EMS Focus Webinar FAQ – Working Together: How 988, Crisis Response, and EMS Can Improve Community Care

July 21, 2022

The following answers are provided by:

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- Richard McKeon, PhD, Chief, Suicide Prevention Branch, Center for Mental Health, Services Substance Abuse and Mental Health Services Administration
- Daniel R. Gerard, MS, RN, NRP, President of the International Association of EMS Chiefs
- Kimberly Behounek, Director of Behavioral Health Gunnison Valley Health
- Jodie Chinn, Executive Director Gunnison Regional 911 Authority
- Sean Caffrey, President of the National EMS Management Association

988 Basics
Richard McKeon, Services Substance Abuse and Mental Health Services Administration

1. *Does 988 only work on a phone connected to a network? Or is it operational like 911, which can make the call even though there is no service to the phone?*

   No, 988 is not like 911 in that respect. There needs to be service for the phone.

2. *How many calls were placed to 988 on Day 1? Did any result in the need for EMS assistance?*

   SAMHSA will not be releasing daily call volume information but has released call volume information for the month of August, the first full month of 988 availability. There was a 45% increase in total contacts through phone, chat, and text in August 2022 compared to August 2021. We are currently examining the August data on callers at imminent risk, but typically between 1-2% of calls require emergency response.

3. *Could you speak briefly about the level of training in behavioral health crises made available to Lifeline counselors?*

   All Lifeline/988 centers are required to adhere to the Lifeline networks standards for suicide risk assessment and guidelines for callers at imminent risk. All centers typically provide intensive training before being allowed to answer calls.

4. *With a credible suicide threat, do law enforcement and EMS still get dispatched like a previous suicide attempt call?*

   Law enforcement and EMS would not be automatically dispatched each time a person is suicidal, because working with suicidal people is one of the core skills and competencies expected of those answering 988 in the over 200 988 centers across the country. However, there are some circumstances 911 would engage in, such as a suicide attempt in progress or if others are in danger. The resources that are dispatched vary based on the local 911 and first responder protocols.

5. *What do you expect EMS's role to be in implementing 988?*

   EMS needs to be a partner in the discussions of how this new evolution of the crisis system will be implemented. In many communities, EMS is already responding to these calls. In some communities, crisis centers and eventually mobile crisis and stabilization centers may reduce the call volume for EMS and 911. However, it will take time for such systems to be widely available across the country. It is critical that EMS and 911 stakeholders are engaged at the state and local level, so such systems evolve collaboratively with existing EMS and 911 systems.

6. *How does the current relationship between 911 and 988 work?*

   For years the suicide lifeline has contacted 911 for those who needed first responders. However, 911 did not have the opportunity to divert callers to the suicide lifeline's 1-800 number. With the implementation of 988, and the development of model programs in cities like Houston, Los Angeles, and St. Louis, this relationship can expand. This provides the opportunity for improved collaboration between the 988 and 911 systems and improved understanding of each other's systems. As 988 and the crisis system evolve, work is being done to move calls from 911 to 988 and 988 to 911 more efficiently so each caller gets the appropriate care at the appropriate time.

7. *Do you have a link for the grant to connect Mobile Crisis and local resources?*

   Fiscal Year 2022 Grant Announcements and Awards | SAMHSA

8. *How can we get information about 988 grants and/or the pathway to access CMS support for mobile crisis services?*

   For information about SAMHSA 988 grants, contact James Wright at james.wright@samhsa.hhs.gov. For information on CMS support for mobile crisis, visit https://www.cms.gov/newsroom/press-releases/new-medicaid-option-promotes-enhanced-mental-health-substance-use-crisis-care

9. *Where in the U.S. is 988 available?*

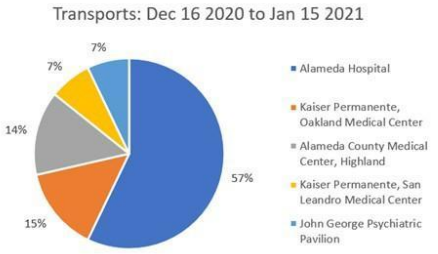
   988 is now available across the country for any call, text or chat. So, while anyone in the country can access 988, resources available following the 988 contact, may differ by state and local jurisdiction. Also, the number and organization of local 988 centers will vary by state.

EMS Field Response with 988
Daniel Gerard, President of the International Association of EMS Chiefs

10. *How were behavioral health patients transported to these alternate locations that were not emergency departments? Via ambulance or another vehicle?*

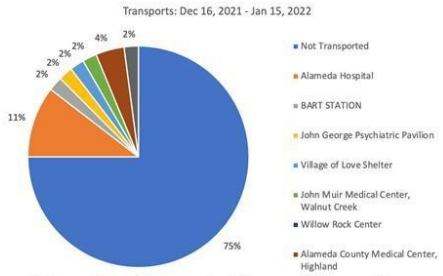
Transport Results Prior to and With Alameda CARE Team
For Reporting Period December 16 – January 15

Prior to ACT



- Prior to Care Team
  - 48 calls during this period
  - 25% of responses were transports
  - 2% of responses went to psych facility
  - 38 clients total involuntarily committed

With ACT



- After Implementation of Care Team
  - 44 calls during this period
  - 27% of responses were transports
  - 0% of responses went to psych facility
  - 13 clients total involuntarily committed

11. *What kind of training was provided to the team?*

    The training provided to the team was provided by an outside contractor who was paid for and contracted by the county public health agency. We had no input into the training, its design, benchmarks or behavioral objectives.

12. *How did the service that ended up somewhere other than a hospital get reimbursed? Does Medicaid in California pay for EMT crisis response to locations other than a hospital?*

    Currently we are not charging for service, although our partner who provides the Licensed Clinical Social Worker (LCSW) under contract to our city will be doing this in the very near future.

13. *Is the NorCal Mobile Crisis Team activated via 911, 988, or another mechanism?*

    Currently through 911, although we have just gone live with 988. We have not received any notifications via 988 yet.

14. *Were people who use the service included in the development of training? Were they asked what works and what does not work for them? Our city council asked*

us if we would assume the duties from the police department because the police department was no longer going to provide this function.

The training offered was specifically designed for social workers by an organization that was already providing social services in the county. It was not designed with EMTs and paramedics in mind.

15. *NorCal mobile units: Does the response start at emergency dispatch? How does the system work between dispatch and field response?*

    Calls are generally initiated through the 9-1-1 system. At the PSAP the dispatcher will make the determination if the scene is safe enough to send our community crisis team. If they determine that the person is not violent and there are no weapons, they will immediately dispatch the team. If there are reports that there are weapons or the person is violent, the police will respond first. If they determine that the scene is safe, then the mobile crisis team will respond.

Training for 988 Implementation
Kimberly Behounek, Director of Behavioral Health Gunnison Valley Health;
Jodie Chinn, Executive Director Gunnison Regional 911 Authority;
Sean Caffrey, President of the National EMS Management Association

16. *Have you considered the use of the "CISM" critical incident stress management team to debrief EMS and Paramedics?*

    In our case, our EMS providers do not provide the bulk of the crisis intervention care as that is left to the mobile crisis clinicians. As such, our baseline care resembles the mental health first aid program. We currently have CISM group and peer support-certified public safety professionals who handle the critical incident debriefings for our agencies as well as a good working relationship with our Behavioral Health Department to provide support when needed.

17. *Regarding 988 training for emergency dispatchers so that the calls are answered consistently: Do they ask specific questions? If not, how do they arrive at the response necessary?*

    We have sent all of our dispatchers to Crisis Intervention Training hosted by Denver 911 to assist in recognizing those in crisis. If we get a call where we believe the caller is having a mental health episode, we first determine if they

have an immediate life threat such as an overdose, suicide attempt, or weapons. If we have determined their need is not law enforcement- or EMS-related, we get the caller over to Colorado Crisis Services (988) for further evaluation. Colorado Crisis has the ability to call us if the situation changes and they need law enforcement or EMS. They also have the ability to contact our Mobile Crisis team directly for a response as well.

18. *I volunteer with a Mobile Crisis Response Team in Rural West Lane County, OR. We have challenges staffing the team with lay/peer support specialist members. We have a master's-level mental health professional overseeing and on-call 24/7, but I don't see having MH professionals on the on-call team around the clock due to shortage of qualified professionals. Is there a model for best practices given our limitations?*

    In the first year, we hired two local individuals 12 months out from a clinical master's program. We also have hired two individuals who have a non-clinical master's degree as it doesn't impact our billing. I operate as the licensed provider overseeing the services and go to the scene as needed. I agree—anything less than a master's in progress or completed master's doesn't work out well due to the complexity of cases.

19. *For the mobile crisis programs: what deciding factors did you use to differentiate between an immediate crisis vs. some chronic behavioral psychiatric patients?*

    I think there is a lot of overlap in those two groups. Our experience has been that the better job we do with getting people to the most appropriate care, the less likely they are to remain chronic patients using high amounts of resources.

    We have a list of questions that Colorado Crisis Services or mobile crisis uses to screen. When we are deployed we assess each call, even from repeat utilizers, for all the statutory criteria (SI, HI, grave disability), what resources were used/not used, and create a new plan each time. There are times we reiterate the same plan if changes are not needed and just keep showing up until the patient can act on one tiny aspect of what we agree to.

    Success is measured by those small steps. We have one chronic utilizer who doesn't call anymore because we were so consistent and he wasn't ready to change. We have another who doesn't call anymore because she is working on her plan for recovery. Questions can be requested by emailing kbehounek@gvh-colorado.org.

20. *What type of training did you do for your 911 professionals?*

    We send all of our 911 professionals to a two-day Crisis Intervention Training program hosted by Denver 911. We also have them take the APCO Suicidal Callers training and are going to be working with GVH's Behavioral Health department to do more training on recognizing and handling a mental health crisis.

21. *Can you share with us a copy of your policies and procedures?*

    I am happy to share our 911 policy with those who would like to request it. Please email me at jchinn@gunnisonco.gov.

22. *Was the voice of the person served at the table at all in this planning and program development?*

    When we were asked to take on a contract for mobile crisis services, we had a lot of data about how our community members were not getting these services. We did not have a panel of community members who used the services represented. We did meet as a team of first responders for about two years before we started and continue to meet monthly.

23. *What are the terms M1 and M.5 about?*

    In Colorado, an involuntary placement to inpatient psychiatric care, alternative treatment unit (ATU) or crisis stabilization unit (CSU) requires a 72-hour mental health hold (M1). The person must meet statutory requirements of imminent risk of suicide or homicide or be gravely disabled due to a mental illness.

    The M.5 is an involuntary transportation hold that can be placed for up to 6 hours in order to arrive at an emergency department or crisis walk-in center for further evaluation and treatment. We use the M.5 to rule out medical- and substance-induced issues as inpatient psychiatric care must be used only after medical and substance issues are treated. Links are here:

    Involuntary Transportation Hold (M-0.5)

    EMERGENCY MENTAL ILLNESS REPORT AND APPLICATION (M01)

24. *I understand the development of Mobile Crisis (MC) and using it as an alternative. Other than using MC, what is the role of EMS in this?*

    So far, our crews have been expected to evaluate for the presence or absence of any emergency medical concerns followed by facilitation of any initial behavioral health care until the mobile crisis clinician arrives. As the mobile crisis clinicians add a significant capacity we've not had before, there has been plenty of learning through experience that continues as we figure out each other's roles and how to most effectively collaborate during a crisis response. If there has been a secret to our success, it has been a willingness to set turf aside and work through issues as they arise, including law enforcement.

25. *Can you share with us a copy of your policies and procedures? I realize every community is unique and needs to create its own, but your model would be helpful.*

    I am happy to share our 911 policy with those who would like to request it. Please email me at jchinn@gunnisonco.gov.

26. *What are the different formats used to fund these programs?*

    From my perspective, it appears most of our initial funding has come from the hospital and hospital foundation with support from local governments. These entities understand the impact of doing crisis response poorly inevitably falls on the hospitals and local government (i.e law enforcement, EMS and the jail). The program is now working through more reimbursement-based funding options.

    We received startup funds and annual matching around $10K from each law enforcement entity in the area. The bulk of our funding ($280K) comes from a contract with Rocky Mountain Health Plans/Cigna. The contract expects we bill insurance (commercial, Medicaid, and Medicare) noting offsets in our monthly invoicing to Rocky/Cigna for what we collect. The current FY23 is our first year taking on this endeavor.