enrollment	Approx.90 to 120 days	Q FY	
3.7	Initial Preparations	CareSource: MCO		Submission of Enrollment	Approx.90 to 120 days	Q FY	
3.8	Initial Preparations	BuckEye (Centene): MCO		Submission of Enrollment	Approx.90 to 120 days	Q FY	
3.9	Initial Preparations	Molina: MCO		Submission of Enrollment	Approx.90 to 120 days	Q FY	
3.10	Initial Preparations	Anthem: MCO		Submission of Enrollment	Approx.90 to 120 days	Q FY	
3.11	Initial Preparations	Optum/ UHC: MCO		Submission of Enrollment	Approx.90 to 120 days	Q FY	
3.12	Initial Preparations	Funder: County		Submission of Enrollment	Approx.90 to 120 days	Q FY	
3.13	Initial Preparations	Any additional contractors (i.e., MCO's or TPL)		Commercial (3rd Party) Payor	Approx.90 to 120 days	Q FY	
4.1	Contracting Preparation: credentilaling/provider configuration	**Credentilaling/provider configuratio**n: Provider credentiling/ payer affiliation		Pending Completion of Funder Configuration	Approx. 30 to 60 days	Q FY	
5.1	Contracting Preparations	**Credentilaling/provider configuratio**n: Obtain needed information from HR regarding staff credentialing and demographics		Pending Completion of Funder Configuration	Approx. 30 to 60 days	Q FY	
5.2	Contracting Preparations	**Contract Review/Execution**:Obtain fee schedule for each MCO for each service		Pending Contract Execution	Approx.90 to 120 days	Q FY	
6.1	Final Contract Execution	**Distribution of deliverables**:Provide Operations staff with needed contract information to setup front end workflows to match contracting needs		Pending Contract Execution	Approx.90 to 120 days	Q FY	
7.1	Information Technology: Requirements	**MyAvatar Configuration:**13.8 Setup EHR structure and enter each staff credentials into Avatar to prep for billing		Pending Contract Execution	Approx.90 to 120 days	Q FY	

Community Engagement, Marketing

ID	Category	Task	Staff Responsible	Start Date	Finish Date	Update/Notes
1.1	Initial Preparations	Identify Implementation Team of key staff for marketing purposes of services				
1.2	Initial Preparations	Meet with stakeholders, including Funder, community supporters, schools, probation and parole, youth services, police, ED's housing and other providers announcing program and introducing it into the community				
1.3	Initial Preparations	Determine budgeting capabilities for external marketing firm				
2.1	Promote & Develop Marketing Plan	Attend Provider meetings				
2.2	Promote & Develop Marketing Plan	Re-Identify key provider agencies including inpatient units, emergency services, drug and alcohol programs, advocacy groups, case management services, housing agencies, adult foster care programs, primary care physicians, outpatient clinics, etc				
2.3	Promote & Develop Marketing Plan	Hold meetings with key provider agencies to facilitate coordination of services				
2.4	Promote & Develop Marketing Plan	Schedule Open House (invitations, invite police & fire)				
2.5	Promote & Develop Marketing Plan	Create invitation				
2.6	Promote & Develop Marketing Plan	Send invitations				
2.7	Promote & Develop Marketing Plan	Hold Open House (internal/external)				
		GO LIVE				

Addendum-HR Due Diligence

HR Implementation

Program Name:

Status Color Legend & Toggle							
Not Started	In Progress	Delayed	Complete	Not Applicable	Custom 2	Custom 3	Custom 4
OFF	ON	ON	ON	ON	OFF	OFF	OFF

Program Information	Comments / Notes
Location Name	
Location Address	
Operating Hours	
Shifts	
Program Type (Crisis / Etc.)	

HRBP / Compensation Tasks	Status	Owner	Assigned to	Anticipated Start Date	Anticipated End Date	Actual Start Date	Actual End Date	Estimated Cost	Actual Cost	Comments / Notes
Position(s) Needed	Not Started									
Licensing Title / # of Positions	Not Started									
Licensing Title / # of Positions	Not Started									
Licensing Title / # of Positions	Not Started									
Licensing Title / # of Positions	Not Started									
Licensing Title / # of Positions	Not Started									
Licensing Title / # of Positions	Not Started									
Licensing Title / # of Positions	Not Started									
Licensing Title / # of Positions	Not Started									
Types of Employment Required (FTE / Part-Time / Pool)	Not Started									
Full-Time	Not Started									
Part-Time	Not Started									
Pool	Not Started									
Position Types (Onsite / Hybrid / Remote)	Not Started									
Onsite	Not Started									
Hybrid	Not Started									
Remote	Not Started									
Licensures / Certification Requirements (State Specific)	Not Started									
License / Certification - Position	Not Started									
License / Certification - Position	Not Started									
License / Certification - Position	Not Started									
License / Certification - Position	Not Started									
License / Certification - Position	Not Started									
License / Certification - Position	Not Started									
FLSA Review of Position(s) Needed	Not Started									
Licensing Descriptions	Not Started									
Licensing / Position Titles Priced (Based on Market Data)	Not Started									
Create Staffing Plan with Licensing / Position Data	Not Started									
Submit Staffing Plan to Talent Acquisition	Not Started									

HProviderS Tasks	Status	Owner	Assigned to	Anticipated Start Date	Anticipated End Date	Actual Start Date	Actual End Date	Estimated Cost	Actual Cost	Comments / Notes
Position / Licensing Code Creation	Not Started									
NAICS Workers' Comp Codes	Not Started									
State-Specific Workers' Comp Codes / Risk Codes	Not Started									
Business Unit(s)	Not Started									
Department(s)	Not Started									
Location	Not Started									
EEO Establishment Address	Not Started									
Assign Management Access for Timekeeping / Self-Service	Not Started									
Hire new hires in ADP Workforce Now	Not Started									
	Not Started									
	Not Started									
	Not Started									

Addendum-HR Due Diligence

Payroll Tasks	Status	Owner	Assigned to	Anticipated Start Date	Anticipated End Date	Actual Start Date	Actual End Date	Estimated Cost	Actual Cost	Comments / Notes
Location of Facility / Program / Center	Not Started									
Tax Location Creation	Not Started									
Are we registered with the state tax department?	Not Started									
Cost Centers / Cost Number Mapping	Not Started									
Cost Center - Position/Department	Not Started									
Cost Center - Position/Department	Not Started									
Cost Center - Position/Department	Not Started									
Cost Center - Position/Department	Not Started									
Pay Schedule	Not Started									
Sunday - Saturday	Not Started									
Pay Frequency	Not Started									
Bi-Weekly	Not Started									
Allowances	Not Started									
Phone - Amount - Position/Person(s)	Not Started									
Car - Amount - Position/Person(s)	Not Started									
Equipment - Amount - Position/Person(s)	Not Started									
Other - Amount - Position/Person(s)	Not Started									
Bonuses	Not Started									
Sign-On Bonus Pay - Stipulations - Position	Not Started									
Sign-On Bonus Pay - Stipulations - Position	Not Started									
Sign-On Bonus Pay - Stipulations - Position	Not Started									
Relocation Pay - Stipulations - Position	Not Started									
Relocation Pay - Stipulations - Position	Not Started									
Stipends	Not Started									
Shift Differentials	Not Started									
2nd Shift Hours - 2nd Shift Pay Differential	Not Started									
3rd Shift Hours - 3rd Shift Pay Differential	Not Started									
Weekend Hours - Weekend Shift Pay Differential	Not Started									
On-Call Pay	Not Started									
On-Call Hours - On-Call Pay - Position	Not Started									
On-Call Hours - On-Call Pay - Position	Not Started									
On-Call Hours - On-Call Pay - Position	Not Started									
On-Call Hours - On-Call Pay - Position	Not Started									
On-Call Hours - On-Call Pay - Position	Not Started									
Pay Codes (New)	Not Started									
GL Mapping for New Pay Codes	Not Started									
Department of Labor Setup	Not Started									
Department of Labor Withholding Setup	Not Started									
Any laws pertaining to separation of employment? (CA / Etc.)	Not Started									

Benefits Tasks	Status	Owner	Assigned to	Anticipated Start Date	Anticipated End Date	Actual Start Date	Actual End Date	Estimated Cost	Actual Cost	Comments / Notes
Benefits Offered (Yes / No)	Not Started									
Medical	Not Started									
Dental	Not Started									
Vision	Not Started									
Life Insurance	Not Started									
401k/Retirement	Not Started									
State Required Benefit Offerings	Not Started									
% of Benefits - Company Paid	Not Started									
Are there other payroll Deductions or Garnishments?	Not Started									
Vacation Time Earned (Any State / County / City - Specific Laws?)	Not Started									
Sick Time Earned (Any State / County / City - Specific Laws?)	Not Started									
Holiday Earned (Any State / County / City - Specific Laws ?)	Not Started									

Addendum-HR Due Diligence

Recruitment / Onboarding Tasks	Status	Owner	Assigned to	Anticipated Start Date	Anticipated End Date	Actual Start Date	Actual End Date	Estimated Cost	Actual Cost	Comments / Notes
Pre-Employment Testing (Any State / County / City - Specific Regulations?)	Not Started									
TB Testing	Not Started									
MVR Testing (Type / Lookback Period i.e. 1, 2, or 3 Years)	Not Started									
Criminal Backgrounds Testing (Type / Lookback Period i.e. 3, 5, or 7 Years)	Not Started									
Finger Printing	Not Started									
Child Protection Register (if necessary)	Not Started									
Physical (if necessary)	Not Started									
Education Verification	Not Started									
Reference Verification	Not Started									
Licensures / Certification Requirements (State Specific)	Not Started									
Types of Employment Required (FTE / Part-Time / Pool)	Not Started									
Position Types (Onsite / Hybrid / Remote)	Not Started									
Position(s) Needed	Not Started									
% of Staffing Required to Open Program	Not Started									
Time to Fill Required Licensings	Not Started									
Software Skills Needed	Not Started									
Soft Skills Needed	Not Started									
Create Licensing Requisitions	Not Started									
Post Licensings on Career Site / 3rd Party Vendors	Not Started									
Offer Letter Templates	Not Started									
Submit Offer Letters to Payroll (if necessary)	Not Started									
Submit Documentation to Credentialing	Not Started									
Equipment Needs (if necessary)	Not Started									
ADA Accommodations	Not Started									
	Not Started									
	Not Started									

Addendum-Medical Supply List

PPE & Food Stock		
Item	Overstock	Ofc Stock
Shields		
Staff masks		
Guest Masks		
Sani Wipes		
Hand Sanitizer		
Gowns		
S Gloves Pr		
M Gloves Pr		
L Gloves Pr		
XL Gloves Pr		
XXL Gloves Pr		
Med Cups		
Pill Cups		
Gatorade		
Gatorade Zero		
Ensure		
Glucerna		
Milk		
Saltines		
Graham Crackers		
Almonds		
Peanut Butter		
Blood glucose strips		
BG QC (2 levels)		
BAC tips		
Dressings (2x2, 4x4, telfa)		
Hot packs		
Cold packs		
Antibiotic ointment		
Hydrocortisone ointment		
UDS		
Fentanyl strips		
UPT		
Needles/syringes (type, gauge per site)		
Insulin syringes		
Lancets		
Bandaids		
Falls socks		
Rx destroyer		
Hand sanitizer		
Sani-wipes		
Temp probe covers		
Home med bags		
Sharps containers		
Ear plugs		
Paper & transpore tape		
Armbands and precautions dots		
Emesis bags		
[illegible] monitor, BAC machine, AED, handheld thermometers, portable PO2)		
Spare AED battery and pads		
Go bag and equipment		
Narcan and educ kits		
First aid kits		
Ambu bag/CPR barriers		
Saline flushes		
Oxygen Tanks		

Addendum-Medical Scope

Determined within Medical Scope	Under consideration for Medical Scope
Diabetes Mellitus	Routine Dialysis
Hypertension	Pic, indwelling port, or other permanent lines
GERD	Ability for IVs
Nausea/Emesis	Accessing medications such as coumadin, antiretrovirals, Clozaril, chemotherapy and cardiac in a timely manner
Allergic Rhinitis	
Back Pain	
Point of Care UDS/Pregnancy Testing	
Hypothyroidism	
Urinary Tract Infection	
Expanded UDS and Pregnancy Testing	
Point-of-care ANC	
EKGs for QT/QTC monitoring	
C Diff	
MRSA	
Breathing Treatment with ability to provide continuous oxygen, Nebulizer, or CPAP	
Drainage Abscesses with local anesthesia with voluntary participation	
Basic Laceration repair wtih voluntary participation	
Need for Go bags	

Appendix F: Frequently Asked Questions

1) **What staff within Community Health and Social Services would be in charge of running the CTC?**
The CTC would be under San Juan County, specifically the Community Health & Social Department – Mental Wellness Resource Center Division. That said, San Juan County would contract the services for a CTC to an outside provider. San Juan County would not operate the CTC nor be responsible for the day-to-day operations.

2) **Can we utilize Safety Net Care Pool funding for the CTC?**
Safety Net Care Pool fund: Established by NM State Statute (§) 27-5-6-1. A. The "safety net care pool fund" is created in the state treasury. The safety net care pool fund, which shall be administered by the department, shall consist of public funds provided through intergovernmental transfers from counties or other public entities and transferred from counties pursuant to Section 16 of this 2014 act. 1. Money in the fund shall be invested by the state treasurer as other state funds are invested. Any unexpended or unencumbered balance remaining in the fund at the end of any fiscal year shall not revert. B. Money in the safety net care pool fund is appropriated to the department to make payments to qualifying hospitals. No safety net care pool fund payments or money in the safety net care pool fund shall be used to supplant any general fund support for the state Medicaid program.

3) **What is the plan for hiring and retaining talent as the business grows?**
San Juan County sought guidance from RI International regarding recruitment and retention strategies within the labor force of a Comprehensive Treatment Center (CTC), in line with the business model. Since the County doesn't plan to directly administer the CTC but rather contract such services, it anticipates the contractor will include competitive salary, benefits, and training. However, recognizing the competitive nature of the labor market, the County values the consultant's input.

4) **Are there contingency plans in place for unforeseen circumstances?**
This was a general inquiry. However, what specific funds or percentage of funds must be allocated within the proforma? Doña Ana County highlighted the significance of having funds in place for unexpected costs and underutilized services, as these factors contributed to its closure. Therefore, from a budgetary perspective, should San Juan County anticipate rising costs? Additionally, what funds should be allocated for marketing? Doña Ana County cited underutilization / lack of awareness of services as another contributing factor, underscoring the importance of effective marketing. Generally, speaking San Juan County always budgets for contingency costs.

5) **What are policies and procedures from other New Mexico CTCs?**

Below is a link to NM State Statue 7.30.13.1. If a Comprehensive Treatment Center (CTC) were to operate within San Juan County, it would be required to adhere to this law, encompassing employment mandates, handling of medical/personal records, floor plan specifications, and more.

https://www.srca.nm.gov/parts/title07/07.030.0013.html#:~:text=The%20CTC%20provides%20emergency%20behavioral,older%20who%20meet%20admission%20criteria

Appendix G: Basic Discharge Criteria

In a crisis triage center, the following indicates areas of consideration for discharge criteria. Each area will vary visit to visit as the presenting challenges will be different.

1. **Stability of mental state**: The patient's acute presenting symptoms should be stabilized or significantly improved based on patient report and observation.
2. **Safety**: The patient should no longer be an immediate danger to themselves or others.
3. **Treatment Plan**: A follow-up treatment plan should be in place, including appointments with mental health providers if necessary.
4. **Medication Management**: If applicable, the patient should have a clear understanding of their medication regimen and access to necessary prescriptions.
5. **Support System**: The patient should have a support system in place, such as family or friends, to assist with their transition back to the community.
6. **Basic Needs**: Arrangements for housing, food, and other essential needs should be addressed.
7. **Understanding of Crisis Plan**: The patient should have a clear understanding of what to do if symptoms worsen or another crisis occurs, including returning to the crisis triage center, if necessary.
8. **Voluntary Status**: The patient should be willing to leave the facility voluntarily, unless legal intervention is required.
9. **Substance Use Management**: If applicable, the patient should have a plan to manage any substance use issues.

APPENDIX H: CHAIRS ONLY BUDGET

Recovery Innovations, Inc., dba RI International
Yearly Comparison

	Operational	Δ %	Start-Up
	Budget		**Budget**
REVENUE	**3,548,893**		**1,014,283**
OPERATING EXPENSES			
Salary & Wages	1,865,614		347,815
Registry Services	120,000		
Employee Benefits	406,634	22%	86,954
Total Employee Expenses	**2,392,248**		**434,769**
Travel	6,000		1,000
Office Occupancy (Facility)	168,000		28,000
Client Occupancy	0		0
Program Services	82,900		13,817
Program Supplies	153,800		25,633
Office Supplies & Equipment	166,982		363,175
Insurance	76,518		12,753
Telephone	24,600		4,100
Other Expenses	13,200		2,200
Net Operating Expenses, excluding Direct Allocations	**3,084,248**		**885,446**
Direct Allocation Expenses	187,062	**6.1%**	53,703
Operating Expenses, including Direct Allocations	**3,271,310**		**939,150**
Indirect Allocation Expenses	277,582	**8.5%**	75,133
Total Expenses	**3,548,893**		**1,014,283**

Recovery Innovations, Inc., dba RI International

Budget Year: FY 23-24

Dept:

GL #		Verify / WS Link	Amt	Period 1 Jul	Period 2 Aug	Period 3 Sep	Period 4 Oct	Period 5 Nov	Period 6 Dec	Period 7 Jan	Period 8 Feb	Period 9 Mar	Period 10 Apr	Period 11 May	Period 12 Jun	FY 23-24 Budget
			Capacity	7	7	7	7	7	7	7	7	7	7	7	7	
			Occupancy	45%	50%	55%	60%	65%	70%	75%	80%	85%	85%	85%	85%	
			Census/Day	3.15	3.5	3.85	4.2	4.55	4.9	5.25	5.6	5.95	5.95	5.95	5.95	58.80
				31	31	30	31	30	31	31	28	31	30	31	30	365
REVENUE		Estimated B'down	**Amt**													
0	Medicaid	70%	$ 1,051.38	71,867	79,852	85,004	95,823	100,459	111,793	119,778	115,399	135,749	131,370	135,749	131,370	**1,314,214**
	Uninsured	12.5%	$ -	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Medicare	11.5%	$ 1,051.38	1,687	1,874	1,995	2,249	2,358	2,624	2,811	2,708	3,186	3,083	3,186	3,083	**30,844**
	EE MCO Plans	6%	$ 1,051.38	880	978	1,041	1,173	1,230	1,369	1,467	1,413	1,662	1,609	1,662	1,609	**16,092**
				-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Doubtful Accounts (10% Risk)			(7,443)	(8,270)	(8,804)	(9,925)	(10,405)	(11,579)	(12,406)	(11,952)	(14,060)	(13,606)	(14,060)	(13,606)	**(136,115)**
				-	-	-	-	-	-	-	-	-	-	-	-	**-**
				-	-	-	-	-	-	-	-	-	-	-	-	**-**
				-	-	-	-	-	-	-	-	-	-	-	-	**-**
				-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Gap funding needed (County)			233,194	225,750	214,804	203,566	200,397	196,590	196,444	174,795	166,962	172,197	174,260	164,899	**2,323,857**
	Total Revenue		**3,154**	**300,184**	**300,184**	**294,040**	**292,886**	**294,040**	**300,797**	**308,095**	**282,364**	**293,499**	**294,653**	**300,797**	**287,355**	**3,548,893**
GL #			**VERIF**													
OPERATING EXPENSES				100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Salary & Wages	Linked To														
60000	Salaries and Wages	24/7 SWB		146,833	146,833	142,292	142,332	142,292	146,833	151,333	133,211	142,332	142,292	146,833	137,792	**1,721,208**
60050	Compensated Absences	Incl in S&W														**-**
60100	Overtime	24/7 SWB		8,324	8,324	8,067	8,054	8,067	8,324	8,594	7,554	8,054	8,067	8,324	7,797	**97,549**
60110	Shift Differential	24/7 SWB		4,154	4,154	4,079	2,321	4,079	4,154	5,987	3,929	2,321	4,079	4,154	2,246	**45,657**
60120	On Call Pay	24/7 SWB		-	-	-	-	-	-	-	-	-	-	-	-	**-**
60125	Standby / Incentive	24-7 Standby-Incentive	1200	100	100	100	100	100	100	100	100	100	100	100	100	**1,200**
60130	Performance Compensation / Bonus	24/7 SWB		-	-	-	-	-	-	-	-	-	-	-	-	**-**
60190	Contingency - SWB +/-	Contingency +/-		-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Salary & Wages			159,411	159,411	154,538	152,806	154,538	159,411	166,015	144,794	152,806	154,538	159,411	147,934	1,865,614
	Registry Services															
60500	Registry - Nursing / CNA	60500	120,000.00	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	**120,000**
60505	Registry - Physicians / NP	60505	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
60510	Registry - Non Medical	60510	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
60515	Registry - Professional / Support Staff	60515	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Registry Services			10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	120,000
	Employee Benefits	Linked To														
61000	FICA	24/7 SWB & EE Cost		12,187	12,187	11,815	11,682	11,815	12,187	12,692	11,069	11,682	11,815	12,187	11,309	**142,628**
61005	Medical Insurance	EE Cost plus CY Data		16,196	16,196	16,196	16,196	16,196	16,196	16,196	16,196	16,196	16,196	16,196	16,196	**194,356**
61010	Workers Compensation	24/7 SWB		1,529	1,529	1,483	1,466	1,483	1,529	1,593	1,389	1,466	1,483	1,529	1,419	**17,898**
61015	Unemployment Tax	24/7 SWB		513	513	513	513	513	513	513	513	513	513	513	513	**6,153**
61020	Employee Education and Training - Non-Related Party	61020		-	-	-	-	-	-	-	-	-	-	-	-	**-**
69300	Employee Education and Training - Related Party	69300		-	-	-	-	-	-	-	-	-	-	-	-	**-**
61025	Retirement	EE Cost plus CY Data	14,400.00	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	**14,400**
61030	Employee Health	61030	14,400.00	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	**14,400**
61035	Employee Credentials	61035	14,400.00	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	**14,400**
61040	Contingency	61040		-	-	-	-	-	-	-	-	-	-	-	-	**-**
61045	Employee Recognition	61045	1,200.00	100	100	100	100	100	100	100	100	100	100	100	100	**1,200**
61055	Meals - Staff	61055	1,200.00	100	100	100	100	100	100	100	100	100	100	100	100	**1,200**
	Total Employee Benefits			34,226	34,226	33,806	33,657	33,806	34,226	34,794	32,967	33,657	33,806	34,226	33,238	**406,634**
	Travel															
61500	Travel - Local Mileage	61500	6,000.00	500	500	500	500	500	500	500	500	500	500	500	500	**6,000**
61505	Travel - Out of Town Domestic	61505		-	-	-	-	-	-	-	-	-	-	-	-	**-**
61510	Travel - International	61510		-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Travel			500	500	500	500	500	500	500	500	500	500	500	500	**6,000**
	Office Occupancy (Facility)															
62000	Rent - Non-Related Party	62000	90,000.00	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	**90,000**
69100	Rent - Related Party	69100	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62005	CAM / Association Fees	62005	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62010	Event/Meeting Space Rental	62010	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62020	Utilities	62020	24,000.00	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	**24,000**
62025	Utilities - Water & Sewer (RIP)	62025	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62030	Utilities - Electric (RIP)	62030	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62045	Janitorial Services	62045	39,000.00	3,250	3,250	3,250	3,250	3,250	3,250	3,250	3,250	3,250	3,250	3,250	3,250	**39,000**
62050	Repairs and Maintenance - Facility	62050	15,000.00	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	**15,000**
62055	Real Estate Taxes	62055	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Office Occupancy			14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	**168,000**

Recovery Innovations, Inc., dba RI International

Budget Year: FY 23-24

Dept:

		Verify WS Link		Period 1 Jul	Period 2 Aug	Period 3 Sep	Period 4 Oct	Period 5 Nov	Period 6 Dec	Period 7 Jan	Period 8 Feb	Period 9 Mar	Period 10 Apr	Period 11 May	Period 12 Jun	FY 23-24 Budget
			Capacity	7	7	7	7	7	7	7	7	7	7	7	7	
			Occupancy	45%	50%	55%	60%	65%	70%	75%	80%	85%	85%	85%	85%	
			Census/Day	3.15	3.5	3.85	4.2	4.55	4.9	5.25	5.6	5.95	5.95	5.95	5.95	58.80
				31	31	30	31	30	31	31	28	31	30	31	30	365
	Client Occupancy															
62500	Transitional Housing Rents	62500	-	-	-	-	-	-	-	-	-	-	-	-	-	-
62505	Transitional Housing Rents - RI Lessee	62505	-	-	-	-	-	-	-	-	-	-	-	-	-	-
62510	Permanent Housing Move-In Deposits	62510	-	-	-	-	-	-	-	-	-	-	-	-	-	-
62515	Permanent Housing Move in Items	62515	-	-	-	-	-	-	-	-	-	-	-	-	-	-
62520	Transitional Housing Utilities	62520	-	-	-	-	-	-	-	-	-	-	-	-	-	-
62525	Transitional Housing Repairs & Maintenance	62525	-	-	-	-	-	-	-	-	-	-	-	-	-	-
62530	Transitional Housing Telephone	62530	-	-	-	-	-	-	-	-	-	-	-	-	-	-
62535	Permanent Housing Rents	62535	-	-	-	-	-	-	-	-	-	-	-	-	-	-
62540	Permanent Housing Rents - RI Lessee	62540	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total Client Occupancy			-	-	-	-	-	-	-	-	-	-	-	-	-

Recovery Innovations, Inc., dba RI International

Budget Year: FY 23-24

Dept:

Acct	Description	Verify WS Link		Period 1 Jul	Period 2 Aug	Period 3 Sep	Period 4 Oct	Period 5 Nov	Period 6 Dec	Period 7 Jan	Period 8 Feb	Period 9 Mar	Period 10 Apr	Period 11 May	Period 12 Jun	FY 23-24 Budget
			Capacity	7	7	7	7	7	7	7	7	7	7	7	7	
			Occupancy	45%	50%	55%	60%	65%	70%	75%	80%	85%	85%	85%	85%	
			Census/Day	3.15	3.5	3.85	4.2	4.55	4.9	5.25	5.6	5.95	5.95	5.95	5.95	58.80
				31	31	30	31	30	31	31	28	31	30	31	30	365
	Program Services															
63000	Laboratory Services	63000	240.00	20	20	20	20	20	20	20	20	20	20	20	20	240
63005	Travel - Client	63005	1,500.00	125	125	125	125	125	125	125	125	125	125	125	125	1,500
63010	Vehicle Related Expenses	63010	3,000.00	250	250	250	250	250	250	250	250	250	250	250	250	3,000
62015	Security Services	62015	-	-	-	-	-	-	-	-	-	-	-	-	-	-
63015	Linen Services	63015	52,000.00	4,333	4,333	4,333	4,333	4,333	4,333	4,333	4,333	4,333	4,333	4,333	4,333	52,000
63020	Pharmacy Services	63020	14,400.00	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	14,400
63030	Client Stipends	63030	-	-	-	-	-	-	-	-	-	-	-	-	-	-
63035	Contract Required Event	63035	-	-	-	-	-	-	-	-	-	-	-	-	-	-
63040	Other Professional Program Services	63040	2,400.00	200	200	200	200	200	200	200	200	200	200	200	200	2,400
63045	Translation & Interpreter Services	63045	1,200.00	100	100	100	100	100	100	100	100	100	100	100	100	1,200
63050	Training Expense Clients - Non-Related Party	63050	-	-	-	-	-	-	-	-	-	-	-	-	-	-
69400	Training Expense Clients - Related Party	69400	-	-	-	-	-	-	-	-	-	-	-	-	-	-
63055	Vehicle Lease	63055	8,160.00	680	680	680	680	680	680	680	680	680	680	680	680	8,160
	Total Program Services			6,908	6,908	6,908	6,908	6,908	6,908	6,908	6,908	6,908	6,908	6,908	6,908	82,900
	Program Supplies															
63500	Recreational Supplies	63500		-	-	-	-	-	-	-	-	-	-	-	-	-
63505	Special Events	63505		-	-	-	-	-	-	-	-	-	-	-	-	-
63510	Cleaning Supplies	63510	6,000	500	500	500	500	500	500	500	500	500	500	500	500	6,000
63515	Client Supplies	63515	6,000	500	500	500	500	500	500	500	500	500	500	500	500	6,000
63520	Kitchen Supplies	63520	2,000	167	167	167	167	167	167	167	167	167	167	167	167	2,000
63525	Other Program Expenses	63525	1,200	100	100	100	100	100	100	100	100	100	100	100	100	1,200
63530	Recovery in Action Days Hui (Flexifunds)	63530	-	-	-	-	-	-	-	-	-	-	-	-	-	-
63535	Program Supplies - Food	63535	120,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	120,000
63540	Program Supplies - Non-Food Items	63540	6,000	500	500	500	500	500	500	500	500	500	500	500	500	6,000
63545	Medical Supplies	63545	12,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	12,000
63550	Training Materials - Non-Related Party	63550	600	50	50	50	50	50	50	50	50	50	50	50	50	600
69200	Training Materials - Related Party	69200	-	-	-	-	-	-	-	-	-	-	-	-	-	-
63555	Start Up	63555	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total Program Supplies			12,817	12,817	12,817	12,817	12,817	12,817	12,817	12,817	12,817	12,817	12,817	12,817	153,800
	Office Supplies & Equipment															
64000	Office Expenses	64000	6,000.00	500	500	500	500	500	500	500	500	500	500	500	500	6,000
64005	Postage and Shipping	64005	1,200.00	100	100	100	100	100	100	100	100	100	100	100	100	1,200
64010	Printing and Copying	64010	-	-	-	-	-	-	-	-	-	-	-	-	-	-
64015	Minor Equipment Purchases & Repairs	64015	150,662.36	12,555	12,555	12,555	12,555	12,555	12,555	12,555	12,555	12,555	12,555	12,555	12,555	150,662
64020	Equipment Lease	64020	9,120.00	760	760	760	760	760	760	760	760	760	760	760	760	9,120
64025	Equipment Maintenance Agreement	64025	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total Office Supplies & Equipment			13,915	13,915	13,915	13,915	13,915	13,915	13,915	13,915	13,915	13,915	13,915	13,915	166,982
			1.1													
	Insurance															
66800	Other Insurance	66800	-	-	-	-	-	-	-	-	-	-	-	-	-	-
66805	Insurance - Automobile	66805	4,800.00	400	400	400	400	400	440	440	440	440	440	440	440	5,080
66810	Insurance - Property	66810	7,500.00	625	625	625	625	625	688	688	688	688	688	688	688	7,938
66815	Insurance - General & Profess. Liability	66815	60,000.00	5,000	5,000	5,000	5,000	5,000	5,500	5,500	5,500	5,500	5,500	5,500	5,500	63,500
	Total Insurance			6,025	6,025	6,025	6,025	6,025	6,628	6,628	6,628	6,628	6,628	6,628	6,628	76,518
	Telephone															
64250	Telephone - Voice & Data Lines	64250	19,200.00	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	19,200
64255	Cell Phones & Wireless Data	64255	5,400.00	450	450	450	450	450	450	450	450	450	450	450	450	5,400
	Total Telephone			2,050	2,050	2,050	2,050	2,050	2,050	2,050	2,050	2,050	2,050	2,050	2,050	24,600
	Other Expenses															
65000	Meals not travel related (business)	65000	-	-	-	-	-	-	-	-	-	-	-	-	-	-
64500	Professional Fees - Accounting	64500	-	-	-	-	-	-	-	-	-	-	-	-	-	-
64505	Professional Fees - Website	64505	-	-	-	-	-	-	-	-	-	-	-	-	-	-
64510	Professional Fees - Legal	64510	-	-	-	-	-	-	-	-	-	-	-	-	-	-
64515	Other Professional Fees	64515	-	-	-	-	-	-	-	-	-	-	-	-	-	-
64520	Consulting Services Support Departments	64520	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60135	Payroll/Benefit Miscellaneous Expense	60135	-	-	-	-	-	-	-	-	-	-	-	-	-	-
65005	Board Expenses	65005	-	-	-	-	-	-	-	-	-	-	-	-	-	-
65010	Conference Expense	65010	-	-	-	-	-	-	-	-	-	-	-	-	-	-
65015	Over/Short/Small Bal Adjustments	65015	-	-	-	-	-	-	-	-	-	-	-	-	-	-
69500	Contingency - Operating Exp	69500	-	-	-	-	-	-	-	-	-	-	-	-	-	-
65025	Non-Reimbursable Expenses	65025	-	-	-	-	-	-	-	-	-	-	-	-	-	-
65030	Bank Service Charges	65030	-	-	-	-	-	-	-	-	-	-	-	-	-	-
65040	Advertising - Employee / Recruiting	65040	12,000.00	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	12,000

Recovery Innovations, Inc., dba RI International

Budget Year: FY 23-24

Dept:

				Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
			Capacity	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	
			Occupancy	**45%**	**50%**	**55%**	**60%**	**65%**	**70%**	**75%**	**80%**	**85%**	**85%**	**85%**	**85%**	
			Census/Day	3.15	3.5	3.85	4.2	4.55	4.9	5.25	5.6	5.95	5.95	5.95	5.95	**58.80**
		Verify WS Link		**Period 1 Jul**	**Period 2 Aug**	**Period 3 Sep**	**Period 4 Oct**	**Period 5 Nov**	**Period 6 Dec**	**Period 7 Jan**	**Period 8 Feb**	**Period 9 Mar**	**Period 10 Apr**	**Period 11 May**	**Period 12 Jun**	**FY 23-24 Budget**
				31	31	30	31	30	31	31	28	31	30	31	30	**365**
65050	Advertising/Sponsorships	65050	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
65055	Public Relations Expenses	65055	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
65060	Promotional Items	65060	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
65065	Dues and Subscriptions	65065	1,200.00	100	100	100	100	100	100	100	100	100	100	100	100	**1,200**
65070	Licenses and Fees	65070		-	-	-	-	-	-	-	-	-	-	-	-	**-**
65075	Donations	65075	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
65085	Business Taxes	65085	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
66600	Interest Expense	66600	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
66610	Mortgage Interest	66610	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
65095	Business Development Houston	65095	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
66000	Bad Debts	66000	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
66200	Gain / Loss on Currency Exchange	66200	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
66400	Loss on Asset Disposal	66400	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
69000	Other Related Party Expenses	69000	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
65100	Penalties / Fines / Late Fees	65100	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
65105	Prior Year Expense	65105	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Other Expenses			1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	**13,200**
	Property Management (RI Properties)															
69505	Management Fee	69505	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62050	Repairs & Maintenance - Facility	62050	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Property Management Expenses			-	-	-	-	-	-	-	-	-	-	-	-	**-**

Recovery Innovations, Inc., dba RI International

Budget Year: FY 23-24

Dept:

			Capacity	7	7	7	7	7	7	7	7	7	7	7	7	
			Occupancy	**45%**	**50%**	**55%**	**60%**	**65%**	**70%**	**75%**	**80%**	**85%**	**85%**	**85%**	**85%**	
			Census/Day	3.15	3.5	3.85	4.2	4.55	4.9	5.25	5.6	5.95	5.95	5.95	5.95	**58.80**
		Verify		**Period 1 Jul**	**Period 2 Aug**	**Period 3 Sep**	**Period 4 Oct**	**Period 5 Nov**	**Period 6 Dec**	**Period 7 Jan**	**Period 8 Feb**	**Period 9 Mar**	**Period 10 Apr**	**Period 11 May**	**Period 12 Jun**	**FY 23-24 Budget**
		WS Link		31	31	30	31	30	31	31	28	31	30	31	30	**365**
			Delete formula in column D for any that are not applicable to the particular department													
	Direct Allocation Expenses		$													
69700	Billing Services & Data Reporting	Formula CY Data	1.74%	4,552	4,552	4,459	4,427	4,459	4,562	4,687	4,285	4,437	4,470	4,562	4,345	**53,798**
69705	Quality & Compliance	Formula CY Data	1.12%	2,929	2,929	2,929	2,929	2,929	2,929	2,929	2,929	2,929	2,929	2,929	2,929	**35,149**
69715	Electronic Health Record	Formula CY Data	2.73%	7,123	7,123	7,123	7,123	7,123	7,123	7,123	7,123	7,123	7,123	7,123	7,123	**85,471**
69720	Recovery Connections Line	Input: if applicable		-	-	-	-	-	-	-	-	-	-	-	-	**-**
69600	Local Shared Services	Input: if applicable		-	-	-	-	-	-	-	-	-	-	-	-	**-**
69725	Regional Services	Input: if applicable		-	-	-	-	-	-	-	-	-	-	-	-	**-**
69730	Regional Services II	Input: if applicable		-	-	-	-	-	-	-	-	-	-	-	-	**-**
69701	Contracts & Credentialling	Input: if applicable	0.40%	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	**12,644**
	PLACEHOLDER			-	-	-	-	-	-	-	-	-	-	-	-	**-**
	PLACEHOLDER			-	-	-	-	-	-	-	-	-	-	-	-	**-**
69735	Direct Services Non Reimbursable	Input: if applicable		-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Direct Allocation Expenses			15,657	15,657	15,565	15,532	15,565	15,668	15,793	15,391	15,542	15,575	15,668	15,450	187,062
	Capital Expenditures:															
99000	Depreciation	99000	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
99100	Amortization	99100	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Capital Expenditures			-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Indirect Allocation Expenses		$													
69805	Indirect Admin Svs - Executive	Formula CY Data	3.41%	8,931	8,931	8,643	8,931	8,643	8,931	8,931	8,067	8,931	8,643	8,931	8,643	**105,160**
69810	Indirect Admin Svs - Finance	Formula CY Data	2.45%	6,416	6,416	6,209	6,416	6,209	6,416	6,416	5,795	6,416	6,209	6,416	6,209	**75,545**
69815	Indirect Admin Svs - HR	Formula CY Data	2.20%	5,755	5,755	5,570	5,755	5,570	5,755	5,755	5,198	5,755	5,570	5,755	5,570	**67,764**
69820	Indirect Admin Svs - MIS	Formula CY Data	0.94%	2,473	2,473	2,393	2,473	2,393	2,473	2,473	2,233	2,473	2,393	2,473	2,393	**29,114**
69800	Indirect Nonreimbursable Contra	Input DR or (CR)		-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Sub Total Indirect Allocations		0													
69830	Indirect Admin Svs - Non Reimbursable	Formula DR	0	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Indirect Allocation Expenses			**23,575**	**23,575**	**22,815**	**23,575**	**22,815**	**23,575**	**23,575**	**21,294**	**23,575**	**22,815**	**23,575**	**22,815**	**277,582**
	Total Expenses			**300,184**	**300,184**	**294,040**	**292,886**	**294,040**	**300,797**	**308,095**	**282,364**	**293,499**	**294,653**	**300,797**	**287,355**	**3,548,893**
Net Income (Loss)				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Recovery Innovations, Inc., dba RI International
FY 23-24

POSITION CONTROL
all linked to 24-7 SP tab

		7 recliners no beds	23 hour obs stabilization	Hours	160	160	160	480	
Position	**FTE**	**Rate**	**Comments**		**Month 1**	**Month 2**	**Month 3**	**Total**	
Admin Staff									
Program Director	1.00	$ 49.30	x		$ 7,888.00	$ 7,888.00	$ 7,888.00	$ 23,664.00	
Office Manager	1.00	$ 23.00	x		$ 3,680.00	$ 3,680.00	$ 3,680.00	$ 11,040.00	
Medical Director	0.10	$ 155.00	x						
Nurse Manager	0.50	$ 46.45	x		$ 3,716.00	$ 3,716.00	$ 3,716.00	$ 11,148.00	
Executive Admin Leadership	0.10	$ 72.00	x						
Executive Medical Leadership	0.05	$ 168.27	x						
Direct Staff									
NP / Psych Worked	0.70	$ 95.00	telehealth as needed		$ 10,640.00	$ 10,640.00	$ 10,640.00	$ 31,920.00	
Nurse RN	4.20	$ 42.95	on site		$ 28,862.40	$ 28,862.40	$ 28,862.40	$ 86,587.20	
TeleHealth Peer	1.50	$ 21.00	on site		$ 5,040.00	$ 5,040.00	$ 5,040.00	$ 15,120.00	
Shift Supervisor (Clinician)	4.20	$ 35.00	on site		$ 23,520.00	$ 23,520.00	$ 23,520.00	$ 70,560.00	
Peer Support Specialist I	4.20	$ 17.00	on site		$ 11,424.00	$ 11,424.00	$ 11,424.00	$ 34,272.00	
Milieu Specialist (Peer)	4.20	$ 21.00	on site		$ 14,112.00	$ 14,112.00	$ 14,112.00	$ 42,336.00	
Transportation Specialist (Peer)	2.10	$ 21.00	on site		$ 7,056.00	$ 7,056.00	$ 7,056.00	$ 21,168.00	
TOTALS	23.85				$ 115,938.40	$ 115,938.40	$ 115,938.40	$ 347,815.20	S&W
								$ 86,953.80	Benefits
								$ 434,769.00	SWB Start-Up

Salary & Wages	$ 1,865,613.97
Registry Services	$ 120,000.00
Employee Benefits	$ 406,634.36
	$ 2,392,248.33

People	10	
Airfare	10,000.00	
Hotel	13,000.00	
Meals	7,900.00	
Rental Car	2,000.00	
Total	32,900.00	Start-UP Travel

APPENDIX I: CHAIRS AND BEDS BUDGET

Recovery Innovations, Inc., dba RI International
Yearly Comparison

	Operational Budget	Δ %	Start-Up Budget
REVENUE	**3,566,483**		
OPERATING EXPENSES			
Salary & Wages	1,994,392		267,961
Registry Services	120,000		
Employee Benefits	437,688	22%	66,990
Total Employee Expenses	**2,552,080**		**334,951**
Travel	6,000		1,000
Office Occupancy (Facility)	168,000		28,000
Client Occupancy	0		0
Program Services	82,900		13,817
Program Supplies	153,800		25,633
Office Supplies & Equipment	22,320		3,720
Insurance	76,518		12,753
Telephone	24,600		4,100
Other Expenses	13,200		2,200
Property Management (RI Properties)	0		0
Recovery Connections Line	0		0
Local Shared Services	0		0
Capital Expenditures	0		0
Net Operating Expenses, excluding Direct Allocations	**3,099,417**		**426,174**
Direct Allocation Expenses	188,119	**6.1%**	25,867
Operating Expenses, including Direct Allocations	**3,287,536**		**452,040**
Indirect Allocation Expenses	278,948	**8.5%**	36,161
Total Expenses	**3,566,483**		**488,201**

GL #	Description	Verify / Linked To	Amt	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	Period 11	Period 12	FY 23-24 Budget
Recovery Innovations, Inc., dba RI International			**Capacity**	**13**	**13**	**13**	**13**	**13**	**13**	**13**	**13**	**13**	**13**	**13**	**13**	
Budget Year:	**FY 23-24**		**Occupancy**	**45%**	**50%**	**55%**	**60%**	**65%**	**70%**	**75%**	**80%**	**85%**	**85%**	**85%**	**85%**	
Dept:			**Census**	5.85	6.5	7.15	7.8	8.45	9.1	9.75	10.4	11.05	11.05	11.05	11.05	**109.20**
		Verify		**Period 1 Jul**	**Period 2 Aug**	**Period 3 Sep**	**Period 4 Oct**	**Period 5 Nov**	**Period 6 Dec**	**Period 7 Jan**	**Period 8 Feb**	**Period 9 Mar**	**Period 10 Apr**	**Period 11 May**	**Period 12 Jun**	**FY 23-24 Budget**
		WS Link		31	31	30	31	30	31	31	28	31	30	31	30	**365**
REVENUE		Estimated B'down	**Amt**													
0	Medicaid 70%	70%	$ 1,051.38	133,467	148,297	157,865	177,957	186,567	207,616	222,446	214,313	252,105	243,973	252,105	243,973	**2,440,684**
	MCO 30%	30%	$ 824.83	3,452	3,835	4,083	4,603	4,825	5,370	5,753	5,543	6,520	6,310	6,520	6,310	**63,124**
	Doubtful Accounts (10% Risk)			(13,692)	(15,213)	(16,195)	(18,256)	(19,139)	(21,299)	(22,820)	(21,986)	(25,863)	(25,028)	(25,863)	(25,028)	**(250,381)**
	Gap funding needed (County)			178,716	165,024	149,668	129,904	123,168	110,869	104,914	85,119	62,057	70,780	69,794	63,043	**1,313,056**
	Total Revenue		**1,876**	**301,943**	**301,943**	**295,421**	**294,207**	**295,421**	**302,556**	**310,293**	**282,990**	**294,820**	**296,034**	**302,556**	**288,298**	**3,566,483**
GL #			**VERIF**													
OPERATING EXPENSES				100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Salary & Wages	Linked To														
60000	Salaries and Wages	24/7 SWB		157,312	157,312	152,445	152,531	152,445	157,312	162,092	142,713	152,531	152,445	157,312	147,665	**1,844,114**
60050	Compensated Absences	Incl in S&W														**-**
60100	Overtime	24/7 SWB		8,740	8,740	8,471	8,453	8,471	8,740	9,027	7,932	8,453	8,471	8,740	8,184	**102,421**
60110	Shift Differential	24/7 SWB		4,254	4,254	4,179	2,321	4,179	4,254	6,187	4,029	2,321	4,179	4,254	2,246	**46,657**
60120	On Call Pay	24/7 SWB		-	-	-	-	-	-	-	-	-	-	-	-	**-**
60125	Standby / Incentive	24-7 Standby-Incentive	1200	100	100	100	100	100	100	100	100	100	100	100	100	**1,200**
60130	Performance Compensation / Bonus	24/7 SWB		-	-	-	-	-	-	-	-	-	-	-	-	**-**
60190	Contingency - SWB +/-	Contingency +/-		-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Salary & Wages			170,406	170,406	165,195	163,405	165,195	170,406	177,407	154,774	163,405	165,195	170,406	158,194	1,994,392
	Registry Services															
60500	Registry - Nursing / CNA	60500	120,000.00	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	**120,000**
60505	Registry - Physicians / NP	60505	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
60510	Registry - Non Medical	60510	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
60515	Registry - Professional / Support Staff	60515	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Registry Services			10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	120,000
	Employee Benefits	Linked To														
61000	FICA	24/7 SWB & EE Cost		13,028	13,028	12,630	12,493	12,630	13,028	13,564	11,833	12,493	12,630	13,028	12,094	**152,479**
61005	Medical Insurance	EE Cost plus CY Data		17,826	17,826	17,826	17,826	17,826	17,826	17,826	17,826	17,826	17,826	17,826	17,826	**213,913**
61010	Workers Compensation	24/7 SWB		1,635	1,635	1,585	1,568	1,585	1,635	1,702	1,485	1,568	1,585	1,635	1,518	**19,135**
61015	Unemployment Tax	24/7 SWB		547	547	547	547	547	547	547	547	547	547	547	547	**6,561**
61020	Employee Education and Training - Non-Related Party	61020		-	-	-	-	-	-	-	-	-	-	-	-	**-**
69300	Employee Education and Training - Related Party	69300		-	-	-	-	-	-	-	-	-	-	-	-	**-**
61025	Retirement	EE Cost plus CY Data	14,400.00	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	**14,400**
61030	Employee Health	61030	14,400.00	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	**14,400**
61035	Employee Credentials	61035	14,400.00	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	**14,400**
61040	Contingency	61040		-	-	-	-	-	-	-	-	-	-	-	-	**-**
61045	Employee Recognition	61045	1,200.00	100	100	100	100	100	100	100	100	100	100	100	100	**1,200**
61055	Meals - Staff	61055	1,200.00	100	100	100	100	100	100	100	100	100	100	100	100	**1,200**
	Total Employee Benefits			36,836	36,836	36,388	36,233	36,388	36,836	37,439	35,490	36,233	36,388	36,836	35,785	**437,688**
	Travel															
61500	Travel - Local Mileage	61500	6,000.00	500	500	500	500	500	500	500	500	500	500	500	500	**6,000**
61505	Travel - Out of Town Domestic	61505		-	-	-	-	-	-	-	-	-	-	-	-	**-**
61510	Travel - International	61510		-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Travel			500	500	500	500	500	500	500	500	500	500	500	500	**6,000**
	Office Occupancy (Facility)															
62000	Rent - Non-Related Party	62000	90,000.00	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	**90,000**
69100	Rent - Related Party	69100	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62005	CAM / Association Fees	62005	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62010	Event/Meeting Space Rental	62010	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62020	Utilities	62020	24,000.00	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	**24,000**
62025	Utilities - Water & Sewer (RIP)	62025	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62030	Utilities - Electric (RIP)	62030	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62045	Janitorial Services	62045	39,000.00	3,250	3,250	3,250	3,250	3,250	3,250	3,250	3,250	3,250	3,250	3,250	3,250	**39,000**
62050	Repairs and Maintenance - Facility	62050	15,000.00	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	1,250	**15,000**
62055	Real Estate Taxes	62055	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Office Occupancy			14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	**168,000**
	Client Occupancy															
62500	Transitional Housing Rents	62500	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62505	Transitional Housing Rents - RI Lessee	62505	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62510	Permanent Housing Move-In Deposits	62510	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62515	Permanent Housing Move in Items	62515	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62520	Transitional Housing Utilities	62520	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
62525	Transitional Housing Repairs & Maintenance	62525	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**

Recovery Innovations, Inc., dba RI International

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				Capacity	13	13	13	13	13	13	13	13	13	13	13	13	
				Occupancy	**45%**	**50%**	**55%**	**60%**	**65%**	**70%**	**75%**	**80%**	**85%**	**85%**	**85%**	**85%**	
				Census	5.85	6.5	7.15	7.8	8.45	9.1	9.75	10.4	11.05	11.05	11.05	11.05	**109.20**
		Verify			**Period 1 Jul**	**Period 2 Aug**	**Period 3 Sep**	**Period 4 Oct**	**Period 5 Nov**	**Period 6 Dec**	**Period 7 Jan**	**Period 8 Feb**	**Period 9 Mar**	**Period 10 Apr**	**Period 11 May**	**Period 12 Jun**	**FY 23-24 Budget**
		WS Link			31	31	30	31	30	31	31	28	31	30	31	30	**365**
62530	Transitional Housing Telephone	62530	-		-	-	-	-	-	-	-	-	-	-	-	-	-
62535	Permanent Housing Rents	62535	-		-	-	-	-	-	-	-	-	-	-	-	-	-
62540	Permanent Housing Rents - RI Lessee	62540	-		-	-	-	-	-	-	-	-	-	-	-	-	-
	Total Client Occupancy				-	-	-	-	-	-	-	-	-	-	-	-	-

Recovery Innovations, Inc., dba RI International

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Acct	Description	Verify WS Link		Period 1 Jul	Period 2 Aug	Period 3 Sep	Period 4 Oct	Period 5 Nov	Period 6 Dec	Period 7 Jan	Period 8 Feb	Period 9 Mar	Period 10 Apr	Period 11 May	Period 12 Jun	FY 23-24 Budget
			Capacity	13	13	13	13	13	13	13	13	13	13	13	13	
			Occupancy	45%	50%	55%	60%	65%	70%	75%	80%	85%	85%	85%	85%	
			Census	5.85	6.5	7.15	7.8	8.45	9.1	9.75	10.4	11.05	11.05	11.05	11.05	109.20
				31	31	30	31	30	31	31	28	31	30	31	30	365
	Program Services															
63000	Laboratory Services	63000	240.00	20	20	20	20	20	20	20	20	20	20	20	20	**240**
63005	Travel - Client	63005	1,500.00	125	125	125	125	125	125	125	125	125	125	125	125	**1,500**
63010	Vehicle Related Expenses	63010	3,000.00	250	250	250	250	250	250	250	250	250	250	250	250	**3,000**
62015	Security Services	62015	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
63015	Linen Services	63015	52,000.00	4,333	4,333	4,333	4,333	4,333	4,333	4,333	4,333	4,333	4,333	4,333	4,333	**52,000**
63020	Pharmacy Services	63020	14,400.00	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	**14,400**
63030	Client Stipends	63030	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
63035	Contract Required Event	63035	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
63040	Other Professional Program Services	63040	2,400.00	200	200	200	200	200	200	200	200	200	200	200	200	**2,400**
63045	Translation & Interpreter Services	63045	1,200.00	100	100	100	100	100	100	100	100	100	100	100	100	**1,200**
63050	Training Expense Clients - Non-Related Party	63050	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
69400	Training Expense Clients - Related Party	69400	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
63055	Vehicle Lease	63055	8,160.00	680	680	680	680	680	680	680	680	680	680	680	680	**8,160**
	Total Program Services			6,908	6,908	6,908	6,908	6,908	6,908	6,908	6,908	6,908	6,908	6,908	6,908	**82,900**
	Program Supplies															
63500	Recreational Supplies	63500		-	-	-	-	-	-	-	-	-	-	-	-	**-**
63505	Special Events	63505		-	-	-	-	-	-	-	-	-	-	-	-	**-**
63510	Cleaning Supplies	63510	6,000	500	500	500	500	500	500	500	500	500	500	500	500	**6,000**
63515	Client Supplies	63515	6,000	500	500	500	500	500	500	500	500	500	500	500	500	**6,000**
63520	Kitchen Supplies	63520	2,000	167	167	167	167	167	167	167	167	167	167	167	167	**2,000**
63525	Other Program Expenses	63525	1,200	100	100	100	100	100	100	100	100	100	100	100	100	**1,200**
63530	Recovery in Action Days Hui (Flexifunds)	63530	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
63535	Program Supplies - Food	63535	120,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	**120,000**
63540	Program Supplies - Non-Food Items	63540	6,000	500	500	500	500	500	500	500	500	500	500	500	500	**6,000**
63545	Medical Supplies	63545	12,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	**12,000**
63550	Training Materials - Non-Related Party	63550	600	50	50	50	50	50	50	50	50	50	50	50	50	**600**
69200	Training Materials - Related Party	69200	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
63555	Start Up	63555	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Program Supplies			12,817	12,817	12,817	12,817	12,817	12,817	12,817	12,817	12,817	12,817	12,817	12,817	**153,800**
	Office Supplies & Equipment															
64000	Office Expenses	64000	6,000.00	500	500	500	500	500	500	500	500	500	500	500	500	**6,000**
64005	Postage and Shipping	64005	1,200.00	100	100	100	100	100	100	100	100	100	100	100	100	**1,200**
64010	Printing and Copying	64010	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
64015	Minor Equipment Purchases & Repairs	64015	6,000.00	500	500	500	500	500	500	500	500	500	500	500	500	**6,000**
64020	Equipment Lease	64020	9,120.00	760	760	760	760	760	760	760	760	760	760	760	760	**9,120**
64025	Equipment Maintenance Agreement	64025	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Office Supplies & Equipment			1,860	1,860	1,860	1,860	1,860	1,860	1,860	1,860	1,860	1,860	1,860	1,860	22,320
			1.1													
	Insurance															
66800	Other Insurance	66800	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
66805	Insurance - Automobile	66805	4,800.00	400	400	400	400	400	440	440	440	440	440	440	440	**5,080**
66810	Insurance - Property	66810	7,500.00	625	625	625	625	625	688	688	688	688	688	688	688	**7,938**
66815	Insurance - General & Profess. Liability	66815	60,000.00	5,000	5,000	5,000	5,000	5,000	5,500	5,500	5,500	5,500	5,500	5,500	5,500	**63,500**
	Total Insurance			6,025	6,025	6,025	6,025	6,025	6,628	6,628	6,628	6,628	6,628	6,628	6,628	**76,518**
	Telephone															
64250	Telephone - Voice & Data Lines	64250	19,200.00	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	1,600	**19,200**
64255	Cell Phones & Wireless Data	64255	5,400.00	450	450	450	450	450	450	450	450	450	450	450	450	**5,400**
	Total Telephone			2,050	2,050	2,050	2,050	2,050	2,050	2,050	2,050	2,050	2,050	2,050	2,050	**24,600**
	Other Expenses															
65000	Meals not travel related (business)	65000	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
64500	Professional Fees - Accounting	64500	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
64505	Professional Fees - Website	64505	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
64510	Professional Fees - Legal	64510	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
64515	Other Professional Fees	64515	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
64520	Consulting Services Support Departments	64520	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
60135	Payroll/Benefit Miscellaneous Expense	60135	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
65005	Board Expenses	65005	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
65010	Conference Expense	65010	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
65015	Over/Short/Small Bal Adjustments	65015	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
69500	Contingency - Operating Exp	69500	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
65025	Non-Reimbursable Expenses	65025	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
65030	Bank Service Charges	65030	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
65040	Advertising - Employee / Recruiting	65040	12,000.00	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	**12,000**

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		Verify WS Link		Period 1 Jul	Period 2 Aug	Period 3 Sep	Period 4 Oct	Period 5 Nov	Period 6 Dec	Period 7 Jan	Period 8 Feb	Period 9 Mar	Period 10 Apr	Period 11 May	Period 12 Jun	FY 23-24 Budget
			Capacity	13	13	13	13	13	13	13	13	13	13	13	13	
			Occupancy	45%	50%	55%	60%	65%	70%	75%	80%	85%	85%	85%	85%	
			Census	5.85	6.5	7.15	7.8	8.45	9.1	9.75	10.4	11.05	11.05	11.05	11.05	109.20
				31	31	30	31	30	31	31	28	31	30	31	30	365
65050	Advertising/Sponsorships	65050	-	-	-	-	-	-	-	-	-	-	-	-	-	-
65055	Public Relations Expenses	65055	-	-	-	-	-	-	-	-	-	-	-	-	-	-
65060	Promotional Items	65060	-	-	-	-	-	-	-	-	-	-	-	-	-	-
65065	Dues and Subscriptions	65065	1,200.00	100	100	100	100	100	100	100	100	100	100	100	100	1,200
65070	Licenses and Fees	65070		-	-	-	-	-	-	-	-	-	-	-	-	-
65075	Donations	65075	-	-	-	-	-	-	-	-	-	-	-	-	-	-
65085	Business Taxes	65085	-	-	-	-	-	-	-	-	-	-	-	-	-	-
66600	Interest Expense	66600	-	-	-	-	-	-	-	-	-	-	-	-	-	-
66610	Mortgage Interest	66610	-	-	-	-	-	-	-	-	-	-	-	-	-	-
65095	Business Development Houston	65095	-	-	-	-	-	-	-	-	-	-	-	-	-	-
66000	Bad Debts	66000	-	-	-	-	-	-	-	-	-	-	-	-	-	-
66200	Gain / Loss on Currency Exchange	66200	-	-	-	-	-	-	-	-	-	-	-	-	-	-
66400	Loss on Asset Disposal	66400	-	-	-	-	-	-	-	-	-	-	-	-	-	-
69000	Other Related Party Expenses	69000	-	-	-	-	-	-	-	-	-	-	-	-	-	-
65100	Penalties / Fines / Late Fees	65100	-	-	-	-	-	-	-	-	-	-	-	-	-	-
65105	Prior Year Expense	65105	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total Other Expenses			1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	13,200
	Property Management (RI Properties)															
69505	Management Fee	69505	-	-	-	-	-	-	-	-	-	-	-	-	-	-
62050	Repairs & Maintenance - Facility	62050	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total Property Management Expenses			-	-	-	-	-	-	-	-	-	-	-	-	-

Recovery Innovations, Inc., dba RI International

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				Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	Period 11	Period 12	FY 23-24
				Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Budget**
			Capacity	13	13	13	13	13	13	13	13	13	13	13	13	
			Occupancy	45%	50%	55%	60%	65%	70%	75%	80%	85%	85%	85%	85%	
			Census	5.85	6.5	7.15	7.8	8.45	9.1	9.75	10.4	11.05	11.05	11.05	11.05	**109.20**
		Verify														
		WS Link		31	31	30	31	30	31	31	28	31	30	31	30	**365**
			Delete formula in column D for any that are not applicable to the particular department													
	Direct Allocation Expenses		$													
69700	Billing Services & Data Reporting	Formula CY Data	1.74%	4,579	4,579	4,480	4,446	4,480	4,589	4,722	4,293	4,457	4,491	4,589	4,358	**54,063**
69705	Quality & Compliance	Formula CY Data	1.12%	2,947	2,947	2,947	2,947	2,947	2,947	2,947	2,947	2,947	2,947	2,947	2,947	**35,358**
69715	Electronic Health Record	Formula CY Data	2.73%	7,165	7,165	7,165	7,165	7,165	7,165	7,165	7,165	7,165	7,165	7,165	7,165	**85,979**
69720	Recovery Connections Line	Input: if applicable		-	-	-	-	-	-	-	-	-	-	-	-	**-**
69600	Local Shared Services	Input: if applicable		-	-	-	-	-	-	-	-	-	-	-	-	**-**
69725	Regional Services	Input: if applicable		-	-	-	-	-	-	-	-	-	-	-	-	**-**
69730	Regional Services II	Input: if applicable		-	-	-	-	-	-	-	-	-	-	-	-	**-**
69701	Contracts & Credentialling	Input: if applicable	0.40%	1,060	1,060	1,060	1,060	1,060	1,060	1,060	1,060	1,060	1,060	1,060	1,060	**12,719**
	PLACEHOLDER			-	-	-	-	-	-	-	-	-	-	-	-	**-**
	PLACEHOLDER			-	-	-	-	-	-	-	-	-	-	-	-	**-**
69735	Direct Services Non Reimbursable	Input: if applicable		-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Direct Allocation Expenses			15,750	15,750	15,651	15,617	15,651	15,761	15,893	15,464	15,628	15,662	15,761	15,529	188,119
	Capital Expenditures:															
99000	Depreciation	99000	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
99100	Amortization	99100	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Capital Expenditures			-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Indirect Allocation Expenses		$													
69805	Indirect Admin Svs - Executive	Formula CY Data	3.41%	8,975	8,975	8,686	8,975	8,686	8,975	8,975	8,107	8,975	8,686	8,975	8,686	**105,677**
69810	Indirect Admin Svs - Finance	Formula CY Data	2.45%	6,448	6,448	6,240	6,448	6,240	6,448	6,448	5,824	6,448	6,240	6,448	6,240	**75,916**
69815	Indirect Admin Svs - HR	Formula CY Data	2.20%	5,784	5,784	5,597	5,784	5,597	5,784	5,784	5,224	5,784	5,597	5,784	5,597	**68,098**
69820	Indirect Admin Svs - MIS	Formula CY Data	0.94%	2,485	2,485	2,405	2,485	2,405	2,485	2,485	2,244	2,485	2,405	2,485	2,405	**29,257**
69800	Indirect Nonreimbursable Contra	Input DR or (CR)		-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Sub Total Indirect Allocations		0													
69830	Indirect Admin Svs - Non Reimbursable	Formula DR	0	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Indirect Allocation Expenses			**23,691**	**23,691**	**22,927**	**23,691**	**22,927**	**23,691**	**23,691**	**21,399**	**23,691**	**22,927**	**23,691**	**22,927**	**278,948**
	Total Expenses			**301,943**	**301,943**	**295,421**	**294,207**	**295,421**	**302,556**	**310,293**	**282,990**	**294,820**	**296,034**	**302,556**	**288,298**	**3,566,483**