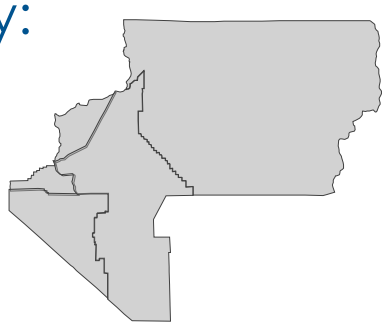
Regional Meeting Consultation Summary: Northern Region



Background & Purpose

On July 28, 2020, Nevada held a virtual Statewide Summit for Crisis Care. The Summit followed a six-part webinar series orienting stakeholders across Nevada to the components of a Crisis Care Response System (CCRS) as outlined in the Substance Abuse and Mental Health Services Administration (SAMHSA) "National Guidelines for Behavioral Health Crisis Care- Best Practice Toolkit" (referred to as, "The National Guidelines").[1] At the Summit, Nevada's Crisis Care Response System: Assets and Gaps Statewide Report was presented.[2] This Report details the assets and gaps related to the Crisis Care Response System identified by Regional Behavioral Health Coordinators (RBHCs) using a standard tool.[3]

Following this overview, Summit participants were invited to participate in regional discussions to further understand the assets and gaps specific to their region and begin thinking about what is needed most in their region. The information presented in this summary is intended to inform discussions and decision-making at the regional level.

Regional Consultation Overview

The Northern Region's Consultation was held on **July 28, 2020, from 9:35 to 10:30 AM**. It included approximately 7 participants from the Northern Region and 2 participants representing agencies throughout the state.

Participant Name	Participant Agency
Darcy Davis	Nevada Division of Public and Behavioral Health
Sarah Dearborn	Nevada Medicaid
Sandra Draper	NAMI Western Nevada Board of Directors
Jessica Flood	Nevada Rural Hospital Partners
Tina Gerber-Winn	DPBH Rural Clinics
Joan Hall	Nevada Rural Hospital Partners

[1] The National Guidelines for Behavioral Health Crisis Care- Best Practice Toolkit, along with recordings and materials from the six-part webinar series, are available at: https://socialent.com/2020/06/nevada-crisis-response-system-virtual-summit/

[2] Nevada's Crisis Response System: Assets and Gaps Statewide Report is available at: https://socialent.com/2020/06/nevada-crisis-response-system-virtual-summit/

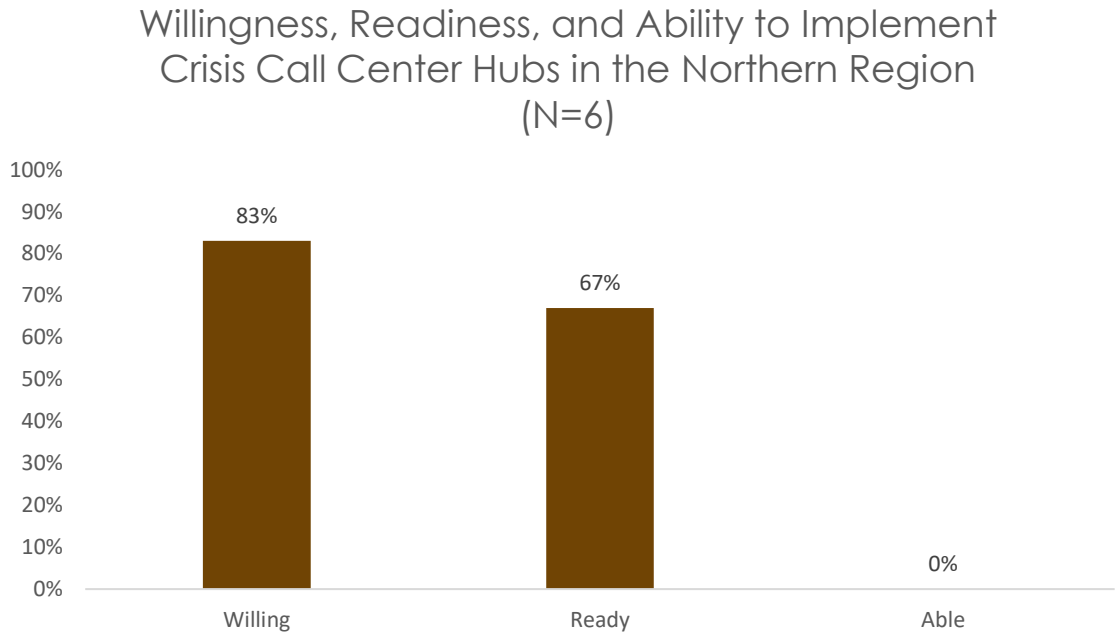
[3] The Crisis Now Scoring Tool developed by RI International can be found at: https://crisisnow.com/wp-content/uploads/2020/02/Crisis-Now-Assessment-Tool.pdf.

Participant Name	Participant Agency
Shayla Holmes	Lyon County Human Services
Stephen Wood	Nevada Division of Public and Behavioral Health
Laura Yanez	NAMI Western Nevada

Following the presentation of the minimum standards for each component and the criteria met within each for the region, polling was used to identify where the region stands in terms of its willingness, readiness, and ability to implement criteria within each component. A subsequent poll asked participants to select the top two gaps within their region for each component and for the essential principles and practices of the Crisis Care Response System. The charts and narrative below summarize these discussions for future consideration.

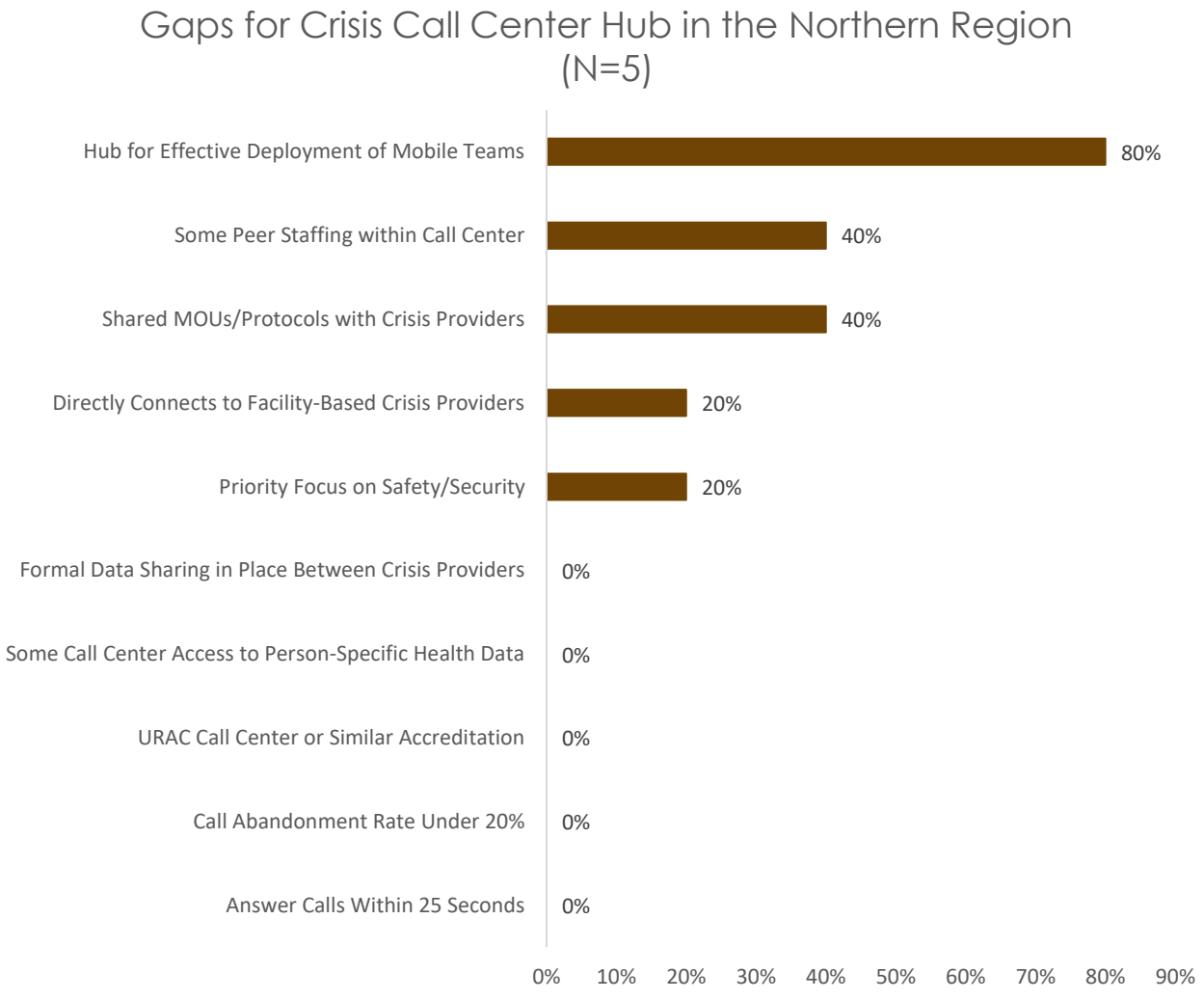
Crisis Call Center Hub

Participants were first asked to identify if the Northern Region and its stakeholders were willing, ready, and able to implement a Crisis Call Center Hub. The responses from 6 of the region's participants summarized in the graph below show that 83% felt the region is willing, 67% felt the region is ready, and 0% felt that the region is able to implement a Crisis Call Center Hub at this point in time. It is important to note that participants were able to respond to all three questions in their response.



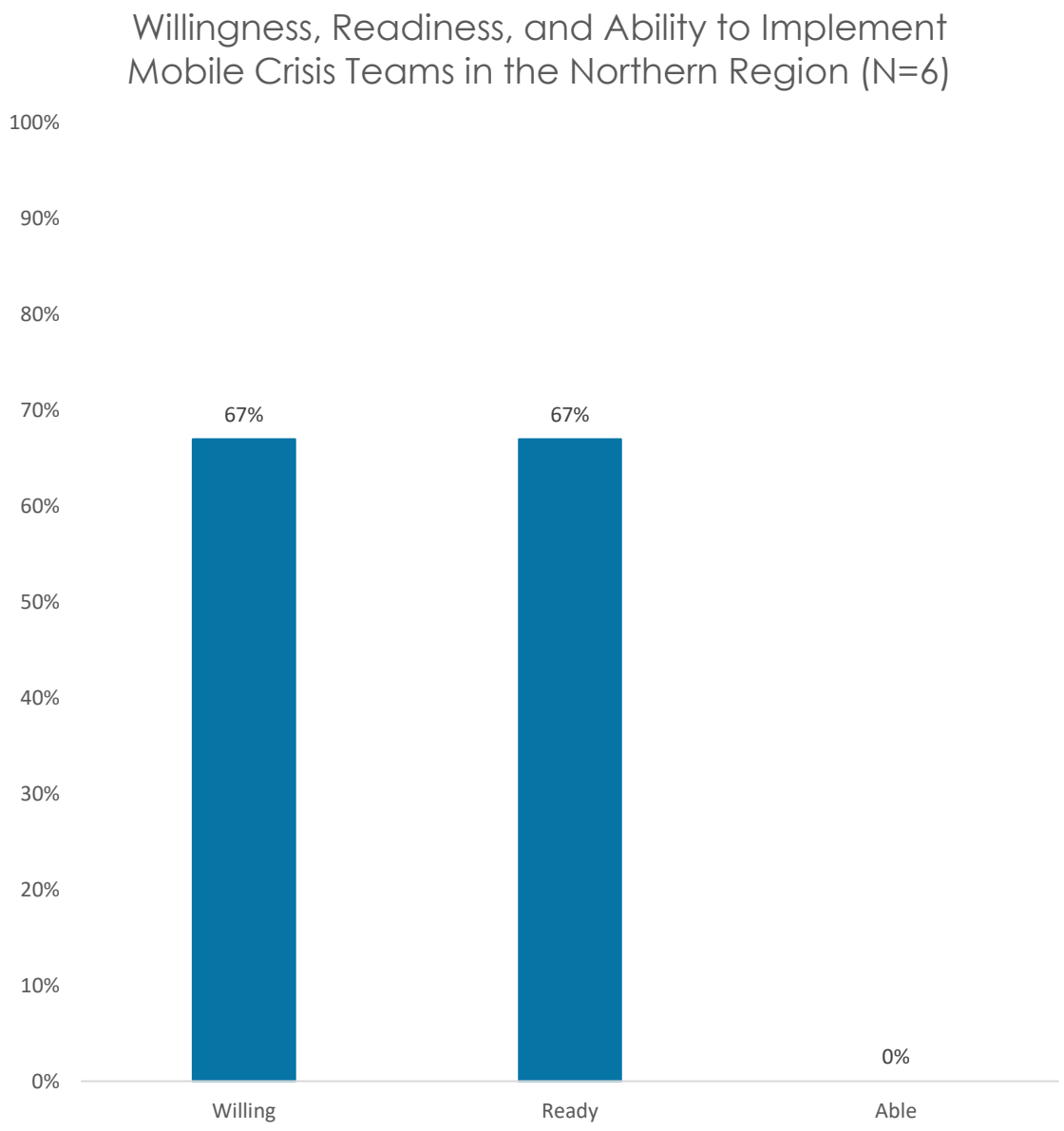
Following the question related to willingness, readiness, and ability to implement a Crisis Call Center Hub in the Northern Region, participants were asked to identify the top two gaps in their region regarding Crisis Call Center Hubs. The answer options were established from the criteria from the region's Crisis Now Scoring Tool that the region indicated they are not currently implementing or do not currently have in place. The graph below summarizes the results of this poll. The top three gaps identified by participants were:

1. Hub for Effective Deployment of Mobile Teams (80%),
2. Some Peer Staffing within Call Center, and Shared MOUs (40%--tie)
2. Protocols with Crisis Providers (40%--tie)



Mobile Crisis Teams

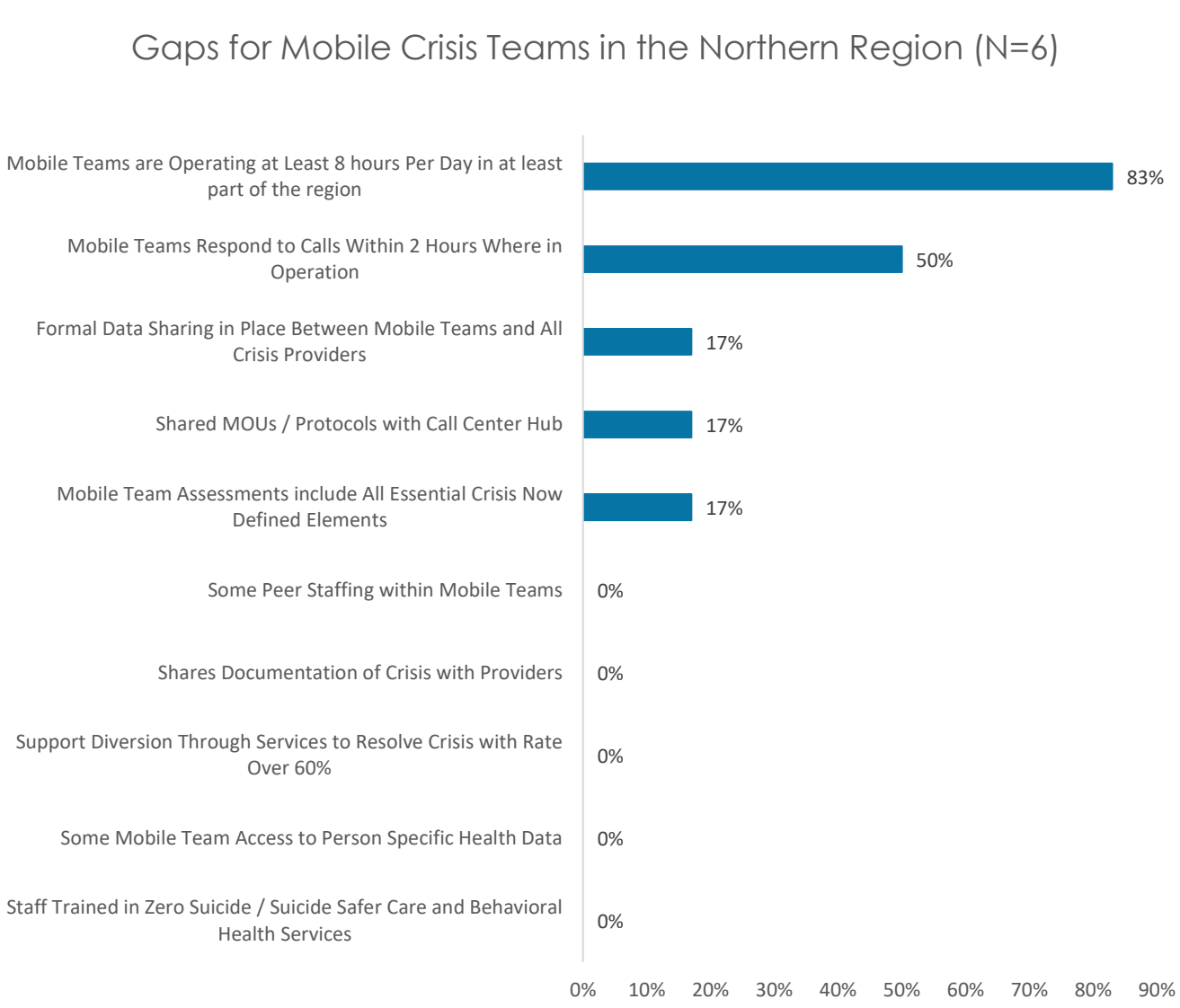
Participants were again asked to identify if the Northern Region and its stakeholders were willing, ready, and able to implement Mobile Crisis Teams. The responses from 6 of the region's participants summarized in the graph below show that 67% felt the region is willing, 67% felt the region is ready, and 0% felt that the region is able to implement Mobile Crisis Teams at this point in time. It is important to note that participants were able to respond to all three questions in their response.



Following the question related to willingness, readiness, and ability to implement Mobile Crisis Teams in the Northern Region, participants were asked to identify the top two gaps in their region regarding Mobile Crisis Teams. The answer options were established from the criteria from the region's Crisis Now Scoring Tool that the region indicated they are not currently implementing or do not currently have in place. The graph below summarizes the results of this poll. The top two gaps identified by participants were:

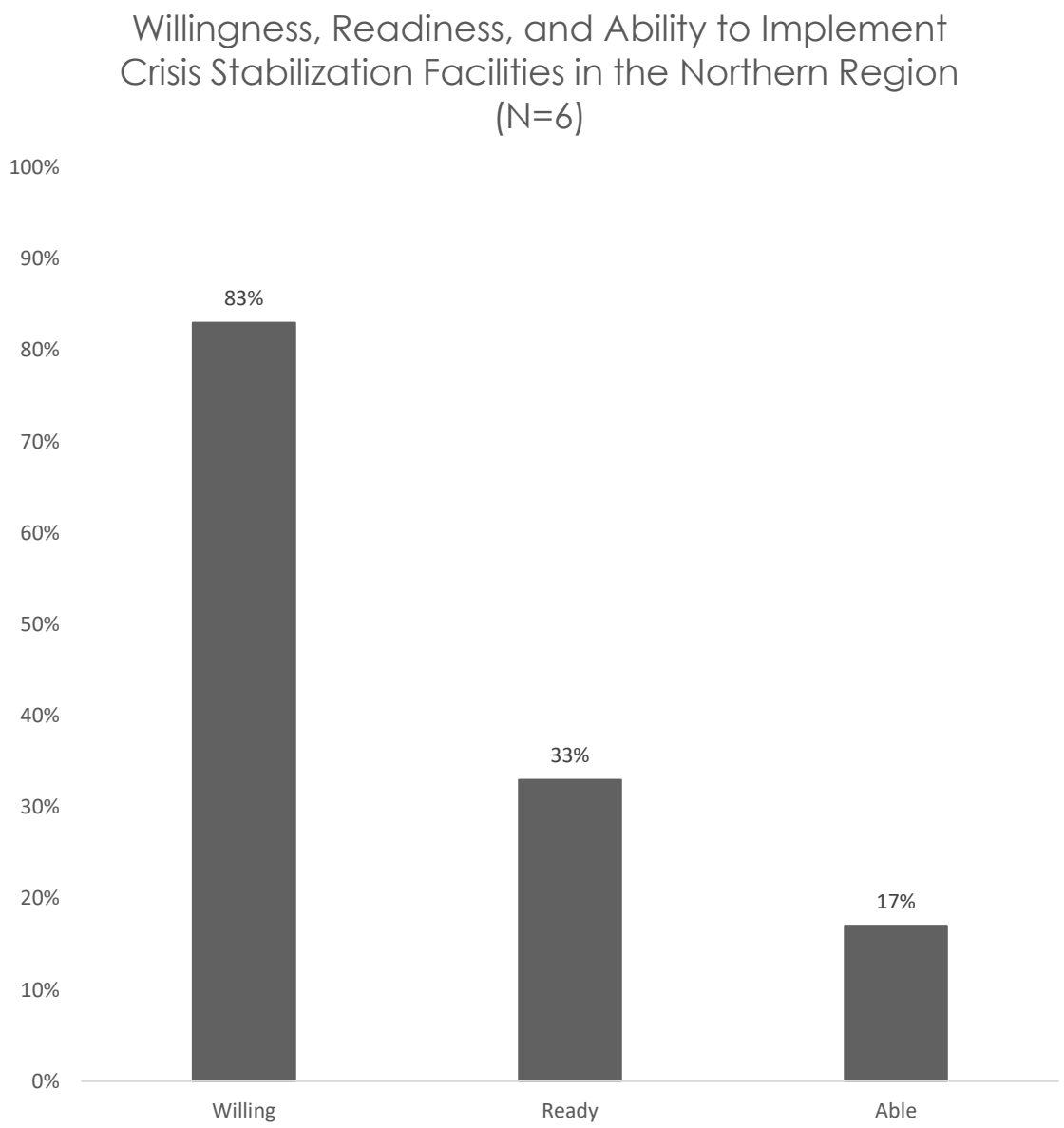
1. Mobile Teams are Available Throughout the Region at Least 8 Hours Per Day in at least part of the region (83%)

2. Mobile Teams Respond to Calls Within 2 Hours Where in Operation (50%)



Crisis Stabilization Facilities

Participants were first asked to identify if the Northern Region and its stakeholders were willing, ready, and able to implement Crisis Stabilization Facilities. The responses from 6 of the region's participants summarized in the graph below show that 83% felt the region is willing, 33% felt the region is ready, and 17% felt that the region is able to implement Crisis Stabilization Facilities at this point in time. It is important to note that participants were able to respond to all three questions in their response.

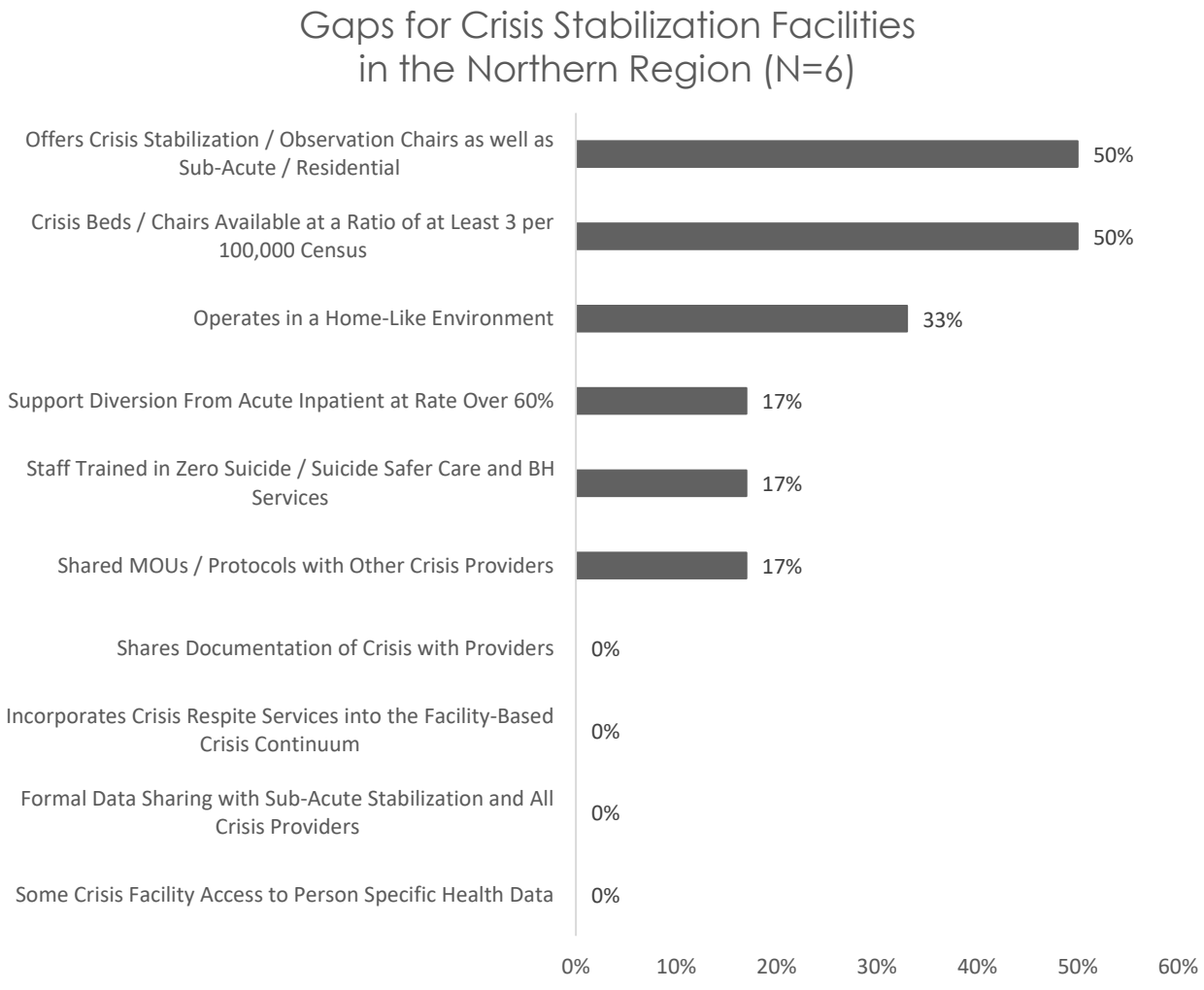


Following the question related to willingness, readiness, and ability to implement Crisis Stabilization Facilities in the Northern Region, participants were asked to identify the top two gaps in their region regarding Crisis Stabilization Facilities. The answer options were established from the criteria from the region's Crisis Now Scoring Tool that the region indicated they are not currently implementing or do not currently have in place. The graph below summarizes the results of this poll. The top three gaps identified by participants were:

1. Offers Crisis Stabilization/Observation Chairs as well as Sub-Acute/Residential, and (50%--tie)

1. Crisis Beds/Chairs Available at a Ratio of at Least 3 per 100,000 Census (50%--tie)

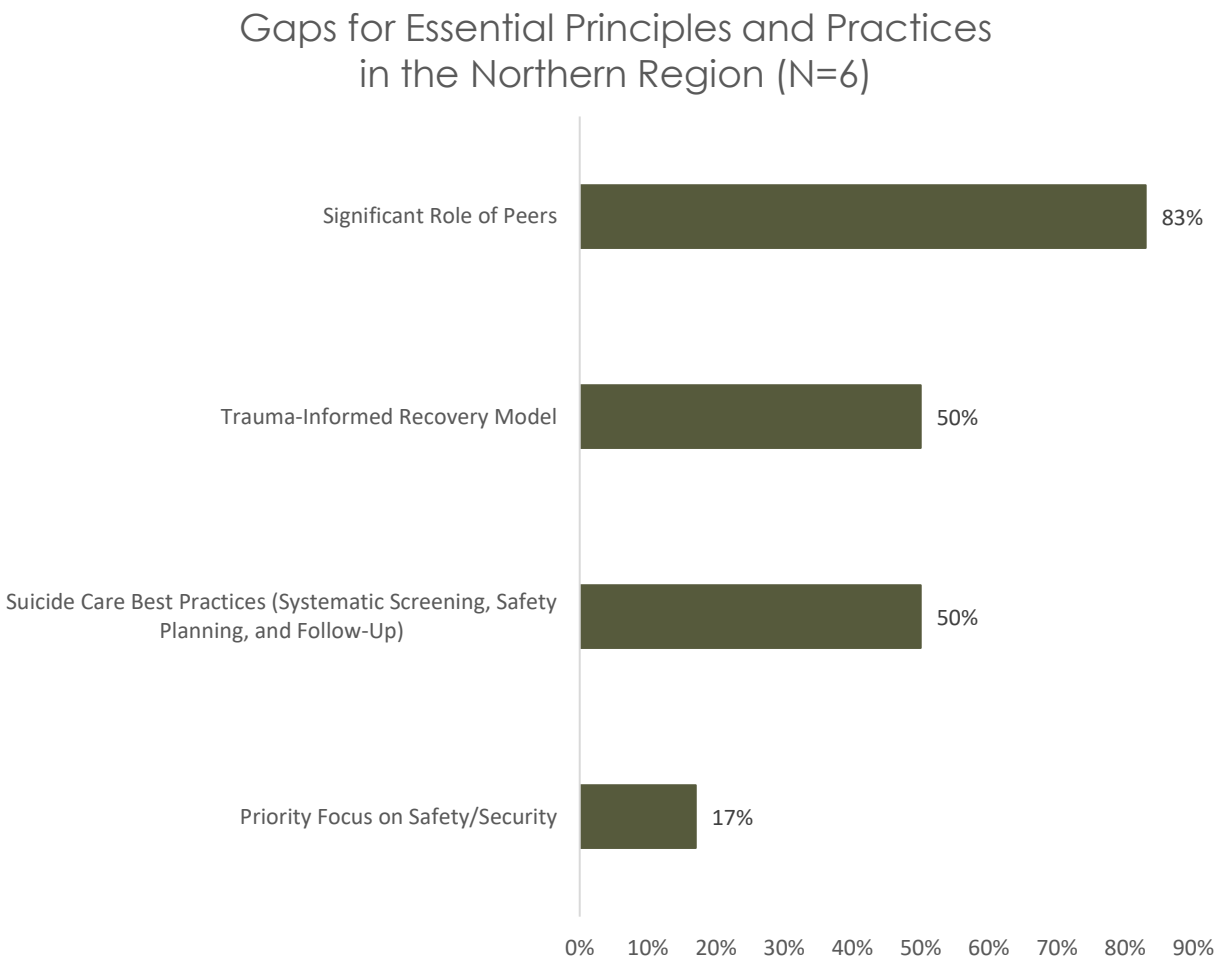
3. Operates in a Home-Like Environment (33%)



Essential Principles and Practices

The Essential Principles and Practices are intended to be integrated into each component of a coordinated crisis response system. This includes evidence-based practices and protocols that guide the access, coordination, and delivery of the crisis response services outlined in the three components above.

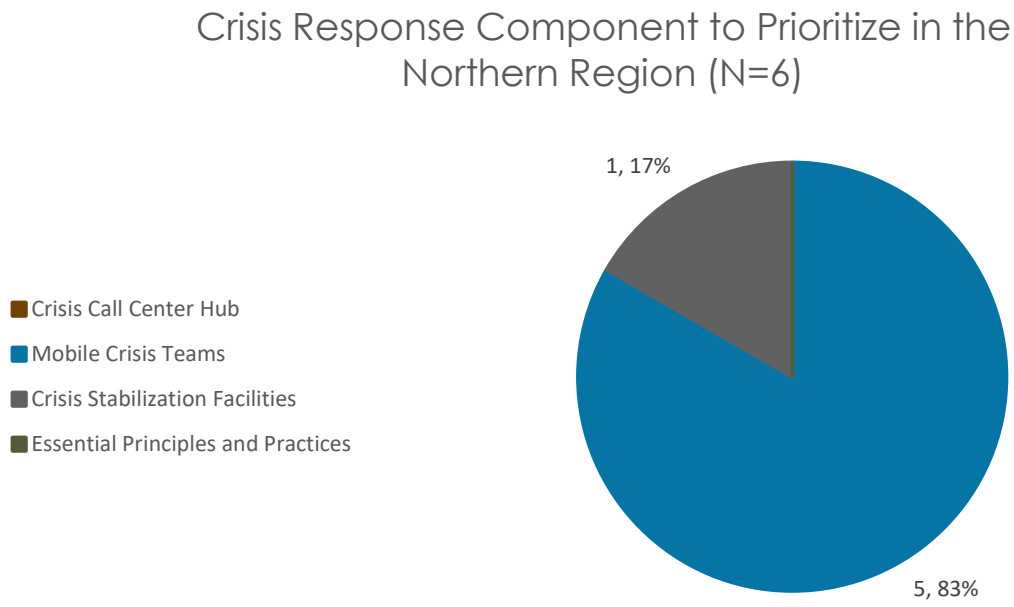
Participants were asked to identify the top two gaps out of the four core elements that make up the Essential Principles and Practices in a Crisis Care Response System. As the graph below shows, 83% of respondents identified Significant Role of Peers as the largest gap in the Essential Principles and Practices in the Northern Region, followed by the Trauma-Informed Recovery Model (50%), Suicide Care Best Practices (50%), and Priority Focus on Safety/Security (17%).



Summary

Participants, while acknowledging that all four components are critical for a Crisis Care Response System, selected Mobile Crisis Teams as the component they would prioritize first for the Northern Region.

The chart below summarizes the responses, with 5 (83%) selecting Mobile Crisis Teams and 1 (17%) selecting Crisis Stabilization Facilities.



The main discussion points during the Northern Regional Consultation were identified as in alignment with the county level behavioral health task forces.

It was identified in the consultation that the region needs a connection to Crisis Support Services of Nevada (CCSNV) and the ability for dispatchers to link to the Crisis Care Response System through CCSNV. It was also noted that there are many crisis call lines in the region. This underscores the need for memorandums of understanding (MOUs) with clear responsibility for triage to be done by CCSNV and to link the crisis lines and ensure they are working together with an understanding of their individual roles in the system. This issue was identified as low-hanging fruit for the region.

Regarding mobile teams, there is a need for expansion of the model. There are mobile crisis teams in the region which is an asset. The region currently benefits from mobile outreach safety teams (MOST) that respond to individuals that lack insight into their issues and are more complex and the MOST teams are viewed as proficient at

responding to those persons in crisis. The opportunity identified in the region is to eventually transition into a model with law enforcement embedded in law enforcement agencies and the addition of mobile response teams of clinicians and peers that could operate 24 hours per day, seven days a week.

The region has the Mallory Crisis Stabilization Center as well as Certified Community Behavioral Health Clinics (CCBHCs). The CCBHCs are currently learning about how they fit in the Crisis Care Response System but there is a wealth of crisis stabilization center resources for the region. However, the gap identified was the lack of sustainable funding for Mallory Crisis Center.

The region also expressed interest in that idea of having satellite facilities throughout the region but noted that funding is an issue for expansion as it is with mobile crisis response. It was noted that the region lacks a specified 'landing strip' for crisis stabilization in the region. It was identified that if there were a living room model that was local where people could be de-escalated or then transported to Mallory if a higher level of care is needed, that could serve as the landing strip. A potential option identified to meet this need are the CCBHCs which are growing and if linked to the system could be able to act as a landing pad for stabilization and then transportation for those guests in need could be arranged to a higher level of care such as Mallory. To that end, it was noted that a gap is the need for data from the CCBHCs.

To implement peer-delivered services, participants in the regional consultation noted the need for a well-trained peer support workforce with adequate training so they can serve as peers. It was identified that there may be an issue of the standards for peers in Medicaid. Providers including CCBHCs need to fully recognize and acknowledge the value of peers. Recruitment of peers is also a challenge and there is a need to publicize career opportunities. This was also identified as low-hanging fruit for the region as potential peers can go through one of two programs to become a peer. Participants felt it was important to get the word out that peer support is an emerging field.

Related to barriers, it was noted that funding is a barrier. Some participants felt that if there was political will, the funding would more likely become available. They also indicated that fostering buy-in for the Crisis Care Response System and being able to communicate the return on investment is critical. Additionally, collecting data on outcomes to support funding of a clinician versus a sheriff's deputy was identified as important.

The group questioned whether MOST teams are willing and able to be Medicaid billable. MOST teams respond rapidly to immediate crisis situations. Stakeholders in the region are open to finding ways to bill Medicaid. However, the Sheriff's Department is

not skilled in Medicaid billing. The majority of MOST clients would have to be Medicaid eligible to support the funding.

Other challenges noted related to the MOST team. For example, courts refer to MOST and MOST teams have built relationships with the courts and the communities in the Northern Region. It was identified as important to communicate that the region needs a clinician mobile team and MOST team and to incorporate peers into both.

Regional results found in this summary are incorporated into the Statewide Assets and Gaps Report.

Next Steps

This overview will be provided to the Regional Behavioral Health Policy Boards and other stakeholders with the intention of moving forward with implementing the National Guidelines at the state and regional level. RBHCs will provide this summary to their Policy Boards to determine how they will use it to determine their next steps.