Joint City-County Commission Agenda

January 30, 2024
5:30 PM
City – County Complex, Community Room

Access Information – Call in information 571-748-4021 ID 3047645#
***Please mute your phone unless you are speaking. Dial *6 to unmute*.**
You may also attend/participate in the meeting at https://gomeet.com/parkcountycommission

---

1. Call to Order

2. Roll Call

3. Public Comment
   Individuals are reminded that public comments should be limited to item over which the City Commission has supervision, control jurisdiction, or advisory power (MCA 2-3-202)
4. Consent Items

5. Proclamations

6. Scheduled Public Comment

7. Action Items

   A. DISCUSSION BETWEEN CITY AND COUNTY COMMISSIONERS AND THE CRISIS COALITION ABOUT FUNDING FOR THE SUSTAINABILITY OF THE MOBILE CRISIS RESPONSE TEAM.

8. City Manager Comment

9. City Commission Comments

10. Adjournment

Calendar of Events

Supplemental Material

Notice

- Public Comment: The public can speak about an item on the agenda during discussion of that item by coming up to the table or podium, signing-in, and then waiting to be recognized by the Chairman. Individuals are reminded that public comments should be limited to items over which the City Commission has supervision, control, jurisdiction, or advisory power (MCA 2-3-202).

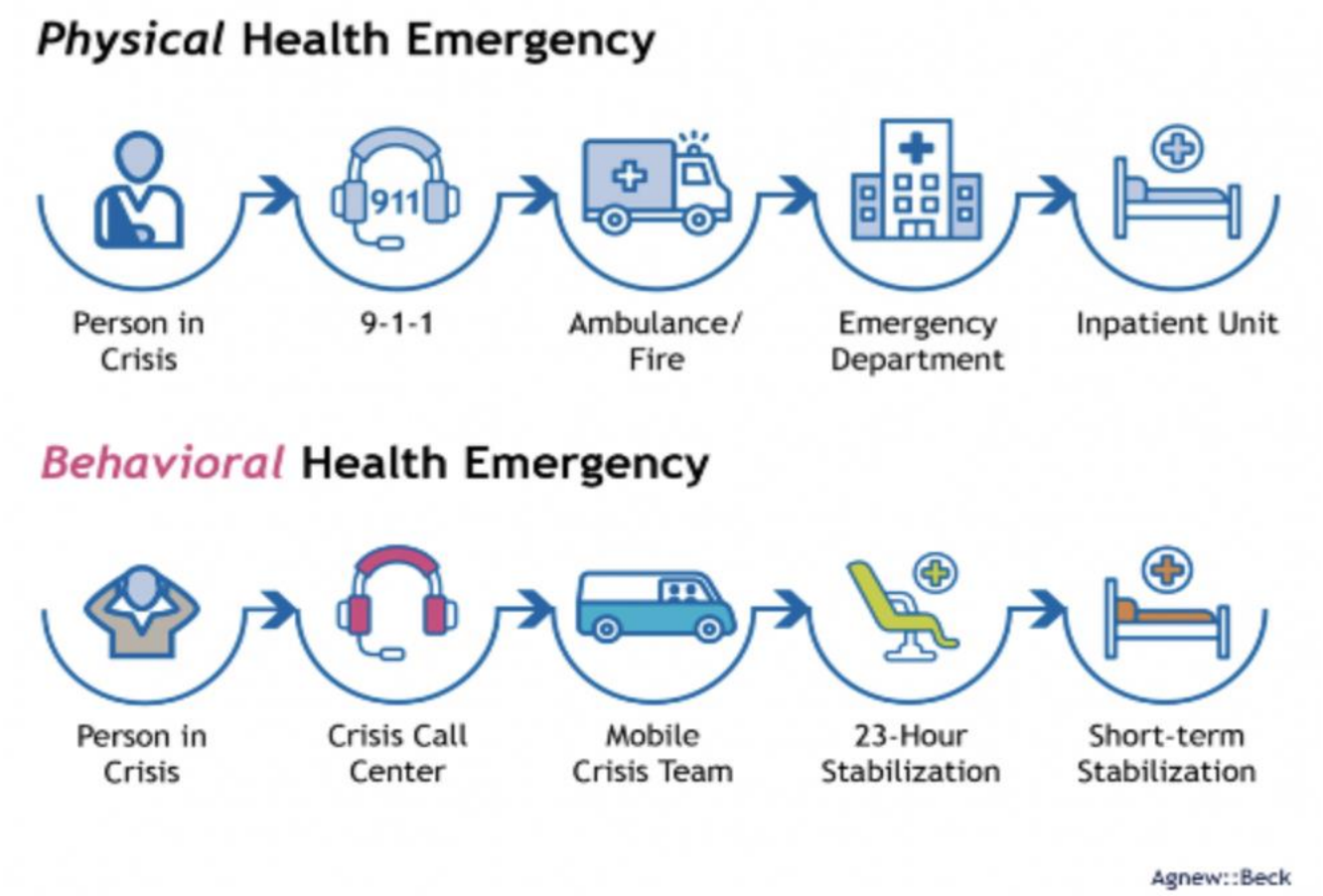
- Meeting Recording: An audio and/or video recording of the meeting, or any portion thereof, may be purchased by contacting the City Administration. The City does not warrant the audio and/or video recording as to content, quality, or clarity.

- Special Accommodation: If you need special accommodations to attend or participate in our meeting, please contact the Fire Department at least 24 hours in advance of the specific meeting you are planning on attending.

File Attachments for Item:

A. DISCUSSION BETWEEN CITY AND COUNTY COMMISSIONERS AND THE CRISIS COALITION ABOUT FUNDING FOR THE SUSTAINABILITY OF THE MOBILE CRISIS RESPONSE TEAM.

Crisis Now Continuum



The Crisis Now model has been informing efforts by the Behavioral Health Crisis Coalition in Park County, to ensure individual access to effective crisis care. The goal of Crisis Now is to develop a continuum of crisis care services that match people's clinical needs by providing immediate and targeted support.

Components of the model are intended to prevent suicide, reduce the inappropriate use of emergency rooms, correctional settings, and provide the best supports for individuals in crisis. This includes: (a) A regional or statewide crisis call center that coordinates in real time with the other components; (b) Centrally deployed, mobile crisis teams (ideally, a clinician and a peer) to respond in-person to individuals in crisis; and (c) 23-hour receiving center and short-term stabilization center, (which may be operated separately or jointly); offering a safe, supportive and appropriate behavioral health crisis placement for those who cannot be stabilized by call center clinicians or mobile crisis team response.

Introduction

The purpose of this brief is to educate decision-makers in Park County and community members on the history of the mission and work of the Park County Behavioral Health Crisis Response Coalition, and to present our recommendations on how together we can enhance crisis care and response to our local community.

Problem Statement

MT DPHHS data show that adults and youth in Montana experiencing behavioral health crises do not have sufficient access to appropriate crisis resources. **The Crisis Now Model, considered a national best practice, highlights the importance of having a crisis system that includes access to the following three services: someone to call (988), someone to respond (Mobile Crisis Response), and somewhere to go (Crisis Receiving and Stabilization).**

All Montanans currently have access to someone to call following the state's roll out of 9-8-8 in October of 2022. However, not all can access the remaining two services outlined in the Crisis Now Model. Those individuals rely on less effective interventions and burden law enforcement and emergency medical service resources. Both Mobile Crisis Response (MCR) and Crisis Receiving and Stabilization (CRS) services will now be Medicaid billable services, but new and existing MCR/CRS programs face fiscal challenges arising from unpredictable client need. One of the main challenges is the requirement for additional investment in funding these projects.

On the local level, Park County has elevated rates of behavioral health concerns and crises compared to other communities in Montana.

- Just over 25% of adults report excessive drinking, compared to only 19% nationally as a whole.
- One in four adults have been diagnosed with depression, compared to only one in five in Montana and the US.
- Park County faces a higher rate of suicide when compared to state and national benchmarks. The age-adjusted suicide mortality rate in Park County was 41.8 per 100,000 residents from 2018-2021 which is three times the rate observed in the US and 1.5 times higher than the statewide rate.

Driven by high rates of behavioral health concerns, community partners in Park County are committed to building a more robust behavioral health crisis system that does not criminalize mental health and substance use issues, but builds pathways to appropriate, behavioral health crisis care that links individuals to community based behavioral health supports for follow up post-crisis.

Purpose of Meeting

The Park County Behavioral Health Crisis response Coalition goal is to review the Coalition's programmatic goals for 2024-2026 with the local Commission members. The Coalition's top priority is the continued planning and expansion of the second component of the Crisis Now Model: a local Mobile Crisis Response Team (MCRT). Establishing a Mobile Crisis Response system was a top priority in the Sequential Intercept Mapping Session/Crisis Coalition Strategic Planning meeting held in 2021 and just recently in November 2023.

Our goal is to share the purpose of a mobile response team and implementation plans for instituting a crisis response team. Secondly, discuss the potential to Identify and allocate local financial resources needed to sustain a Mobile Crisis Response Team as recommended by Substance Abuse Mental Health Services

Administration (SAMHSA) National Guidelines for Behavioral Health Crisis Care Best Practice Tool Kit and the Montana DPHHS Mobile Response and Stabilization Services (MRSS) Policies for adults and youth.

The City of Livingston has expressed its desire to help fund the project. The Coalition has been working with Livingston Fire and Rescue, which has expressed an ardent desire to house and operate the MCRT and be the formal mobile crisis provider.

As the Coalition prepares to apply for a new grant award, we want to concentrate on improving our response efforts to individuals in a behavioral health crisis. Our vision is to increase linkages to appropriate stabilization and recovery services while minimizing involvement of the law enforcement, criminal justice, hospitals, and emergency response systems

PARK COUNTY CRISIS RESPONSE COALITION BACKGROUND

THE PLANNING AND DEVELOPMENT OF PARK COUNTY CRISIS RESPONSE COALITION

The Park County Behavioral Health and Crisis Response Coalition, comprising eleven local organizations and twenty-eight individual stakeholders, was established in 2021. The 2021 County Tribal Matching Grant funded the formation of the county-level planning coalition to guide and make progress in the design and implementation of crisis services in Park County. Overseen by DPPH/BHDD, the funds provided local community grants; to support capacity building for crisis response delivery services. The Coalition was charged with focusing on developing a robust, community-based behavioral health system that diverts individuals from the Montana State Hospital, jail or the emergency department and instead assesses, de-escalates, and stabilizes individuals in the community whenever possible and in the least restrictive and most supportive environment possible.

In 2022 Montana Health Care Foundation funded the Behavioral Health Peer Support Specialist (BHPSS) to assist law enforcement and mental health agencies in supporting individuals with mental health crisis and to be part of the crisis response team. Coalition members create infrastructure to incorporate BHPSS into Park County Sheriff's Office. The Peer Specialist role was designed to co-respond with law enforcement once scene is deemed safe to provide non-clinical assistance to individuals in crisis using live experienced to build rapport, de-escalate and stabilize the individual on scene.

In January of 2023 Park County was again awarded an 18-month Crisis Diversion grant (CDG) to continue funding the creation and implementation of a robust crisis response system. Projects and services that qualified for funding included infrastructure, crisis staff, Crisis Intervention Training (CIT), community crisis planning, and mobile crisis teams.

The Crisis Coalition is working with CIT Montana to implement CIT Academy. Coalition Members Janella Johnson, behavioral health clinician and Livingston Police Officer Dan Lashinski are certified CIT Coordinators. The CIT Academy is to be held this spring.

As the Coalition begins preparing to apply for the upcoming Crisis Diversion Grant (CDG), we need to repurpose our current Mobile Crisis Team to adapt to changes to CDG funding for Mobile Crisis. As part of the state plan, mobile crisis providers will bill Medicaid for mobile crisis services and the GDG funds will no longer

be utilized to support mobile crisis service operations. The changes in funding source could affect mobile crisis providers, who are justifiably concerned Medicaid billing will not cover the cost of operations.

The goal now is to implement a complete team that meets the provider service requirements of Mobile Crisis Response Services, as outline in the Montana Medicaid Manual. A MCRT must now provide coverage every day of the year with at least one team member which must include a mental health professional (MHP). **In the Crisis Now model, law enforcement officers are not members of the MCRT.** Our MCRT program currently operating in Park County does not meet the Crisis Now standards or MTDPHHS standards.

Utilization trends estimate that a local program will not deliver the number of encounters needed to sustain the service through Medicaid reimbursement alone. The Park County Behavioral Crisis Response Coalition is seeking City of Livingston and Park County Commissioners to consider appropriating funds to support the operations of a Park County Mobile Crisis Response not entirely covered through Medicaid.

This past fall, the Coalition held discussions with City of Livingston Fire Department, regarding the prospects of transitioning the mobile crisis response team to the fire department. There is clear momentum and commitment from the City of Livingston to continue to build and improve our crisis response services. The department will be able to take advantage of the Peer Specialist services and utilize Community RN embedded with ambulance and fire unit to contribute to operating a MCRT.

Goal of Implementing a Mobile Crisis Response Team

The Park County Crisis Coalition is committed to implementing nationwide best practices for crisis care in alignment with Substance Abuse Mental Health Services Administration (SAMHSA) National Guidelines for Behavioral Health Crisis Care Best Practice Tool Kit and the Montana DPHHS Mobile Response and Stabilization Services (MRSS) Policies for adults and youth in Park County.

Scope

Mobile crisis response (MCR) services must be provided in the community, outside of a hospital, jail, or other facility setting to individuals in need every day of the year. Services must be delivered in-person; when furnished by a mobile crisis team, the responding team must have at least one team member responding in-person. One Team member may respond via telehealth and must remain connected throughout the duration of the response. **In the Crisis Now model, law enforcement officers are not members of the MCRT**

Keys to Success

- Triage/screening/assessment, including explicit screening for suicidality and risk of harm to others
- Respond without law enforcement accompaniment, unless special circumstances warrant inclusion, to support true justice system diversion
- Reduce the use of emergency departments
- Assessing for risk and opportunities to resolve the crisis in the least restrictive setting
- Developmentally appropriate de-escalation/resolution
- Peer support
- Coordination with medical and behavioral health services (arrangement of Mobile Crisis Care Coordination Services with referrals to health, social, and other services and supports)
- Crisis planning and follow-up

Minimum requirements and mobile crisis team standards

This section of the report offers an overview of Mobile Crisis Teams

(MCT) models which need to be applied.
1. Are a minimum of a one -person team comprised of at least a licensed behavioral health professional, (i.e., counselor, psychologist, social worker, advanced practice registered nurse, physician assistant with clinical psychiatric specialty).
2. Respond in the community, seven days a week, 365 days a year).
3. Is dispatched to respond, intervene, assess, and de-escalate crisis events on-scene to a range of behavioral health related crisis calls entailing psychiatric, social and/or emotional stressors, familial relations, conflicts, safety and welfare, substance use, and suicidality.
4. Engages, reconnects, refers, and links people in crisis to behavioral health support, services and treatment based on on-scene assessment.
5. Provides/arranges transportation to a secondary location as indicated.
6. Provides follow-up to the initial response.

Composition of the team is paramount to the Crisis Now model. When operating within the model standards, the team is comprised of highly trained behavioral health professionals and optimally paraprofessionals (including Peer Specialists) who collaborate with other behavioral health specialists or medical providers.

Mobile Crisis Response services must be available to individuals experiencing a behavioral health crisis. Services should be provided in person for youth and for adults. A trained staff should remain, in person, with the individual in crisis to provide stabilization and support until the crisis is resolved or referral to another service is accomplished. **Minimally, the responding service must be delivered by one clinical mental health professional,** licensed under Title 37, MCA, who is qualified to provide a biopsychosocial assessment within the authorized scope of practice.

Two Mobile Crisis Models

A). Team Model: One mental health professional and one paraprofessional. One Team Member must respond on-site. One team member may respond via telehealth and must remain connected throughout the duration of the response.

B. Individual Responder: Mental health Professional is the sole responder

Overall team composition can be flexible based on regional need and staff availability. Each team shall have a mental health professional (MHP) available during hours of operation for clinical consultation. The consulting MHP can be an on-call model. At the discretion of the provider, teams may also include other professional or paraprofessionals with expertise in developmentally appropriate behavioral health crisis intervention.

Location of Services

Mobile crisis response services should be provided wherever the individual in need is in Park Couty. The team will assess risk and opportunities to resolve the crisis in the least restrictive setting.

Mobile crisis response services reduce the need for and the use of law enforcement, other first responders, and emergency departments.

Availability

Mobile crisis response services must be available, every day of the year, and be able to respond to a crisis within the following times of dispatch within 2 hours for rural/frontier areas and one hour for urban areas.

All members of the team must be trained in trauma-informed care, de-escalation strategies, and harm reduction.

Mobile Crisis Care Coordination

An important focus for mobile crisis response teams will be identifying and addressing the recovery needs of individuals served by the MCRT, by providing crisis planning and linking clients with needed social, medical, and behavioral health services that can help resolve the current crisis and help prevent a return to a crisis state in the future.

How funds received from local sources will be used to support the Park County MCRT

services housed in the City of Livingston Fire Department

1. Staff roles and descriptions

Below is an outline of staffing expectations for mobile crisis teams. Teams have flexibility in overall team composition.

1.0 FTE Team Lead/Program Manager

Manages the mobile crisis response team and be the administrative supervisor for the mobile crisis response team staff. Supplies supervision and oversight of the mobile response teams. Is responsible to ensure the service provided by the team meets medical necessity, is clinically appropriate, and meets all state necessary requirements. This position could be a Mental Health Professional but not a requirement. **Mental Health Professional** means: A psychiatrist, psychologist, an advanced practice registered nurse, with a clinical specialty in psychiatric mental health nursing, a social worker social, a professional counselor or a marriage and family therapist according to MCA/Title 37.

Mental Health Professional a required team member, qualified to provide a biopsychosocial assessment to community members experiencing a behavioral health crisis. Based on the Mobile Crisis Response Model adopted, total annual hours for mental health professionals would vary minimally from 3,650 hours to a maximum of 8,760. This is a contractual position with more than one provider or alternatively a contract for a remote service.

Paraprofessional, or Certified Behavioral Health Peer Support Specialist. A peer support specialist provides peer support to a person in crisis with the focus of building trust, rapport, and helping the person in crisis feel heard and understood while crisis services work to resolve the crisis or find the next steps to resolve the crisis. Incorporating peers into mobile crisis response teams can provide the individual in crisis with someone to relate to who has their own experience with behavioral health symptoms and the crisis system. Peers should focus on building rapport, sharing experiences, and strengthening engagement. They may also engage family members or other natural supports to provide ideas around self-care and providing support.

0.5 Mobile Crisis Care Coordination. Members who receive Mobile Crisis Response Services require a referral to outpatient care; or follow-up care coordination to connect with ongoing services**.**

Mobile Crisis Response Team Estimated Labor Cost based on the Medicaid tiered models

Mobile Crisis Response Services				Model 1	Model II	Model III	Model IV
I. Labor Cost							
				24/7 **Mobile Crisis Team Model** : 1 mental health professional and one paraprofessional. One team mmember must respond on-site.	24/7 Mobile Crisis Deliverd by an individual responder. Mental Health Professional is the sole reponder	10/7 **Mobile Crisis Team Model**	10/7 **Mobile Crisis Team without Paraprofessional**
			Hours	24	24	10	10
		a.	Hourly Wage	$39.80	$39.80	$39.80	$39.80
		b.	Annual Wage	$82,785.66	$82,785.66	$82,785.66	$82,785.66
Program Manager (1 FTE)		c.	ERE (as Percent of Wages)	25.00%	25.00%	25.00%	25.00%
		d.	Hourly Compensation (Wages + ERE)	$49.75	$49.75	$49.75	$49.75
			FTE Assumption	1	1	1	1
		e.	Annual Compensation (Wages + ERE)	$103,480.00	$103,480.00	$103,480.00	$103,480.00
		a.	On-Call Wage	$8.33/Per Hour Compensation	$8.33/Per Hour Compensation	$8.33/Per Hour Compensation	$8.33/Per Hour Compensation
Clinical Mental Health Professional	Licensed Clinical Social Worker (LCSW)		Total Annual On Call Hours	8,556	8,556	3,446	3,446
			Total On Call Cost	$71,271.48	$71,271.48	$28,705.18	$28,705.18
		b.	Hourly Response Wage	$30/Per hour Compensation	$30/Per hour Compensation	$30/Per hour Compensation	$30/Per hour Compensation
			Total Respons Hours (Baed on 17 responses per month/204 annual cases per year each at 1 hour of response time	204	204	204	204
			Total Response Cost	$6,120.00	$6,120.00	$6,120.00	$6,120.00
		c.	Total Annual Compensation	$77,391.48	$77,391.48	$34,825.00	$34,825.00
		a.	On-Call Wage	4.17/Per Hour Compensation		4.17/Per Hour Compensation	
Paraprofessional, or Certified Behavioral Health Peer Support Specialist	Behavioral Specialist/Technic ian		Total Annual On Call Hours	8,556		3,432	
			Total On Call Cost	$35,678.52		$14,311.44	
		b.	Hourly Response Rate	$20/Per Hour Compensation		$20/Per Hour Compensation	
			Total Respons Hours (Based on 17 responses per month/204 annual cases per year each at 1 hour of response time	204.00		204.00	
			Total Response Cost	$4,080.00		$4,080.00	
		c.	Total Annual Compensation	$39,759		$18,391	
Care Coordination		a.	Hourly Wage	$22	$22	$22	$22
		b.	Annual Wage	$22,880	$22,880	$22,880	$22,880
		c.	ERE (as Percent of Wages)	25%	25%	25%	25%
		d.	Hourly Compensation (Wages + ERE)	$27.50	$27.50	$27.50	$27.50
			FTE Assumption	0.50	0.50	0.50	0.50
		e.	Total Annual Compensation	$28,600.00	$28,600.00	$28,600.00	$28,600.00
Total Labor Cost				$249,230.48	$209,471.48	$185,296.00	$166,907.07
II. Potential revenue for mobile crisis response services							
Response				Description	Description	Description	Description
				UNIT RATE	RATE TBD	Unit Rate	Unit Rate
				15 min $113.18		15 min 75.18	15 min 47.72
Total Respone Revenue				$92,355	$92,355	61,346.88	61,346.88
Care Coordination				Unit RATE	Unit RATE	Unit RATE	Unit RATE
				15 Min $14.09	15 Min $14.09	15 Min $14.09	15 Min $14.09
Total Care Coorination Revenue				$2,874.36	$2,874.36	$2,874.36	$2,874.36
Total MCRT Revenue				95,229.24	95,229.24	$64,221.24	64,221.24
Variance				$156,875.00	$114,244.31	$121,076.83	$102,685.83