



CRISIS NOW SUMMIT



A Summary of Conference Proceedings

October 18, 2019

A Project of Nevada's Crisis Now Initiative

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Introduction and Background

On October 18, 2019, the State of Nevada Division of Public and Behavioral Health (DPBH) hosted the Crisis Now Summit, the first of two summits 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.

This document serves as a summary of the summit proceedings, with a specific focus on how the model could successfully be implemented in Nevada's unique context. Special attention is also given to audience questions, concerns, and potential challenges that may need to be addressed as Nevada works to develop its own crisis response system. An outline of each of the presentations summarized in this document is as follows.

Topic	Speaker	Description of Presentation
State of the State	<i>Dr. Stephanie Woodard, State of Nevada</i>	An overview of Nevada's current and ideal crisis response system.
Zero Suicide	<i>David Covington, RI International</i>	An introduction to the Zero Suicide model and the "big ideas" that will support it.
Crisis Now	<i>David Covington, RI International</i>	An introduction to the Crisis Now model and its three core components, Air Traffic Control, Mobile Crisis, and Crisis Stabilization Centers.
Crisis Stabilization Centers	<i>Frank O' Halloran, Mercy Maricopa Integrated Care</i> <i>Jamie Sellar, RI International</i>	An overview of the crisis system in Maricopa County, Arizona and a deeper dive into the new model for crisis stabilization.
Mobile Crisis	<i>Erica Chestnut-Ramirez, La Frontera/Empact</i> <i>Nick Margiotta, Crisis System Solutions</i>	An overview of the goals of mobile crisis interventions, the process for such interventions, and a new vision of the partnership with law enforcement to undertake these interventions.
High Tech Crisis Lines	<i>Wendy Farmer, Behavioral Health Link</i> <i>Deborah Atkins, Georgia Dept. of Behavioral Health and Developmental Disabilities</i>	An overview of how the high-tech crisis line in Georgia, Behavioral Health Link, was implemented, the services it provides, and how it has influenced the development of a crisis response system in Georgia.
Closing Remarks,	<i>David Covington, RI International</i>	A review of key points in the development of a crisis system in Nevada.

Plenary Presentations

State of the State

Presented by Dr. Stephanie Woodard

Dr. Woodard is the Nevada State Mental Health Authority and the Single State Authority for Substance Abuse. In her position with the Nevada Department of Health and Human Services she evaluates outcomes of behavioral health interventions, and guides policy and financing options across the Department.

Dr. Woodard presented an overview of both the current conditions in in the State of Nevada and the vision for the future regarding a crisis response system that is responsive to individuals when they need help, where they need help, and how they need help.

She began by noting that services in Nevada for people in crisis are still reactive and fragmented. This results in a revolving door for people in crisis and a system that still struggles to match the “right treatment” to the “right person.” Research from the National Association of State Mental Health Program Directors demonstrates that dependence on inpatient beds alone is not effective in helping people in crisis. Nevada currently has an immature outpatient system and hospitals can become a bottleneck as people await services. In terms of understanding the challenges fully, there are significant gaps in the data that do not allow for a complete picture of how people in crisis are being served. For example, there are no data regarding the average length of stay in an inpatient facility.

However, Dr. Woodard also explained that progress is being made in the state. There is some previous infrastructure in place through Community Triage Centers, which provided a different way to access mental health services and ensured stabilization within a community setting, and were funded creatively when they were established. Furthermore, 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 persons in crisis. Mobile crisis teams, including law enforcement deflection and diversion programs, are facilitating diversion from hospitals and justice involvement. Outpatient crisis stabilization is taking place at

State of the State: Key Ideas

- A variety of barriers exist to prevent people in crisis from accessing the right levels of care and from systems serving individuals in a cost-effective manner
- Investment must be made in prevention and early intervention
- There is an underdeveloped outpatient care system in Nevada
- The state is working from the ideal crisis continuum to create an integrated service system
- Progress is being made at the policy level and to provide services at all levels of care

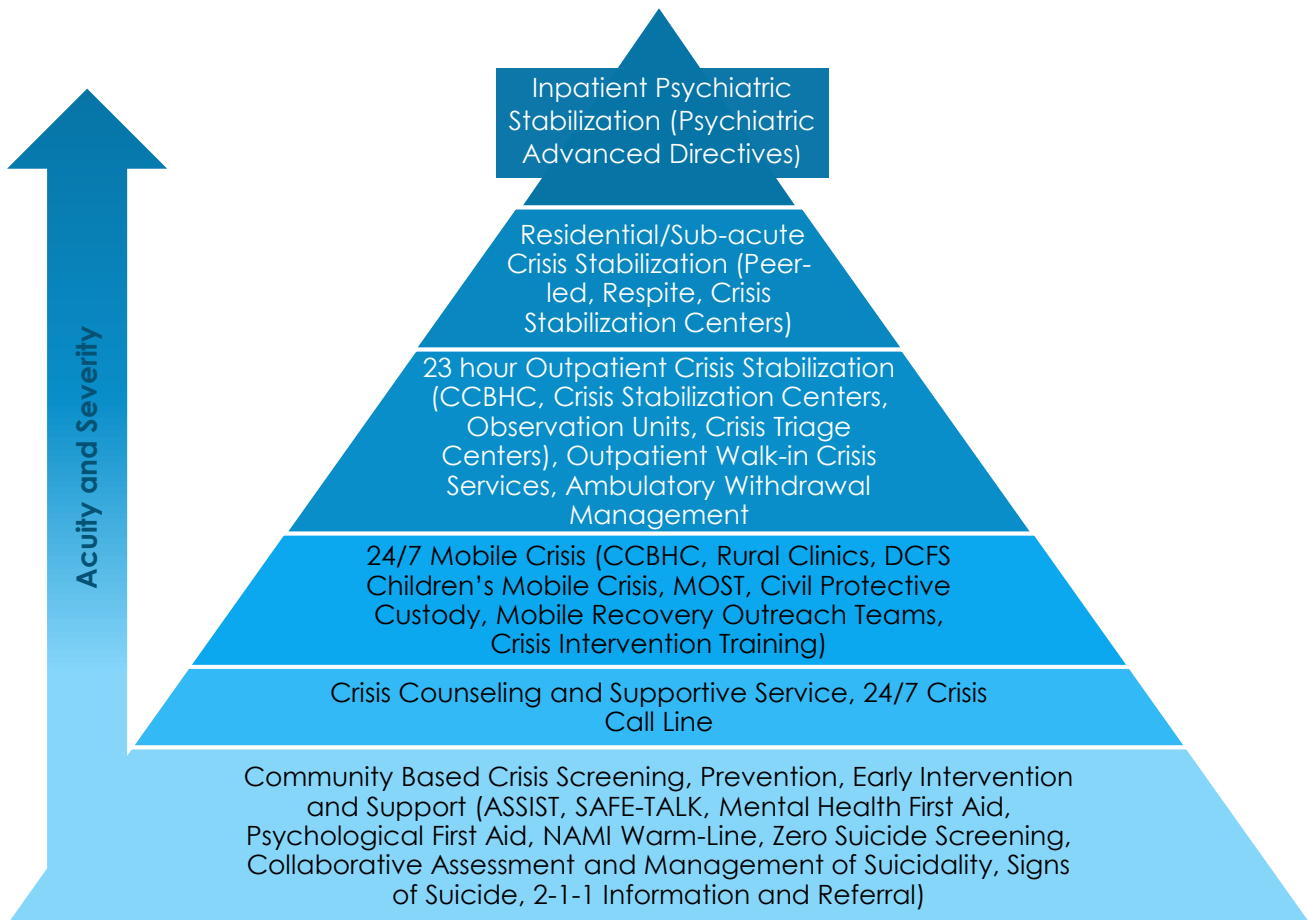
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recently created Certified Community Behavioral Health Clinics, Crisis Triage Centers, and through Children's Mobile Crisis and community-based/hospital-based stabilization.

Another important development in the crisis response system includes recent legislative changes. For civil commitments and legal holds, a diagnosis of mental illness is no longer required. Additionally, the state has established the ability to create Psychiatric Advanced Directives, which will allow individuals who may be able to anticipate a mental health crisis to establish legal directives. Finally, Dr. Woodard noted that with funding from opioid crisis grants, the state has invested in OpenBeds, a technology platform designed to connect referral sources to providers and better coordinate care.

Dr. Woodard also presented Nevada's Ideal Crisis Continuum, which is illustrated in the graphic below. She concluded that while there are some components already in play, there is still significant work to be done 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.

Nevada's Ideal Crisis Continuum



Zero Suicide

Presented by David Covington

David Covington, LPC, MBA serves as Chief Executive Officer and President of RI International (formerly Recovery Innovations), is a partner in Behavioral Health Link, co-founder of CrisisTech 360, and leads the international initiatives "Zero Suicide," "Crisis Now" and "Peer 2.0."

David Covington proposed that a paradigm shift is needed to address suicide in America. With an estimated 1.5 million years of potential life lost in America to suicide, Mr. Covington noted that the paradigm shift needs to include a determination that suicide can actually be addressed.

Suicide is not currently considered a health care issue. Those with the greatest risk of suicide are receiving screenings, but focusing only on these populations may be insufficient. There is a way to drive the rate of suicide to zero. In health care, this includes screening and assessment, direct treatment and follow up, and collaborative safety planning. However, there are limitations in applying this model to only a clinical setting because common beliefs about suicide prevent us from committing to the idea that suicide can be prevented. Mr. Covington then presented "Four Big Ideas for a Paradigm Shift." These ideas are summarized as follows:

#1: Reject the myths. Aspire for zero. Mr. Covington noted that we need to question the idea of suicide as a "choice" and reframe the language that we use, such as the term "committed suicide." Using William Styron's *Darkness Visible* as an example, he noted that suicide could be reconsidered as a reaction to extraordinary pain, and that people have succumbed when all their strength was fully, completely gone.

#2: Include lived experience in your design process and leadership. Contagion and clusters are a concern, but in reality, suicide itself is not contagious; however, courage is. For suicide, an individual may see someone like them do something they didn't think they could do. It's powerful and dangerous. However, sharing lived experience also demonstrates courage that is equally contagious. There is a concept called herd immunity; as we begin to talk about hope and healing and individuals hear stories about people who found a way to survive, there is an even more powerful effect.

Zero Suicide: Key Ideas

- As a society, we must determine that we can prevent suicide
- In order to do this, there are four "Big Ideas" key to a paradigm shift. These are described in the summary provided and included the following ideas:
 - Reject the myths. Aspire for zero.
 - Include lived experience in your design process and leadership.
 - Start from the other end.
 - The goal should emanate from the leader.

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#3: Start from the other end. There needs to be an internal belief that suicide is preventable. The thought-provoking question provided was "why does zero prostate cancer not bother us but zero suicide does?"

#4: The goal should emanate from the leader. Grassroots efforts must join with decisions emanating from policy makers. If the focus were on what is known to work and implementing it effectively, as well as learning from it, this will allow the state to be bolder in 2020 to drive zero suicide forward.

Crisis Now

Presented by David Covington

David Covington began by stating that "systems are designed perfectly to achieve what we want them to achieve," and that for people with a psychiatric emergency, "we are communicating that we don't care about them". He then outlined the ways in which crisis response systems are failing people and provided a high-level overview of how the Crisis Now model provides the building blocks to address these failures and has created a positive impact in the communities where it has been implemented.

The systemic failures he noted include the following:

- Referrals by fax to multiple facilities
- Individuals are sent to the first facility that accepts them, rather than the most appropriate
- There is no way to know how many people are stuck in an ER unless people "make noise"
- Receiving staff may sift through all referrals, and pick out those that will be easiest
- No one knows how many individuals are sent home without care
- Communication depends on archaic phone and fax systems. There are call backs required and no time frames are given for referral decisions
- Costly, invasive and time-consuming medical tests are often required unnecessarily
- Medical clearance is often needed for admission, and clearance itself is not standardized
- There is no transparency around a bed census for inpatient facilities
- There is no accountability for using Emergency Departments as holding cells
- Hospitals are the bottleneck and a funnel for all mental health crises in both rural and urban environments

Crisis Now: Key Ideas

- There are multiple barriers for people experiencing a mental health crisis to receiving care, and hospitals continue to be the funnel for most mental health crises
- The essence of the Crisis Now Model contains three sequential steps
 - Someone to talk to
 - Someone to come to them
 - Somewhere to go
- Multiple metrics show community cost-savings for law enforcement and medical services when this model is implemented

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- There is an average three-day wait in a hospital, according to 2013 Seattle Times
- In a recent survey, 20% of hospitals said they had people on hold for five days or longer

Mr. Covington noted that a three-part solution to many of these problems is providing people someone to talk to, someone to come to them and someplace to get care for “a night or three.” These aspects of the Crisis Now model are summarized below:

#1: Someone to talk to: A Crisis Hub or Air Traffic Control model ensures that technology is used for the continued support of individuals, tracking people from the start to wherever they need to go to receive the right level of care.

#2: Someone to come to them: Mobile crisis response units are deployed to where the person is located in order to stabilize them in place. If this is not possible, then they are sent to a crisis stabilization facility.

#3: Someplace to get care for a night or three: Crisis stabilization programs provide alternatives to acute care. Using scores from the Level of Care Utilization System (LOCUS), it was noted that 82% of people in crisis are going to need care that falls in “the middle” of the LOCUS scores. Additionally, these programs can partner with law enforcement for direct drop off of people in crisis.

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. Mr. Covington noted that Arizona and Nevada share many similarities and that application of the model could result in meaningful change in Nevada.



Breakout Presentations

Crisis Stabilization Centers

Presented by Frank O'Halloran and Jamie Sellar

Frank O'Halloran, MA, is the Crisis Services Coordinator and Veteran Advocate at Mercy Care Regional Behavioral Health Authority in Maricopa County, Arizona where he coordinates services within the extensive behavioral health crisis provider network, focusing on crisis system performance and improvement.

Jamie Sellar, Licensed Professional Counselor, MA, serves as the Chief Strategy Officer for RI International where he is focused on improved crisis system delivery throughout the country, overseeing the company's mission to effectively integrate Crisis Now, Zero Suicide and Peer 2.0 methodologies.

Frank O'Halloran began the session by presenting an overview of how the crisis system developed in Maricopa County, Arizona, with a focus on facilities designed for crisis stabilization and the community partnerships necessary to support the system. Jamie Sellar then described a new model for crisis stabilization centers.

Mr. O'Halloran explained how the Mercy Care Regional Behavioral Health Authority in Maricopa County, Arizona has created a Crisis Intervention Team (CIT) with five components. These components include evidence-informed police training, community collaboration, a vibrant and accessible crisis system, behavioral health staff training, and collaboration and mutual education between family, persons with behavioral health illnesses and advocates.

He described that the portal to this crisis system is the crisis line, and illustrated its success by noting that the vast majority of people are stabilized through the crisis line. He explained that police can directly call the crisis line and request a mobile team and noted how this allows people to get an appropriate level of care while preventing them from entering and staying in the criminal justice system. He highlighted that there is a "No Wrong Door" philosophy for first responders, allowing for all drop offs from police to be accepted at all times. Previous programs with Fire Departments have not been as successful, but another pilot program is set to begin soon.

Crisis Stabilization Center Challenges:

- Police training, including length of evidence-based training needed for law enforcement
- Bridging the gap between mental health professionals and law enforcement
- Children's drop off centers are not in place to connect children to care
- Funding sources, including insurance
- Community Size



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In Maricopa County, Emergency Psychiatric Centers accept drop offs or walk-ups and are part of the “No Wrong Door” philosophy. Both voluntary and involuntary admissions occur, with involuntary processing requiring witnesses and an electronic form that can be completed by officers in their vehicle. There are also access points offering assessments for ongoing services, brief interventions and care coordination, and Addiction Recovery Centers providing 24/7 medically monitored detox.

Mr. O’Halloran completed his presentation by noting the many similarities between Arizona and Nevada, including their geography and challenges with accessibility in rural areas, as well as the lack of a children’s drop off center.

Mr. Sellar began by defining crisis services as something that should serve anybody at any time, wherever they are. He explained that current research from the Substance Abuse and Mental Health Services Administration (SAMHSA) finds that crisis residential care is generally as effective as other longer psychiatric inpatient care, which is more costly. He compared Crisis Now to a ladder, with the bottom as outpatient care and the top as inpatient care, noting that 82% of people need help between the two rungs. Crisis Now adds rungs in the ladder to provide the right level of care at the right time.

The Crisis Stabilization Facilities in the Crisis Now model function as an integral part of a regional crisis system serving the whole population. The facilities operate in a home-like environment where peers are utilized as integral staff members and patients have 24/7 access to psychiatrists. A fusion model is used in the design of the facilities, where the physical layout is an open floor model, peer support is utilized, people are referred to as guests, and there is a positive community impact filled with compassion and engagement. This model decreases costs and reduces incarceration. A [facility tour video](#) was shown to participants.

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.

He explained that there are two components to a “No Wrong Door” Crisis Receiving Facility. The first is a 23-hour observation unit with 35 recliners, flexible limits on capacity, and staffing variability depending on capacity. 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. He noted that about 70% of guests are stabilized in the first 24 hours.

Mr. Sellar stressed that culture and beliefs are extremely important and that providers cannot operate outside of the culture. The facilities bring a new culture of guest engagement with crisis stabilization as the focus using a high engagement model. The role of lived experience is honored and there is a lean modeling of workflow including peers and nurses. It is important to consider the guest’s interest first, followed by the community interest, and the agency interest considered last. The facilities engage guests

so they don’t feel that they are burdensome or lonely by using a high tech and high touch approach.



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Participants were curious about the funding source for crisis stabilization centers and Mr. Sellar explained that funding comes from Medicare and Medicaid as well as some state and county funds. They strive to make investments in prevention; for example, Mercy Care is responsible for the entire community even though they are supposed to serve those with Medicaid. People without insurance are also admitted. They are moving to a multi-payor model.

One participant asked for more details on advanced CIT and Mr. Sellar explained there are single-day trainings offered at least twice a year to provide a deeper dive into some aspects of CIT based on surveys of officers who have completed the CIT training. A follow up question was asked about CIT being included as part of the Peace Officer Basic Training (POST), which currently is in place in Northern Nevada. Mr. Sellar explained that CIT is appropriate after an officer has been practicing for a while and has had experience as a law enforcement professional. He noted that CIT is discretion-based, and attendees of the POST academy may not have had experience on the street sufficient to understand the appropriate applications of CIT.

Key Implementation Ideas for Nevada:

- No Wrong Door Policy
- Train mental health professionals regarding “cop culture”
- Utilize Fusion Model in crisis stabilization facilities, adopting culture and beliefs with crisis stabilization as the focus
- Start with a single payor and law enforcement champion
- Seek leadership and accountability from funders
- Collect data on the number of individuals experiencing homelessness who are brought to crisis stabilization facilities by law enforcement

Mobile Crisis

Presented by Erica Chestnut-Ramirez and Nick Margiotta

Erica Chestnut-Ramirez, Licensed Independent Substance Abuse Counselor, MA, serves as the Director of Crisis and Trauma Healing Services for La Frontera AZ, EMPACT-Suicide Prevention Center in Tempe, Arizona. She is responsible for the oversight and management of all crisis programs.

Nick Margiotta, MA, is the President of Crisis Systems Solutions, and provides national-level consultation and technical assistance to communities across the country on a variety of behavioral health and criminal justice initiatives. He has extensive experience in the areas of crisis services, homelessness and crisis intervention team (CIT) programs.

Erica Chestnut-Ramirez began the presentation by describing mobile crisis employees as the “first responders” of a behavioral health agency. She outlined the key precepts for effectively running a mobile team, noting that it is imperative for mobile crisis to be community-based and emphasizing that the overall goal is stabilization of the individual.

She explained that mobile crisis teams arrive in an unmarked van, which is less stigmatizing than other official vehicles that draw attention. When dispatched, there is an expectation that the teams will arrive on the scene within 60 minutes, and within 30 minutes if it's law enforcement. She explained that the standard is to utilize two-person mobile crisis teams and the majority of situations do not require a law-enforcement response, which saves the system money. A mobile team typically requests a law enforcement response less than five percent of the time. If a police officer is already on the scene, the focus is on releasing the officer as soon as possible.

Using a centrally deployed air traffic control model, mobile crisis teams are dispatched from a call center. Mobile crisis teams are dispatched from four different sites and data is tracked and analyzed throughout the year to identify gaps and how demands have been met. The call center has clinicians on staff.

Ms. Chestnut-Ramirez provided an overview of the work carried out by mobile crisis teams, explaining that they provide evidence-based crisis assessment including a comprehensive risk assessment, as well as crisis intervention and de-escalation.

Goals for Mobile Crisis Teams:

- 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



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Mobile crisis teams help create a safety plan to ensure people are well connected to services, and consider their insurance plan and benefits when doing this. If necessary, they can also arrange for a higher level of care (detox, crisis facility) and provide transports if the individual is not at risk. The teams also assist with the emergent petition/non-emergent petition process, which is similar to the Legal 2000 process in Nevada.

Ms. Chestnut-Ramirez explained that it takes a unique individual to be able to perform crisis work, but that with intensive training which includes advanced techniques in crisis de-escalation and in-home safety training, the staff becomes equipped and passionate about their work. Staff are monitored in order to track if they do not call for back up at the expected rate and likewise for staff who contact law enforcement too frequently. Surveys for quality control are also conducted.

Nick Margiotta discussed why collaboration with law enforcement is so important, noting that law enforcement can be the eyes and ears helping to connect people to community-based treatment. He explained that law enforcement's primary tool is to use arrest in order to solve a problem, and said that crisis response teams help officers use diversion which is a better approach.

Mr. Margiotta detailed considerations to keep in mind when working with law enforcement, emphasizing the importance of accessible and expedient hand offs to mobile crisis teams. The goal is to allow behavioral health providers to take over and get officers off the scene as soon as possible. He explained that behavioral health only calls for law enforcement when there is a safety concern. Individuals in crisis may be escalated by the presence of police officers which can be intimidating, whereas the crisis teams consist of two people coming to visit in an unmarked van.

There have been huge wins as a result of this collaboration, with less than 1,800 police responses required out of a total of 18,000 mobile team responses. He noted that the vast majority of people are stabilized in their community, with only about 15% transported to a Psychiatric/Substance Community Based Receiving Center and less than 3% transported to the Emergency Department by the mobile team. A participant questioned how a mobile crisis team would transport an individual who is suicidal and it was stressed that this is all part of a necessary cultural shift where mobile teams don't treat people as if they are beneath them and use common sense based on their suicidal ideation, which has a big range.

Mobile Crisis Challenges:

- Culture change to get line staff to buy into crisis model
- Identifying individuals who are comfortable performing crisis work

Key Implementation Ideas for Nevada:

- Use of unmarked minivans without plexiglass as part of community based mobile team
- Consult Colorado's integrated model
- Bring together representatives from homeless providers, jails, advocates, politicians, etc. and put together a grand plan of where we want to move and write this into contracts
- Find clinicians with the "right amount of cowboy/girl"
- Ensure Crisis System is easy to navigate, fast and reliable so law enforcement is more likely to use it
- Allow mental health clinicians to lead and engage law enforcement only when needed

High Tech Crisis Lines

Presented by Deborah Atkins and Wendy Farmer

Wendy Martinez Farmer, Licensed Professional Counselor, MBA, MS, is the President and CEO of Behavioral Health Link (BHL), where she leads the award-winning Statewide Georgia Crisis and Access Line and 24/7/365 Crisis Services across the state. In this position, she spearheaded the development and ongoing refinement of the BHL Care Traffic Control electronic tracking process.

Deborah Atkins, Licensed Professional Counselor, MA, serves as the Director of Crisis Coordination for the Department of Behavioral Health and Developmental Disabilities in Georgia. In this position she has worked towards the development of a holistic crisis system across the state of Georgia, overseeing the Department's Strategic Crisis Plan.

Deborah Atkins and Wendy Martinez Farmer began their presentation with an overview of the Georgia Crisis and Access Line (GCAL). GCAL functions as a state-wide telephonic crisis de-escalation, assessment and referral and is free for anyone in Georgia. It serves as the single point of dispatch for Georgia's mobile crisis teams. GCAL is the single point of entry for state-funded contract beds at private hospitals and the preferred point of entry for state hospitals and crisis stabilization units. It also serves as Georgia's SAMHSA's treatment locator and provides National Suicide Prevention Lifeline Calls with a goal of 90% of calls from Georgia.

A new service is being offered to target Georgia's youth through the use of the "MyGCAL" text and chat mobile app. The app provides a connection to GCAL and allows young people to choose how they want to reach out, whether through text, chat, or phone call.

Information about the state of Georgia was provided. The state has a current estimated population over 10.5 million and is not a Medicaid expansion state. There is

Five Elements of "Care" Traffic Control:

- 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



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a mix of urban and rural communities. Staff is hired based on geography and there are some team building activities as well as zoom staff meetings to keep everyone connected.

For over a decade, Georgia has been developing and enhancing a statewide live census and referral system to complement their statewide crisis response system. GCAL staff may resolve the crisis by phone, schedule an appointment in a local clinic, or dispatch a locally established mobile crisis team to conduct a face to face assessment and determine treatment needs. GCAL has been developed as an interface for doctors to connect directly with units. This has resulted in more referrals in less time, as well as increased utilization of capacity. As a result of better coordination and transparency, more individuals have been served closer to home with a focus on individual care with appropriate lengths of stay.

Since the live census was launched in 2012, Georgia has monitored performance using the following metrics and benchmarks: occupancy rate of crisis stabilization units (90% required), denial rate (no more than 10%), length of stay (average of seven calendar days or less), and diversion rate (50% of individuals who present to Walk-In Centers or Temporary Observation Units and are treated in 24 hours or less and no longer require inpatient admission to a crisis unit or hospital).

Current enhancements are in progress and include dashboards that show demand and capacity at a glance and key performance indicator (KPI) dashboards for program managers to view current progress. They are also working on a secure messaging portal for referring and receiving facilities and a secure portal for ER's to check for updates on their referrals. They are looking to implement ways for providers to better communicate challenges as well as produce better data analytics.

Key Implementation Ideas for Nevada:

- Use of text and chat mobile app targeting youth
- Design what you want and ask for more than you think is possible
- Develop live census and referral system to complement crisis response system
- Establish benchmarks to monitor progress

Wrap Up and Next Steps

Presented by David Covington

David Covington concluded the Crisis Now Summit with a brief discussion about how the crisis continuum has been around for a while but has not been prioritized and as a result has been underfunded, under resourced, and services have been siloed.

Mr. Covington suggested that between now and the next summit participants look into what is currently in place, what is working, and what can be easily shifted. He guided participants to consider how targeted investments will make a difference over time and noted that 23-hour units bring huge cost savings. He explained that Nevada can leverage the lessons from Virginia, Southern California, Georgia, Arizona and Colorado to accelerate gains to be made in the state.

Key Ideas:

- Language is important
- Crisis Team doesn't fit if it's not anyone, anywhere, anytime
- Say "yes" – the Contact Center must recognize that it is a crisis to the individual who calls and don't carve people out based on certain variables (e.g., ages, geography, etc.)
- Invest in it and fund it
- Scale and bring it together (e.g., consolidate crisis lines into one)
- Community engagement