



COMMONWEALTH OF MASSACHUSETTS
THE GENERAL COURT
STATE HOUSE BOSTON 02133 1053

April 13, 2020

Michael Hurley, Senate Clerk
Office of the Clerk of the Senate
24 Beacon Street
Room 335 – State House
Boston, MA 02133

Steven T. James, House Clerk
Office of the Clerk of the House
24 Beacon Street
Room 145 – State House
Boston, MA 02133

Governor Charles D. Baker
24 Beacon Street
Room 280 – State House
Boston, MA 02133

Senator Julian Cyr, Chair
Joint Committee on Mental Health, Substance Use and Recovery
24 Beacon Street
Room 309 – State House
Boston, MA 02133

Representative Marjorie Decker, Chair
Joint Committee on Mental Health, Substance Use and Recovery
23 Beacon Street
Room 33 – State House
Boston, MA 02133

Secretary Thomas Turco
Executive Office of Public Safety and Security
1 Ashburton Place, Suite 2133
Boston, MA 02108

Secretary Marylou Sudders
Executive Office of Health and Human Services
1 Ashburton Place, 11th Fl.
Boston, MA 02108

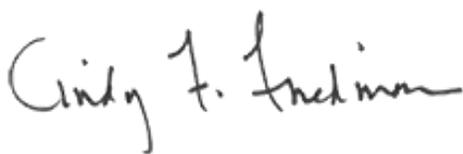
Dear Senate Clerk Hurley and House Clerk James, Governor Baker, Chairs Cyr and Decker, and Secretaries Turco and Sudders:

We write as the legislative members of the Restoration Center Commission (“Commission”) established under *An Act Relative to Criminal Justice Reform*, Chapter 69 of the Acts of 2018 (“Act”). The Act directs the Commission to “plan and implement a county restoration center and program to divert persons suffering from mental illness or substance use disorder who interact with law enforcement or the court system during a pre-arrest investigation of the pre-adjudication process from lock-up facilities and hospital emergency departments to appropriate treatment.” The Act further directs the Commission to report on its findings and recommendations, together with drafts of legislation necessary to carry out those recommendations, including “a report on the outcome of the pilot programs and provide a full implementation plan for a restoration center including, but not limited to, deliverables, barriers to implementation and costs” by April 13, 2020.

The Commission has met five times and gone on one site visit since delivering its last report on June 11, 2019. All agendas, minutes and documents used in those meetings are enclosed in this Findings and Recommendations Package. Also enclosed is the Planning and Design for a Restoration Center in Middlesex County report submitted by Advocates, Inc. to the Commission, which includes the implementation plan for the restoration center.

The Commission intends to meet once more as part of their Year Two activities to generate a further set of recommendations related to the implementation of a Restoration Center in Middlesex County, and to produce any drafts of legislation necessary to carry out these recommendations as required by the legislation. The Commission will submit an update to the General Court and all copied parties to this package.

Sincerely,



Senator Cindy F. Friedman



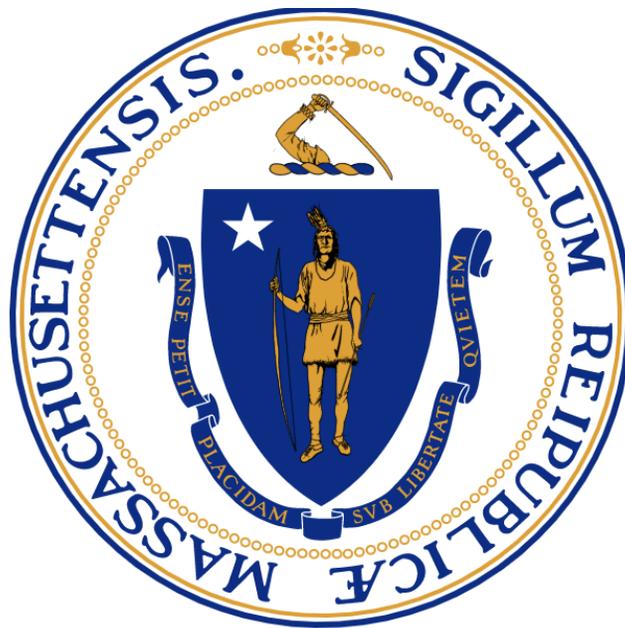
Representative Kenneth Gordon

cc: Sheriff Peter J. Koutoujian, Middlesex County
Dr. Danna Mauch, President and CEO, Massachusetts Association for Mental Health
Co-Chairs, Restoration Center Commission

Senate President Karen Spilka

House Speaker Robert DeLeo

**Middlesex County
Restoration Center Commission
Year Two Findings and
Recommendations**



April 2020

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The Planning and Design for a Restoration Center in Middlesex County

*Prepared for the
Commonwealth of Massachusetts
Middlesex County Restoration Center Commission
and the Middlesex Sheriff's Office*

Acknowledgments

Advocates would like to thank the Middlesex County Restoration Center Commission for inviting the organization to join as consultants and help design the Restoration Center from the perspective of service delivery.

Advocates recognizes the ongoing support and advisement received from the following community partners: Sheriff Peter J. Koutoujian, Middlesex Sheriff's Office; Danna Mauch, President and CEO of the Massachusetts Association for Mental Health; Catia Sharp, Coordinator of Smart Justice Initiatives, Middlesex Sheriff's Office; Chief Robert Bongiorno, Bedford Police Department; Scott Taberner, Special Advisor for Behavioral Health and Criminal Justice, Executive Office of Health and Human Services; David Ryan, Policy Director, Middlesex Sheriff's Office; and Julie Gray, Executive VP of McCall & Almy.

The following Advocates staff made significant contributions to this report: Brenda Miele Soares, MSW, LICSW, VP of Behavioral Health Services; Beth Lacey, MSW, LCSW, SVP Community Services; Opal Stone, MBA, Director of Reentry Services; Craig Gaudette, LICSW, Senior Operations Director; Sarah Abbott, PhD, Jail Diversion Program Director; and Robert Hallion, Operations Director, MH Division. Advocates appreciates the insight gained from its project partner, Spectrum Health System, through the participation of Sherry Ellis, COO, and Kristin Nolan, VP of outpatient and inpatient services. Also, Advocates was supported by Alison Glastein Gray, President of Pear Associates, who provided project management and helped to draft project deliverables.

About Advocates

Established in 1975, Advocates is one of the largest providers of behavioral health services in Middlesex County and the first organization in the Commonwealth to launch a jail diversion program. The organization provides a broad range of services for people facing life challenges, such as addiction, mental health challenges, autism, brain injury, intellectual disabilities, and aging. Each year, Advocates help more than 30,000 children and adults. The organization provides outpatient mental health and substance use treatment, residential supports and day programs for adults with disabilities, emergency psychiatric services, support services for individuals re-entering the community after incarceration, employment training programs, behavioral health care coordination and service navigation, family support services and more. With corporate offices in Framingham, Advocates provides services at more than 125 sites located in 75 cities and towns throughout Middlesex County and beyond.

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I. EXECUTIVE SUMMARY

Overview: In 2019, the Middlesex County Sheriff's Office (MSO) and the Middlesex County Restoration Center Commission selected Advocates to provide planning and design for a Restoration Center through a competitive procurement process. The Restoration Center – a model proven successful elsewhere in the United States – could provide an alternative to arrest and emergency room utilization among individuals with behavioral health challenges. The envisioned Restoration Center would provide short-term crisis stabilization, triaging people to the appropriate levels of treatment, helping them to navigate the complex behavioral health system, and increasing the use of services supporting social determinants of health in the community.

Advocates, one of the largest behavioral health providers in Middlesex County, is known for its expertise in providing mental health and substance use disorder services for justice-involved populations. Leveraging senior leadership with experience overseeing reentry, emergency services, and jail diversion programs, Advocates embarked on a four-month planning process, which included:

- Collecting and analyzing data to specify the target population for a Restoration Center;
- Identifying the service mix necessary for effective intervention, including triage, assessment, medical clearance, crisis stabilization, behavioral health urgent care, respite, care coordination, and psychopharmacology;
- Determining the accessibility of services for those with MassHealth, commercial insurance, or no coverage;
- Specifying a geographic location to maximize utilization in Middlesex County with consideration for the real estate market and proximity to additional resources;
- Determining transportation options available, including innovative models;
- Developing a staffing plan that provides 24/7 coverage and includes security, medical staff, and peer support workers;
- Developing a mechanism for engaging and maintaining relationships with stakeholders from across criminal justice and behavioral health landscapes; and
- Building a proposed budget to support the recommended Restoration Center model.

Data Collection and Analysis: Advocates compiled data collected by the Commission and the MSO's Data-Driven Justice Initiative, as well as its internal Emergency Services Program (ESP) and Jail Diversion Program (JDP). Additionally, Advocates requested and analyzed the Massachusetts Behavioral Health Partnership (MBHP) Emergency Services Programs (ESP) data. Also, Advocates reviewed US Census Data, incarceration rates, poverty, homelessness, available behavioral health resources, and possible social determinants of health resources. Furthermore, Advocates reviewed the Middlesex Sheriff's Office Police Survey and the Data-Driven Justice Initiative (DDJ) profiles on frequent utilizers. Finally, Advocates reviewed the Massachusetts Trial Court, Community Justice Project *Sequential Intercept Maps* that identified existing services and service gaps, as well as the need for behavioral health and criminal justice diversion services

Once Advocates obtained the data, the team was able to analyze the information to identify and quantify the Restoration Center's target population and to inform the compilation of lists of advantages and disadvantages for each of the proposed Restoration Center regions related to service mix and location. With assistance from the MSO, Advocates used *ESP Sankey Diagrams*, which illustrate how individuals engaged in ESP services, move from encounter to intervention to disposition, which depicts the likely referral sources for the Restoration Center.

Target Population: To reduce arrests and emergency department utilization and hospitalization, the Restoration Center aims to assess, stabilize, and connect people to timely and appropriate levels of care to increase their functioning in the community. The target population includes those with mental health, substance abuse, and co-occurring disorders who are involved with the justice system, are at risk of becoming involved in the justice system, or reentering individuals, and individuals who have not accessed appropriate levels of care on their own. Based on the target population, Advocates identified ESP providers, police officers, emergency rooms, MSO, and Department of Correction as referral sources for the Restoration Center.

Service Mix: The Advocates team explored a comprehensive list of possible Restoration Center functions, conducted internet research, and tapped into the knowledge and expertise of committee members to identify existing services and service gaps in each geographical region. As a result, Advocates' recommended service mix includes triage assessment, crisis stabilization, a sober support unit, respite care, medical screening, reentry services, a housing specialist, and medication-assisted treatment (MAT). Beyond the services offered at the Restoration Center, care managers should connect individuals to comprehensive, strengths-based aftercare supports that address their concurrent medical, behavioral health, social determinants, and criminogenic needs.

Transportation: People require transportation services when accessing the Restoration Center during a crisis, returning home or going to aftercare supports, and then when they need to access the Restoration Center for follow up or non-urgent care. Beyond the recommended internal transportation services, Advocates explored five transportation options to meet the overall transportation needs of the Restoration Center. These included encouraging local police departments to drop off at the center; relying on the current ambulance system to provide transportation; developing regional contracts with ambulance companies that allow expanded reach; partnering with a transportation company, such as VIA, to provide on-demand transportation; and increasing internal staff and create an app to deploy staff most effectively – all of which have advantages and disadvantages for consideration, as well as varying associates costs. Given the importance of transportation services to increase utilization and provide the connection to aftercare supports, any model considered must be flexible in responding to the demand and flow of those utilizing the Restoration Center.

Location: While geography and inventory of commercial real estate will play an integral role in the selection of a potential location, Advocates encourages the Commission to

choose a site that will maximize Restoration Center utilization. Advocates explored real estate possibilities in all three geographies, including office space and industrial space options. Because real estate costs vary by property type, Advocates recommends a warehouse building vs. an office building due to cost-effectiveness and likelihood of being located in a non-residential area. Advocates emphasizes that there would be community concerns no matter where the Restoration Center is situated. Once the MSO identifies its intended location for the Restoration Center, Advocates recommends embarking on a stakeholder process that informs and engages local officials.

Targeted Geographies: Based on information collected in the Commission's Year One report, as well as documentation of existing services and service gaps reported in the Sequential Intercept Mapping (SIM) exercise conducted during the data analysis process, Advocates further refined the identified potential Restoration Center geographic regions by towns. With MSO guidance, Advocates identified three prospective Restoration Center geographic regions – Lowell Region, MetroWest Region, and Southeast Region. These identified regions are the distinct population centers in the county and represent established service areas from which Advocates could garner utilization patterns for ESP, ED use, among other services.

Advocates created a list of considerations to identify the advantages and disadvantages of each geography. Such factors included the need for services based on social determinants of health (poverty and homelessness), returning citizens from incarceration, the concentration of likely Restoration Center users, and high ESP utilization. Advocates also considered projected utilization based on a region's proximity to feeder sources and collateral resources for supported referrals. Also noteworthy was the availability of existing resources, including services to refer individuals to, as well as the complexity of the current service system within a particular region.

Lowell Region: For the Restoration Center planning process, the Lowell Region is defined as the six communities of Lowell, Dracut, Tewksbury, Billerica, Tyngsborough, and Chelmsford, all located north of Boston. Lowell is the only community within the three studied regions with the designation as a Gateway City, according to MassINC. The Lowell Region is a high-need area with fewer available resources to address those needs as compared to the other regions studied. Advocates considered data available on primary feeder sources to the Restoration Center, including inpatient diversions, ED referrals, police referrals, walk-ins, reentering citizens, and individuals from surrounding towns.

MetroWest Region: For the Restoration Center planning process, the MetroWest Region is defined as the seven communities of Framingham, Marlborough, Hudson, Hopkinton, Ashland, Holliston, and Maynard, all located west of Boston. US Census Bureau 2018 population estimates indicate the MetroWest Region has a total population of 194,522 residents, including 153,601 residents over the age of 18. Framingham is the largest community in the region, with 73,123 residents. The MetroWest Region is a high-need area; however, there are numerous resources in the community to address the needs. Advocates considered data available on primary feeder sources to the

Restoration Center, including inpatient diversions, ED referrals, police referrals, walk-ins, reentering citizens, and individuals from surrounding towns.

Southeast Region: For the Restoration Center planning process, the Southeast Region is defined as the 12 communities of Cambridge, Somerville, Malden, Medford, Everett, Arlington, Woburn, Watertown, Wakefield, Belmont, Winchester and Stoneham, all located northwest of Boston. US Census Bureau 2018 population estimates indicate the Southeast Region has a total population of 587,240 residents, including 485,987 residents over the age of 18. Cambridge is the largest community in the region, with 118,977 residents. The Southeast Region is a high-need area; however, there are numerous resources in the community to address the needs.

Budget: Advocates estimates a 30-bed Restoration Center will require \$3.28 million annually in operating revenue not currently available. Based on regulatory requirements, staffing salaries, and the high need, high-risk population designated to be served in the restoration center, 3rd party billing does not cover all the costs. Therefore, additional dollars will need to be allocated to the restoration center to have available capacity at all times to serve individuals in crisis.

Licensing Consideration: The envisioned Restoration Center will include elements of a mental health clinic, substance use treatment clinic, offer medication-assisted treatment (MAT) facility, and addiction treatment services (ATS). Currently, the Commonwealth provides distinct licensing for each of these services.

Legislative Barriers: Advocates explored potential hurdles that regulatory or legislative action may help resolve, including regulations for sober beds and respite beds, mixing service types within one physical space, and the licensing of ATS beds. Furthermore, there are numerous barriers to insurance reimbursement, and 3rd party billing for medical services may need more consideration under the MassHealth ACO billing regulations.

Involuntary Care: Under Section 12 and Section 35, if an individual is determined to be a hazard to themselves or others, a police officer or a clinician can restrain or authorize a restraint of the individual. A collaborative decision was made that the planned Restoration Center will not provide inpatient services to Section 12 or Section 35 patients. However, the Restoration Center clinicians will be able to assess and issue a Section 12.

No Wrong Door Policy: The Restoration Center will be available for anyone seeking services, regardless of insurance status and type, and will support law enforcement drop-offs, ED transfers, reentering citizens, and walk-ins. The creation of a No Wrong Door policy is a crucial component of the Restoration Center's viability to ensure a flexible use of funding to support multi-disciplinary teams, maximize the efficacy of available treatment resources, and provide an organized and integrated set of services responsive to the needs of the target population.

II. INTRODUCTION

A. History and Background

Under the leadership of Peter J. Koutoujian, the Middlesex Sheriff's Office (MSO) provides care, custody, and control of both sentenced inmates and pre-trial detainees – functions the MSO carries out at the Middlesex Jail and House of Correction in Billerica. Data presented in the Abt June 7, 2019 report, *Middlesex County Restoration Center Commission Consulting Services*ⁱ, indicates that MSO's incarcerated population has disproportionately high rates of mental health and substance use disorders compared to the general population.

Furthermore, the Abt report asserts that such behavioral health disparities contribute to the high number of individuals cycling through jail and prison. Evidence in the report also suggests individuals with these risk factors are also frequent utilizers of emergency hospitalization and other psychiatric institutions. While detainment in a jail, prison, or institution may be necessary, these interventions are costly, and not the only option.

Sheriff Koutoujian sought to explore additional responses to serving high-risk individuals in Middlesex County and learned about the Restoration Center model. The Bexar County Restoration Center in Texas, for example, provides a sobering unit, detox, crisis care, medication-assisted treatment (MAT), medical clearance, and access to an offsite respite facility. Since it was established in 2003, the Bexar County Model has diverted more than 100,000 individuals from jail and emergency departments.ⁱⁱ

In Tucson, Arizona, Pima County established the Crisis Response Center in 2011, and an Urgent Psychiatric Center in 2015 to provide targeted short-term care for patients in crisis as an alternative to emergency room visits. Through these centers, Tucson drastically reduced the percentage of jail inmates with serious mental illness, while significantly decreasing emergency department visits.ⁱⁱⁱ

Based on these success stories, in 2018, Sheriff Koutoujian, with support from State Senator Cindy Friedman (4th Middlesex District) championed the passing of Section 225 of Chapter 69^{iv}, "An Act Relative to Criminal Justice Reform," to establish the Middlesex County Restoration Center Commission (hereinafter, the "Commission"). The Commission was established, "to plan and implement a county restoration center and program to divert persons suffering from mental health or substance use conditions who interact with law enforcement or the court system during a pre-arrest investigation or the pre-adjudication process from lock-up facilities and hospital emergency departments to appropriate treatment." Appendix 1 includes a roster of the 11-member Commission Roster. By establishing a Restoration Center in Middlesex County, the Sheriff hoped to reduce arrests and emergency department visits among individuals with behavioral health conditions.

B. The Value of a Restoration Center

With support from the Commission, the MSO engaged in a year-long exploratory process to determine the extent to which a Restoration Center model would address the behavioral health needs identified among high-risk individuals within Middlesex County. Beyond exploring Restoration Center models elsewhere in the United States, the MSO researched existing state and county behavioral health, law enforcement, and criminal justice systems, policies, regulations, and legislation to better understand the local landscape. Through such inquiry, the MSO aimed to identify mobilizers and impediments to establishing a similar Restoration Center model for Middlesex County.

The Commission presented its research in the June 2019 ***Middlesex Country Restoration Center Commission Year One Findings and Recommendations Report***.^v These findings assert that a Restoration Center could provide an alternative to arrest and emergency room utilization by providing short-term crisis stabilization, triaging people to the appropriate levels of treatment, and helping them to navigate the complex behavioral health system. Furthermore, the MSO maintains that a Restoration Center could increase the use of services supporting social determinants of health in the community. Finally, a well-designed Restoration Center could help to reduce arraignment and forensic commitments, reduce recidivism, and reduce involuntary treatment petitions.

C. Procurement of Planning and Design Vendor:

In October 2019, the MSO and the Commission released a request for response (RFR), seeking qualified bidders to provide planning and design for a Restoration Center. The MSO and the Commission requested responses from community-based behavioral health services providers to participate in a four-month planning process to design a service model, identify existing funding streams for components of services, and create a budget for necessary services.

Advocates submitted a proposal to the MSO in response to the procurement and was selected to oversee the process. The MSO selected Advocates based on the organization's demonstrated history as one of the largest provider of behavioral health services in Middlesex County and its commitment to serving justice-involved populations; Advocates operates a pilot reentry program for MassHealth and provides mental health services for Worcester County Department of Corrections. Also, Advocates holds the Emergency Services Program contract for the Central Region and operates a Jail Diversion Program. Finally, Advocates actively participated in the Commission's meetings.

Advocates met all minimum bidder qualifications required by the MSO and demonstrated expertise in the Commission's preferential services areas. In its proposal to the MSO and Commission, Advocates outlined a plan of action for designing a Restoration Center that aligns with the June 2019 Year One Findings and Recommendations Report.

D. Purpose of this Report

This report provides an overview of Advocates' five-month Restoration Center planning and design process. The findings presented in the report are the result of Advocates leadership engaging in the following key action steps:

- Collecting and analyzing data to specify the target population for a Restoration Center;
- Identifying the service mix necessary for effective intervention, including triage, assessment, medical clearance, crisis stabilization, behavioral health urgent care, respite, care coordination, and psychopharmacology;
- Determining the accessibility of services for those with MassHealth, commercial insurance, or no coverage;
- Specifying a geographic location to maximize utilization in Middlesex County with consideration for the real estate market and proximity to additional resources;
- Determining transportation options available, including innovative models;
- Developing a staffing plan that provides 24/7 coverage and includes security, medical staff, and peer support workers;
- Developing a mechanism for engaging and maintaining relationships with stakeholders from across criminal justice and behavioral health landscapes; and
- Building a proposed budget to support the recommended Restoration Center model.

This document presents the process by which Advocates collected and analyzed qualitative and quantitative data, and identified advantages, disadvantages, and considerations of various scenarios. Advocates developed these findings by leveraging internal and external expertise, along with recommendations from the MSO and the Commission.

III. METHODOLOGY

A. Planning Process

The MSO selected Advocates as the Restoration Center planning and design vendor in December 2019. Upon notification of the planning grant award, the Advocates team immediately embarked on an intensive four-month process that engaged experts from across the organization. Advocates convened a cross-discipline Restoration Center Planning Team (Table 1) to oversee the planning process.

| TABLE 1: ADVOCATES RESTORATION CENTER PLANNING TEAM | |
|--|---|
| Name | Title |
| Brenda Miele Soares, MSW, LICSW, Chair | VP of Behavioral Health Services |
| Mark Viron, MD | Chief Medical Director |
| Beth Lacey, MSW, LCSW | Senior Vice President of Community Services |
| Thomas Wagner MSW | VP of Business Integrity |
| Keith Scott CPS | VP of Peer Supports and Self Advocacy |
| Bob Hallion | Operations Director, MH Division |
| Opal Stone, M.B.A. | Director of Reentry Services |
| Craig Gaudette, LICSW | Senior Operations Director |
| Sarah Abbott, Ph.D. | Jail Diversion Program Director |
| John DeRonck, MSW, LICSW | Senior Director of Emergency Services |
| Danielle Dunn, LMHC | Senior Director of Integrated Clinical Services |
| Theresa Brasier, Psy.D. | Program Director of Forensic Services |
| Diana St. Cyr, CMC | Director, Revenue Cycle Management |
| Rob Karr MD | Associate Medical Director |

Advocates created Restoration Center Planning Team committees to focus on particular planning areas (Figure 1), including a Data Collection and Analysis Committee, Transportation Committee, Location Selection Committee, and Aftercare and Services Committee. Appendix 2 provides a roster of committee members; Appendix 3 includes meeting dates and Appendix 4 consists of all meeting minutes.

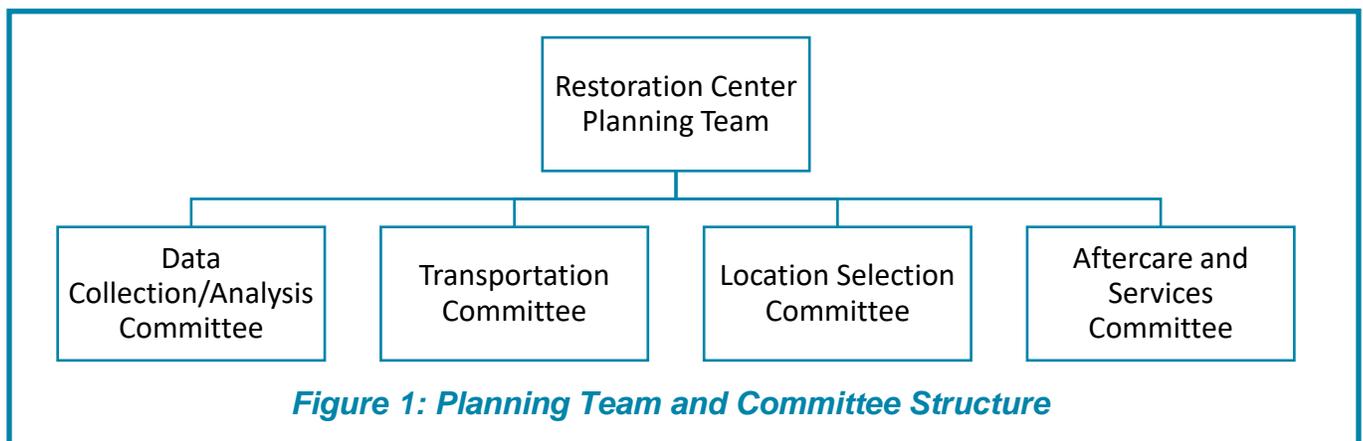


Figure 1: Planning Team and Committee Structure

The Restoration Center planning process was informed by qualitative and quantitative data, including that which the Commission shared in the Year One Findings and Recommendations Report, supplemental data collected by the MSO, and information collected by Advocates during the planning phase.

To inform its planning process, Advocates joined members of the Commission on a site visit to the Tucson Crisis Response Center to learn first-hand about their proven model. This site visit was particularly valuable to the team's understanding of staffing, operations, security, and service-mix.

Advocates engaged senior leaders from Spectrum Health Systems to participate in the planning and design process. Spectrum behavioral health expertise was particularly helpful as the team mapped out substance use disorder treatment and medication-assisted therapy components of the Restoration Center model.

B. Data Collection and Analysis

Advocates identified and obtained data collected by the Commission in Year One, the MSO's Data-Driven Justice Initiative, census information, and the organization's Jail Diversion Program (JDP). Additionally, Advocates requested and analyzed the Massachusetts Behavioral Health Partnership (MBHP) Emergency Services Programs (ESP) data. Also, Advocates reviewed incarceration rates, poverty, homelessness, available behavioral health resources, and possible social determinants of health resources. Finally, Advocates reviewed the Commission's Police Survey and the Data-Driven Justice Initiative (DDJ) profiles on frequent utilizers.

Once Advocates obtained the data, the team was able to analyze the information to identify and quantify the Restoration Center's target population and to inform the compilation of lists of advantages and disadvantages for each of the proposed Restoration Center regions related to service mix and location.

The following provides an overview of each data source and its value in informing the Restoration Center planning and design process.

Data-Driven Justice Initiative data provided profiles of individuals who interfaced with the police a minimum of eight times between January 1, 2016 – December 31, 2018. This data provided an understanding of the level of acuity of need in a particular area. They illustrated how a Restoration Center could provide a diversion from the utilization of higher and more expensive levels of care. Source: Middlesex Sheriff's Office

Emergency Services Program (ESP) data highlights how people move through the ESP system from encounter, to intervention, to disposition. Advocates segmented this data to determine ESP encounters by region, town, and service type to inform Restoration Center utilization (target population size). This information helped predict whether there would be a critical mass of potential Restoration Center users in particular areas of Middlesex county, and how ESP users are currently utilizing existing behavioral health resources. Source: Massachusetts Behavioral Health Partnership (MBHP)

Middlesex Sheriff's Office Police Survey data provided input on the following domains: dispatch, mental health incident response, incident reporting incident disposition, and diversion. Survey data informed the Location Committee and Transportation Committee on the existing 911 Call Center infrastructure and likely modes of transportation to the Restoration Center. These committees considered the survey data in combination with ESP encounters to understand how current services might impact the behavior of referring organizations, and thus, the utilization of a Restoration Center. Source: Middlesex Sheriff's Office

Advocates' Jail Diversion Program data identifies the number of police encounters, the encounters diverted from the emergency department, individual insurance coverage, and individuals' disposition. This data provided a profile of common frequent utilizers and helped establish diversion opportunity expectations. Source: Advocates

2018 Estimated Census provided population size, socioeconomic indicators by town such as median household income, and percent of residents under the Federal poverty level. Census data also provides a population breakdown by race, ethnicity, and languages spoken. Such indicators offered perspective on the social determinants of health impacting high-risk populations and helped to determine the level of need in various regions of Middlesex County. Source: U.S. Census Bureau

MSO Incarceration data provided information about where the current inmate population lived before incarceration, as well as where inmates went upon release. This data helped predict where individuals already deeply involved in the criminal justice system may seek services from the Restoration Center upon release. Source: Middlesex County Sheriff's Office

Sequential Intercept Mapping identified existing services and service gaps, as well as the need for behavioral health and criminal justice diversion services. Mapping data provided an array of perspectives of behavioral health and criminal justice professionals to identify the most pressing service needs in a community. This information also identified opportunities at each of the Intercepts to divert people from deeper criminal justice involvement. Source: Massachusetts Trial Court, Community Justice Project

Opiate Use Data identified the number of hospitalizations related to opiate use, as well as the number of opioid-related overdoses by geography and population. Source: MBHP ESP Data

ESP Sankey Diagrams illustrate how individuals engaged in ESP services, moving from encounter to intervention to disposition. This representation depicts the likely referral sources for the Restoration Center. It informs the kinds of services needed in the Restoration Center to triage and stabilize individuals and connect them with the most appropriate levels of care. This data was used in collaboration with information on how service-rich or poor an area is, including what kinds of diversionary services exist and their maturity and functioning. Source: MBHP ESP Data/Catia Sharp, Restoration Center Commission staff, Middlesex County Sheriff's Office

MBHP ESP Payer Information indicates a higher percentage of uninsured individuals in each of the three regions of consideration, as compared to the Commonwealth as a whole. These findings support the need for innovative services and funding structures to support the target population. Advocates also used this data to analyze and formulate essential considerations about the payer mix in the Restoration Center's No Wrong Door approach, which is discussed in Section VII of this report.

Advocates also reviewed MBHP ESP data to understand the population's interaction with other agencies, particularly the Department of Mental Health and the Department of Developmental Services. The Committee also compared MBHP ESP data against frequent utilizer data, in addition to the target population profiles provided by Advocates' Jail Diversion Program and the Middlesex County Sheriff's Office Data-Driven Justice Initiative. This data analysis helped to define further the acuity of need among people projected to be the most frequent utilizers of the Restoration Center.

Poverty and Homelessness Data: Advocates relied on data available from MBHP ESP encounters, US Census, Housing and Urban Development (HUD) local Continuums of Care, and other internet-based research to understand the prevalence of poverty and homelessness. This data provided a more robust picture of the social determinants of health, as well as the barriers that inhibit access to appropriate levels of care.

C. Stakeholder Engagement

Critical to establishing a Restoration Center will be the engagement of stakeholders within the targeted community who may be impacted, including first responders, police and fire departments, behavioral health partners, and city/town officials. Advocates also worked with the Commission members, who represent stakeholders hailing from public safety, criminal justice, courts, behavioral health providers, peer and family advocacy, public policy organizations, and government agencies. This close collaboration with the Commission provided Advocates a window into the interests and concerns of stakeholders at the county and state levels.

Advocates' experience selecting a site for its behavioral health facilities has shown the importance of informing and involving local community members early and often to ensure they are aware of and have the opportunity to provide their perspective into the process. Once the MSO identifies its intended location for the Restoration Center, Advocates recommends embarking on a systematic plan that includes hosting community meetings, sharing the intention of the Restoration Center, and soliciting input from a range of local, county, and state-level stakeholders.

IV. RESTORATION CENTER MODEL

A. Targeted Geographies

Based on information collected in the Commission’s Year One report, as well as documentation of existing services and service gaps reported in the Sequential Intercept Mapping (SIM) exercise conducted during the data analysis process, Advocates further refined the identified potential Restoration Center geographic regions by towns. With MSO guidance, Advocates identified three prospective Restoration Center geographic regions – Lowell Region, MetroWest Region, and South East Region -- outlined in Table 2.

| TABLE 2: RESTORATION CENTER REGIONS | |
|--|---|
| Region | Cities and Towns |
| Lowell | <ul style="list-style-type: none"> • Billerica • Chelmsford • Dracut • Lowell • Tewksbury • Tyngsborough |
| MetroWest | <ul style="list-style-type: none"> • Ashland • Framingham • Holliston • Hopkinton • Hudson • Marlborough • Maynard |
| Southeast | <ul style="list-style-type: none"> • Arlington • Belmont • Cambridge • Everett • Malden • Medford • Somerville • Stoneham • Wakefield • Watertown • Winchester • Woburn |

These identified regions are the distinct population centers in the county and represent established service areas from which Advocates could garner utilization patterns for ESP, ED use, among other services. In defining each region by cities and towns, illustrated in Figure 2, Advocates included those communities for which there were higher rates of utilization. This regional definition process explains, for example, why Advocates included Maynard in the MetroWest region, yet did not include the bordering communities of Sudbury and Stow.

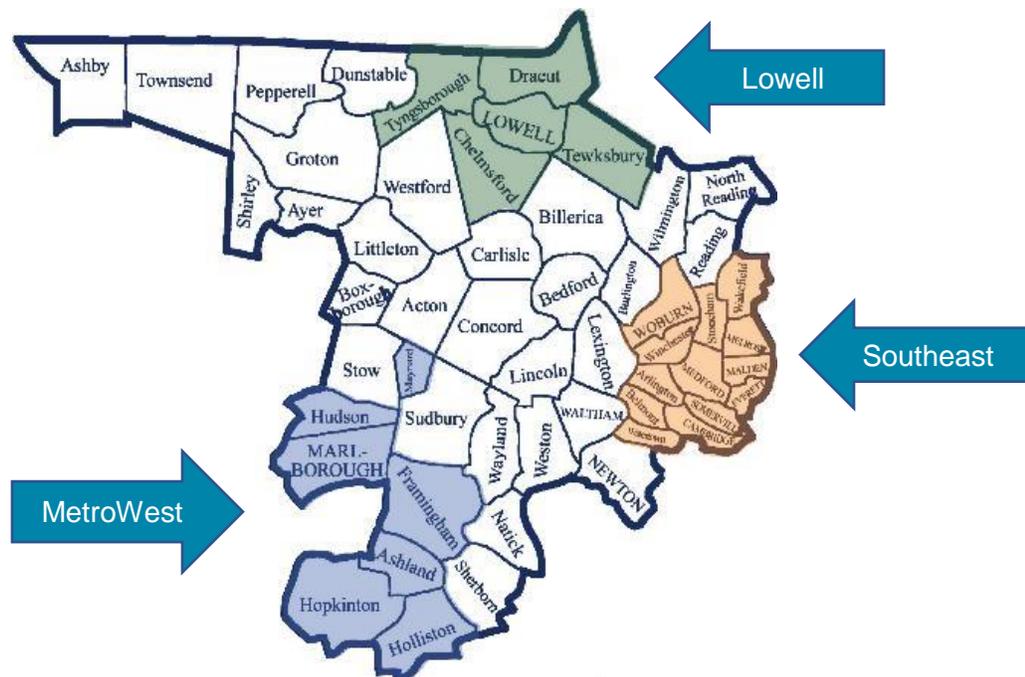


Figure 2: Restoration Center Targeted Regions

B. Target Population

As mentioned previously, the goal of the Restoration Center is to reduce arrests and emergency department utilization and hospitalization with services that assess, stabilize, and connect people to timely and appropriate levels of care to increase their functioning in the community. The target population includes those with mental health, substance abuse, and co-occurring disorders who are involved with the justice system, are at risk of becoming involved in the justice system, who frequently utilize multiple systems, and who have not accessed appropriate levels of care on their own.

Advocates used the 2018 Census data, MBHP-provided ESP encounter data, MSO inmate address data (Feb 2020), and the MSO’s DDJ initiative to compare the target population of likely restoration center users. The team also analyzed frequent utilizer data from Advocates Jail Diversion Program (JDP) program (2019). This information was supplemented with Internet research to provide a fuller picture of the socioeconomic determinants of health in each region.

During 2019, Advocates Framingham JDP clinicians had 623 encounters. Of those encounters, JDP diverted 53% (n=328) from the emergency room. As shown in Figure 3, of those diverted from the emergency room, 47% returned to present treaters, 26% refused treatment, 13% accepted an outpatient referral, 6% (n=15) went into police custody, and the remaining 8% went to another level of care.

Disposition of the 328 Encounters Diverted from the ED

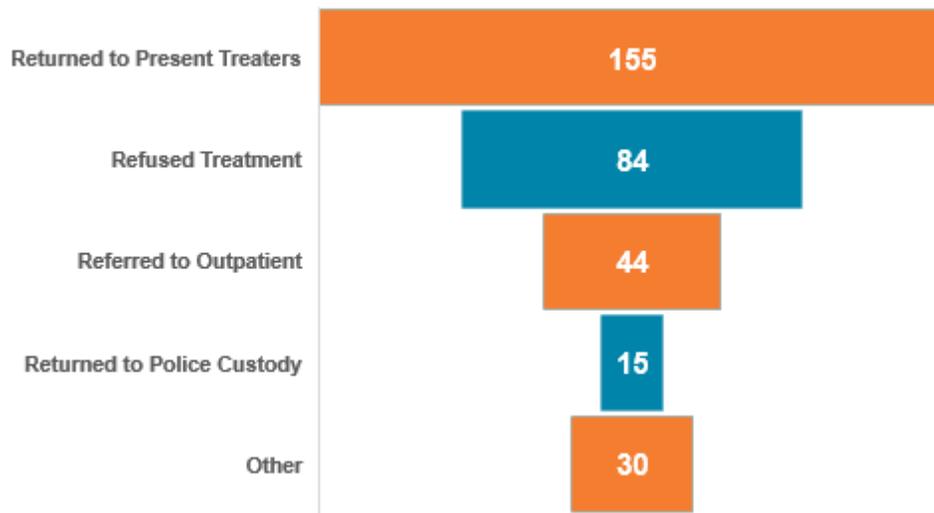


Figure 3: Disposition of Diverted Encounters

Arrest diversions included 533 for whom no criminal act present to divert existed. Of these, JDP diverted 61 people from arrest; the remaining 29 were arrested. As shown in Figure 4, of those diverted from arrest, 49% (n=30) received hospital level of care, 33% (n=20) returned to present treaters, and the remaining 18% (n=11) went to another level of care.

Disposition of Encounters Diverted from Arrest

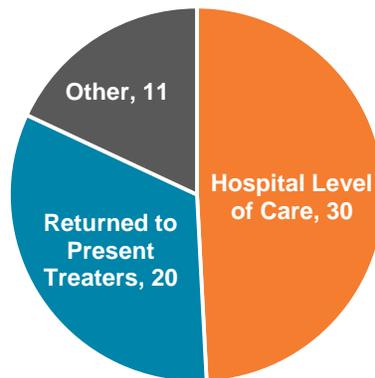


Figure 4: Disposition of Encounters Diverted from Arrest

Of the 623 encounters from 2019, 25 people accounted for 26% of all encounters (n=165). Of these frequent utilizers, the average age is 44, and slightly more than half are male (52%). Among this population, 44% receive DMH-funded services such as case management, Adult Community Clinical Services (ACCS), and respite. Also, 76% of people have current or past involvement with the justice system. Of note, 84% are White.

Individuals who cycle in and out of the criminal justice and behavioral health systems often present with co-occurring mental health and substance use disorders. Without appropriate access to care, they experience poor behavioral and physical health outcomes. Further, once individuals with mental health issues encounter the justice system, they are more likely than others to be entrapped in the system longer.^{vi}

Compared to the MBHP ESP data, individuals who were well-known and frequent utilizers of the JDP services had significantly higher rates of multi-service involvement. For instance, in the Lowell area, ESP utilizers who were also DMH-involved accounted for just over 6% of all encounters; this was the case for nearly 8.5% in the Southeast region and 15.5% in the MetroWest region. Persistent utilization of high-cost services, including emergency departments and interactions with the police, is impacted by multiple risk factors and the lack of protective factors, which can vary significantly from one individual to another. However, involvement in numerous publicly-funded systems provides indicators that can be predictive of future crisis service utilization and thus contributes to the profile of likely Restoration Center utilizers.

The Restoration Center must provide an integrated care model that addresses the complex behavioral health needs of frequent utilizers. Such integrated care will be of particular importance if the Commission sites the Restoration Center in a region with inadequate diversion services or where there is a shortage of providers with expertise in co-occurring disorders.

Based on the target population, numerous feeders will refer people to the Restoration Center. Referral sources (Figure 5) include police officers, ESP providers, emergency rooms, and MSO and Department of Correction (for reentering populations); Advocates also expects people will walk in on their own.

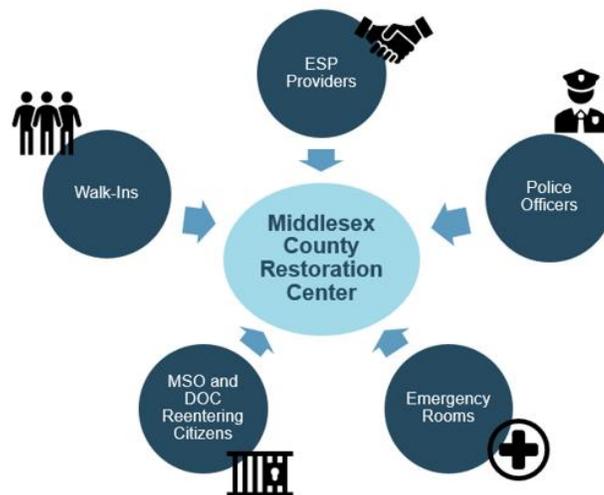
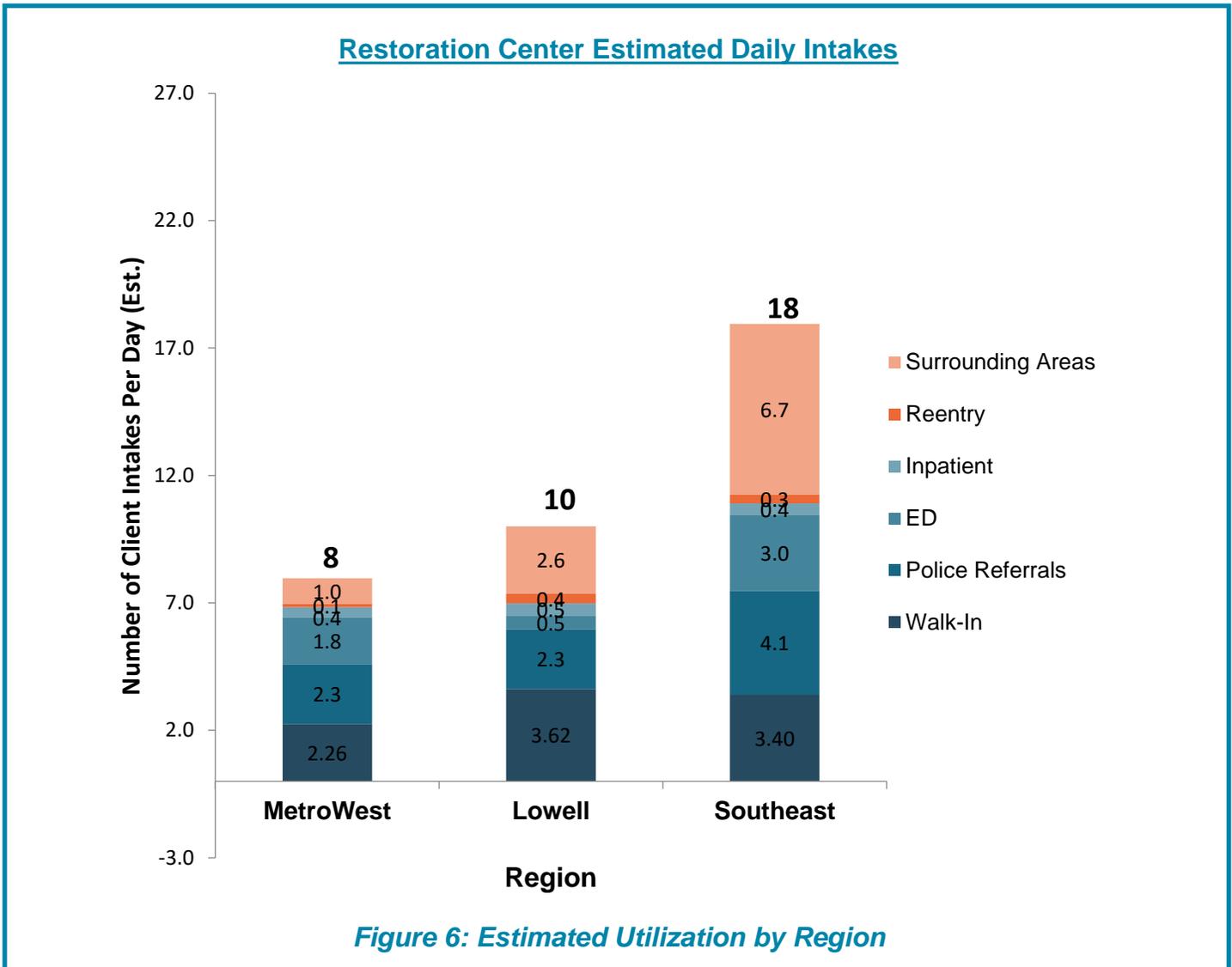


Figure 5: Feeders to the Restoration Center

Advocates used a range of data sources to estimate utilization by feeder source for each of the three targeted regions, presented in Figure 6.



To estimate the possible daily utilization rate for each Restoration Center region, Advocates relied upon available data from likely referral sources, including Advocates jail diversion and ESP program estimates for ED referral, inpatient diversion, and individuals reentering from incarceration. To estimate police utilization of the Restoration Center, Advocates used a combination of town population and poverty rate to weight each town, as well as JDP data to scale usage by city/town; the team also reviewed the frequency of ESP utilization from neighboring catchment areas and factored that into the estimation. Advocates anticipates that an implementation evaluation following operational year one will include a closer inspection of the rate of utilization, feeder sources, and other factors that impact utilization volume. These estimates offer a strong starting point to begin understanding the size of operations for a pilot restoration center.

C. Restoration Center Service Mix

Advocates began its process of identifying the ideal Restoration Center service mix by reviewing a long list of potential services that could be offered. Such services were drawn from the Commission's reports, peer-reviewed literature, public policy reports, Advocates' expert knowledge and experience, and key informants to this work. The team explored a comprehensive list of possible functions, including but not limited to triage, community crisis stabilization, medical clearance, ambulatory detox, intensive outpatient services, structured outpatient alcohol program, psychiatric day services, sobering unit, medicated assisted recovery, among others.

Advocates reviewed Sequential Intercept Models, conducted internet research, and tapped into the knowledge and expertise of committee members to identify existing services and service gaps in each geographical region. Once the team identified what was currently available through other providers in the County, and what was essential to offer at a Restoration Center, Advocates was able to create its recommended service mix described below.

- **Triage Assessment** to enable staff to make an initial determination about the nature and severity of the person's needs, to assess whether the person is at risk of harm to themselves or others, and to ensure the Restoration Center is the appropriate place for the individual to receive care at this time.
- **Crisis Stabilization** will enable the Restoration Center to provide suicide prevention services, address the immediate need for behavioral health treatment, divert individuals from entering a higher level of care, and address the distress experienced by an individual.
- **Sober Support Unit** to provide a supportive environment for people experiencing the side effects of drug and alcohol use who need detoxification services and have no health risks associated with the withdrawal process. The Unit would also provide police officers with the ability to drop off people in protective custody who need sobering support, instead of being jailed for minor offenses such as trespassing and public intoxication.
- **Respite Care** provides temporary short-term, community-based clinical and rehabilitative services that enable a person to live in the community as fully and independently as possible.
- **Medical Screening** and laboratory tests should be provided as part of a medical clearance process.
- **Reentry Services** support those returning to their homes following incarceration to assess their behavioral health needs and connect them with community-based resources. Through Reentry Services, the Restoration Center can address social determinants of health, such as supplemental nutrition assistance, health insurance, legal benefits).
- **Housing Specialist** to support homeless and housing insecure individuals to access necessary shelter, as well as long-and short-term housing solutions.
- **Medication-Assisted Treatment (MAT) or Medication-Assisted Recovery (MAR)**, which combines counseling with pharmacology and behavioral therapies to those with opioid use disorder, alcohol use disorder, and tobacco use. Clinic licensure will determine the level of psychopharmacology services that can be

provided; most clinic licenses allow for the prescribing of Vivitrol and Suboxone, for example, yet do not include Methadone, which requires a distinct license.

Advocates recognizes how critical outpatient services and aftercare supports are to the success of the Restoration Model. Without such wraparound for individuals, the Restoration Center would become a revolving door for high-risk and high-need individuals. Restoration Center care managers should, therefore, connect individuals to comprehensive, strengths-based aftercare supports that address their concurrent medical, behavioral health, social determinants, and criminogenic needs.

The model should consider how to provide motivation and support to individuals as they navigate numerous and often complex health, insurance, and social services systems, which can be especially stressful to those already in crisis. Given the wealth of outpatient services and aftercare supports already available in the targeted regions, Advocates recommends relying on existing service providers for these services rather than duplicating these services within the Restoration Center

Advocates recommends that person-centered treatment planning begins once a person is stabilized. The recommended service mix model utilizes multidisciplinary staff teams, including physicians, nurses, clinicians, and care coordinators, along with peer supports who bring lived experience to those served. Also, Advocates anticipates the Restoration Center would have considerable collaboration with the criminal justice system and other stakeholders in creating comprehensive support plans. The Restoration Center must provide appropriate office space to allow for individuals to meet with a range of professionals and support providers, such as case managers, legal representation, and care coordinators, in a safe and confidential setting.

Beyond these clinical services, Advocates recommends offering essential services, such as food, bathing, clothing, and washing machines. Also, the team recommends creating a fitness facility within the Restoration Center to provide an opportunity for physical activity as a stress reliever.

Based on recommendations from the Commission's Year One work, Advocates identified the Restoration Center's base services from which it was able to construct a budget methodology for the first year of implementation.

D. Transportation

Advocates identified three transportation situations which each could lead to different transportation solutions, including:

1. people accessing the Restoration Center during a crisis;
2. people returning home or to aftercare supports after receiving services at the Restoration Center; and
3. people needing to access the Restoration Center for follow up or non-urgent care.

The Restoration Center Transportation Committee engaged in exploratory conversations with police, ambulance companies, and private transportation representatives to better understand the options and limitations of each transportation model.

Based on this research, the Transportation Committee recommends that the Restoration Center, regardless of other transportation options used, have access to its own independent transportation resources. With at least two vans available —at least one of which is wheelchair accessible – the Restoration Center can assist individuals in getting to and from critical appointments to address needs beyond those provided inhouse. In creating the proposed budget for internal transportation services, the Transportation Committee considered actual costs for van depreciation, insurance, gas for transportation within a 10-mile radius, and repairs. The Committee did not factor in costs for drivers in this model as it is assumed these local trips would be managed by program staff. The total cost for these vans and all expenses is approximately \$32,000 per year.

Beyond this baseline internal transportation center, Advocates explored five transportation options to meet the overall transportation needs of the Restoration Center:

1. Encourage local police departments to drop off at the center;
2. Rely on the current ambulance system to provide transportation;
3. Develop regional contracts with ambulance companies that allow expanded reach;
4. Partner with a transportation company, such as VIA, to provide on-demand transportation; and
5. Increase internal staff and create an app to deploy staff most effectively.

Table 3 Provides the advantages and disadvantages of each of these proposed transportation models for consideration by the Commission in building a transportation system for the Restoration Center.

| TABLE 3: ANALYSIS OF TRANSPORTATION MODELS | | | |
|---|--|---|---|
| Model | Advantages | Disadvantages | Considerations |
| Local Police Drop Off | <ul style="list-style-type: none"> • Low cost as transportation is part of police operating costs; • Police would get to know the Restoration Center; • Wait time would be minimal for police offers at the site; • Increase diversion from arrests; and • Protocols could expedite transferring people from police custody into the Restoration Center | <ul style="list-style-type: none"> • The least preferred choice among the police (according to the survey) • Barriers (time and regulations) to transportation beyond city/town • Barriers to transporting people not under arrest in a police cruiser • The time required for transportation and transfer • It does not address | To utilize this option, the Commission would need to change police practices and the ability for police vehicles to leave the community to conduct a drop off to the Restoration Center |

| | | | |
|-------------------------------|---|--|--|
| | | transportation needs for aftercare services. | |
| Ambulance Drop Off | <ul style="list-style-type: none"> The most preferred option among the police (according to the survey) Similar to current model when someone is in crisis Cost determined by insurance reimbursements They can use non-ambulance vehicles with EMTs to provide a lower-cost “chair car” option | <ul style="list-style-type: none"> Relationships need to be established with each ambulance company to assess willingness to transport Some communities have multiple ambulance companies Ambulance companies may be reluctant to travel long distances due to lack of resources or limited reimbursement rates Insurances may not cover as a reimbursable service It does not address transportation needs for aftercare services. | Regulation changes needed to bill for ambulance companies; If the billing option included a per-mile adjustment, this would support ambulance companies being willing to transport beyond the local ED |
| Ambulance Contractor Drop Off | <ul style="list-style-type: none"> Contracting with a specific ambulance company would reduce the need to negotiate or on-board multiple companies in a region Would provide a centralized service provider Could assist with developing protocols with the police department regarding responses to these requests. Provide broader coverage | <ul style="list-style-type: none"> Using the regional model may reduce a local source of income Creation of competition among ambulance companies for regional contract The cost of the ambulance ride would be between \$1,200-2500 per trip, depending on the distance, which, at four trips per day, brings transportation costs to \$1.7 million annually It does not address transportation needs for aftercare services. | Insurance changes allowing ambulance companies to bill for trips across regions would reduce the costs to Restoration Center |
| VIA Option | <ul style="list-style-type: none"> Police could summon a driver with an app to take a person to Restoration Center Pick up time would be reduced as the drivers would be center specific. It works like a dedicated taxi service Could cover the whole county if desired | <ul style="list-style-type: none"> The cost would range from \$200,000 to about \$1,000,000 annually, depending on the size of the region, the size of the fleet, and the response time desired | This option would be a contracted service, and no regulation changes would be needed |

| | | | |
|--------------------------------------|---|---|---|
| | <ul style="list-style-type: none"> It addresses transportation needs for aftercare services. | | |
| Center Drivers Supported by Ride App | <ul style="list-style-type: none"> Drivers would be familiar with the Restoration Center It could be scaled up or down depending on the desired coverage and distance. An App would be deployed to all police in the region Staff can travel across the region not limited to specific areas It addresses transportation needs for aftercare services. | <ul style="list-style-type: none"> App cost would be about \$40-50,000 to develop with a \$45,000 per year fee Staff and vehicle costs would be \$470,000 for 24/7 year-round access It could be scaled back to reduce times of operation, such as noon to midnight seven days a week, which may be more peak use times for this service. The response time of 20 minutes (desired by police) can be adhered to in the city the center is situated in and contiguous cities and towns | As this would be a direct contract service, no regulation changes would be needed |

For each of the three regions studied, the Committee considered all transportation models for the initial access to the Restoration Center, transportation home, and transportation in non-crisis scenarios. The Committee also considered all available public transportation options, including taxis, Uber/Lyft, and The Ride, especially for individuals who were not in crisis and were traveling home or to an appointment. Based on this analysis, which considered budgetary factors as well as public transportation options, the Committee determined little region-specific variation in its recommendations.

The success of the planned Restoration Center will depend upon its accessibility relative to the target population, as well as the scope of the services provided. Appropriate and inclusive transportation services will increase utilization and will strengthen the Restoration Center’s ability to provide seamless integration and connection to aftercare supports. Transportation models must be flexible in responding to the demand and flow of those utilizing the Restoration Center.

E. Location

The Restoration Center will ideally accommodate all of the services outlined within this report, and additional space will encourage growth as demand for its services increases. While geography and current inventory will play an integral role in the selection of a potential location, Advocates encourages the Commission to choose a site that will maximize Restoration Center utilization.

Commercial Real Estate Options: Advocates explored real estate possibilities in all three geographies with assistance from Julie Gray, Executive Vice President of McCall & Almy, a Massachusetts-based commercial real estate advisement firm. Advocates explored a range of available properties throughout the targeted regions, including Class A/B office space, Class C office space, Rooming House/Religious venues, and warehouse space.

Generally speaking, Grade A office space is usually new or redeveloped with a high-specification renovation, is well -located with good access, and is professionally managed. Grade B properties have been previously occupied and are usable, but not as high-quality space as Grade A. Grade C buildings are older, located in less-desirable areas, not aesthetically pleasing, and may have outdated technology.

Table 4 provides an estimated annual net rent per square foot per region for the various types of properties. As this data shows, real estate costs vary by property type and by region. Advocates recommends a warehouse building vs. an office building, as this would allow for the creation of a sally port, which is a secure, controlled entryway.

| TABLE 4: ESTIMATED ANNUAL NET RENT (PER SQUARE FOOT) | | | |
|---|----------------------|----------------|------------|
| <i>Does not include operating expenses, utilities, property insurance, or real estate taxes</i> | | | |
| Market | Property Type | | |
| | Office- Class A/B | Office Class C | Industrial |
| Lowell | \$16-\$20 | \$12-\$15 | \$6-\$10 |
| MetroWest (Framingham/Marlboro) | \$20-\$30+ | \$16-19 | \$6-10 |
| South East | \$25-\$30+ | \$19-24 | \$12-16 |

Commercial vs. State-Owned Space: The Location Committees explored the benefits of siting the Restoration Center within a state-owned property, given that they are exempt from zoning regulations. The Commonwealth would have to issue a formal request for proposals, inviting bids from all interested parties. Alternatively, the Commonwealth could maintain ownership and lease it to the Restoration Center via a long-term lease. The process for leasing may involve legislative approval. Based on the regulatory process the Division of Capital Asset Management and Maintenance (DCAMM) must follow, leasing a state-owned property can be costly and time-intensive.

Location Committee Chair Beth Lacey joined Commission members to conduct a site visit of two properties on the site of the former Tewksbury State Hospital. While this location would be advantageous given the array of services available on the Tewksbury campus, including a hospital that could provide food service, both buildings require extensive renovations.

Logistical considerations: Based on Advocates' experience establishing new program sites, the organization recommends a single level; the Commission could consider a multi-level building if the Restoration Center used the second floor for administration. The Location Committee considered whether the building should be a stand-alone

building, or combine efforts with another hospital, whereby they could aggregate their services and marketing purposes.

The Committee noted that there would be community concerns no matter where the Restoration Center is situated and that it be sited in a nonresidential setting. However, a remote location may limit easy access to other services, including hospitals and aftercare services.

Stakeholder Engagement

Once the Commission identifies its intended location for the Restoration Center, Advocates recommends embarking on a stakeholder engagement process that includes hosting community meetings, sharing the intent of the Restoration Center, and soliciting input from those who live and work in the community. The MSO will need to engage city officials and the police departments in this critical stakeholder engagement process.

V. TARGETED REGIONS

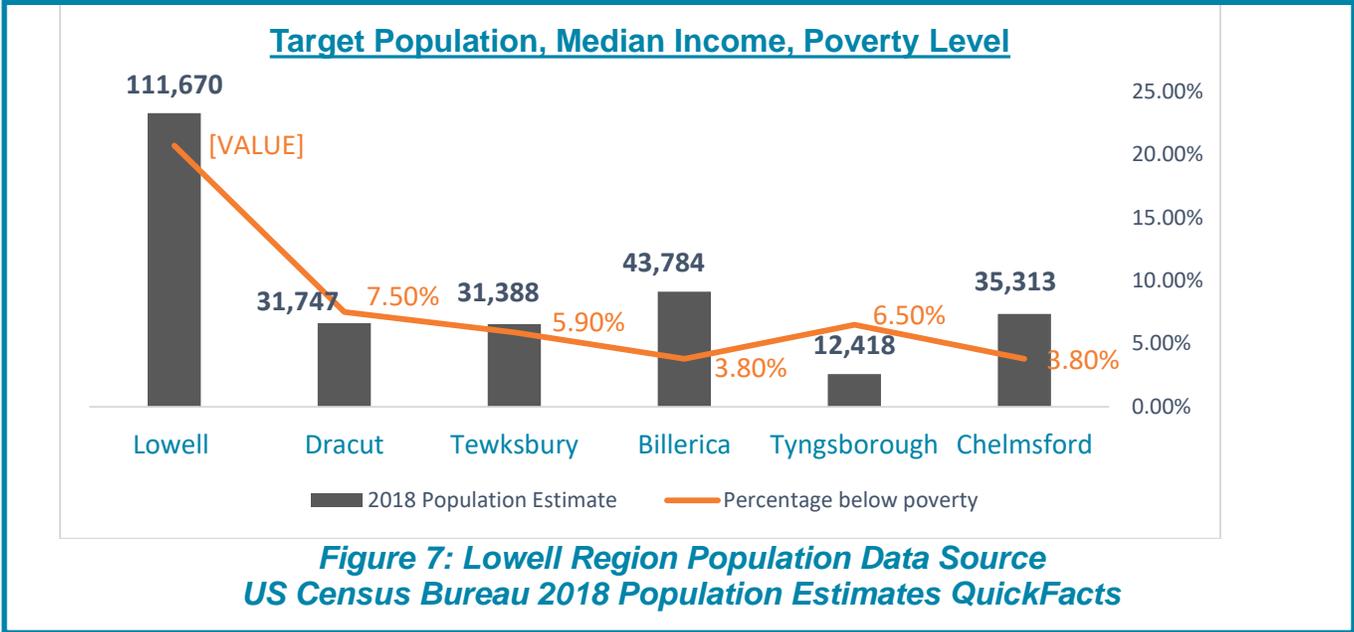
With advisement from the MSO, Advocates identified three potential geographies to explore for the Restoration Center, including the Lowell, MetroWest, and Southeast regions of Middlesex County. The Restoration Center Planning Committee created a list of considerations to identify advantages and disadvantages for each geography. Such factors included the need for services based on social determinants of health (poverty and homelessness), returning citizens from incarceration, the concentration of likely Restoration Center users, and high ESP utilization. The Committee also considered projected utilization based on a region's proximity to feeder sources and collateral resources for supported referrals.

Also noteworthy was the availability of existing resources, including services to refer individuals to, as well as the complexity of the current service system within a particular region. Finally, the Committee explored estimated real estate costs, as well as the availability of real estate. For each of the targeted areas, this report presents a summary of data and provides advantages, disadvantages, and considerations when siting a Restoration Center.

A. Lowell Region

Introduction: For the Restoration Center planning process, the Lowell Region is defined as the six communities of Lowell, Dracut, Tewksbury, Billerica, Tyngsborough, and Chelmsford, all located north of Boston. Lowell is the only community within the three studied regions with the designation as a Gateway City, according to MassINC. US Census Bureau 2018 population estimates indicate the Lowell Region has a total population of 266,320 residents, including 210,848 residents over the age of 18. The Lowell Region is a high-need area with fewer available resources to address those needs as compared to the other regions studied.

Census Data: As shown in Figure 7, the city of Lowell has the highest poverty rate in this geographic region, with more than 20% of the population experiencing financial instability. The towns surrounding Lowell are more affluent. Individuals facing economic uncertainty are more likely to be on Medicaid and more likely to take advantage of public resources, such as the Restoration Center.



Lowell has a significant immigrant population, with many residents facing linguistic and cultural barriers to accessing behavioral health services. Based on US Census Bureau data,^{vii} as shown in Table 5, more than 24% of Lowell’s residents are Asian, and more than 8% are Black. Table 6 indicates that 47% of Lowell residents speak a language other than English. Many immigrants—especially those who are undocumented or in the United States on a temporary Visa – fear using government-funded and operated services. To reach this population, the Restoration Center must consider its outreach strategies to ensure all residents feel safe accessing these services. Also, with the diversity among the targeted population, the Restoration Center should provide culturally competent care models.

| Town | White | Black | Asian | Other |
|--------------|-------|-------|-------|-------|
| Billerica | 85.3% | 2.8% | 8.5% | 3.4% |
| Chelmsford | 83.3% | 1.4% | 12.6% | 2.7% |
| Dracut | 85.7% | 3.9% | 5.7% | 4.6% |
| Lowell | 52.4% | 8.4% | 24.2% | 15.0% |
| Tewksbury | 91.6% | 1.5% | 4.3% | 2.6% |
| Tyngsborough | 87.5% | 1.5% | 7.7% | 3.3% |

| TABLE 6: LANGUAGES SPOKEN IN LOWELL REGION | | | |
|--|---|---------------------|-----------------------------|
| Town | % who speak a language other than English | % who speak Spanish | % who speak other languages |
| Billerica | 9% | 2% | 7% |
| Chelmsford | 10% | 2% | 8% |
| Dracut | 11% | 3% | 8% |
| Lowell | 37% | 13% | 23% |
| Tewksbury | 8% | 1% | 7% |
| Tyngsborough | 11% | 2% | 9% |

MSO Incarceration Data: A third of the Middlesex County House of Correction inmates report Lowell as the address to which they will return upon release. Lowell is among the top 10 towns for releasing inmates from the Massachusetts Department of Correction. The fact that so many newly released inmates will be seeking reentry services, the Restoration Center would provide a much-needed resource to this Lowell Region population.

ESP Data: The Lowell Region has the highest ESP utilization of the three regions studied (n=4,256), the highest number of people who have a Mental Health-only diagnosis, and the highest number of encounters with individuals who are homeless. As shown in Figure 8, more than half (n=2,644) were self/family referrals; the second and third largest referral sources were the police (n=486) and emergency departments (n=400). Figure 9 provides disposition outcomes for Lowell Region ESP utilizers; the majority required acute inpatient psychiatric care (n=1,743) or outpatient services (n=1,262).

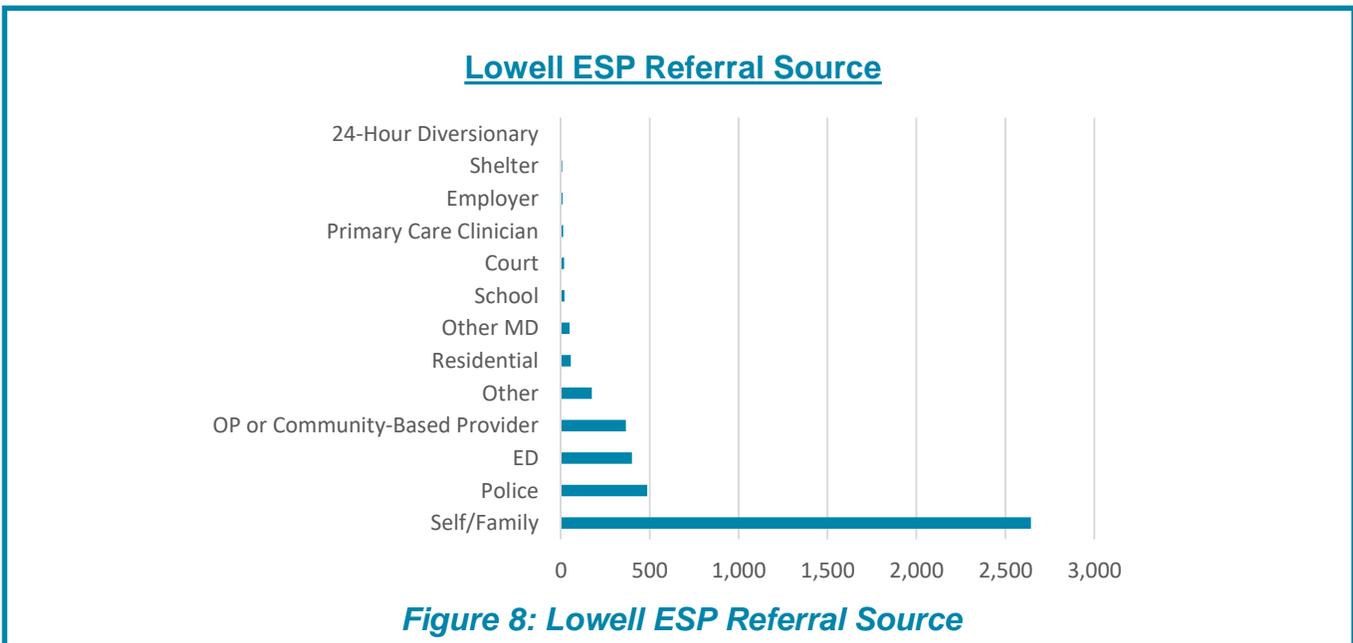


Figure 8: Lowell ESP Referral Source

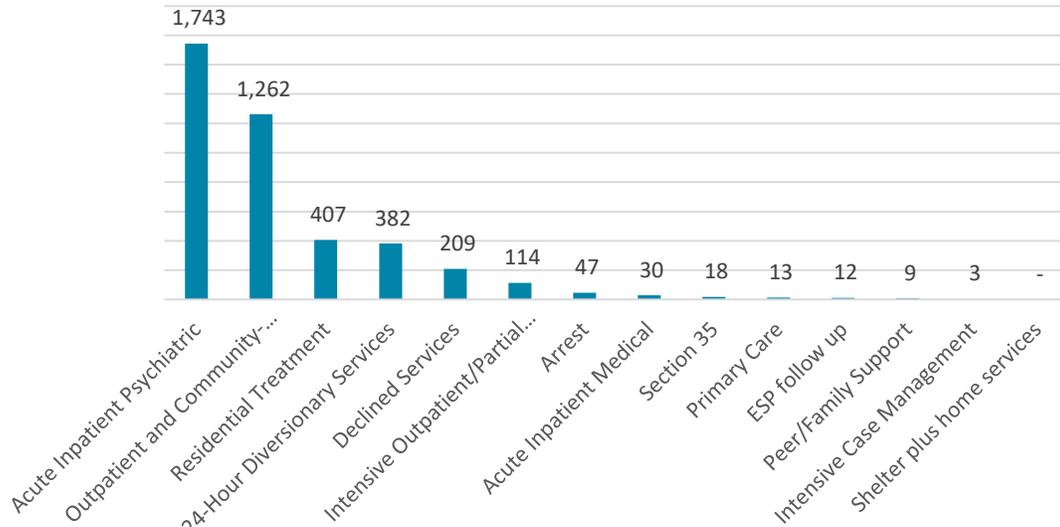


Figure 9: Lowell ESP Utilizer Disposition Data

Frequent Utilizers: ESP Utilization patterns are further illustrated in the ESP Sankey Diagram (Figure 10), which shows an individuals' movement from the encounter, intervention, and disposition. Within the defined Lowell Region, ESP encounters from July 2018 to June 2019 show that of 4,256 encounters, 2,479 (or 58.2%) are possible Restoration Center users. An additional 1,759 encounters resulted in Inpatient hospitalization.

ESP Intervention Flow From Main Sources Lowell

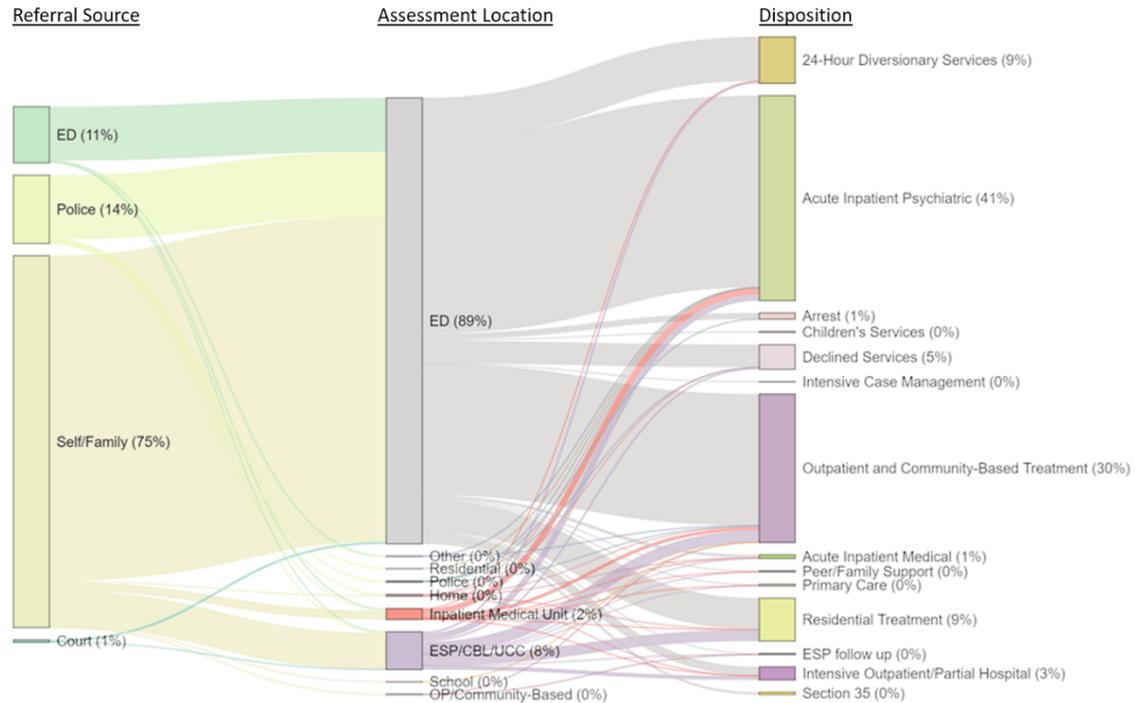


Figure 10: Lowell Area ESP Sankey Diagram

Based on ESP data, Advocates expects that besides the Lowell Region communities, the Restoration Center may be utilized by individuals from Lawrence, Methuen, Andover, Haverhill, and other surrounding towns that have a high need.

Homeless Data: The Lowell Continuum of Care (CoC)^{viii} reports high numbers of unsheltered and homeless persons in Lowell. Based on risk indicators, Advocates would expect this particular subpopulation to have higher substance use, mental health, and primary health needs, mainly crisis-related needs, and have less access to resources than other segments of the target population. While Advocates anticipates that individuals experiencing homelessness are likely to access Restoration Center services, it is essential to recognize that many would require assistance finding housing upon leaving.

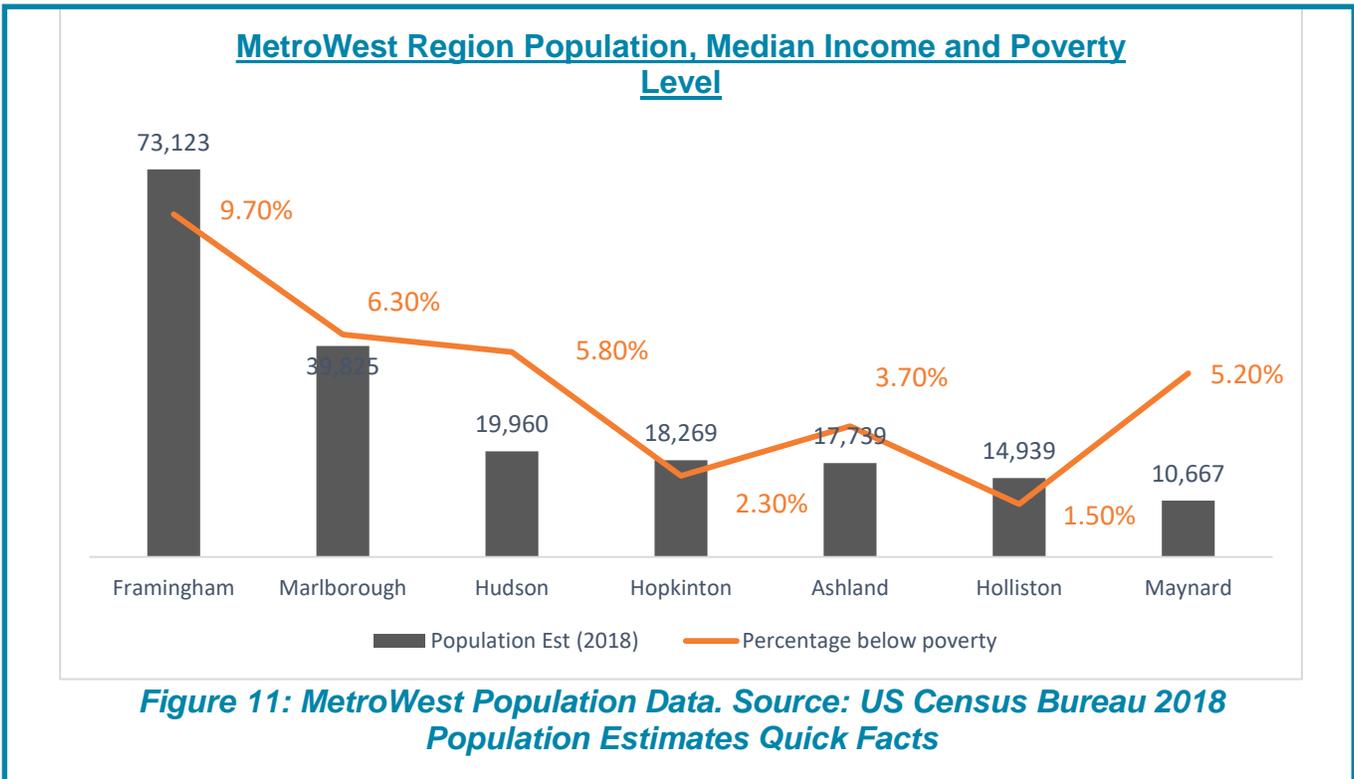
Service Coordination: A single ESP provider covers the Lowell Restoration Center region. There is an insufficient number of crisis services, post-crisis collateral support, and treatment services in the Lowell area. A preliminary list of Lowell Region services is included in Appendix 5. Lowell is in the process of implementing a co-responder jail diversion program; once this program is fully operational, it will likely contribute to higher numbers of referrals to the Restoration Center. Until it is operational, however, the lack of this service represents a gap and a complication in service coordination.

Utilization Estimate: Advocates considered data available on primary feeder sources to the Restoration Center, including inpatient diversions, ED referrals, police referrals, walk-ins, reentering citizens, and individuals from surrounding towns. The team projects that around ten people per day could use an RC based in Lowell (2,000 – 2,500 annually).

B. MetroWest

Introduction: For the Restoration Center planning process, the MetroWest Region is defined as the seven communities of Framingham, Marlborough, Hudson, Hopkinton, Ashland, Holliston, and Maynard, all located west of Boston. US Census Bureau 2018 population estimates indicate the MetroWest Region has a total population of 194,522 residents, including 153,601 residents over the age of 18. Framingham is the largest community in the region, with 73,123 residents. The MetroWest Region is a high-need area; however, based on the assessment of service providers (Appendix 5), there are numerous resources in the community to address the needs of the population likely to utilize a Restoration Center.

Census Data: As shown in Figure 11, the poverty rate ranges from 1.5% to 9.7% across the MetroWest communities. Overall, the poverty rate in the MetroWest region is the lowest as compared to the other areas studied.



Based on the most recently available demographic data available from the Census Bureau released in December 2019,^{ix1} 31.1% of Framingham’s foreign-born residents

are from Brazil; an additional 15% are from the Spanish-speaking countries of Guatemala (5.2%), El Salvador (4.7%), the Dominican Republic (3.4%) and Mexico (2.4%). Framingham has the largest Portuguese-speaking Brazilian population in the state,^x which is reflected in Table 8, showing that a quarter of residents speak a language other than English. As illustrated in Table 7, except Framingham, most towns across the MetroWest Region are White; Ashland has a significant (15.2%) Asian Population. Similar to the Lowell Region, the MSO must consider the specialized outreach necessary to attract immigrants to the Restoration Center to ensure they feel safe and welcome. Also, the Restoration Center staff would need to provide culturally and linguistically competent services to have the most significant impact.

TABLE 7: RACIAL DIVERSITY IN THE METROWEST REGION

| Town | White | Black | Asian | Other |
|-------------|-------|-------|-------|-------|
| Ashland | 76.5% | 2.7% | 15.2% | 5.5% |
| Framingham | 66.3% | 6.5% | 8.2% | 19.1% |
| Holliston | 92.0% | 1.0% | 4.3% | 2.7% |
| Hopkinton | 88.5% | 0.9% | 8.5% | 2.1% |
| Hudson | 89.0% | 2.1% | 3.3% | 5.5% |
| Marlborough | 75.1% | 3.3% | 6.9% | 14.8% |
| Maynard | 90.4% | 2.2% | 4.0% | 3.4% |

TABLE 8: LANGUAGES SPOKEN IN METROWEST REGION

| Town | % who speak a language other than English | % who speak Spanish | % who speak other languages |
|-------------|---|---------------------|-----------------------------|
| Ashland | 18% | 5% | 14% |
| Framingham | 25% | 11% | 15% |
| Holliston | 6% | 1% | 5% |
| Hopkinton | 9% | 1% | 8% |
| Hudson | 18% | 1% | 16% |
| Marlborough | 22% | 9% | 13% |
| Maynard | 9% | 3% | 7% |

ESP Data: Of the 3,368 ESP encounters in FY 2019 in the MetroWest, as shown in Figure 12, more than half (n=1,184) were self/family referrals; the second and third largest referral sources were the emergency departments (n=17) and police (n=698). Figure 13 provides disposition outcomes for MetroWest Region ESP utilizers; the majority required acute inpatient psychiatric care (n=1,422) or outpatient services (n=918).

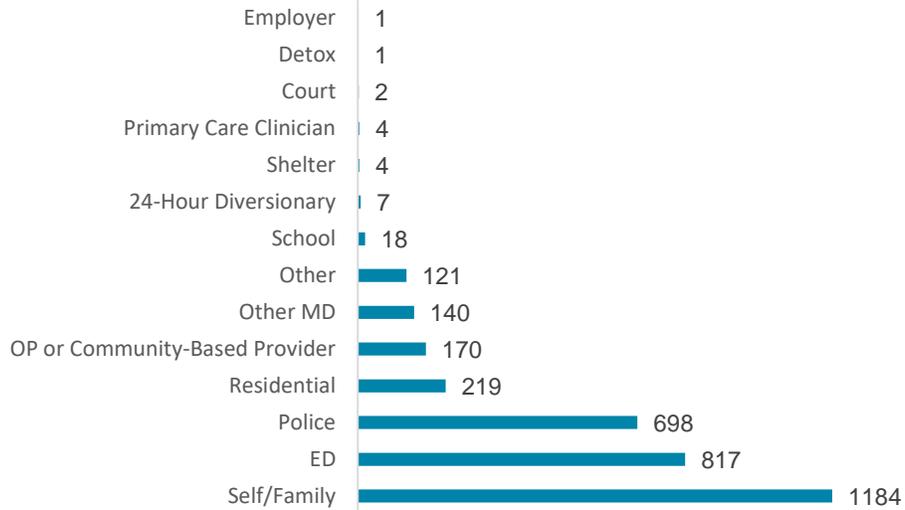


Figure 12: MetroWest ESP Referral Source

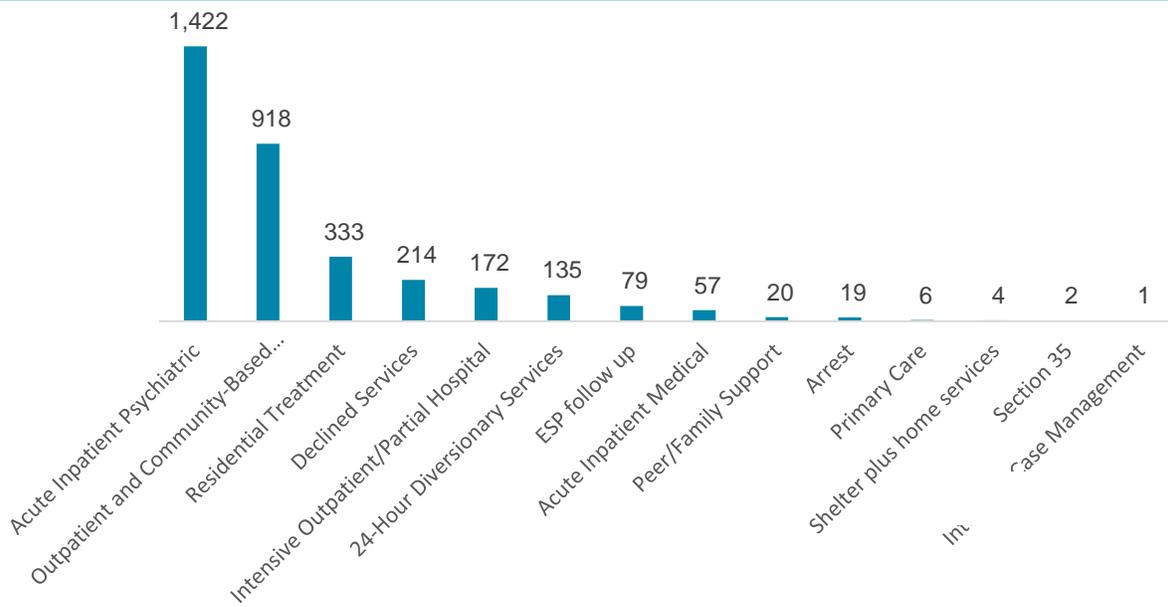


Figure 13: MetroWest ESP Disposition

Frequent Utilizers: ESP Utilization patterns are further illustrated in the ESP Sankey Diagram (Figure 14), which shows an individuals' movement from the encounter, intervention, and disposition. Based on cross-catchment ESP encounters, the MetroWest region could also see utilization from individuals who live in border towns in Worcester and Norfolk counties.

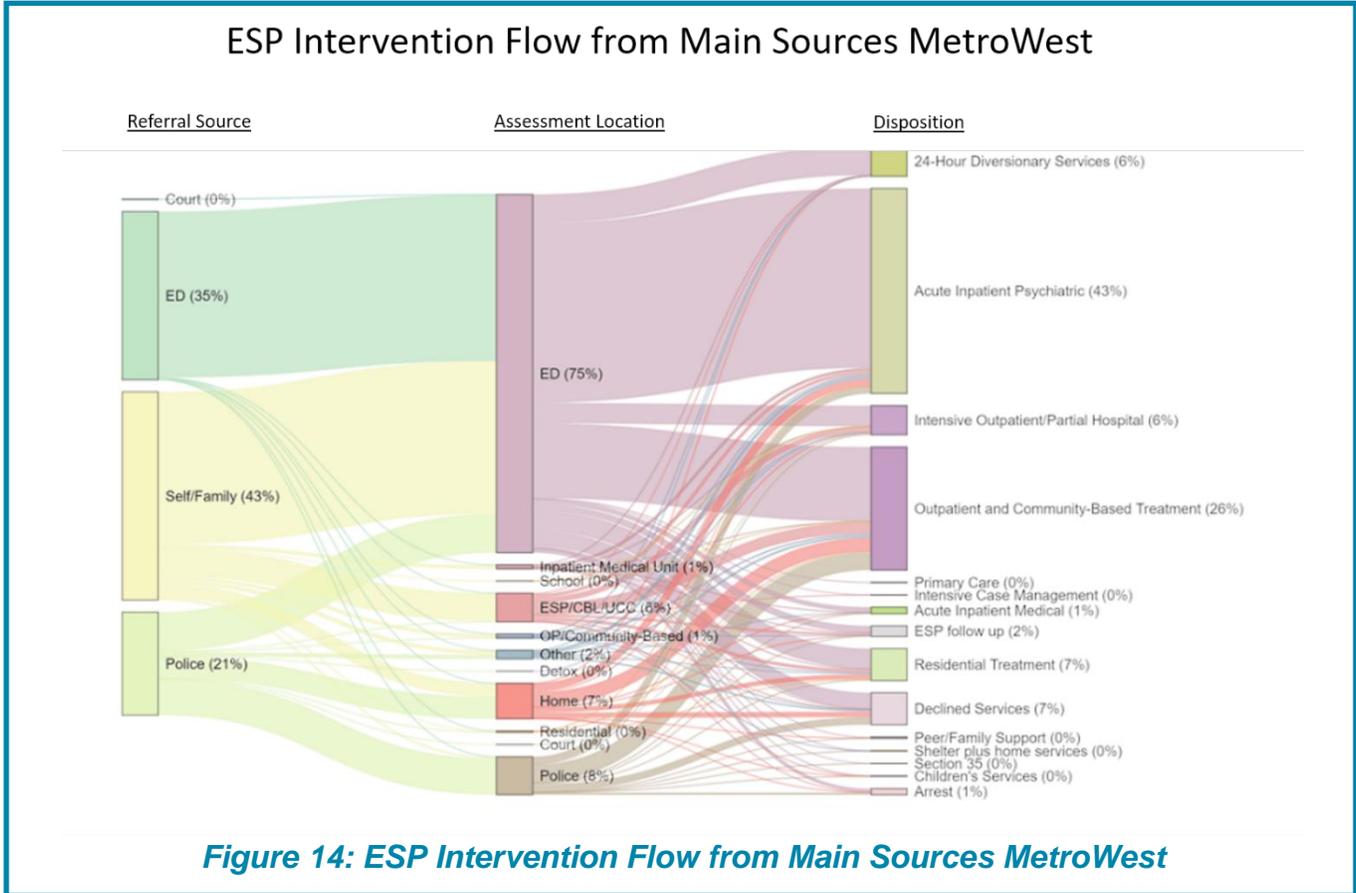


Figure 14: ESP Intervention Flow from Main Sources MetroWest

Homelessness Data: The ESP homelessness numbers are indicative of a population that should feed directly into the Restoration Center. Of the 3,386 ESP encounters in FY 2019 performed in MetroWest, 460, or 13.6%, involved homeless persons, compared to 625, or 14.7%, in Lowell region and 295, 8.7%, in communities in the Southeast if the county. While the homeless population in the MetroWest region is not as high as in Lowell, this population is significant; these individuals are likely to utilize the services of a Restoration Center.

MSO Incarceration Data: Of the three regions, MetroWest has the lowest number of returning citizens from the Middlesex House of Correction (63 vs. 166 in Southeast and 228 in Lowell). However, inmates will be seeking reentry services that will be provided by the Restoration Center.

Services Coordination: A Single ESP provider is serving this region. There is a mature Jail Diversion Program with institutional knowledge and operational understanding that would add value to the Restoration center, through increased referrals and reduced

service coordination complexity. The Jail Diversion Program provider covers all the defined RC MetroWest Region. The overlap of hospital catchment areas and crisis services is low, posing little complexity to service coordination. A preliminary list of MetroWest Region services is included in Appendix 5.

Utilization Estimate: Advocates considered data available on primary feeder sources to the Restoration Center, including inpatient diversions, ED referrals, police referrals, walk-ins, reentering citizens, and individuals from surrounding towns. Advocates projects eight individuals would use services each day if located within the MetroWest Region (just under 2,000 annually).

C. Southeast Region

Introduction: For the Restoration Center planning process, the Southeast Region is defined as the 12 communities of Cambridge, Somerville, Malden, Medford, Everett, Arlington, Woburn, Watertown, Wakefield, Belmont, Winchester and Stoneham, all located northwest of Boston. US Census Bureau 2018 population estimates indicate the Southeast Region has a total population of 587,240 residents, including 485,987 residents over the age of 18. Cambridge is the largest community in the region, with 118,977 residents. The Southeast Region is a high-need area; however, there are numerous resources in the community to address the needs.

Census Data: As shown in Figure 13, the poverty rate in the Southeast Region ranges from 2.5% in Winchester to 16.4% in Malden.

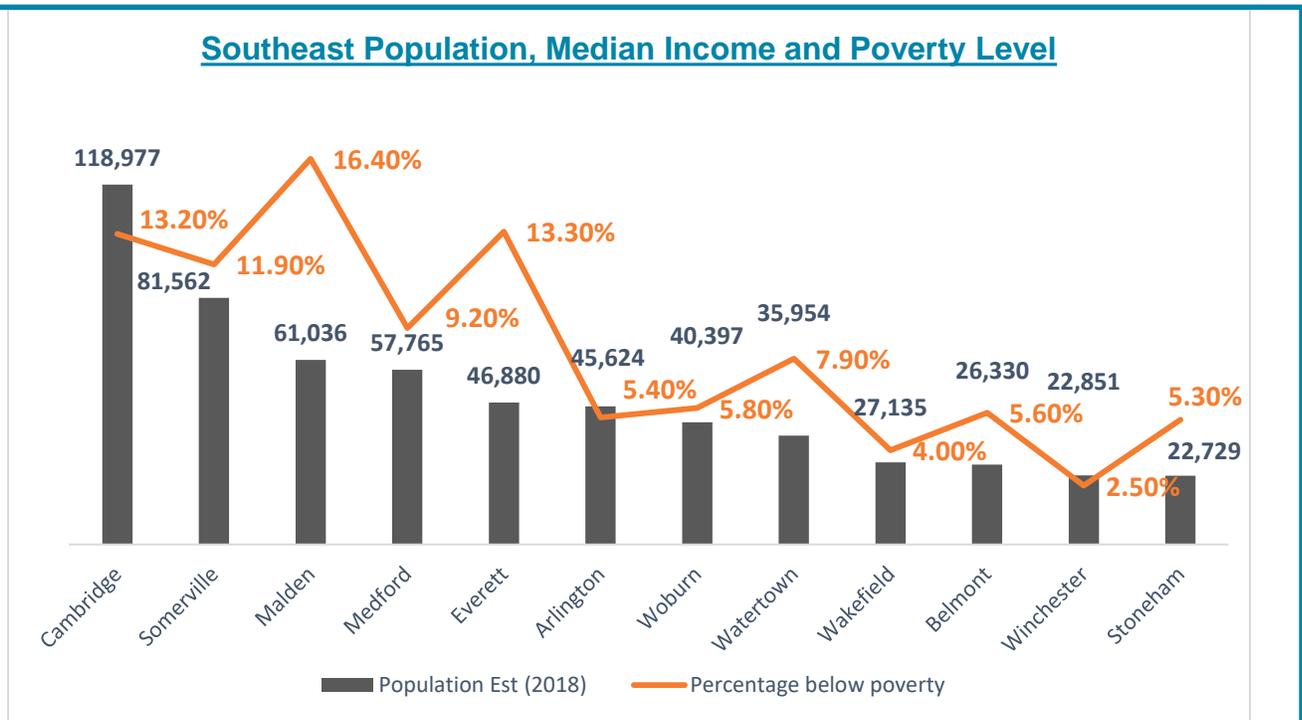


Figure 15: Southeast Region Population Data:

Source US Census Bureau 2018 Population Estimates QuickFacts

In addition to having the highest poverty rate, Malden has the most diverse population, with 55% of its population representing communities of color (Table 9) and 40% of its residents speaking a language other than English (Table 10). While these low-income individuals may be likely to utilize the Restoration Center, the Commission must consider the diversity of residents and the need to provide safe, welcoming, and culturally-competent services.

| TABLE 9: RACIAL DIVERSITY ACROSS SOUTHEAST REGION | | | | |
|--|--------------|--------------|--------------|--------------|
| City/Town | White | Black | Asian | Other |
| Arlington | 79.7% | 3.0% | 12.2% | 5.0% |
| Belmont | 74.8% | 2.5% | 17.3% | 5.4% |
| Cambridge | 62.4% | 11.2% | 19.3% | 7.1% |
| Everett | 50.8% | 19.3% | 6.7% | 23.2% |
| Malden | 44.3% | 18.7% | 26.7% | 10.3% |
| Medford | 71.1% | 10.7% | 10.8% | 7.3% |
| Somerville | 69.7% | 6.9% | 11.6% | 11.8% |
| Stoneham | 88.8% | 2.6% | 4.9% | 3.7% |
| Wakefield | 91.7% | 1.3% | 4.2% | 2.8% |
| Watertown Town | 78.1% | 3.9% | 11.2% | 6.8% |
| Winchester | 80.0% | 1.3% | 15.0% | 3.6% |
| Woburn | 77.9% | 5.9% | 10.5% | 5.7% |

| TABLE 10: LANGUAGES SPOKEN IN SOUTHEAST REGION | | | |
|---|--|----------------------------|------------------------------------|
| Town | % who speak a language other than English | % who speak Spanish | % who speak other languages |
| Arlington | 14% | 3% | 11% |
| Belmont | 21% | 3% | 18% |
| Cambridge | 22% | 6% | 16% |
| Everett | 43% | 14% | 29% |
| Malden | 40% | 7% | 33% |
| Medford | 20% | 4% | 17% |
| Somerville | 18% | 5% | 13% |
| Stoneham | 13% | 3% | 11% |
| Wakefield | 7% | 2% | 5% |
| Watertown | 21% | 4% | 17% |
| Winchester | 14% | 2% | 13% |
| Woburn | 14% | 3% | 11% |

ESP Data: Despite having the highest population among the three regions studied, the Southeast Region had the lowest number of ESP encounters (n=3,399), of which 295

were homeless. As shown in Figure 13, 1,325, or 39% of ESP encounters in the Southeast Region, were from Emergency Departments (ED) and 1,226, or 36% were self/family referrals. Only 188, or 5.5% of ESP encounters were initiated by a police department. 89% of the ESP encounters were provided in hospital Emergency Departments.

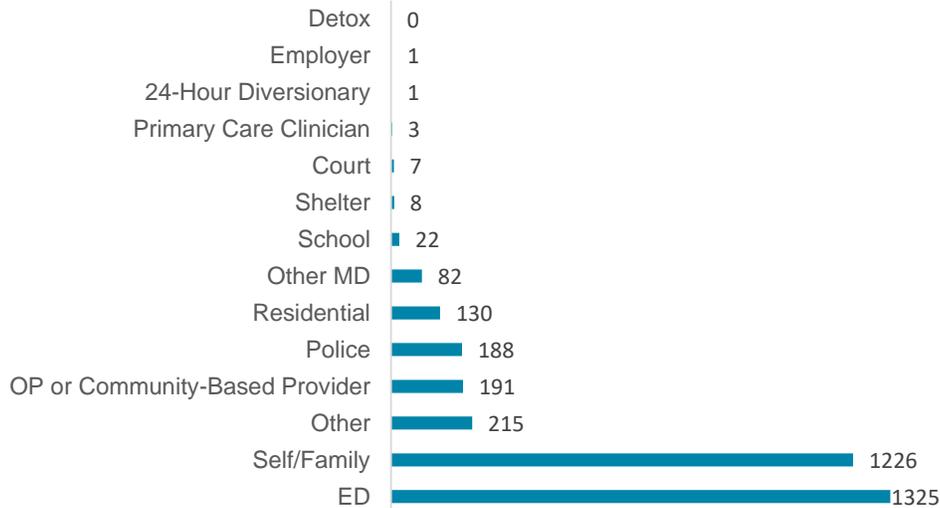
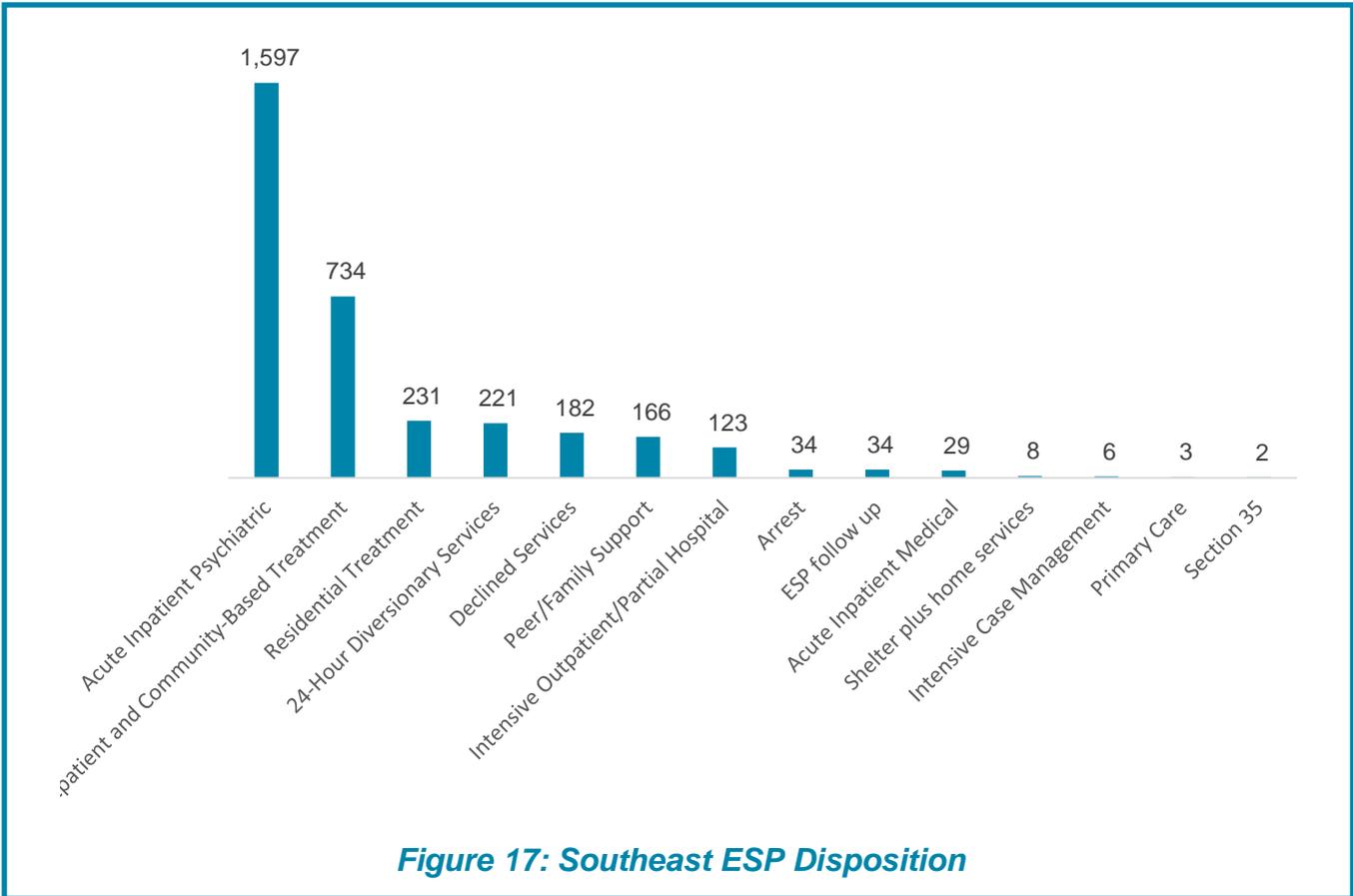


Figure 16: Southeast ESP Referral Source

Figure 17 provides disposition outcomes for Southeast Region ESP utilizers. Forty-eight percent of people were disposed of in an Acute Inpatient Psychiatric unit and 23% in Outpatient and Community-Based Treatment.



Frequent Utilizers: An ESP Sankey Diagrams for the South East Quadrant (Figure 18) illustrates individuals’ movement from the encounter, intervention, and disposition.

ESP Intervention Flow from Main Sources Southeast

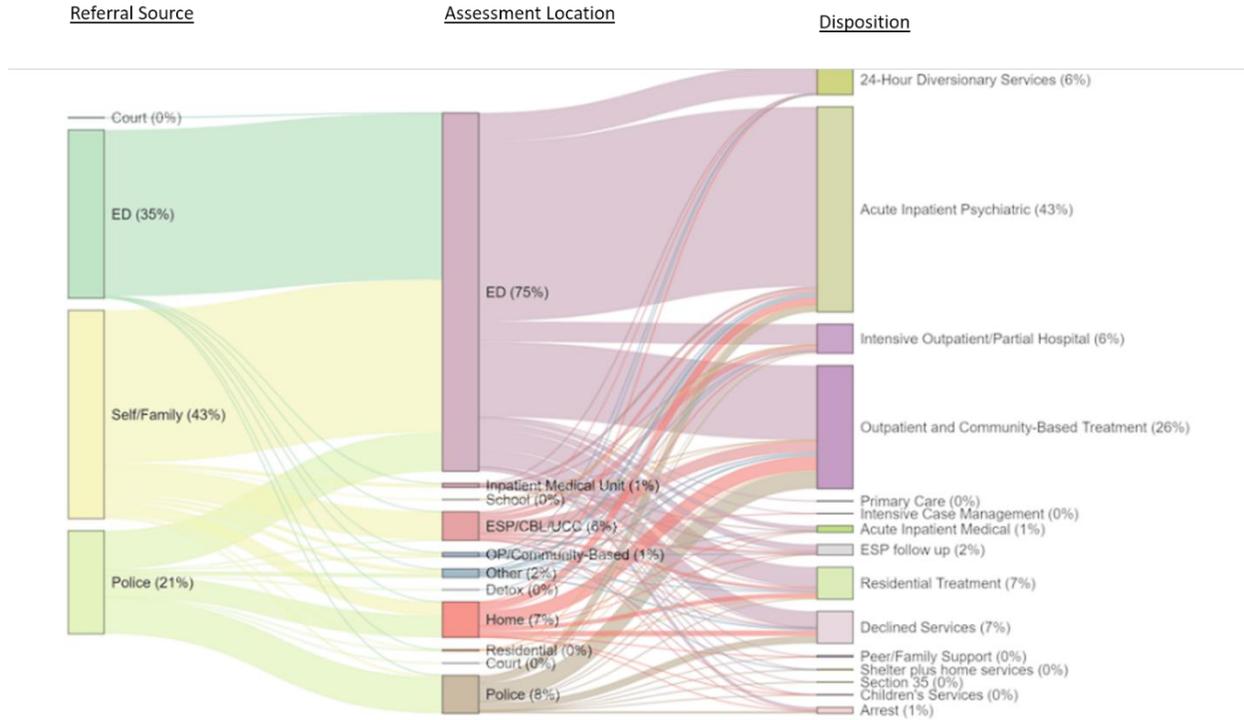


Figure 18: ESP Intervention Flow from Main Sources South East Region

Service Coordination: There are numerous hospitals, crisis services, and other resources in the Southeast Region, and three different ESP providers. The catchment areas for hospitals overlap considerably, which would pose complexity in the operation of the Restoration Center. This complexity may also lead to the additional time needed for waivers and coordination with partners and licensing bodies to start up the program. Several police diversion programs overlap in this geography. It is a reasonable assumption that these diversion programs would increase Restoration Center referrals but also that they add service complexity issues. A preliminary list of Southeast Region services is included in Appendix 5.

Utilization: Advocates estimates that at Restoration Center in this region could see nearly 25 people per day use the center, the majority of which (13.4) would come from surrounding areas, including Suffolk and Essex counties (2,750 annually).

VI. BUDGET

As shown in Table 11, Advocates estimates the Restoration Center will require \$3.28 million annually in operating revenue not currently available.

| TABLE 11: RESTORATION CENTER EXPENSES AND REVENUE | |
|--|---------------|
| Total Direct Expense | \$5,902,617 |
| Administrative Overhead | \$708,314 |
| Total Expense | \$6,610,931 |
| Total Revenue | \$2,673,815 |
| Variance | \$(3,228,802) |

Based on regulatory requirements, staffing salaries, and the high need, high-risk population designated to be served in the restoration center, 3rd party billing does not cover all the costs. Therefore, additional dollars will need to be allocated to the restoration center to have available capacity at all times to serve individuals in crisis.

One central tenet of a Restoration Center is that all individuals will be served regardless of how they access the center. For the Restoration Center to be successful, police departments need to know they can drop off anyone irrespective of their physical and psychological condition or payer. The Restoration Center staff will determine the correct services the person needs, including services provided outside of the restoration center. To do this, the Restoration Center requires adequate staffing and clinical expertise to treat individuals and keep them safe.

Advocates estimates that the annual minimum required staffing cost to operate a Restoration Center (before billing) is \$2,484,600. Table 12 provides a list of the Restoration Centers Fixed Costs related to personnel.

| TABLE 12: RESTORATION CENTER FIXED COSTS- PERSONNEL | | |
|--|----------------|---|
| Staff | # Units | Comment |
| Program Director | 1 | Must have Program Director |
| Recovery coaches/Peer Specialists all shifts | 4.2 | ESP requirements are 2 Peers and 2 Recovery Coaches |
| On-Call Psychiatrist | 1 | ESP requirement |
| Direct Care Staff all shifts 4.2 | 4.2 | One staff to float between all services |
| Master's Level Clinician all shifts | 5 | Must have Master's Level Clinician 24/7 for ESP evaluations |
| Medical PCP | 1 | Offering urgent care BH and medical |
| EMTs | 4 | Must have for medical clearance to avoid ED |
| Psychiatrist | 1 | Must have for all services will float between |

| | | |
|------------------------|------|---|
| Nurse Manager | 1 | Must have for all services will float between |
| Relief | 1.23 | To meet min staffing ratios when regular staff are off |
| Security (3 shifts) | 4.2 | Cover 1 shift 24/7 |
| Housing Specialist | 0.3 | To support members with housing recourses |
| Eligibility Specialist | 1 | Need to be able to verify insurance for third party billing |

The minimum required non-staffing cost to open a Restoration Center (before billing) is \$3,561,142. Following is a list of the Restoration Fixed Costs (non-personnel).

TABLE 13: RESTORATION CENTER FIXED COSTS- NON-PERSONNEL

| Item | #Unit | Comment |
|---------------------------------------|-------|---|
| Food services | 2 | Need to provide three meals per day to anyone at the program |
| Meals | | Need to provide three meals per day to anyone at the program, cost per bed per week is \$55 |
| BH-JI Reentry | 2 | Part of the Aftercare for Restoration Center |
| BH-JI supervisor | 0.3 | Required to provide supervision for BH-JI services per MassHealth |
| IT/Phones | | Phones and computers are needed |
| Contracted Services | | Snow removal, landscaping, etc. |
| Professional Liability Insurance | | Must have |
| Supplies Office medical and household | | Must have office supplies, medical supplies, and household supplies |
| Training | | Staff will require ongoing training to support members |
| Marketing | | Outreach, marketing, and relationship-building to drive traffic to the Restoration Center |
| Communication Access | | Must provide service in the language preference of the member |
| Linen Service | | Must have for bedding |
| Transportation | | To have access for members to and from the Restoration Center |
| Furniture | | Beds \$2,500 x 30 beds, \$1,000 per office, common area tables and chairs, dining area tables and chairs, meeting space tables and chairs, medical office (exam tables) \$4,000 |

As shown in Figure 19, staffing for specific programs is \$1,761,182. For the Community Crisis Stabilization staffing model, Advocates used MBHP staffing requirements. In developing the Sober Support Unit staffing model, Advocates relied on requirements for MAT and ATS, combined with the MDs in the fixed personnel. For the Respite program, Advocates modeled is staffing structure after DMH Respite requirements. The projected rent was based on an estimation of square footage, and an average cost per square foot for property type across the regions.

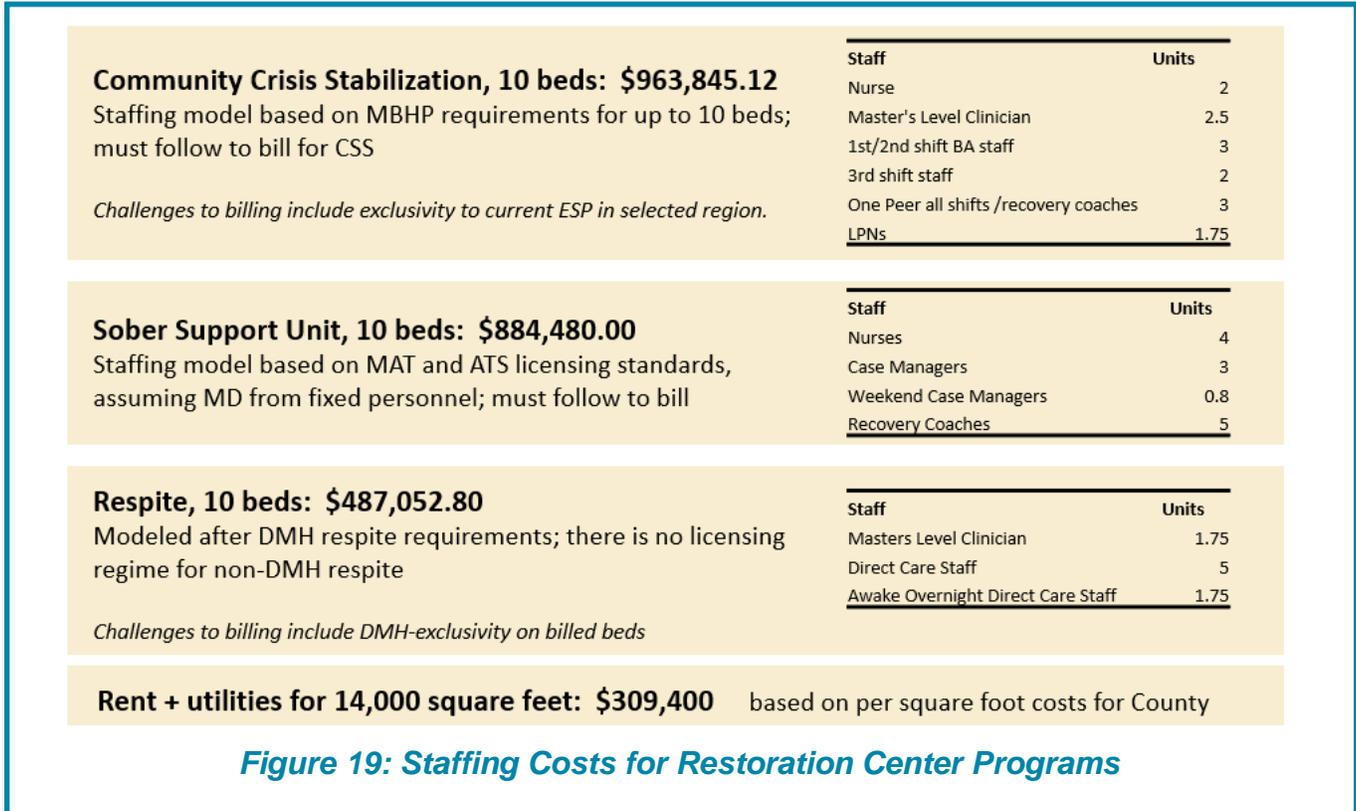


Table 14 presents Advocates' estimated revenue projections for the Restoration Center. The budget assumes that triage and assessment may be billable at either the ESP assessment rate of \$819 or the BH urgent care assessment rate of \$171. Advocates estimated that 50% of Restoration Center utilizers would require an ESP Screen, and 50% will require Urgent Care Behavioral Health assessment. Also, Advocates forecasts that 66% of members that receive an ESP screen will require Crisis Stabilization services.

Table 15 presents the projected rate based on several assumptions. For the ESP Screen, Advocates assumes 50% of assessments will be ESP screen rate, and 50% will be urgent care. Advocates also assumes ~ 2/3 of those receiving an ESP screening would need Community Crisis Stabilization beds based on current ESP program utilization rates. Advocates based the 70% utilization Factor on current CCS utilization statewide. This projection also assumes 70% of the individuals dropped off for the sobering unit will accept Alcohol Treatment Services.

TABLE 14: RESTORATION CENTER ESTIMATED REVENUE

| | Members Per Month | Number of Beds | Total |
|------------------------|-------------------|----------------|-------------|
| Triage and Assessment | 180 | | |
| Crisis Stabilization | | 10 | |
| ATS/Sober Support Unit | | 10 | |
| Respite | | 10 | |
| BH-JI | 17 | | |
| Revenue | \$1,157,373 | \$1,516,442 | \$2,673,815 |

TABLE 15: RESTORATION CENTER ESTIMATED REIMBURSEMENT RATE

| | |
|---------------------------------|-------|
| ESP Screen | \$819 |
| Urgent Care Behavioral Health | \$171 |
| Crisis Stabilization Daily Rate | \$506 |
| Sober Support/BSAS ATS Rate | \$248 |
| Respite | \$- |
| BH-JI | \$14 |
| Utilization Factor | 70% |

VII. ADDITIONAL CONSIDERATIONS

A. Licensing

Advocates, in partnership with the Commission members and staff, reviewed the options available under the Commonwealth's current licensing schema. The goal was to identify licensing regulations/laws that could be changed, streamlined, or integrated to enable improved services in a Restoration Center. For example, the envisioned Restoration Center will include elements of a mental health clinic, substance use treatment clinic, medication-assisted treatment (MAT) facility, and addiction treatment services (ATS). Currently, the Commonwealth offers distinct licensing for each of these services.

B. Potential Regulatory or Legislative Issues

Advocates explored potential hurdles that regulatory or legislative action may help resolve.

- Regulation covering sobering beds does not exist.
- DMH has a Respite bed model, but those programs are a closed referral system.
- The respite beds designed for the Restoration Center models the DMH regulations, but it is not funded or licensed by that state agency.
- Mixing service types may pose challenges with staff sharing and physical building set-up based on current regulations.
- Licensing for ATS beds requires a minimum of 15 to make it financially sustainable. This design has a 10-bed capacity.

There are numerous barriers to insurance reimbursement, and 3rd party billing for medical services may need more consideration under the MassHealth ACO billing regulations. Currently, health care providers must be affiliated with a particular ACO to receive reimbursement. Within this ACO structure, the Restoration Center would need to employ a provider from each ACO in the Commonwealth to bill for payment. Given that this model is not an option at this time, the proposed Restoration Center budget model does not consider 3rd party revenue for medical services. The Commission may wish to explore whether a contractual partnership with a Federally Qualified Health Center or other similar entity may allow for such a 3rd party billing arrangement.

C. Involuntary Care

Advocates discussed whether the Restoration Center should accept involuntary commitments. Under Section 12, if an individual is determined to be a hazard to themselves or others, a police officer or a clinician can restrain or authorize a restraint of the individual for up to 72 hours.

Under Section 35, if an individual with an alcohol or SUD is deemed to be a threat to oneself or others as a result of their addiction, the individual can be committed for up to 90 days in an appropriate facility after a formal review from a judge.

After a conversation on February 4, 2012, between the Restoration Center Planning Committee and the Commission, a collaborative decision was made that the planned Restoration Center will not provide inpatient services to Section 12 or Section 35

patients. The Restoration Center might evaluate a person and determine the person needs a Section 12 or 35 commitment; however, they will refer them out to treatment facilities licensed to accept civilly committed patients for services.

D. Security

Advocates has reviewed other restoration center security models and discussed with Commission members whether the Restoration Center should have protection for the building, the staff, and the individuals served. Advocates recommends appropriate security measures. Based on preliminary conversations, the MSO is open to the possibility of providing security for the Restoration Center. In the absence of this, the Restoration Center should have one security personnel on shift. This person will be casually dressed, not in a security officer's uniform, and will not carry a weapon. Individuals coming to the Restoration Center should expect that this is a treatment facility, not a locked facility.

E. No Wrong Door Policy

The expectation is that the Restoration Center will be available for anyone seeking its services regardless of their insurance status and type, and will support law enforcement drop-offs, ED transfers, reentering citizens, and walk-ins.

As a resource for crisis stabilization, the Restoration Center will support individuals who have multiple concurrent needs, including physical health, substance use, and social determinants of health needs (such as housing and nutrition). The service model described previously in this report supports the triage and stabilization needs of the target population and provides resources and structure to ensure supported aftercare.

MBHP ESP encounter data indicate significantly higher rates of uninsured individuals using ESP services than in the Commonwealth as a whole. In the Lowell region, 5.38% of ESP utilizers in the Lowell regions were uninsured, while 11.44% in the Southeast and 18.13% in the MetroWest regions were uninsured. The rate of uninsured ESP utilizers in the targeted areas is significantly higher than the Commonwealth's overall uninsurance rate, which is approximately 2%. Among all ESP users, only 15% of individuals had a commercial insurer, and 12% were covered under Medicare/Medicaid. It is reasonable to assume that individuals who are likely Restoration Center users will present with a similar insurance profile.

The creation of a No Wrong Door policy is a crucial component of the Restoration Center's viability. Such a system will ensure a flexible use of funding to support multi-disciplinary teams, maximize the efficacy of available treatment resources, and provide an organized and integrated set of services responsive to the needs of the target population. Equally critical is to establish systems to ensure individuals can receive access to services no matter their insurance status. Advocates recommends a care-coordination model to provide consistency throughout their entrance to the Restoration Center, triage and comprehensive assessment, creation of a care plan, access to Restoration Center-based services, and coordination of aftercare supports.

VIII. CONCLUSION

With the passing of Section 225 of Chapter 69, Sheriff Koutoujian, with support from Senator Friedman, established the Commission to oversee the creation of a Restoration Center. In doing so, the Sheriff hoped to reduce arrests and emergency department visits among individuals with behavioral health conditions in Middlesex County. Advocates was contracted by the MSO and the Commission to leverage its behavioral health expertise to outline a plan of action for designing a Restoration Center.

This report builds upon the MSO's June 2019 Year One Findings and Recommendations Report by enhancing recommendations on the service mix, identifying targeted regions for siting the Restoration Center, and further segmenting the target population that would benefit from such a resource. In this document, Advocates has shared the findings from a four-month process to analyze the need and viability of a Restoration Center in three targeted regions. These include the Lowell, MetroWest, and the Southeast regions of Middlesex County.

In its analysis, Advocates considered Restoration Center utilization based on each region's proximity to feeder sources and collateral resources for supported referrals. Advocates analyzed social determinants of health (poverty and homelessness), returning citizens from incarceration, the concentration of likely Restoration Center users, and high ESP utilization. Also, Advocates explored estimated real estate costs, as well as the availability of real estate.

Advocates' recommends the Restoration Center service model includes triage assessment, crisis stabilization, a sober support unit, respite care, medical screening, reentry services, a housing specialist, and medication-assisted treatment (MAT). Care managers must be available to connect individuals to comprehensive, strengths-based aftercare supports once the individual is stabilized. These outpatient services can address an individual's longer-term medical, behavioral health, social determinants, and criminogenic needs.

Advocates recommends a No Wrong Door approach to ensure equal access to care regardless of an individual's insurance status and type, the condition(s) that brought them to services, or the method of access. The Restoration Center should, therefore, be designed to support law enforcement drop-offs, as well as emergency department transfers, reentering citizens, and walk-ins.

As the MSO and the Commission move forward with the Restoration Center implementation, Advocates recommends the following critical next-steps:

- Support from the Commission for program siting in the region most likely to embrace the model and realize high-levels of utilization;
- Stakeholder engagement within the targeted community to ensure local officials, providers, and residents understand the purpose and value of the Restoration Center;

- Evaluation and continuous quality improvement to refine the model during its initial phase of implementation;
- Explore 3rd party billing and a diverse payer mix to fund the project and operations adequately; and
- Review of the factual findings in this report to identify and implement any needed legislative action to overcome systemic barriers.

IX. APPENDICES

- Appendix 1: MSO Restoration Center Commission
- Appendix 2: Advocates Restoration Center Committee Rosters
- Appendix 3: Advocates Restoration Center Committee Meeting Dates
- Appendix 4: Restoration Center Planning Committee Meeting Minutes
- Appendix 5: Preliminary List of Region-Specific Services

Appendix 1: MSO Restoration Center Commission

- Co-chair Sheriff Peter J. Koutoujian, Middlesex Sheriff's Office
- Co-chair Danna Mauch, President/CEO of the Massachusetts Association for Mental Health
- Senator Cindy Friedman
- Representative Kenneth Gordon
- Paula Carey, Chief Justice of the Massachusetts Trial Court
- Scott Taberner, Special Advisor for Behavioral Health and Criminal Justice, Executive Office of Health and Human Services
- Chief Robert Bongiorno, Bedford Police Department
- Nancy Connolly, Assistant Commissioner for Forensic Services at the Department of Mental Health
- Jennifer Barrelle, Chief of Staff at the Department of Public Health
- Rosemary Minehan, a former judge
- Amanda Gilman, Senior Director of Public Policy and Strategic Initiatives at the Association for Behavioral Healthcare
- Eliza Williamson, Director of Community Education and Training at the National Alliance on Mental Illness of Massachusetts
- Steven Mastandrea, Chief Probation Officer, Lowell

Appendix 2: Advocates Restoration Center Committee Rosters

Aftercare & Services

- Brenda Miele Soares, MSW, LICSW, VP Behavioral Health Services
- Mark Viron MD, Chief Medical Officer
- Opal Stone MBA, Director of Reentry Services
- Sherry Ellis MSW, LICSW, Chief Operating Officer, Spectrum Health Systems
- Kristen Nolan MA, MBA, VP of Inpatient and Outpatient Services, Spectrum Health Systems
- Keith Scott, CPS, VP of Peer Support and Self-Advocacy
- John DeRonck MSW, LICSW, Senior Director of Emergency Services
- Danielle Dunn, Senior Director of Integrated Clinical Services
- Rob Karr MD, Associate Medical Director and Forensic Director
- Sarah Abbott Ph.D., Jail Diversion Program Director
- Theresa Brasier PsyD, Program Director of Forensic Services.

Data Collection & Analysis

- Opal Stone, MBA, Director of Reentry Services
- Sarah Abbott Ph.D., Jail Diversion Program Director
- John De Ronck MSW, LICSW, Senior Director of Emergency Services
- Diane Schiller, VP of Analytics
- Kristen Nolan MA, MBA, VP of Inpatient and Outpatient Services, Spectrum Health Systems
- Theresa Braiser PsyD, Program Director Forensic Services
- Tom Wagner, MSW, VP of Business Integrity.

Location

- Beth Lacey, MSW, LCSW, SVP Community Services
- Keith Neal, Chief Financial Officer
- Tom Wagner, MSW, VP of Business Integrity
- Craig Gaudette, MSW, LICSW, Senior Operations Director
- Danielle Dunn, LMHC, Senior Director of Integrated Clinical Services
- Colin Walker, Director of Facilities

Transportation

- Craig Gaudette, MSW, LICSW, Senior Operations Director
- Keith Neal, Chief Financial Officer
- Beth Lacey, MSW, LCSW, SVP Community Services
- Tom Wagner, MSW, VP of Business Integrity
- Danielle Dunn, LMHC, Senior Director of Integrated Clinical Services
- Colin Walker, Director of Facilities

Appendix 3: Advocates Restoration Center Committee Meeting Dates

| Date | Time | Committee |
|------------------------------|------------------|--|
| Friday, December 27, 2020 | 10:00 – 11:00 AM | Restoration Center Planning Team Kick-Off Meeting |
| Monday, January 6, 2020 | 3:00 – 4:00 PM | Weekly Conference Call with MSP/Catia Sharp |
| Tuesday, January 7, 2020 | 12:00 – 1:00 PM | Restoration Center Aftercare & Services |
| Wednesday, January 8, 2020 | 1:00 – 2:00 PM | Restoration Center Data and Analysis Committee |
| Friday, January 10, 2020 | 9:30 – 10:30 AM | Restoration Center Planning Team Meeting |
| Monday, January 13, 2020 | 12:00 – 1:00 PM | Restoration Center Data and Analysis Committee |
| Tuesday, January 14, 2020 | 12:00 – 1:00 PM | Location & Transportation Committee |
| Tuesday, January 14, 2020 | 1:00 – 2:00 PM | Restoration Center Planning Aftercare and Services Committee |
| Wednesday, January 15, 2020 | 3:00 – 4:00 PM | Restoration Center Commission Consulting Call |
| Monday, January 20, 2020 | 12:00 – 1:00 PM | Restoration Center Data Collection & Analysis Committee |
| Tuesday, January 21, 2020 | 11:00 – 12:00 PM | Restoration Center Location Selection & Transportation Committee |
| Tuesday, January 21, 2020 | 1:00 – 2:00 PM | Restoration Center Aftercare and Services Committee |
| Wednesday, January 22, 2020 | 3:00 – 4:00 PM | Restoration Center Commission Consulting Call |
| Monday, January 27, 2020 | 12:00 – 1:00 PM | Restoration Center Data Collection & Analysis Committee |
| Tuesday, January 28, 2020 | 1:00 – 2:00 PM | Restoration Center Aftercare and Services Committee |
| Wednesday, January 29, 2020 | 3:00 – 4:00 PM | Restoration Center Commission Consulting Call |
| Monday, February 3, 2020 | 12:00 – 1:00 | Restoration Center Planning Data and Analysis Workgroup |
| Tuesday, February 4, 2020 | 10:00 – 12:00 PM | Present Workplan to MSO/Commission |
| Wednesday, February 5, 2020 | 3:00 – 4:00 PM | Restoration Center Commission Consulting Call |
| Thursday, February 6, 2020 | | Restoration Center Planning Data and Analysis Workgroup |
| Tuesday, February 11, 2020 | 9:00 – 12:30 | Restoration Center Planning Data and Analysis Workgroup |
| Tuesday, February 11, 2020 | 1:00 – 2:00 PM | Restoration Center Aftercare & Services Committee |
| Wednesday, February 12, 2020 | 3:00 – 4:00 PM | Restoration Center Commission Consulting Call |
| Friday, February 14, | 9:30 -10:30 AM | Restoration Center Planning Committee |

| | | |
|------------------------------|-----------------|--|
| 2020 | | |
| Friday, February 14, 2020 | | Restoration Center Planning Data and Analysis Workgroup |
| Monday, February 17, 2020 | 12:00-1:00 PM | Restoration Center Planning Data and Analysis Workgroup |
| Tuesday, February 18, 2020 | 12:00 – 1:00 PM | Restoration Center Location and Transportation Committee |
| Tuesday, February 18, 2020 | 1:00 – 1:45 PM | Restoration Center Aftercare & Services |
| Wednesday, February 19, 2020 | 3:00 – 4:00 PM | Restoration Center Commission Consulting Call |
| Monday, February 24, 2020 | 12:00 – 1:00 PM | Restoration Center Planning Data and Analysis Workgroup |
| Tuesday, February 25, 2020 | 12:00 – 1:00 PM | Restoration Center Location and Transportation Committee |
| Tuesday, February 25, 2020 | 1:00 -2:00 PM | Restoration Center Aftercare and Services Committee |
| Wednesday, February 26, 2020 | 2:30 – 3:30 PM | Restoration Center Commission Consulting Call |
| Wednesday, February 26, 2020 | | Progress Report submitted to Catia Sharp for her review |
| Monday, March 2, 2020 | 12:00 – 1:00 | Restoration Center Planning Data and Analysis Workgroup |
| Tuesday, March 3, 2020 | 10:00 – 12:00 | Restoration Center Commission Meeting |
| Wednesday, March 4, 2020 | 3:00 – 4:00 | Restoration Center Commission Consulting Call |
| Tuesday, March 10, 2020 | 12:00 – 2:00 | Restoration Center Aftercare and Services Committee |
| Wednesday, March 11, 2020 | 3:00 – 4:00 | Restoration Center Commission Consulting Call |
| Wednesday, March 18, 2020 | 3:00 – 4:00 | Restoration Center Commission Consulting Call |
| Tuesday, March 24, 2020 | 1:00 – 2:00 | Restoration Center Aftercare and Services Committee |
| Wednesday, March 25, 2020 | 3:00 – 4:00 | Restoration Center Commission Meeting |

Appendix 4: Restoration Center Planning Committee Meeting Minutes



Restoration Center Planning Team Kick-Off Meeting Friday, December 27, 2020 – 10:00 to 11:00 AM MEETING NOTES

In Attendance:

- Advocates - Brenda Miele Soares, VP of Behavioral Health Services; Beth Lacey, SVP of Community Services; Keith Scott, VP of Peer Supports and Self Advocacy; Bon Hallion, Operations Director; Opal Stone, Director of Reentry Services; John DeRonck, Senior Director of Emergency Services; Diana St. Cyr, Director, Revenue Cycle Management; Craig Gaudette, Sr. Director of Operations; Keith Neal, CFO; Mary Fam, Data Analyst; and Lindsey Konan, Executive Assistance, Behavioral Health Services.
- Spectrum Health Systems - Sherry Ellis, COO; Kristin Nolan, VP of Outpatient and Inpatient Services
- Pear Associates - Alison Glastein Gray, President; Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Brenda Soares called the meeting to order and welcomed the participants. All members introduced themselves.

II. Updates/Conversations with Middlesex Sheriff's Office

Brenda Soares provided an update based on her conversation with the Middlesex Sheriff's Office (MSO). MSO is expecting the following deliverables:

- Project Update within two months
- Location recommendations within three months
- Final recommendations report delivered by the end of April 2020, which will inform their submission to the state legislature.

III. Project Management

Advocates has contracted with Pear Associates to provide project management during the planning process. Caroline Conlin from Pear Associates provided an overview of the project management role, which includes creating agendas and meeting minutes, working with Lindsey Konan to schedule all meetings, providing project support to the Committee point of contact, and following up on all action items. Alison Glastein Gray from Pear Associates will assist with the development of all deliverables to the MSO.

IV. Planning Process (Planning Committee Descriptions Attached)

Brenda Soares distributed a table that included the proposed Planning Team Committee information. For each Committee, there was an intended purpose, membership roster, frequency of meetings, and activities/key discussion questions.

A. Data Collection and Analysis Committee

- Point of Contact: Opal Stone MBA/Director of Re-entry Services
- **ACTION ITEM:** Brenda to connect with Sonya Khan at the MSO, who has been compiling data that will inform the Restoration Center planning, and make an introduction to Opal/Caroline

B. Transportation Committee

- Point of Contact: Craig Gaudette, Senior Operations Director

C. Location Selection Committee

- Point of Contact: Beth Lacey, SVP Community Services
- The group agreed that the siting of the Restoration Center was a priority.
- Brenda shared that when she spoke to David Ryan at the MSO, he had confirmed that a third of people Middlesex County House of Correction return to Lowell
- Tewksbury (site of former state hospital campus/20 minutes from Lowell) was mentioned as a possible location; however, there were concerns about the area not being centralized within the County. Group also discussed the existence of Lahey's full detox program on this campus
- Preliminary questions discussed:
 - What is our threshold for intake volume to make this work?
 - Lease or purchase?
- **ACTION ITEM:** Invite *Julie Gray from McCall and Almy to come to the next meeting and share her commercial real estate expertise and knowledge of the Lowell area.*

D. Aftercare Partnership / Services Line Committee

- Point of Contact: Brenda Miele Soares, VP of Behavioral Health Services
- Preliminary questions discussed:
 - What services will we consider: Detox units? Overnight?
 - What is the extent of medical services/primary care?
 - What is the best license for the model?
- Brenda shared that the Commission would like to see a sobering unit, detox, crisis management, MAT, and primary care
- **ACTION ITEM:** *Kristen Nolan and Beth Lacey to connect about licensing options*

V. Next Steps

Lindsey will send out a Doodle Poll to determine the availability of planning team members. All Committees will meet weekly.



**Restoration Center Aftercare & Services Committee
Tuesday, January 7, 2020 – 12:00 to 1:00 PM
MEETING NOTES**

In Attendance:

- Advocates - Brenda Miele Soares, VP of Behavioral Health Services; Keith Scott, VP of Peer Supports and Self Advocacy; Bob Hallion, Operations Director; Opal Stone, Director of Reentry Services; John DeRonck, Senior Director of Emergency Services; Danielle Dunn, Senior Director of Integrated Services; Mark Viron, Chief Medical Officer
- Spectrum Health Systems - Kristin Nolan, VP of Outpatient and Inpatient Services
- Pear Associates - Alison Glastein Gray, President; Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Brenda Soares called the meeting to order and welcomed the participants. All members introduced themselves. The committee viewed video footage of The Center for Health Care Services - The Restoration Center in San Antonio, TX.

II. Services Discussion

Brenda Soares reviewed the services at the San Antonio Center and invited the committee's input on identifying what services the Center should offer. Some considerations included the following:

A. ED Triage

• **Questions Discussed:**

- Is ED Treatment critical given that the Center is an alternative destination to the ED?
- Acute vs. Non – Acute care: If you are evaluated as needing a higher level of care - how does the Center work with that? Ideally, the Center will work as hard as possible to avoid the ED. It was noted that the Center is failing if it is sending people to the ED regularly.

B. Security

• **Questions Discussed:**

- Would security be needed? What does security look like?
- Would only a portion of the Center need to be locked?
- Is this a good basis for the relationship that we want the Center to have with its' patients? Voluntary service utilization outcomes vs. coerced are better.
- Are we considering building security or patient security?
- What type of security would we need, given the population that the Center serves?
 1. Would we include Section 12 or 35 individuals?
 2. What population data do we have?
 3. What gaps in the data exist?

- Would co-mingling a locked facility with the other services being offered by the Center be challenging?
- ACTION ITEM: Opal Stone to identify the Section 12, or 35 population in Middlesex County

C. Mobile Clinicians

- **Questions Discussed:**

- Would we want to consider offering mobile clinicians as a service?

D. Shelter Beds

- **Questions Discussed:**

- People are desperate for a place to be. Would we want to have a housing coordinator on-site to show people where to go and secure outside housing as quickly as possible?
- ACTION ITEM: Opal Stone to identify what percent of Middlesex County is without housing.

E. Peer Support

- Would the Center offer recovery coaches?

III. Next Steps

- The committee was invited to re-read the Middlesex County Restoration Center Commission Year One Findings and Recommendations, to help finalize what services they would like to offer.
- Opal Stone, John DeRonck, and Brenda Soares to draft a flowchart outlining what would happen when you first walked through the door of the Restoration Center.
- Subsequent committee meetings will be held from 1:00 – 2:00 PM every Tuesday.



**Restoration Center Data and Analysis Committee
Wednesday, January 8, 2020 – 1:00 to 2:00 PM
MEETING NOTES**

In Attendance:

- Advocates – Sarah Abbott, PhD, Jail Diversion Program Director, John DeRonck, MSW, LICSW, Senior Director of Emergency Services; Diane Schiller, VP of Data Analytics; Opal Stone, MBA, Director of Re-Entry Services; Theresa Brasier PsyD, Program Director Forensic Services & Tom Wagner, VP of Business Integrity
- Spectrum Health Systems - Kristen Nolan, VP of Outpatient and Inpatient Services
- Pear Associates - Alison Glastein Gray, President; Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Opal Stone called the meeting to order and introduced the committee.

II. Data and Analysis Discussion

Opal Stone led the Committee through a discussion around what the characteristics of our target population might be, and how many people within that target population would use the services that the Restoration Center would offer. Transportation needs and aftercare support needs were also considered.

Data & Analysis

Questions Discussed:

- If we used the data that is available from the Arlington and Bedford Police Departments, would that data be representative of the population that we are targeting?
- If we had access to the Framingham data – how would that information compare to the Arlington and Bedford data?
- Would it be possible to partner with the Massachusetts Behavioral Health Partnership, and obtain substantial data from their records? Encounter data? Total # of people seen in the ED vs. a community health center?
- Should we do a market research analysis, and augment those findings with other, relevant data?
- Is there any legislation in place that should be considered relevant to the data?
- What data do we need to obtain to support the services that we would offer?
- What are the characteristics of our target population that we should consider?
- What is the initial demand as the Center opens, and as it grows? What does that demand look like over time?

III. Next Steps

- The Committee will prioritize what data needs to be obtained
- Opal Stone and Caroline Conlin will draft a chart that will include the following:
 - Data that could inform the project

- Source of the Data
- Process for collecting the data
- Whether the data will help to answer key programmatic questions
- The Committee will review the Commission's Year One Findings and Recommendations again to see if it will help highlight any gaps in data that are currently available to the Committee.
- The Committee will review any available data on Lowell to understand its challenges better and identify a framework to support that area.
- The Committee will identify who would be considered a "Frequent Utilizer" in the 10 Districts in Middlesex County.
- Subsequent committee meetings will be held from 12:00 – 1:00 on Mondays



**Restoration Center Planning Team Meeting
Friday, January 10, 2020 – 9:30 to 10:30 AM
MEETING NOTES**

In Attendance:

- Advocates - Brenda Miele Soares, VP of Behavioral Health Services; Beth Lacey, SVP of Community Services; Keith Scott CPS, VP of Peer Supports and Self Advocacy; Bob Hallion, Operations Director; Sarah Abbott PhD, Jail Diversion Program Director, Opal Stone MBA, Director of Reentry Services; Diana St. Cyr, Director, Revenue Cycle Management; Craig Gaudette, Sr. Director of Operations; Keith Neal, CFO; Rob Karr MD, Associate Medical Director & Forensic Director; Danielle Dunn, Senior Director of Integrated Clinical Services; Theresa Brasier PsyD, Program Director of Forensic Services, Mark Viron MD, Chief Medical Officer & Colin Walker, Director of Facilities
- Spectrum Health Systems – Sherry Ellis, COO; Kristen Nolan, VP of Outpatient and Inpatient Services
- Pear Associates – Alison Glastein Gray, President; Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Brenda Soares called the meeting to order and welcomed the participants. All members introduced themselves.

II. Updates/Conversations

- Brenda Soares provided an update based upon the meetings that were held throughout the week. The Committee discussed how to schedule the Planning Team meetings moving forward now that the Committee Points of Contact will be checking in with the Sherriff's Office weekly.
 - The entire Planning Team will meet monthly.
 - To streamline communication relative to the Restoration Center, all data distribution and all communication will come from Pear Associates.

III. Committee Updates

A. Data Collection and Analysis Committee

- Point of Contact: Opal Stone MBA/Director of Re-entry Services
- **ACTION ITEM:** *Introduction to Sonya Khan at MSO, who has been compiling data that will inform the Restoration Center planning, is in process.*

B. Transportation Committee

- Point of Contact: Craig Gaudette, Senior Operations Director
- Craig Gaudette and Brenda Soares met with VIA on Tuesday
- **ACTION ITEM:** *Committee will continue to review transportation options & meet weekly.*

C. Location Selection Committee

- Point of Contact: Beth Lacey, SVP Community Services
- ACTION ITEM: *Beth Lacey will meet with Catia Sharp on Tuesday, January 14, 2020, to review the available data.*

D. Aftercare Partnership / Services Line Committee

- Point of Contact: Brenda Soares, VP of Behavioral Health Services
- ACTION ITEM: *Committee to create a flowchart that outlines what services you would engage with under varied scenarios when you walk into the RC.*

IV. Next Steps

- Add Sarah Abbott to Aftercare / Services Committee
- Brenda Soares to confirm the expectations of the 2/4 meeting with Catia Sharp on Monday, January 13, 2020
- Add Rob Karr and Theresa Brasier to the Restoration Center - Aftercare and Services Committee



**Restoration Center Data and Analysis Committee
Monday, January 13, 2020 – 12:00 to 1:00 PM
MEETING NOTES**

In Attendance:

- Advocates – Sarah Abbott, PhD, Jail Diversion Program Director; John DeRonck, MSW, LICSW, Senior Director of Emergency Services; Opal Stone, MBA, Director of Re-Entry Services & Theresa Brasier PsyD, Program Director Forensic Services
- Middlesex County Sheriff's Office: Catia Sharp, Coordinator of Smart Justice Initiatives
- Pear Associates - Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Opal Stone called the meeting to order and introduced the committee.

II. Data and Analysis Discussion

Opal Stone led the Committee through discussions focused on identifying the characteristics of the Restoration Center's target population, and how many people within that target population would use the Restoration Center's services. Transportation needs and aftercare support needs were also reviewed.

- Target population considerations: Who has been incarcerated in each town? Are they insured? What are the transportation options available? Who is calling 911 in these towns? What are the calls about?
- Middlesex County has 54 cities/towns.
- Catia Sharp provided the Committee with an overview of its data from Bedford and Arlington. Recently, the MSO surveyed all police departments in Middlesex County. The initiative received many responses; however, efforts continue to secure more. The goal of the survey was to assess the depth of knowledge in local police departments about diversion programs & better understand the process that police are undertaking on the street regarding behavioral health calls.
- It was observed that in one town, a firefighter might be making behavioral health decisions, while in another, an EMT might be making the decision.
- Catia Sharp encouraged the Committee to stay open to location and make a good case for what we think is best. The Commission would like to see a list of 3 viable sites.
- Transportation will impact the effectiveness of the Restoration Center. Ambulances & local fire departments will need to be engaged, so they understand the value of the Restoration Center and bringing people there instead of ED. We do not have an emergency response system for behavioral health. Housing and homelessness concerns were discussed. The planning process will need to address the homeless population in the respective areas. We should have extra office space that accommodates housing intake. Catia Sharp identified that Lowell has a shelter that is dry half of the year and wet the other half.



**Restoration Center Location Committee
Tuesday, January 14, 2020 – 12:00 to 1:00 PM
MEETING NOTES**

In Attendance:

- Advocates - Beth Lacey, SVP Community Services; Tom Wagner, VP of Business Integrity; Craig Gaudette, Senior Operations Director; Danielle Dunn, Senior Director of Integrated Clinical Services & Bob Hallion, Operations Director
- Spectrum Health Systems -Sherry Ellis, COO
- Pear Associates - Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Beth Lacey called the meeting to order and welcomed the participants. All members introduced themselves.

II. Location Discussion

Beth Lacey discussed workplan updates. The meeting's discussion focused on the utilization of consultant and internal agency expertise related to plans to engage with the community as we analyze the different location possibilities for a Restoration Center.

The Committee concluded that we need to identify the product line to solidify a location. We need to understand what we are building/growing. We need to identify the needs of the structure and the services offered before we make any significant recommendations, including but not limited to, the following:

- Anticipated volume
- Lease vs. Buy?
- Stand-alone vs. connected building?

III. Next Steps

- Beth Lacey will connect with Catia to obtain a better understanding of the data that is currently available.
- Beth Lacey will work with the Data and Analysis Committee to monitor data needs and next steps



**Restoration Center After Care & Services Committee
Tuesday, January 14, 2020 – 1:00 to 2:00 PM
MEETING NOTES**

In Attendance:

- Advocates - Brenda Miele Soares, VP of Behavioral Health Services; Mark Viron MD, Chief Medical Officer; Opal Stone MBA, Director of Reentry Services; John DeRonck, MSW, LICSW, Senior Director of Emergency Services; Danielle Dunn, Senior Director of Integrated Clinical Services; Rob Karr MD, Associate Medical Director and Forensic Director; Sarah Abbott, PhD, Jail Diversion Program Director; Bob Hallion, Operations Director & Theresa Brasier PsyD, Program Director Forensic Services
- Pear Associates - Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Brenda Soares called the meeting to order and welcomed the participants. All members introduced themselves.

II. Discussion

Brenda Soares reviewed the vignettes (attached) with the Committee. It was noted that the conversations with Catia Sharp at the MSO have been extremely helpful in understanding what the Commission is looking for.

The Committee will focus on the following services, as outlined in the Commission Year One Report:

1. Assessment of behavioral health needs & triage
2. Medical clearance
3. Crisis Stabilization
4. Behavioral health urgent care
5. Respite services (Advocates to describe what sort of respite services will be offered)
6. Mobile crisis teams
7. Case management
8. Sober support unit
9. Psychopharmacology

As the Planning Committee thinks about medical clearance, we should make sure that nothing is compromised health-wise. The model needs to focus on diversions from higher levels of care. Providing basic needs will go a long way with this population. The Restoration Center should offer blankets, food, showers, etc. The more that we do onsite, the better. The goal of the Restoration Center should be to restore the patient to stability. It was highlighted that in 23 hours, a lot of support could occur.

III. Next Steps

- The committee needs to identify if detox is going to be offered/required at the Restoration Center.
- Committee to determine the availability of identified state-owned buildings
- Committee to identify the value of proposing a staged implementation / build-out. Identify what stages we need to progress through.
- Committee to determine how long it took the Arizona model to get to where it is today.
- Committee to think about a Restoration Center that is 23 vs. 24 Hours and understand what the licensing, staffing, and service requirements are of each option.
- Committee to determine if the Restoration Center will be licensed as a healthcare facility.
- Committee will create a “dictionary” of all relevant terminology.
- Committee to obtain a better understanding of accepting/licensing Section 12 patients and the security required. The community is going to want some level of protection.
- Once we determine the location, Aftercare Services will need to be examined with greater detail.



**Restoration Center Data and Analysis Committee
Wednesday, January 20, 2020 – 12:00 to 1:00 PM
MEETING NOTES**

In Attendance:

- Advocates – Sarah Abbott, PhD, Jail Diversion Program Director; John DeRonck, MSW, LICSW, Senior Director of Emergency Services; Opal Stone, MBA, Director of Re-Entry Services & Theresa Brasier PsyD, Program Director Forensic Services
- Pear Associates – Alison Gray, President; Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Opal welcomed the Committee, reviewed the work from last week, and flagged some dates for deliverables.

II. Discussion

Sarah Abbott updated the committee on the police survey – all but one agency has given the data. She has populated the survey with Framingham, Ashland, Hopkinton & Marlborough. She is waiting for data from Holliston.

Sarah Abbott noted that based upon the Middlesex County data that Advocates has access to, we could drill down and establish a profile of a frequent utilizer in each of twelve communities.

Diane Schiller reached out to Scott Taberner to get data on the three locations that will be considered:

1. Lowell
2. MetroWest
3. Southeast: Cambridge, Somerville, Woburn, bordered by Waltham

The Committee is working to obtain profile data for all communities and discussed where gaps in data exist.

Opal Stone discussed that when we start the analysis – the Committee will use the data that we have to help identify the pros and cons of each Restoration Center Region.

Considerations will include Size of population, demand for services, commission report, transportation, and accessibility.

By location, the Committee would like to understand who makes 911 calls, who responds, who might want to use the Restoration Center, and what % of the population the police will bring to the Restoration Center instead of the ED.

It was noted that this is mainly going to be geographic and will depend upon the model.

III. Next Steps

- John DeRonck to provide a list of ESP providers by town to Opal Stone
- Opal Stone will follow up with Diane Schiller and see if she was able to obtain data (including encounter data) from MBHP
- Request additional police data from Sonya Khan
- Sarah Abbott will email the Committee sequential mapping reports for the three RC regions under consideration



**Restoration Center Location & Transportation Committee
Tuesday, January 21, 2020 – 11:00 to 12:00 PM
MEETING NOTES**

In Attendance:

- Advocates - Beth Lacey, SVP Community Services; Tom Wagner, VP of Business Integrity; Craig Gaudette, Senior Operations Director; Danielle Dunn, Senior Director of Integrated Clinical Services & Bob Hallion, Operations Director
- Spectrum Health Systems -Sherry Ellis, COO
- Pear Associates – Alison Gray, President & Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Beth Lacey called the meeting to order and welcomed the participants. All members introduced themselves.

II. Location Discussion

The following three locations have been identified for potential Restoration Center sites:

1. Southeast (Cambridge Somerville (up to Woburn and Waltham)
2. Lowell (The site in Tewksbury is included in this geography)
3. MetroWest

The Planning Committee needs to Identify the pros and cons of each location and focus on 1 – 2 possible sites.

- Who is the population that needs / might use this service? What kind of data do we need to identify the population demands?
 - ESP data / Incarceration data (in the One Year report)
 - Police data (overdose rates?)
 - ER data
 - Census data
- Services: We need to consider what other services are available in the area? What is the services mix?
- Aftercare: We would want to know the availability of higher levels of care. Where are we going to refer people to? It may be that a pro and a con to a specific area is that it is resource-rich or resource-poor. It was noted that 30% of participants typically need to move onto a more acute level of care.
- Real estate availability & cost
- Zoning considerations
- Square footage
- Transportation needs: Access vs. Discharge vs. Aftercare
- Walk-ins (People being identified by 911 - how are they going to get to the RC?)
- Community engagement: Does each geographic area know that this could be an option, and what is the timing behind bringing the community into the planning process?

- Costs/Budget

III. Next Steps

- Beth to determine the address of the vacant building next to Lowell Hospital
- Identify how many people are on Medicaid by town
- Connect with Data Committee on their findings to date
- Identify a coverage radius for each location



**Restoration Center After Care & Services Committee
Tuesday, January 21, 2020 – 1:00 to 12:00 PM
MEETING NOTES**

In Attendance:

- Advocates - Brenda Miele Soares, VP of Behavioral Health Services; Mark Viron MD, Chief Medical Officer; Opal Stone MBA, Director of Reentry Services; John DeRonck, MSW, LICSW, Senior Director of Emergency Services; Danielle Dunn, Senior Director of Integrated Clinical Services; Rob Karr MD, Associate Medical Director and Forensic Director; Sarah Abbott, PhD, Jail Diversion Program Director; Bob Hallion, Operations Director, Theresa Brasier PsyD, Program Director Forensic Services & Amy Donahue Vice President, Performance Management
- Spectrum Health Systems -Sherry Ellis, COO
- Pear Associates – Alison Gray, President; Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Brenda Soares called the meeting to order and welcomed the participants. All members introduced themselves.

II. Discussion

Brenda invited Amy Donahue to the meeting to facilitate a conversation around Structural Options for the Restoration Center. The Commission is looking for the Planning Committee to develop a list of the services that we would recommend for these structures and the pros and cons of each as well.

Amy Donohue presented three options as follows:

- a. Inpatient Model: A locked facility that targets a higher risk population
- b. Hybrid Model: Some locked areas that best suit a combination of a high and low-risk population
- c. Community MH Model: Unlocked facility focused on a lower – risk population

It was noted that each option addresses different needs. The Community MH Model, for example, offers fewer services geared toward the higher risk population. Brenda Soares suggested that the Hybrid Model is a good option that would enable the Restoration Center to outsource security to protect the locked area of the Center.

Brenda Soares charged the Committee to start thinking about the pros and cons of each model and the kinds of services that are best suited for each.

The mix of services offered in the Restoration Center is likely to be proportional to the more secure services that you need. As we address what service belongs in what model – it was suggested that they could all offer the same services. However, the needs of the community will drive how much of each service will be required.

The following service options were discussed:

1. Triage/ESP/Crisis Line in all three options. The Planning Committee would recommend the inclusion of a Restoration Center 24-hour crisis line.
2. Preventative community support in all three models—pre-crisis preventative outreach.
3. High security
4. “Dorming” capacity: It was noted that some people do not qualify for inpatient, so a “dorming” option is helpful.
5. A small CSS (full detox is 90 days) to support patients that the Restoration Center detoxes. Small unit to accommodate those coming out of CSS transition center.
6. Outpatient Treatment Program / MAT. Can prescribe all three medications used to treat addiction: Methadone, Naltrexone & Buprenorphine. Addicts must take more responsibility for their treatment. The goal is to bring the patient into the Restoration Center, stabilize them, and move them back out into the community. The hybrid model would need to offer Methadone in the RC. Sherry Ellis noted that the staffing for OTP requires nursing on-site and is open seven days a week.

Brenda Soares noted that the Committee needs to think about three models in each of the recommended locations, and how much these models are going to be utilized. What do you need most and more of in each community & how does that influence the services that you can afford to put in that location?

How long do people need to access services, and from how far away are people coming from?

III. Next Steps

- The committee is going to meet on Thursday, January 22nd at 10:00 to continue mapping out the services for each structure
- Sarah Abbott is going to share data with the Committee that will help facilitate the discussion around what each model will look like in each location.
- Sherry Ellis suggested that the Committee reach out to Kristen Nolan at Spectrum to help understand where a sobering unit would go in each of these options.



**Restoration Center Data and Analysis Committee
Monday, January 27, 2020 – 12:00 to 1:00 PM
MEETING NOTES**

In Attendance:

- Advocates – Sarah Abbott, Ph.D., Jail Diversion Program Director; John DeRonck, MSW, LICSW, Senior Director of Emergency Services; Opal Stone, MBA, Director of Re-Entry Services; Theresa Brasier PsyD, Program Director Forensic Services; Diane Schiller, VP of Data Analytics
- Pear Associates – Alison Gray, President; Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Opal welcomed the Committee, reviewed the work from last week, and flagged some dates for deliverables.

II. Discussion

- Opal Stone provided some updates on the status of the data collection. She noted that when Brenda presents to the Commission next week, she will address timelines for completion. There is an internal meeting Tuesday with Catia Sharp to review & prepare the presentation.
- Data Analysis:
- Diane Schiller will obtain and share 2020 national census data for all the towns under consideration for the Restoration Center.
- The national census data is slightly different than the census data from Middlesex county:
 - Town/Zip Code
 - Median Home Value
 - Median Household Income
 - % who Own versus Rent
 - % Race, White, Black Asian & Other
- Diane expects to have opioid data by Friday.
- ESP Data: Please see the attached ESP encounter form. We expect this data by Friday. The highlighted fields are what we will receive from MBHP. This data is deidentified member data, and there will be many ways of dissecting it. We will provide an estimate on the completion of the analysis once we have had an opportunity to review the data set.

It was noted that the data outlined above, compiled with Sarah's JDP data, should provide a comprehensive picture of the landscape.

We have enough police encounter data to summarize the characteristics of a person who would use the Restoration Center from MetroWest. We also need to identify this individual for the Southeast.

III. Next Steps

- Diane, Sarah, and Opal will finalize the timeline for the compilation/analysis of data
- The Committee will convene a workgroup for data analysis and agreed that having Catia Sharp join some of those meetings would be of great value
- Committee will work on finalizing what data is available and the timelines for both availability and analysis – Including how do we envision sharing data and what is the work plan and schedule around that?



**Restoration Center After Care & Services Committee
Tuesday, January 28, 2020 – 1:00 - 2:00 PM
MEETING NOTES**

In Attendance:

- Advocates – Mark Viron MD, Chief Medical Officer; Opal Stone MBA, Director of Reentry Services; John DeRonck, MSW, LICSW, Senior Director of Emergency Services; Danielle Dunn, Senior Director of Integrated Clinical Services; Rob Karr MD, Associate Medical Director and Forensic Director; Sarah Abbott, PhD, Jail Diversion Program Director; Bob Hallion, Operations Director; Keith Scott, VP of Peer Supports and Self Advocacy & Theresa Brasier PsyD, Program Director Forensic Services
- Spectrum Health Systems - Sherry Ellis, COO
- Pear Associates – Alison Gray, President; Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Opal Stone called the meeting to order and welcomed the participants. All members introduced themselves.

II. Discussion

- The Committee reviewed the service mix by location and discussed as a group what makes the most sense. We are supposed to have a full aftercare plan in place for all patients.
 - It was noted that the mix of services would vary based upon how many services are around the planned site, and the number of people in the area who have a specific need. How unmet are the needs in the respective community? What does that data look like?
 - The Committee discussed whether they plan to recommend more services beyond just the critical stabilization.
 - The Committee discussed looking at the ER in Framingham and analyzing the wait time for an in-patient bed in Framingham vs. Lowell, as well as establishing a general understanding of wait times.
- The Committee reviewed whether we could have a Living Room model in conjunction with a locked space.
- A private exam room was incorporated into the list of services offered to mirror urgent care services. This room would ideally provide a lab, tox screens & triage. The Committee will look further into how urgent care is outfitted. We want to be able to evaluate vitals, labs, and offer sutures as part of the stabilization process.
- Homelessness/Tent: It is unlikely that the Restoration Center will have a significant impact on any pre-existing homelessness concern in the surrounding area. Alternatively, we need to plan for additional “dorming” capacity to direct people into local treatment programs.

- Location: It was discussed that we need to recommend sites that will allow for the flexibility for adjustments in size. If we plan on initially occupying a smaller footprint – is there room to grow with the expansion?
- Group agreed that training first responders is essential, as also noted in SIMS, and should be included. Training may consist of mental health first aid and eCPR, for example, as well as how to utilize the RC services.
- Group discussed the need to have an innovative programming mix to address the goals of the Restoration Center

III. Next Steps

- Sherry Ellis to review what psychiatric services are available in relevant Emergency Departments and understand what happened to those patients after they were released from the ED back into the Community.
- Caroline Conlin will populate the services currently available in each geographic area.
- Opal will add clarifying information to the services listed in the Restoration Center models, including in response to Danielle's email to highlight the core services. This document will be sent to the Committee for review.
- Committee to identify what training is needed in each recommended location. Considerations include Mental health, first aid, CPR. One does not preclude the other.
- John DeRonck to provide the data for wait time for evaluation requested and the wait time to be seen in the ER.



**Restoration Center Data and Analysis Committee Workgroup
Monday, February 3, 2020 – 12:00 to 1:00 PM
MEETING NOTES**

In Attendance:

- Advocates – Sarah Abbott, Ph.D., Jail Diversion Program Director; John DeRonck, MSW, LICSW, Senior Director of Emergency Services; Opal Stone, MBA, Director of Re-Entry Services; Theresa Brasier PsyD, Program Director Forensic Services; Diane Schiller, VP of Data Analytics

I. Welcome/Introductions

Opal Stone called the meeting to order and welcomed the participants.

II. Discussion

Committee reviewed the census data and began to compile an analysis

The members reviewed the Internet community profile data and research and discussed what a synthesis of this information might look like.

The committee considered the data that was currently available and identified what gaps now exist.



**Restoration Center Data and Analysis Committee Workgroup
Thursday, February 6, 2020
MEETING NOTES**

In Attendance:

- Advocates – Sarah Abbott, PhD, Jail Diversion Program Director; Opal Stone, MBA, Director of Re-Entry Services; Diane Schiller, VP of Data Analytics

I. Welcome/Introductions

Opal Stone called the meeting to order and welcomed the participants.

II. Discussion

The Committee met to identify gaps in the Commission Year One Report, the Abt report, and all Advocates work.

The members analyzed the ESP and Opioid data.

The Committee continued to coordinate analysis efforts with Catia Sharp, and discussed the following:

- Defining "MetroWest" by towns
- Reviewing the list of data needs from the other committees and determining if this information is contained in the Year One Commission report and Appendices.
- Identifying what is completed and what is dependent on the ESP analysis.
- Target Population definitions by type (as listed in the Commission report)
- Police focus groups - who should attend, what questions should be asked?
- Reviewing the report from Sonya Khan and listing the additional analysis needed so that she can run the report for other towns
- Data-related updates from the Commission presentation (MSO/MassHealth data)
- Assigning additional research requests to other Data Committee Members- (ex. Transportation surveys to identify barriers in towns)
- Discussing data needed from EDs (will ESP data provide this? If no, is there another method for getting this information?)



**Restoration Center Data and Analysis Committee Workgroup
Tuesday, February 11, 2020 12:00 – 1:00 PM
MEETING NOTES**

In Attendance:

- Advocates – Sarah Abbott, PhD, Jail Diversion Program Director; Opal Stone, MBA, Director of Re-Entry Services; Diane Schiller, VP of Data Analytics

I. Welcome/Introductions

Opal Stone called the meeting to order and welcomed the participants.

II. Discussion

The Committee reviewed appendices and the report.

Members collaborated on a strategy for Friday's meeting and identified what reports, sections, data was needed.



**Restoration Center After Care & Services Committee
Tuesday, February 11, 2020 – 1:00 to 2:00 PM
MEETING NOTES**

In Attendance:

- Advocates – Brenda Miele Soares, VP Behavioral Health Services; Mark Viron MD, Chief Medical Officer; Opal Stone MBA, Director of Reentry Services; John DeRonck, MSW, LICSW, Senior Director of Emergency Services; Danielle Dunn, Senior Director of Integrated Clinical Services; Rob Karr MD, Associate Medical Director and Forensic Director; Sarah Abbott, Ph.D., Jail Diversion Program Director; Bob Hallion, Operations Director; Theresa Brasier PsyD, Program Director Forensic Services; Diana St. Cyr CMC, Director of Revenue Cycle Management
- Spectrum Health Systems – Kristen Nolan MBA, VP of Inpatient and Outpatient Services
- Pear Associates – Alison Gray, President; Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Brenda Miele Soares called the meeting to order and welcomed the participants. All members introduced themselves.

II. Discussion

The Committee reviewed the budget that Catia Sharp provided. The budget is preliminary and will rely heavily on input from Advocates.

It was observed that the preliminary budget is based upon 30 beds total (10 in triage, 10 in urgent care & 10 in crisis stabilization). The group noted the Spectrum Westborough facility has 62 beds, and patients stay as long as they are scoring according to the American Society of Addiction Medicine's criteria. There are insurance companies that will only allow them to stay five days, so they are staying at least that period.

The budget also assumes that the crisis length of stay is only 24 hours. The group discussed CCS options with 3 – 4-day stays.

Staffing Considerations:

Recovery Specialist: The goal would be to keep the flow of the unit going. For a ten-bed unit, it would require that we budget for one specialist for each shift.

Case Manager: The budget should accommodate one Manager per shift/10 beds, except for the overnight.

Admissions Staff: The budget should plan for one per shift.

Security Guards: 3 Guards, 3 Shifts in plain clothes

Drivers: The preliminary budget does not have drivers on it. We will need to budget for drivers to take care of patients.

Additional Budget Considerations:

- Re-entry options
- Coordinated Case Management

Aftercare Supports

- Should we have EATS beds instead? (Group noted the increased expense of the staffing model for that level of care.)
- Medical assessment needs: Intake and check-in daily.

It was noted that as we plan the Restoration Center, the Commission would like us to flag any legislative barriers.

The Committee discussed pharmacy access and would like to explore options focused on obtaining medication promptly. Would a Genoa Pharmacy be an option?

Once an analysis of the ESP data is available – it will help the Planning Committee evaluate the need by geography.

III. Next Steps

- Bob Hallion is going to confirm volume requirements for Genoa, as the pharmacy chain has surpassed all of the Massachusetts pharmacy regulations.
- Kristen Nolan will send the EATS regulations to the Planning Committee
- Bob Hallion and Brenda Miele Soares will produce a budget for next week, including a paragraph detailing a recommended service mix (w/care management who could manage referrals out).
- Mark Viron will compile a workflow that represents the needs of Doctors and Psychiatrists: If someone walked through the door – what would we want to be doing medically (do we want to have a nurse look at them first, etc.). What would that flow look like? What do we need medically to support the services that we are budgeting for?
- Diana St. Cyr will help provide a greater understanding of third-party options.



**Restoration Center Planning Committee
Tuesday, February 14, 2020 – 9:30 to 10:30 PM
MEETING NOTES**

In Attendance:

- Advocates – Brenda Miele Soares, VP Behavioral Health Services; Mark Viron MD, Chief Medical Officer; Opal Stone MBA, Director of Reentry Services; John DeRonck, MSW, LICSW, Senior Director of Emergency Services; Danielle Dunn, Senior Director of Integrated Clinical Services; Rob Karr MD, Associate Medical Director and Forensic Director; Sarah Abbott, Ph.D., Jail Diversion Program Director; Bob Hallion, Operations Director; Theresa Brasier PsyD, Program Director Forensic Services; Diana St. Cyr CMC, Director of Revenue Cycle Management; Diane Schiller, VP of Data Analytics; Craig Gaudette, Senior Operations Director
- Pear Associates – Alison Gray, President; Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Brenda Miele Soares called the meeting to order and welcomed the participants. All members introduced themselves.

II. Budget Discussion

Brenda Miele Soares and Bob Hallion met to draft a budget. The exercise highlighted that they need to have a better understanding of Restoration Center utilization.

The Committee reviewed the list of services that the Commission would like to see in the Restoration Center, including:

- Crisis Stabilization
- Respite
- Mobile Crisis Teams
- Case Management and Navigation Services
- Transportation Services
- Outpatient Treatment
- Urgent Psychiatric Treatment
- Psychopharmacology including MAT

The discussion also reviewed the following:

- Is this the right group of services for the people that we are targeting?
- Advocates will work with Spectrum to figure out what the systems should look like in the Restoration Center (i.e., Brenda Miele Soares would like to understand staffing an EATS (Enhanced Alcohol Treatment Services) better)
- The budget currently accounts for a 14-day stay
- The budget combines triage and assessment.

- In planning the budget, nurses were switched out with EMTs because nurses are cautious and send people to the ED. EMTs medically clear people in the community, and this is our goal. EMTs can decide whether or not an individual goes to the ED.
- It was noted that police drive further to avoid bringing someone who is not sober to the PD.
- The planning budget to date includes an Eligibility Coordinator.
- The planning budget should also include a room where patients can relax, enjoy a coffee, sandwiches, etc.

III. Data and Analysis Update

Opal Stone provided the Planning Committee with folders incorporating all the data compiled to date. The packets provided Committee members with an overview of how the data is collected, analyzed, and detailed. An overview highlighted which Committee will benefit from the information extrapolated from the initial analysis.

Data Collection to date includes the following:

- MSO Police Survey Data:
 - Hospital Catchment Areas: Identifies hospital coverage in Middlesex County
 - Diversion Programs: Highlights diversion programs in Middlesex County
 - Dispatch Protocol: Identifies who responds to a behavioral health emergency
 - Emergency Medical Transportation: Identifies what ambulance contractor is servicing what areas. From an operations perspective, police would prefer to see patients transported by ambulances.
 - Restoration Center Transportation
- Census data (National database projected out to 2020): Provides you with insight into the economic structure of a town/city. The race information is not as granular as we would like it to be, but it remains an essential piece of data.
- Advocates JDP Encounter Data: Identifies ED diversion and insurance coverage
- MBHP ESP Data for 2019: Highlights how people move through the system, ESP encounters by region/town & estimates the Restoration Center utilization (target population size).
- Incarceration Data: Provides information from individuals currently incarcerated in the Middlesex County House of Correction on addresses (by town) to which they expect to release.

III. Next Steps

- The Data and Analysis Committee will continue to refine and obtain relevant data.



**Restoration Center Data and Analysis Committee Workgroup
Friday, February 14, 2020
MEETING NOTES**

In Attendance:

- Advocates – Sarah Abbott, Ph.D., Jail Diversion Program Director; Opal Stone, MBA, Director of Re-Entry Services; Schiller, VP of Data Analytics

I. Welcome/Introductions

Opal Stone called the meeting to order and welcomed the participants.

II. Discussion

Committee met to compile remaining data, organize and submit folders to the Restoration Center Planning Committee members.



**Restoration Center Data and Analysis Committee Workgroup
Monday, February 17, 2020, 12:00 – 1:00 PM
MEETING NOTES**

In Attendance:

- Advocates – Sarah Abbott, PhD, Jail Diversion Program Director; Opal Stone, MBA, Director of Re-Entry Services; Diane Schiller, VP of Data Analytics

I. Welcome/Introductions

Opal Stone called the meeting to order and welcomed the participants.

II. Discussion

Committee further developed an analysis of the target population



**Restoration Center Location & Transportation Committee
Tuesday, February 18, 2020 – 12:00 to 1:00 PM
MEETING NOTES**

In Attendance:

- Advocates - Beth Lacey, SVP Community Services; Craig Gaudette, Senior Operations Director; Diana St. Cyr CMC, Director of Revenue Cycle Management; Danielle Dunn, Senior Director of Integrated Clinical Services & Keith Neill, CFO
- Spectrum Health Systems -Sherry Ellis, COO
- Pear Associates – Caroline Conlin, Operations and Project Manager
- VIA – Grant Rowland, US Regional Lead - Partnerships

I. Welcome/Introductions

Craig Gaudette called the meeting to order and welcomed the participants. All members introduced themselves.

II. Location Discussion

Craig Gaudette introduced Grant Rowland of VIA and VIA for Health. VIA is a global technology company that focuses on shared rides, partnering with public transportation agencies to alleviate traffic congestion. Uber and Lyft digitalized the taxi. VIA digitalized public mobility/ transportation by deploying transportation support in different manners throughout the world. VIA strives to create public mobility and access for all people within the network. VIA provides branding, marketing, the technology-focused on the client.

The Committee discussed three VIA models:

- SaaS: Use the VIA technology with an existing fleet
- Transit as a Service: Rent VIA vehicles by the hour to support the Restoration Center's needs.
- Consumer: Two-sided marketplace for riders (NYC, Washington DC, Chicago). Same as Uber and Lyft, except that they are shared rides.

Medical Transportation:

- VIA for Health: automated, dynamic, efficient network, optimized for scheduling (know where the fleet is down to the minute), transparent operation.
- Seats in the Vehicles: Assigns the rides based upon the number of seats available.
- Discussion ensued about whether we want the technology solution or the transportation solution. How much capacity do we need? VIA would own the fleet. The price of the fleet would be paid for by MSO. How much capacity do we need? Are we going to be paying for the capacity over time? We would have to estimate how many vehicle hours you would need over some time. From a financial perspective, it is a flexible model.
- VIA is intriguing because we need to identify how we get people to the RC if it is further away from a police officer's immediate community. Do we train the police officers on the VIA app, and they can access the transportation to the Restoration Center? The

proposed partnership would be a closed system that is managed by VIA and the Restoration Center.

- The vehicles are outfitted appropriately.
- The minimum vehicle requirement/deployment: 4 – 5 vehicles.
- We need to identify where the majority of the population originates by geographic location.
- As we evaluate transportation options, we should note that ambulances get paid per run

III. Next Steps

- Beth Lacey: Present to the Commission the pros and cons of each location and a recommendation of the most appropriate location for the Restoration Center. One piece of data is that there is a considerable incarceration rate in Lowell – which is a “pro” for Lowell.
- Craig: Identify if there are any transportation options that we may be missing: *How do we get people to the RC, how do we get them home and if you voluntarily want to go to the Center – how would you get there? If we build it, how do we get people there?*



**Restoration Center After Care & Services Committee
Tuesday, February 18, 2020 – 1:00 to 1:45 PM
MEETING NOTES**

In Attendance:

- Advocates – Brenda Miele Soares, VP Behavioral Health Services; Opal Stone MBA, Director of Reentry Services; John DeRonck, MSW, LICSW, Senior Director of Emergency Services; Danielle Dunn, Senior Director of Integrated Clinical Services; Rob Karr MD, Associate Medical Director and Forensic Director; Bob Hallion, Operations Director; Theresa Brasier PsyD, Program Director Forensic Services
- Pear Associates – Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Brenda Miele Soares called the meeting to order and welcomed the participants. All members introduced themselves.

II. Discussion

Bob Hallion and Brenda Miele Soares are building a budget based upon the following assumptions:

- 30 beds
- 15 detox beds (only qualify for licensing with 15 beds) They looked at 15 beds as a smaller option. It is less money and eliminates third party payments.
- The group discussed that a determination had been made in the Commission meeting that the Restoration Center could provide evaluations for Section 12s but would not be a holding facility.
- The Restoration Center will not admit Section 35s.

The Committee reviewed the MBHP/ JDP data:

- The total # of encounters should include private insurance.
- Community vs. ED and diversion rate only includes Mass Health.
- Diane Schiller presented FY 2019 data with private insurance and Mass Health: Youth is excluded. Diane's data indicates that the demand will be around 12 patients a day.
- Can we get the homelessness information for each of the regions? Would the Massachusetts Health Policy Commission Report be helpful?

III. Next Steps

- Opal Stone to explore the availability of post – arraignment data
- Opal Stone will investigate the homelessness information for each geographic area.
- Committee to explore the Lowell probation population, and identify what services are needed



**Restoration Center Data and Analysis Committee Workgroup
Monday, February 24, 2020 12:00 – 1:00 PM
MEETING NOTES**

In Attendance:

- Advocates – Sarah Abbott, Ph.D., Jail Diversion Program Director; Opal Stone, MBA, Director of Re-Entry Services; Diane Schiller, VP of Data Analytics

I. Welcome/Introductions

Opal Stone called the meeting to order and welcomed the participants.

II. Discussion

Committee reviewed the JDP data, collaborated on a synthesis of all data and worked on the progress report.



**Restoration Center Location & Transportation Committee
Tuesday, February 25, 2020 – 12:00 to 1:00 PM
MEETING NOTES**

In Attendance:

- Advocates - Beth Lacey, SVP Community Services; Opal Stone MBA, Director of Reentry Services; Danielle Dunn, Senior Director of Integrated Clinical Services; Bob Hallion, Operations Director
- Spectrum Health Systems – Sherry Ellis, COO
- Pear Associates – Alison Gray, President; Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Beth Lacey called the meeting to order and welcomed the participants. All members introduced themselves.

II. Location Discussion

Beth Lacey encouraged members of the Committee to review the available data and identify the pros and cons of each recommended geographic location. The Committee referenced the “Middlesex Restoration Commission Location Committee Data Review” reference slide deck for the meeting (attached).

ESP Encounter Data: Homeless Status

- This data indicates that the most significant homelessness population currently exists in Lowell. This could be considered a “pro” for building the Restoration Center in Lowell. However, it could also be a “con,” as the area might not have adequate services to support the discharged patients.
- The ESP homelessness numbers are indicative of a population that should feed directly into the Restoration Center.

ESP Encounter Data: Final Disposition

- There is a belief that the 30 beds will be used every night. It may be helpful to look at diversionary services that are or are not available and compare it to inpatient numbers.
- ESP data indicates, among other things, that there is a similar number of people in all three geographies that could benefit from a Restoration Center.

Beth Lacey looked at two properties in Tewksbury – a former hospital and a house. She does not think that either of them will be feasible options due to the anticipated amount of work required to bring them both up to code.

Beth Lacey noted that there is an abandoned hospital in Malden that they would like to consider for a Restoration Center.

Hospital Catchment Area Data

- The Committee noted that the S.E. Region has many EDs and discussed presumed high levels of service coordination complexity.

Emergency Medical Transportation Data

Once the Restoration Center contract is awarded, the vendor will need to work with emergency medical transportation companies.

Regions and Disposition Data

- Southeast: High number of Emergency departments.
- Lowell has a high rate of poverty relative to other towns and regions under consideration, whereby the towns around it are more affluent. Mental Health issues are the biggest concern in this area, paired with substance abuse issues.

Lowell Data / Information

- Mental health issues are the biggest concern, paired with substance abuse issues.
- From a need perspective, there is a large, poor immigrant population who are also homeless
- Data indicates a high number of ESPs
- There is no inpatient psychiatric unit in that area
- The Committee is concerned about bringing people into a Restoration Center, and not having anywhere for them to go. Case management is critical. We need to set people up for success.
- There must be an organization that supports the social determinants of health.

MetroWest Data/Information

- There is more service availability in MetroWest than Lowell. Poverty is lower, and needs in Framingham and Marlborough are high.

Southeast Region Data/Information:

- Service coordination complexity in this area would make piloting the first RC here more challenging. Also, there are many EDs & the real estate costs are high

Spectrum just purchased and rehabbed two buildings. They noted that with the growth of the economy, building costs have significantly increased. The group discussed the disincentive of leasing buildings that require extensive renovations and costs. The break-even over time would have to be factored into any contracts to justify the renovation costs.

III. Next Steps

- The Natick ED is closing and should be removed from the police survey data slides.
- Identify Gateway cities in towns under consideration



**Restoration Center After Care & Services Committee
Tuesday, February 25, 2020 – 1:00 to 2:00 PM
MEETING NOTES**

In Attendance:

- Advocates – Brenda Miele Soares, VP Behavioral Health Services; Opal Stone MBA, Director of Reentry Services; Mark Viron MD, Chief Medical Officer; Danielle Dunn, Senior Director of Integrated Clinical Services; Bob Hallion, Operations Director
- Pear Associates – Alison Gray, President; Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Brenda Miele Soares called the meeting to order and welcomed the participants.

II. Budget Discussion

Preliminary real estate considerations have indicated that a Restoration Center might need to budget approx. \$8 million for the building itself.

- If this is a pilot, the Committee discussed that it would be difficult for a provider to pick up an \$8 million project as a pilot.
- For budgeting purposes, Bob Hallion is assuming \$100 per square foot for renovations.
- Funding, utilization volume, and projected ramp-up will be key components in the final report
- The existing budget assumes 35 beds
- Brenda Soares would like to incorporate staffing into the budget for EATS beds.
- We were going to look at reducing the bed requirements for ATS / EATS.
- ATS requires a minimum of 15 beds to bill for it.
- EATs beds help with patients with co-occurring disorders.
- You need to meet the minimum number of beds to bill.
- DMH respite was removed because DMH is not procuring.
- Sober beds do not maintain rules around staffing because you cannot bill for it.
- Need to finalize the mix of beds in the Restoration Center

III. Progress Report

Opal Stone will meet with Catia Sharp on Monday, March 2, 2020, to review the report and presentation

- Opal Stone is synthesizing the content from all the Restoration Center planning meetings for inclusion in the progress report.
- The MSO has confirmed that this report is the first deliverable, and will be reviewed Wednesday, February 26, 2020.
- The focus of this report has been data collection and how the data has informed other committees. The following will also be documented:
 - What did we say that we were going to do?
 - What data collection did we do?
 - What still needs to be done?

- Advantages / Disadvantages of each of the geographies
- Licensing Considerations
- Legislative barriers
- No Wrong Door Approach

IV. Next Steps

- Brenda Soares and Bob Hallion will create a budget for a sobering bed center
- Brenda Soares will follow up with Spectrum to understand how they manage sobering units (Are comfort meds provided? How is it laid out in the facility? How is it staffed? Do they take detox patients as walk-ins?)
- Bob Hallion to add linen expenses to the budgets
- Bob Hallion to incorporate washing machines and dryers into the budgets



**Restoration Center Data and Analysis Committee Workgroup
Monday, March 2, 2020 12:00 – 1:00 PM
MEETING NOTES**

In Attendance:

- Advocates – Sarah Abbott, Ph.D., Jail Diversion Program Director; Opal Stone, MBA, Director of Re-Entry Services; Diane Schiller, VP of Data Analytics

I. Welcome/Introductions

Opal Stone called the meeting to order and welcomed the participants.

II. Discussion

Committee met to prepare for the final Restoration Center Planning Commission Presentation.



**Restoration Center After Care & Services Committee
Tuesday, March 10, 2020 – 12:00 to 2:00 PM
MEETING NOTES**

In Attendance:

- Advocates – Brenda Miele Soares, VP Behavioral Health Services; Beth Lacey, SVP Community Services; Craig Gaudette, Senior Operations Director; Opal Stone MBA, Director of Reentry Services; Mark Viron MD, Chief Medical Officer; Danielle Dunn, Senior Director of Integrated Clinical Services; Bob Hallion, Operations Director; John DeRonck, MSW, LICSW, Senior Director of Emergency Services; Theresa Brasier PsyD, Program Director Forensic Services; Rob Karr MD, Associate Medical Director and Forensic Director
- Pear Associates – Alison Gray, President; Caroline Conlin, Operations and Project Manager

I. Welcome/Introductions

Brenda Miele Soares called the meeting to order and welcomed the participants.

II. Budget Discussion

Bob Hallion and Brenda Miele Soares reviewed the budget template that they established for the planning of the Restoration Center. They created the budget so that calculations can be easily adjusted.

The planned Restoration Center budget makes the follow quantitative assumptions:

- (10) DMH Respite beds
- (10) Crisis Stabilization beds
- (10) ATS/Sober Beds

Based on ESP data, it is assumed that the Restoration Center will have approx. 6 walk-ins/day.

If the Restoration Center is planning on billing at the ESP rate, an ESP provider will have to bid on the RC, or the agency will have to get a waiver to run the Restoration Center.

The planned Restoration Center budget assumes a 50% ESP utilization rate

The conversion rate from sobering and moving on to additional services is low and considered a short-term stay facility.

The following variable expenses were noted:

- The more beds that are added, the more staff will be required
- The number of food service staff and meals

The following costs were incorporated into the budget:

- Food service staff
- Food & Beverage
- Office Supplies
- Medical and Household supplies
- Transportation
- Professional Liability Insurance
- Administrative Overhead

In the planned Restoration Center, the Triage section will take the calls and verify the insurance. The ESP team would triage people, and all services would be made available for the short term, including care management and ongoing coordinated care.

The budget template is based upon a 14,000 square foot Center. The Tucson buildings were 28,000 and 56,000 feet.

The Committee discussed the recent trip to visit several Restoration Centers in Tucson. They noted that there were security concerns involving weapons. Staff addressed this issue by taking the client's clothing, inventorying their belongings, and use of electromagnetic wands (wand = \$150).

One of the Centers in Tucson had 40 beds in the triage area and allowed patients to stay up to 23 hours. Their equivalent of MassHealth paid the Center for the required service, no matter what it was. In the alcohol center that they visited, no stay was longer than five days.

For ease of identification, each staff member was dressed in different colored scrubs depending upon their title. It is easier for people to identify others when they are color-coded.

The Committee discussed that infection control questions should be anticipated, as plans for the Restoration Center continue to unfold.

Other considerations from the Tucson visit:

- A dedicated police entrance is helpful to avoid intimidation from police officers being in the general area
- Center staff released handcuffs to help prevent further discussions between the police officer and the patient
- The Tucson centers call their patients "familiar faces."
- The Tucson Police who brought patients to the Centers were dedicated to that job and did not answer any other calls during that shift.
- The CRS Center sometimes transfers patients to the sobering unit
- The Alcohol focused Center had 100 beds, and 40 of them were triage beds that were filled. The Center needs to fill 20 of those beds to make money.

III. Transportation Model

- Transportation considerations need to a) Get people to the Center b) Bring people out of the Center and c) Bring patients to support care
- It is not likely that police will provide any transportation to the Center outside of their immediate service area. Through surveys, police indicated that they would prefer to

have ambulances handle the inpatient. Ambulances would have to each contract with the Restoration Center. If an ambulance were to operate outside of their typical service area, they would need to be reimbursed.

- To be successful, we would need a system that would facilitate communication between ambulances (if not local) and the police.
- Group discussed barriers with Uber. For it to work correctly, the rider must agree to the Uber terms, which only the person requesting the ride can do. The Restoration Center cannot assume that responsibility.
- VIA can customize transportation vans and offer more security to the drivers. VIA also provides the Center with a transportation option that gets people home.
- It was noted that response time will be critical and needs to be under 20 minutes.
- Costs that need to be considered include:
 - Insurance
 - Vehicles
 - Staffing of Vehicles
- Paid first responders should be considered when weighing local transportation options.

IV. Community Specific Pros / Cons

- There are three viable areas for consideration: Lowell, MetroWest, and the Southeast region.
- Lowell has several surrounding towns that are considered bedroom communities
- MetroWest is a very wealthy community overall – with the most significant Restoration Center opportunity in Framingham and Marlborough.
- In the Southeast, there are a lot of hospitals, the real estate is expensive, and there are already many services in the area (shelters). The upside to this area is the availability of transportation options.
- There are several different types of real estate options to consider:
 - Class A/B office space
 - Class C office space (i.e., old office space in a city)
 - Religious / “Rooming House” venues
 - Warehouses
 - State properties (do not have to worry about zoning issues)
- It was noted that there would be Community concerns no matter where this Restoration Center is situated.
- One floor space would be ideal, and two floors would be considered if it made sense for administrative use only.

Next Steps

- Bob Hallion to forward an updated draft budget template to the Committee
- Bob Hallion will add pricing for marketing, training, interpreters and other startup costs to the budget
- Bob Hallion to add pricing for renovations – assuming \$100 square foot
- Bob Hallion to review the difference between an “ESP Rate” and an “Urgent Care” rate on the budget and determine whether a blended rate should be incorporated into the numbers.
- Brenda Miele Soares to identify specific security concerns in Tucson
- Brenda Miele Soares to draft a budget for an advanced detox model Restoration Center
- Craig Gaudette to explore costs for VIA
- A draft report will be written by 3/20. The draft of 3/27 will be a professionally written complete draft so that leaders of the commission can provide feedback.

Appendix 5: Preliminary List of Region-Specific Services

The following is a preliminary list of region-specific resources compiled during the planning phase. Advocates recognizes that this list is not comprehensive and is designed to provide a high-level picture of the resources available in each studied area.

LOWELL REGION

| |
|---|
| <u>Psychiatric Inpatient:</u> |
| - |
| <u>Adult CCS</u> |
| Beth Israel Lahey Health CCS Program |
| Afya Home Care |
| <u>ESP (Emergency Service Provider)</u> |
| Beth Israel Lahey Health |
| <u>Partial Hospitalization (Day)</u> |
| Lowell Community Health Center |
| Lowell General Hospital |
| Metta Health Center (Focused on SE Asian & Refugee Populations) |
| Circle Health Urgent Care |
| <u>EATS (Enhanced Detox) Acute MH and SA</u> |
| Beth Israel Lahey Health: Tewksbury Treatment Center |
| <u>Detox (ATS)</u> |
| Lowell House: Zack's House/ Glenice Sheehan Women's Program |
| Lahey Behavioral Services |
| <u>Intensive Outpatient/SOAP for SA</u> |
| Arbour Counseling Services |
| Lowell House: Hanover House, Savings Grace |
| Lowell House (SOAP): Structured Outpatient Addictions Program |
| Circle Health |
| Lowell House: Men's Recovery Home |
| <u>Detox Step-Down</u> |
| None |
| <u>Adult Day Programs</u> |
| New England Community Cares |
| <u>Methadone/Suboxone Clinics</u> |
| South Bay Mental Health Opioid Addiction Center |
| Lowell Community Health Center |
| Lahey Behavioral Services Tewksbury Treatment Center |
| <u>CSP (Community Support Program)</u> |
| Lowell Alliance for Families and Neighborhoods |
| Lowell Hunger Homeless Commission |
| Greater Lowell Health Alliance |

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| Living Waters, Center of Hope |
| Northeast Independent Living Center (Lawrence) |
| Beth Israel Lahey Health Behavioral Health Community Partner Program |
| Lowell House: CO-OP |
| Lowell House (LHATR) Supportive Case Management |
| Center for Hope and Healing |
| Lowell Community Health Center |
| Vinfen Community and Family Counseling Services |
| Middlesex DUII Program |
| <u>Outpatient (Mental Health and/or Substance Abuse)- Adults</u> |
| Beth Israel Lahey Health Mobile Crisis Intervention |
| Column Health |
| Habit Opco, Inc. |
| The Outpatient Clinic |
| Lowell House Inc Outpatient Substance Abuse Services |
| Lowell Community Health Center |
| Beth Israel Lahey Transitional Support Services |
| Clean Slate Outpatient Addiction Center |
| <u>Shelters (for individuals)</u> |
| Lowell Transitional Living Center |
| Bridgewell Pathfinder Residential Program |
| Lowell House (LHATR) HOPWA: Housing opportunities for people with AIDS |
| <u>Shelters (for families)</u> |
| - Alternative House |
| - House of Hope |

METROWEST

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| <u>Psychiatric Inpatient:</u> |
| MetroWest Hospital (Natick) |
| Marlborough Hospital |
| Westborough Behavioral (Westborough) |
| Taravista Behavioral Health Hospital (Devens) |
| Newton-Wellesley (Hospital) |
| Walden Behavioral (Waltham) |
| <u>Adult CCS</u> |
| None |
| <u>ESP (Emergency Service Provider)</u> |
| Framingham: Advocates |
| <u>Partial Hospitalization (Day)</u> |
| MetroWest (Natick) |
| Marlborough Hospital |

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| Westborough Behavioral |
| <u>EATS (Enhanced Detox) Acute MH and SA</u> |
| None |
| <u>Detox (ATS)</u> |
| Westborough: Spectrum |
| Westborough: New England Recovery Center |
| <u>Intensive Outpatient/SOAP for SA</u> |
| None |
| <u>Detox Step-Down</u> |
| Westborough: Spectrum Residential and TSS |
| Worcester: Passages |
| <u>Adult Day Programs</u> |
| Framingham: Programs for People |
| Marlborough: Employment Options |
| <u>Methadone/Suboxone Clinics</u> |
| Framingham: Spectrum Outpatient |
| Framingham: New Horizons (Suboxone, no Methadone (in Framingham clinic)) |
| Spectrum (Westborough) |
| Woburn: Arbour (Woburn) |
| <u>CSP (Community Support Program)</u> |
| Framingham/Marlborough: Advocates |
| Watertown & Newton: Riverside |
| <u>Outpatient (Mental Health and/or Substance Abuse)- Adults</u> |
| Advocates, Acadia, Aurora, Castlebrook, DCS, Framingham Center for Healing, Framingham Counseling, Genesis, MetroWest Counseling, Psych Services (Natick), SMOC, Spectrum |
| <u>Shelters (for individuals)</u> |
| Turning Point (Framingham), Marlborough Shelter (Mechanic St.), Shadows (women's shelter in Ashland), Bristol Lodge (separate men's and women's shelters) in Waltham |
| <u>Shelters (for families)</u> |
| Pathways (Framingham), SMOC (Framingham), Winterhaven (Milford), Hestia House (Waltham) |

SOUTHEAST

Psychiatric Inpatient:

Somerville: Cambridge Health Alliance

Waltham: Walden Psychiatric Care

Adult CCS

Waltham: Advocates

ESP (Emergency Service Provider)

None

Partial Hospitalization (Day)

Medford: Melrose-Wakefield Hospital
Somerville: Cambridge Health Alliance

EATS (Enhanced Detox) Acute MH and SA

Somerville: Column Health

Detox (ATS)

Waltham: Hurley House

Intensive Outpatient/SOAP for SA

Waltham: Spectrum Outpatient Treatment Center

Waltham: The Psych Garden (Belmont)

Waltham: Walden Behavioral Care

Cambridge/Somerville: Riverside Outpatient Center

Allied Health Services of Medford

Detox Step-Down

None

Adult Day Programs

Cambridge/Somerville: CASPAR

Methadone/Suboxone Clinics

Waltham: Spectrum Outpatient

CSP (Community Support Program)

Medford: DCS Mental Health

Waltham: Riverside

Outpatient (Mental Health and/or Substance Abuse)- Adults

Waltham: Tharras House (Lexington)

Waltham: Spectrum Outpatient Treatment Center

Shelters (for individuals)

Medford: Medford Family Life Education Center

Cambridge/Somerville: CASPAR

Somerville Homeless Coalition - Adult Shelter

Somerville: St. Patrick's Shelter - Homeless Shelter for Women

Waltham: Bristol Lodge Women's Shelter

Y2Y Young Adult Shelter

Waltham: Bristol Lodge Men's Shelter

Shelters (for families)

Somerville Homeless Coalition - Family Shelter

Waltham: Mary's House Family Shelter

X. CITATIONS

i

https://www.mamh.org/assets/files/Restoration%20Center%20Commission%20Findings%20and%20Recommendations_FINAL%20Appendix%20Volume.pdf

ii Middlesex County Restoration Center Commission Launch Meeting, April 2, 2018 presentation slides.

iii Ibid.

iv <https://malegislature.gov/Laws/SessionLaws/Acts/2018/Chapter69>

v

https://www.mamh.org/assets/files/Restoration%20Center%20Commission%20Findings%20and%20Recommendations_FINAL%20Appendix%20Volume.pdf

vi <https://www.judiciary.senate.gov/imo/media/doc/02-10-16%20Osher%20Testimony.pdf>

vii

<https://data.census.gov/cedsci/table?q=s1601&g=0600000US2501701605,2501702130,2501705070,2501705805,2501713135,2501711000&hidePreview=true&tid=ACSST5Y2018.S1601>

viii <https://lowellma.gov/526/Continuum-of-Care-Homelessness-Assistance>

ix <https://www.towncharts.com/Massachusetts/Demographics/Framingham-CDP-MA-Demographics-data.html#Figure44>

x <https://www.wbjournal.com/article/brazilian-americans-have-transformed-metrowest-communities-like-framingham-and-marlborough>



Middlesex County Restoration Center Commission
Thursday, September 19, 2019
State House Room 222, Boston, MA

AGENDA

- | | |
|-------------------|---|
| 10:00AM – 10:05AM | Welcome and Introductions <i>Co-Chairs, Sheriff Koutoujian and Danna Mauch</i> |
| 10:05AM – 10:10AM | Legislative Update <i>Senator Friedman and Representative Gordon</i> |
| 10:10AM – 10:20AM | Approval of Minutes from Year One <i>Co-Chairs, Sheriff Koutoujian and Danna Mauch</i> |
| 10:20AM – 10:40AM | Review Recommendations from Year 1 <i>Senator Friedman</i> |
| 10:40AM – 11:00M | Proposed Meeting Schedule and Work Plan <i>Danna Mauch</i> <ul style="list-style-type: none">• Potential funding pathway for SFY 2021: House 1 |
| 11:00AM – 11:15AM | Planning Grant Procurement <i>Sheriff Koutoujian</i> |
| 11:15AM – 11:25AM | EOHHS Request for Information Commission Response <i>Danna Mauch</i> |
| 11:25AM – 11:30AM | Next Steps and Closing <i>Co-Chairs, Sheriff Koutoujian and Danna Mauch</i> |



**Middlesex County Restoration Center
Thursday, September 19, 2019
State House Room 222
Boston, MA**

MINUTES

Attendees: Sheriff Peter J. Koutoujian, co-chair; Danna Mauch, Massachusetts Association for Mental Health, co-chair; Senator Cindy Friedman; Representative Kenneth Gordon; Scott Taberner, MassHealth; Nancy Connolly, Department of Mental Health; Marisa Hebble, MA Trial Court; Elizabeth Berman, Office of Senator Cindy Friedman; David Ryan, Middlesex Sheriff's Office; Michael Blatus, Middlesex Sheriff's Office; Catia Sharp, Middlesex Sheriff's Office; Rachel Bishop, MassHealth; June Binney, Health and Justice Strategies.

10:00 AM: WELCOME AND INTRODUCTION

Danna Mauch called the meeting to order. Danna asked for Commission members and community members in the room to introduce themselves. The Commission welcomed Elizabeth Berman from Senator Friedman's office to her first Commission meeting.

10:05 AM: LEGISLATIVE UPDATE

Senator Friedman noted that the state fiscal year 2020 budget included \$250,000 in funding for the Commission. Senator Friedman and Representative Gordon had no other updates on pending legislation to share with the Commission.

Danna Mauch thanked the Commission and staff members for their work on the Commission Findings and Recommendations, which were filed with the legislature in June. She noted the strong effort that Catia Sharp provided the Commission in preparing, reviewing, and promulgating the year one report.

10:10 AM: APPROVAL OF MINUTES FROM YEAR ONE

Danna Mauch noted that minutes from the first year of the Commission were prepared for approval by the body. However, Scott Taberner noted that the Commission failed to have a quorum, and therefore would not be able to approve the minutes at the current meeting. The item was tabled for a future meeting when a quorum of Commission members would be present.

10:15 AM: REVIEW RECOMMENDATIONS FROM YEAR ONE

Commission members received copies of the recommendations, plan for year two, and executive summary from the Commission Findings and Recommendations report.

Senator Friedman noted that this is the roadmap for the Commission, so the items requiring legislative support to accomplish ought to be identified for a future meeting. Additionally, Senator Friedman observed that there are short, medium, and long-term items on the list, so the Commission should separate the work into streams.

Danna Mauch used this as an opportunity to transition to a discussion about the work plan. She asked Catia Sharp to hand out copies of the work plan and to walk Commission members through it.

10:25 AM: PROPOSED MEETING SCHEDULE AND WORK PLAN

Catia Sharp outlined the three types of recommendations that were included in the Commission Findings and Recommendations: (1) findings related to the operation of a restoration center; (2) additional research on gaps and target population needed after year one; and (3) recommendations for improvements to existing services or programs that are outside of the scope of a restoration center, but would support the mission of the restoration center, including diversion of individuals with behavioral health conditions. The first set of recommendations would be the subject of a planning grant to a service provider who would help the Commission finalize plans for a restoration center, including securing a location and developing a staffing plan. The second set of recommendations would be accomplished through a survey of police departments, data matching between the Middlesex Sheriff's Office (MSO) and MassHealth, and seeking out a specific police department and emergency room that has high-quality data for a more in-depth analysis. The final set of recommendations could, in part, be the subject of a response to the Request for Information expected to be released by the Executive Office for Health and Human Services on redesigning the delivery of ambulatory behavioral healthcare, to be discussed later in the meeting.

Danna Mauch added that the data matching between MSO and MassHealth could build upon similar work already being done by those two agencies.

Sheriff Koutoujian agreed, further elaborating on the MassHealth-funded reentry initiative he is working on and his Data-Driven Justice Initiative, discussed in previous Commission meetings.

Senator Friedman asked how this work plan would identify those individuals who never had any behavioral health services.

Danna Mauch responded that it would attempt to do so, and that it would also be helpful to look at how many individuals become disaffected and drop out of the treatment system as well.

Sheriff Koutoujian agreed, citing the high number of individuals who become detained or incarcerated who don't have a behavioral health diagnosis at the time of their arrival, but are identified for the mental health caseload in the facility.

Senator Friedman thought this was interesting, and it might be helpful to look at common diagnoses as well.

Senator Friedman added that police departments often do not collect this information, so she wanted to make sure that information is being collected from them in the least intrusive possible way.

Sheriff Koutoujian suggested that Sonya Khan, Data-Driven Justice Manager in his office, would be helpful in the police data collection efforts.

Representative Gordon suggested that information from police represent a variety of community types, including both urban and rural.

Catia Sharp responded that this is the goal, but that unfortunately larger, more urban departments tend to have more resources devoted to data collection and maintenance.

Danna Mauch added that this is why the Sheriff's Data-Driven Justice Initiative is so needed, because it will bring this capability to departments with fewer resources.

Senator Friedman sought to ensure that an overall financial plan, including a variety of revenue sources, is included as part of the work plan.

Danna Mauch noted that the comprehensiveness of the Commission's Findings and Recommendations from its first year would be a strong supporting document for fundraising from non-state revenue sources.

Sheriff Koutoujian offered Kashif Siddiqi in his office to assist in grant proposals and fundraising.

Scott Taberner pointed out that fiscal sustainability would be key for a restoration center, so fundraising should account for how to optimize the use of one-time vs sustainable resources. He recommended the inclusion of commercial payers in the funding plan.

Danna Mauch agreed that commercial payers need to be part of the conversation.

Nancy Connolly asked staff to delineate the work streams where help is needed from Commission members.

Danna Mauch agreed, and added that the need for Commission members and other stakeholders can be added to the work plan.

Danna Mauch noted the large amount of work planned for year two, and thanked the Sheriff's office staff and others for their work. She noted the assistance of Dave Ryan, Michael Blatus, and Bridget Cook specifically.

Sheriff Koutoujian raised the prospect of making a third out-of-state site visit to Miami or Tucson, as had been discussed previously.

Danna Mauch shared that she had seen Judge Leifman (who is in charge of the development of a Miami restoration center) and Dr. Margie Balfour (who runs the Tucson restoration center) at a convening the week before, and each was happy to host Commission members. She shared that the Miami center is still under construction, and that there wouldn't be anything to see until at least February. She recommended visiting the Tucson center because it is a good example of the police drop-off process and good clinical management.

Sheriff Koutoujian added that he knows the Tucson police chief and sheriff, and could reach out to solicit meetings with them as well. He suggested that the Commission make a trip to Tucson in the fall.

Scott Taberner agreed, adding that the site visits last year were valuable to crystallize what drive up capacity looks like, what staffing models are

used, and how officer transfers can work. He added that Michigan has a robust Medicaid program, and Bexar County was an eye opener due to the use of Medicaid funds for restoration center funding despite Texas not being an expansion state.

Danna responded that Arizona is not an expansion state, but they have a robust Medicaid funding stream that channels \$165 million to behavioral health emergency response. She offered to share a slide from a behavioral health crisis services conference she had recently attended on the subject. Danna noted that Massachusetts, while having a robust Medicaid program, has a disadvantage in terms of the complexity of the Medicaid delivery system in terms of funding a restoration center.

Commission members present reached consensus to plan a third site visit to Tucson in the fall.

10:55 AM: PLANNING GRANT PROCUREMENT

Sheriff Koutoujian asked his Director of Purchasing, Michael Blatus, to present on the procurement of a planning grantee.

Michael Blatus shared with Commission members that staff were working on a Request for Responses (RFR) to procure a planning grantee to help the Commission plan staffing levels, select a location for a restoration center, and generally prepare to launch services in fiscal year 2022. He noted that the staff conversations to date have assumed that this procurement would only include planning grant services, because a decision has not been made about which state agency would hold the contract for the implementation of services in FY 2022. Therefore, the state agency who is designated to manage the contract for implementation of services would need to hold its own procurement for a service provider to implement a restoration center.

Scott Taberner suggested that it may be valuable to solicit input from the provider community on the open planning questions before releasing the RFR document, because once the document is published, there are strict rules forbidding conversations with potential bidders.

Danna Mauch listed the reviewed opportunities for soliciting planning assistance from the provider community: a Request for Information, an RFR, or a combination of the two. She added that input had been sought from some providers last year through site visits to the Behavioral Health Network and Community Healthlink, while other providers presented directly to the Commission. Danna expressed concern over the compressed time frame that the Commission has to use these tools before their year

two report is due to the legislature in April, and funding must be secured in the state budget for year three. Danna proposed that the Association for Behavioral Healthcare (ABH) and the state agencies represented on the Commission might identify additional providers that they would like to solicit input from, and convene a meeting.

Scott Taberner responded that the Commission ought to access provider expertise in a meaningful way.

Nancy Connolly suggested that this could be done with a number of providers with direct expertise in diversion and re-entry services.

Danna Mauch asked Michael Blatus how the Commission might do this without undercutting the procurement.

Sheriff Koutoujian suggested that it would be important to get the right providers in the room to get helpful and reliable information.

Nancy Connolly suggested delaying posting the RFR a couple of weeks to accommodate a meeting with providers.

Michael Blatus suggested that an RFI could also solicit this type of information.

Dave Ryan said that the procurement could be postponed a couple of weeks to solicit more information from the provider community.

Nancy Connolly asked what the timeline for procurement and contracting is.

Catia Sharp responded that the response window was drafted for three weeks' time to accommodate the submission of high-quality responses, putting an anticipated contract start date around November 1. This would give a short amount of time to work with the selected bidder to develop an implementation plan for a restoration center in time to include the plan in a submission of year two findings and recommendations to the legislature on April 13. She noted that it would be more difficult to submit the report late this year, given the need for a more complex budget request and the timing of the state budget process.

Marisa Hebble asked if the meeting would be kept to only Middlesex County providers, or providers statewide.

Danna Mauch thought the meeting would include statewide providers.

Consensus of the Commission members present was to set up a meeting as soon as possible, before an RFR is published, with the help of ABH, in its role as a member of the Commission.

Dave Ryan added that the procurement for planning services would need to be separated from a procurement in the next fiscal year for implementation of a restoration center given that the Commission may decide that Sheriff's office might not be the ultimate entity to manage the contract for a restoration center.

Sheriff Koutoujian thanked his staff, adding that a lot of work had gone into preparing for this discussion.

11:25 AM: EOHHS REQUEST FOR INFORMATION COMMISSION RESPONSE

Danna Mauch asked Scott Taberner to explain the EOHHS behavioral health ambulatory care redesign process and timeline.

Scott explained that Commissioners of departments across human services agencies have held eight or nine listening sessions across the state to solicit input of a diverse array of stakeholders – from consumers to family members to providers to advocates – on the state of behavioral health services and how to improve them. EOHHS will then release an RFI to solicit written responses on this subject. Scott asked Rachel Bishop from his office, who works more directly on this project, for additional comments.

Rachel Bishop said that staff at EOHHS are still poring through the results of the listening sessions and working on the RFI, but expect to release the RFI in mid- to late-October. They are seeking input on the availability and accessibility of services ranging from outpatient treatment to urgent and crisis care. Rachel noted that from responses reviewed so far, it is clear that walk-in and urgent behavioral health care access is clearly needed.

The Commission members present reached a consensus to respond to the RFI when it is released.

Danna Mauch asked if any of the community members present had any additional comments.

Marisa Hebble shared an initiative at the Trial Court to develop standards on clients with substance use and mental health conditions. They will spend the next year gathering input from a wide range of stakeholders, and invite feedback from Commission members and others.

11:35 AM: NEXT STEPS

Danna Mauch asked Catia Sharp to describe the next steps for the Commission.

Catia Sharp noted that a schedule for meetings for the rest of the calendar year would be forthcoming, which after the current discussion will include a site visit to Tucson. She also listed initiatives that would be opportunities for Commission member involvement, including reviewing respondents for the planning grant award, data sharing projects, the Commission response to the EOHHS RFI, and a meeting with community-based providers prior to release of the planning grant RFR.

11:40 AM: CLOSING

Sheriff Koutoujian and Danna Mauch adjourned the meeting.



**Middlesex County Restoration Center Commission
Tuesday, November 12, 2019
400 Mystic Ave, Medford, MA**

AGENDA

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|-------------------|---|
| 12:00PM – 12:05PM | Welcome and Introductions <i>Co-Chairs, Sheriff Koutoujian and Danna Mauch</i> |
| 12:05PM – 12:10PM | Legislative Update <i>Senator Friedman and Representative Gordon</i> |
| 12:10PM – 12:20PM | Approval of Minutes from Year One <i>Co-Chairs, Sheriff Koutoujian and Danna Mauch</i> |
| 12:20PM – 12:50PM | Police Survey Presentation and Discussion <i>Catia Sharp</i> |
| 12:50PM – 1:00PM | Update on Planning Grant Procurement <i>Sheriff Koutoujian</i> |
| 1:00PM – 1:30PM | Update to Diversion White Paper <i>Danna Mauch</i> |
| 1:30PM – 1:55PM | EOHHS Request for Information Commission Response <i>Danna Mauch</i> |
| 1:55PM – 2:00PM | Next Steps and Closing <i>Co-Chairs, Sheriff Koutoujian and Danna Mauch</i> |



**Middlesex County Restoration Center
Tuesday, November 12, 2019
State House Room 222
Boston, MA**

MINUTES

Attendees: Sheriff Peter J. Koutoujian, co-chair; Danna Mauch, Massachusetts Association for Mental Health, co-chair; Senator Cindy Friedman; Representative Kenneth Gordon; Eliza Williamson, National Alliance on Mental Illness; Scott Taberner, MassHealth; Nancy Connolly, Department of Mental Health; Marisa Hebble, MA Trial Court; David Ryan, Middlesex Sheriff's Office; Michael Blatus, Middlesex Sheriff's Office; Sonya Khan, Middlesex Sheriff's Office; Catia Sharp, Middlesex Sheriff's Office.

12:00 PM: WELCOME AND INTRODUCTION

Danna Mauch called the meeting to order. She reviewed the staff work that has happened since the last Commission meeting: a police survey was circulated; a provider listening session was held; a Request for Proposals (RFP) was released for a planning grantee; and a bidder's conference was held pursuant to the RFP. Danna thanked Michael Blatus and Dave Ryan in the Sheriff's Office for their work on the procurement.

12:05 PM: LEGISLATIVE UPDATE

Senator Friedman and Representative Gordon had no updates on pending legislation to share with the Commission.

Danna Mauch reported that she, Sheriff Koutoujian, and Senator Friedman testified before the Joint Committee on Revenue in late October in support of a bill Senator Friedman has filed to create a criminal justice diversion trust fund, in part intending to fund a restoration center.

12:10 PM: APPROVAL OF MINUTES FROM YEAR ONE

The Commission tabled this agenda item until later in the meeting to await a quorum to approval the minutes.

12:15 PM: POLICE SURVEY PRESENTATION AND DISCUSSION

Danna Mauch asked Catia Sharp to present to the Commission on the results of a survey of police departments in Middlesex County.

Catia shared that the survey had five domains: first responder dispatch; mental health incident response; incident reporting; incident disposition; and diversion. There were 37 responses from 30 communities and two universities, primarily from chiefs of police, but also from clinicians and other civilian and non-civilian law enforcement personnel. There was a good mix of responses from urban and rural communities. Nearly all responding departments operate their own 911 call center, and no respondents said they participate in a regional call center. Most call centers do not provide behavioral health training for dispatchers, but of those who do, mental health first aid (MHFA) is the primary training regimen. About 2/3 of respondents said they have direct connection capabilities from the 911 call center to a suicide hotline or ESP.

Eliza Williamson asked whether there is a preference for a specific kind of training for 911 dispatchers, including between MHFA and crisis intervention training (CIT). She also asked whether departments who said they provide CIT training to dispatchers are providing dispatcher-specific CIT (which is available in Massachusetts), or if they are including dispatchers in law enforcement officer CIT.

Catia Sharp responded that the survey was not developed with a preference in mind for a specific type of training, but instead was attempting to identify how much training is happening and what type. The question of preference for a particular training could be a subject for Commission discussion. Catia also responded that the survey did not go enough in-depth to find out whether CIT for dispatchers was dispatcher- or officer-specific.

Sheriff Koutoujian noted that the idea of regionalizing 911 has come up in Massachusetts, including in response to success in Maryland. However, it has not been widespread here. He cited the example of the Essex County regional 911 center that was recently developed, but which is struggling. In the Sheriff's opinion, there is value in regionalizing 911 due to the cost savings that could be achieved. He added that he had not before considered the additional value of regionalizing 911 service to standardize training, including behavioral health training.

Senator Friedman agreed that there is difficulty with regionalizing 911 service and with providing additional training to 911 call takers and dispatchers. These services are locally-operated and funded primarily through state local aid. Because of state funding, the state could require 911 dispatcher training, but there is strong local resistance to requirements tied to local aid funding.

Sheriff Koutoujian agreed, adding that leadership from the top would be needed to make changes like regionalizing 911 service or requiring standardized training of dispatchers.

Danna Mauch added that many of the national models for restoration centers are backed by regional call centers, and that the finding from the police survey of the fractionalized nature of 911 service in Middlesex County may be a complicating factor in developing a restoration center here.

Nancy Connolly wanted to know, for those departments responding “yes” to the question about direct connections to suicide hotlines, who they connect to.

Catia Sharp responded she cannot answer that question, because those departments did not respond to the follow-up question asking who they connect to.

Scott Taberner thought that the Behavioral Health and Community Policing Advisory Committee that he co-chairs would benefit from a presentation of this information to their committee. They might be able to answer Eliza Williamson’s question about the most appropriate training for dispatchers.

Representative Gordon asked whether there might be an opportunity for a carrot and stick approach to expanding behavioral health training of 911 dispatchers.

Catia Sharp shared that there is as wide a variety of the dispatch protocols among the responding police departments as there is variety in dispatch centers. The answer to “who responds to a behavioral health emergency?” is “it depends.” 7 responding departments dispatch police, EMS, and fire; 7 dispatch police and EMS; 5 dispatch only police; and 3 dispatch only EMS. She highlighted Lowell Police Department, which dispatches police and EMS on all behavioral health calls, but only sends the Fire Departments if the call has a medical component like self-harm or overdose.

Senator Friedman added that dispatch may also depend on time of day and available resources.

Catia Sharp reviewed information on the use of Emergency Services Providers (ESPs). 2/3 of responding departments accurately identified their local ESP provider, which means most but not all departments are educated on this. The chart in the presentation shows that there is higher ESP utilization on a weekly basis for those departments who estimate that the ESP comes within an hour than those who say it comes in hours or days. Most respondents estimated that ESPs respond within the hour window set by MassHealth. Catia added that responses seemed to indicate that there may be both a misunderstanding among law enforcement personnel (even those who know who their ESP is) of the role of the ESP and/or of what constitutes a behavioral health emergency, as well as a mismatch of the needs of law enforcement and the role of the ESP. There is often a need for immediately addressing social problems like homelessness even if the individual is not in a mental health crisis that requires immediate hospitalization or in-person intervention.

Catia Sharp shared a map of hospital catchment areas, adding that most communities (except for the Lowell area and the Concord/middle county area) have choice when it comes to hospitals. There are three decision criteria that first responders use: patient condition and match to available services (for example, the fact that some hospitals have acute inpatient psychiatric facilities); patient choice; and proximity.

Catia Sharp reviewed transportation options to a restoration center. When asked their preferred method of transportation to a restoration center, police departments overwhelmingly said they prefer to use an ambulance (advanced life support or ALS), followed by a chair car (basic life support or BLS), and then a police cruiser. However, there are 46 different providers of ALS and BLS in Middlesex County (including municipal Fire Departments), with nearly half of municipalities running their own emergency medical services (EMS) through the Fire Department. This could be a lot of providers to contract with for restoration center transportation or to create Mobile Integrated Health programs with to allow for restoration center drop-off as opposed to emergency department drop-off.

Catia Sharp reviewed responses related to involuntary hospitalization. In agreement with formerly presented information about the widespread preference for ambulance transportation for behavioral health purposes, the vast majority of departments said they only use ambulances (not police cruisers) to transport individuals to the hospital under a Section 12 order. Most departments said they receive less than one warrant per week pursuant to Section 35 substance use commitments. Extrapolating the average warrants per week among responding departments, that could total 4,454 warrants per year in the county as a whole.

Senator Friedman asked what percentage of all statewide Section 35 warrants this represents.

Nancy Connolly responded that there are roughly 7,500 Section 35 warrants per year statewide.

Catia Sharp cautioned against using Department of Mental Health (DMH) numbers to compare survey results to, because the methodologies for data collection are different.

Catia Sharp showed that the survey revealed additional police department participation in diversion programs that had not been discovered in the Commission's first year of operation by comparing a map of diversion programs included in the Commission's Year One Findings and Recommendations to an updated map of survey results. She noted that most of the additional diversion programs were co-responders or CIT training that were not funded by DMH. She also noted that when asked, 2/3 of departments report that their officers are involved in regular case conferencing with social services (sometimes using a Hub Table model).

Senator Friedman asked which programs on the diversion program maps were specific to substance use or mental health.

Catia Sharp responded that most programs are not specific, though Police-Assisted Addiction and Recovery Initiative (PAARI) is specific to substance use.

Danna Mauch added that the Law Enforcement-Assisted Diversion (LEAD) program developed in Seattle is not specific to substance use, but is more often used for these types of needs.

Sheriff Koutoujian shared that the International Association of Chiefs of Police (IACP) has a MHFA training program, and asked whether the survey showed which departments are using this funding source.

Catia Sharp responded that the survey did not go into that level of detail, but perhaps this could be a subject of additional follow up with some departments.

Catia Sharp shared that DMH is the largest funder of co-responders, followed by grants, police departments, and municipal governments. She also added that there is a wide variety of choices among departments doing CIT as to what percentage of their sworn officers to train.

Sheriff Koutoujian asked why there is such a wide variety of CIT trained officer percentages.

Catia Sharp responded that this is a subject of debate that lacks sufficient research. Leon Evans in San Antonio advocates for

training 25% of the force because he believes CIT officers should be those who seek out doing this type of work; others believe that every officer should have training to deal with individuals in behavioral health crisis because all officers will at some point encounter such individuals.

Danna Mauch pointed out the difference between CIT, a 40-hour training program that accompanies a management structure aimed at diverting individuals with mental health conditions, and MHFA, an 8-hour course on the basic signs and symptoms of behavioral health.

Scott Taberner wondered if there should be a training standard in Massachusetts, because that is a subject of his Behavioral Health and Community Policing Advisory Committee.

Catia Sharp discussed how police departments flag behavioral health emergencies in both 911 data (in Computer-Aided Dispatch (CAD) databases) and police incident reports. Most responding departments have a primary CAD code for mental health, and many also have a secondary CAD code for overdose. Otherwise most departments do not track these items.

Danna Mauch asked in what circumstances an incident report is completed.

Sonya Khan responded that departments have different rules around what incidents require reports – for example, an arrest likely always requires an incident report, but an interaction with an individual that does not result in any action being taken may not warrant a report.

Sheriff Koutoujian added that CAD data is more inclusive than incident report data.

Sonya Khan added that CAD data is also “dirtier” than incident report data, in the sense that it often has less information on a single emergency than incident report data.

Senator Friedman asked whether the number of departments saying they have behavioral health flags has changed since the Sheriff’s Data-Driven Justice Initiative (DDJI) started.

Sonya Khan thought that the number of departments using flags may have increased, but said that the question is more whether or not they use the flags. Some departments who shared data through DDJI had flags, but almost never used the flags.

Catia Sharp showed that every department responded that they would use a restoration center in Middlesex County. Most said they would use it for diversion from arrest for low-level offenses, followed by diversion from voluntary emergency department transports; providing services to individuals who otherwise would have no formal disposition to hospital or arrest; Section 12 and Section 35 diversion; and lastly, diversion of arrest for high-level crimes.

Sheriff Koutoujian shared ideas on how to get more departments to respond to the survey.

The rest of the Commission agreed that more responses should be solicited, and a plan was made to do so.

1:00 PM: APPROVAL OF MINUTES FROM YEAR ONE

Sheriff Koutoujian asked for motions to approve the minutes from year one of Commission meetings.

Scott Taberner made the motion.

Nancy Connolly seconded the motion.

The Commission unanimously approved the minutes from year one.

1:05 PM: UPDATE ON PLANNING GRANT PROCUREMENT

Sheriff Koutoujian asked his Director of Purchasing, Michael Blatus, to present an update on the procurement of a planning grantee.

Michael Blatus shared with Commission members that a Request for Responses (RFR) to procure a planning grantee was released, and a bidder's conference held. A two week extension of the deadline was requested by potential bidders and granted by the MSO.

Nancy Connolly asked who was present at the bidder's conference.

Michael Blatus said that participants included representatives from Adcare, Advocates, Vinfen, South Bay.

Scott Taberner thought that it was impressive that providers from outside Middlesex County are interested in bidding on this procurement.

Danna Mauch opined that providers do not want to miss an opportunity to be on the cutting edge of designing a new, desperately needed service. She added that she has heard that there

is at least one group of providers considering submitting a joint bid.

1:15 PM: EOHHS REQUEST FOR INFORMATION COMMISSION RESPONSE

Danna Mauch shared that EOHHS has released a request for information (RFI) related to their behavioral health ambulatory care redesign effort, which the Commission should respond to.

Scott Taberner agreed that the Commission ought to respond.

Catia Sharp shared that responses are due back on December 20. Given the Commission's interest in submitting a response, Catia will be drafting a response. She invited any Commission members who want to participate in the drafting and/or editing of the response to directly contact Catia, but that all Commission members will receive a copy of a final response document.

1:20 PM: UPDATE TO DIVERSION WHITE PAPER

Danna Mauch let Commission members know that she and Catia Sharp have updated the white paper on diversion services, and copies are in Commission member packets and will be shared electronically. For the sake of time, she did not review the updates with Commission members.

Danna Mauch also shared that she will be on panels at the Mental Health Legal Advisors Committee conference this month talking about the white paper and the Restoration Center Commission.

Sheriff Koutoujian shared a conversation he had with Audrey Shelto of the Blue Cross and Blue Shield of Massachusetts Foundation recently, in which she expressed interest in the work of the Restoration Center Commission. He shared that he hopes to get her more involved in the work of the Commission, including inviting her to travel to Tucson with the Commission to view their restoration center.

Scott Taberner asked about scheduling the Tucson trip.

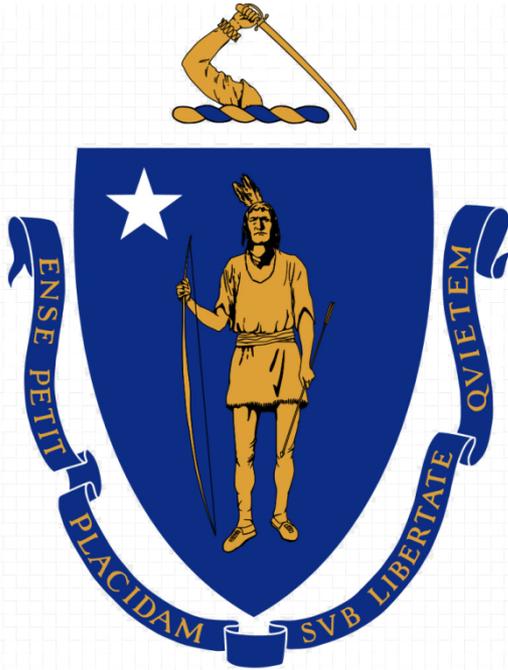
Catia Sharp asked Commission members to hold January 14-16 for such a trip, though these dates have not been confirmed by Tucson.

1:30 PM: NEXT STEPS AND CLOSING

Sheriff Koutoujian and Danna Mauch adjourned the meeting.

Restoration Center Commission

Police Department Survey Findings





Year Two Activities

- ➔ Refining the target population
- ➔ Specifying the service model
- ➔ Developing recommendations for improvements to existing, related services



Survey Domains

- Dispatch
- Mental health incident response
- Incident reporting
- Incident Disposition
- Diversion



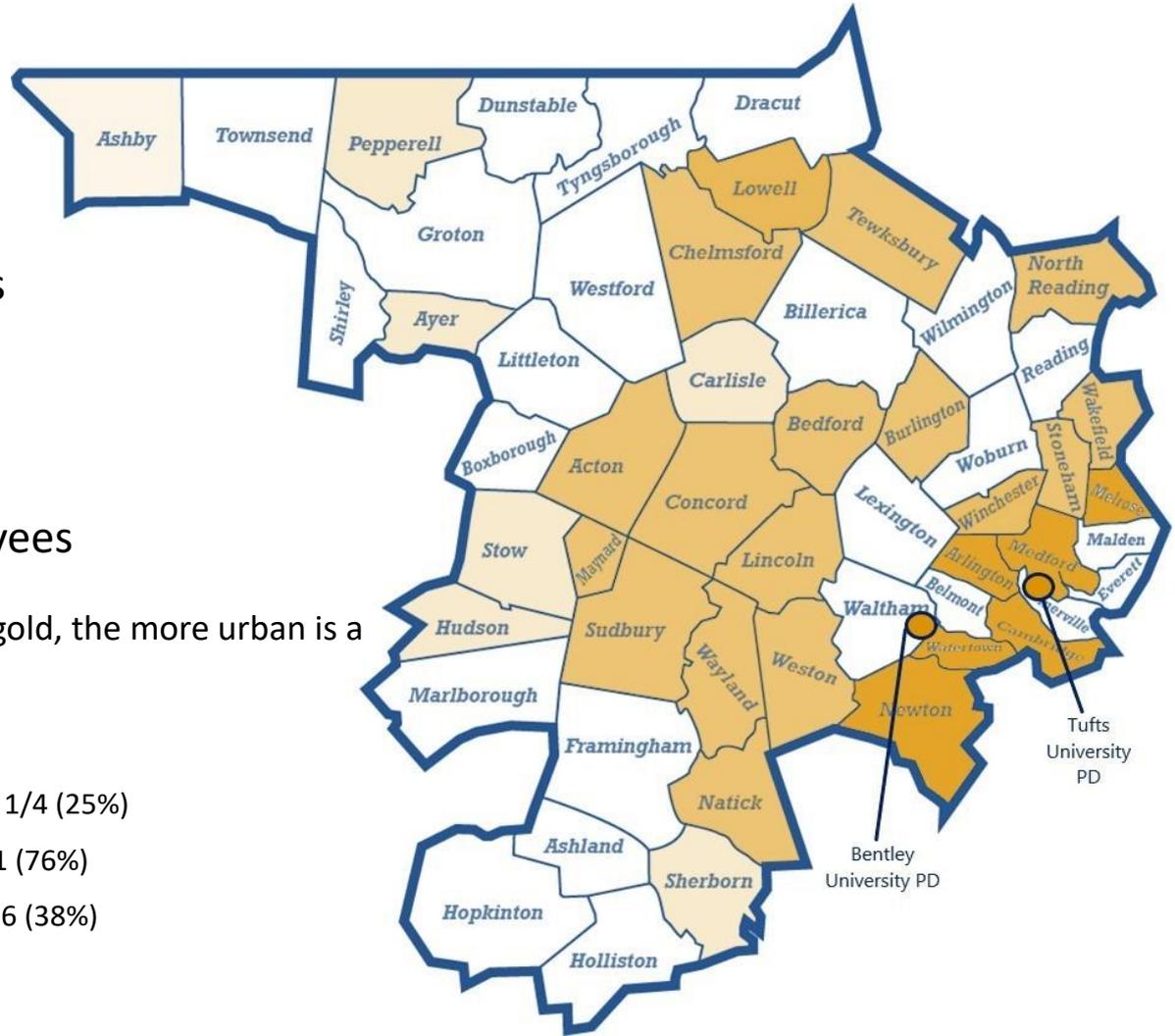
Who Responded to the Survey?

Who responded?

- 23 Chiefs
- 6 ranked officers
- 2 patrol officers
- 3 clinicians
- 2 civilian employees

The deeper the shade of gold, the more urban is a community.*

- Inner Core: 7/11 (64%)
- Regional Urban Centers: 1/4 (25%)
- Maturing Suburbs: 16/21 (76%)
- Developing Suburbs: 6/16 (38%)
- Rural Towns: 1/1 (100%)
- 2 University PD's



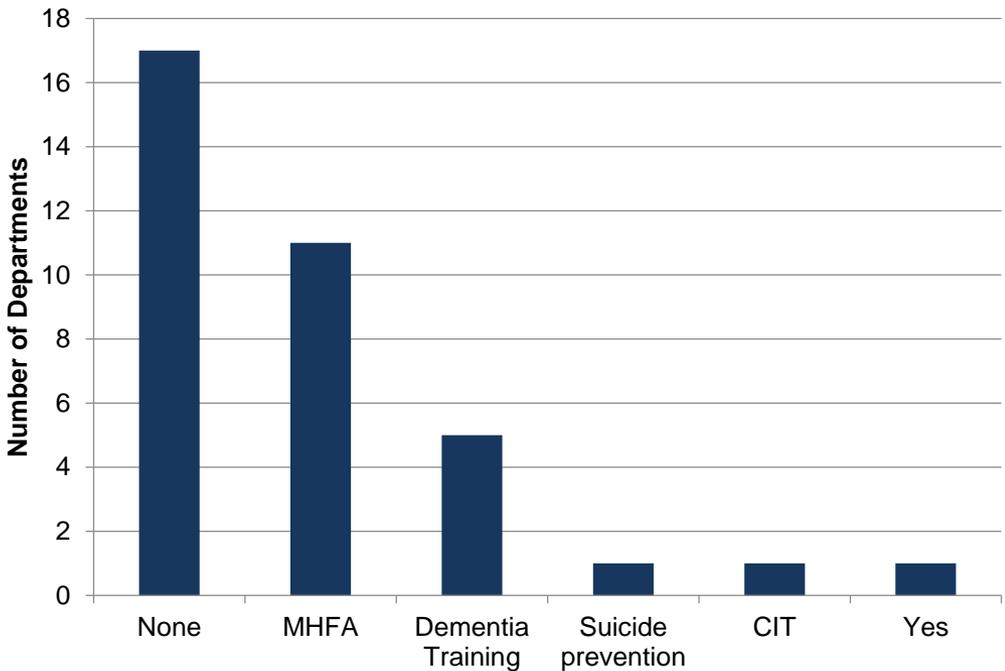
*from MAPC http://www.mapc.org/wp-content/uploads/2017/09/Massachusetts-Community-Types-Summary-July_2008.pdf



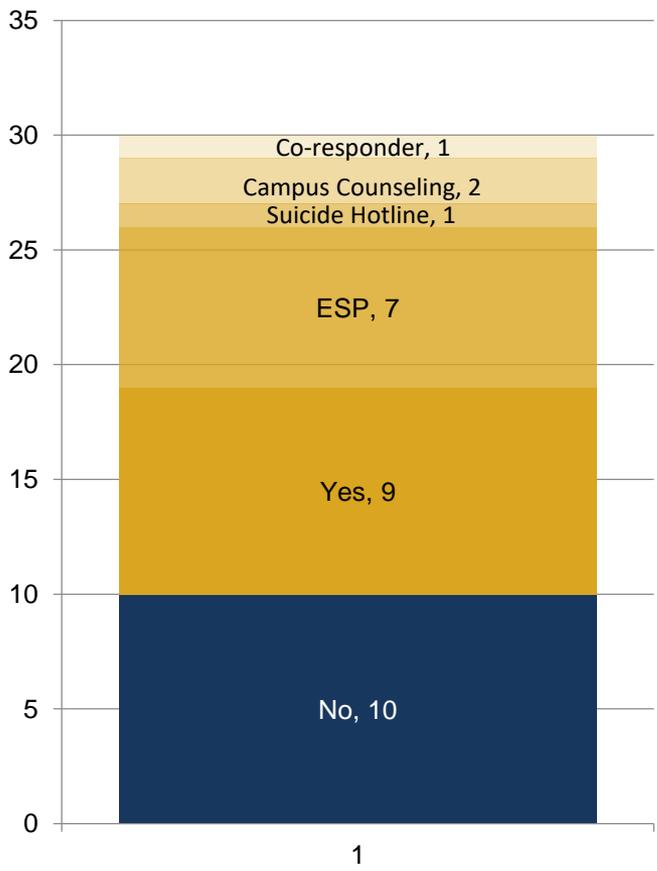
911 Call Centers

Nearly all 911 call centers are operated by the police department; no respondents said they participate in regional call centers.

BH Training for Dispatchers



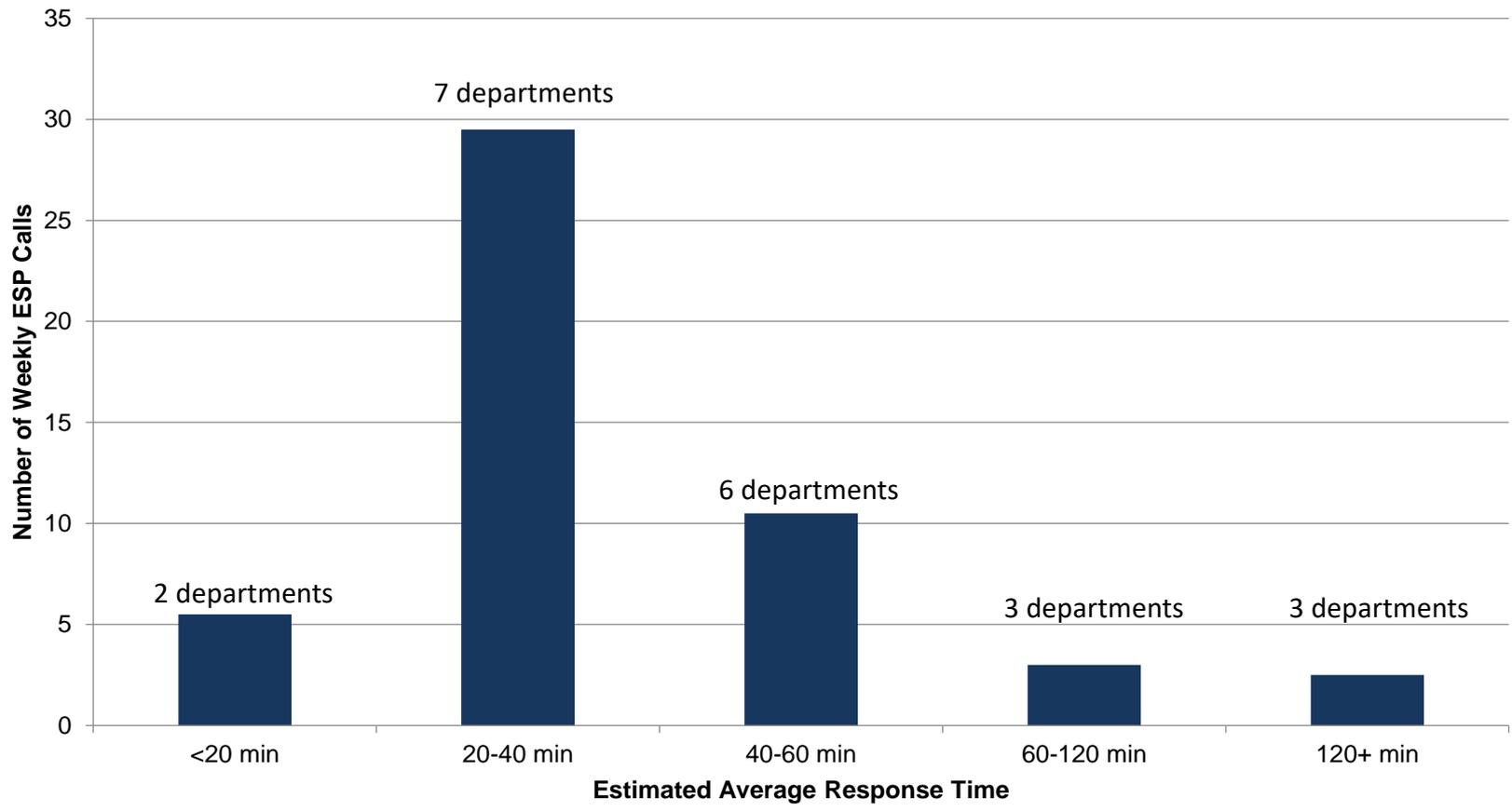
Direct Hotline Connection





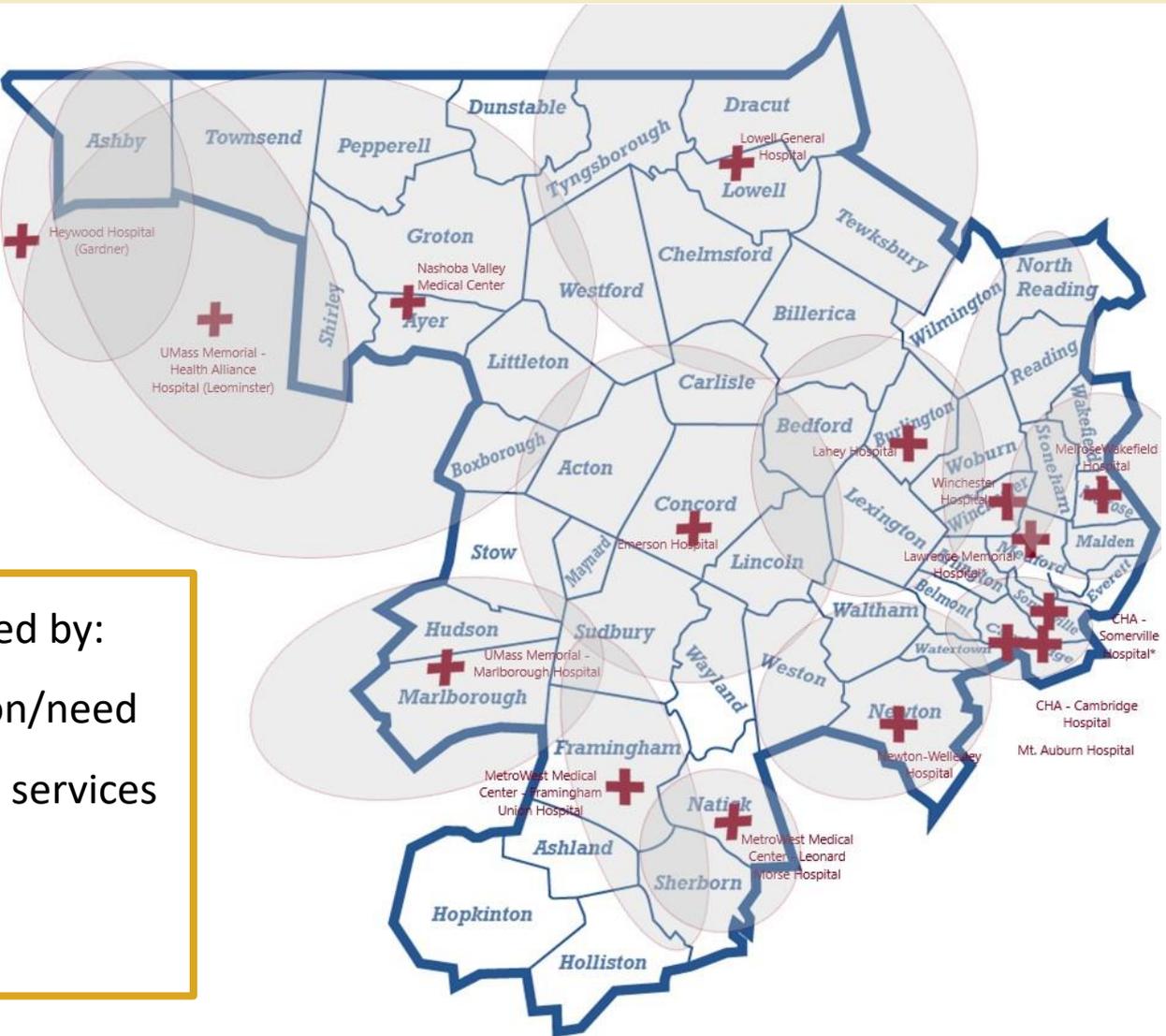
Emergency Services Providers

ESP Utilization Per Week by Response Time





Hospital Catchment Areas

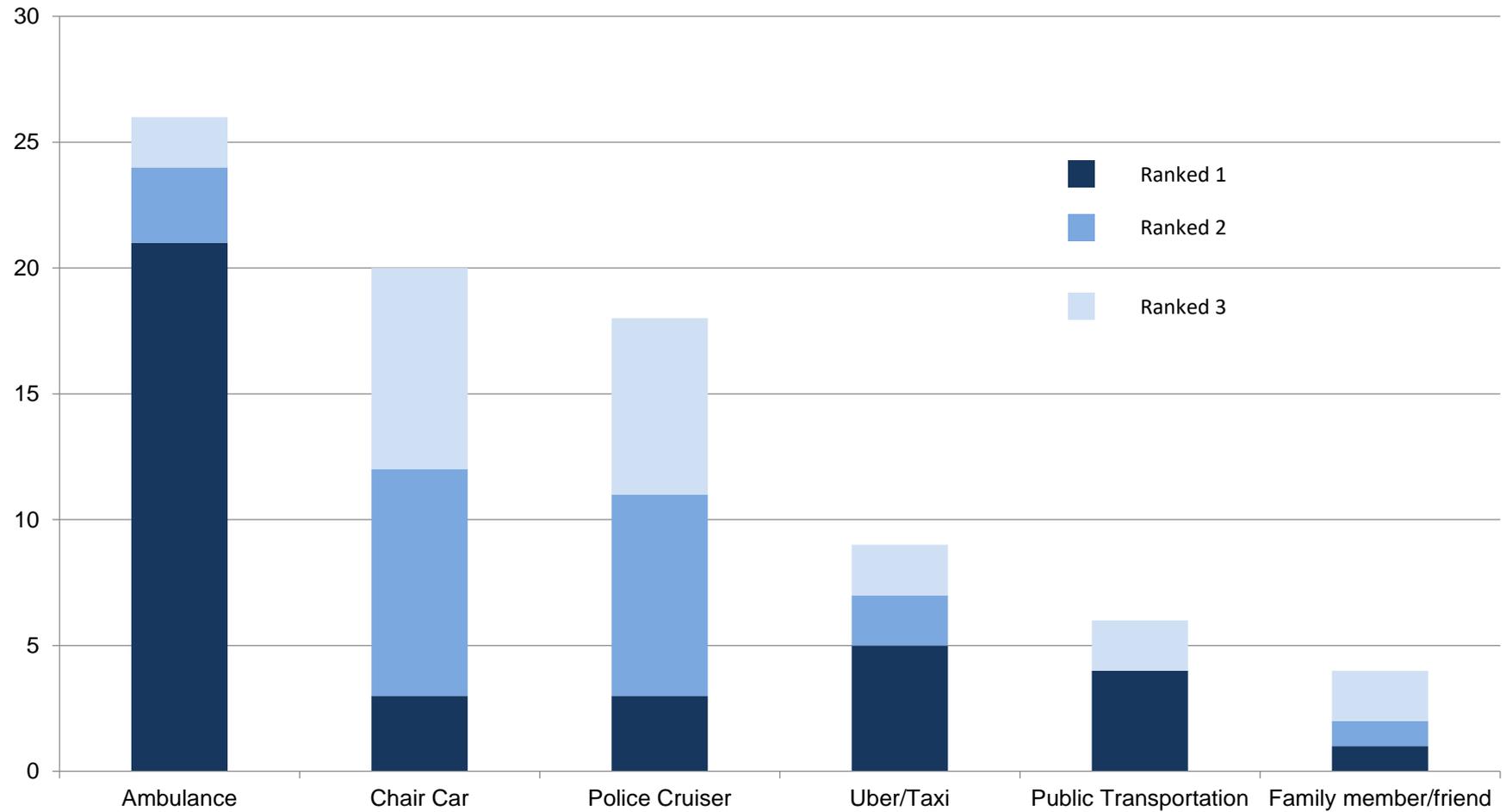


- Hospital is determined by:
1. Patient condition/need match available services
 2. Patient choice
 3. Proximity



Restoration Center Transportation

Restoration Center Transportation





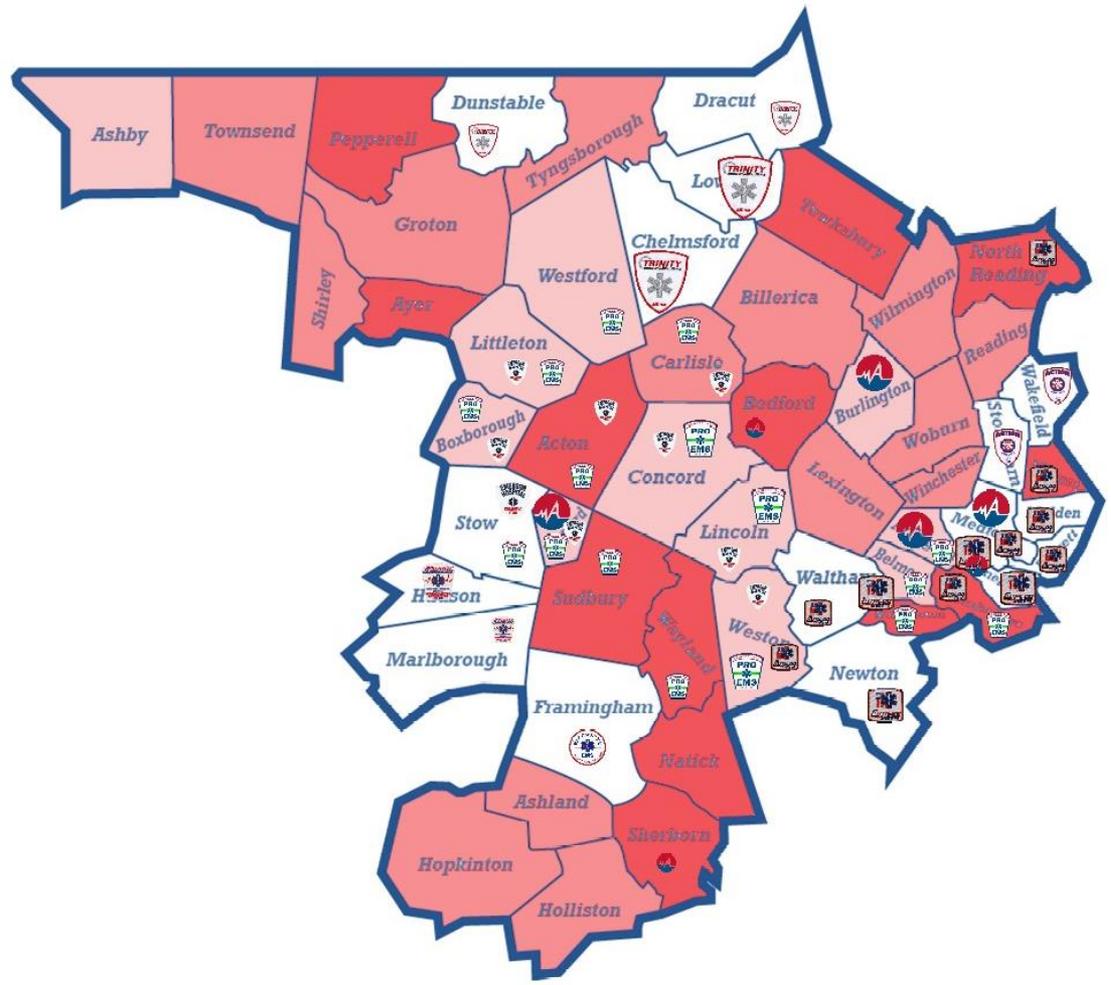
Emergency Medical Transportation

KEY

- Fire Department Primary ALS - survey
- Fire Department Licensed for EMS - DPH
- Fire Department BLS - survey

Primary ALS provided by contractor
 Backup provided by contractor or listed on contractor website

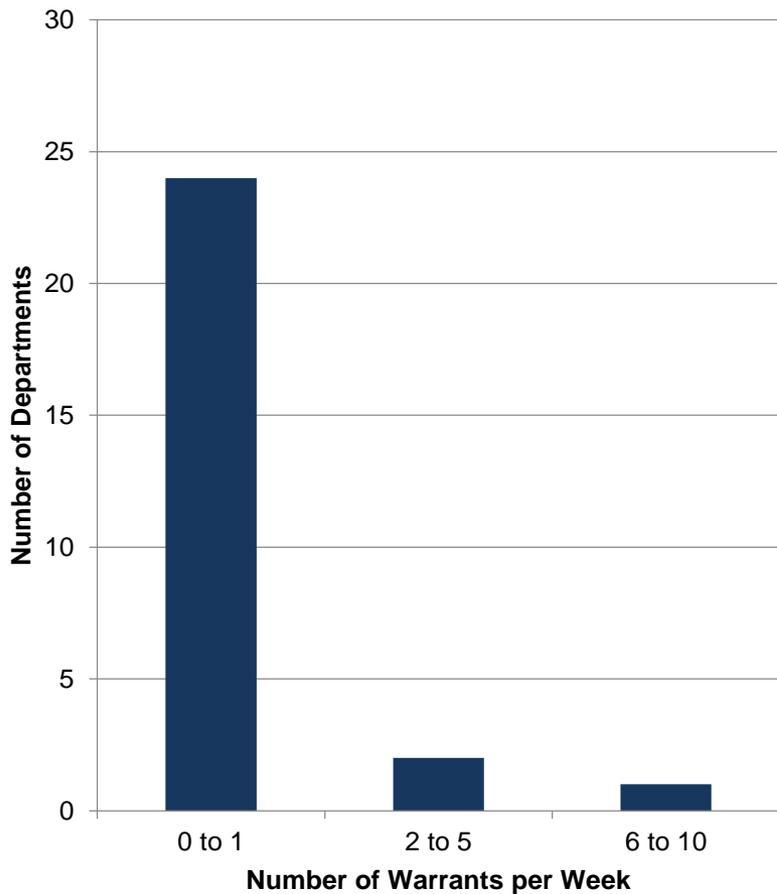
- | | | |
|---|-----------------------------|---|
|  | Action Ambulance |  |
|  | Armstrong Ambulance |  |
|  | Brewster Ambulance Service |  |
|  | Cataldo Ambulance |  |
|  | Emerson Hospital Paramedics |  |
|  | Patriot Ambulance |  |
|  | PRO EMS |  |
|  | Trinity EMS |  |



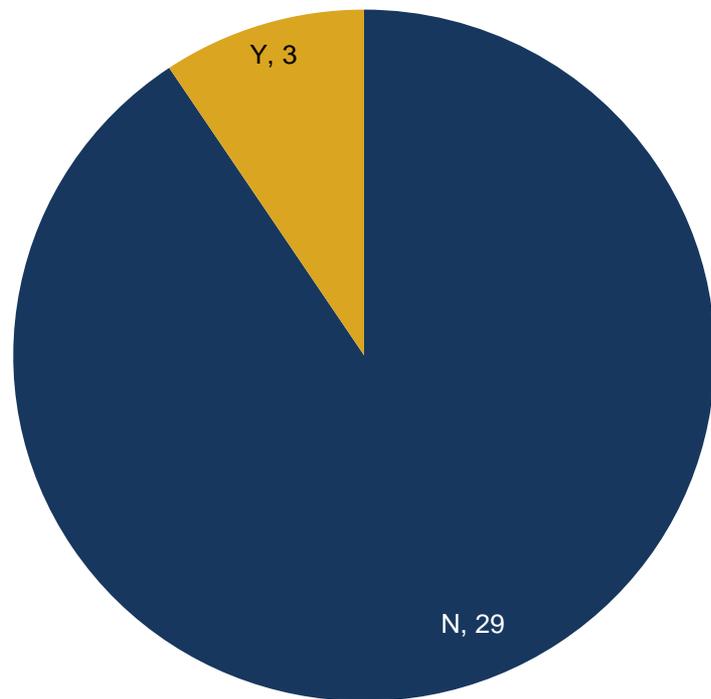


Involuntary Hospitalization

Section 35 Warrants/Week



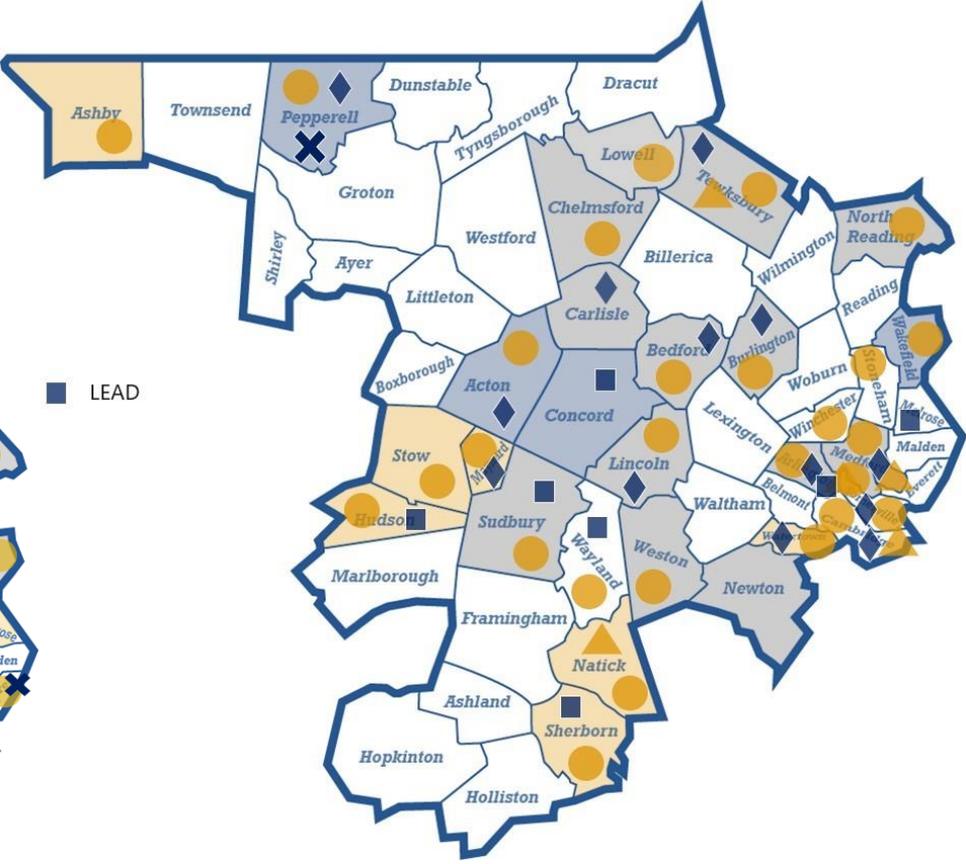
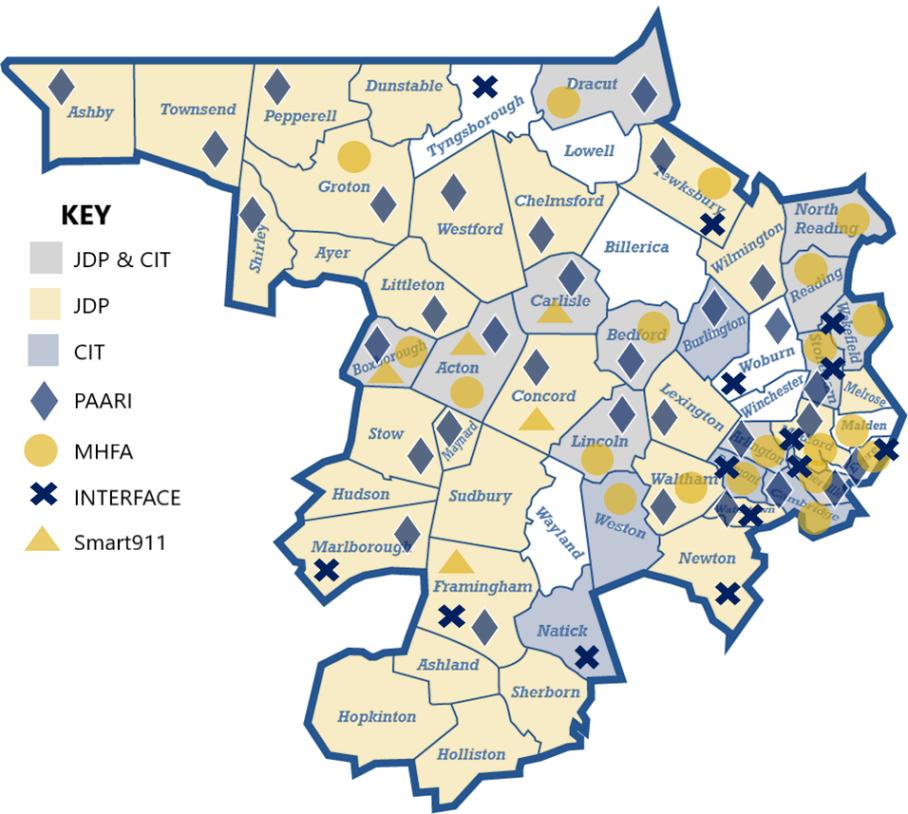
Hospital Transports in Police Cruisers





Diversion Programs

Year One Findings and Recommendations

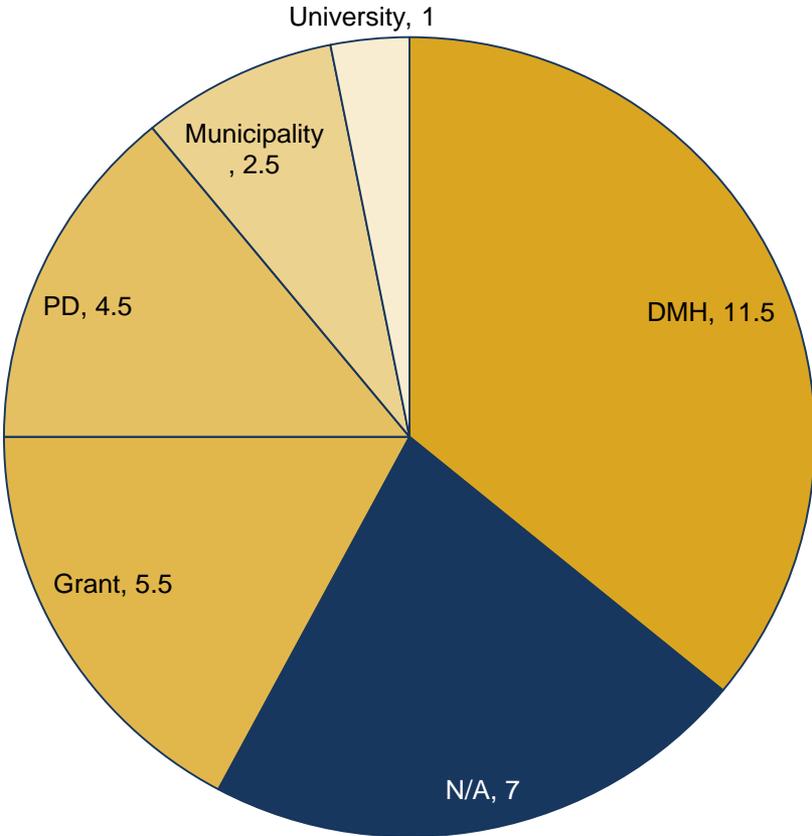


Police Survey

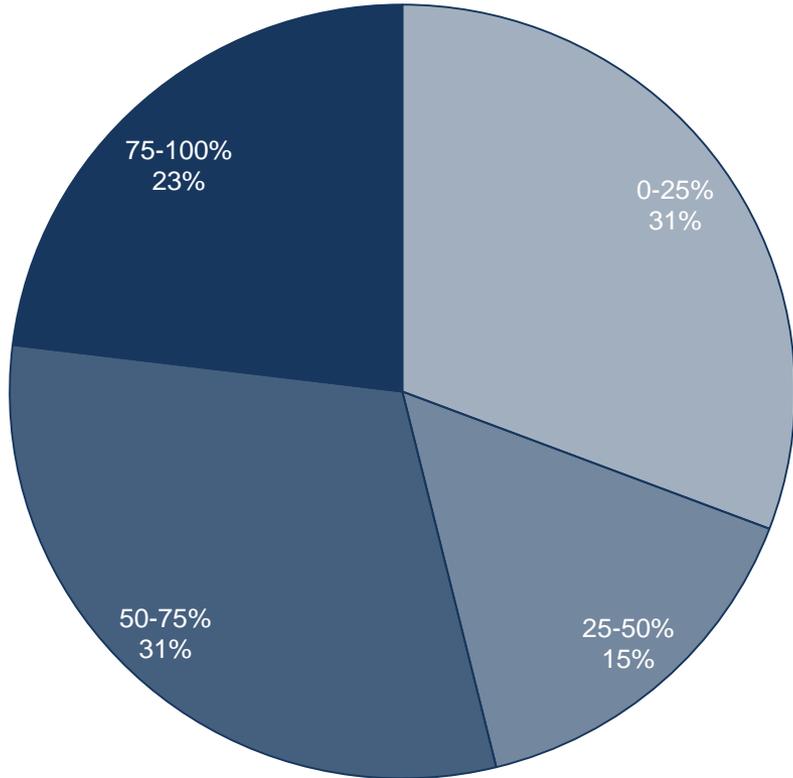


Diversion Programs

Co-Responder Funding

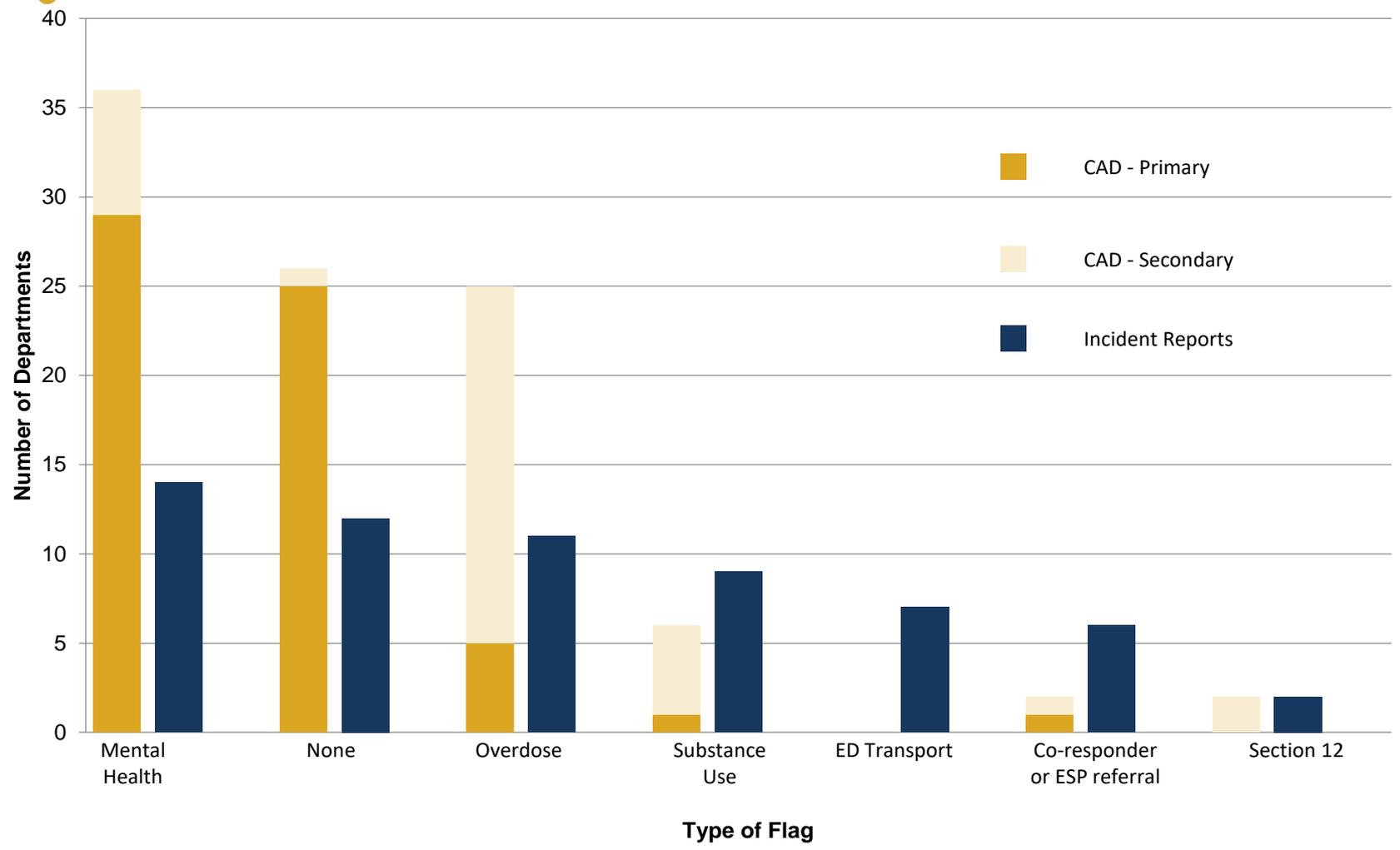


CIT Trained %



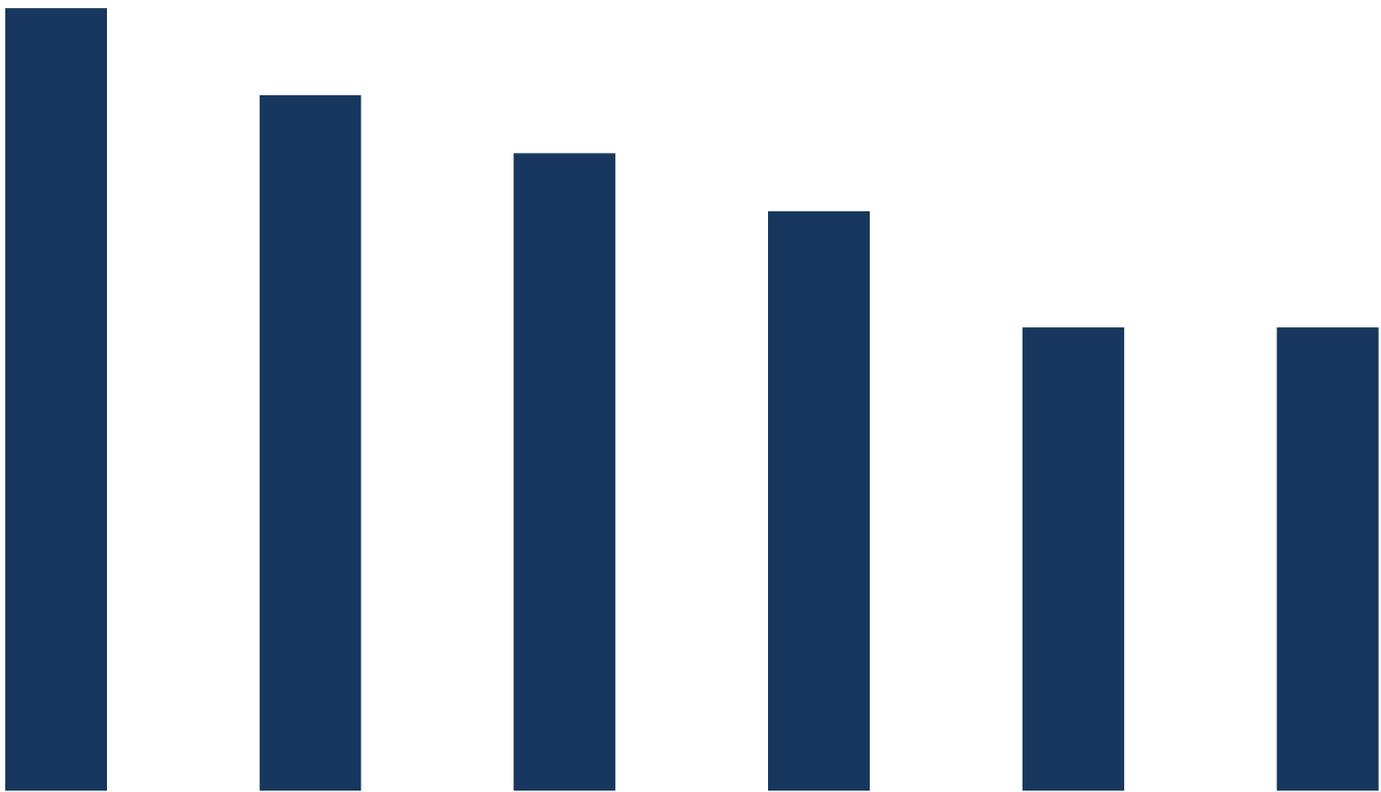


Database Flags for BH





Departments said they would use a Restoration Center for...

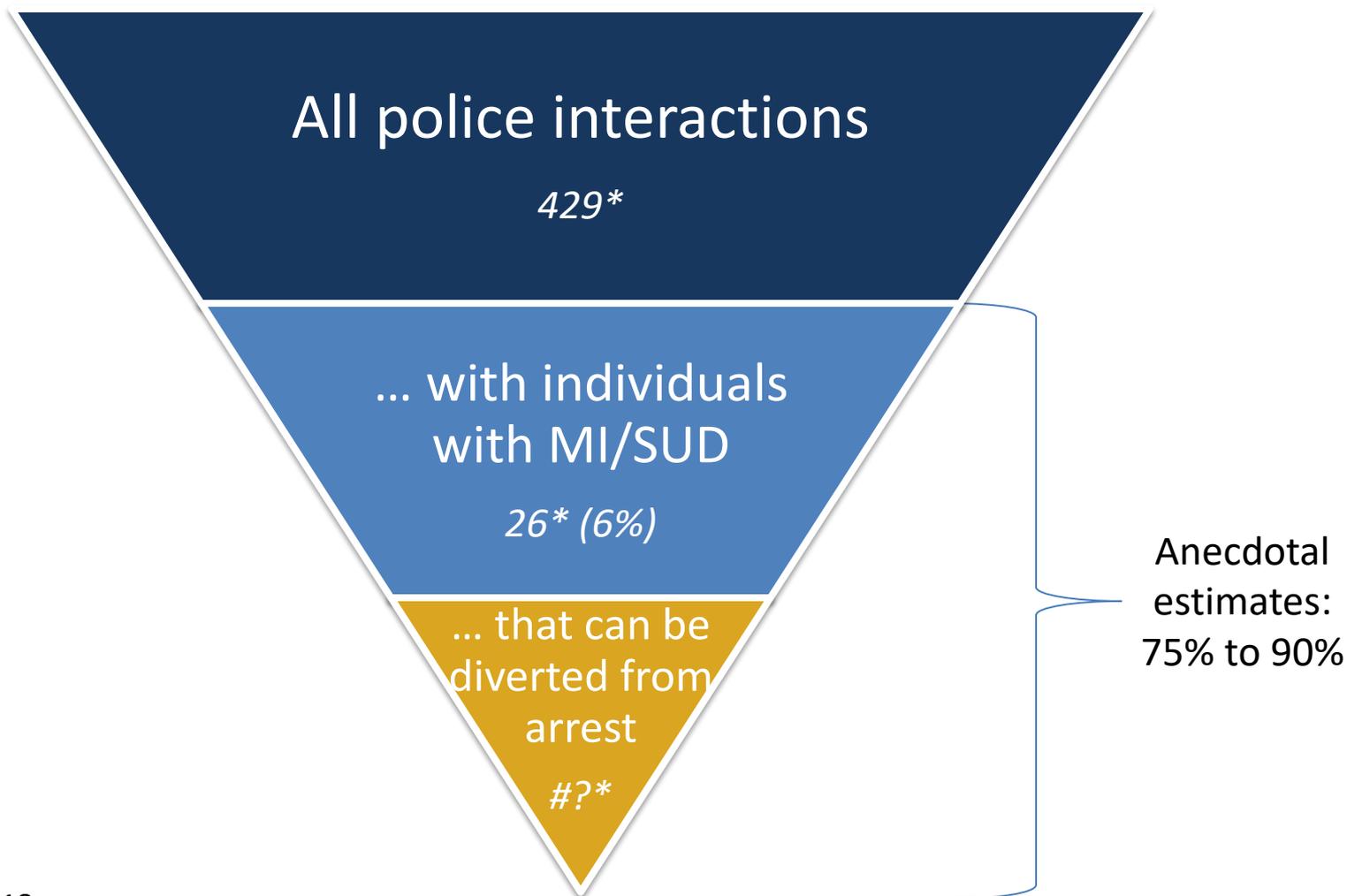


APPENDIX





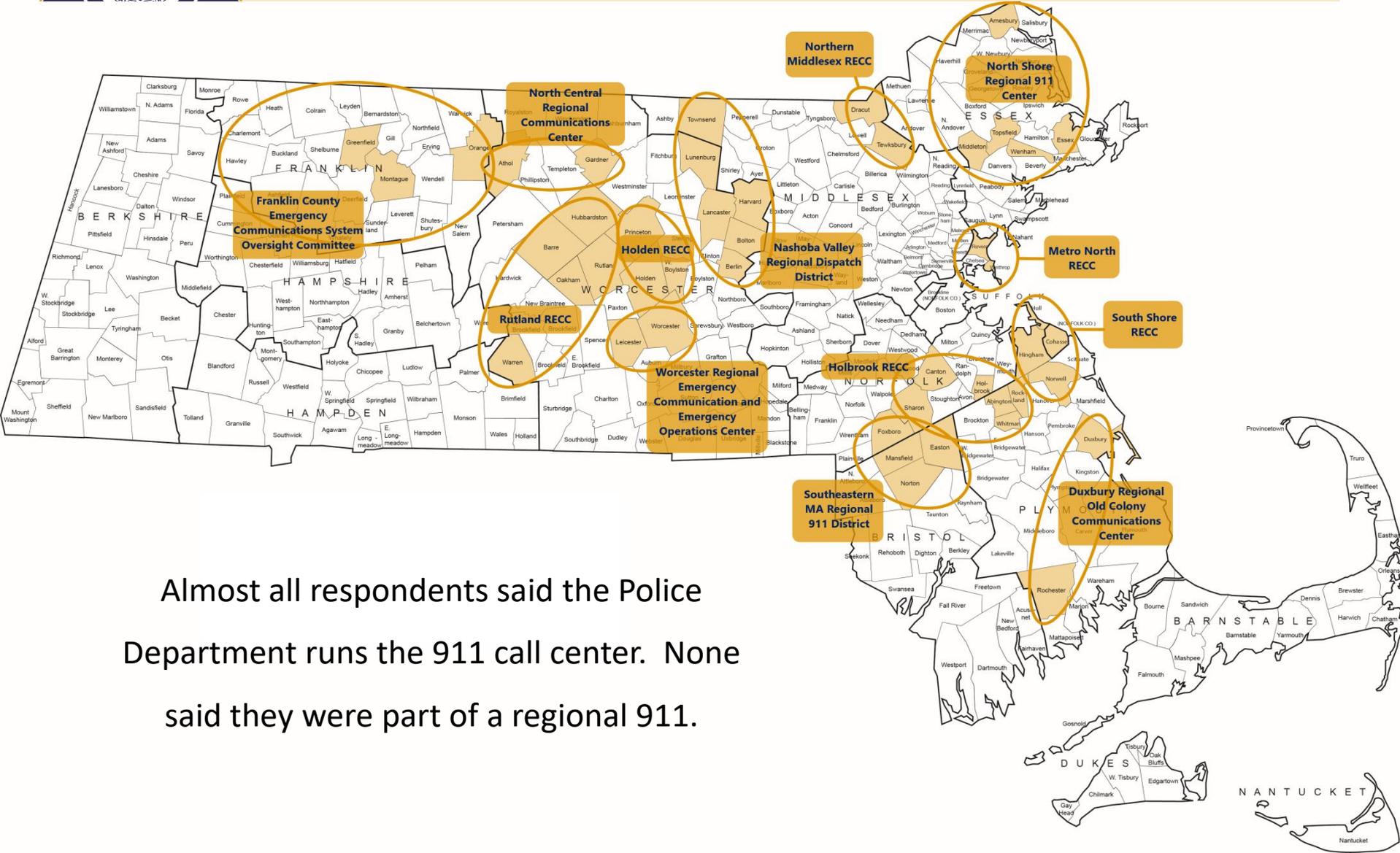
Defining the Target Population



*Arlington PD
October 1-15, 2018



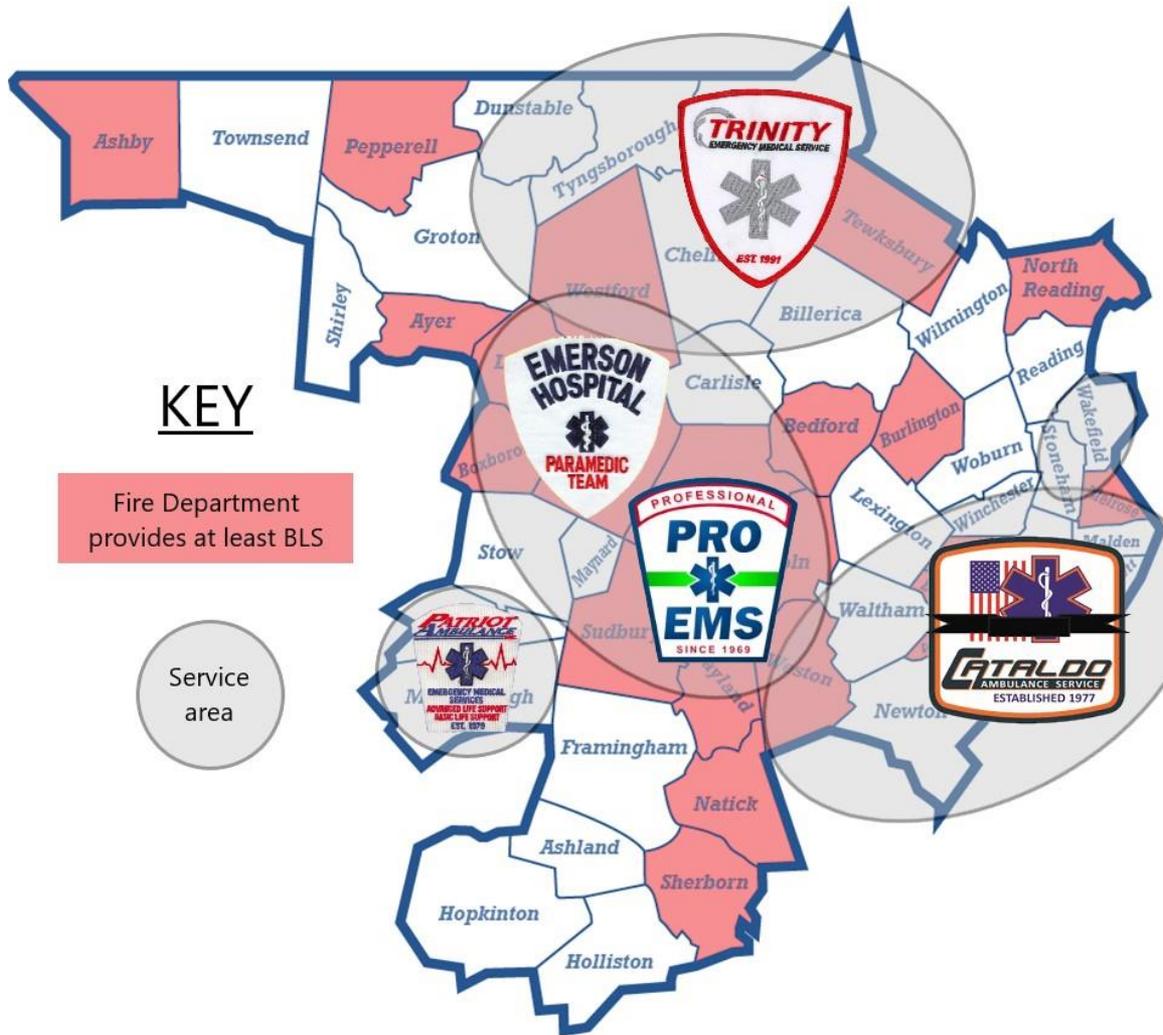
Regional 911



Almost all respondents said the Police Department runs the 911 call center. None said they were part of a regional 911.



Emergency Medical Transportation



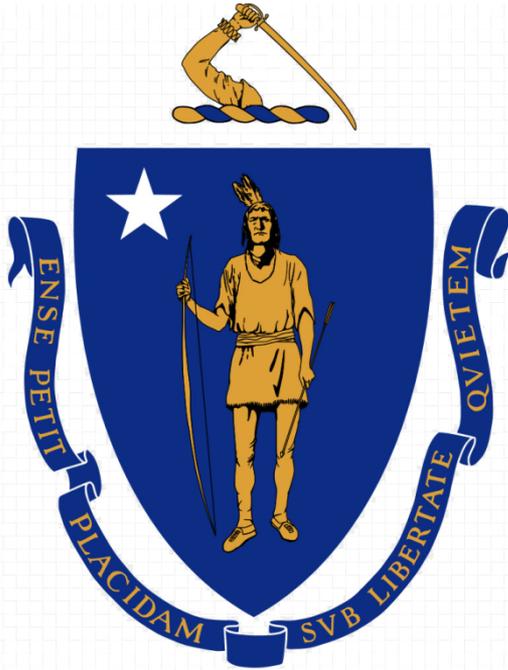
KEY

Fire Department provides at least BLS

Service area

Restoration Center Commission

Work Plan Update





Completed

| | |
|-----------------------------------|--------------------|
| Commission Meeting | September 19, 2019 |
| Commission Meeting | November 12, 2019 |
| Planning Grant Procurement | December 30, 2019 |
| RFI Response | December 20, 2019 |
| MassHealth data request submitted | January 6, 2020 |
| Police Survey | February 3, 2020 |



Looking Forward

| | |
|---------------------------------------|-----------------------|
| Commission Meeting | February 4, 2020 |
| Planning Grant Progress Report Due | February 26, 2020 |
| Tucson Site Visit | February 27-29, 2020 |
| Commission Meeting: Progress Report | March 3, 2020 |
| Commission Meeting: Report Feedback | April TBD |
| Planning Grant Final Report Due | April TBD |
| Legislative Reporting Deadline | April 13, 2020 |



Middlesex County Restoration Center Commission
Tuesday, February 4, 2020
10 am – 12 pm
400 Mystic Ave, Medford, MA

AGENDA

- 10:00AM – 10:05AM Welcome and Introductions
Co-Chairs, Sheriff Koutoujian and Danna Mauch
- Introducing the consulting team
- 10:05AM – 10:20AM Legislative Update
Senator Friedman and Representative Gordon
- Budget timeline
 - Health care reform bills
- 10:20AM – 10:30AM Approval of Minutes from Year One
Co-Chairs, Sheriff Koutoujian and Danna Mauch
- 10:30AM – 11:30AM Consulting Work Plan
Brenda Miele Soares and Kristin Nolan
- 11:30AM – 11:45AM Update on Commission Work Plan; Rest of Year 2
Co-Chairs, Sheriff Koutoujian and Danna Mauch
- 11:45AM – 11:55AM EOHHS Request for Information Commission Response
Danna Mauch
- 11:55AM – 12:00PM Next Steps and Closing
Co-Chairs, Sheriff Koutoujian and Danna Mauch



**Middlesex County Restoration Center
Tuesday, February 4, 2020
400 Mystic Ave., 4th Fl.
Medford, MA**

MINUTES

Attendees: Sheriff Peter J. Koutoujian, co-chair; Danna Mauch, Massachusetts Association for Mental Health, co-chair; Senator Cindy Friedman; Representative Kenneth Gordon; Judge Rosemary Minehan; Chief Robert Bongiorno; Scott Taberner, MassHealth; Nancy Connolly, Department of Mental Health; Jennifer Barrelle, Department of Public Health; Mandy Gilman, Association for Behavioral Health; Brenda Miele Soares, Advocates; Opal Stone, Advocates; Beth Lacey, Advocates; Marisa Hebble, MA Trial Court; David Ryan, Middlesex Sheriff's Office; Sonya Khan, Middlesex Sheriff's Office; Catia Sharp, Middlesex Sheriff's Office; Lisa Lana, Committee for Public Counsel Services; Kristen Dame, Committee for Public Counsel Services.

10:00 AM: WELCOME AND INTRODUCTION

Sheriff Koutoujian called the meeting to order and welcomed representatives from Advocates, the planning grant awardee for the Commission. Danna Mauch invited a round of introductions from those present at the meeting.

Sheriff Koutoujian asked Committee for Public Counsel Services (CPCS) representatives what sparked their interest in the Commission.

Lisa Lana responded that they are interested to see what the service model will look like, and are in favor of pre-arrest diversion. She noted that CPCS will not be working with people who are diverted pre-arrest.

Representative Gordon added that he has heard of interest in the model from other defense counsellors as well.

10:05 AM: CONSULTING WORK PLAN

Sheriff Koutoujian introduced Brenda Miele Soares from Advocates to begin a presentation on the work plan for planning grant services.

Brenda provided an organizational overview of Advocates, including a review of the services they provide that are relevant to the Commission's work.

Sheriff Koutoujian added that Advocates is also working with the Middlesex Sheriff's Office through the MassHealth Behavioral Health – Justice Involved (BH – JI) community support program demonstration.

Brenda presented the structure of Advocates' work plan, which divides the work into work streams for data, services, location, and transportation.

Brenda turned the floor over to Opal Stone from Advocates to present on the data work. Opal discussed Advocates' review of data provided by the Commission, additional data sources that Advocates is pursuing, and the timeline for this work.

Scott Taberner asked for what percent of Middlesex County communities does Advocates provide ESP services?

Opal responded that Advocates' ESP service area includes 31 towns total, and includes about one third of Middlesex County cities and towns running from Winchester to Framingham/Marlborough. She added that there are three ESP providers in Middlesex County.

Sheriff Koutoujian noted that there are lots of services in the MetroWest area where Advocates operates.

Scott Taberner noted that Advocates has asked for data from the Massachusetts Behavioral Health Partnership (MBHP) on ESP services provided in Middlesex County. He added that the list was generated last night and will be ready to share shortly.

Danna Mauch asked if the data would be by town.

Opal responded that Advocates expects the data to be by ESP. She added that some geographies are well-defined, like the Lowell area, while others are less clearly delineated, like Woburn and the southeast portion of the county. Opal thanked Scott for his help in getting access to this data.

Judge Minehan asked who gets ESP services – is it for a 12(a); voluntary treatment; etc.?

Brenda Miele Soares replied that ESPs serve people in all of these areas: individuals can call an ESP directly, as can police, schools, parents, etc. She added that Advocates is also insurance-blind, and serves people with a range of insurance or no insurance coverage.

Senator Friedman clarified that this does not necessarily mean that Advocates is insurance “blind,” but rather that Advocates will serve some clients without reimbursement from insurance at a loss.

Scott Taberner added that MassHealth is pivoting to look at ESPs in a different way to use clinicians more in the field. This model will work nicely together with a Restoration Center.

Brenda Miele Soares presented Advocates’ work looking at services. She noted that they are thinking about billable vs non-billable services, and looking at what is already available in each geography and what’s needed in a center in each geography.

Senator Friedman recommended that Advocates attempt to capture any barriers to implementation – for example, regulatory/licensing barriers that exist.

Brenda responded that licensing is definitely a challenge. For example, under current licensing standards, you need two different waiting rooms for outpatient and crisis services.

Mandy Gilman noted that the Association for Behavioral Health is working with the Department of Public Health on this – the goal is to improve how all of the regulations and licenses work together.

Jennifer Barrelle added that DPH is looking at the regulations already, so the Commission could get involved in that process. Jenn offered to circulate draft language for updated regulations with the working group.

Mandy Gilman asked where is the line between billable and non-billable services?

Brenda replied that they are looking at that question, and it ties closely to licensing.

Senator Friedman noted that it is important for the Commission to know these details and distinctions so that we might relieve some of the regulatory or financial restrictions to make the Restoration Center work.

Beth Lacey presented Advocates' work on finding a suitable location for a Restoration Center. She noted that they are looking at three rough geographical areas with the perspective of cost/availability of space, as well as availability of services to address social determinants of health.

Sheriff Koutoujian added that they should also be thinking about how far people will travel to use the service. He noted his experience taking "safe keeps" (individuals who have been arrested by local police departments but not yet arraigned whose custody is transferred to the Billerica Jail for a variety of reasons, including the provision of health and behavioral health care services that are often unavailable in municipal police lock-up). 30 communities have signed up for the program, some of whom are willing to travel significant distances to transfer custody of detainees.

Judge Minehan asked whether this program is pre- or post-arrest.

Sheriff Koutoujian responded that the safe keep program is post-arrest/pre-arraignment, but the Restoration Center will be pre-arrest.

Chief Bongiorno added that police/EMS/fire community concerns should also be considered for the community that would ultimately host the Restoration Center.

Beth Lacy presented Advocates' work on transportation. She talked about not only getting people to the Restoration Center, but identifying transportation models for aftercare services and returning home (wherever home is).

Senator Friedman noted that police already do a lot of the transportation for this population, so they should be included in these conversations.

Beth added that Chief Bongiorno has been included in conversations on transportation.

Chief Bongiorno noted that aftercare is critical, and asked how specifically the center would be getting people home.

Danna Mauch thanked Advocates at the conclusion of their presentation for their work.

Scott Taberner added that the proposal they submitted for the procurement was very good.

Sheriff Koutoujian asked Chief Bongiorno to talk about an ongoing conversation about the use of a Restoration Center to do involuntary treatment.

Chief Bongiorno reiterated the mandate of the Commission to divert people from emergency department utilization because the emergency department is a revolving door currently. He wanted to raise a point that, in his view, the Restoration Center would need to be taking Section 12 involuntary holds to effectively achieve this mandate.

Mandy Gilman asked a clarifying question as to whether most emergency department transports by police are Section 12 or voluntary.

Chief Bongiorno said yes, most ED transports are Section 12 because most people don't want to go to the hospital.

Danna Mauch said that police use Section 12(a) to get people evaluated at the ED; the revolving door is mostly from people who aren't in need of an inpatient level of care (which would require a 12(b) petition by a doctor at the ED allowing for a 72-hour involuntary hold for treatment purposes after the 12(a) evaluation of need has been performed). Those who don't meet the level of need for the 72-hour hold are evaluated and released, and they are the people who cause the frustration for police.

Brenda Miele Soares expressed the opinion that a Restoration Center should not be another ED. It should take people who don't meet the inpatient commitment standard. If a Restoration Center did involuntary treatment, then people would not want to voluntarily use the Restoration Center.

Senator Friedman added that police should not be deciding who goes where (ED or Restoration Center). The Restoration Center will have to section people using a 12(b) to send them to inpatient levels of care if that level of care is required.

Brenda Miele Soares agreed with this point. She said the Restoration Center will need to send people to inpatient treatment if that level of care is required based on an evaluation.

Beth Lacey added that, for this reason, transportation is a key question.

Brenda Miele Soares said that new regulations from the Department of Public Health allow ambulance transports for this purpose.

Jennifer Barrelle said she would check on the status of those regulations.

Scott Taberner said that the Restoration Center should be connected into a network of care, and that having the ESP coordinate with this would greatly expand the promise of the center.

Beth Lacey said that the difference here is between needing a Section 12(a) to do transportation to a Restoration Center versus the person being involuntarily held when they arrive under a Section 12(b). Getting people to the center is important and how we get people there is important, but this isn't an inpatient unit.

Sheriff Koutoujian said that public safety personnel are concerned with transportation because their vehicles were made for involuntary, as opposed to voluntary, transportation.

Judge Minehan added that if Section 12 can't hold people (which is a potential outcome of a case currently before the Supreme Judicial Court), then the police will have to charge people with crimes to make sure they are safe.

Danna Mauch noted that the SJC case is about when the 72 hour hold starts, and whether it starts in the ED (where a person is not getting treatment) or whether it starts when the patient is evaluated and ordered to inpatient unit admission.

Judge Minehan said that if the case outcome is that the 72-hour hold includes ED time, then people will be discharged without ever getting actual inpatient treatment. The Restoration Center is going to be a huge asset to solve this problem. Police will be able to convince people to go to the Restoration Center instead of involuntary hospitalization or arrest.

Sheriff Koutoujian added that people should want to go to the Restoration Center voluntarily.

Chief Bongiorno asked to confirm that Advocates doesn't think a Restoration Center should be intake.

Beth Lacey responded that they don't think it should be involuntary intake, because the center should not have an inpatient unit. The Restoration Center should provide services to people who do not rise to the level of need to commit them to an inpatient unit, and it should send people who do need that level of care to an appropriate psychiatric facility.

Chief Bongiorno said that in his experience, people are not staying in the ED for 72 hours, and asked why the Restoration Center can't be the place that keeps people for that length of time.

Senator Friedman replied that the ED is not required to have the services available for behavioral health in order to keep people for that length of time. She added that the purpose of the Restoration Center would be to act as a door to treatment. She said that people are more likely to stay for longer if someone at the center sits down, talks to them, finds out what's going on, and gets you in front of the right provider. Currently, people are sitting in EDs because no one at the ED is doing anything like this with them.

Chief Bongiorno asked why the Restoration Center wouldn't want to take such individuals.

Beth Lacey responded that the Restoration Center does want to take these people.

Senator Friedman added that someone who tried suicide would still be a Section 12 and needs hospitalization. This means that the police will have to make some decisions about where to take people in crisis. The Restoration Center is going to help people navigate to the right level of care.

Chief Bongiorno asked for additional clarification on whether the Restoration Center is voluntary or not.

Beth Lacey said that the Living Room is a good example of what Advocates is talking about – it's a place where people go voluntarily that's more welcoming and therapeutic than a hospital.

Mandy Gilman added that Advocates has strong peer services.

Senator Friedman noted that the Commission will need to create a clear set of criteria for police to use in making decisions about bringing someone to the Restoration Center.

11:30 AM: LEGISLATIVE UPDATE

Senator Friedman updated the Commission on the budget process for the year. She noted that the expectation would be to include \$250,000 in the budget for the Restoration Center for next year for implementation. If staff and Advocates identify a need for more than that, they should include a proposal in their report to the legislature.

She added that she is very interested in the barriers to implementation of a Restoration Center because the Senate is hearing a set of bills on the scope of practice for behavioral health, telemedicine, ED boarding, and others related to behavioral health. If there are bills that would be needed to enhance/enable a Restoration Center, the time to do them would be in the next 5 months along with these other packages in order to get them done this session.

Sheriff Koutoujian noted that there have been conversations with Advocates about security that could be provided at a Restoration Center. He added that we want to make sure it is done the right way, and if it is provided by the Sheriff's Office, then there would need to be funding to do it because it would require a specially trained unit. He highlighted the value of training by noting that the Billerica Jail and House of Corrections almost never uses restraints anymore because officers are getting better at de-escalation.

Chief Bongiorno added that discussions had included the idea of a "kindler, gentler uniform" for security.

Jennifer Barrelle noted that the Commission has discussed Section 12 a lot; what will the Commission do to manage people who are in withdrawal at a Restoration Center.

Brenda Miele Soares replied that Advocates is looking at sobering units and comfort meds for this purpose.

Sheriff Koutoujian added that the staff at the Billerica Jail and House of Corrections do a good job medically managing withdrawal for people who are detained.

Senator Friedman added that the Restoration Center should also be initiating MAT.

Mandy Gilman offered to set up a call with Advocates and Commission staff to discuss legislative items to address the barriers to implementation for a Restoration Center.

Scott Taberner noted that the Governor included funding in the budget for the trial court to expand the reentry program for justice-involved behavioral health clients (BH-JI) statewide to all counties, the Department of Correction, probation and parole.

Senator Friedman expressed a preference for the Commission to focus on the restoration center discussions, because she is afraid talking too much about related programs would make people think a restoration center is not needed.

Representative Gordon said that he is supporting the important bills filed by Senator Friedman.

11:45 AM: UPDATE ON COMMISSION WORK PLAN; REST OF YEAR TWO

Danna Mauch asked Catia Sharp to update the Commission on progress on the work plan and preview the rest of year two.

Catia Sharp discussed the work that has already happened this fiscal year, including: three Commission meetings; a planning grant procurement; a response to the Executive Office of Health and Human Services Ambulatory Care Redesign Request for Information; and a data request submitted to MassHealth to match to MSO data.

She then discussed the plan for the rest of year two. There is a planning grant progress report due on February 26, which will feed into a presentation to the Commission meeting on March 3. Many Commission members will be participating in a site visit to Tucson on February 27-28. Then, there will be a Commission meeting in April (specific date to be determined) and the Advocates report will be due in April as well. These are both in preparation for the legislative reporting deadline on April 13th.

Danna Mauch added that the April timeline is ok for budget purposes but might be tight if there is a need to promote changes to licensure to enable a restoration center. She also apologized to Chief Bongiorno for not understanding his concern earlier in the meeting with regard to Section 12. She appreciated his raising the issue and the importance of clarifying the question.

Catia Sharp suggested convening police departments at some point in this process to clarify the role of the restoration center in a diversionary continuum of care.

Chief Bongiorno agreed.

11:55 AM: EOHHS REQUEST FOR INFORMATION COMMISSION RESPONSE

Danna shared that staff and participating Commission members drafted and submitted a Commission response to the EOHHS Request for Information (RFI) on Ambulatory Care Redesign. She asked Scott Taberner what the status of the RFI is.

Scott Taberner said that the larger redesign of the behavioral health system is ongoing at EOHHS.

Danna noted that we haven't seen anything like this process before, and commended the work being done.

Senator Friedman agreed that the EOHHS process shares the goal of preventing justice involvement among people with behavioral health needs with the Restoration Center Commission, and commended them for their work.

11:58 AM: APPROVAL OF MINUTES FROM LAST MEETING

Mandy Gilman moved to approve the minutes from the February Commission meeting.

The vote was unanimous in favor of approval.

12:00 PM: NEXT STEPS AND CLOSING

Sheriff Koutoujian and Danna Mauch adjourned the meeting.



Presentation to the Middlesex County Restoration Center Commission

February 4, 2020

Agenda

- Introductions
- Overview of Organization
- Overview of Restoration Center Planning Process
- Data Collection and Analysis
- Services and Aftercare Supports
- Location Selection
- Transportation

Organization Overview

Community Support Program (CSP)

DMH-Funded Respite Services

- including Deaf, Hard-of-Hearing, and Deafblind programs

Community Crisis Stabilization (CCS)

The Living Room

Emergency Services Program (ESP)

Adult Community Clinical Services

Outpatient Clinics

Jail Diversion

Reentry

Behavioral Health Community Partners & Integrated Care Management Programs

Driver Alcohol Education (DAE) & Second Offender Groups

Residential Recovery Services

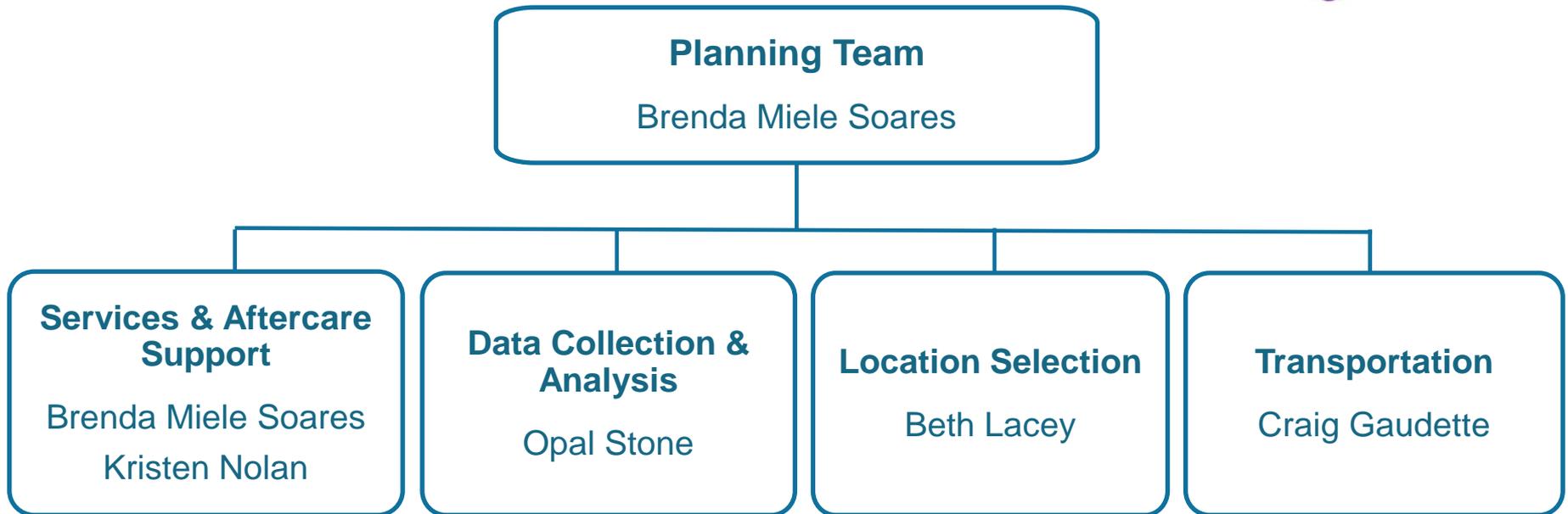
Overview of Planning Process



Restoration Center Planning Team

| Name | Title |
|--|---|
| Brenda Miele Soares, MSW, LICSW, Chair | VP of Behavioral Health Services |
| Mark Viron, MD | Chief Medical Officer |
| Beth Lacey, MSW, LCSW | Senior VP of Community Services |
| Keith Scott, CPS | VP of Peer Support and Self-Advocacy |
| Opal Stone, MBA | Director of Reentry Services |
| Sarah Abbott, PhD | Jail Diversion Program Director |
| John DeRonck, MSW, LICSW | Director of Emergency Services |
| Danielle Dunn, LMHC | Senior Director of Integrated Clinical Services |
| Theresa Brasier, PsyD | Program Director of Forensic Services |
| Diana St. Cyr, CMC | Director, Revenue Cycle Management |
| Rob Karr, MD Forensic Psychiatrist | Associate Medical Director |
| Craig Gaudette LICSW | Senior Operations Director |
| Diane Schiller | VP of Data Analytics |
| Sherry Ellis MSW, LICSW | COO, Spectrum Health Systems |
| Kristen Nolan MA, MBA | VP of Inpatient and Outpatient Services, Spectrum Health Systems |

Committee Structure



Monthly Planning Timeline

| | January 2020 | February 2020 | March 2020 | April 2020 |
|--|--------------|---------------|------------|------------|
| Planning Meetings | X | X | X | |
| Presentation to the Commission on workplan | | X | | |
| Status Report | | | X | |
| Final Recommendations | | | | X |

Data Collection and Analysis Committee



Data Committee

| Frequency of Meetings | Weekly with ad hoc teams meeting more frequently |
|-----------------------|--|
| Membership | <ul style="list-style-type: none">• Researchers• Data analysis professional• Criminal justice and behavioral health experts |
| Purpose | Use the knowledge and expertise of its members, the documented gaps and recommendations identified in the Commission's One Year report, and the Services, Location and Transportation Committees' ongoing data requests to specify and quantify the target population, estimate utilization, and inform the analysis work of other committees. |

Data Committee

| Action Items | Timeline |
|--|-----------------|
| Determine availability of data and data gaps via review of Commission One Year Report. Coordinate with Advocates Data Analytics, JDP and PES services, Meetings with Commission Staff, and Data Driven Justice Initiative Staff. | Completed |
| Coordinate with the Services, Location, and Transportation Committees to identify additional data needs and access appropriate sources. | Ongoing |
| Collect all identified data. | Ongoing-March |
| Conduct survey of likely restoration center users; Surveys of Police Departments in progress, additional survey work TBD based on planning project needs identified at the end of February. | End of February |
| Specify and quantify the target population, the number likely to use the restoration center, and service needs and provide to the Location, Transportation and Services committees. | February 14 |
| Identify and report out on availability of additional data requests, collection and analysis timelines, and update work plan as needed. | February 28 |

Services and Aftercare Supports Committee



Services Committee

| Frequency of Meetings | Weekly |
|--------------------------------|--|
| Membership | <ul style="list-style-type: none">• Behavioral health experts• Psychiatrists• Community justice practitioners |
| Purpose | <ul style="list-style-type: none">• Identify service model and aftercare options specific each geographic area. |
| Decision-Making Process | <ul style="list-style-type: none">• Ultimate goals to reduce hospital utilization and arrest.• Key drivers informing our decision-making is service availability, barriers to access, and needs of those individuals defined as repeat users. |

Services Committee

| Action Items | Timeline |
|--|-------------|
| Determine the target population characteristics, size and service needs profile. | February 19 |
| Define core set of services for restoration center in each of three geographies. | February 19 |
| Build staffing plan, budgets, and estimates of service capacity. | March 13 |
| Identify most likely payer mix of population. | March 13 |
| Develop resource plan for integrated care, establish protocols to for aftercare. | March 13 |

Location Selection



Location Selection Committee

| Frequency of Meetings | Weekly |
|--------------------------------|---|
| Membership | <ul style="list-style-type: none">• Behavioral health experts• Real estate professionals• Legal expertise |
| Purpose | <ul style="list-style-type: none">• Analyze Pros and Cons of Target Geographic locations.• Make recommendations to the Commission. |
| Decision-Making Process | <ul style="list-style-type: none">• The location committee will utilize their identified expertise and researched data to develop a pros and cons for each geography and make recommendations to the Commission.• Explore possible building locations in each geographic location and develop a pros and cons list for each. |

Location Selection Committee

| Action Items | Timeline |
|--|---|
| Identify needed data sources | Completed |
| Obtain available data from the Data Committee and present to the Location Committee. | February 19 |
| Identify gaps where additional data may be helpful. | February 19 |
| Develop a pros and cons document for discussion and presentation. | February 28 |
| Prepare recommendation for presentation to the Commission. | TBD |
| Identify possible buildings. | Ongoing |
| Obtain square footage/specifications from Model Committee. | February 28 |
| Provide Real Estate professional with details to begin a real estate search. | February 28 |
| Visit two currently identified locations: As soon as can be scheduled | TBD but no later than February 14 |
| Prepare a pros and cons document for each property. | TBD |
| Develop a community engagement plan in collaboration with the Commission. | TBD after a geography has been determined |

Transportation Committee



Transportation Committee

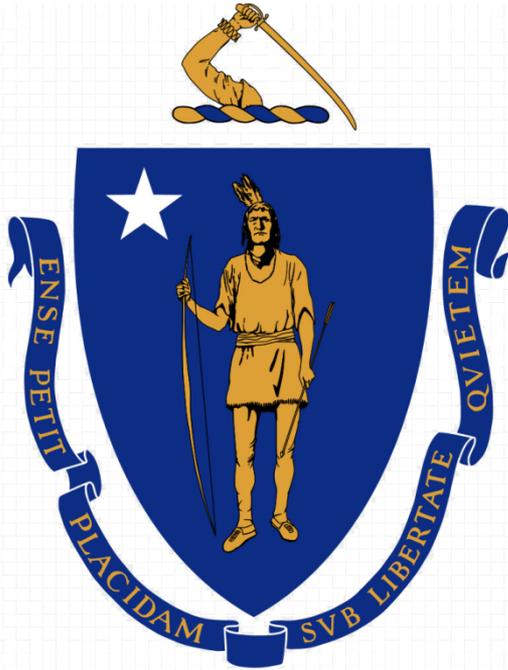
| Frequency of Meetings | Weekly |
|--------------------------------|--|
| Membership | <ul style="list-style-type: none">• Behavioral health experts• Fleet management professionals• Consultants on mobile technology• Legal expertise |
| Decision Making Process | <ul style="list-style-type: none">• Done through lens of maximizing access to restoration center through most cost-effective means.• Will develop and use team expertise to evaluate pro's and con's list of transportation options that address the cost-access continuum. |
| Purpose | <ul style="list-style-type: none">• Identify pros and cons of various transportation options related to the locations of Lowell, Metro West, Cambridge/Somerville areas. |

Transportation Committee

| Action Items | Timeline |
|--|--|
| Identify conduct gap analysis potential transportation resources available in Middlesex county. | Completed |
| Review regulations regarding different transportation options which create barriers. | February 14 |
| Obtain available data from Data Committee regarding population transportation need. | February 14 |
| Identify cost models for different transportation options, including Via model, Uber, Lyft, and site-based models. | February 28 |
| Obtain from location committee narrowed down list of sites to refine transportation recommendations for each area. | TBD once geography has been identified |
| Obtain from services committee potential list of services and licensing options and review impact on transportation options. | March 5 |
| Identify potential regulation change recommendations which could support enhanced transportation options. | March 5 |
| Finalize pro's and con's for transportation options in each area, with recommendations for transportation model. | March 13 |
| Identify conduct gap analysis potential transportation resources available in Middlesex county. | Completed |

Restoration Center Commission

Work Plan Update





Completed

| | |
|-----------------------------------|--------------------|
| Commission Meeting | September 19, 2019 |
| Commission Meeting | November 12, 2019 |
| Planning Grant Procurement | December 30, 2019 |
| RFI Response | December 20, 2019 |
| MassHealth data request submitted | January 6, 2020 |
| Police Survey | February 3, 2020 |



Looking Forward

| | |
|---------------------------------------|-----------------------|
| Commission Meeting | February 4, 2020 |
| Planning Grant Progress Report Due | February 26, 2020 |
| Tucson Site Visit | February 27-29, 2020 |
| Commission Meeting: Progress Report | March 3, 2020 |
| Commission Meeting: Report Feedback | April TBD |
| Planning Grant Final Report Due | April TBD |
| Legislative Reporting Deadline | April 13, 2020 |
| MassHealth Data Match | TBD |



Middlesex County Restoration Center Commission
Tuesday, March 3, 2020
10 am – 12 pm
400 Mystic Ave, Medford, MA

AGENDA

- | | |
|-------------------|---|
| 10:00AM – 10:05AM | Welcome and Introductions <i>Co-Chairs, Sheriff Koutoujian and Danna Mauch</i> |
| 10:05AM – 10:20AM | Legislative Update <i>Senator Friedman and Representative Gordon</i> |
| 10:20AM – 10:30AM | Approval of Minutes from Year One <i>Co-Chairs, Sheriff Koutoujian and Danna Mauch</i> |
| 10:30AM – 10:45AM | Update on Police Survey <i>Catia Sharp</i> |
| 10:45AM – 11:55AM | Consulting Update <i>Brenda Miele Soares and Opal Stone</i> |
| 11:55AM – 12:00PM | Next Steps and Closing <i>Co-Chairs, Sheriff Koutoujian and Danna Mauch</i> |



**Middlesex County Restoration Center
Tuesday, March 3, 2020
400 Mystic Ave., 4th Fl.
Medford, MA**

MINUTES

Attendees: Sheriff Peter J. Koutoujian, co-chair; Danna Mauch, Massachusetts Association for Mental Health, co-chair; Senator Cindy Friedman; Judge Rosemary Minehan; Chief Robert Bongiorno; Nancy Connolly, Department of Mental Health; Jim Cremer (representing Jennifer Barrelle), Department of Public Health; Mandy Gilman, Association for Behavioral Health; Eliza Williamson, National Alliance on Mental Illness (NAMI) Massachusetts; Brenda Miele Soares, Advocates; Opal Stone, Advocates; Beth Lacey, Advocates; David Ryan, Middlesex Sheriff's Office (MSO); Sonya Khan, MSO; Catia Sharp, MSO; Carl Abate, MSO; Carrie Hill, Middlesex Sheriff's Association (MSA); Mark Larson, Committee for Public Counsel Services (CPCS); Nan Whitfield, CPCS.

10:00 AM: WELCOME AND INTRODUCTION

Sheriff Koutoujian called the meeting to order and invited a round of introductions.

Sheriff Koutoujian asked Committee for Public Counsel Services (CPCS) representatives what sparked their interest in the Commission.

Mark Larson replied that as the head of the mental health unit, his interest is to decrease their caseload as much as possible (meaning decrease the number of individuals with mental illness needing defense in competency hearings and who are otherwise held in state hospitals related to criminal involvement).

Nan Whitfield added that as a criminal public defender, she has an interest in diversion.

Sheriff Koutoujian asked Chief Bongiorno to recap the trip many Commission members made the week prior to Tucson to conduct a site visit for the Commission.

Chief Bongiorno thought the trip included a great mix of our team with multiple perspectives. He thought the Tucson Police Department (TPD) did a great job, and that the ride along was amazing. He expressed how impressed he was with how the TPD are working with high risk individuals, explaining that law enforcement has evolved into a “we’re here to help” mentality. He was able to see on a ride along their intervention with homeless individuals, ultimately convincing an individual to be transported to CODAC (the detox facility). Chief Bongiorno explained the distinct roles played by the Crisis Response Center (CRC) and CODAC in the system, but how both locations work with law enforcement to make interactions seamless. He noted that neither location will turn people away and they have a relentless focus on getting officers back on the street quickly. He thinks that is how you need to do this to be effective. Chief Bongiorno expressed respect for the “A to Z services” there, and thinks it is a great model.

Danna Mauch added a couple of things she found striking: the culture in the TPD and in behavioral health providers are aligned in engaging people in need in a compassionate way, using leverage if they have it to engage people and invite them to service in a transparent way; the “no wrong door” approach to creating a seamless continuum of care; and that everyone in the system feels a sense of responsibility for serving individuals with complex needs. She noted that both CODAC and the CRC take people without question, and without second-guessing the judgement of law enforcement or others who complete drop-offs. The police are released very quickly.

Chief Bongiorno added an example in which his team went into a tunnel where homeless individuals were living. He saw the compassion of the police when one man had two active warrants, one of which was for a felony offense, and the police told him that they would deal with those warrants later. They offered to assign a liaison to deal with the legal issues, prioritizing a trip to a treatment facility first. Chief Bongiorno thought this was an excellent way to avoid jail and promote treatment.

Eliza Williamson asked what the police would have done if the person said no to treatment in that situation.

Chief Bongiorno said that the police were still not prepared to arrest the person. They gave out snacks, naran, and other needed items and made it clear that the person was committing a crime by trespassing, but that they wanted to help promote treatment by avoiding arrest for that crime.

Sheriff Koutoujian asked what the crimes were that the person had warrants for, and whether any were against a person.

Chief Bongiorno said that the crimes were not against persons, and that TPD makes that distinction. He says that they don't call it "diversion," but rather "deflection." The mindset is different, and indicates that criminal issues will still be dealt with, but that health will be prioritized. He noted that a focus on terminology was similar with their use of "familiar faces" instead of "frequent fliers."

Danna Mauch added that there is a sense of continuing ownership in the culture across services, and that they can actually deliver on the array of services that they talk about. Providers there can actually ensure aftercare services, and have the authority to do that. She added that some people in Massachusetts on our crisis teams don't have that authority, and this undercuts our continuum.

Sheriff Koutoujian added that it seems like some of the places with more successful systems are those with more centralized county and city government.

Senator Friedman said that she thought it is important to understand the authority to get people where they need to go, because maybe only the courts have that authority.

Judge Minehan asked if the authority referred to is Assisted Outpatient Treatment (AOT). She noted that only three states, including Massachusetts, don't have AOT.

Danna Mauch replied that AOT is not necessarily the linchpin. In Tucson, they actually have the services to offer, and people have come to understand that they will deliver on those services.

Mandy Gilman agreed, and added that this is critical to directing care.

Danna added that she was impressed that they had standing capacity in many parts of their continuum of care.

Sheriff Koutoujian thought that some of this we won't be able to do in Massachusetts, and what is key is to take pieces of other systems that we can implement here.

Senator Friedman pushed back, saying that she thought a lot of the things we could do here.

Sheriff Koutoujian pointed to the phenomenal amount of resources available in Bexar County, Texas, for example related to housing.

Senator Friedman said that there is something from every example that we can take, and that we need to understand how they do it because we aren't doing it. She added that the only place we currently have to get people into treatment is through the court, and that is unacceptable. She also said that whatever we do has to have the basic concept of a quick dropoff.

Brenda Miele Soares added that she thought one of the reasons they had a seamless system in Tucson is because they have a more seamless Medicaid system there. Through block grants, the regional behavioral health authority could direct parts of the system to retain open slots in care, and that is key.

Jim Cremer noted that the issue of how to ensure standing capacity comes up all the time here, and asked if this was accomplished through a rate.

Danna Mauch responded that yes, standing capacity is a systemic need that we could simply pay for here.

Senator Friedman said that is something we could do here.

Sheriff Koutoujian noted that Carrie Hill, the Executive Director of the Massachusetts Sheriff's Association, has been a driving force with regard to Medicaid reimbursement to jails and prisons for the health and behavioral health services they provide to inmates and detainees.

Carrie Hill described a federal task force composed of sheriffs, judges, and others that is seeking to address the federal Medicaid exclusion for jails and prisons. She said they are pursuing the issue related to Medicaid for detainees in particular as a constitutional violation, but that for both detainees and inmates the main issue is continuity of care. She promised to share a link with the group to the task force report that was recently released.

Sheriff Koutoujian added that this issue has been very bipartisan, and that Senator Ed Markey has been a champion of the issue. He added that money will be the main barrier to getting it done. He said that there are two strategies to get it done: legislative and judicial.

Danna Mauch asked Sonya Khan and Catia Sharp to speak to the data sharing being done in Tucson.

Catia said there was a culture of getting to “yes” instead of immediate “no” in Tucson.

Sonya Khan added that the high amount of collaboration across providers was the key to data sharing in Tucson.

Brenda Miele Soares reiterated that the regional behavioral health authority supports the data sharing by requiring reporting by providers and encouraging providers to enter into data sharing agreements with each other.

10:30 AM: LEGISLATIVE UPDATE

Senator Friedman noted that the Senate budget is coming up, so she will need a budget to react to soon for SFY 2021.

Sheriff Koutoujian noted that it is likely that the Restoration Center will require funding above the level that has been used in past years.

Senator Friedman thought that the timing of launch may allow for some creativity.

Mandy Gilman added that the Association for Behavioral Healthcare is involved in budget development with Advocates and Catia.

Senator Friedman noted that DMH and DPH and EOHHS are going to need to step up and make sure the Secretary of EOHHS and Governor Baker’s administration are involved in this process and supportive of the effort.

Mandy Gilman noted that Advocates is currently going through the list of services and benefits the state already provides to see who pays now. She added that respite is a good example of something that DMH currently pays for, but it is restricted to DMH clients. For the Restoration Center to be truly payer blind, it will need respite beds that can accept any client regardless of payer.

Sheriff Koutoujian noted that we need to be careful about quantifying the costs as well as the savings to make the case for the center.

Senator Friedman said that it is true that we expect there to be savings, but that these savings won’t necessarily be directly monetizable. There is a wrong pockets problem. Savings at DPH, for example, could be used to pay for DPH services, but there will still be a need for general fund revenue as well. For this, we will need buy-in from the Administration.

Sheriff Koutoujian added that the hospitals will save money, so maybe they will chip in for it.

Jim Cremer added that the EOHHS behavioral health redesign is happening now, and that there will be significant overlap with this project.

Danna Mauch noted that Scott Taberner, Nancy Connolly, and Jenn Barrelle (represented by Jim Cremer today) are instrumental in making sure the two projects are aligned.

Jim Cremer said that the intention is to reveal details of behavioral health redesign later this month, and that one of the goals is to deflect people from higher levels of care in part to save money.

Senator Friedman reiterated her note of caution to say that we are not in a savings place yet, and that we can't ensure that people with so many unmet needs are going to save money immediately. We are starting from scratch, but it is the right thing to do. The goal is to get people treated, even if we can't show savings yet. We should be cautious about short-term savings promises.

Sheriff Koutoujian agreed, and added that up there (the State House), you have to make the savings argument as well.

Mandy Gilman asked when the Restoration Center is expected to open, because it is an important part of the budgeting process.

Senator Friedman replied that we haven't decided yet. The legislation is very general that the 3rd and 4th year budgets are for getting the pieces in place.

Mandy Gilman said that her personal opinion is that January 1 is the absolute earliest you could do this.

There was general agreement in the room that even January 1 would be an extraordinarily fast timeline.

Before the legislative update ended, Danna Mauch noted to the group that Senator Friedman has championed a very important piece of legislation that recently passed the Senate in a large behavioral health reform package that is now before the House.

Sheriff Koutoujian agreed, adding that they had the Governor at a hearing for several hours and that Senator Friedman was amazing in running that hearing with her knowledge and management of the hearing.

11:00 AM: APPROVING THE MINUTES FROM THE LAST MEETING

Sheriff Koutoujian asked for a motion to approve the minutes from the last meeting.

Mandy Gilman made the motion.

Sheriff Koutoujian asked for all of those in favor, and then all of those opposed. The vote was unanimous in favor of approving the minutes from the last meeting.

11:05 AM: POLICE SURVEY UPDATE

Sheriff Koutoujian asked Catia Sharp to update the Commission on the police survey.

Catia Sharp shared that, thanks in large part to Sonya Khan's relationships with police departments across the county, we are up to 46 respondents to the survey. She focused on any material that had changed with the new respondents. Most information remained the same, though the utilization of ESPs by ESP response time had changed slightly.

Rosemary Minehan asked a question about slide 11 on involuntary commitments.

Catia Sharp clarified that the graph on the left represents Section 35, while the graph on the right includes data on Section 12.

11:20 AM: ADVOCATES WORK PLAN UPDATE

Opal Stone presented an update to Advocates' work plan. She shared the data work that had been done since the last meeting, which will inform the work on location selection, service model specification, and transportation options.

Opal shared three geographic regions of the county that Advocates is using for potential Restoration Center locations. She shared an estimate of the number of individuals who might enter a Restoration Center per day in each of the regions. She made clear that the number of intakes is not the only factor in assessing what region a Restoration Center ought to go in, but that this is an attempt to provide some specification of the size of the potential target populations in each area. She also highlighted that there remain some reservations and gaps in the data used to produce these estimates.

Opal highlighted that homeless individuals have some of the highest needs among subsections of the target population, and that Lowell has the highest volume of homeless individuals and has the highest rate of ESP utilization.

Senator Friedman asked why the estimate of daily intake in the southeast county region is so much higher than that in Lowell, given the higher amount of need in Lowell.

Opal showed a heat map of the ESP utilization by town of residence of client which showed that many people access ESP services outside of their town of residence. For this reason, in addition to the population of the southeast part of the county being higher, there are high estimates of Restoration Center utilization from surrounding cities and towns baked into that assumption.

Catia Sharp added that the ESP utilization patterns showed that more people used BEST and Eliot whose address of residence was outside the boundaries of the southeast part of the county than those who used those ESPs who lived in that region. Therefore, half of the southeast region bar on the bar chart showing estimated Restoration Center utilization is attributable to people coming in from outside of the region for services.

Sonya Khan asked whether the people referred to the ESP by self/family are mostly repeat ESP users or new customers (i.e., do they know the ESP serves already).

Brenda Miele Soares said that it could be either.

Opal Stone added that we don't have the information about how many people are in the sample, so we don't know how many of these are duplicates.

At slide 7, Chief Bongiorno said that Advocates was being modest, and they were the first Jail Diversion Program clinicians.

At slide 10, Senator Friedman asked if substance use was so low in Framingham because Advocates is better at identifying dually diagnosed individuals at intake.

Opal responded that it could be true that there could be a higher level of sophistication given the maturity of the program.

At slide 17, Danna Mauch noted that the estimates of utilization may be missing some sources like Section 35 diversions that could occur if family members are aware of the Restoration Center.

Catia Sharp responded that this is true. She noted that there are a few caveats with the data that was used to produce these numbers – as Danna mentioned, there are some sources that are missing,

which might mean an undercount of the number of users of a Restoration Center, but that might be offset by imperfections in the data that is included. She suggested that any estimates will be imperfect and we won't truly know until implementation. Utilization of the Center will also depend in part on marketing and outreach activities, as Opal had mentioned earlier.

Chief Bongiorno asked whether a person could go to the Restoration Center after becoming involved in the criminal justice system, for example if they were arrested and subsequently bailed out of jail.

Sheriff Koutoujian suggested that the Commission should look at that.

Senator Friedman responded that the Center is really looking at Intercept 0, which would be pre-arrest.

Sheriff Koutoujian agreed, noting that the goal would be to divert those people before arrest. He also mentioned medically managed withdrawal in the jail (detox).

Catia Sharp added that some places that are doing crisis stabilization centers, like Cook County Illinois (Chicago) and Bernalillo County, New Mexico are also using them as places to accept individuals reentering from jails and prisons in need of connections to care. For this reason, Advocates included some numbers of reentering residents from HOCs and the Doc in the estimates of Restoration Center utilization. In this respect, people bailed out of jail in need of services would not differ substantially from a person reentering the community from prison, and therefore might be a very good candidate for using the Restoration Center. In fact, bailed out detainees might be more in need of services given their potentially short stays in the jail and limited access to mental health and substance use services.

Mandy Gilman noted for Senator Friedman's benefit that ABH and Advocates are discussing barriers to the services under consideration, and wanted to highlight two potential items: the idea that the state could investigate standardizing medical clearance, and that the state could investigate standardizing HIPAA and 42 CFR data sharing forms to improve utilization and continuity of care.

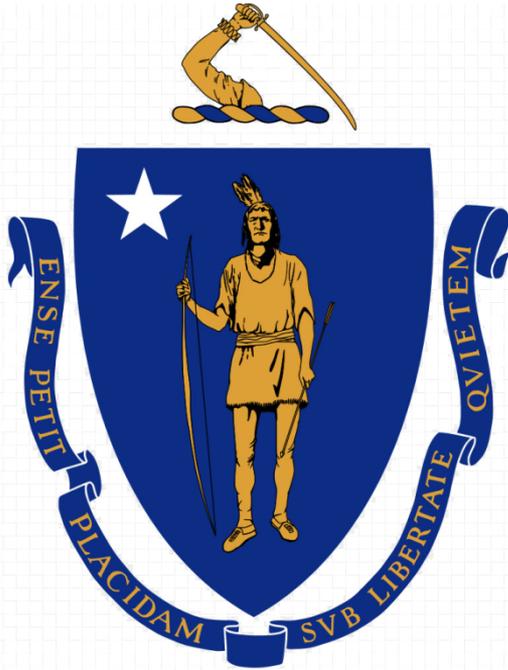
Judge Minehan added that the definition of a "facility" in the language of the Section 12(a) would also need to be tweaked to add the Restoration Center.

12:00 PM: NEXT STEPS AND CLOSING

Sheriff Koutoujian and Danna Mauch adjourned the meeting.

Restoration Center Commission

Police Department Survey Findings





Year Two Activities

- ➔ Refining the target population
- ➔ Specifying the service model
- ➔ Developing recommendations for improvements to existing, related services



Survey Domains

- Dispatch
- Mental health incident response
- Incident reporting
- Incident Disposition
- Diversion



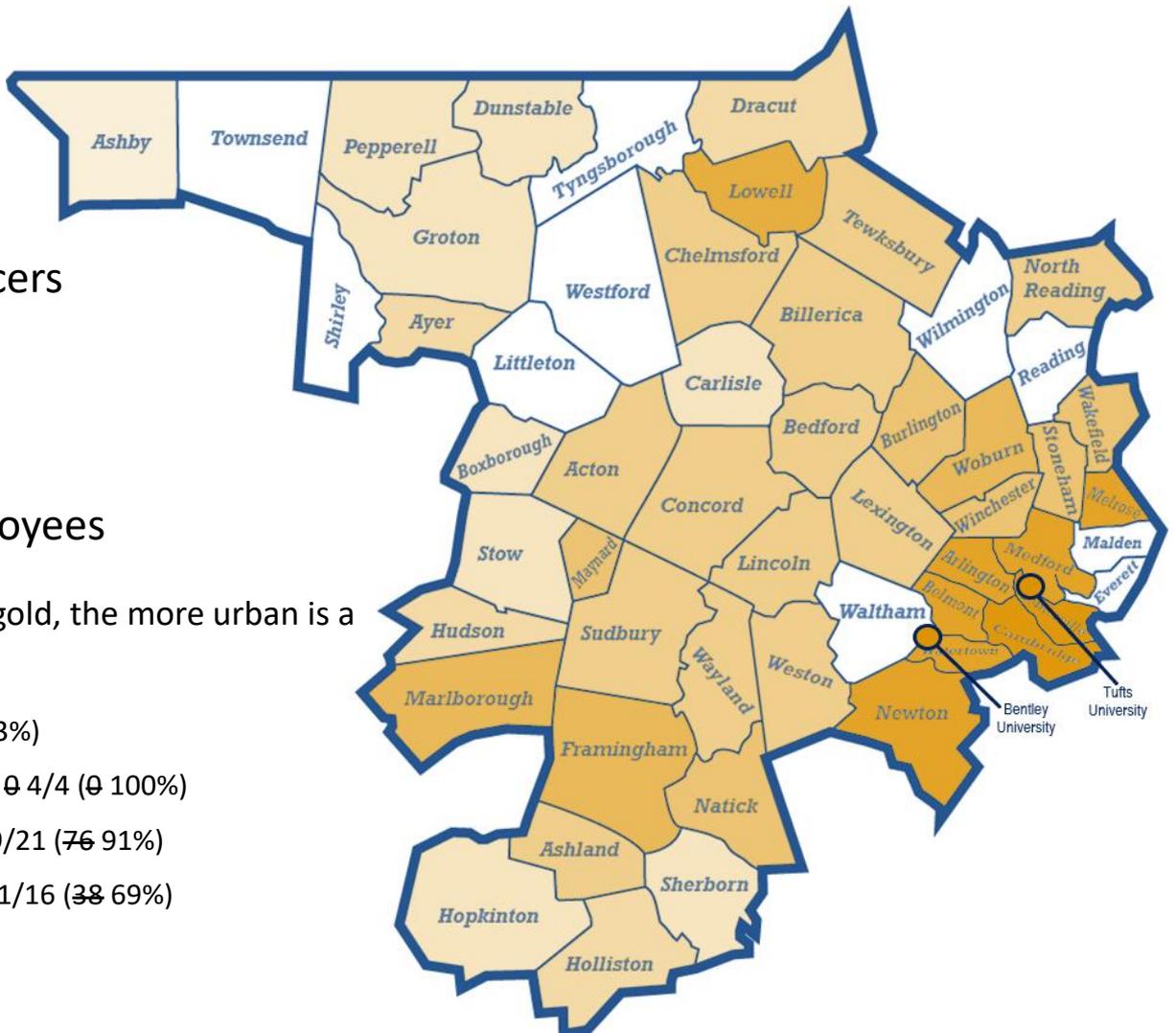
Who Responded to the Survey?

Who responded?

- 23 29 Chiefs
- 6 10 ranked officers
- 2 patrol officers
- 3 clinicians
- 12 civilian employees

The deeper the shade of gold, the more urban is a community.*

- Inner Core: 7 8/11 (64 73%)
- Regional Urban Centers: 0 4/4 (0 100%)
- Maturing Suburbs: 16 19/21 (76 91%)
- Developing Suburbs: 6 11/16 (38 69%)
- Rural Towns: 1/1 (100%)
- 2 University PD's

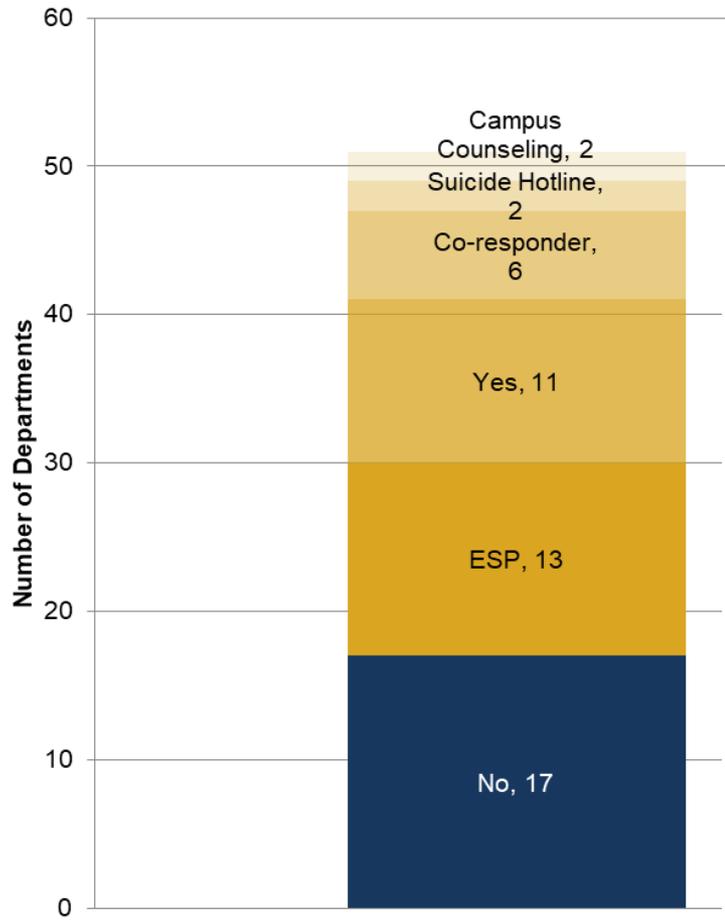


*from MAPC http://www.mapc.org/wp-content/uploads/2017/09/Massachusetts-Community-Types-Summary-July_2008.pdf



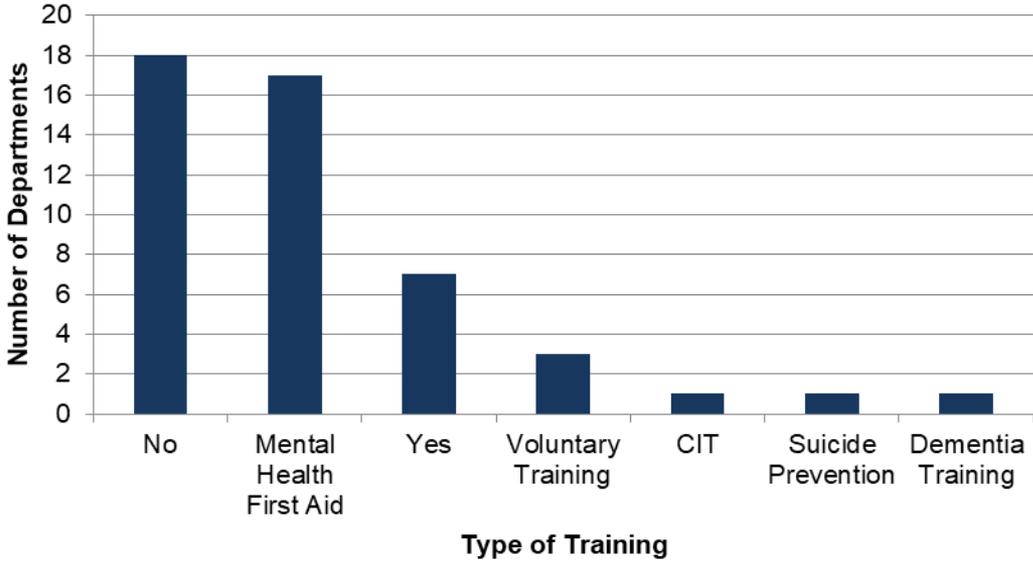
911 Call Centers

911 Hotline Direct Connection



Nearly all 911 call centers are operated by the police department; no respondents said they participate in regional call centers.

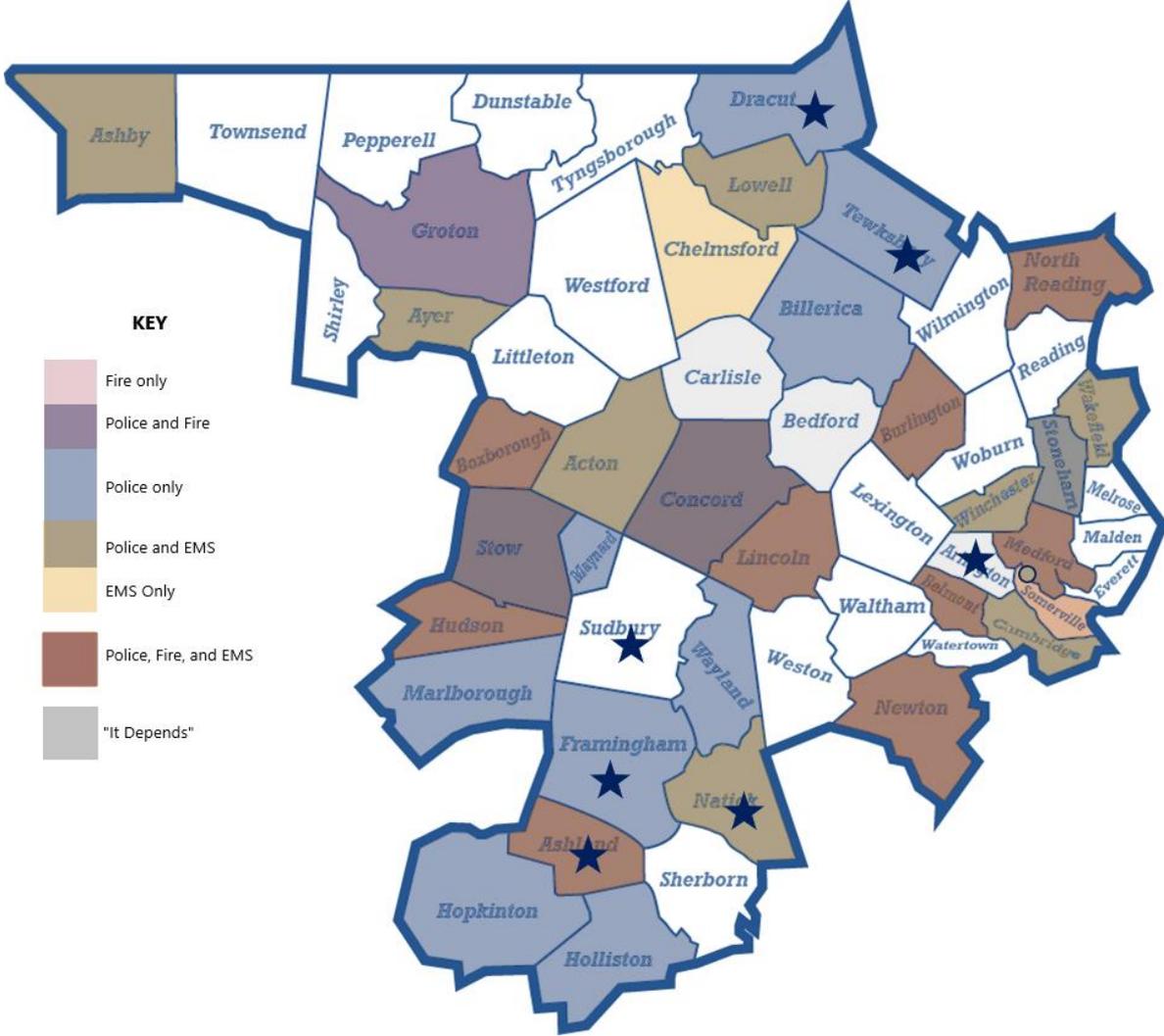
BH Training for Dispatchers





Dispatch Protocol

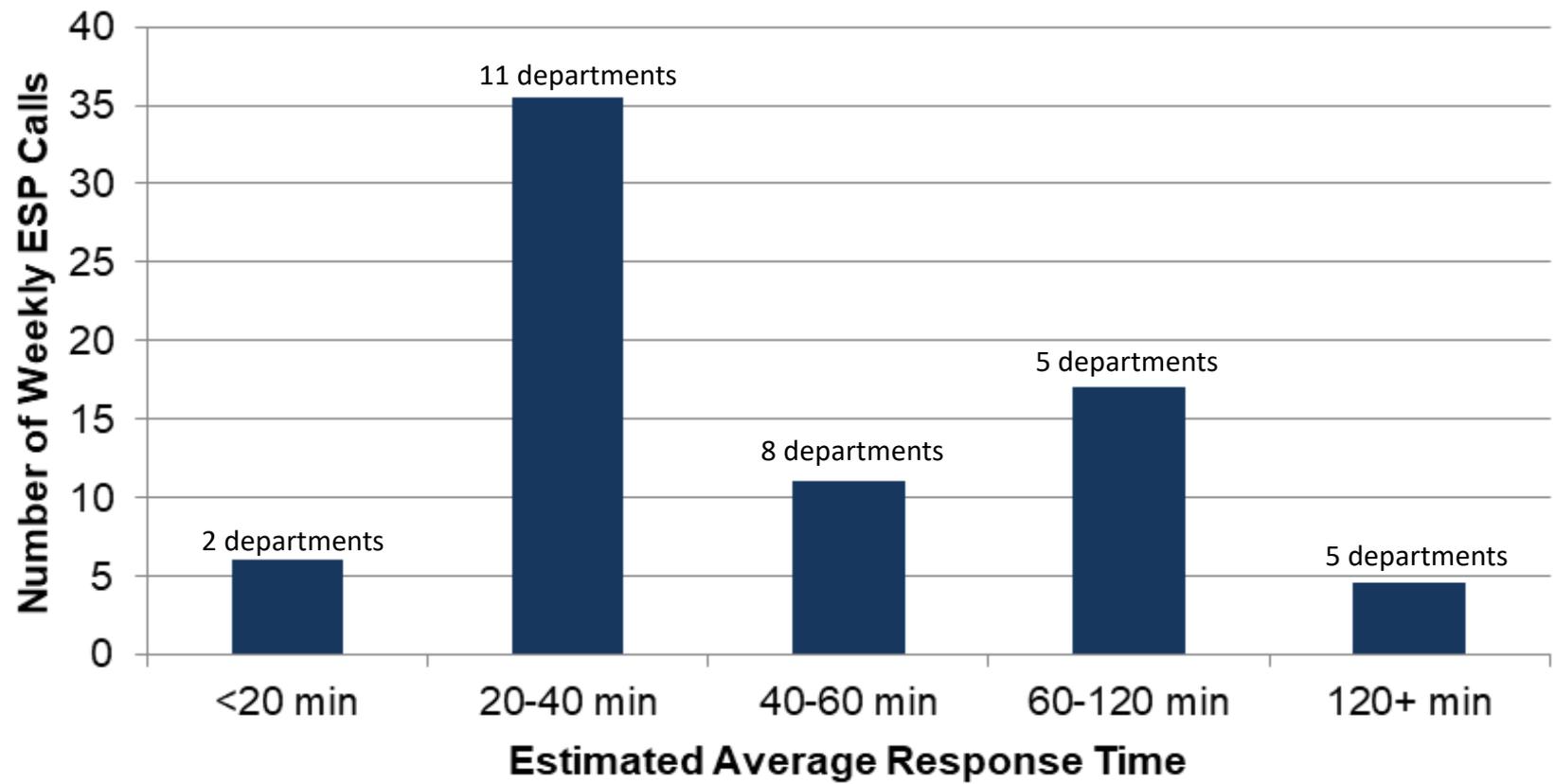
Who responds to a behavioral health emergency?
“It depends.”





Emergency Services Providers

ESP Utilization Per Week by Response Time





Hospital Catchment Areas

Hopkinton, Holliston, Ashland, Wayland -> Metrowest natick and framingham

Hopkinton -> milford regional

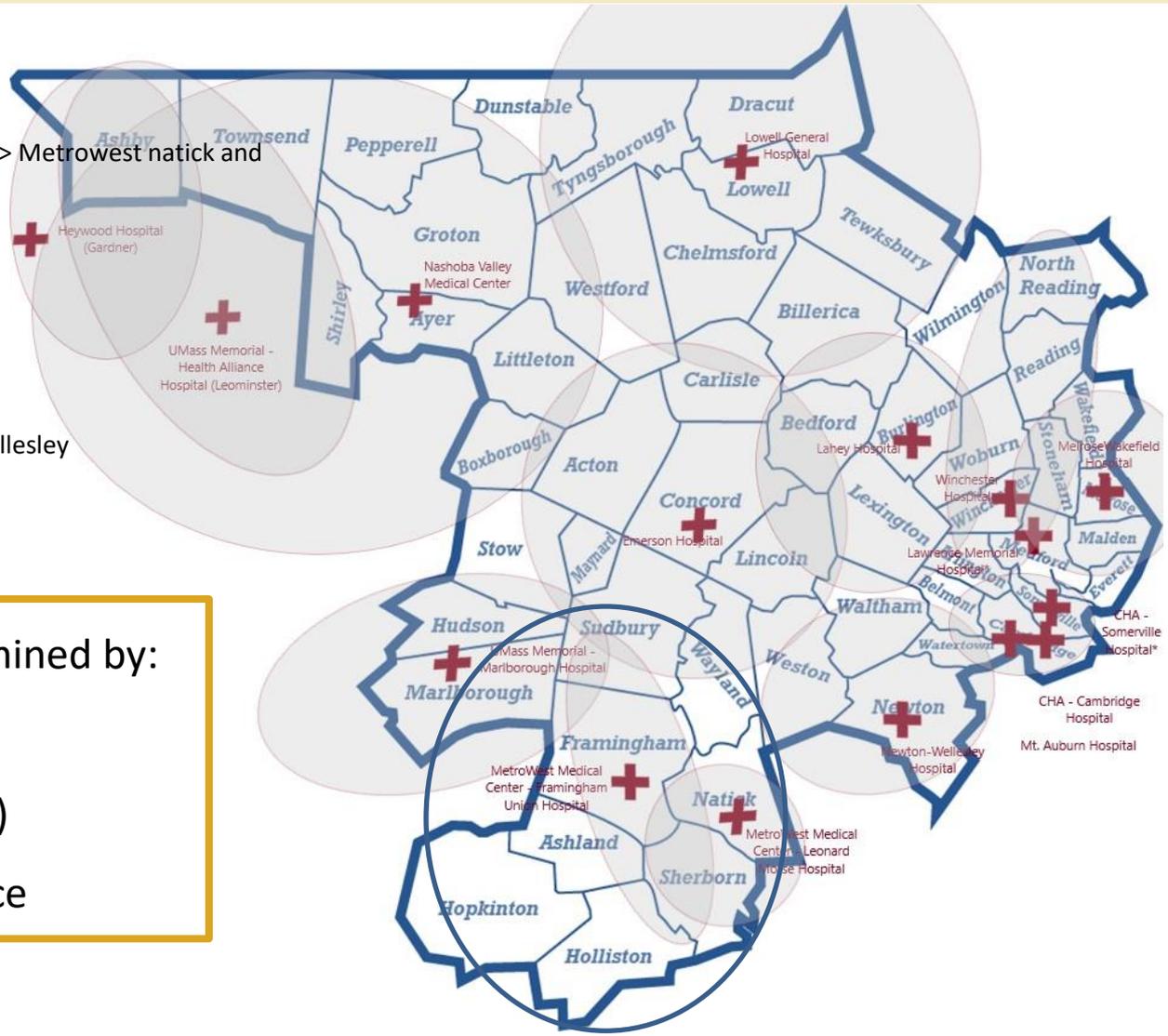
Boxborough -> emerson

Belmont -> mt auburn

Lexington -> lahey, emerson, newton/wellesley

Groton -> nashoba and emerson

Dunstable -> lowell

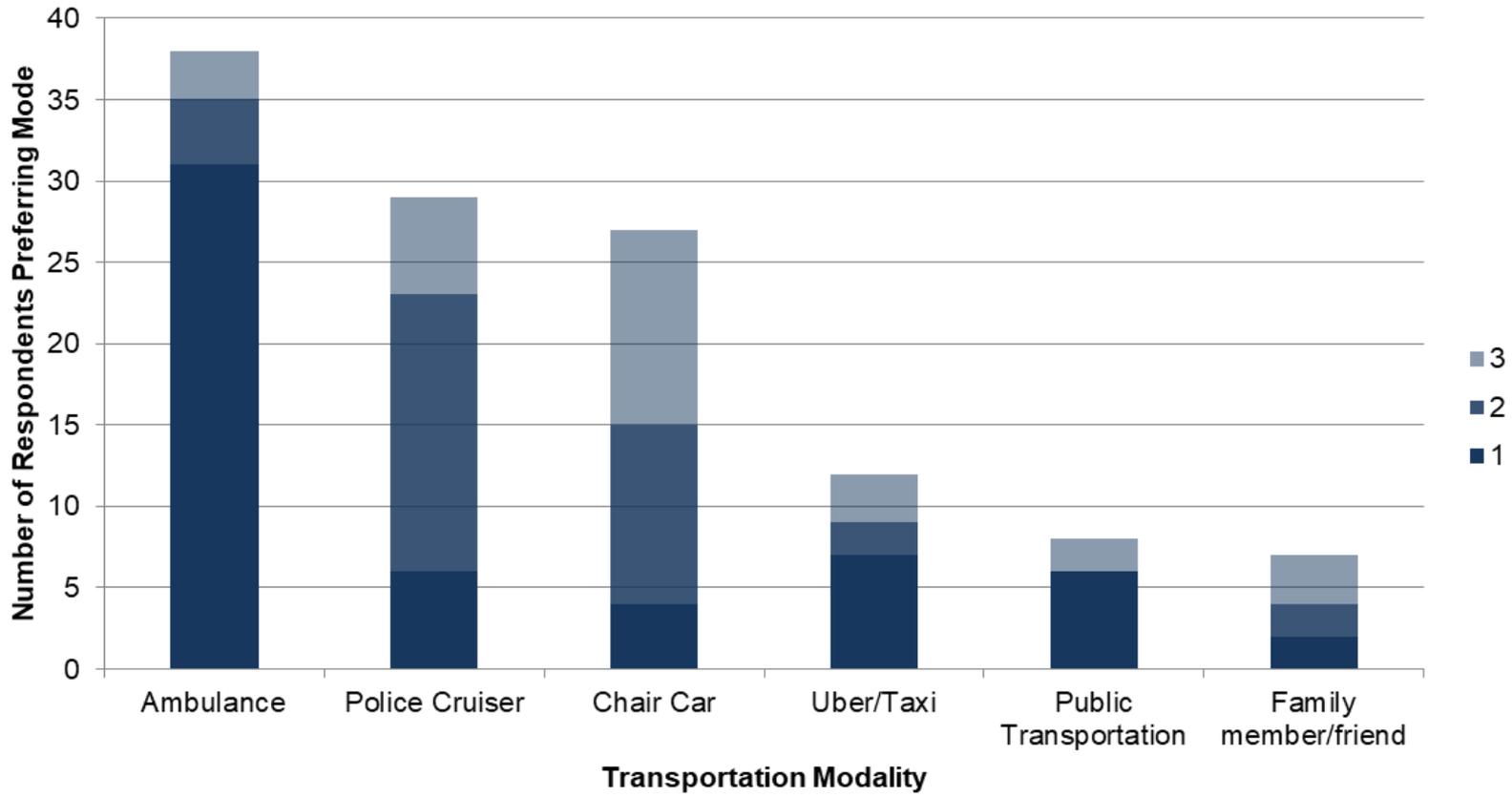


- Hospital is determined by:
1. Proximity
 2. Services (BH)
 3. Patient choice



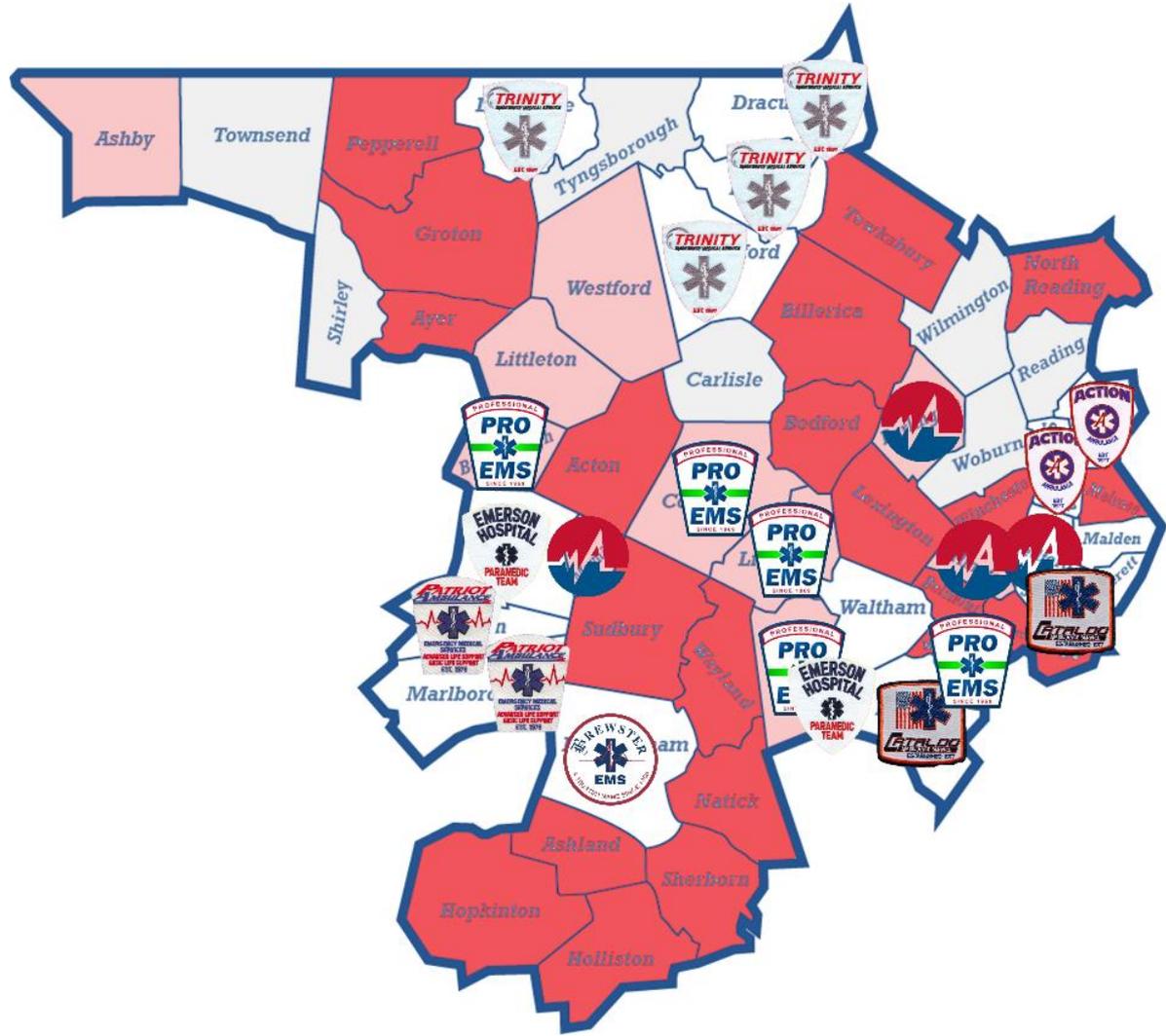
Restoration Center Transportation

Restoration Center Transportation: Police Preferences





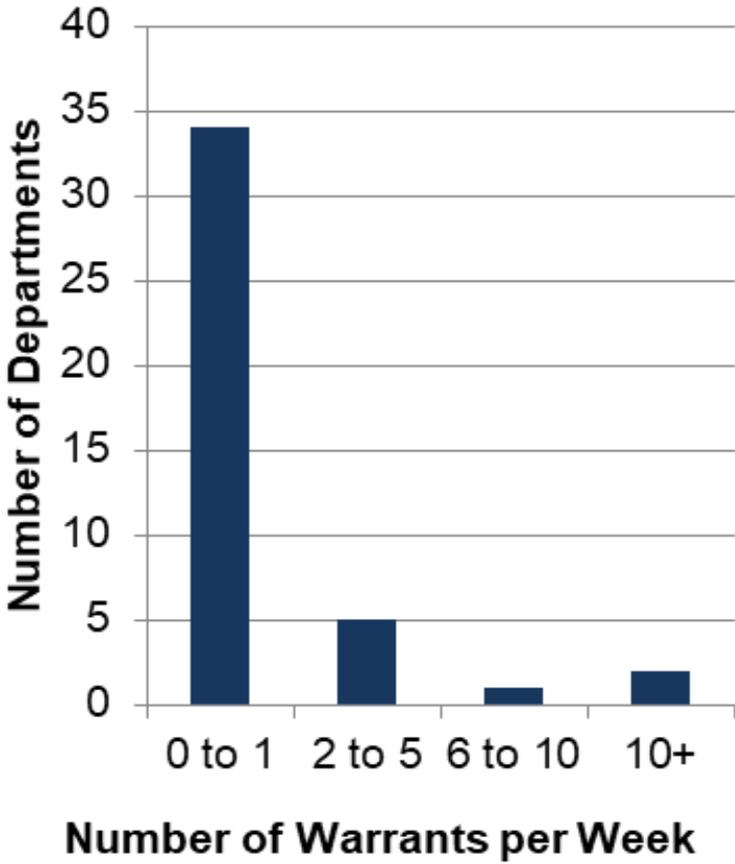
Emergency Medical Transportation



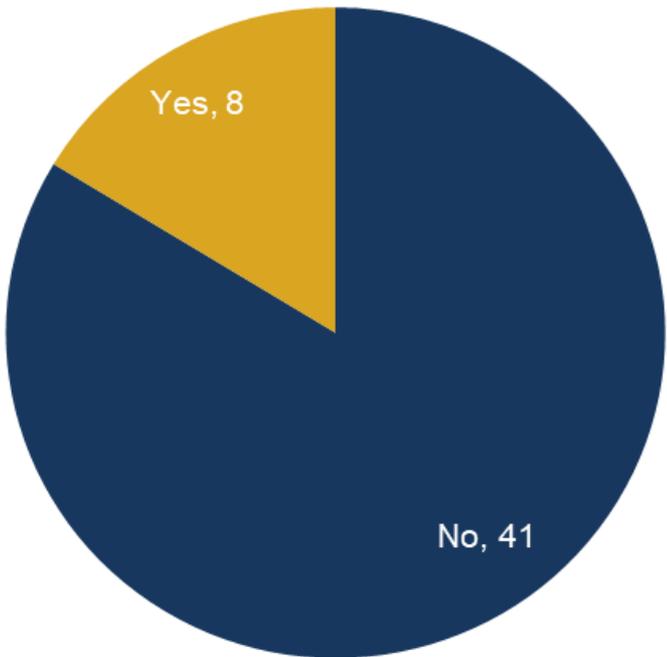


Involuntary Hospitalization

Section 35 Warrants/Week



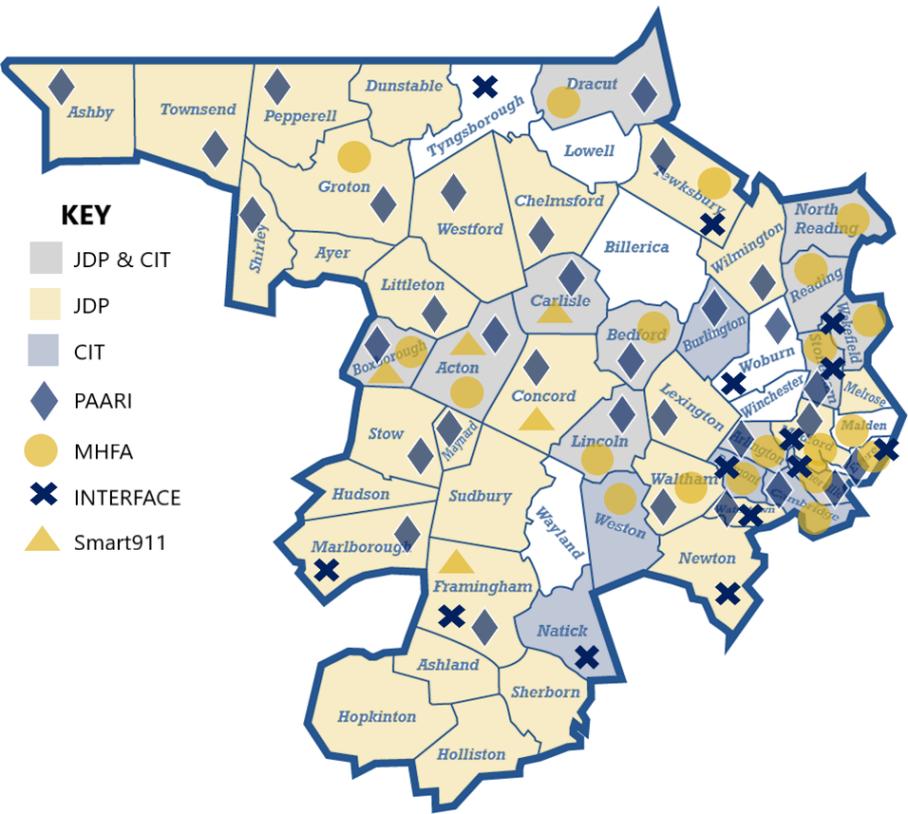
Hospital Transports in Police Cruisers



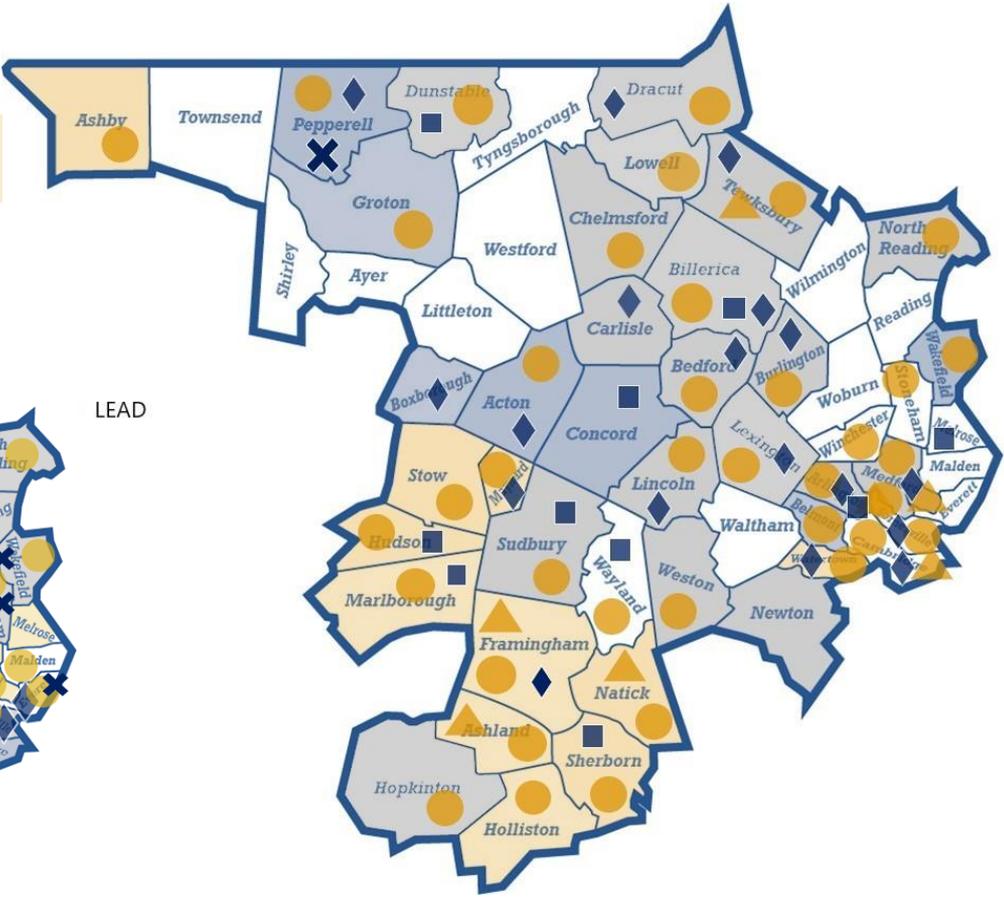


Diversification Programs

Year One Findings and Recommendations



LEAD

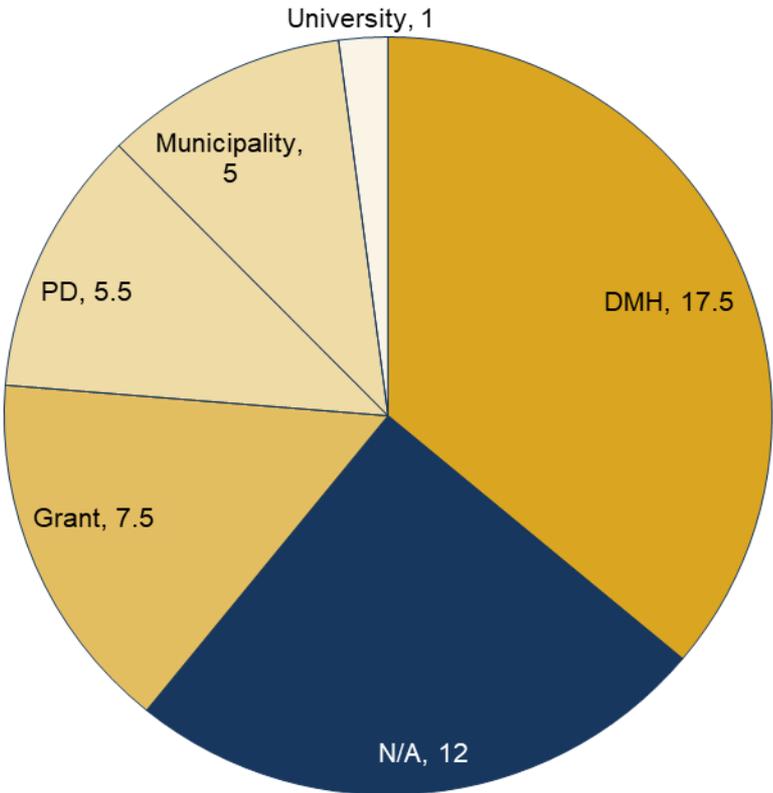


Police Survey

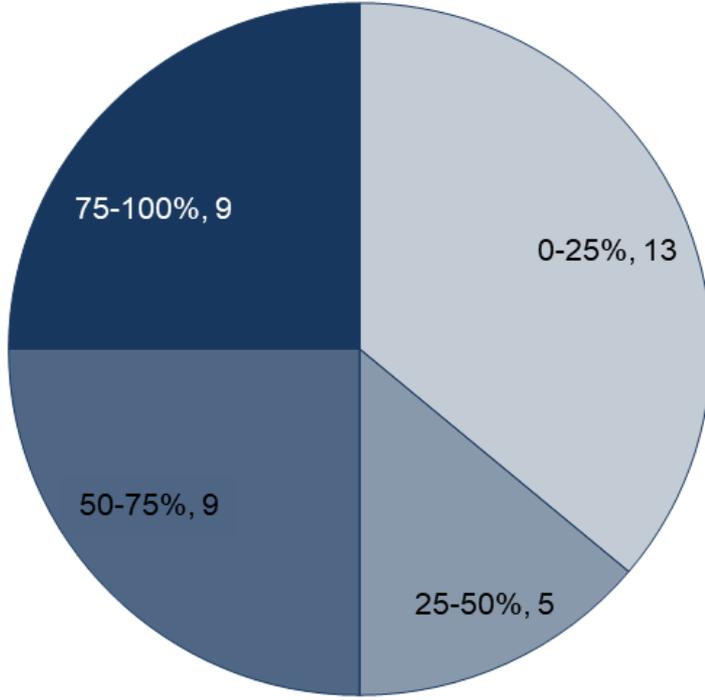


Diversion Programs

Co-Responder Funding



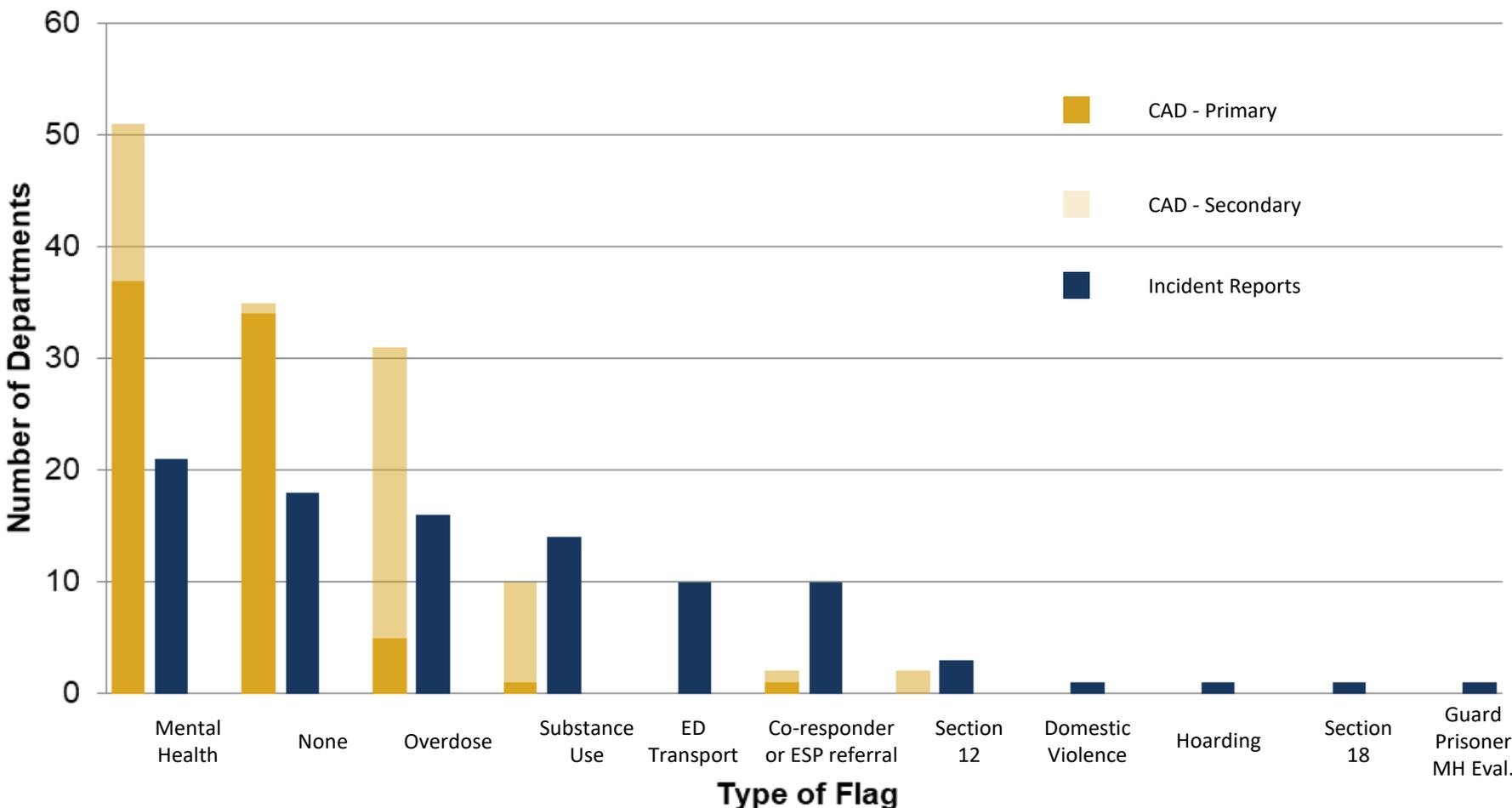
CIT Trained %





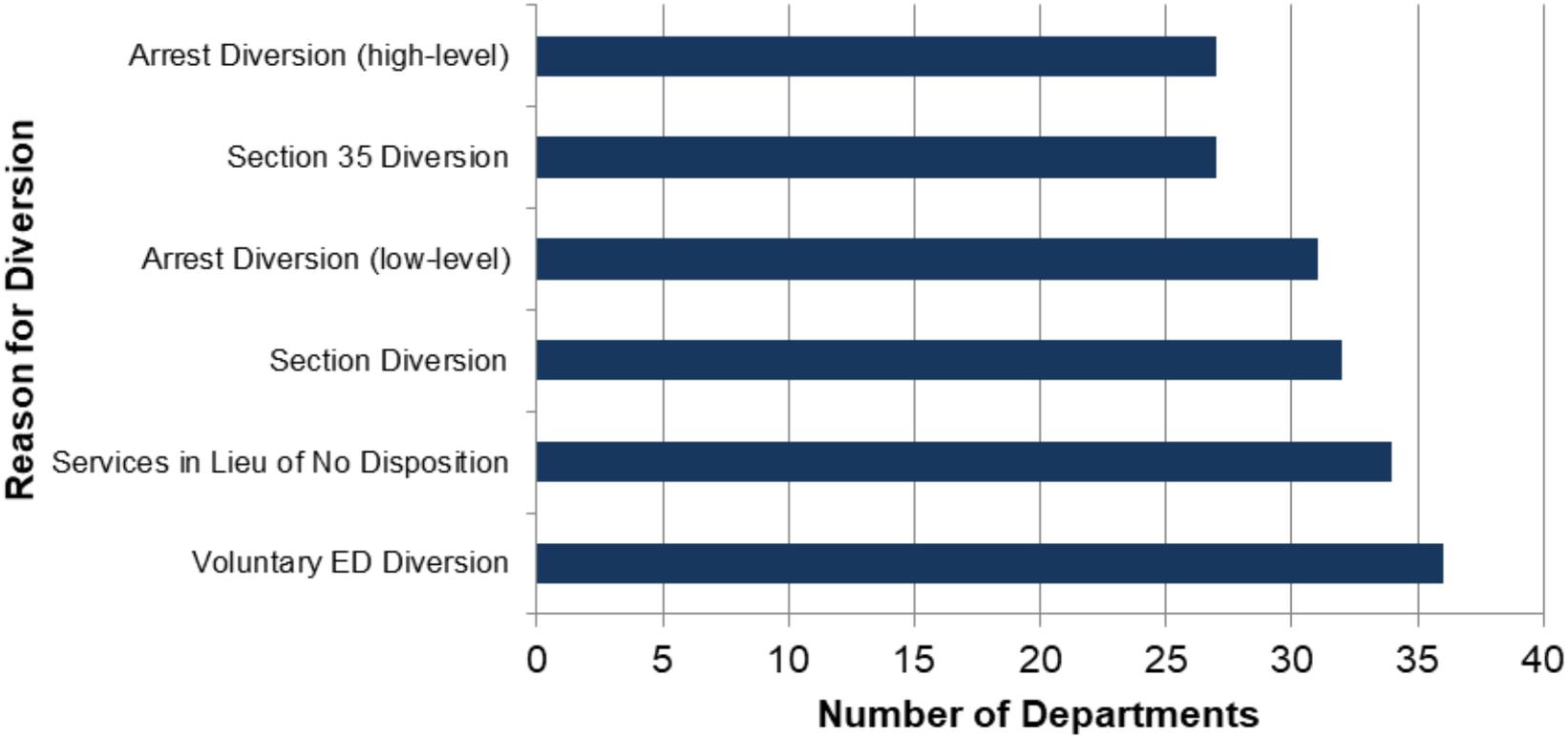
Database Flags for BH

Database Flags for BH





Departments said they would use a Restoration Center for...

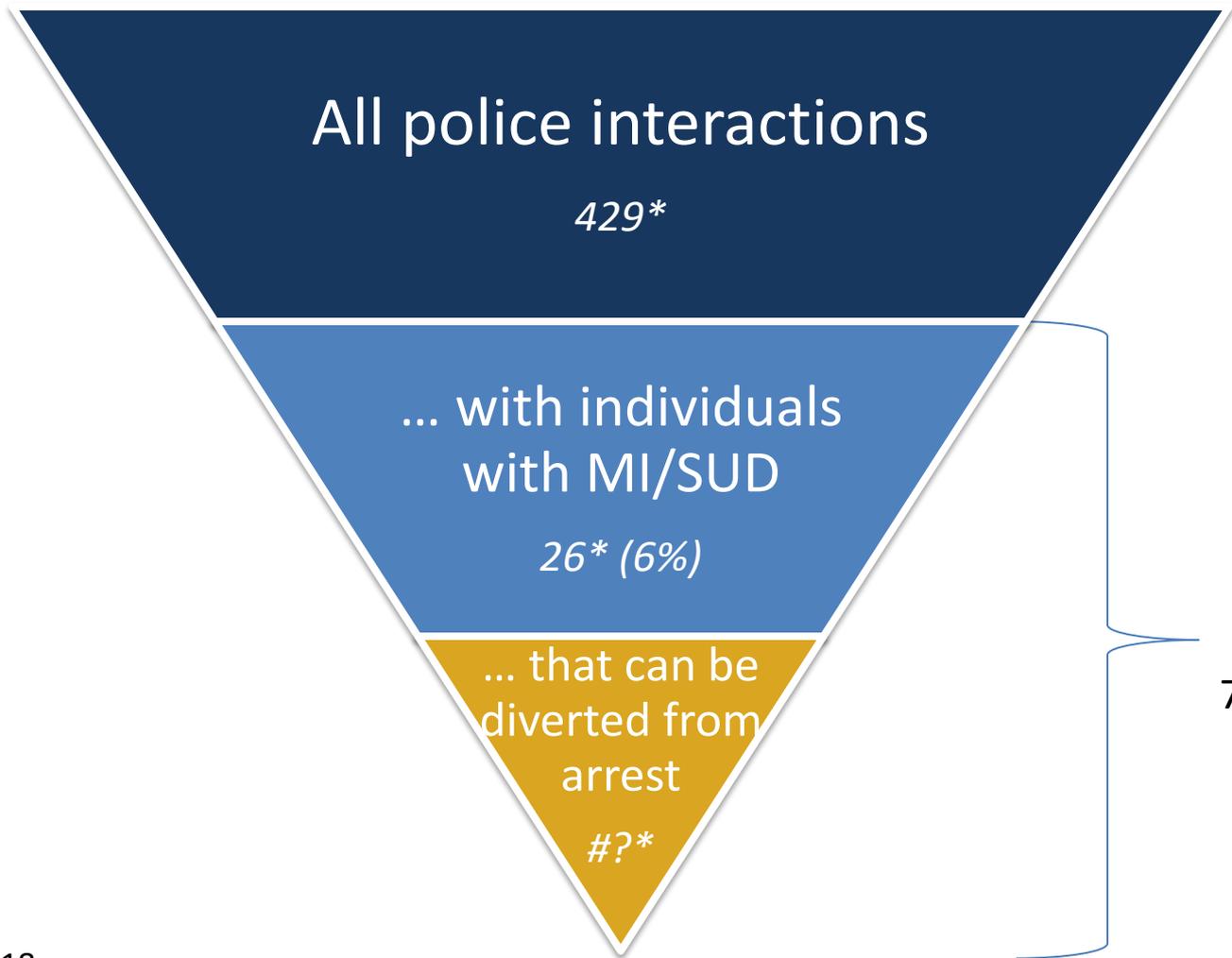


APPENDIX





Defining the Target Population

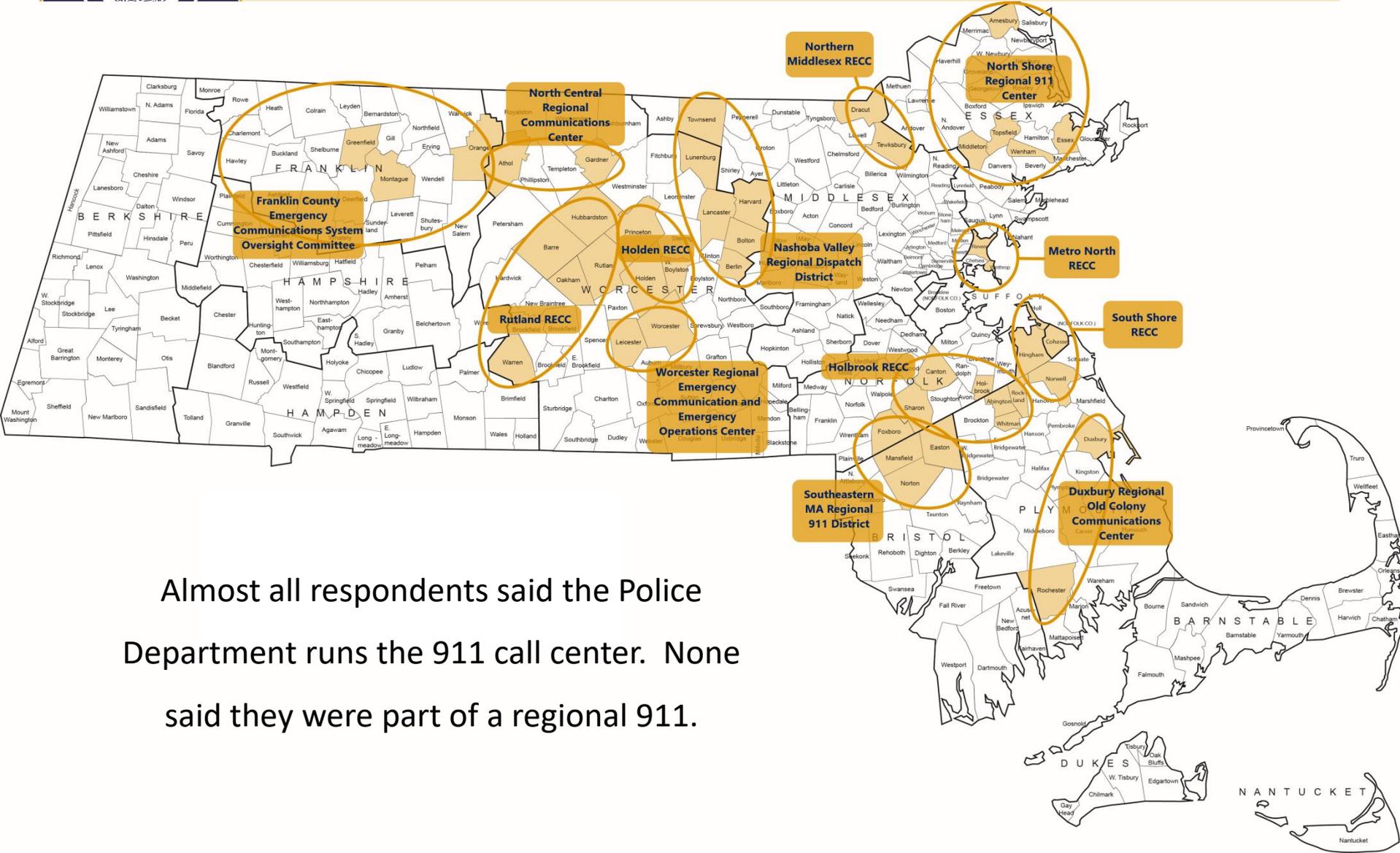


Anecdotal estimates:
75% to 90%

*Arlington PD
October 1-15, 2018



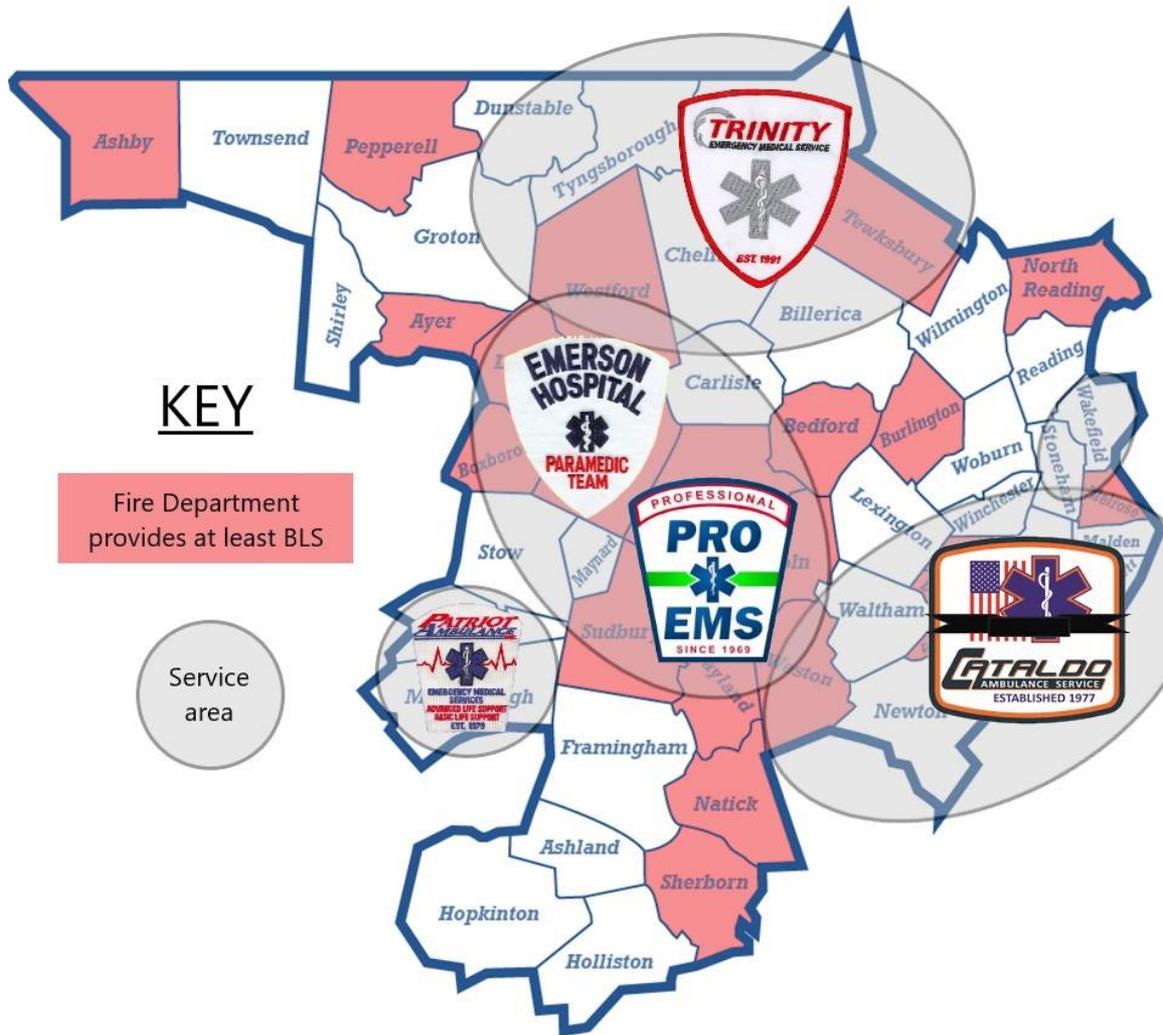
Regional 911



Almost all respondents said the Police Department runs the 911 call center. None said they were part of a regional 911.



Emergency Medical Transportation



KEY

Fire Department provides at least BLS

Service area



Presentation to the Middlesex County Restoration Center Commission

**Project Update:
March 3, 2020**

Brenda Miele Soares
Beth Lacey
Opal Stone

Agenda

- Identifying and Quantifying the Target Population
 - Feeders and Target Population
 - Restoration Center Regions' Towns Defined
 - Restoration Center Utilization
 - Comparison of Restoration Regions by Population Characteristics and ESP Flow
 - Jail Diversion and Frequent Utilizers
- How we Estimated Restoration Center Utilization
- Expectations for Program Utilization Ramp-Up: Two Examples
- Target Population by Region
- Legislative and Regulatory Considerations Barriers
- Final Report Outline

Referral Sources and Target Population

Referral and Feeder Sources



Police Officers



ESP Providers



Emergency Rooms



Self/Family



Jails and Prisons



**Middlesex
County
Restoration
Center**

Restoration Center Goals:

- Reduce Arrest
- Reduce ED use and Hospitalization
- Increase Community Stabilization

- Triage
- Assess
- Stabilize
- Coordinate After Care

Target Population

Individuals with MH, SA or Dual Diagnosis, who are:



Justice-
Involved

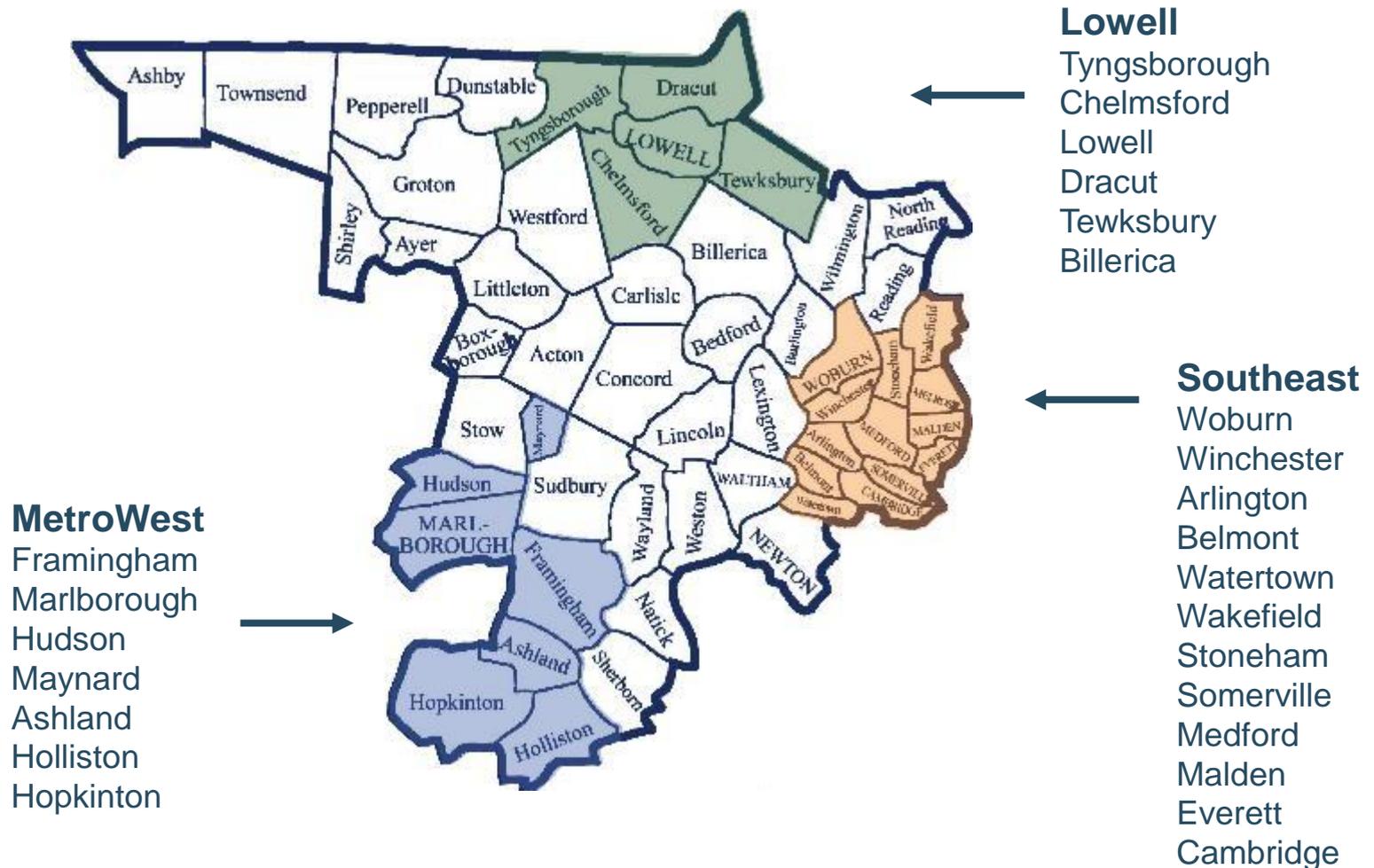


At-Risk for
Justice-
Involvement

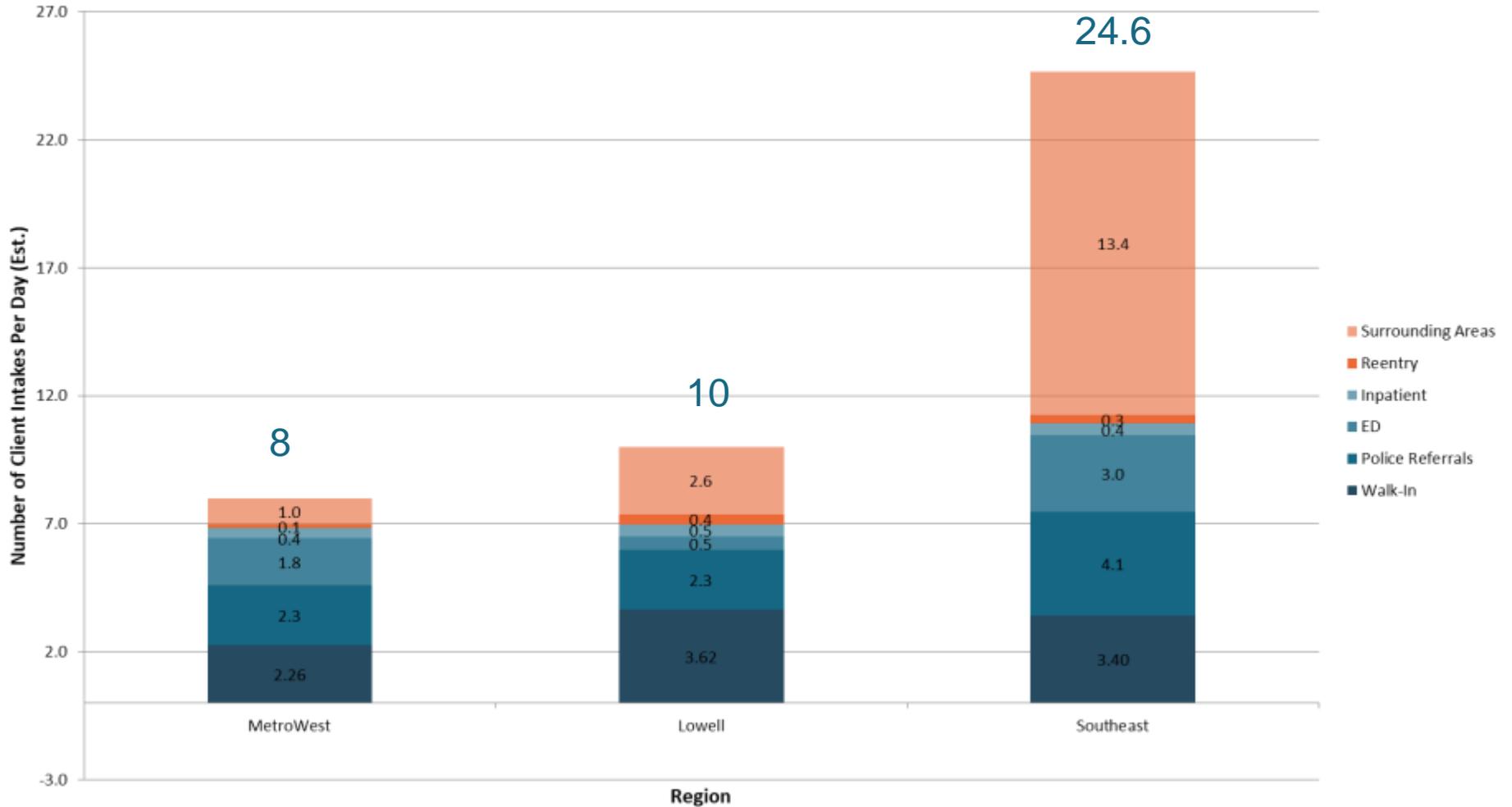


Not
Connected to
Services

Towns Comprising Identified Restoration Center Regions



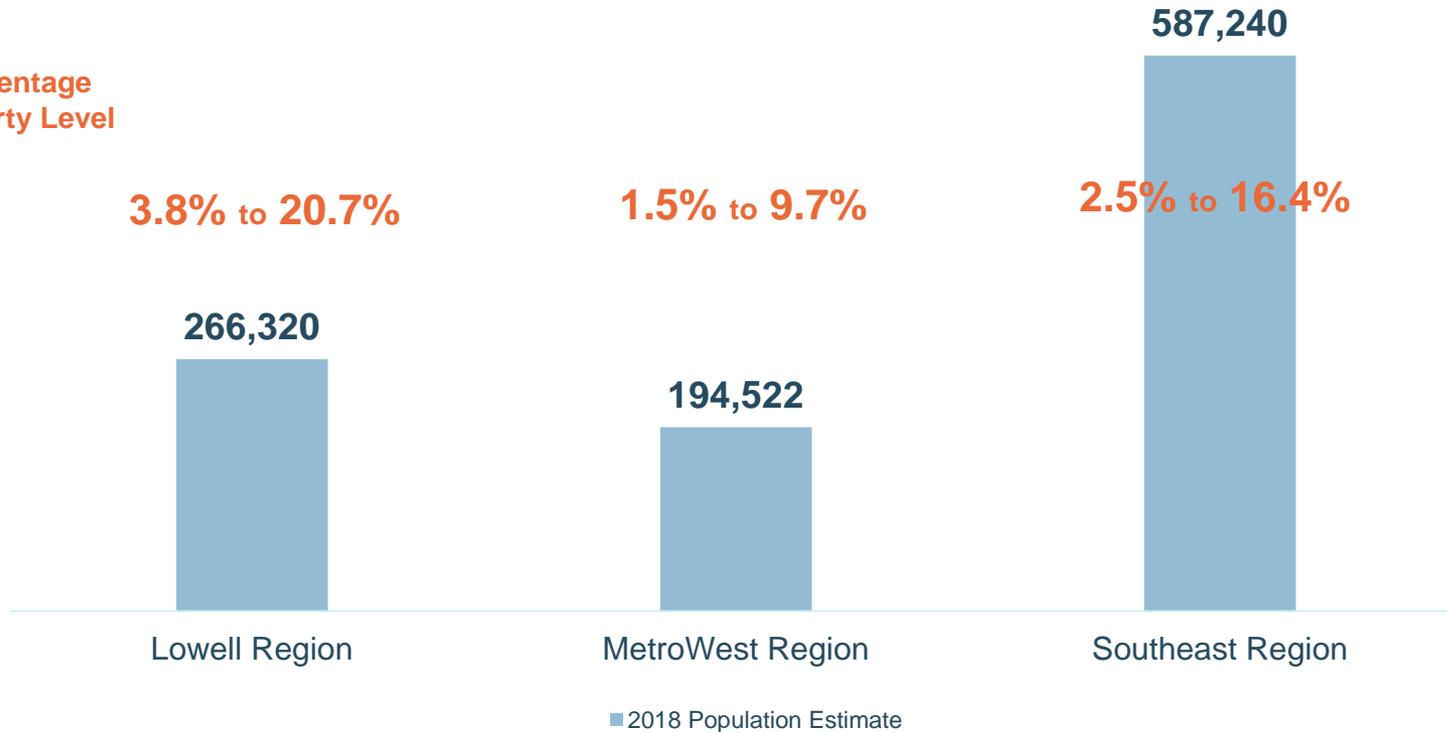
Restoration Center Daily Intakes





Region Population Size and Poverty Level Range

Range: Percentage
Below Poverty Level

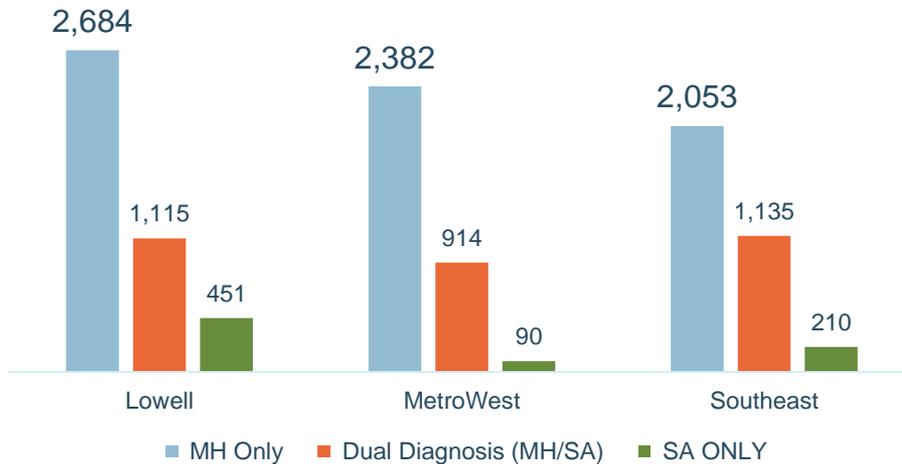


ESP # Encounters, Diagnosis and Homelessness

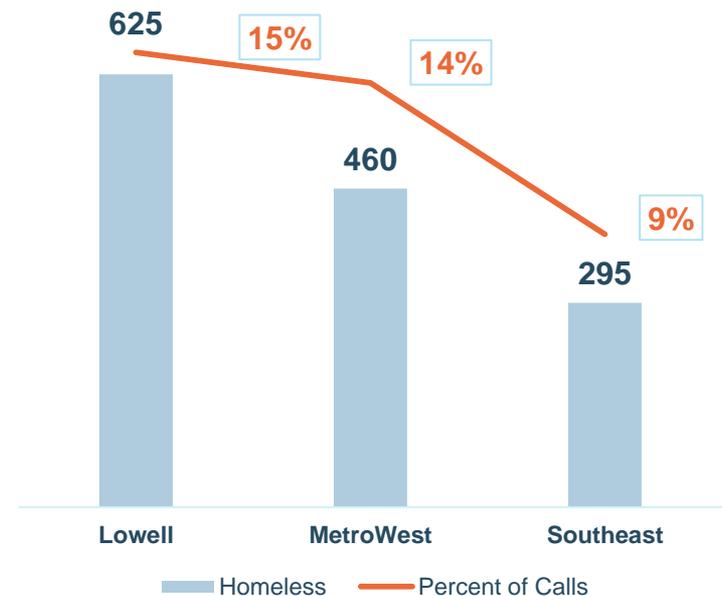
Total ESP Encounters by Region



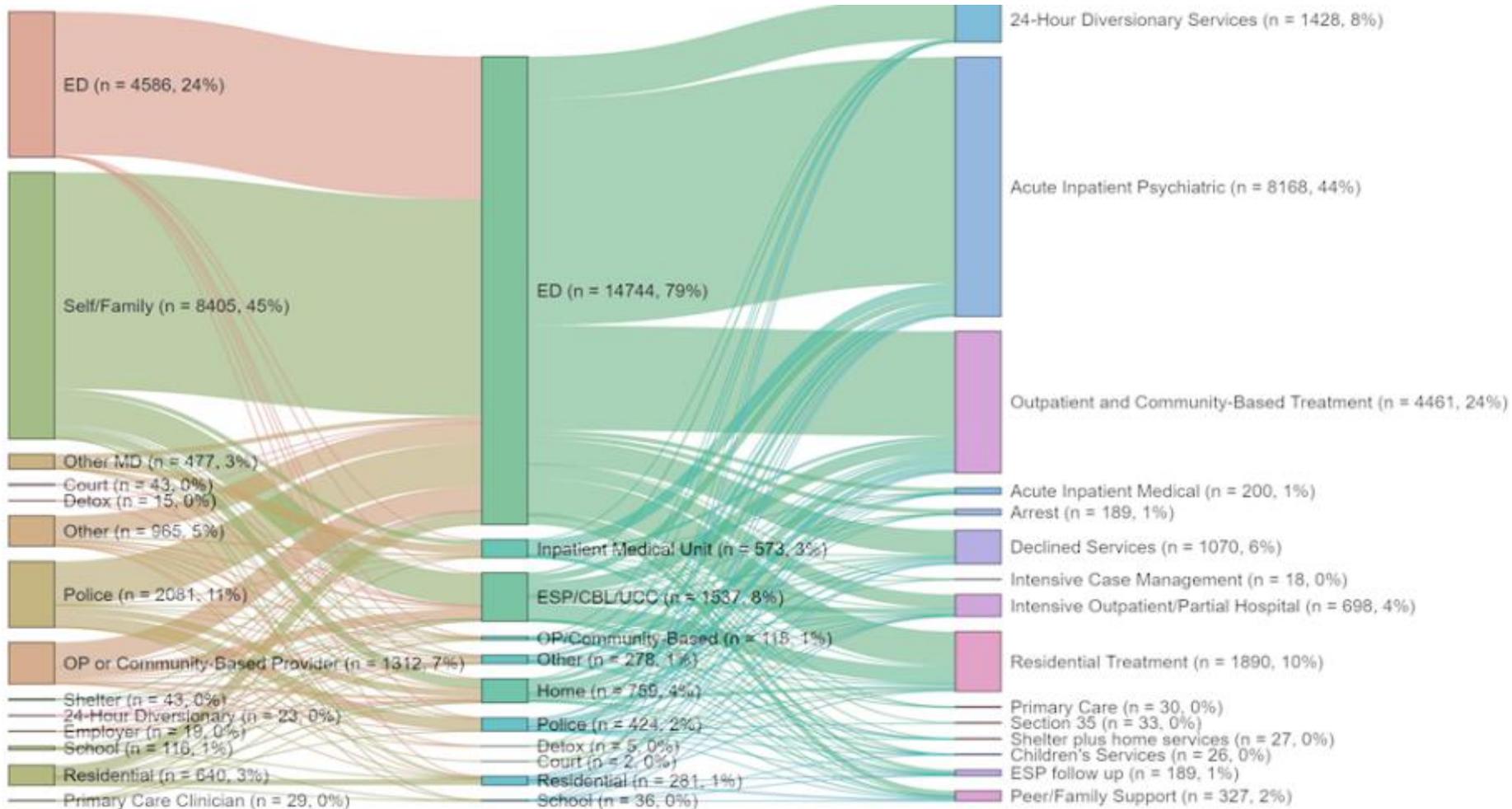
ESP Diagnosis by Region



ESP Encounters with Individuals Who are Homeless



ESP Intervention Flow: All Regions



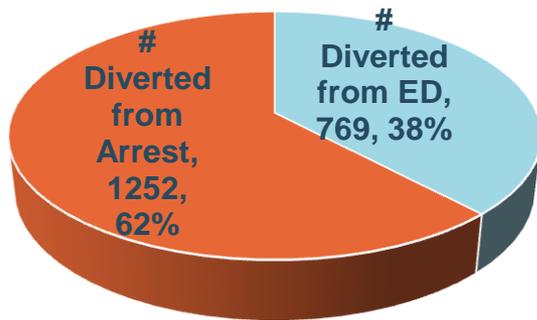
Advocates Jail Diversion Program

Advocates Jail Diversion Program (JDP) Diversions

1,367

Encounters

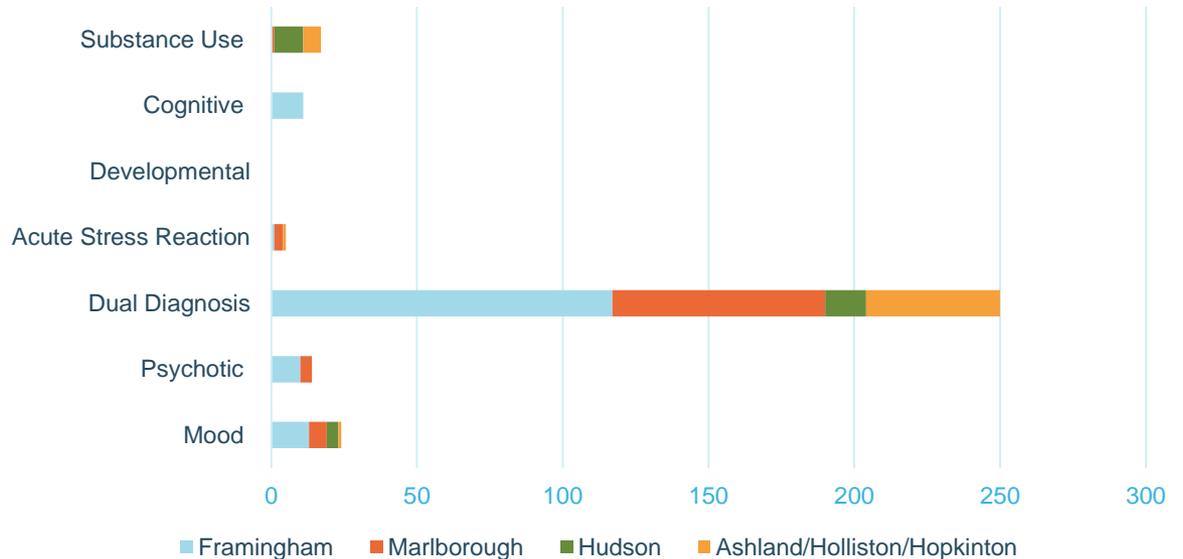
Advocates JDP Diversions



JDP Encounters by Town:

- Framingham: 623
- Marlborough: 400
- Hudson: 119
- Ashland: 95
- Holliston: 95
- Hopkinton: 35

Diagnostic Categories Where Substance Abuse is Present



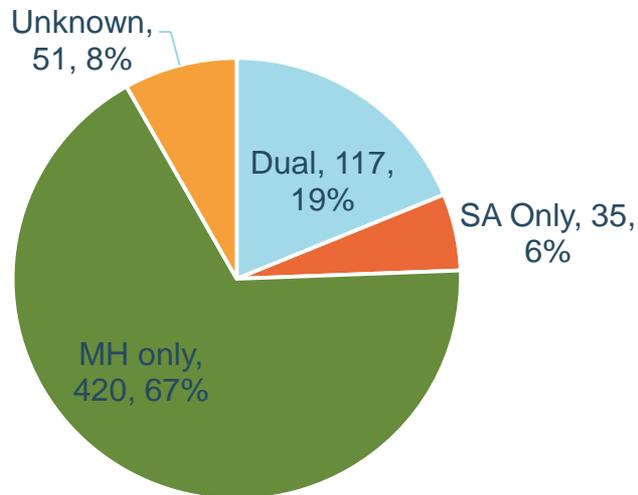
Source: Advocates Jail Diversion Program, January 1-December 31, 2019

Advocates Framingham JDP

623

Encounters

Framingham JDP Encounters:
Substance Use, Mental Health, Dual
Diagnosis



Profile of JDP Frequent Utilizer

25 people accounted for
26% (n=165) of these encounters

- **Average Age:**
 - 44
- **Ethnicity:**
 - White 84%
- **DMH:**
 - 44% have services
- **Gender:**
 - 52% Male
- **Primary Diagnosis**
 - 48% Mood disorder
 - 24% psychotic disorder
 - 24% dual diagnosis
 - 4% cognitive
- **Legal History:**
 - 76% Past/Current
- **Arrest Aversions:**
 - 71%

Disposition: Framingham JDP

53%

ED Diversion (n=328)

- 47% returned to present treaters
- 26% refused treatment
- 13% referred to outpatient
- 5% returned to police custody
- 9% other*

47% Not Diverted from ED (n=295)

66% received hospital level of care
13% returned to present treaters
6% refused treatment
4% were medically admitted
11% other*

68%

Diverted from Arrest (n=90)

- 10% were diverted and committed criminal act

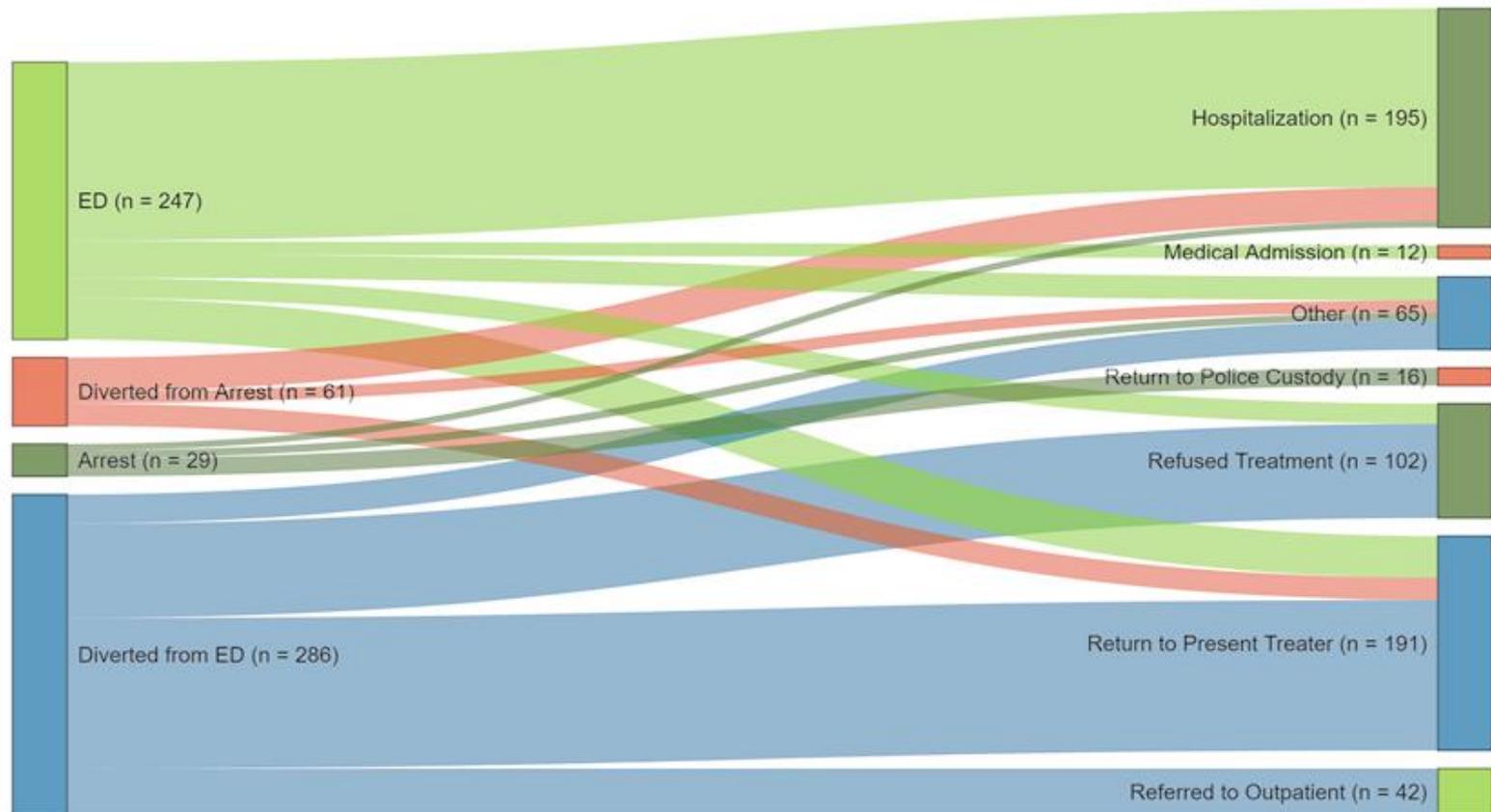
Of those committing criminal acts who were diverted (n=61):

- 49% received hospital level of care
- 20% returned to present treaters
- 18% Other

Of those arrested (n=29):

55% returned to police custody
21% to hospital level of care
24% other*

Framingham JDP Dispositions



Estimating Restoration Center Utilization

Some Factors that Could Impact Utilization



Police Officers



Proximity
Ease of Use
Service/Mix
Targeted Marketing/Education



ESP Providers



Cross-Catchment Area Utilization
Inpatient Diversion
Service Mix
Co-Location of Services



Emergency Rooms



Proximity
Service Mix
Targeted Marketing/Referral



Self/Family



Social Determinants of Health
Service Mix
Targeted Marketing/Outreach

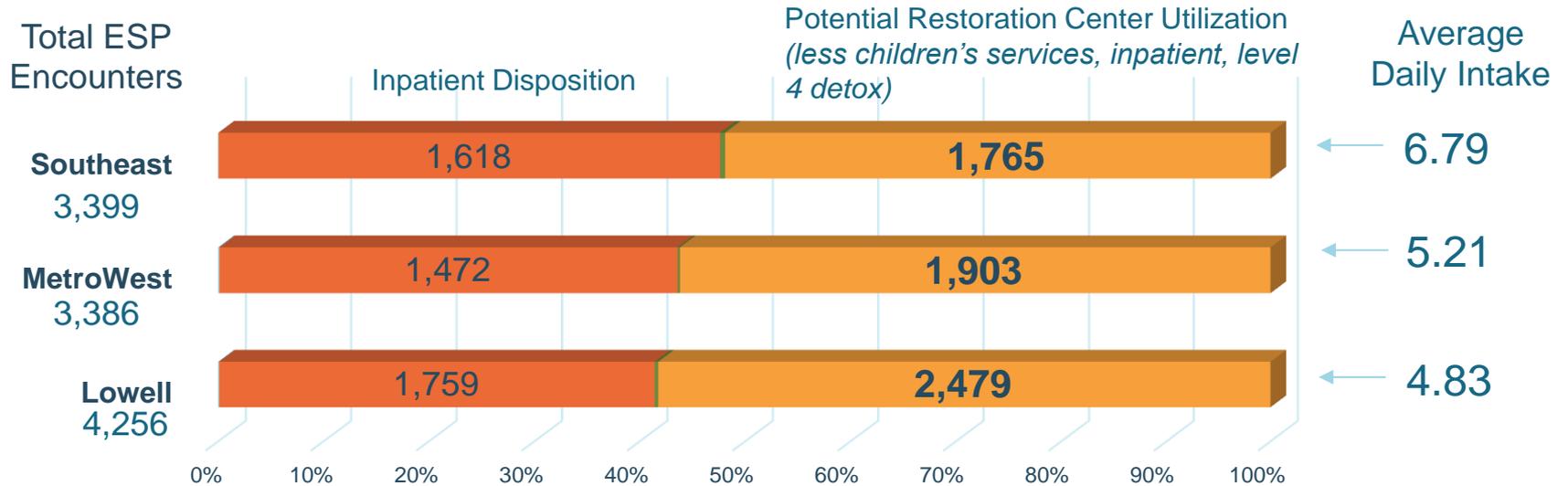


Jails and Prisons

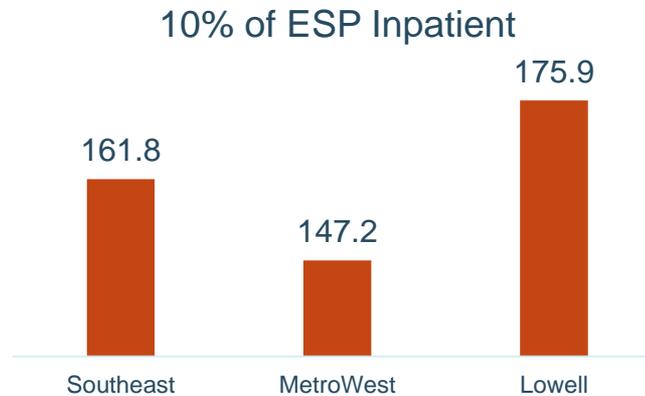


Changing Profile of Sentenced and Pretrial Population
Targeted Marketing/Education
Co-Location of Reentry Services

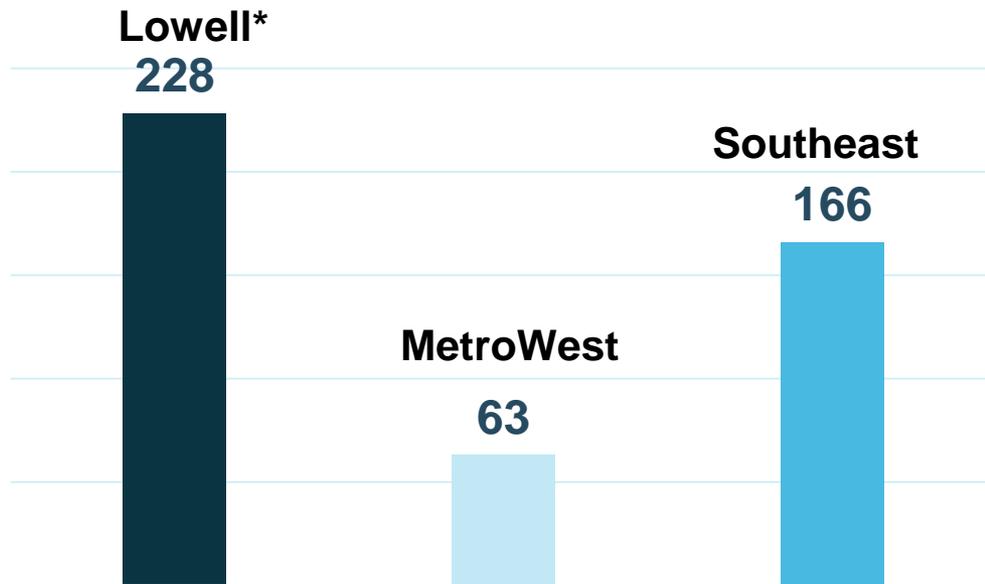
Estimating ESP Restoration Center Utilization



In areas where the Inpatient Disposition is affected by ED Boarding, we estimate up to 10% could be diverted to the Restoration Center.



MSO Inmate Addresses by Region

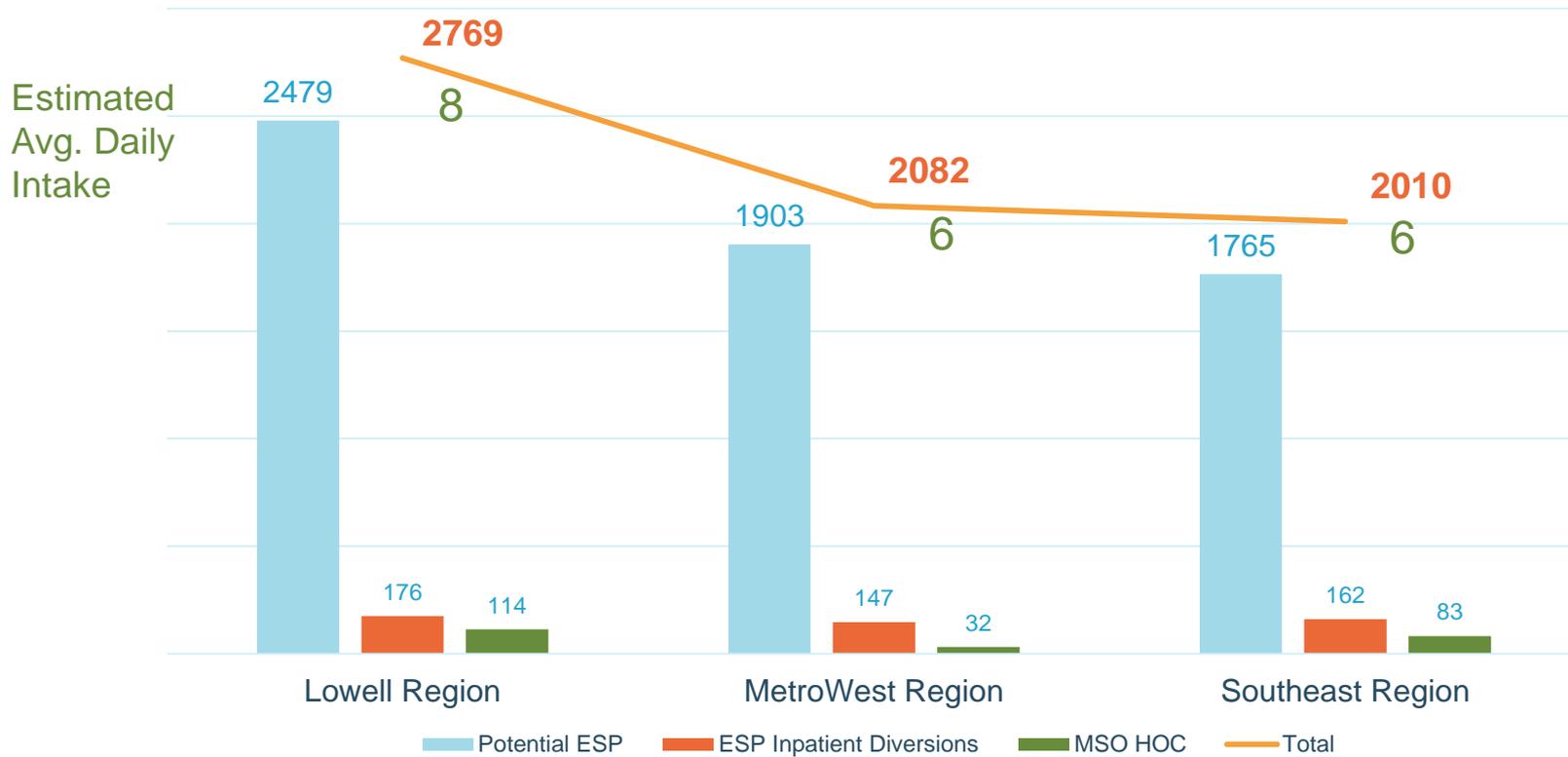


*Lowell is also among the top 10 towns in which DOC inmates release. (DOC 2016)

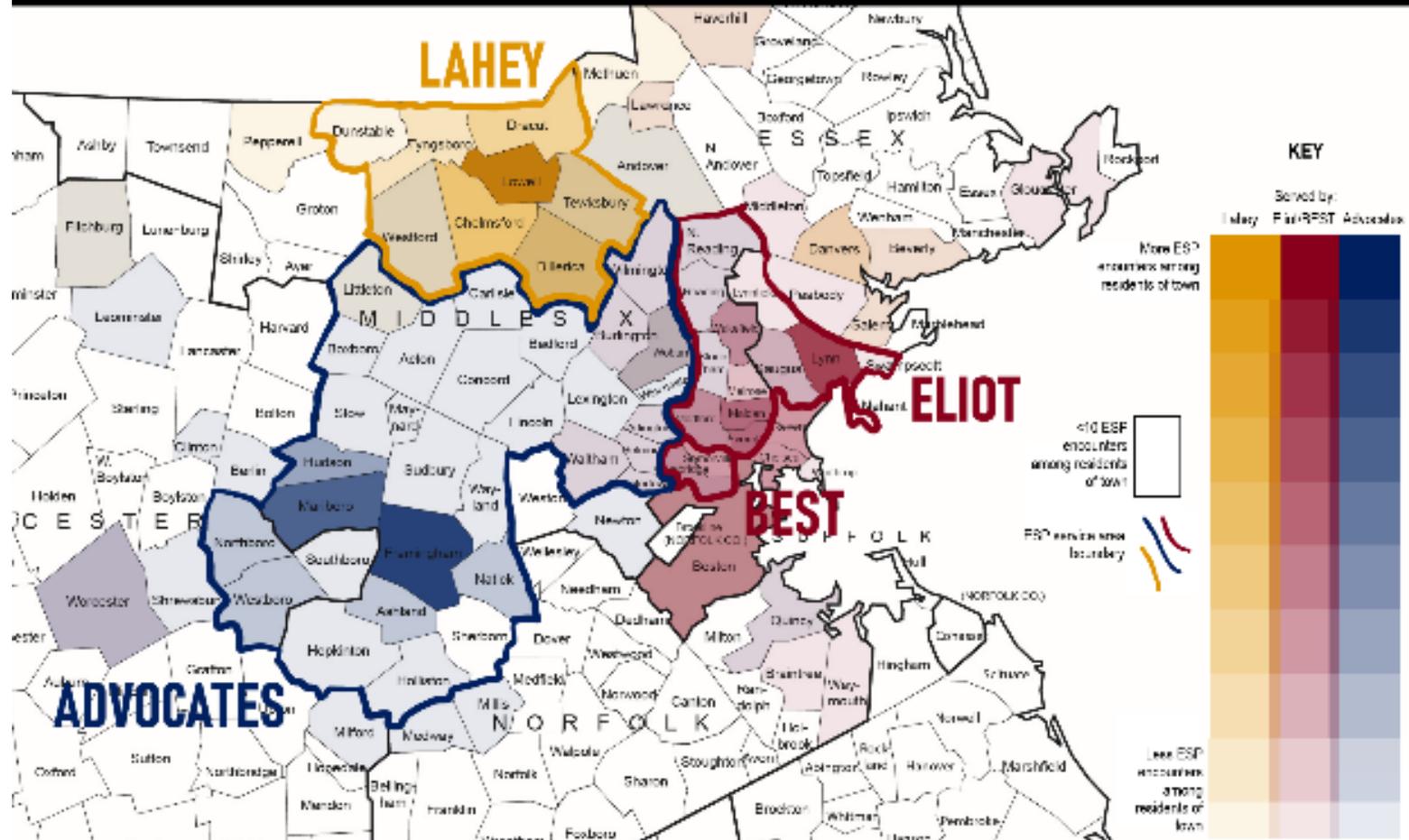
If we assume 50% of releasing inmates would use the Restoration Center, annually we may expect:

- 114 in the Lowell region
- 31.5 in MetroWest region
- 83 in the Southeast region

ESP and HOC Potential Restoration Center Utilization

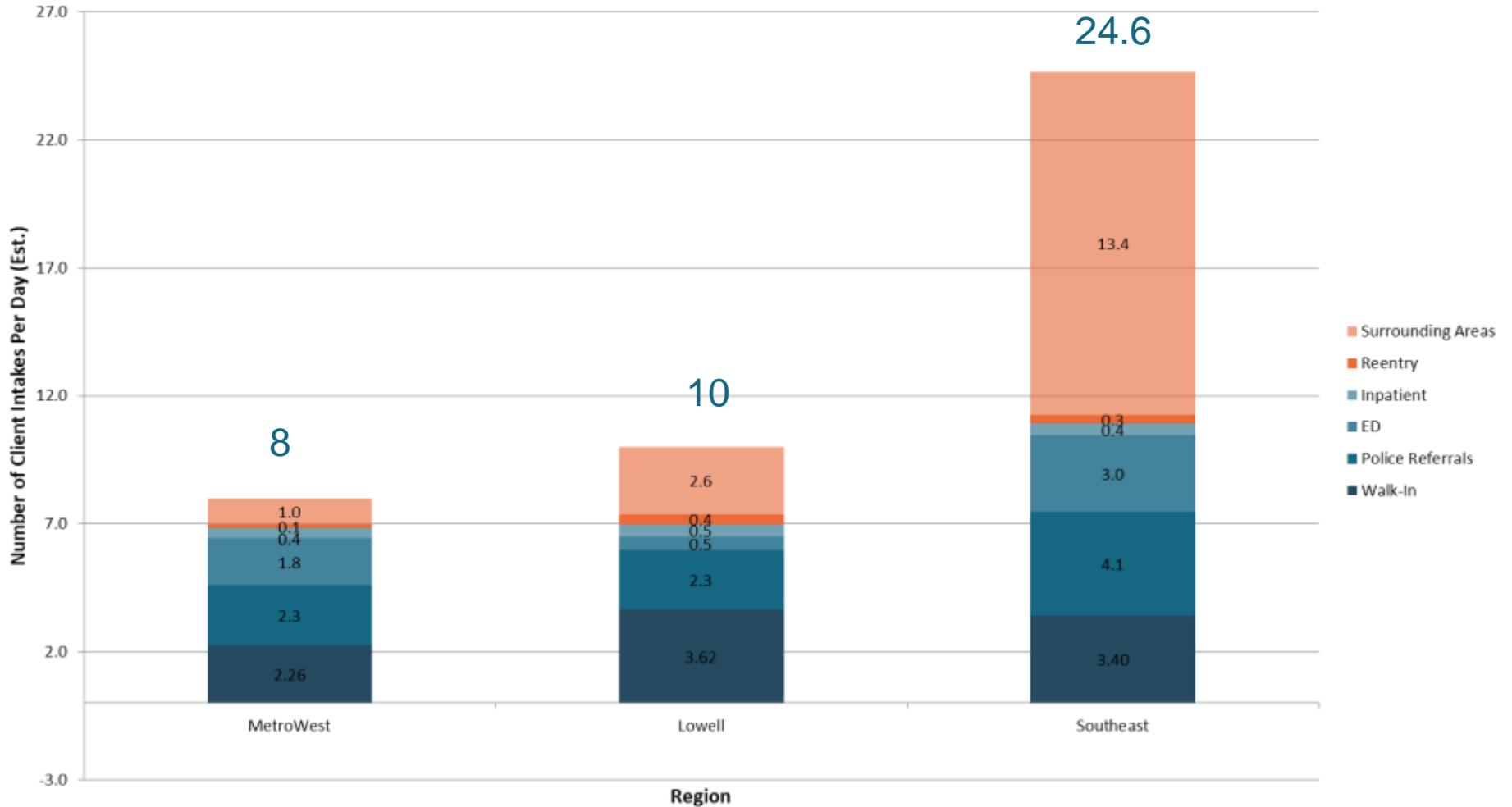


ESP ENCOUNTERS BY CLIENT ADDRESS AND PROVIDER



Heat Map provided by Catia Sharp

Restoration Center Daily Intakes



Utilization Ramp-Up Expectations

Advocates Living Room Program

- **Expected Utilization:** 20 people/week
- It took **6 months** achieve weekly average target (Months 1-5 ranged from 6 to 74 visits)
- Program met and exceeded this target at months 6-12 for all but one month
- *Established relations and considerable additional marketing and outreach resulted in achieving these results*

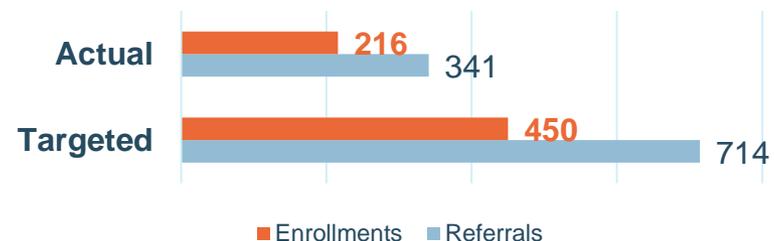
Living Room Visits by Month



Behavioral Health for Justice Involved (BH-JI) Program

- **Targeted Utilization:** 75 enrollments and 119 referrals per month for 714 referrals and 450 enrollments at 6-month mark
- **Actual Utilization at 6-month mark:**
 - Referrals and enrollment rates have increased but are at still only at 48% of target

BH-JI 6-Month Targeted to Actual Referrals and Enrollment



Target Population by Region

Lowell Region

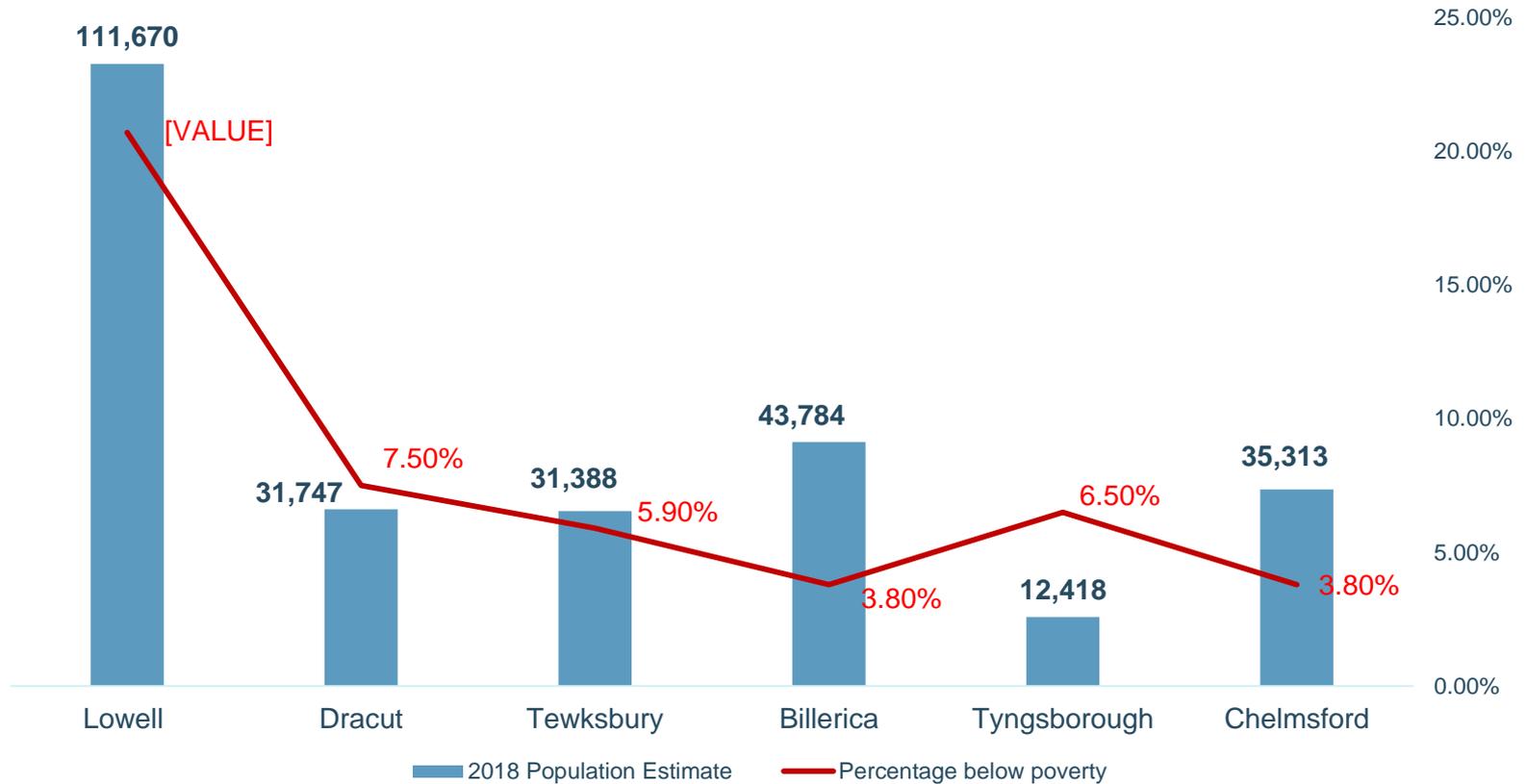


Population
266,320

People 18
years +
210,848

Lowell Region

Target Population, Median Income, Poverty Level

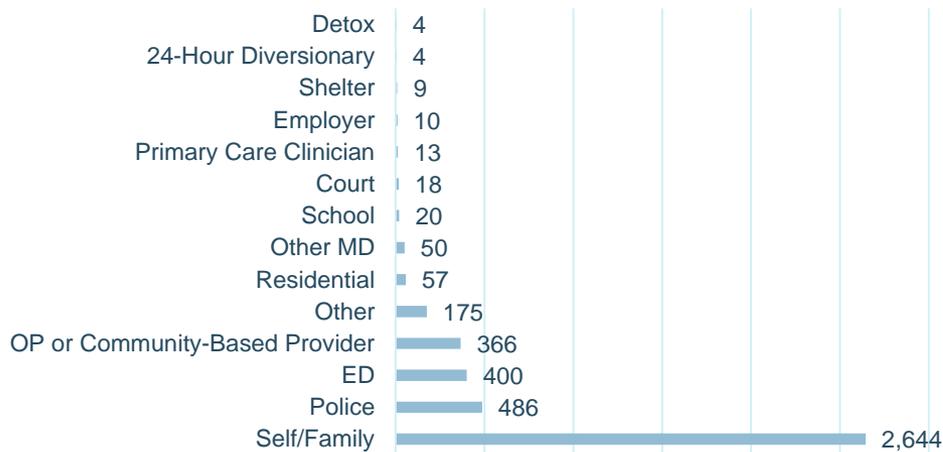


Source: US Census Bureau 2018
Population Estimates QuickFacts

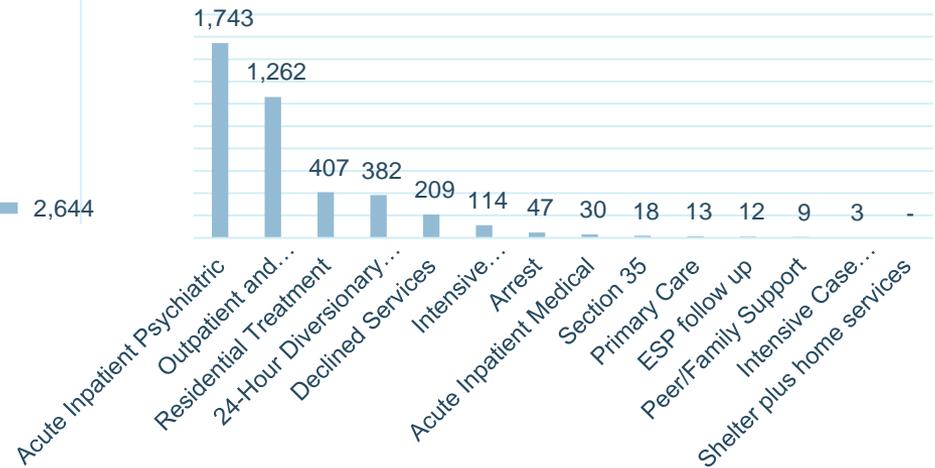
Lowell ESP Data

ESP Encounters: 4,256

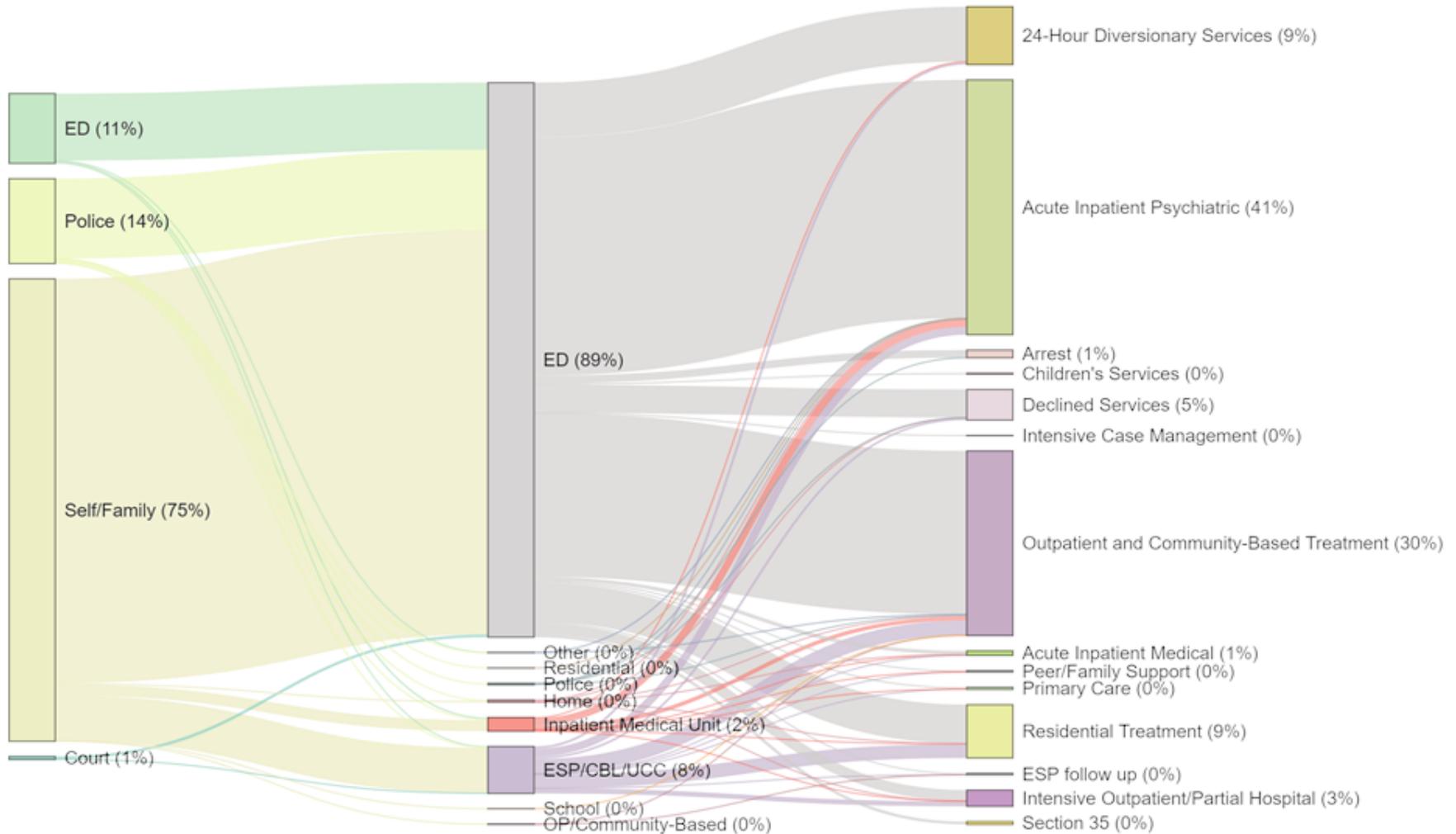
Lowell # ESP Referrals



Disposition by # People



ESP Intervention Flow From Main Sources Lowell



MetroWest Region

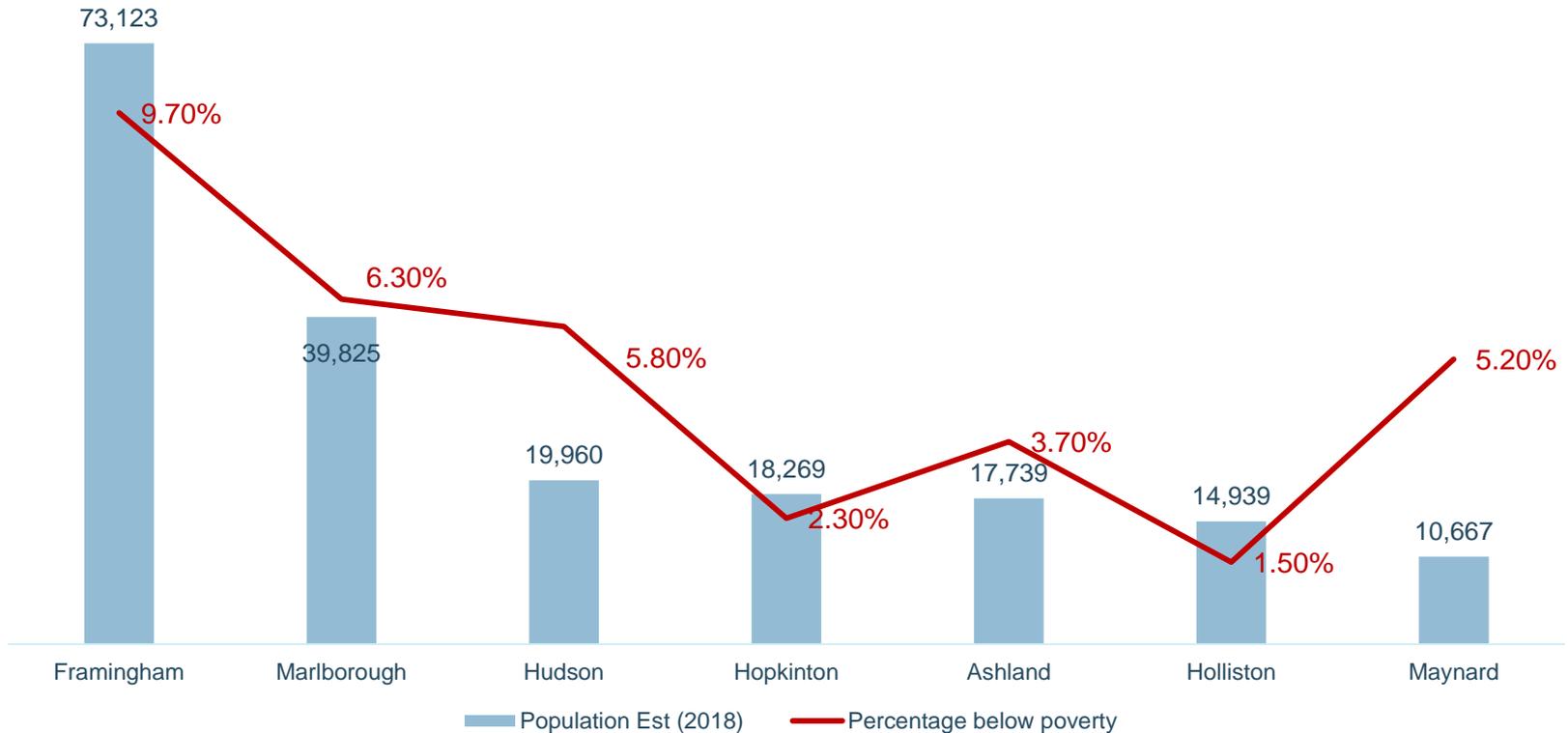


Population
194,522

People 18
years +
153,601

MetroWest Region

MetroWest Region Population, Median Income and Poverty Level

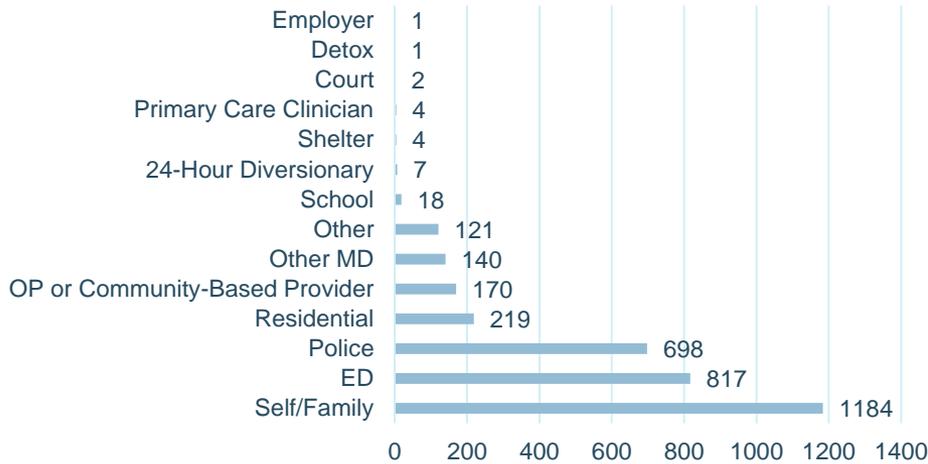


Source: US Census Bureau 2018
Population Estimates QuickFacts

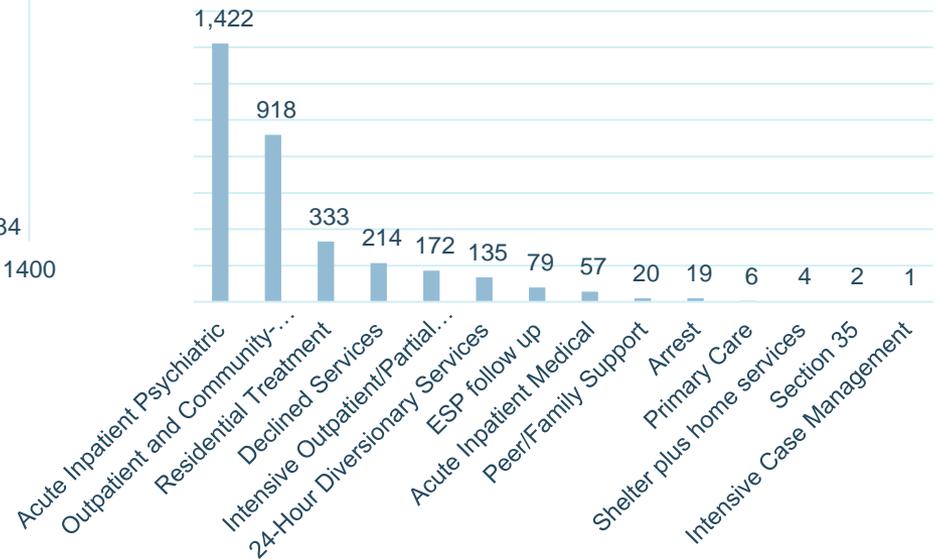
MetroWest ESP Data

ESP Encounters: 3,386

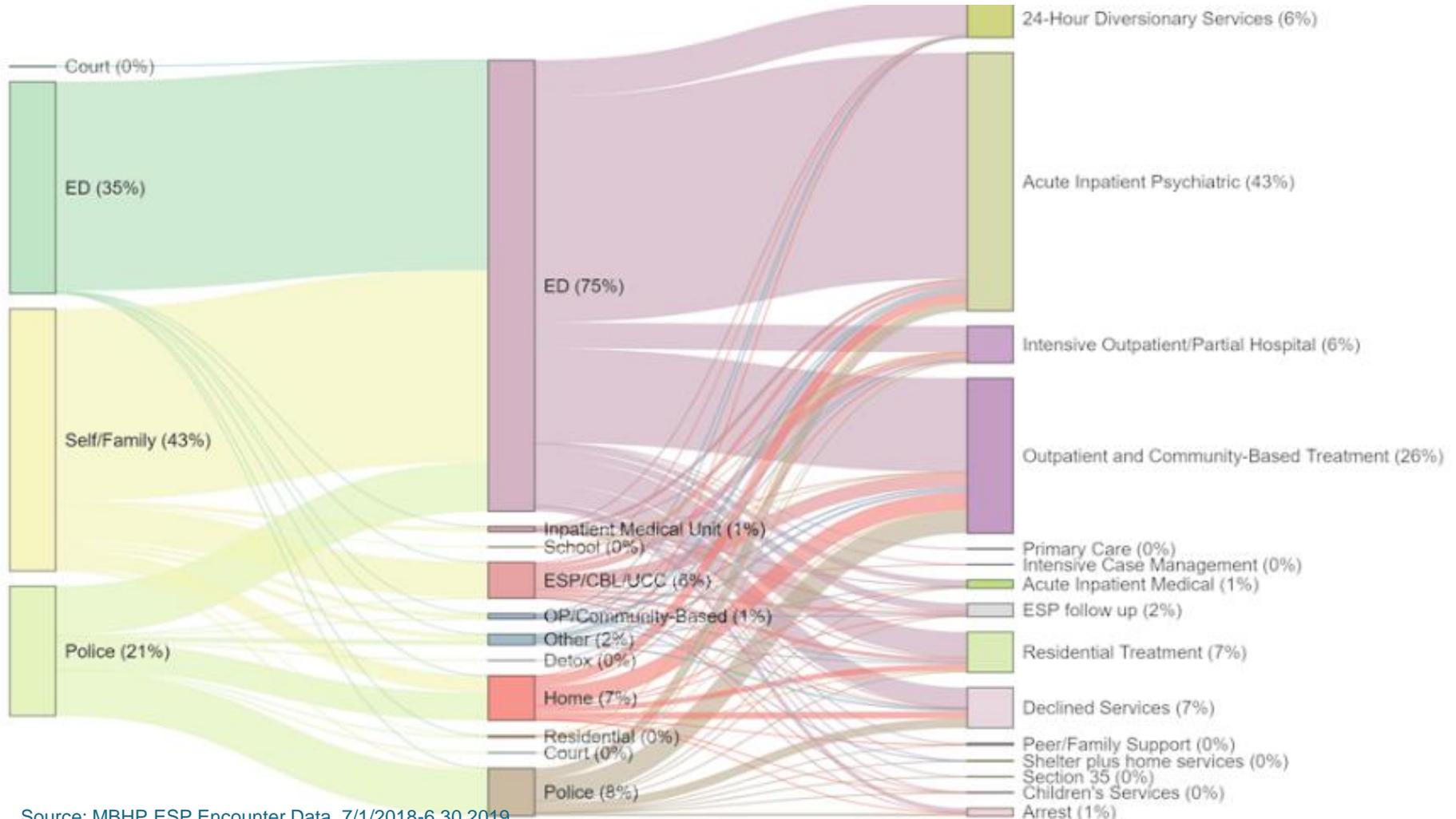
MetroWest #Referrals



Disposition by # People



ESP Intervention Flow from Main Sources MetroWest



Southeast Region

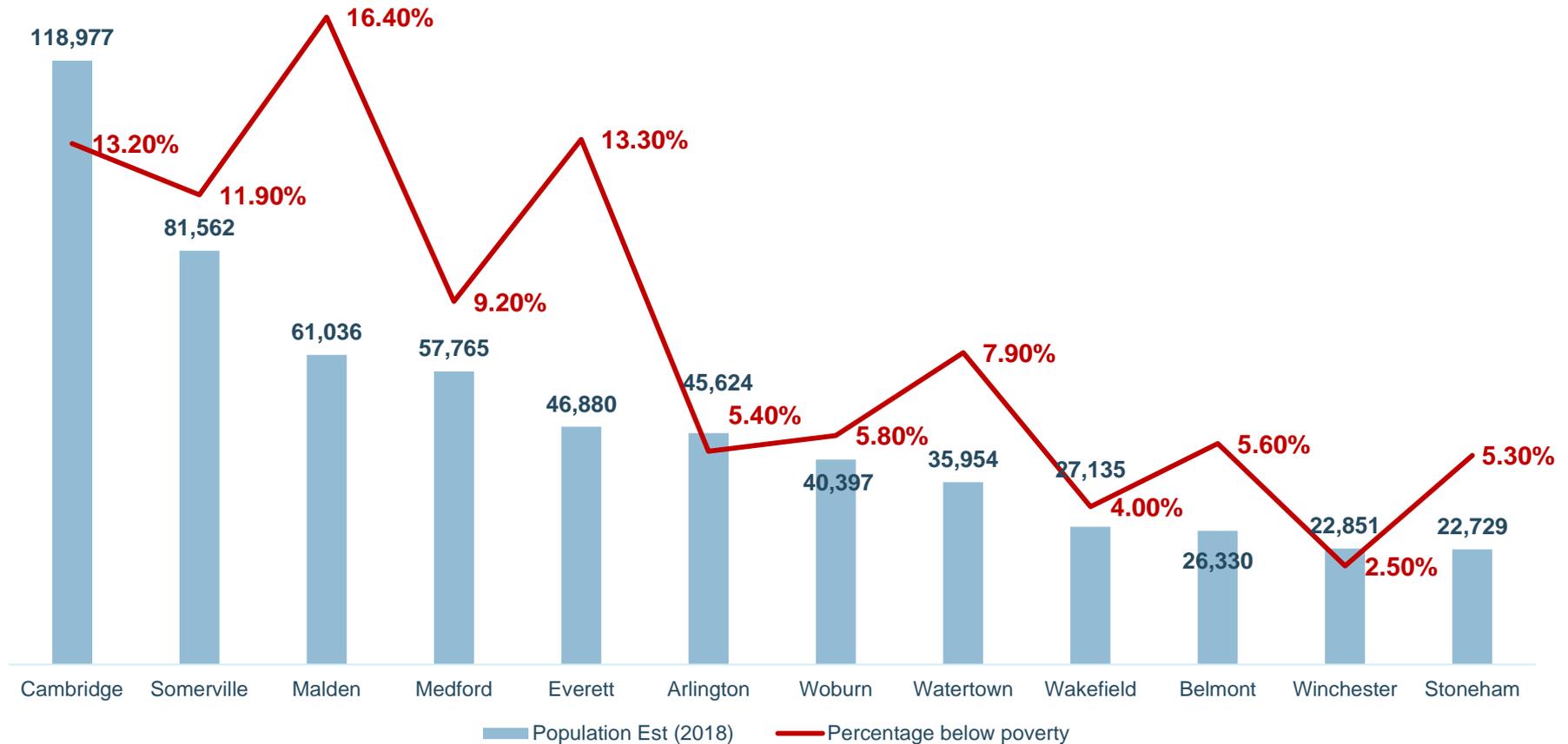


Population
587,240

People 18
years +
485,987

Southeast Region

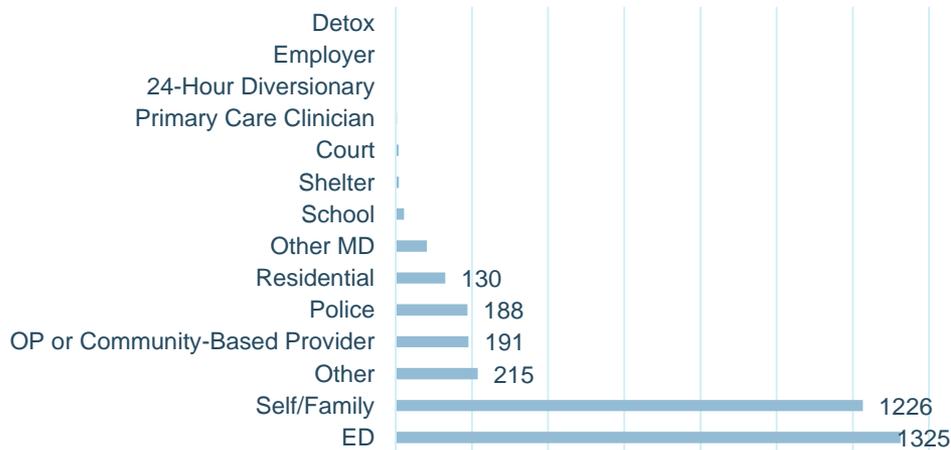
Southeast Population, Median Income and Poverty Level



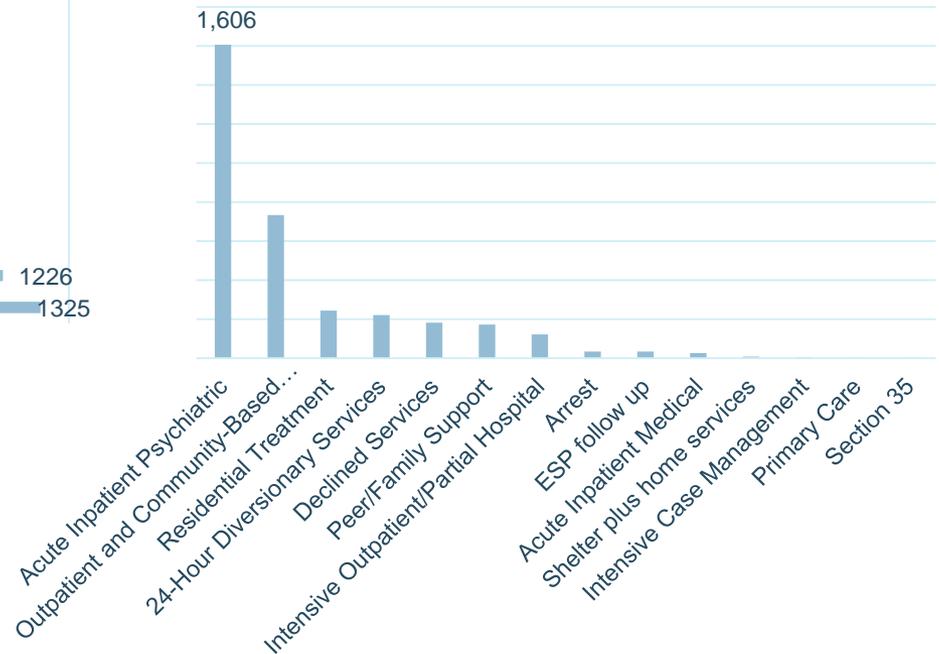
Southeast ESP Data

ESP Encounters: 3,399

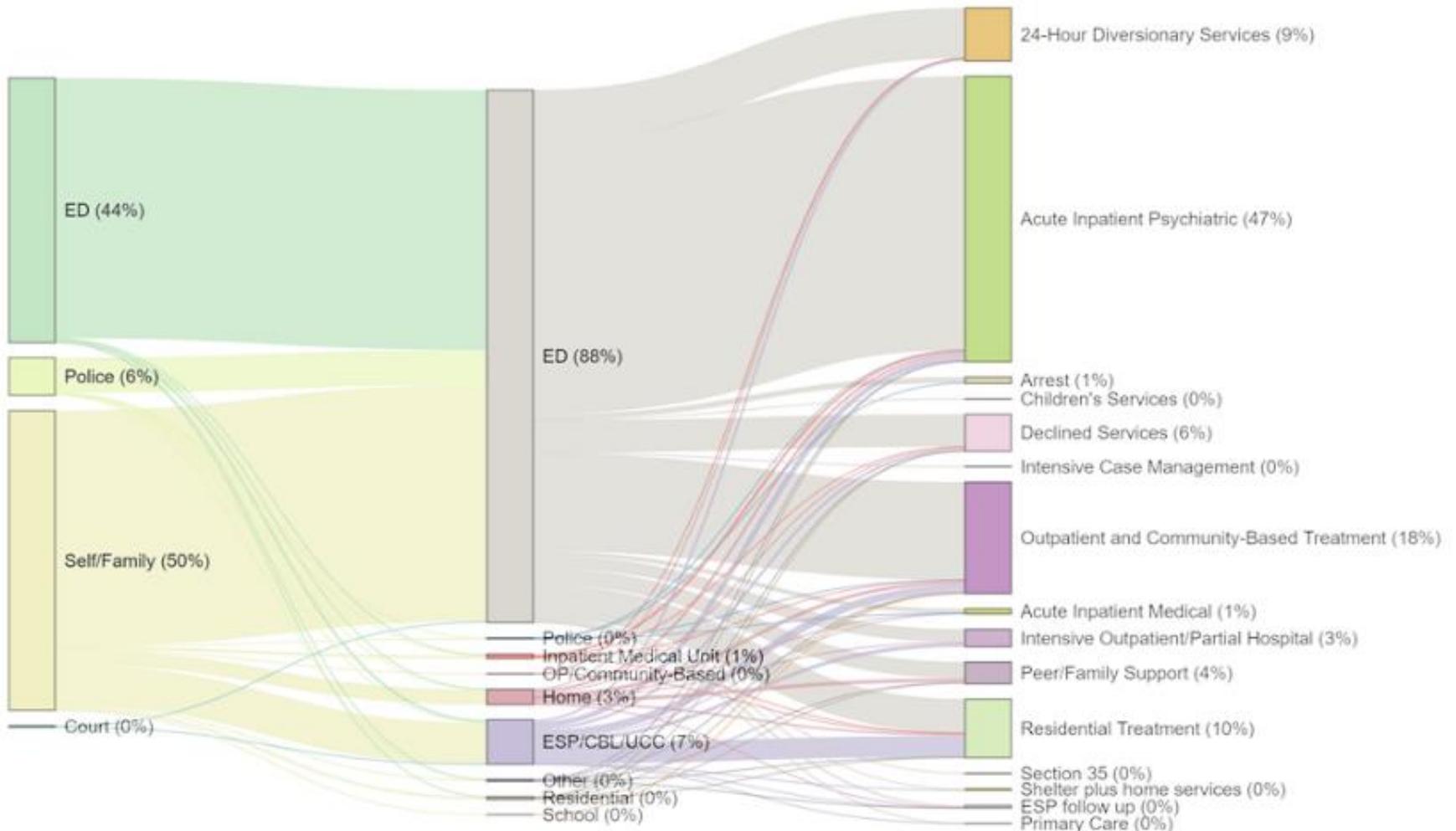
Southeast # Referrals by Source



Disposition by # People



ESP Intervention Flow from Main Sources: Southeast



Legislative and Regulatory Considerations

- Licensing for Sober Beds
- Inclusion of DMH Respite Bed Model
- CCS Beds Underutilized
- ATS Licensing Bed Threshold
- Capital Investment - Facilities

Final Report Overview

Overview: Targeted Restoration Center Regions

- Target Population Identification and Quantification
- High-Level Three Region Comparison

For Each of the Three Regions:

- Target Population
- Recommended Restoration Center Services Mix
- Tailored Aftercare Services & Care Coordination
- Advantages and Disadvantages
 - Location
 - Transportation
 - Community Citing and Engagement

Budget

- Budget Calculator
- Staffing Design

Considerations

- Barriers
- Summary of the Advantages and Disadvantages for each region
- Increasing referrals to the Restoration Center



Middlesex County Restoration Center Commission
Tuesday, April 7, 2020
3:30 pm – 5 pm
Virtual – [Zoom](#)

AGENDA

- | | |
|-----------------|---|
| 3:30PM – 3:35PM | Welcome and Introductions <i>Co-Chairs, Sheriff Koutoujian and Danna Mauch</i> |
| 3:35PM – 3:45PM | Legislative Update <i>Representative Gordon</i> |
| 3:45PM – 3:50PM | Approval of Minutes from Last Meeting <i>Co-Chairs, Sheriff Koutoujian and Danna Mauch</i> |
| 3:50PM – 4:55PM | Draft Consultant Report Presentation and Questions <i>Brenda Miele Soares, Advocates</i> |
| 4:55PM – 5:00PM | Next Steps and Closing <i>Co-Chairs, Sheriff Koutoujian and Danna Mauch</i> |



The Planning and Design for a Restoration Center

Presentation of the Final Report to the
Middlesex County Restoration Commission

April 7, 2020

3:30 – 5:30 PM

Agenda

- Target Population and Feeders
- Recommended Service Mix
- Transportation Models
- Location
- Targeted Geographies
- Budget
- Additional Considerations
- Q&A

Target Population and Feeders

- Cycle in and out of the criminal justice and behavioral health systems
- Co-occurring mental health and substance use disorders
- Have not accessed appropriate levels of care on their own



Recommended Service Mix

Clinical Services

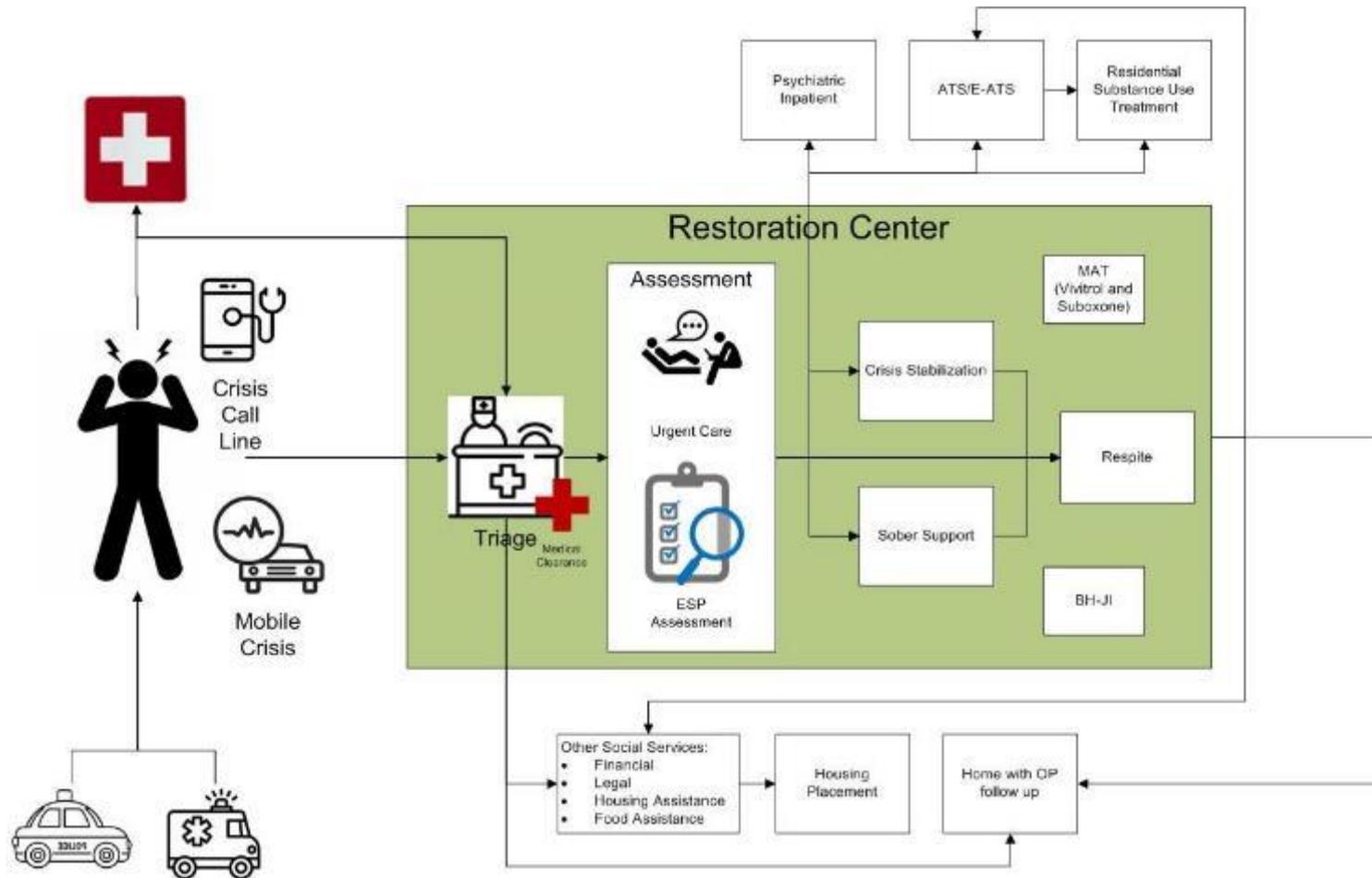
- Triage Assessment
- Crisis Stabilization
- Sober Support Unit
- Respite Care
- Medical Screening
- Reentry Services
- Housing Specialist
- Medication-Assisted Treatment (MAT)

Essential Services

- Food
- Bathing
- Clothing
- Washing machines
- Fitness facility

Individuals connect to outpatient services and aftercare supports through care managers

Restoration Center Flow Chart



Transportation Model

- Individuals require transportation to
 - Access Restoration Center (crisis)
 - Return home or obtain aftercare supports
 - Access Restoration Center for follow up (non-crisis)
- In-house transportation services necessary for day-to-day (~32K)
- Reliance on public transportation for non-crisis needs
- Five partnership models explored
 - Local police departments drop off
 - Current ambulance system to provide transportation
 - Develop regional contracts with ambulance companies
 - Partner with VIA to provide on-demand transportation
 - Increase internal staff and create an app to deploy vehicles

| Model | Advantages | Disadvantages | Consideration |
|-----------------------------|---|--|---|
| Police | <ul style="list-style-type: none"> • Low cost • ↑ arrest diversion • Expedite transfer from police custody | <ul style="list-style-type: none"> • Barriers to transportation beyond city/town or those not under arrest • Does not address aftercare needs | Need to change police practices to transport beyond local community |
| Ambulance | <ul style="list-style-type: none"> • Like current crisis response model • Cost determined by insurance reimbursements | <ul style="list-style-type: none"> • Multiple companies required multiple relationships • Reimbursement model does not support long distance transport • Does not address aftercare needs | Regulation change needed to allow ambulance companies to bill for transport beyond local ED |
| Regional Ambulance Contract | <ul style="list-style-type: none"> • Would provide centralized service • Could assist with developing protocols with PDs • Provide broader coverage | <ul style="list-style-type: none"> • May reduce local source of income • Creation of competition among ambulance companies • Expenses • Does no address aftercare need | Regulation change needed to allow ambulance companies to bill for transport beyond local ED |
| VIA | <ul style="list-style-type: none"> • Police could summon driver with app • Pick up drive reduced with drivers on demand • Could cover entire county • Addresses aftercare needs | <ul style="list-style-type: none"> • Most expensive option (\$200,000 to 1,000,000 annually) | |
| Center Drivers | <ul style="list-style-type: none"> • Drivers familiar with Center • Scaled up or down depending on needs • Could cover entire county • Addresses aftercare needs | <ul style="list-style-type: none"> • Costs needed to develop and maintain app (~50K annually) • Must employ year-round staff (additional cost) • Must operate and maintain vehicles | |

Location

Explored commercial real estate and compared type of property across each region

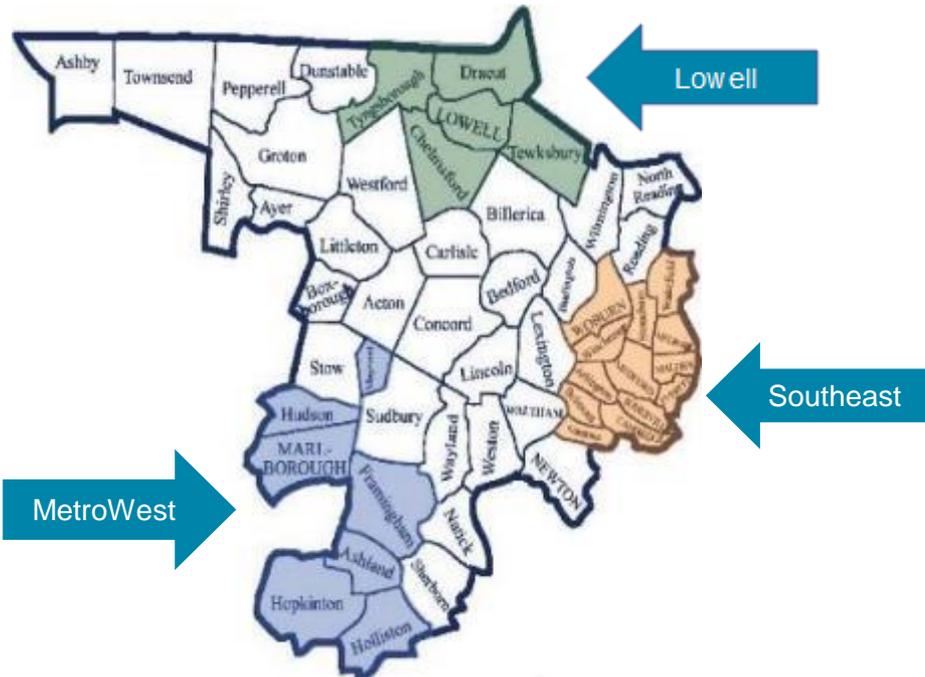
TABLE 4: ESTIMATED ANNUAL NET RENT (PER SQUARE FOOT)
Does not include operating expenses, utilities, property insurance, or real estate taxes

| Market | Property Type | | |
|---------------------------------|-------------------|----------------|------------|
| | Office- Class A/B | Office Class C | Industrial |
| Lowell | \$16-\$20 | \$12-\$15 | \$6-\$10 |
| MetroWest (Framingham/Marlboro) | \$20-\$30+ | \$16-19 | \$6-10 |
| South East | \$25-\$30+ | \$19-24 | \$12-16 |

Location Recommendation

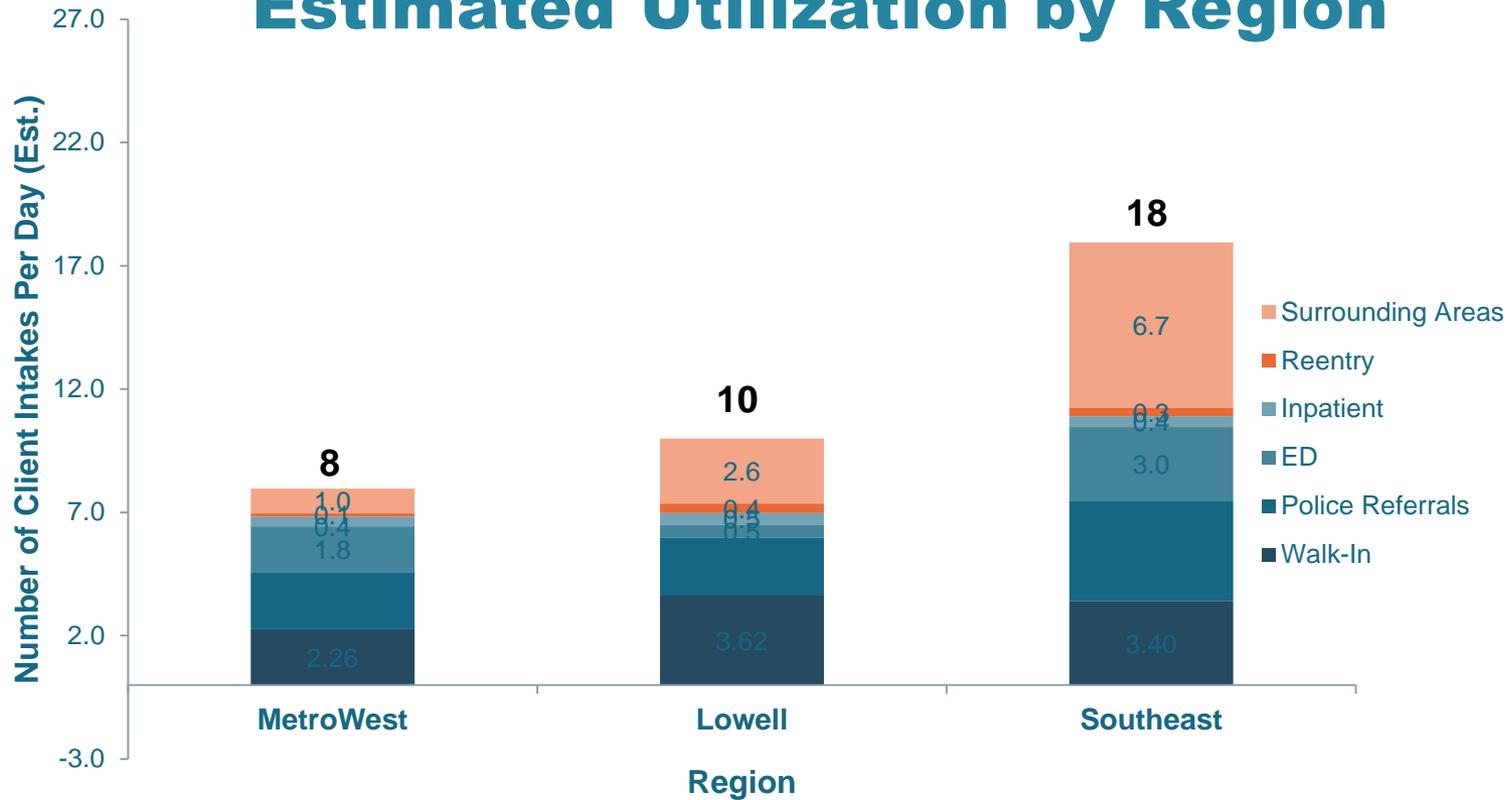
- Logistical Recommendations
 - Single-level building
 - Warehouse building vs. an office building in a non-residential setting
- Remote location
 - *Benefits are fewer community concerns*
 - *Disadvantages is limited access to other services*
- Stakeholder engagement will be critical

Targeted Geographies and Considerations



- Concentration of likely users
- Social determinants of health
- Returning from incarceration
- High ESP utilization
- Proximity to feeder sources
- Supported referrals
- Local resources
- Service system complexity
- Real estate costs

Estimated Utilization by Region



Estimates based upon Advocates Jail Diversion Program (JDP) data, ESP utilization, city/town population and poverty rates

Budget Model

The planned recommended Restoration Center will require \$3.8 million annually in operating revenue not currently available

TABLE 11: RESTORATION CENTER EXPENSES AND REVENUE

| | |
|--------------------------------|---------------|
| Total Direct Expense | \$5,902,617 |
| Administrative Overhead | \$708,314 |
| Total Expense | \$6,610,931 |
| Total Revenue | \$2,673,815 |
| Variance | \$(3,228,802) |

Staffing Model

Based on MBHP
staffing
Requirements

Community Crisis Stabilization, 10 beds: \$963,845.12

Staffing model based on MBHP requirements for up to 10 beds;
must follow to bill for CSS

Challenges to billing include exclusivity to current ESP in selected region.

| Staff | Units |
|---------------------------------------|-------------|
| Nurse | 2 |
| Master's Level Clinician | 2.5 |
| 1st/2nd shift BA staff | 3 |
| 3rd shift staff | 2 |
| One Peer all shifts /recovery coaches | 3 |
| <u>LPNs</u> | <u>1.75</u> |

Based on requirements
for MAT and ATS,
combined with MDs in the
fixed personnel costs

Sober Support Unit, 10 beds: \$884,480.00

Staffing model based on MAT and ATS licensing standards,
assuming MD from fixed personnel; must follow to bill

| Staff | Units |
|-------------------------|----------|
| Nurses | 4 |
| Case Managers | 3 |
| Weekend Case Managers | 0.8 |
| <u>Recovery Coaches</u> | <u>5</u> |

Based on DMH
Respite requirements

Respite, 10 beds: \$487,052.80

Modeled after DMH respite requirements; there is no licensing
regime for non-DMH respite

Challenges to billing include DMH-exclusivity on billed beds

| Staff | Units |
|--|-------------|
| Masters Level Clinician | 1.75 |
| Direct Care Staff | 5 |
| <u>Awake Overnight Direct Care Staff</u> | <u>1.75</u> |

Rent + utilities for 14,000 square feet: \$309,400 based on per square foot costs for County

Assumptions: 50% of Restoration Center utilizers would require an ESP Screen; 50% will require Urgent Care Behavioral Health assessment. Forecasts; and 66% that receive an ESP screen will require Crisis Stabilization services

Assumptions: 50% of assessments will be ESP screen rate and 50% will be urgent care; ~ 2/3 of those receiving an ESP screening would need CCS beds; based 70% utilization on current CCS utilization statewide; 70% of the individuals dropped off for the sobering unit will accept ATS

| ESTIMATED REVENUE | | | |
|-------------------------------|-------------------|----------------|-------------|
| | Members Per Month | Number of Beds | Total |
| Triage and Assessment | 180 | | |
| Crisis Stabilization | | 10 | |
| ATS/Sober Support Unit | | 10 | |
| Respite | | 10 | |
| BH-JI | 17 | | |
| Revenue | \$1,157,373 | \$1,516,442 | \$2,673,815 |

| ESTIMATED REIMBURSEMENT RATE | |
|--|-------|
| ESP Screen | \$819 |
| Urgent Care Behavioral Health | \$171 |
| Crisis Stabilization Daily Rate | \$506 |
| Sober Support/BSAS ATS Rate | \$248 |
| Respite | \$- |
| BH-JI | \$14 |
| Utilization Factor | 70% |

Additional Considerations

- **Licensing under current Community schema**
- **Potential regulatory or legislative Issues**
 - Regulations for type of bed or mixing service types
 - 3rd party insurance reimbursement/ACO models
- **Involuntary care under Section 12 and Section 35**
- **Security to ensure safety of individuals and employees**
- **No Wrong Door Policy**
 - Ensure access regardless of insurance status and type
 - Support law enforcement drop offs, ED transfers, reentering citizens, family referrals, walk-ins



Questions & Answers



Key Questions for the Commission

- Given data on need/demand and information on local service area capabilities, what **geographic region** of the County makes the most sense for a Restoration Center?
- What **administrative, legislative and/or regulatory changes** might support development of this model and improve billing to reduce need for new revenue?
- What transportation model makes the most sense?



Tucson Police Department
Middlesex County, Massachusetts
Learning Site Visit
February 27-28th, 2019

Thursday, February 27th

Tucson Police Department Headquarters, 270 S. Stone, Tucson, AZ, 85710

13:00-13:30

Welcome/Introduction: Sergeant Jason Winsky

13:30-15:15

Tucson System Overview: Sgt. Ericka Stropka, Sgt. Dan Bustamante, Sgt. Jack Julsing

15:15-15:30

Break, Welcome from Chief Chris Magnus

15:30-16:30

Crisis Response Center: Dr. Margaret Balfour

16:30-17:30

Specialty Courts and the Criminal Justice Reform Unit: Ms. Kate Vesely

Friday, February 28th

Tucson Police Department Headquarters, 270 S. Stone, Tucson, AZ, 85710

09:00-12:00(approx.)

Mental Health Support Team Ridealongs

12:00-13:00

Lunch, El Charro Café, 311 N. Court Ave

13:30-16:00

CRC Tour, 2802 E. District

16:00-17:00

Wrap up/Debrief



**Middlesex County Restoration Center
February 27-28, 2019
Crisis Response Center – Tucson, AZ**



Notes

Attendees: Co-Chair Danna Mauch; Representative Kenneth Gordon; Chief Robert Bongiorno, Bedford Police Department; Scott Taberner, MassHealth; David Ryan, Middlesex Sheriff's Office (MSO); Sonya Khan, MSO; Catia Sharp, MSO; Brenda Miele Soares, Advocates; Danielle Dunn, Advocates; Audrey Shelto, Blue Cross and Blue Shield of Massachusetts Foundation.

Th. 2/27 10:00AM **MEETING WITH PIMA COUNTY SHERIFF'S DEPARTMENT AND ARIZONA COMPLETE HEALTH**

*Tara Barrera, Pima County Sheriff's Department
Maria Stengel, First Responder Liaison, Arizona Complete Health
Johnnie Gasper, Manager, Crisis System, Arizona Complete Health*

Note: Only part of the site visit group was present for this meeting: Scott Taberner, Brenda Miele Soares, Danielle Dunn, David Ryan, Catia Sharp.

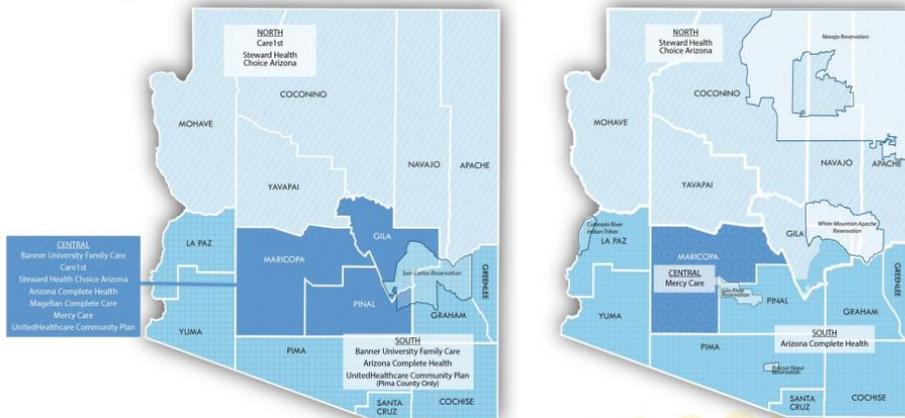
Background: Arizona Complete Health

Arizona Complete Health is the Regional Behavioral Health Authority (RBHA) designated by the Arizona Medicaid agency (called the Arizona Health Care Cost

Geographic Service Areas

AHCCCS Complete Care (ACC) Services Map

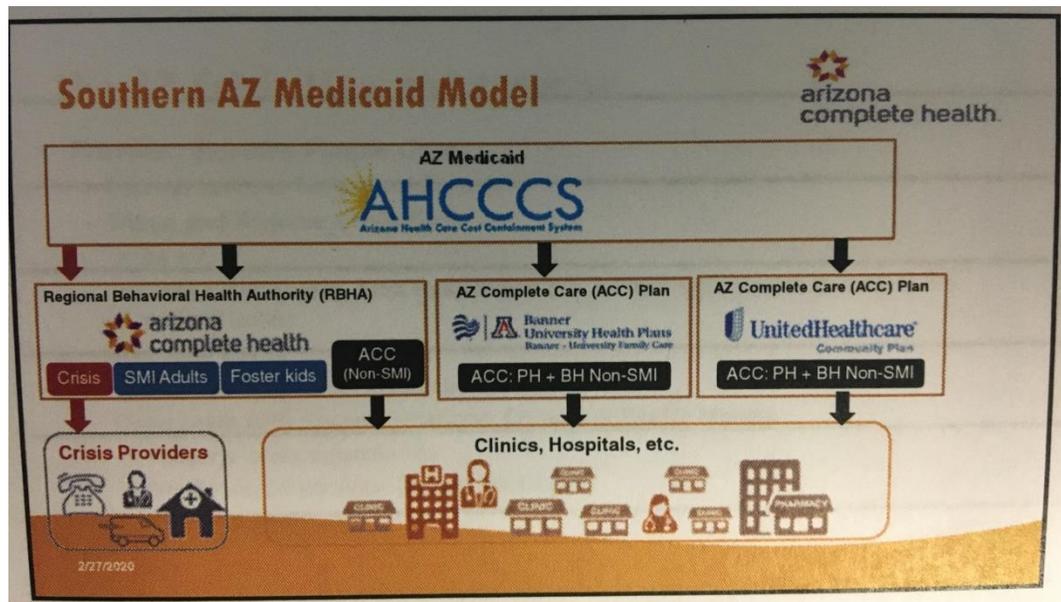
RBHA/TRBHA and Crisis Services Map



Note: Zip codes 85542, 85192, 85550 representing San Carlos Tribal area are included in the South GSA.



Containment System, or AHCCCS) to receive and spend a Medicaid block grant for behavioral health funding for one of three regions of Arizona. At left is a map of the AHCCCS general services and behavioral health carve-out services regions.



As the RBHA, Arizona Complete Health is contracted with the state to provide crisis services to anyone in crisis in the South region, behavioral health services to individuals with serious mental illness, and behavioral health services to kids in foster care. Additionally, Arizona Complete Health contracts with Indian Health Services (HIS) and some of the tribes in the South region to provide crisis care for native populations, and will also serve non-contracted native communities for crisis services only.

The Medicaid block grant pays for an initial crisis episode of care constituting the first 24 hours of crisis. Medicaid pays for this crisis care for everyone, regardless of payer. After the 24 hour initial crisis episode of care, commercial insurers begin to be billed for additional ongoing care. The block grant includes block pay for 24/7 availability of all services in the crisis continuum of care plus the billing for specific interventions described above.

The goal of the crisis system is to reduce “revolving door” usage of 911 and crisis system; reduce unnecessary detentions; reduce unnecessary use of hospital emergency departments; and reduce unnecessary psychiatric inpatient hospitalizations.

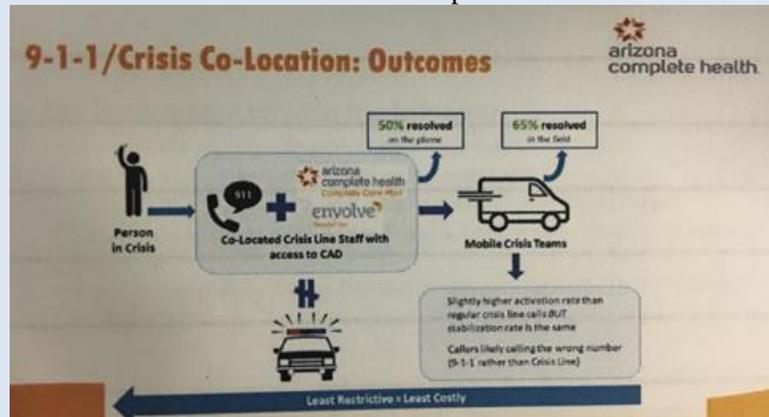
Arizona Complete Health contracts with services providers to provide the services listed below within the crisis continuum of care. Arizona Complete Health monitors performance through these contracts with an eye toward the goals listed above.

- A **crisis call line** run by Evolve People Care
 - 2 call centers in Tempe and Tucson
 - Triage and resolve crisis calls 24/7 from 911 communications centers, first responders (law enforcement, fire, and EMS), and people in crisis/the general public

- Dispatch Crisis Mobile Teams – there is a fast track for first responder requests
- Coordinate with 911 communications centers and health homes by communicating the person’s crisis episode information

A new partnership begun in April 2019 to co-locate crisis call line staff inside of a 911 communications center to more seamlessly respond to 911 calls that can be either transferred to the crisis call line or require CMT dispatch.

- Implementation:
 - April 2019: Tucson Police Department 911 evaluated pending police calls for service Priority 3 and 4
 - June 2019: direct transfer of 911 calls to crisis professionals placed in the communication center began
- Call types selected for crisis call diversion and intervention:
 - Suicidal (no weapon no plan)
 - Check welfare
- Crisis call center process:
 - Educate 911 staff on the process
 - Train crisis professionals to use 911 computer-aided dispatch (CAD) system
 - Built a 911 call flow for crisis professionals referred to as the 911 transfer configuration
 - Acclimate, adjust, evaluate, and expand – bring on additional law enforcement departments
- Averaging 100 calls per month in the pilot.
- 9-10 minute average dispatch time for mobile teams.
- Enter the calls that are transferred to crisis line personnel in both the CAD and the EHR.

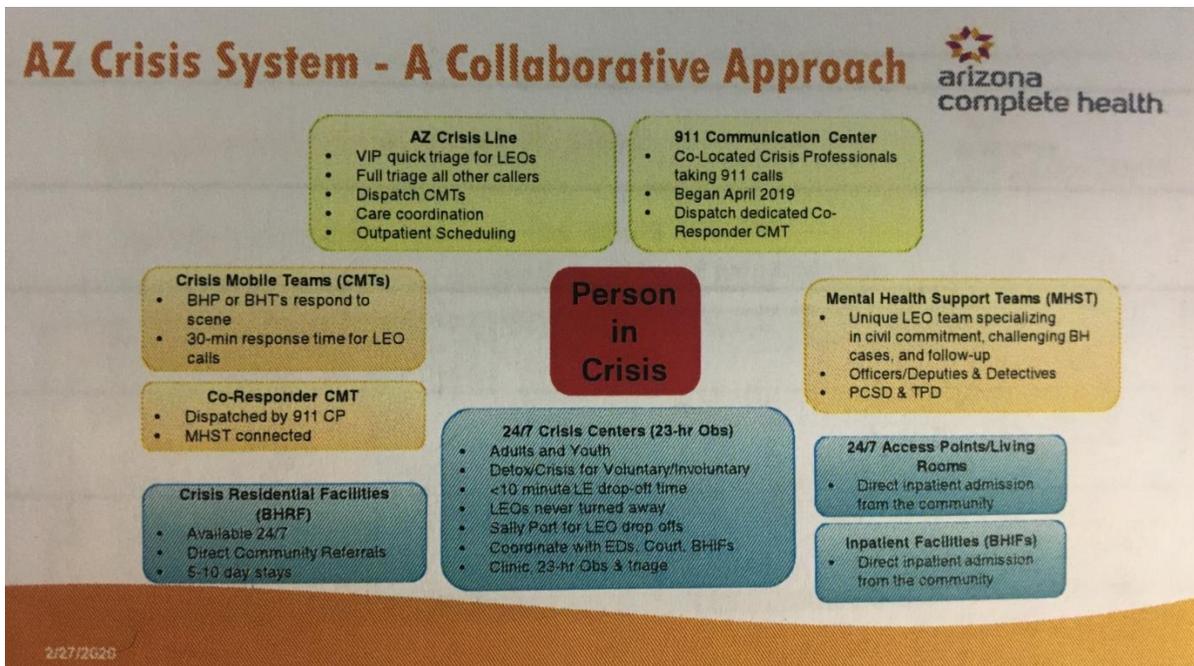


- **Crisis Mobile Teams (CMT)** run by Community Bridges, Inc. (CBI) and Community Health Associates (CHA)
 - Dispatched by the crisis line
 - One- or two-person teams driving in an unmarked vehicle. Behavioral health “technician” (licensing recently changed, but this is typically a bachelors level person with a couple of years of experience in mental health) overseen by a masters level clinician (LPC or LMSW).

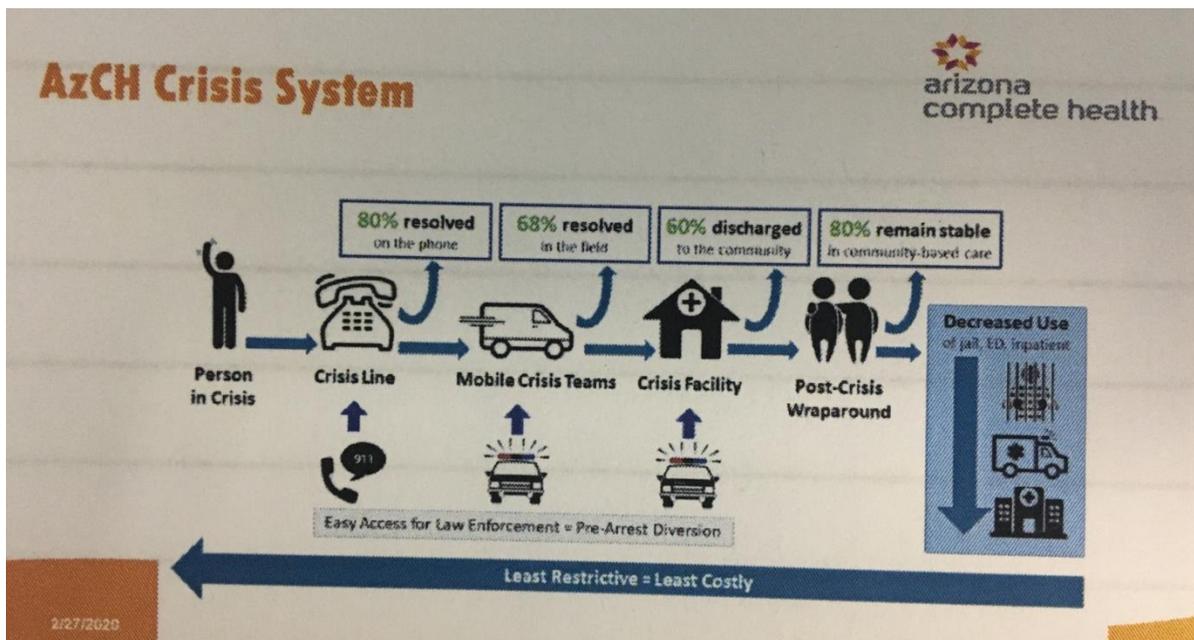
- Teams are decentralized so that they are dispersed across their geographic service area in the same way ambulance services often are
- Expedited response for first responders: under 30 minutes in town, up to 90 minutes in rural areas
- Mobile services include:
 - Assessment and coordination of expedited crisis services
 - Stabilize acute psychiatric and behavioral symptoms
 - Evaluate treatment needs and develop plans to meet those needs
 - Conduct evaluations in *some* EDs and detention facilities
 - Assist in complete emergency and involuntary applications for admission or evaluation
- Before 2015, a different entity served as the RBHA, and had 4-5 mobile teams. Since AZ Complete Health took over, they have tripled the number of teams, and utilization is way up as a result of increased access and a focus on marketing – they hired a full time-staff person to market to law enforcement personnel.
- Transportation: mobile team does it. If they feel transport is unsafe in their mobile team vehicle, they can do ambulance or law enforcement transport. Transport hours are billable. They try not to transport out of the region because of field coverage ratios.
- Average response time: 38 minutes
- **Community Observation Centers (COCs)** – 23 hour observation, open 24/7
 - Service over 2,000 members per month in 5 units across the South region
 - Eligible members without an outpatient provider can request real-time enrollment, which is done face-to-face by an outpatient provider – can be requested by 24-hour observation center for a one-hour response time (members admitted to inpatient levels of care receive a 24-hour response time)
 - After crisis/ongoing support:
 - Coordinated by outpatient team
 - Block grant with outpatient providers for standing capacity to provide one hour response times with 23 hour notice or less
 - Discharge to:
 - Crisis residential facilities – RBHA pays for standing capacity to ensure step-down is available – they use this a lot for medication stabilization
 - 45 day post-crisis follow-up services (peer-driven)
 - Specialty coordination for those regularly accessing the inpatient crisis system
 - Transportation to aftercare is done through a contract with a transportation provider

- Community Response Center (CRC) run by Banner Health through a subcontract to Connections Health Solutions – voluntary and involuntary mental health crisis treatment for adults and children
 - ~48% of volume from law enforcement drop off
 - Triage, monitor, and refer members to the adequate level of care
- CBI Toole: 23-hour substance use observation – voluntary, adults only
- Behavioral Health Inpatient Facilities (BHIFs)
 - BUMC South, Palo Verde, Sonora, etc.
 - Critical Incident Stress Management (CISM)
 - Designed to provide support for those who have experienced a traumatic event as well as those who are prone to repetitive trauma exposure, including victims, witnesses, and law enforcement staff
 - Accessed by calling the crisis call line
 - CMT providers are all required to be CISM trained
 - Additional crisis system management and resources
 - Quarterly crisis system meetings in each of the 8 counties improve communication and collaboration between systems partners
 - Crisis system protocols are updated annually, customized for each county, and are intended to be crisis system “user guides”
 - Law enforcement and first-responder workgroups are run as needed/requested per county
 - Training for first responders:
 - ◆ Crisis system overview – covers what to expect from the crisis system, how to access services, and what to do when issues arise
 - ◆ First responder resiliency 101 – stress, PTSD, and suicide rates, plus resiliency (what it is, why it’s important, and ways to improve it)
 - ◆ Resiliency: 5 skills = new and evidence based; learn how to develop 5 key skills: (1) belief, (2) strength, (3) persistence, (4) trust, (5) adaptability.
 - ◆ Mental health first aid – for public safety, fire/EMS and veterans. The Sheriff’s Department and Tucson Police Department are 100% trained in MHFA, and have now introduced it into the academy on a go-forward basis.
 - ◆ Crisis intervention training (CIT). AZ Complete Health estimates that the Sheriff’s Department and Tucson PD are both over 20% trained in CIT, per the Memphis Model.

The below chart maps this crisis system with the person in need of care at the center. At the top are diversionary, light-touch services; in the middle are mobile services intended to de-escalate and prevent site-based care; and at the bottom are more intensive site-based services.



In striving to reach the goals of delivering the least restrictive care needed, the below is a depiction of the rate of success at resolving crises at each level of care.



Two additional keys to success we discussed:

- Marketing:
 - Hired a full-time staff person who formerly worked for the Sheriff's Department to market to law enforcement personnel.
 - Market to health plans by talking about cost-savings. Market to law enforcement by emphasizing time to drop off.
- Culture: law enforcement as “preferred customer.”

Background: Pima County Sheriff's Department Mental Health Support Team

- Demographics/statistics on Pima County, Tucson AZ
 - 9,187 square miles
 - 1.047 million population
 - 85% white, 4% black/African American, 4% American Indian/Alaska Native
- “As a law enforcement officer, the most dangerous person you will meet is you.” – Sheriff Napier
 - Sheriff cited officer suicide, domestic violence, substance use, and financial instability.
 - AS CH: “We recognize that these partnerships are important,” and therefore invest in staff to focus on law enforcement partnership building around that relationship.
 - Want law enforcement to feel like a partner
 - “If I’ve ever interacted with the crisis system before, I’m calling 911. And we need to recognize that.”
- Catia note: the Sheriff’s policing role seems to drive this partnership. The jail is the reason for wanting the partnership (reduce population), but to actuate the partnership, you need police to interact with crisis service providers.
 - Law enforcement support drives state health funding for crisis services.
- MHSU
 - Created after Gabby Giffords shooting
 - Team is the law enforcement liaison for the crisis center
 - 3 units:
 - MH warrants (2 officers)
 - Detectives (use MHST tag on reports)
 - Dogs – with funding from AZCH
 - ◆ “liability”
 - ◆ Has reduced the need for SWAT

Th. 2/27
1:00PM

“CLASSROOM” SESSION WITH TUCSON POLICE DEPARTMENT
Sergeant Jason Winsky, Tucson Police Department

Welcome and Introductions

In 2011, Tucson already had one of the oldest CIT programs in the nation, but still, the Gabby Giffords shooting was a catalyst for taking a fresh look at their approach to mental health crises. The Police Department realized that CIT provided the tools to help officers respond to a person in behavioral health crisis, but perhaps with a different approach, they could prevent some crises and related threats to public safety altogether. In 2012, the Pima County Sheriff’s Department created a Mental Health Support Team (MHST), and in 2013 Tucson Police Department did as well. They dedicated a Sergeant, Detective, and Transport Officers to the new unit.

“The ability to remain flexible in operations and adaptive in nature will ensure the relevancy of the unit and mission.”

- Co-responder model
- Homeless outreach
- Opioid use disorder/substance use disorder
- Co-occurring disorders
- Frequent or high utilizer outreach
- Diversion or deflection of vulnerable populations from incarceration to treatment and services



Other interesting items that came up:

- The Police Department pays the Sheriff's Office for the cost of arrestees being held all the way through detention and incarceration.
 - The City of Tucson collects sales taxes; Pima County collects property taxes.
- Training
 - For CIT, they follow the Memphis Model – training is voluntary. 60% of the officers are trained.
 - Back-trained all officers with MHFA; now offer in academy.
- “If we build it, they will come.” – NOT TRUE
 - Need to focus on law enforcement as a “preferred customer”
 - “If it works, they will come”
- MHST
 - “dedicated not designated” – don't also work on other things, so have the time to spend de-escalating calls
- Managed care organization funds co-responders
 - Hiring 6 more in-house co-responders at the PD in part to improve access and data sharing
 - *Catia note: interesting that they think access and data sharing is a problem
- Grant funds peer navigators for substance use
- Outcomes metrics: reduce “total public safety contacts” (police, arrest, fire, ED, crisis, etc.)

Tucson System Overview

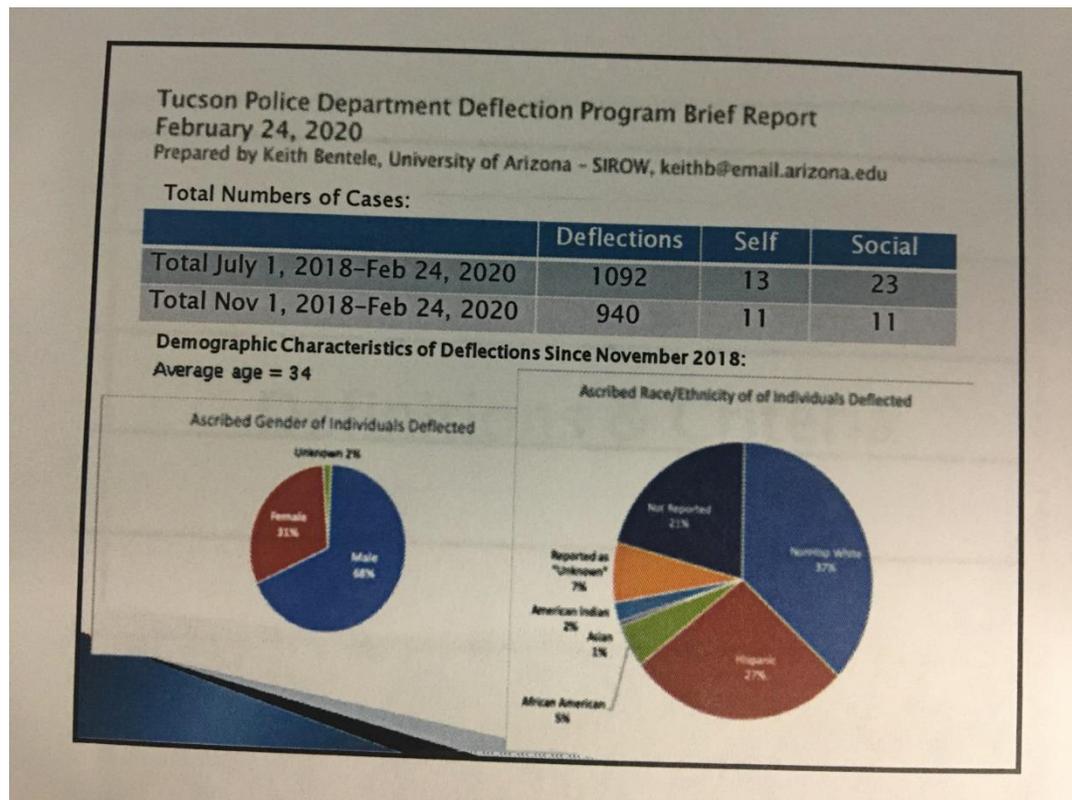
Deflection program

Sergeant Ericka Stropka, Tucson Police Department

- Started in 2017: all Tucson police officers trained to carry and administer Narcan
 - Assistant Chief researched deflection programs in other jurisdictions, met with AHCCCS, Cenpatico, CODAC, and the CRC; selected CODAC as primary service partner for the program
 - 2018: all officers trained in the deflection program and began using it
- Goal: save lives
 - Reduce overdose deaths
 - Establish trust with substance users
 - Provide an avenue for substance users to access treatment
 - Reduce crime and improve quality of life in communities
- “Get out of jail free card” – not holding charges over people's heads
 - Transport the person to MAT facility (CODAC) – there, they can not only get substance use services, but also whole person services (ob/gyn, primary care, etc.)

- Most people are only getting deflected once
- When appropriate, deflection is the process of moving a person away from the criminal justice system, so they do not enter in the first place
 - Even though there is probable cause to arrest for a criminal offense, the person is directed into treatment in lieu of an arrest
 - Charges are only documented, not processed
- Benefits
 - Connected with a multitude of other services when deflected into treatment: mental health services (CRC), housing, counseling, healthcare, job readiness and placement, educational support
- Self-referral – contact initiated by an individual
 - A person can enter a police substation or approach a uniformed officer to request recovery support
 - The officer will ask for name and DOB
 - A warrant check is completed
 - Warrants related to domestic violence charges or violent felony arrest warrants may be served
 - Absent servable arrest warrant, the person is connected to recovery services
 - The person will not be arrested if they forfeit any narcotics or paraphernalia
 - Transportation will be arranged for the person
- Active outreach – Substance Use Resource Team does this, but all officers are encouraged to proactively engage community members in this same way
 - Also called homeless outreach team
- Deflection – contact is initiated by the officer – these decisions are discretionary
 - Probable cause exists to make an arrest, rather than citing or booking, the officer determines treatment is a better outcome
 - Call for service
 - On-sight activity
 - Reasonable suspicion – investigatory stop
 - Probable cause for an arrest
- Eligibility criteria
 - Personal, usable amount of heroin, meth, cocaine, or any combination thereof – officer must distinguish personal use from commercial use
 - Prescription pills for personal use
 - Narcotic paraphernalia to include pipes, foil, syringes
 - Some misdemeanor crimes can be considered for deflection if the nexus is SUD related (trespassing, shoplifting, etc.)
- Ineligible criteria
 - 17 years or younger
 - Violent felony warrants
 - Domestic violence offenses

- DUI offenses
- Involved in a crime of violence at time of contact
- Involved in the exploitation/victimization of minors, elderly, or vulnerable adults
- Involved in sex trafficking
- Substance Use Resource Team also does:
 - Naloxone distribution
 - Follow-ups on cases of people suffered an overdose
 - Follow-ups on cases from CNA
 - Community events – education for the public
- On the horizon
 - Training all officers on mental illness
 - Training all officers on trauma-informed care
 - Introducing the UNCOPE assessment tool
- Doing an evaluation of the program through a SAMHSA grant and with a partnership with University of Arizona



Mental Health Support Team (MHST)

Sergeant Dan Bustamante, Tucson Police Department

- Big difference from regular officers is time to spend on scene engaging people
- What they do:

- Serve mental health orders (their equivalent of Sections)\
- Intervene with chronic callers
- Investigative follow up
- Stop potential active killers
- “support the field”
- Outcomes:
 - Reduce risk to officers
 - Reduce risk to community
 - Reduce risk to persons with mental illness
 - Reduce waste of taxpayer dollars
 - Reduce calls for service
 - Increase collaboration
 - Increase field stabilization
- Other officers think of MHST as “easy button”

Welcome from Chief Chris Magnus

Chief Chris Magnus, Tucson Police Department

- “One and done” – people have one bad interaction with police and they’re done. Making it harder for your colleagues who will interact with them later
- Compassion is a bad word among police – need to be proud of compassion

Background: Crisis Response Center

Dr. Margaret Balfour

- System vs services
 - 3 key ingredients
 - Data
 - Collaboration
 - accountability
- 16 mobile crisis teams across the county
- “Assume most people don’t need to go to inpatient” – therefore, accept most people
- If she could design the space over, she would do multiple rooms for intake at law enforcement drop off
- Medical model vs “recovery” – not a linear thing, more like Maslow’s hierarchy of needs – everyone needs safety; recovery is higher on the list of needs after the basic needs for safety are met.
 - Restraints are sometimes needed because if you don’t use them, the person may end up going to ED/jail; try to avoid restraints if at all possible
- Dorm style – can and do flex up on numbers for occupancy
- When people bond out of jail in the middle of the night, can voluntarily transport to CRC for MAT induction
- “door to doctor time” – 90 minutes

- Use CIT to encourage chiefs to use crisis services – create peer pressure
- Post-crisis wrap around – 45 days – paid by Medicaid
- Monthly meeting with crisis center and police departments (sergeant level)

Specialty Court Programs

Terrance Cheung

- Weekly jail population review meeting – prosecutors, service providers, jail, etc.

Fri. 2/28
9:00AM

MENTAL HEALTH SUPPORT TEAM RIDEALONGS/CBI TOUR

Sergeant Jason Winsky, Tucson Police Department

Fri. 2/28
12:30PM

CRISIS RESPONSE CENTER TOUR

Dr. Margie Balfour

- Waiting room – triage acutely suicidal/homicidal/psychotic people immediately in; otherwise, they will see you in the order you come in
- Intake – masters level people of various types
- Lesson learned: separate seclusion/restraint room from other clinical offices “grandma needs her Prozac”
- Send people to the ED if they need to, but will always take the person back from ED when they are ready
- 24/7 doc/NP coverage
- Low/moderate risk -> observation unit
- High risk/involuntary -> individual rooms
- “safe clench” = hands-on training for behavioral health technicians who move people from the sally port to the observation unit
- Peers, nurses, behavioral health technicians, doctors, residents
- 2-way barricade-proof door on seclusion/restraint room
- 70% co-occurring disorders – “expect it”
- All specialties are flexed across “subacute” inpatient; adult crisis; kids crisis
- Upstairs “subacute” inpatient unit