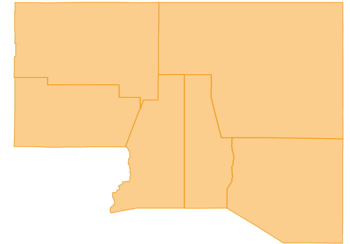
Regional Meeting Consultation Summary: Rural Region



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 understanding of 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 Rural Region's Consultation was held on **July 28, 2020, from 9:35 to 10:30 AM**. It included approximately 8 participants from the Rural Region and 4 participants representing agencies throughout the state.

Participant Name	Participant Agency
Ashley Gurr	Elko County Social Services
Betti Magney	Vitality Unlimited
Melissa Washabaugh	Pershing General Hospital
Kim Donohue	Nevada Department of Veterans Services
Lori Follett	Division of Healthcare Financing & Policy- Medicaid
Valerie Cauhape	Rural Regional Behavioral Health Policy Board
James Thornton	PACE Coalition

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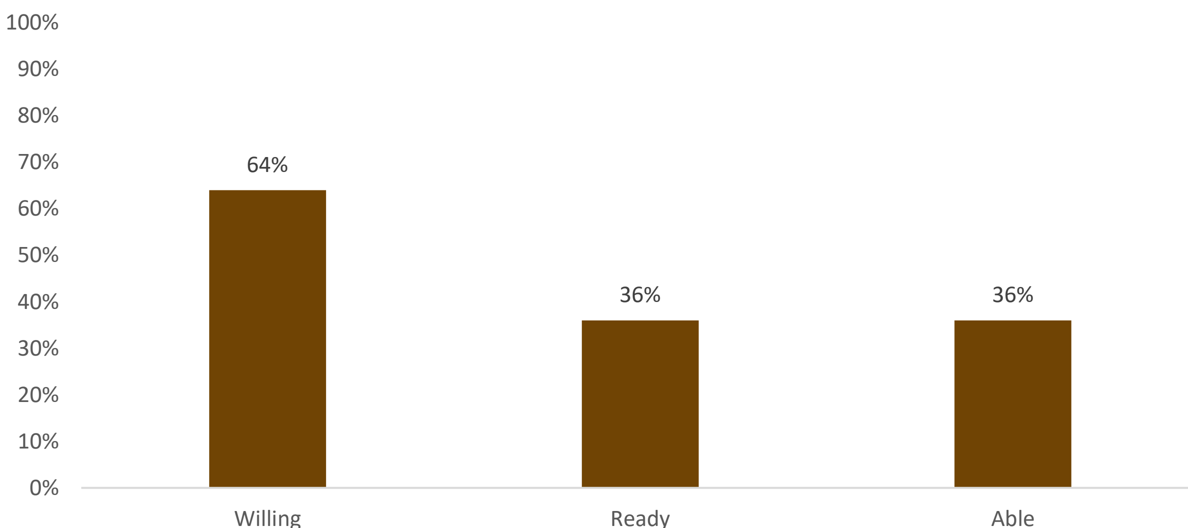
[1] The National Guidelines for Behavioral Health Crisis Care- Best Practice Toolkit, along with recordings and materials from the six-part webinar series, are available at: https://socialent.com/2020/06/nevada-crisis-response-system-virtual-summit/
[2] Nevada's Crisis Response System: Assets and Gaps 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
Nancy Snyder	NAMI
Brooke O'Byrne	Rural Regional Behavioral Health Policy Board
Joan Hall	Nevada Rural Hospital Partners
Misty Allen	Office of Suicide Prevention
Kim Gilbert	NAMI Western Nevada and Carlin Combined Schools

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 asked to identify if the Rural Region and its stakeholders were willing, ready, and able to implement a Crisis Call Center Hub. The responses from 11 of the region's participants summarized in the graph below show that 64% felt the region is willing, 36% felt the region is ready, and 36% 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.



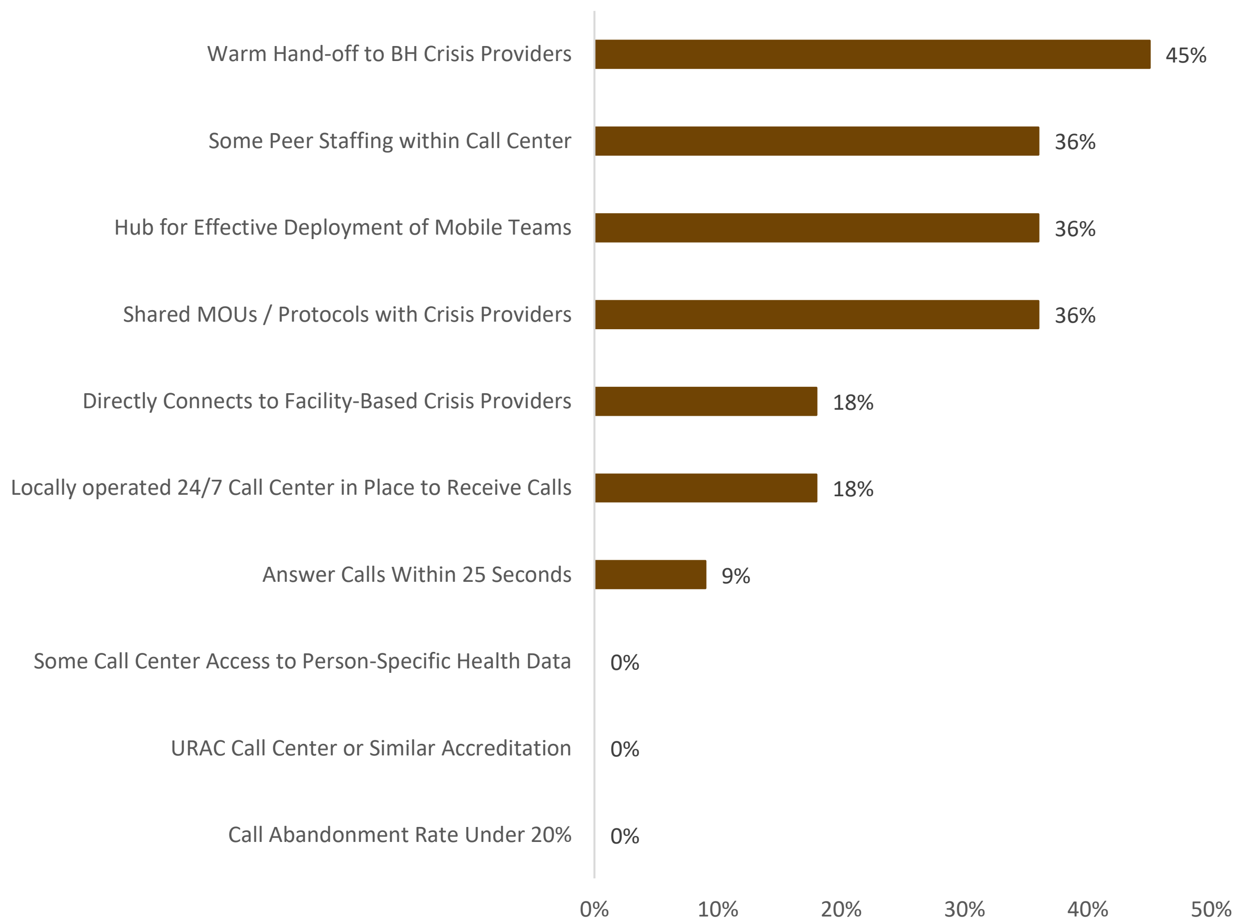
Following the question related to willingness, readiness, and ability to implement a Crisis Call Center Hub in the Rural Region, participants were asked to identify the top two gaps in their region regarding Crisis Call Center Hubs. The answer options were established from the criteria from the region's 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 two gaps identified by participants were:

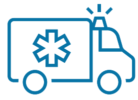
1. Warm Hand-off to Behavioral Health Crisis Providers (45%)

2. Some Peer Staffing within Call Center (36%-tie)

2. Hub for Effective Deployment of Mobile Teams (36%-tie)

2. Shared MOUs/Protocols with Crisis Providers (36%-tie)





Mobile Crisis Teams

Participants were asked to identify if the Rural Region and its stakeholders were willing, ready, and able to implement Mobile Crisis Teams. The responses from nine of the region's participants summarized in the graph below show that 67% felt the region is willing, 33% 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.

Willingness, Readiness, and Ability to Implement Mobile Crisis Teams in the Rural Region (N=9)

	Percent
Willing	67%
Ready	33%
Able	0%

Following the question related to willingness, readiness, and ability to implement Mobile Crisis Teams in the Rural 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 (60%-tie)

1. Mobile Teams Respond to Calls Within 2 Hours Where in Operation (60%-tie)

2. Directly Connect to Facility-Based Crisis Providers as Needed (25%-tie)

2. Shared MOUs/Protocols with Call Center Hub (25%-tie)

Gaps for Mobile Crisis Teams in the Rural Region
(N=10)

Gap	Percent
Mobile Teams are Available Throughout the Region at Least 8 hours Per Day	60%
Mobile Teams Respond to Calls Within 2 Hours Where in Operation	60%
Directly Connect to Facility-Based Crisis Providers as Needed	25%
Shared MOUs / Protocols with Call Center Hub	25%
Some Peer Staffing within Mobile Teams	10%
Support Diversion Through Services to Resolve Crisis with Rate Over 60%	10%
Formal Data Sharing in Place Between Mobile Teams and All Crisis Providers	10%
Some Mobile Team Access to Person Specific Health Data	10%
Trauma-Informed Recovery Model Applied	0%
Mobile Team Assessments include All Essential Crisis Now Defined Elements	0%

0% 10% 20% 30% 40% 50% 60% 70%

Crisis Stabilization Facilities

Participants were asked to identify if the Rural Region and its stakeholders were willing, ready, and able to implement Crisis Stabilization Facilities. The responses from 10 of the region's participants summarized in the graph below show that 90% felt the region is willing, 20% felt the region is ready, and 0% 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.

Willingness, Readiness, and Ability to Implement Crisis Stabilization Facilities in the Rural Region (N=10)

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Willing	Ready	Able
90%	20%	0%

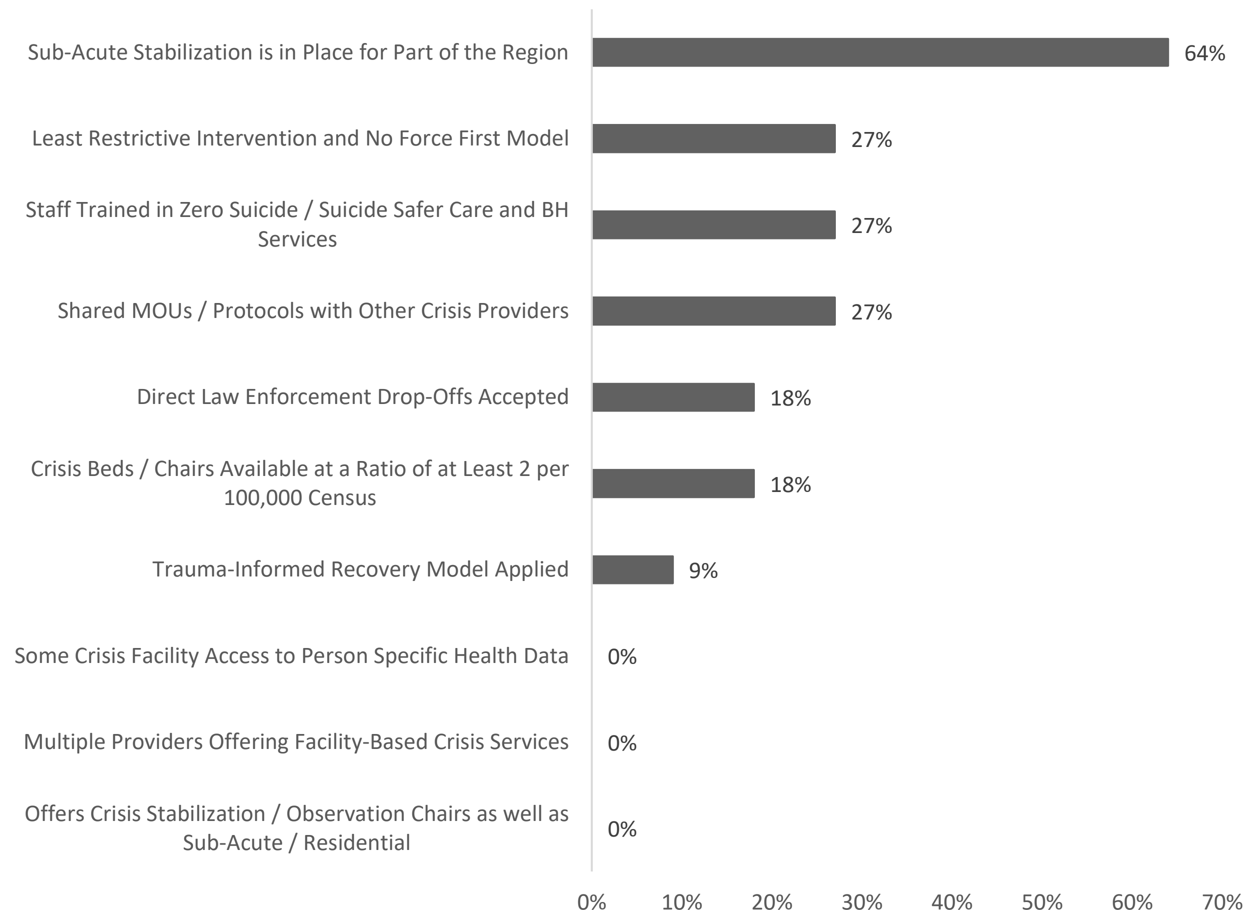
Following the question related to willingness, readiness, and ability to implement Crisis Stabilization Facilities in the Rural Region, participants were asked to identify the top two gaps in their region regarding Crisis Stabilization Facilities. The answer options were established from the criteria 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 two gaps identified by participants were:

1. Sub-Acute Stabilization is in Place for Part of the Region (64%)

2. Least Restrictive and No Force First Model (27%-tie)

2. Staff Trained in Zero Suicide/Suicide Safer Care and Behavioral Health Services (27%-tie)

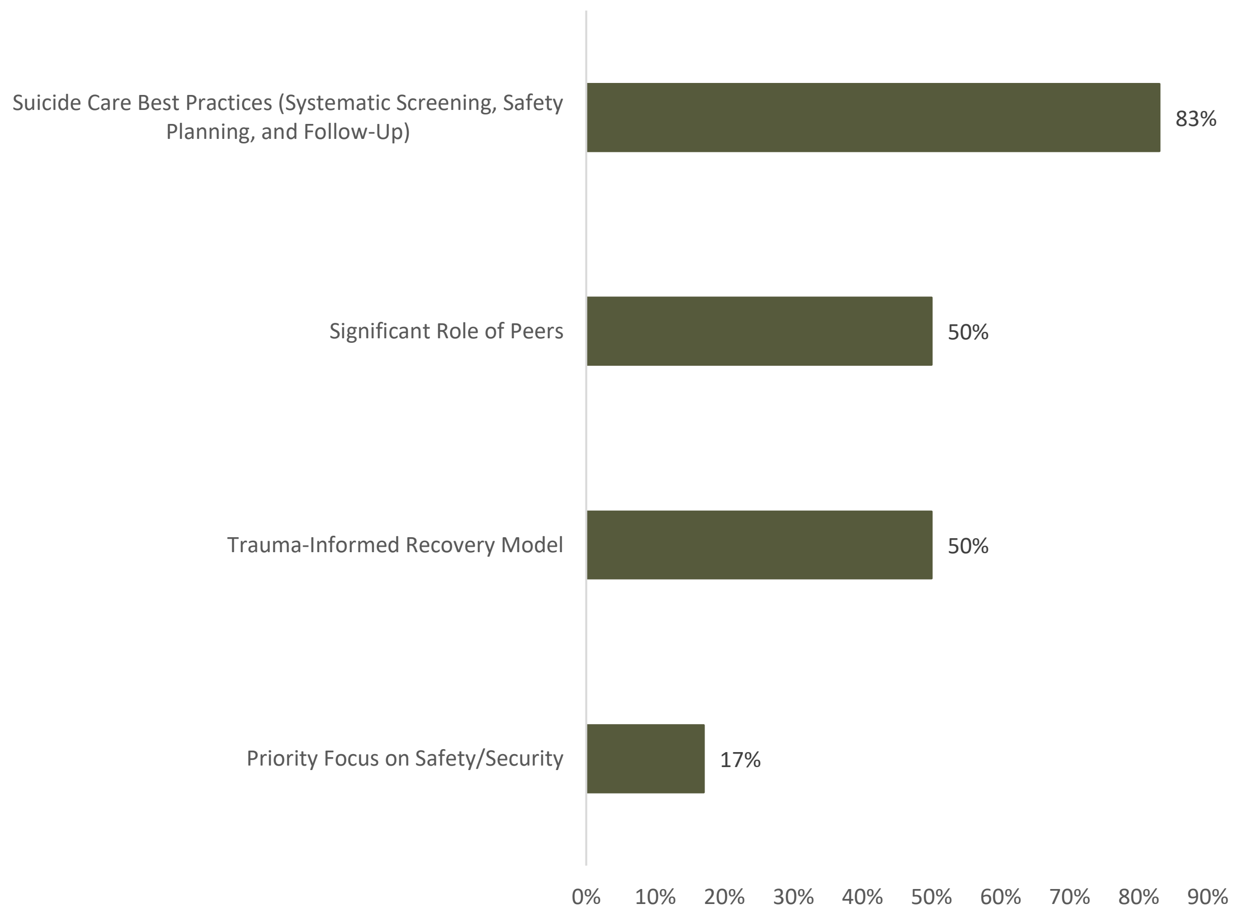
2. Shared MOUs/Protocols with Other Crisis Providers (27%-tie)



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 Suicide Care Best Practices as the largest gap in the Essential Principles and Practices in the Rural Region, followed by Significant Role of Peers (50%), and the Trauma-Informed Recovery Model (50%).

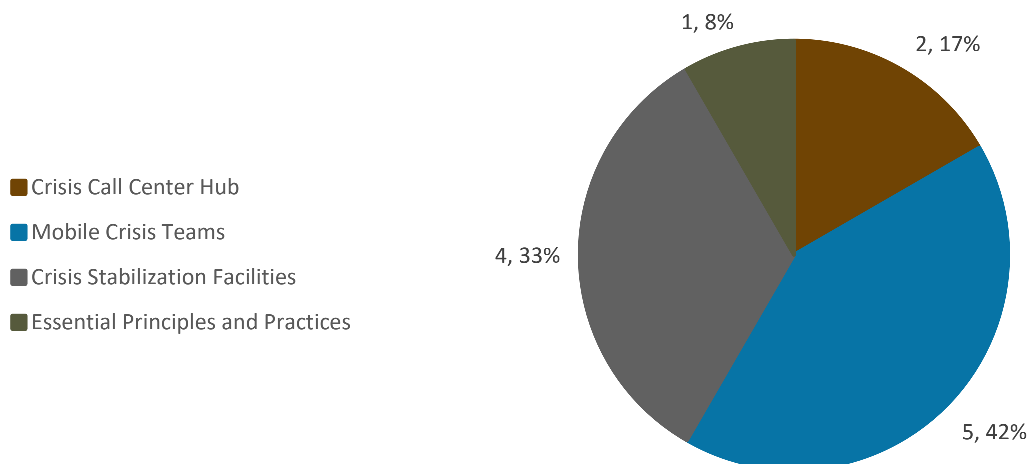


Summary

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 region.

The chart below summarizes the responses, with five (42%) selecting Mobile Crisis Teams, four (33%) selecting Crisis Stabilization Facilities, two(17%) selecting Crisis Call Center Hubs, and one (8%) selecting the Essential Principles and Practices.

Crisis Response Component to Prioritize in the Rural Region (N=12)



Discussions during the Rural Regional Consultation focused on prioritizing gaps by component (as described above), the need to increase stakeholder knowledge of resources and services, ideas for capacity building, and identifying barriers to implementation that are unique within the rural region.

Communication was identified as a strategy to increase stakeholder knowledge and utilization of community resources, as participants noted that they, or their communities, were unaware of resources such as the 24-hour accessible crisis call center, region-specific National Alliance on Mental Illness (NAMI) resources (e.g. the warmline, classes, and support groups), and the text option for the hotline. The latter was noted specifically to engage young people who might be more comfortable with that communication method. The consultation session also clarified some misconceptions about services, such as the differences between Certified Community Behavioral Health Clinics (CCBHC) and Crisis Stabilization Facilities.

Approaches to capacity building were discussed, with participants noting that an option would be to focus on reaching minimal capacity as a baseline within the region and then building up services using evidence-based practices, rather than building up more advanced services within one area and then spreading services throughout the region. The former was considered a more appropriate approach because many areas of the Rural Region currently have no Crisis Response services or access to services in place.

While the Rural Region faces similar barriers to implementation as other regions, such as lack of funding and staffing issues, participants noted barriers unique to this region as well. These included vast distances and long travel times, which can impact mobile team response times. It was noted by the RBHC that even if all major communities in the Rural Region had a mobile team, many areas in the region would still be outside the ideal two-hour response time. One participant noted that Elko recently lost access to a program that helped overcome these barriers by providing free air transport between hospitals. The lack of reliable, or any, cell phone service within certain areas was also listed as a barrier to services within this region. Finally, the limited use of peers in the area was noted as a barrier to inspiring help-seeking.

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.