RURAL CRISIS CENTER NETWORK (RCCN) May through September 2020
PUBLIC HEALTH – IDAHO NORTH CENTRAL DISTRICT

The Rural Crisis Center Network in Region 2 is submitting an additional Third Quarter report. To standardize the reporting time frames for Crisis Centers, the Department of Health and Welfare, Behavioral Health has asked all centers to move to reporting on a calendar year basis. For the Region 2 Rural Crisis Center Network this means submitting a report that covers the timeframe from May 1, 2020 through September 30, 2020. The following report and statistics cover this period.

REFERRALS IN

	Walk–Ins	Law Enforcement	Hospital	Private Practitioner
	62%	21%	10%	7%
1st Quarter	15	4	3	3
2nd Quarter	18	13	2	2
3rd Quarter	81	22	13	7
Total	114	39	18	12

The Rural Crisis Center Network in Region 2 uses the WITS system as an Electronic Health Record (EHR) and gathers demographic data through the intake and treatment process with clients. While this report does not include any client specific health information it does attempt to paint a picture of the clients we serve.

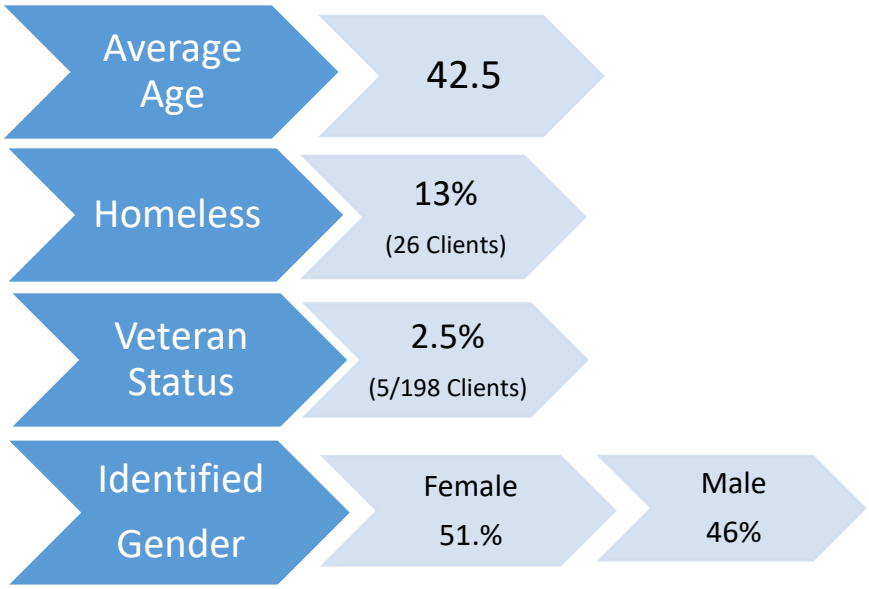
The above graph illustrates the most common method clients use to access a facility. Historically, most clients' access crisis services by walking into a center. We have assertively reached out to Law Enforcement, Hospitals and Private Practitioners in effort to partner in the best interests of the client and our individual agencies. Both Law Enforcement and Hospital referrals during the COVID Pandemic period have increased. In addition to the options listed above, our WITS EHR lists approximately fifty other methods for referral, but the client numbers associated with those methods are not statistically significant.

During the COVID pandemic, many partnering agencies reached out and recognized the centers as a resource to the communities. Services offered include assessing for risk, safety and treatment planning, access to resources, and appropriate intervention. The average time spent physically in the Crisis Centers is 4.9 hours. The Crisis Centers served a total of 198 clients during this reporting period. Fifty-three or 26% of those clients were helped via telephone. Services provided telephonically included de-escalations, risk assessment, safety planning and follow-up. There has been a trend during the pandemic to avoid direct admission to the centers, possibly due to fear of contagion. The telephone interventions are provided by master's level clinicians who are available on a 24/7 basis.

REFERRALS OUT

	1ST Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Community Hospital	3	7	17		27
No Referral – Client Refused	6	8	6		20
No Referral – No MH/SA Diagnosis	0	3	19		22
Other	18	25	156		199

Information gathered at discharge from the Crisis Center is valuable to growing and measuring our influence with the client and in the community. The WITS EHR is limited to the above information categories to record information for referrals at discharge. Most referrals at discharge are categorized as "other". Other is a general term, but usually includes referrals to peer support, counseling, case management, medical care, medication management, and higher levels of care including hospital. The specific unique referral information is recorded in the clients' paper file at the respective center. The Rural Crisis Center Network routinely connects clients with appropriate on-going services in the community.



DEMOGRAPHICS

Pictured is an overview, by percentage, of the basic demographics of the patient population served across the crisis centers District 2. A total of 198 patients received services through the Crisis Response Network during this reporting period.

During this reporting period we continue to see clients with an average age of between 35 and 45. Outliers include increasing individuals between 18 and 23 and seniors between 55 and 75.

The Rural Crisis Center Network is experiencing an increase in Veteran's seeking services. This is directly related to a Veteran's intervention program associated with Latah Recovery Community Center in Moscow. Teamwork between the Recovery Center and Crisis Center staff, in addition to some cross-discipline training and shared interns has enhanced the Recovery Center's staff in recognizing a behavioral health crisis and appropriate referral for clients to intervention services.

Insurance

- 81 Medicaid 41%
- 10 Medicare 5%
- 107 Self-Pay 54%

Race

•157 Caucasian	79%
•2 - Other	**
•6- American Indian	3%
•1 - Asian	**
•1 - Pacific Island	**
•1 - Black/African American	**
•30 - Unknown/Refused	16%

County

- 69 - Clearwater 35%
- 1 - Lewis **
- 73 - Latah 37%
- 36 - Nez Perce 18%
- 16 - Out of State 8%
- 3 - Ada/Kootenai **

The WITS EHR demographic information includes gathering unique client information including race, county of residence and insurance. These items are self-reported by the client gathered during the intake process.

The statistics listed above regarding race are a relatively true reflection of the Region 2 area, where the majority population is not of Hispanic or Latino Origin and White/Caucasian. Region 2 is home to the Nez Perce tribe; however, most behavioral health services are provided on the reservation. Meetings between the Rural Crisis Center Network and NiMiiPuu Health on the reservation are on-going as NiMiiPuu develops their own behavioral health crisis center modeled on the Rural Crisis Center Network concept.

It is important to know where our clients are originating. The WITS EHR allows us to gather and record county of residence for our clients. Unfortunately, the provider in Lewiston decided to terminate their facility contract in May. The Crisis Center in Lewiston has been relocated to the clinical provider agency. Reaching out to Law Enforcement, hospitals and clinics continues to rebuild community engagement in Lewiston. There was no lapse in service availability due to the quick response by our contractor to take on the additional tasks of running the facility in addition to clinical services.

As the Rural Crisis Center Network addresses sustainability issues, we pursued credentialing by OPTUM and Blue Cross and can bill crisis center services for our clients who have these insurances. We are in the process of becoming credentialed with Molina which will expand our ability to bill.

Billing with the OPTUM system began in June. The table below outlines the total clients who have a Medicaid benefit, specific eligibility, the total amount billable and the receipts associated with those eligible clients. The Rural Crisis Center Network is taking every opportunity to seek funding opportunities to ensure sustainability.

OPTUM BILLING

MONTH	MEDICAID CLIENTS	ELIGIBLE	BILLABLE	RECEIPT
June	16	10	$ 5280.38	$ 3012.19
July	15	7	$ 3453.85	$ 1560.38
August	25	9	$ 2910.86	$ 622.83

This has been a challenging time for the Rural Crisis Center Network. As outlined above, many clients are fearful of physically admitting to the centers. Those that do come into the centers as reluctant to stay, but have been engaging in brief crisis interventions and setting up safety and treatment plans.

Challenges continue with meeting the needs in our ever-changing environment. Staff and providers have been flexible and creative in meeting the behavioral health crisis needs in our communities. Most recently, the Rural Crisis Center Network is partnering with DHW Region 2, Behavioral Health Mobile Crisis Team in developing a sustainable crisis response process where our two organizations complement one another, work together in our communities to provide a continuum of care model and avoid duplication of services while providing a system of care that meets and anticipates the needs of our communities.