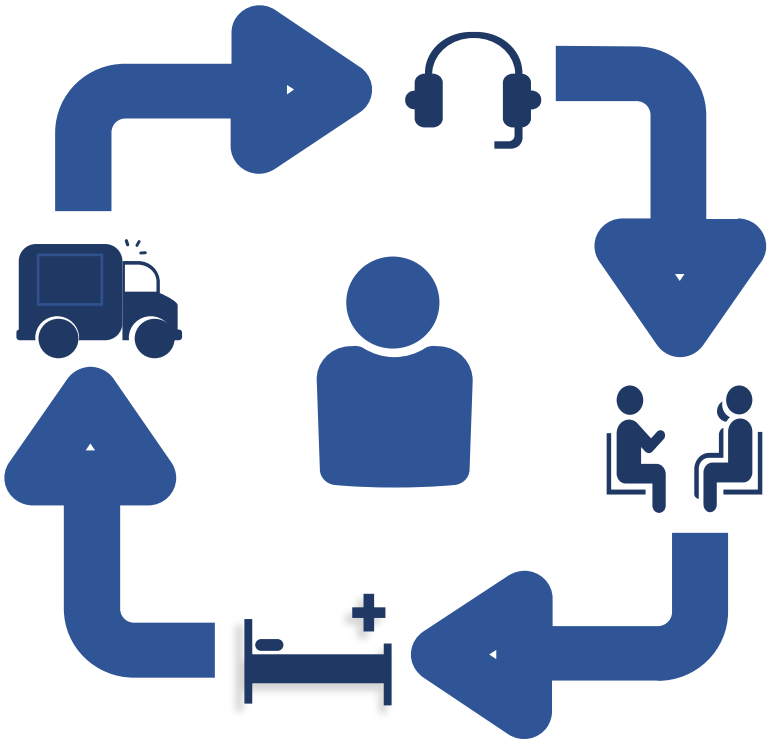
Nevada Department of Health and Human Services

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Towards A Comprehensive Crisis Response System in Nevada



Acknowledgements

This white paper was written with guidance from RI International and highlights lessons learned from the implementation of the Crisis Now Model in Maricopa County, Arizona. The Department of Health and Human Services has permission to use any of RI International's publications. Full publications can be found at the following website: www.crisisnow.com

Additionally, the Department of Health and Human Services relied on the National Action Alliance for Suicide Prevention's complementary work in the area of crisis services. The National Action Alliance for Suicide Prevention (Action Alliance) is the public-private partnership advancing the National Strategy for Suicide Prevention by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the National Strategy for Suicide Prevention (NSSP), and cultivating the resources needed to sustain progress. Launched in 2010 by Health and Human Services Secretary Kathleen Sebelius and former Defense Secretary Robert Gates, the Action Alliance envisions a nation free from the tragic event of suicide. Education Development Center, Inc. (EDC), operates the Secretariat for the Action Alliance through the Suicide Prevention Resource Center.

Information for this white paper is drawn from the following document:

> National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc.

Learn more at http://actionallianceforsuicideprevention.org

Social Entrepreneurs Inc., a company dedicated to improving the lives of people by helping organizations realize their potential, also assisted in the development of this white paper.

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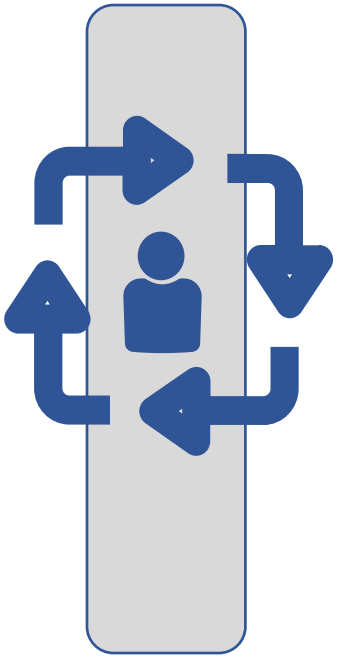
Introduction and Overview

An individual experiencing a mental health crisis in Nevada may be subjected to significant delay in accessing services, awaiting care in an emergency department instead of receiving services in an appropriate mental health facility. Inability to access appropriate, timely care can have serious consequences, resulting in unnecessary decompensation and decline in well-being. Because this scenario is more likely the norm for people in crisis across the state, a significant change to Nevada's crisis response system is required. Nevada, it should be noted, is not alone in recognizing the need to transform crisis care within the state.

The Crisis Now model of care, which consists of four core elements and ensures that crisis care is available for **anyone, anytime, anywhere**, is being adopted by several states. The four core elements are:



1. Regional or Statewide Crisis Call Centers. These programs use technology for real-time coordination across a system of care and leverage "big data" for performance improvement and accountability across systems. At the same time, they provide high-touch support to individuals and families in crisis that adheres to National Suicide Prevention Lifeline (NSPL) standards.

2. Centrally Deployed Mobile Crisis on a 24/7 Basis. Mobile crisis offers outreach and support to locations where people are in crisis. Programs include contractually required response times and medical backup.

3. Residential Crisis Stabilization Programs. These programs offer short-term, "sub-acute" care for individuals who need support and observation, but not emergency department holds, or medical inpatient stay, at lower costs and without the overhead of hospital-based acute care.

4. Essential Crisis Care Principles and Practices. These principles include a recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

While Nevada has built some of the infrastructure necessary to support these core elements, significant developments are needed to ensure that 100% of individuals experiencing a crisis receive the right care at the right time.

Summary of the Problem

According to Mental Health America's 2020 State of Mental Health in America report, **Nevada currently ranks 51st in the nation overall for mental health, a ranking that indicates a high prevalence of mental illness and low levels of access to mental health care**.[1] *Additionally, every day there are on average 102 individuals waiting in emergency rooms across Nevada for behavioral health services*.[2] Because hospital emergency departments are the primary means by which people in Nevada gain access to necessary behavioral health services, hospitals can become a bottleneck to appropriate treatment. Furthermore, even after transitioning to other services, Nevada's system still struggles to match the "right treatment" to the person. For people experiencing a mental health crisis in Nevada, mental health care systems and services are inadequate.

Research from the National Association of State Mental Health Program Directors (NASMHPD) demonstrates that dependence on inpatient beds alone is not effective in helping people in crisis. According to Nevada's Medicaid Decision Support System, the average length of stay for individuals at a psychiatric inpatient facility was six days, but it is not known if this length of stay is suitable for a person in crisis. Additionally, Nevada has 11 inpatient psychiatric facilities and seven residential treatment organizations, with approximately 739 mental health beds.[3] These inpatient facilities may not provide the appropriate level of care needed for a person experiencing a crisis.

In terms of understanding the challenges within Nevada's system fully, there are significant gaps in the data available in Nevada.

Data Gaps in Nevada

Data gaps include, but are not limited to, the following:

- The number of people turned away from services due to a lack of beds or appropriate care
- The number of referrals made and accepted to various mental health services
- The number of people experiencing a mental health crisis becoming justice involved
- Patient assessment information that identifies individuals needs and the services appropriate to address those needs

These gaps do not allow for a complete picture of how people in crisis are being served in Nevada.

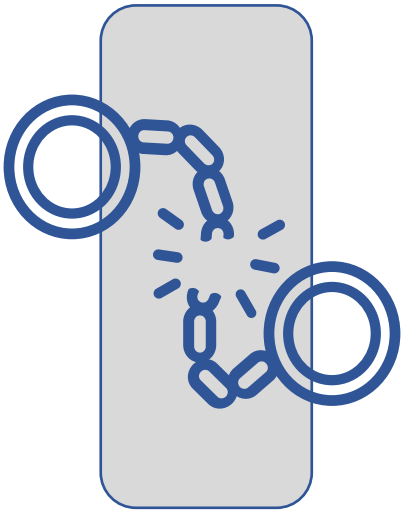
[1] Accessed on March 24, 2020: https://www.mhanational.org/issues/ranking-states
[2] Nevada Department of Health and Human Services, Office of Analytics. Behavioral Health Chart.
[3] Implementation of Psychiatric Bed Registries by 2019 Transformation Transfer Initiative (TTI) States: Summary and Profiles of State Applications. February 27, 2019.

However, what is understood is that on the whole, crisis mental health care in Nevada is reactive and fragmented, creating a revolving door for people in crisis, increasing costs to the community, and potentially increasing risks for individuals experiencing crises. Systems currently deliver minimal care for some individuals while others (often those who have not been engaged in care) fall through the cracks. This can result in multiple readmissions to inpatient care or hospitals, potential homelessness[4], increased mental health acuity, involvement in the criminal justice system, or even death by suicide.

Nevada, however, is not alone in the struggle to improve care and strengthen systems serving people in crisis. Throughout the US, systemic failures in crisis care have been identified.

These failures include, but are not limited to, the following:

- Referrals are sent by fax to multiple facilities
- Individuals are sent to the first facility that accepts them, rather than to the most appropriate level of care
- There is no way to know how many people are stuck in an emergency department unless people "make noise" and there is no accountability for psychiatric boarding in emergency departments
- Receiving staff may sift through all referrals and pick out those patients that will be easiest to serve
- No one knows how many individuals are sent home without the behavioral health care needed
- Communication depends on phone and fax systems. There is no real time coordination of care
- Costly, invasive, and time-consuming medical tests are often required unnecessarily to obtain medical clearance



- Medical clearance is often needed for admission, and the clearance itself is not standardized
- There is no transparency around a bed census for inpatient facilities
- Hospitals are the bottleneck and funnel for all mental health crises in both rural and urban environments [5]

Furthermore, in the National Action Alliance for Suicide Prevention: Crisis Services Task Force's document entitled "Crisis now: Transforming services is within our reach," the authors note that "In too many communities in the US, the "crisis system" has been unofficially handed over to law enforcement, sometimes with devastating outcomes."[6] Due to the lack of a crisis system, individuals in crisis often interface with the justice system, first responders, hospital emergency departments, and correctional facilities. These resources are essential to supporting a healthy

[4] It is important to note that although not having access to proper crisis care can potentially lead to homelessness, being homeless does not necessarily mean an individual is in a mental health crisis.

[5] Covington, David. (2019, October) *Plenary Presentation: Crisis Now.* Presented at Nevada's Crisis Now Summit.

[6] National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). *Crisis now: Transforming services is within our reach*. Washington, DC: Education Development Center, Inc.

community but are not designed to meet the unique needs of individuals experiencing a mental health crisis.

It is also important to understand how determining the appropriate level of care—and the inability to do so—can negatively impact people experiencing crises. In "Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness," David Covington explains:

> **"A decade of Level of Care Utilization System (LOCUS) assessment data gathered in Georgia by mobile crisis teams, emergency departments and crisis facilities indicates that 14% of individuals experiencing a crisis who have reached these higher levels of care have a clinical need that aligns with inpatient care (LOCUS level 6). A majority (54%) of these individuals experiencing a mental health crisis have needs that align better with services delivered within a crisis facility and 32% have lower level needs that would benefit from assessment by a mobile team (LOCUS levels 1-4)."[7]**

These data demonstrate the while some individuals are in need of acute, inpatient care, many are not, and most crisis systems are not well-equipped to address those who do not require acute care. If the majority of the population experiencing a crisis needs the middle tiers of these levels of care and it is unavailable, individuals may be directed inappropriately into the highest level, which could be traumatizing, or to outpatient care, which may be insufficient. Even worse, an individual may fall through the cracks and not get any treatment services at all.

In fact, a number of tragedies result from inadequate systems. The National Alliance's Crisis Services Task Force asserts that the tragedies experienced in struggling crisis systems across the united states include suicide deaths, family pain, psychiatric boarding, inappropriate care, and law enforcement deployed to deliver crisis care.

While the tragic human cost of limited crisis response services in Nevada may be extensive, the substantial cost of continuing to treat people experiencing a crisis through Nevada's emergency rooms and limited acute inpatient care is also substantial. According to the Crisis Now Crisis System Calculator, which is based on Nevada's population of 3,031,919 in 2019, the number of crisis episodes annually is estimated at 72,766. The average cost of an acute bed is $792 per day, with an average stay of six days. The amount of acute inpatient beds needed to address these episodes is 972, which carries an annual cost of $280,857,237, plus emergency room costs averaging of $1,233 per acute admission.

This then, is a clear argument for the development of a comprehensive crisis response system:

> **"An adequate crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources."[8]**

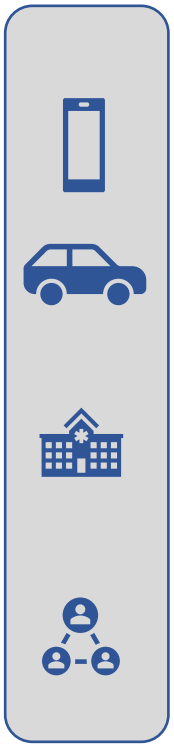
[7] Covington, D. Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness, August 2018.

[8] National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc

The Crisis Now Model

Many states—including Arizona, California, Colorado, Georgia, and Washington— have moved to implement crisis care systems in order to avoid delays in treatment, create better outcomes for people experiencing psychiatric crises, and deploy resources appropriately.

There are four common core elements in each state deemed necessary for a successful crisis response system. Additionally, in February 2020, the Substance Abuse and Mental Health Administration released "National Guidelines for Behavioral health Crisis Care—A Best Practice Toolkit," which also focuses on these elements. The core elements of a successful system include:



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4. Essential Crisis Care Principles and Practices. These principles include a recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

These elements together form a new model for crisis response systems known as Crisis Now.

Progress in Nevada

The development of a crisis response system in Nevada is possible and existing infrastructure is in place to support, at least in part, each of the core elements of the Crisis Now Model. A brief summary of some of these current assets follows:

- **Crisis Call Centers**: Nevada has one of six National Suicide Prevention Lifeline National Call Centers and the crisis line is experiencing great success deploying resources when necessary and otherwise deescalating people in crisis.
- **Mobile Crisis**: Various configurations of mobile crisis teams have already been established throughout the state and include law enforcement deflection and diversion programs. These programs are also facilitating diversion from hospitals and meeting patients where they are at in the community.
- **Stabilization Programs**: Community Triage Centers were defined in Nevada Revised Statute in 2005 and provide a different pathway for accessing mental health services,

ensuring stabilization within a community setting without first accessing a hospital. These centers were funded creatively, braiding together resources from both state and local sources. Currently, there are three Triage Centers operating in Nevada (two in Las Vegas, and one in Reno)[9].

Additional foundational elements of an improved mental health system are in place with mental health uniformity, insurance coverage expansion resulting from the Affordable Care Act, the launch of the Certified Community Behavioral Health Centers, the Excellence in Mental Health Act, and the implementation of First Episode Psychosis programs throughout the state. The State has also moved to implement OpenBeds technology to support these efforts.[10]

OpenBeds Technology

OpenBeds is an electronic healthcare referral network platform that allows providers to be connected with real time referral and patient acceptance capabilities. The platform works to facilitate the following processes:

- Identification of appropriate placement based upon initial assessment using American Society for Addiction Medicine (ASAM) criteria
- Enhancement of patient care through real time referral
- Streamlined and standardized electronic referral processes that capture real time response and use shared definitions
- Transparency between providers
- Capture of data specific to level of care, services, and continuums of care

Through these capabilities, Open Beds is expected to decrease placement times and provide transparent service availability, decrease declines in referrals through identifying service availability by payer type, and improve access to decision making tools. Additionally, it will increase system transparency, providing policymakers and community leaders the ability to identify system resources and level of care gaps. This information can be used to inform treatment policy and program funding through data-driven decision making.

How the OpenBeds Platform Works:

1. Referring agencies will see real time treatment availability
2. Referring agency creates and sends a digital referral
3. Treatment facilities are alerted to referral requests; creating a way to manage and communicate with the referring agency
4. Treatment facilities are then able to accept patients into the appropriate level of care

The 2019 Crisis Now Summit

Another important step taken towards development of a Crisis Response System in Nevada was the Crisis Now Summit held on October 18, 2019 and hosted by the State of Nevada Division of

[9] Accessed on March 25, 2020: http://dpbh.nv.gov/Reg/HealthFacilities/HF_-_Non-Medical/Community_triage_center/

[10] Woodard, Stephanie. (2019, October). *Responsive and Resilient: Nevada's Solution to Addressing Crisis*. Presented at Nevada's Crisis Now Summit.

Public and Behavioral Health (DPBH). The Summit was designed to introduce Nevada's social service and behavioral health providers, policy makers, law enforcement officers, funders, and other interested parties in Nevada to the Crisis Now model of crisis intervention. The Summit itself was embedded in the state-sponsored Nevada Suicide Prevention Conference, given the obvious intersection between suicide prevention efforts and crisis intervention and stabilization.

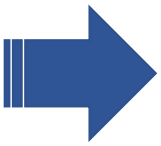
During the Summit an overview of the model was presented, and then breakout sessions allowed representatives from Arizona and Georgia to present about how the four core elements of the Crisis Now model have been implemented in their communities. A brief summary of these sessions is provided below.

Crisis Call Centers

Wendy Farmer, President and CEO of Behavioral Health Link and Deborah Atkins, Director of Crisis Coordination for the Georgia Department of Behavioral Health and Developmental Disabilities provided an overview of Georgia's high-tech crisis line.

The five elements of Georgia's crisis call line include the following:

1) Status disposition for intensive referrals where colors are used to demonstrate patient wait times
2) 24/7 outpatient scheduling where providers are required to give open slots so patients can be placed
3) Shared bed inventory tracking where detailed data such as the number of beds and patient gender by room is included
4) High tech GPS mobile crisis dispatch with transit time calculated in real time. Mobile crisis dispatch can request law enforcement if a situation is escalated, but they cannot make the decision to de-escalate
5) Real-time performance outcomes dashboards, which allows for greater transparency by showing geographical activity as well as internal dashboards detailing scheduling and staffing patterns



Potential implementation ideas for Nevada may include the use of text and chat mobile app targeting youth, the development of a live census and referral system to complement the crisis response system, and the establishment of benchmarks to monitor progress towards full crisis call line implementation.

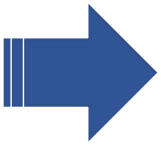
24/7 Mobile Crisis

Erica Chestnut Ramirez, Director of Crisis and Trauma Healing Services for La Frontera/Empact and Nick Margiotta, President of Crisis System Solutions, described the work carried out by mobile crisis teams in Arizona and discussed the need for collaboration with law enforcement.

They noted that the goals for mobile crisis teams in their areas include:

- Community stabilization

- Reduce costs by preventing the overuse and misuse of emergency departments, psychiatric hospitalizations, and unnecessary law enforcement involvement
- Reduce trauma
- Facilitate referrals
- Remove barriers to seeking mental health crisis care
- Collaborate with partners in the community at key intercept points



Potential implementation ideas for Nevada's mobile teams may include the use of unmarked vehicles without restraints or dividers in community-based mobile teams, convening representatives from homeless providers, jails, advocates, politicians, etc. to plan and develop contracts, seeking clinicians with the personality and passion appropriate for the job, ensuring the system is easy to navigate, fast and reliable so law enforcement is more likely to use it, and allowing mental health clinicians to lead and engage law enforcement only when needed.

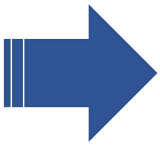
Crisis Stabilization

Frank O'Halloran, Crisis Services Coordinator and Veteran Advocate at Mercy Maricopa Integrated Care and Jamie Sellar, Chief Strategy Officer for RI International, provided an overview of the crisis stabilization centers in Maricopa County, Arizona.

The crisis stabilization facilities in Arizona function as an integral part of a regional crisis system serving the whole population. There are two parts to the facilities; the first is a 23-hour observation unit with 35 recliners, flexible limits on capacity, and staffing variability depending on capacity, and the second component is a 16-bed short-term psychiatric unit for more acute guests with firm limits on capacity and a predictable staffing model.

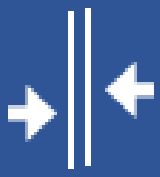
Other important characteristics include:

- A No Wrong Door Policy
- The facilities operate in a home-like environment
- Peers are utilized as integral staff members
- Patients have 24/7 access to psychiatrists
- The physical layout is an open floor model
- Persons admitted are referred to as guests



Potential implementation ideas for crisis stabilization in Nevada may include the development of a "No Wrong Door" policy, training mental health professionals regarding "cop culture" to facilitate cooperation, adopting culture and beliefs with crisis stabilization as the focus, starting with a single payor for the crisis stabilization services and support from local law enforcement, and seeking leadership and accountability from funders.

No Wrong Door Policy:



- Direct requests for mobile crisis care from police are always honored, without question
- Admission occurs regardless of involuntary status, Substance Use Disorder (SUD) issues, a potential for violence, medical status, intellectual or developmental disability, or readmission status

Essential Principals and Practices

Panelists described how these important concepts were incorporated in their work during their presentations on the other core components.

The summit concluded with brief recap of the transformational possibilities available through implementation of the Crisis Now model. **In Arizona, implementation of this model has led to impressive results including a calculated 45 years of consecutive psychiatric boarding eliminated, the equivalent of 37 full time police officers' time redirected to the community and a 50% reduction in cost to the community.** Plenary Speaker David Covington noted that Arizona and Nevada share many similarities and that application of the model could result in meaningful change for Nevadans.

Assets and Gaps Mapping

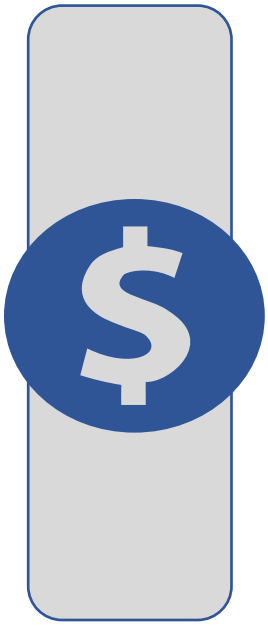
Since the Summit, the State of Nevada has identified crisis services, level of care needs determination, provision of outpatient crisis stabilization, expedient access to higher levels of care, including inpatient psychiatry, and facilitated transitions between levels of care across the continuum as essential components to Nevada's behavioral healthcare system infrastructure.

However, in order to fully understand what aspects of the system are in place and what aspects are needed to ensure a complete and comprehensive Crisis Response System, Nevada has engaged Regional Behavioral Health Coordinators to document regional assets and gaps in the system, using as a basis the Crisis Now Scoring Tool, developed by RI International. The tool identifies key criteria (conditions, practices, operations, services available, etc.) for each of the core elements. Assets and gaps in each region will be identified based on each of these criteria, creating an in-depth inventory of what is available to individuals experiencing a crisis in any given community across the state. The tool also requires the assessment of a score reflecting the level at which each core element of the Crisis Now model is functioning and whether it is operating as intended.

The State of Nevada and its regional partners can then consider how to leverage those assets already in place while actively seeking the resources necessary to address gaps.

Financing Crisis Care

In "Crisis now: Transforming services is within our reach," the authors assert that "the method of financing crisis mental health services varies from state to state. In many cases, it is cobbled together. Inconsistently supported. Inadequate. The federal government provides a very small Substance Abuse and Mental Health Services Administration (SAMHSA) investment (just over $6 million annually) in the NSPL." However, that investment only provides for a national call infrastructure and does not cover the state/local costs of either crisis lines or crisis intervention systems. This is in contrast to the nearly $400 million provided to combat the nation's opioid crisis.



While financing for crisis care can be scraped together from a variety of sources, including state grant funding, federal funding, fee for service payments, and private organizations, it is by nature unreliable. This is because dependence on funding that is parceled out both by source and by component makes it so that the system itself is inadequately resourced. It is clear that payment reform must also occur for optimal comprehensive crisis system implementation, supporting payment of less expensive and more effective services by all payers of health services. Mental health crisis services need to be covered by all payers of healthcare services. "Funding of comprehensive crisis care is critical to any effective mental health reform,"[11] and ultimately, beyond development of a comprehensive system, systematic funding may save individuals' lives and protect valuable community resources.

The recently published National Guidelines for Behavioral Health Crisis Care, the following is explained:

> **"A leading solution to the crisis care funding puzzle is to model reimbursement after the physical health service counterparts already in place. Subsequent efforts to enforce parity laws in a manner that removes much of the burden on local communities by shifting the expense to the person's health insurance plan that, by law or contract, is actually responsible for covering this care will position crisis care to have sustainable funding streams in support of best practice care; leading to care that can truly lower health care costs while dramatically improving the experience of people in crisis and the health of communities through justice system and ED diversion."[12]**

[11] National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc

[12] Substance Abuse and Mental Health Services Administration (2020). National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. Rockville, MD.

Crisis Now System Calculators for Nevada

Crisis System Calculators based on population, the average length of stay in acute care, and the average cost of an acute bed per day are available. These calculators help to estimate both the cost of a fragmented system and the cost savings possible through the implementation of a comprehensive crisis response system, such as the Crisis Now model.

It was noted previously that based on Nevada's population of 3,031,919 in 2019, the number of crisis episodes annually is estimated at 72,766 individuals. Additionally, the average cost of an Acute Bed is $792 per day with an average stay of six days. The amount of acute inpatient beds needed is 972, which would carry a cost of $280,857,237, plus the emergency department costs averaging $1,233 per acute admission.

Yet, with the Crisis Now Model, while the number of crisis episodes remains the same at an estimated total of 72,766 individuals annually, the number of acute inpatient beds decreases to 280 due to the addition of 123 crisis beds, 145 crisis observation chairs, and 22 mobile teams. The cost for acute beds would then total $80,808,409, and the more cost-effective crisis beds would total $35,635,443. Finally, crisis observation chairs would carry a cost of $52,362,283 and mobile teams a cost of $8,931,286.

With no crisis response system in place, Nevada's costs are estimated at $341,867,209 per year. However, with a system following the Crisis Now Model in operation, the total cost would be $195,291,247 per year. This represents an average savings of 43% annually, a financial boon that would also allow for all individuals involved in a crisis episode to be served with the appropriate level of care.

Estimated cost in Nevada per year
without a crisis system in place:
$341,867,209

Estimated cost in Nevada per year
with Crisis Now model implemented:
$195,291,247

The same calculator was used to understand costs and savings per region and to determine the necessary amount of acute inpatient beds, crisis beds, observation chairs and mobile crisis teams. The following charts demonstrate the cost saving by region, using the population, the average length of stay of six days, and the average cost of an acute bed per day of $792. Each chart underscores the fact that with a crisis system, significant savings are possible. Beyond the financial savings, implementation of a crisis response system ensures that all individuals in a crisis episode are able to be cared for in an appropriate level of care. Without a comprehensive crisis system with varying levels of care, individuals are diverted to higher levels of care or do not receive care at all.

State Level Crisis Now System Calculator

The chart below demonstrates this calculation at the state level.

	No Crisis Care	Crisis Now
Number of Crisis Episodes Annually *(200/100,000 Monthly)*	72,766	72,766
Number Initially Served by Acute Inpatient	49, 481	10,187
Number Referred to Acute Inpatient from Crisis Facility	-	4,049
Total Number of Episodes in Acute Inpatient	49,481	14,237
Number of Acute Inpatient Beds Needed	**972**	**280**
Total Cost of Acute Inpatient Beds	**$ 280,857,237**	**$ 80,808,409**
Number Referred to Crisis Bed From Stabilization Chair	-	16,198
Number of Crisis Beds Needed	**-**	**123**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 35,635,443**
Number Initially Served by Crisis Stabilization Facility	-	39,294
Number Referred to Crisis Facility by Mobile Team	-	6,986
Total Number of Episodes in Crisis Facility	-	46,279
Number of Crisis Observation Chairs Needed	**-**	**145**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 52,362,283**
Number Served Per Mobile Team Daily	4	4
Number of Mobile Teams Needed	**-**	**22**
Total Number of Episodes with Mobile Team	-	23,285
Total Cost of Mobile Teams	**$ -**	**$ 8,931,286**
Number of Unique Individuals Served	**49,481**	**72,766**
Total Inpatient and Crisis Cost	**$ 280,857,237**	**$ 177,737,422**
Emergency Department Costs ($1,233 Per Acute Admit)	**$ 61,009,972**	**$ 17,553,825**
TOTAL Cost	**$ 341,867,209**	**$ 195,291,242**
TOTAL Change in Cost	**$ (146,575,967)**	**-43%**

Washoe County System Calculator

The chart below demonstrates this calculation for the Washoe County, with a population of 456,038.

	No Crisis Care	Crisis Now
Number of Crisis Episodes Annually *(200/100,000 Monthly)*	10,945	10,945
Number Initially Served by Acute Inpatient	7,443	1,532
Number Referred to Acute Inpatient From Crisis Facility	-	609
Total Number of Episodes in Acute Inpatient	7,443	2,141
Number of Acute Inpatient Beds Needed	**146**	**42**
Total Cost of Acute Inpatient Beds	**$ 42,244,391**	**$ 12,154,581**
Number Referred to Crisis Bed From Stabilization Chair	-	2,436
Number of Crisis Beds Needed	**-**	**19**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 5,360,010**
Number Initially Served by Crisis Stabilization Facility	-	5,910
Number Referred to Crisis Facility by Mobile Team	-	1,051
Total Number of Episodes in Crisis Facility	-	6,961
Number of Crisis Observation Chairs Needed	**-**	**22**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 7,875,933**
Number Served Per Mobile Team Daily	4	4
Number of Mobile Teams Needed	**-**	**3**
Total Number of Episodes with Mobile Team	-	3,502
Total Cost of Mobile Teams	**$ -**	**$ 1,343,376**
Number of Unique Individuals Served	**7,443**	**10,945**
Total Inpatient and Crisis Cost	**$ 42,244,391**	**$ 26,733,900**
Emergency Department Costs ($1,233 Per Acute Admit)	**$ 9,176,652**	**$ 2,640,312**
TOTAL Cost	**$ 51,421,043**	**$ 29,374,211**
TOTAL Change in Cost	**$ (22,046,832)**	**-43%**

Northern Nevada Region Calculator

The chart below demonstrates this calculation for the Northern Region, with a total population of 190,228, and which consists of Carson City, Churchill, Douglas, Lyon, Mineral, and Storey Counties.

	No Crisis Care	Crisis Now
Number of Crisis Episodes Annually *(200/100,000 Monthly)*	4,565	4,565
Number Initially Served by Acute Inpatient	3,105	639
Number Referred to Acute Inpatient From Crisis Facility	-	254
Total Number of Episodes in Acute Inpatient	3,105	893
Number of Acute Inpatient Beds Needed	**61**	**18**
Total Cost of Acute Inpatient Beds	**$ 7,621,483**	**$ 5,070,064**
Number Referred to Crisis Bed From Stabilization Chair	-	1,016
Number of Crisis Beds Needed	**-**	**8**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 2,235,831**
Number Initially Served by Crisis Stabilization Facility	-	2,465
Number Referred to Crisis Facility by Mobile Team	-	438
Total Number of Episodes in Crisis Facility	-	2,904
Number of Crisis Observation Chairs Needed	**-**	**9**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 3,285,303**
Number Served Per Mobile Team Daily	4	4
Number of Mobile Teams Needed	**-**	**1**
Total Number of Episodes with Mobile Team	-	1,461
Total Cost of Mobile Teams	**$ -**	**$ 560,365**
Number of Unique Individuals Served	**3,105**	**4,565**
Total Inpatient and Crisis Cost	**$ 17,621,483**	**$ 11,151,563**
Emergency Department Costs ($1,233 Per Acute Admit)	**$ 3,827,874**	**$ 1,101,358**
TOTAL Cost	**$ 21,449,358**	**$ 12,252,921**
TOTAL Change in Cost	**$ (9,196,437)**	**-43%**

Rural Nevada Calculator

The chart below demonstrates this calculation for the Rural Region, with a population of 95,919 and which consists of Elko, Eureka, Humboldt, Lander, Lincoln, Pershing and White Pine Counties.

	No Crisis Care	Crisis Now
Number of Crisis Episodes Annually *(200/100,000 Monthly)*	2,302	2,302
Number Initially Served by Acute Inpatient	1,565	322
Number Referred to Acute Inpatient From Crisis Facility	-	128
Total Number of Episodes in Acute Inpatient	1,565	450
Number of Acute Inpatient Beds Needed	**31**	**9**
Total Cost of Acute Inpatient Beds	**$ 8,885,312**	**$ 2,556,487**
Number Referred to Crisis Bed From Stabilization Chair	-	512
Number of Crisis Beds Needed	**-**	**4**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 1,127,377**
Number Initially Served by Crisis Stabilization Facility	-	1,243
Number Referred to Crisis Facility by Mobile Team	-	221
Total Number of Episodes in Crisis Facility	-	1,464
Number of Crisis Observation Chairs Needed	**-**	**5**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 1,656,554**
Number Served Per Mobile Team Daily	4	4
Number of Mobile Teams Needed	**-**	**1**
Total Number of Episodes with Mobile Team	-	737
Total Cost of Mobile Teams	**$ -**	**$ 282,554**
Number of Unique Individuals Served	**1,565**	**2,302**
Total Inpatient and Crisis Cost	**$ 8,885,312**	**$ 5,622,972**
Emergency Department Costs ($1,233 Per Acute Admit)	**$ 1,930,136**	**$ 555,340**
TOTAL Cost	**$ 10,815,448**	**$ 6,178,312**
TOTAL Change in Cost	**$ (4,637,136)**	**-43%**

Southern Region

The chart below demonstrates this calculation for the Southern Region, which consists of Esmeralda and Nye Counties, with a population of 57,558.

	No Crisis Care	Crisis Now
Number of Crisis Episodes Annually *(200/100,000 Monthly)*	1,381	1,381
Number Initially Served by Acute Inpatient	939	193
Number Referred to Acute Inpatient From Crisis Facility	-	77
Total Number of Episodes in Acute Inpatient	939	270
Number of Acute Inpatient Beds Needed	**18**	**5**
Total Cost of Acute Inpatient Beds	**$ 5,331,798**	**$ 1,534,068**
Number Referred to Crisis Bed From Stabilization Chair	-	307
Number of Crisis Beds Needed	**-**	**2**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 676,504**
Number Initially Served by Crisis Stabilization Facility	-	746
Number Referred to Crisis Facility by Mobile Team	-	133
Total Number of Episodes in Crisis Facility	-	879
Number of Crisis Observation Chairs Needed	**-**	**3**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 994,046**
Number Served Per Mobile Team Daily	4	4
Number of Mobile Teams Needed	**-**	**0**
Total Number of Episodes with Mobile Team	-	442
Total Cost of Mobile Teams	**$ -**	**$ 169,552**
Number of Unique Individuals Served	**939**	**1,381**
Total Inpatient and Crisis Cost	**$ 5,331,798**	**$ 3,374,170**
Emergency Department Costs ($1,233 Per Acute Admit)	**$ 1,158,214**	**$ 333,242**
TOTAL Cost	**$ 6,490,013**	**$ 3,707,412**
TOTAL Change in Cost	**$ (2,782,601)**	**-43%**

Clark County

The chart below demonstrates this calculation for Clark County, with a population of 2,232,176.

	No Crisis Care	Crisis Now
Number of Crisis Episodes Annually *(200/100,000 Monthly)*	53,572	53,572
Number Initially Served by Acute Inpatient	36,429	7,500
Number Referred to Acute Inpatient From Crisis Facility	-	2,981
Total Number of Episodes in Acute Inpatient	36,429	10,481
Number of Acute Inpatient Beds Needed	**715**	**206**
Total Cost of Acute Inpatient Beds	**$ 206,774,252**	**$ 59,493,209**
Number Referred to Crisis Bed From Stabilization Chair	-	11,925
Number of Crisis Beds Needed	**-**	**91**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 26,235,721**
Number Initially Served by Crisis Stabilization Facility	-	28,929
Number Referred to Crisis Facility by Mobile Team	-	5,143
Total Number of Episodes in Crisis Facility	-	34,072
Number of Crisis Observation Chairs Needed	**-**	**107**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 38,550,447**
Number Served Per Mobile Team Daily	4	4
Number of Mobile Teams Needed	**-**	**16**
Total Number of Episodes with Mobile Team	-	17,143
Total Cost of Mobile Teams	**$ -**	**$ 6,575,440**
Number of Unique Individuals Served	**36,429**	**53,572**
Total Inpatient and Crisis Cost	**$ 206,774,252**	**$ 130,854,817**
Emergency Department Costs ($1,233 Per Acute Admit)	**$ 44,917,095**	**$ 12,923,573**
TOTAL Cost	**$ 251,691,348**	**$ 143,778,390**
TOTAL Change in Cost	**$ (107,912,958)**	**-43%**

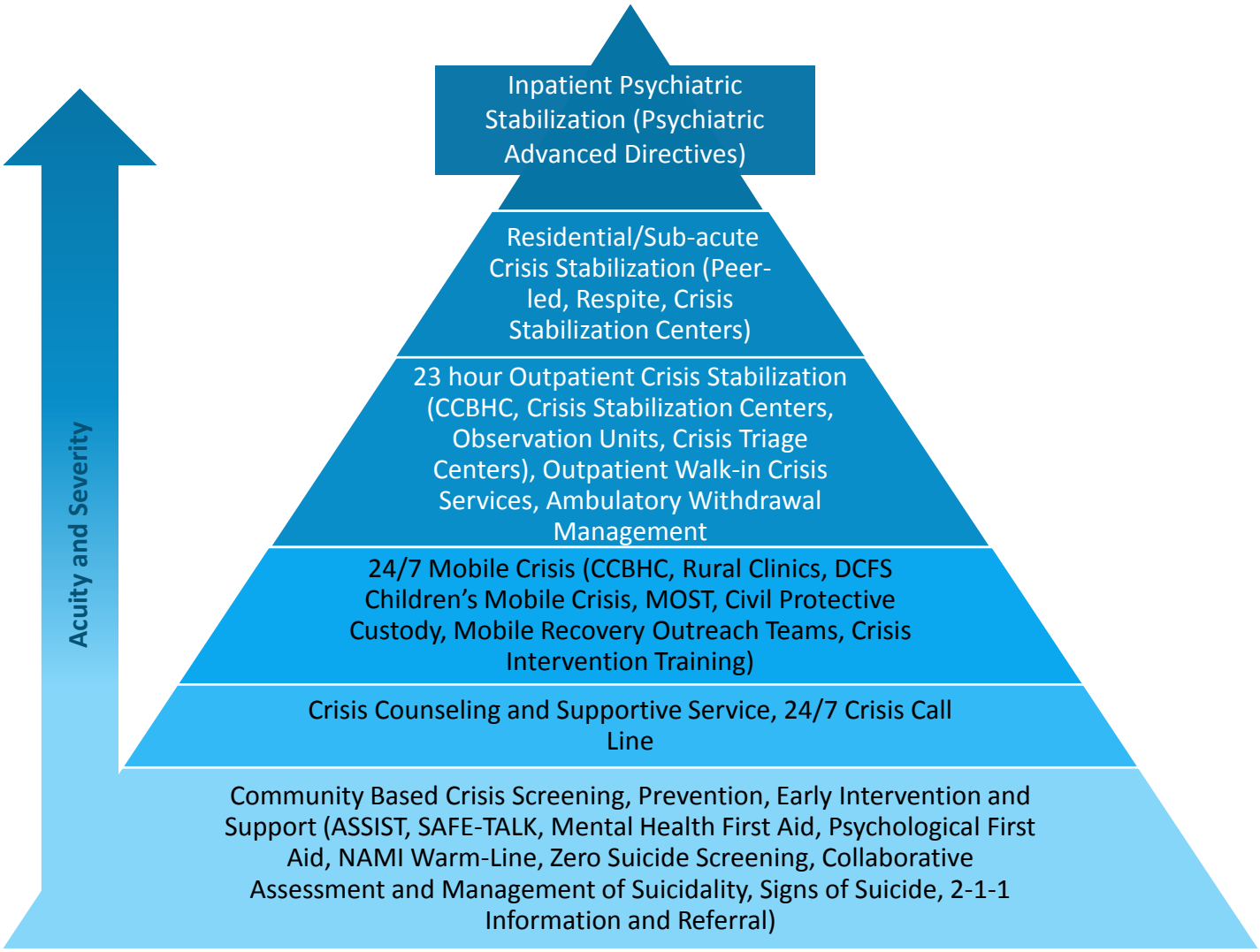
In all of the charts above, there is an average calculated savings of 43% for every region in the state. These savings are made possible in deploying services through a more comprehensive crisis system. While the benefit of these savings is significant, it is most important to note that

all individuals experiencing crisis in such a system would receive appropriate levels of care, rather than wrong care and no care at all.

Conclusion: Towards A Comprehensive Crisis Response System in Nevada

While there are clearly some components of this model for care already operating in Nevada, there is still significant work required to further flesh out these emerging systems and practices, improve outpatient stabilization and subacute crisis stabilization, incorporate research and evidence-based practices to guide a new standard of care, and to increase use of crisis lines and the mobile crisis teams. The graphic below demonstrates an ideal system.

Nevada's Ideal Crisis Continuum

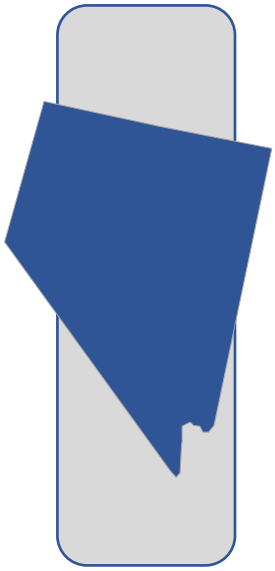


Some of the work to strengthen the crisis system related to each core component of the model for Nevada may entail the following:

- **Crisis Call Centers**: Crisis Support Services of Nevada is part of the National Suicide Prevention Lifeline though funding is often fragmented. Crisis Support Services of Nevada could become the qualified hub for crisis care in Nevada.
- **Mobile Crisis**: Nevada can ensure that mobile crisis teams who have access to law enforcement and medical care are available to each part of the state. This, with the technology of OpenBeds already emerging, will be able to be the appropriate hub to assist with de-escalation or appropriate deployment of services.
- **Stabilization Programs**: Residential crisis stabilization alternatives to hospitalization should be made available as a core component of comprehensive crisis systems in Nevada. These facilities will be locked facilities with a five to seven minute drop off time and 100% acceptance rate.

Within these elements, the core principles and practices discussed earlier will ensure appropriate treatment and crisis care for all individuals experiencing a crisis in Nevada.

Ideally, funding for this system would come from an expansion of the Mental Health Block Grant, coupled with a requirement that states ensure the presence of qualified call centers covering their population. All major health payers should recognize and reimburse crisis services provided to their members by comprehensive crisis systems. Payers often reimburse emergency medical care, but they do not reimburse for the equivalent services for behavioral health. This step is necessary in order to have adequate capacity for crisis care and for efficiency.



Without a crisis system, communities throughout Nevada will continue to pay exorbitant amounts of money for poor crisis care. This paper has highlighted the essential elements to create a comprehensive and effective crisis care system, as well as the infrastructure within in Nevada upon which these elements can be fully realized. These key elements include:

- **Crisis call centers coordinating in real time**
- **Mobile crisis care**
- **Crisis stabilization programs**
- **Essential crisis care principles and practices**

Ultimately, a comprehensive system can and should provide the appropriate level of care to 100% of individuals experiencing crisis in Nevada.

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