

December 2025

Blaine County Crisis Response System Final Report



Prepared for:
Blaine County Mental Well-Being Initiative

Prepared by:
Third Horizon



Table of Contents

Background.....	3
Methodology	5
Limitations	7
Crisis Stabilization Needs Assessment Findings.....	8
Emergency Department and 911 Call Center Data Analysis	8
Key Takeaways from Crisis Data Analysis	14
Communities for Youth Survey	14
Behavioral Health Provider Survey	14
Behavioral Health Community Survey	14
Stakeholder Engagement	17
“Someone to Call”	21
“Someone to Respond”	27
“Somewhere to Go”	30
Key Themes From the Case Studies	30
Facility Model Scenarios and Feasibility	32
Development and Funding Strategy.....	36
Understanding of the Current Policy and Funding Environment	36
Financial Analysis of “Place to Go” Models	36
Expenses	36
Revenues	38
Final Recommendation for “A Place to Go”	40
Stakeholder Collaboration and System Integration Plan	41
Conclusion	42
Appendices	43

Background

The Blaine County Mental Well-Being Initiative (MWBI) seeks to grow an integrated mental health and well-being ecosystem that improves the lives of all people in the community. The MWBI is a collaboration of over 50 partners¹—including local government, health care, nonprofit, education, business, and religious organizations—working to achieve a shared vision. With support from the St. Luke’s Wood River Foundation, the MWBI incorporated as a 501 (c)(3) nonprofit organization in 2025 to serve as a “backbone organization” to facilitate and support these efforts.

The MWBI is working to develop a sustainable, outcomes-focused behavioral health crisis system that reflects national best practices while tailored to appropriately meet the unique needs, assets, and constraints of a mountain resort community. In March 2025, the MWBI contracted Third Horizon, a strategic health care advisory firm with deep behavioral health systems design and implementation expertise, to help build and strengthen the crisis system infrastructure.

Third Horizon is a strategic, boutique advisory firm focused on designing integrated health and social systems so all communities, families, and individuals can thrive. Through its work across three advisory areas – [behavioral health](#), [community health](#), and [payment design and analytics](#) – the firm offers a 360° view of complex challenges across three horizons (past, present, and future) to help industry leaders and policymakers interpret signals and trends and develop upstream innovations, strategies, and structural changes that maximize the value of the yearly spend on health care.

The firm’s scope of work included:

- Analyzing local crisis data to help inform strategic planning efforts
- Developing a comprehensive mobile crisis response operational plan
- Assessing the feasibility of crisis stabilization settings that complement the mobile response system, including program and facility models, and financial viability
- Designing a coordinated care model that enhances continuity of care beyond the initial crisis intervention.

Third Horizon provided subject matter expertise, data analytics, research, and facilitation of multi-stakeholder engagement sessions, all designed to help the MWBI and its partners assess community needs and determine bold yet realistic and sustainable options for enhanced service delivery.

This report serves as the culmination of the 9-month planning process. It offers strategic recommendations for the MWBI and its partners to expand access to behavioral health crisis and treatment services while improving the overall mental well-being of Blaine County residents.

¹ Initiative community pledged partners as of December, 2025 include:

- **Nonprofits:** St. Luke's Wood River Foundation, Spur Community Foundation, The Hunger Coalition, Love Like Ky, Wood River Community YMCA, The Crisis Hotline, Blaine County Education Foundation, Far + Wise, The Advocates, The Space, Just Serve, Higher Ground, Flourish Foundation, The Alliance of Idaho, National Alliance on Mental Illness WRV, The Community Library, Men's Second Chance Living, Sawtooth Botanical Garden, BCFIRST, Argyros Performing Arts Center, Swiftsure Ranch, Sun Valley Ski Education Foundation, Wood River Pickleball Alliance
- **Healthcare:** St. Luke's Wood River, Family Health Services, KH Counseling, Alpine Integrative Wellness, Sun Valley Ketamine Clinic, Flow State Psychotherapy, Resiliency Rising, Carbonate Recovery Center, St. Luke's Wood River Community Board, Ellie Newman Coaching, South Central Public Health District
- **Government:** Blaine County, Blaine County Prosecuting Attorney's Office, Blaine County Sheriff's Department, Blaine County Recreation District, Hailey Public Library, Hailey Fire Department, Hailey Police Department, City of Ketchum
- **Education:** Blaine County School District, The Sage School, Pioneer Montessori School, Seed Mother
- **Faith-based:** Wood River Interfaith Council, Light on the Mountains Center for Spiritual Living
- **Businesses:** Sun Valley Company, IdaYoga
- **Collaborations:** 5B Suicide Prevention Alliance, 5B Digital Wellness Network, Wood River Early Learning Collaborative, Communities for Youth
- **Individuals:** Rene Smey, Tom Poole, Laurie Strand



Methodology

Third Horizon's overall approach was guided by the Substance Abuse and Mental Health Services Administration's [2025 Guidelines for a Behavioral Health Coordinated System of Crisis Care](#) (SAMHSA BHCSCC).

The essential elements of a BHCSCC include:



Someone to Call: Services like the 988 Suicide and Crisis Lifeline and other hotlines fulfill a crucial role by offering free and easily accessible support to individuals experiencing an acute crisis, those facing barriers to accessing behavioral health care, and/or people who support help seekers.



Someone to Respond: Mobile crisis services deliver rapid, on-site interventions to de-escalate crises and connect individuals to care and other community-based support services. SAMHSA describes a variety of models, including mobile crisis teams, co-response teams, and community outreach teams.



A Safe Place for Help: A.K.A. "somewhere to go": A range of models and care to support individuals through emergent and urgent behavioral health needs, typically involving a physical location offering crisis stabilization and services on demand. SAMHSA notes that coordination for follow-up care is "particularly crucial for emergency and crisis stabilization. Since these services are typically time-limited and facility-based, participants' continued progress is dependent on coordinated follow-up care."

SAMHSA encourages strong coordination across the three elements and with other behavioral health and community-based services in a community. The guidelines indicate that to realize the vision of a robust, high-quality BHSCC, communities should ensure that individuals have access to each of the three essential elements of behavioral health crisis care. In addition, providers, system partners, and payers should collaborate to ensure coordination of services and that system components are accountable for effective crisis response in communities.

SAMHSA encourages strong coordination across the three elements and with other behavioral health and community-based services in a community.

While SAMHSA's guidelines helped inform the planning process, Third Horizon and the MWBI recognized the importance of tailoring interventions to meet the unique characteristics of Blaine County, including local needs, available resources, and geography.

The project team employed a mixed-methods approach to the engagement.

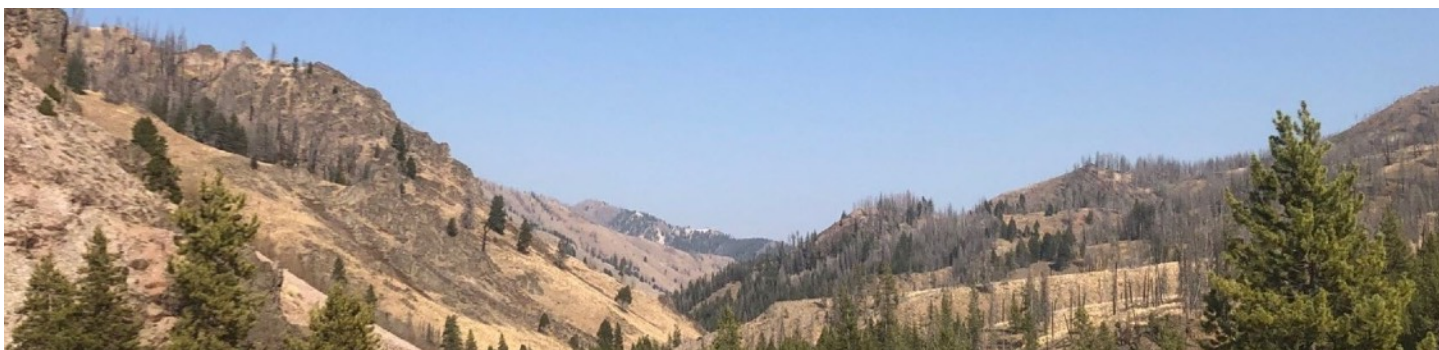
This included:

- **Discovery:** The project team examined historical MWBI documents and had extensive dialogue with MWBI leadership. Third Horizon also researched Idaho’s behavioral health and crisis services landscape, including the Idaho Department of Health and Welfare [2025 Medicaid Overview](#) and State Plan, the state’s contract with Magellan, [Medicaid minimum requirements for crisis centers](#), and state level efforts related to Certified Community Behavioral Health Clinics (CCBHCs).
- **Literature review:** Third Horizon researched publicly available information on evidence-based practices, national guidelines, federal and state of Idaho policy, funding related to behavioral health, and crisis services in other states and communities (particularly the mountain west and other relevant models). The project team gathered pertinent information from its extensive network, including connections made previously by the MWBI, as well as internet-based research. Additionally, Third Horizon utilized artificial intelligence (ChatGPT) solely for efficiency in gathering information. All data was fact-checked. AI did not replace the sound judgment, professionalism, and subject matter expertise of the Third Horizon team.
- **Stakeholder engagement:** The project team conducted extensive stakeholder engagement in alignment with the collective impact approach used by the MWBI. Activities included four focus groups with behavioral health providers, partner organizations, St. Luke’s staff, and county government, including law enforcement. Additionally, Third Horizon facilitated a one-day Prevention Planning Retreat, a one-day Behavioral Health Crisis Planning Retreat, a 90-minute meeting with crisis call center operators, and a one-day Place-to-Go Feasibility Planning Retreat to present research and preliminary recommendations to partners and stakeholders for input. The project team also held targeted one-on-one meetings with key individuals and organizations to gather more detailed input and to support planning for the group sessions. Lastly, Third Horizon facilitated virtual meetings with the MWBI workgroups.
- **Crisis data analysis:** Third Horizon analyzed crisis data from public safety and St. Luke’s to assess the current state of behavioral health crisis response.
- **Survey data analysis:** Third Horizon analyzed data from the Katz Amsterdam community survey and provider survey, as well as the Communities for Youth survey to understand community perceptions of needs and resources.
- **Analysis of operational feasibility:** Third Horizon applied its behavioral health system-level expertise and experience. The team assessed feasibility based on community needs, available resources, political will, and the level of readiness to adopt behavioral health crisis response models.
- **Financial Feasibility Analysis:** Third Horizon identified the expense and revenue implications of funding and maintaining a “place to go” model. Research on personnel expenses and facility costs was conducted using relevant publicly available information. Revenue options and billing guidance were

explored based on Magellan provider manuals and access to Third Horizon's commercial reimbursement rate sets. Third Horizon also conducted interviews with key stakeholders, including Magellan, St. Luke's, St. Luke's Wood River Foundation, Family Health Services, and Blaine County Government, focusing on funding sources and limitations. The findings from interviews and research were synthesized and presented at the November 12th retreat. Third Horizon provided initial utilization metrics (such as potential patient and visit volume) for future modeling considerations.

Limitations

- **Crisis data analysis:**
 - o Third Horizon relied on data provided under an agreement with St. Luke's Wood River, as well as data the MWBI had collected from the 911 call center. The firm did not engage in any primary data collection. Third Horizon also did not collect or analyze protected health information (PHI).
- **Survey data analysis:**
 - o All three of the surveys analyzed by Third Horizon were conducted before the firm was contracted by the MWBI. Analysts were not involved in developing the survey tools. The surveys did not ask respondents to break down data points by level of care. There was limited reference to substance use in the provider and community surveys.
- **Financial analysis:**
 - o **Pro Forma:** Third Horizon's scope of work did not include pro forma development. A pro forma financial statement uses hypothetical data or assumptions about future values to project performance and financial position over a period that hasn't yet occurred. To develop a pro forma for a service line and facility, analysts require facility, operating and personnel costs and means to project revenues. Third Horizon's financial analysis was intended to help the MWBI assess the feasibility of different models for "A Place to Go", rather than to implement one specific model. The firm recommends this as a next step in the process now that a model has been selected.
 - o **Claims:** Third Horizon's scope of work did not include a claims analysis, which limited the ability to fully understand the Medicaid, Medicare and commercial insurance landscape in Blaine County.



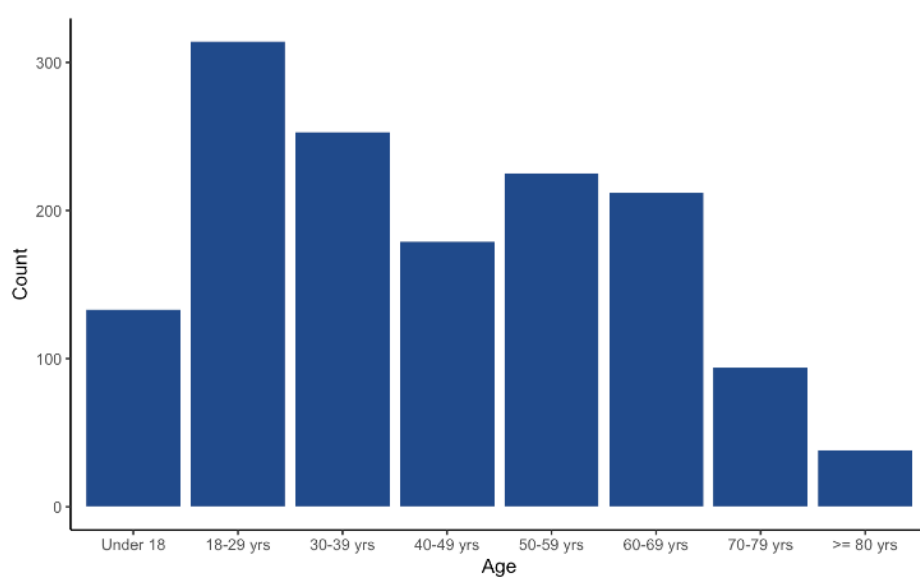
Crisis Stabilization Needs Assessment Findings

Emergency Department and 911 Call Center Data Analysis

Third Horizon analyzed aggregated data provided by St. Luke's Wood River Medical Center (SLWR). SLWR provided a data summary of all mental health and substance use (MH/SUD) related emergency department visits from January 2021 through October 20, 2025. There were 1,448 total MH/SUD emergency department visits in that time frame, or approximately one per day.

Twenty-one percent of patients identified as Hispanic or Latino, in line with the American Community Survey (ACS 2023) estimate of 21% for the total population of Blaine County. The patient population consisted of 55% males and 45% females. Figure 1 shows that the total number of visits is highest among individuals aged 18-29 years.

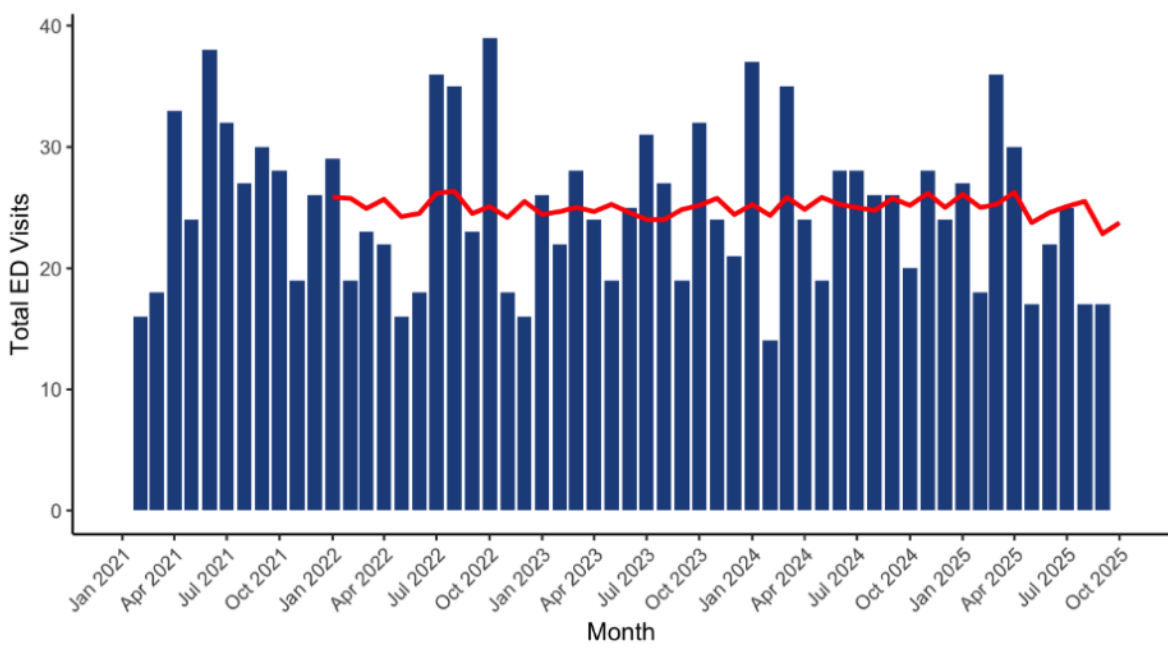
Figure 1 – SLWR MH/SUD ED visits by age group, Jan 2021 – Oct 2025



Thirty-eight percent (361/942) of individuals seen within this timeframe had multiple MH/SUD-related ED encounters. This suggests that there may be an opportunity to reduce overall volume in the ED department by managing avoidable visits through other forms of care. The data show that 40% of visits included referral to additional treatment.

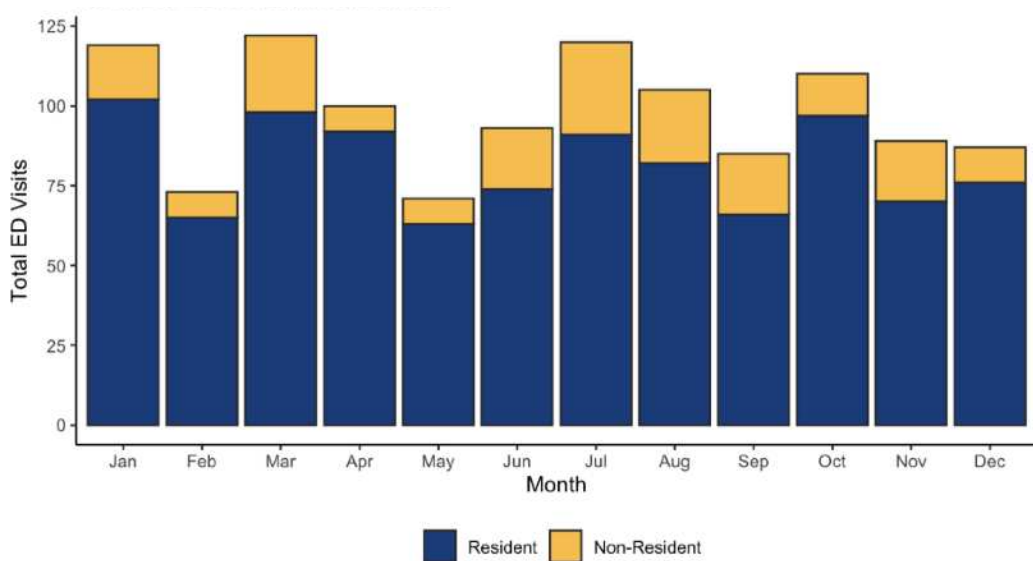
For emergency department visits with a mental health and/or SUD-related diagnosis, monthly totals from January 2021 through October 2025 show a flat trend with an average of 25 visits per month, or slightly less than one per day. See Figure 2.

Figure 2 - SLWR MH/SUD visits by month with trailing 12-month average, Jan 2021 - Oct 2025



There is some seasonality to mental health and SUD-related emergency department visits. Figure 3 shows that visits are highest in January, March, and July. This is partially driven by increased counts for non-residents.

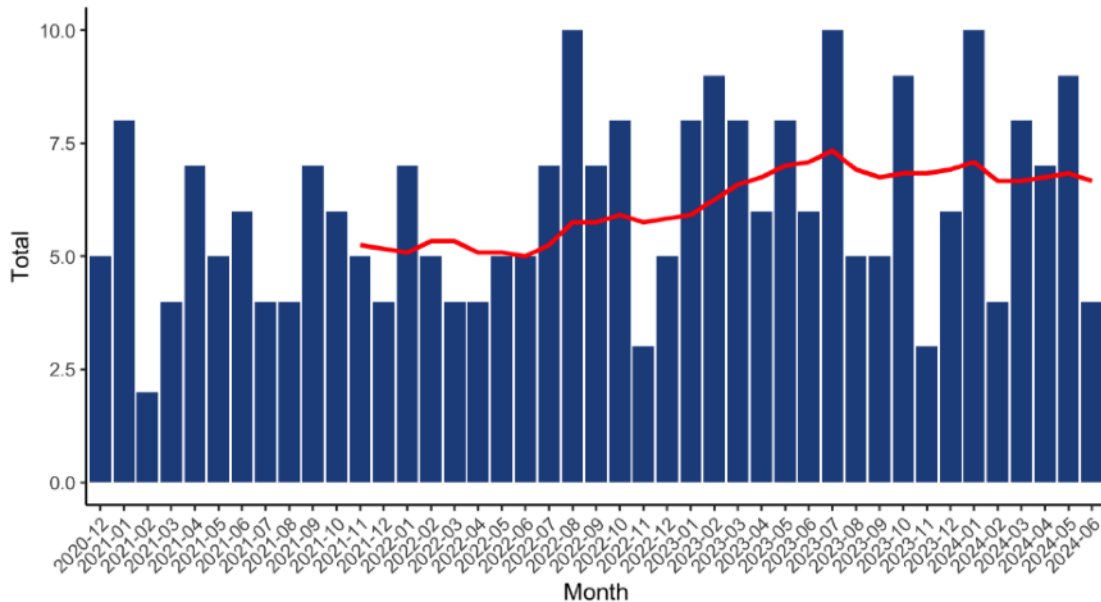
Figure 3 - SLWR MH/SUD ED visits by month, Nov 2021 - Oct 2025



Third Horizon recommends further investigation into the factors driving these fluctuations, such as whether they are primarily attributable to increases in alcohol-related incidents or other causes.

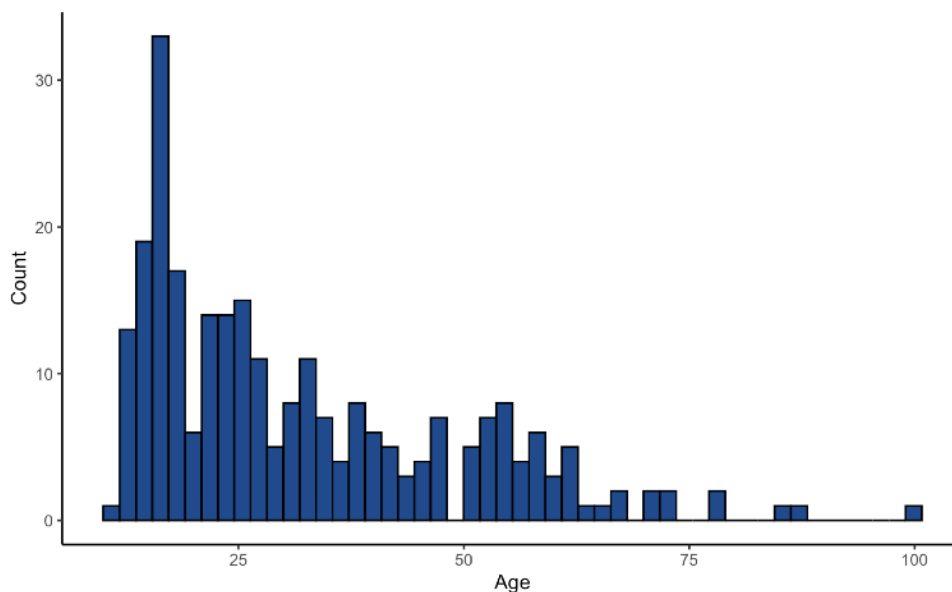
SLWR also provided data over a similar timeframe (Dec 2020 – Jun 2024) for a specific subset of mental health-related visits – those involving suicidal ideation and/or a component of intentional self-harm. Using a trailing 12-month average, Figure 4 shows these incidents increasing over time.

Figure 4 – SLWR ED visits for suicidal ideation and/or self-harm (Dec 2020 – Jun 2024)



Contrary to the overall MH/SUD numbers, 60% of these encounters were female. The age distribution was also skewed towards younger individuals. The median age was 26, meaning half of all visitors were under 26 years old. Figure 5 shows how visits for this group skew younger, with the highest prevalence for suicidal ideation/intentional self-harm being among 16-year-olds.

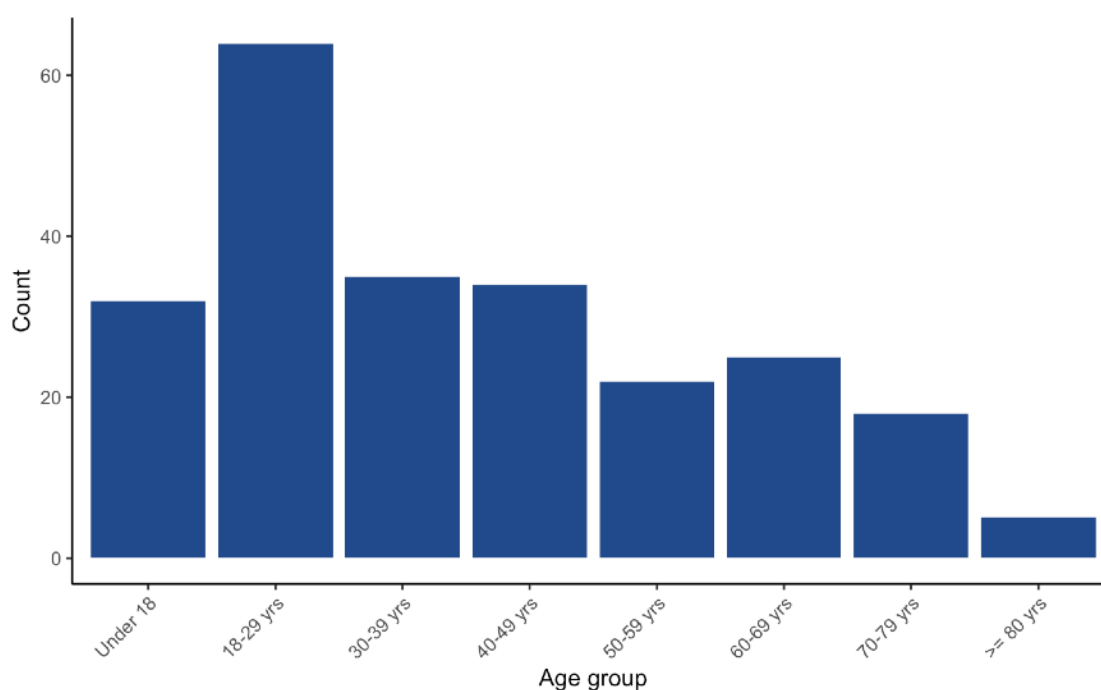
Figure 5 – Age distribution of SLWR ED visits for suicidal ideation and/or self-harm (Dec 2020 – Jun 2024)



An examination of the diagnoses in this data showed that 73% of visits were for suicidal thoughts/ideation, while 27% involved a component of intentional self-harm.

Third Horizon analyzed 911 crisis response dispatch data from Jan 2021 – May 2025. The data were narrowly defined to mental health crises only. Of the 274 crisis response incidents recorded in the data over this time period, ~70% included suicidal ideation and/or a suicide attempt. The data showed a similar pattern to the emergency department data with the most incidents among 18-29 year-olds (Figure 6).

Figure 6 – 911 Crisis Response Calls (Jan 2021 – May 2025)



Approximately half of the mental health crisis 911 calls required some sort of transport from the scene. Figure 7 shows the breakdown of incidents by transport status. Thirty-five observations were removed from this table for missing information.

Figure 7 – 911 Crisis Response Transport Status (Jan 2021 – May 2025)

Transport Status	Count	Share
Ambulance	85	36%
Law Enforcement	32	13%
Both	4	2%
Neither	118	49%

The 911 dispatches showed signs of seasonality, with the volume of incidents higher in summer months and on weekends (Thursday – Saturday). Figure 8 and Figure 9 show the breakdown of calls by month and day of week, respectively.

Figure 8 – Crisis Response calls by month (June 2021 – May 2025)

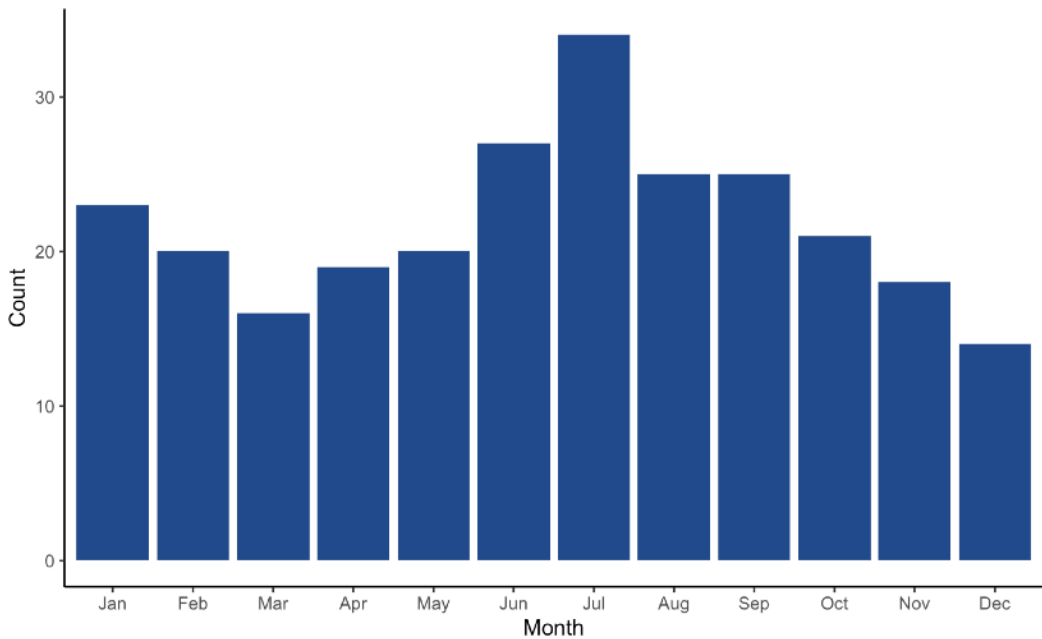
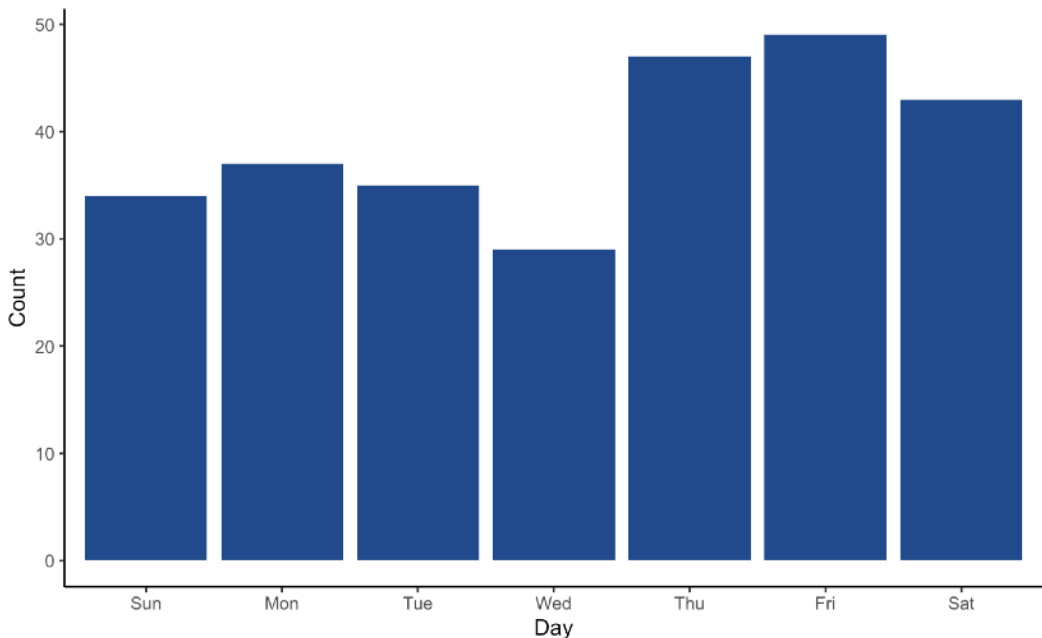
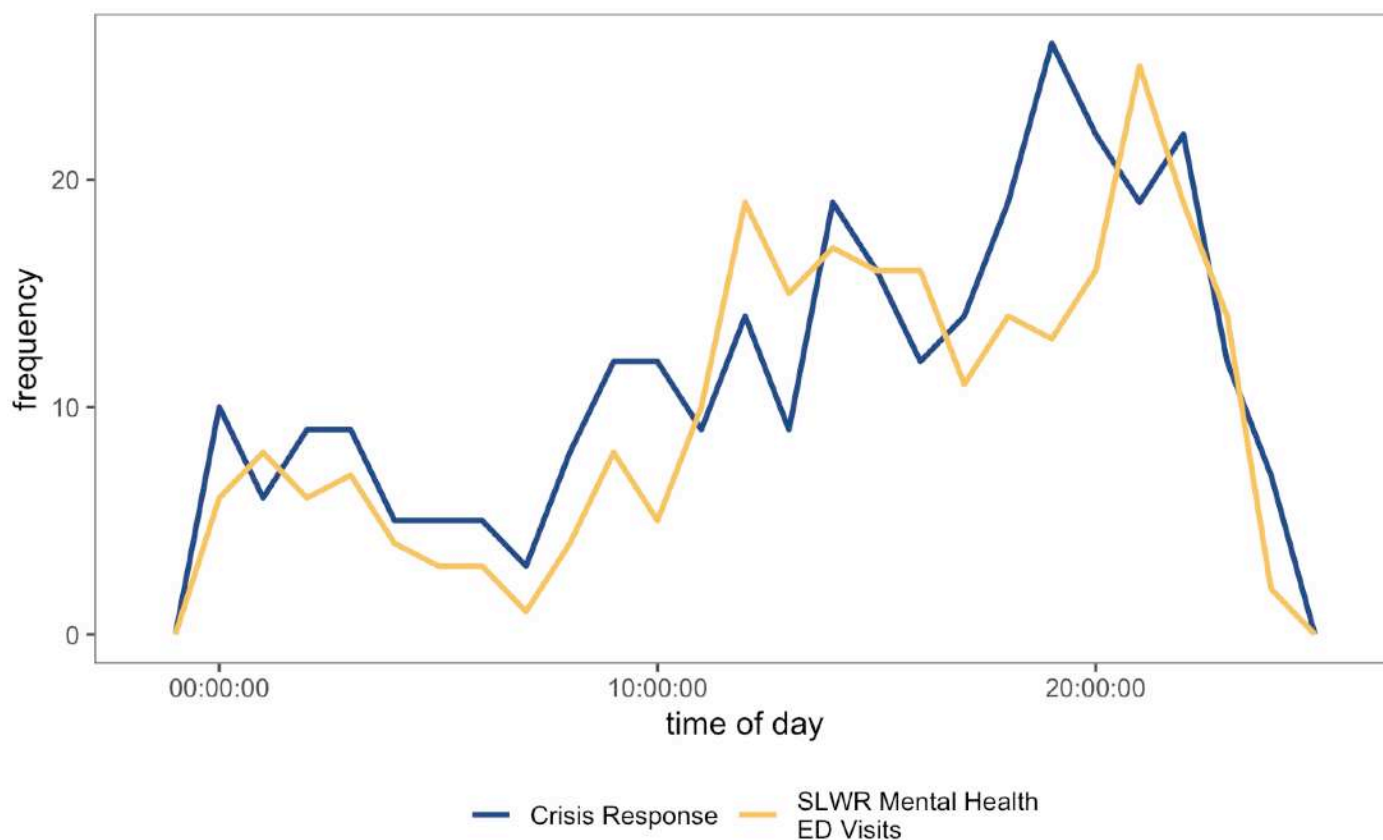


Figure 9 – Crisis Response calls by day of week (Jan 2021 – May 2025)



Both the 911 crisis response and SLWR suicidal ideation/self-harm data track closely regarding time of day. **The frequency plot in Figure 10 shows incidents rising throughout the day, with a peak between 7:00 p.m. and 10:00 p.m. This highlights a need to provide crisis intervention services during these peak hours.**

Figure 10 – Crisis Response and SLWR suicidal ideation/self-harm visits by time of day



The MWBI has been informed that 911 dispatch is working on enhancing its data collection for crisis response, specifically around identifying and classifying these incidents. Third Horizon recommends a thoughtful approach to collecting and monitoring this data. A primary goal of a co-responder program is to reduce the number of incidents in which individuals experiencing a behavioral health crisis are transported to jail or an emergency department by having a trained clinician-led team on the scene to help stabilize them and properly assess the required level of care.

The MWBI should also continue to monitor the volume of crisis responses and their impact on diversion from the Emergency Department. The SLWR ED data on suicidal ideation/self-harm shows how splitting data by presenting issue can open the door to new insights that can help inform community mental well-being. Third Horizon recommends that the MWBI maintain these data channels, especially while piloting this new model.

Key Takeaways from Crisis Data Analysis

1. The data indicate that while the overall behavioral health crisis trend line is flat when SUD is included, suicidal ideation and self-harm are increasing.
2. Young adults (ages 18–29) account for the highest share of both ED crisis visits and 911 behavioral-health dispatches, making this a key population for prevention, early intervention, and crisis alternatives.
3. Recurring crises highlight gaps in stabilization and follow-up. Thirty-eight percent of individuals had multiple MH/SUD ED encounters, and 40% of crisis visits included a referral to additional treatment — signaling a need for stronger diversion and post-crisis connection to care. Third Horizon did not have access to data on the number of people who accessed services after being referred to treatment.
4. The frequency of behavioral health crises tends to rise throughout the day, with peak hours between 7:00pm and 10:00pm.
5. Suicide-related crises skew younger and more female. In suicidal-ideation/self-harm ED data, the median age is 26, the most common age is 16, and 60% of encounters are female.
6. Third Horizon recommends that the MWBI and its partners continue to refine data collection processes and review the longitudinal data to gauge the impacts of new behavioral health interventions.

Communities for Youth Survey

Third Horizon reviewed data from a school-based youth well-being survey as part of the Communities for Youth Blaine County Initiative, measuring risk and protective factors tied to mental health, substance use, and social connection among students in grades 6–12. The most recent administration occurred in November 2024 in the Blaine County School District, with 1196 or 68% of students responding.

Behavioral Health Provider Survey

The project team also reviewed data from the provider survey developed by PRC and the Katz-Amsterdam Foundation. This focused survey engaging mental health providers serving Blaine County is designed to understand provider capacity, service gaps, and challenges in delivering care. Data were collected over a three-week period in 2025 from 57% (91 out of 161) of eligible local providers.

Behavioral Health Community Survey

Finally, Third Horizon reviewed the results of a community survey developed by PRC and the Katz-Amsterdam Foundation. This was a countywide survey of adults who live or work in Blaine County to assess community connection, behavioral health needs, and barriers to care. A total of 1169 responses were gathered in 2025, combining random-sample phone/online household outreach with a broader open online survey promoted through community channels.

Third Horizon analyzed each of these three data sets with a particular eye to how they informed the behavioral health crisis planning process.

Blaine County residents and providers describe a community that is engaged and proud of where they live, while also experiencing significant behavioral health strain. In the 2025 PRC Community Engagement & Behavioral Health Survey, most respondents rated Blaine County as an excellent or very good place to live (76%). However, that positive rating is not evenly shared: older residents, higher-income residents, and White respondents view community life more favorably than very low-income, Hispanic, and younger residents. This gap in perceived quality of life is significant because it reflects where some behavioral health needs are most concentrated.

Loneliness and social isolation are significant, cross-cutting concerns, particularly for young people. About three in ten adults meet a loneliness threshold, with higher prevalence among younger adults, lower-income residents, Hispanic residents, LGBTQ+ residents, and those feeling less connected socially. Youth data mirror and intensify this pattern: 63% of students reported intermediate or high levels of social isolation, and isolation is strongly associated with higher depression scores. This data suggests a broad middle group of students who struggle with feelings of belonging and connection.

Substance use, particularly alcohol, emerges as both normalized and harmful. In the adult community survey, 73% agreed that alcohol is important to the social life of the community, and respondents noted the challenges of substance misuse in a resort context. Community impact is substantial: 68.5% of Blaine County adults reported that substance use has negatively affected their lives, far above the national benchmark of 45.4%. Of the 91 providers who responded to the 2025 survey, 24 of them (26%) listed “Substance Abuse Disorders” as an area of specialization. Forty-two % of respondents treat children (ages 0-11), and 60% treat adolescents (ages 12-17). However, it is essential to note that the PRC surveys did not distinguish between school counselors who focus on academic achievement and those who provide therapy. Third Horizon suggested a new question for next year’s survey to help Blaine County better understand its current service capacity in addressing youth behavioral health needs. Youth results indicate alcohol use is more prevalent at younger ages locally, reinforcing the need for prevention and early intervention. Respondents explicitly called for more normalization of discussing alcohol and drug challenges and more support for families and peers affected by use.

Finally, the service landscape shows real strengths but persistent gaps in affordability, crisis care, and youth-specific prevention. Most providers (77%) are accepting new patients, and many can see new clients within a week, but affordability and coverage barriers remain. About two-thirds accept commercial insurance, while only slightly more than one-third accepts Medicaid. Sliding-scale options are available but not universally offered. Unfortunately, PRC Survey data are not broken down by level of care or insurance status. So, Third Horizon does not have a line of sight as to whether wait times vary across those domains. More granular data would be beneficial in the future to assess community needs and capacity to meet those needs.

Providers identify crisis response, stabilization, and follow-up care as the largest service gap for people in acute need. Adults who needed services in the last year (36%) frequently cited cost and limited availability as the reasons they did not receive care. For youth, barriers are as much social as structural: “feeling awkward,” stigma, and uncertainty about how to find help remain top hurdles.

Key Takeaways from Survey Data

1. Blaine County is a strong and engaged community, but its benefits are experienced unevenly. Younger residents, Hispanic residents, and lower-income households report lower quality-of-life ratings and higher behavioral-health strain, signaling the need for targeted equity-focused supports.
2. Isolation is a significant risk factor, particularly for young people. With nearly two-thirds of students reporting intermediate/high isolation and clear links to depression, investments in school-based belonging, peer connection, and community youth programming are critical.
3. Alcohol norms and substance-use harms are both widespread. Prevention efforts need to focus on offering pro-social activities without alcohol and address social normalization of alcohol, youth drinking patterns, and the high proportion of adults affected by substance use in their lives. Increased access to trauma-informed therapy, peer support, and family resources may be beneficial.
4. Access is improving, but affordability and crisis care remain as weak points. Short wait times for many providers are a strength; however, gaps in Medicaid acceptance, a shortage of Spanish-speaking therapists, a perceived lack of affordability, and inadequate crisis response require coordinated system investment.



Stakeholder Engagement

The MWBI convenes more than 50 partner organizations working to achieve a shared vision: to make it possible for everyone in the community to achieve mental well-being. The MWBI did extensive work between 2023 and early 2025 to identify local needs, gaps, and priorities related to a behavioral health crisis response system. Third Horizon was contracted in early 2025 to provide recommendations for the best course of action to structure and operationalize a mental health crisis response system that addresses service gaps and ensures seamless care transitions for individuals in need. The project team began by reviewing all prior community input to ensure continuity and alignment with community and stakeholder feedback that had been previously shared. Third Horizon then built on these earlier conversations with more targeted discussions, sharing data and research findings, and synthesizing inputs from diverse stakeholders.

To inform the development of the county's crisis response system recommendations, Third Horizon conducted a comprehensive series of stakeholder engagement activities, engaging over 60 individuals across more than 30 organizations. These efforts were designed to capture perspectives from a broad cross-section of community partners, service providers, local government, and system stakeholders. Engagement included both group-based and individual discussions to ensure depth, relevance, and alignment with local priorities.



Stakeholder engagement activities included:

- **Introductory virtual meetings with the Prevention Workgroups and Crisis Response Workgroups** (April–August 2025) provided early input to shape both the mobile response model and the broader strategic planning process.
 - Meetings with the prevention workgroups (1&2) focused on refining its strategic vision by identifying clearer priorities, stronger communication and community engagement, and more structured accountability within the prevention ecosystem.
 - Meetings with the crisis response workgroups (3&4) concentrated on gathering insight for a mobile response model in Blaine County, sharing initial research, identifying additional research needs, and developing early recommendations for a clinician-led co-response model.
 - These sessions also enabled Third Horizon to build relationships with community stakeholders and deepen understanding of the county’s current crisis system environment.
- **Four virtual focus groups** (August–September 2025) with:
 - Behavioral health and social service providers
 - Community partners
 - Local government representatives
 - St. Luke’s leadership and staff
- **A one-day Prevention Planning Retreat** (September 2025), focused on identifying upstream opportunities to strengthen mental well-being and reduce crisis demand.
- **A one-day Behavioral Health Crisis Planning Retreat** (September 2025), centered on developing a shared understanding of crisis system needs, priorities, and system design considerations.
- **A 90-minute meeting with crisis call centers** (November 2025) to explore opportunities to improve coordination and define processes to deploy the newly forming Clinician-led Co-Response Team.
- **A one-day Place-to-Go Feasibility Planning Retreat** (November 2025), dedicated to evaluating options for a local “place to go” for adults and youth in behavioral health crisis.
- **Targeted one-on-one meetings** with key individuals and organizations. These conversations supported planning for group sessions and gathered detailed input on specific operational, policy, and system questions requiring deeper expertise.

Together, these engagement efforts provided the foundation for the recommendations and articulated vision presented in this report. Full meeting notes from all focus groups, retreats, and one-on-one discussions are included in the Appendix.



Across the various stakeholder engagement sessions, several consistent themes and priorities emerged. These insights reflect broad stakeholder consensus on the needs, gaps, and opportunities for strengthening behavioral health prevention and crisis response in Blaine County. Third Horizon's synthesis of stakeholder inputs included:

1. Commitment to Serving Both Youth and Adults

Stakeholders consistently emphasized the need to address behavioral health needs across the lifespan. There was strong interest in ensuring services are responsive to the most at-risk populations, including immigrants, LGBTQ individuals, people with very low incomes, and older adults.

2. Substance Use as a Critical Area of Concern

Participants identified alcohol and substance use—among both youth and adults—as a central community challenge requiring focused, coordinated strategies across prevention, early intervention, and treatment.

3. Leveraging and Strengthening Existing Community Resources

Stakeholders underscored the importance of building on current assets, improving coordination among service providers, and increasing awareness of available supports. Many advocated for a “scaffolding approach” that enhances and connects existing resources rather than creating entirely new, standalone structures.



4. Need for Greater Awareness and Education

Across groups, participants noted limited awareness of behavioral health resources—even among providers. Stakeholders emphasized the need for improved communication, education, and navigation support for community members, families, and system partners.

5. Importance of Care Coordination and Transitions

Participants highlighted significant challenges in supporting individuals after a behavioral health crisis. Strengthening care coordination, follow-up, and transition supports was identified as essential for improving outcomes and reducing repeat crises.

6. Refining Data to Guide Planning

Stakeholders expressed interest in more detailed data to inform decision-making, including levels of

care available locally and differences in access for Medicaid members, commercially insured residents, and uninsured community members. More granular information was viewed as valuable for ongoing planning.

7. Direction for a “Place to Go” Model

During the Feasibility Planning Retreat, the group reviewed four model options for a community “place to go” for individuals experiencing behavioral health crises. After evaluating operational, financial, and staffing considerations, stakeholders reached consensus to develop a Behavioral Health Hub that could potentially evolve into a CCBHC over time. See the “Place to Go” section for more details.





“Someone to Call”

The 2025 SAMHSA Guidelines emphasize that a comprehensive crisis system begins with ensuring there is always someone to call when individuals experience mental health or substance-use-related distress. Contact centers serve as free, safe, and immediately accessible points of support, and may include the 988 Suicide & Crisis Lifeline, other behavioral-health crisis hotlines, peer-operated warmlines, and emotional-support lines. Regardless of the model, crisis workers must be trained to support diverse behavioral-health needs across all age groups, including specialized training such as mandated reporting and developmentally appropriate de-escalation techniques for youth. These call centers must be tightly integrated with the broader crisis-care continuum, coordinating with other crisis lines, community providers, and 911, with clearly defined roles for situations that require law enforcement involvement.

Effective coordination is supported by having a dedicated local leader and champion who can convene partners, as well as formal agreements that reinforce collaboration. The guidelines highlight practices such as warm transfers—for example, 911 staff remaining on the line with a caller until a 988 crisis counselor answers and is briefed on the reason for the transfer—and coordination with local hotlines and warm lines. They also call for established protocols with local Mobile Crisis Teams and Co-Responder teams to support dispatch, referrals, and information sharing while complying with privacy laws. Additionally, the guidelines acknowledge that rural communities face longer response times and limited mobile crisis capacity, often requiring virtual clinical consultation models, shared regional protocols, and/or local adaptation.

SAMHSA also underscores the importance of continuous data collection, evaluation, and quality improvement, providing sample metrics to guide ongoing monitoring. Ensuring equity and accessibility is essential; therefore, services should be offered in multiple languages, with translation support as needed, and alternative modalities such as video options for individuals who are hard of hearing or chat-based features for those who prefer text communication. Collectively, the “Someone to Call” component ensures that anyone, at any time, can reach a trained and trusted responder who can provide immediate support and connection to appropriate care.

Idaho’s current crisis response system landscape includes the Idaho Behavioral Health Plan (IBHP), administered by Magellan Healthcare, which brings behavioral health and crisis services together under a single statewide contract. The Idaho Crisis & Suicide Hotline (ICSH) operates as part of the Vibrant-approved network, answering all 988 calls and coordinating dispatch with Magellan’s network of Mobile Response Teams (MRTs). To provide MRT coverage across wide geographic areas, Magellan primarily subcontracts with Benchmark Human Services and Community Bridges, Inc.

Currently, Magellan is in the very early stages of considering potential statewide coordination between 911 and 988. Blaine County’s local hotline, The Crisis Hotline Idaho, is not part of the Vibrant/988 network.

In accordance with Third Horizon’s recommendation in its “MCRT Operational Plan” and interim report, the Blaine County Sheriff’s Department, Family Health Services, and the Blaine MWBI are collaborating to establish a new clinician-led co-response team. The team is being established locally because the Magellan-operated mobile crisis team cannot always respond quickly enough to meet the community’s needs. The local sheriff has

shown a strong interest in this model as a way to reduce unnecessary involvement of the justice system in behavioral health crises, and it was noted that many communities successfully operate both types of teams simultaneously.

To develop and implement a robust and well-coordinated crisis call system, Third Horizon facilitated a stakeholder meeting to discuss strategies for deploying the clinician-led co-response team and improving overall system-level coordination. Included in this meeting were representatives from the MWBI, Magellan, the Idaho Crisis & Suicide Hotline (988), the Crisis Hotline, and the Blaine County Emergency Communications Center (911). The group discussed potential scenarios and the identified pros and cons related to each.

A. 988 Driven Response

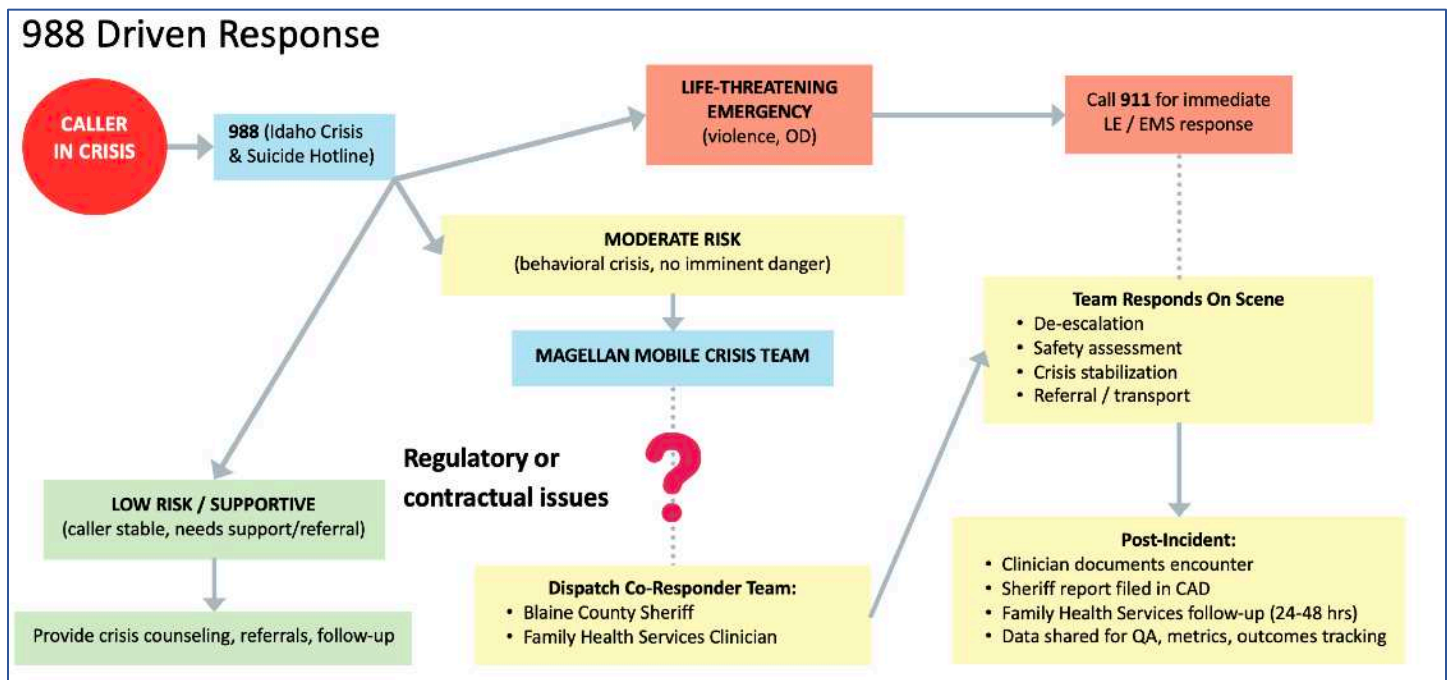
This 988-driven response model begins when a caller in crisis contacts the Idaho Crisis & Suicide Hotline. Depending on the assessment, the call may be categorized as low risk, moderate risk, or a life-threatening emergency. Low-risk callers who are stable and primarily need support may receive crisis counseling, referrals, and follow-up directly through 988. Moderate-risk situations, where a behavioral crisis is present, but no imminent danger exists, may be directed to the Magellan MRTs. For life-threatening emergencies such as violence or overdose, 988 may route the situation to 911 for an immediate law enforcement or EMS response. When a team responds on scene, they provide de-escalation, safety assessment, crisis stabilization, and referral or transport.

Participants noted that 988 maintains daily communication with dispatch centers and public safety answering points, and that only about one percent of contacts ultimately involve law enforcement for imminent suicide risk. Magellan's MRTs are deployed in about 6% of calls to 988 currently. Approximately 89% of calls are resolved on the phone, with the 988 crisis team providing live de-escalation and safety planning services.

There was broad agreement that geographic or system barriers should not delay people in crisis who may benefit from a mobile response from receiving one. The group discussed whether it would be feasible for Magellan to deploy the Clinician-led Co-Response Team if the MRT's response time could not be expedited. At present, local mobile crisis teams that are not part of Magellan's network cannot be dispatched directly through 988. This limitation stems from financial constraints as well as regulatory and contracting barriers. Furthermore, co-response teams that include law enforcement, even though paired with a clinician, are not comparable to the MRTs, which are clinicians paired with peer support.



Figure 11 Scenario: 988 Driven Response



The group determined that, instead, the Idaho Crisis and Suicide Hotline could offer 988 callers the option of being connected to the co-response team. This would align with the organization’s philosophy of empowering clients and respecting their choices.

It was also noted that Magellan is in the early stages of piloting 911- 988 warm hand-off capabilities in Caribou County. Participants expressed an interest in monitoring the pilot and potentially implementing it in Blaine County. There may be some advantages to helping to shape the pilot by entering it early rather than waiting to see the results in Caribou.

B. 911 Driven Response

In a 911-driven response, a caller in crisis contacts the 911 dispatch center, which evaluates the situation and directs the response based on the level of risk. If the situation is life-threatening, dispatch may send an immediate law enforcement or EMS response. Cases assessed as moderate risk, where there is a behavioral crisis without imminent danger, may be directed to the local co-responder team.

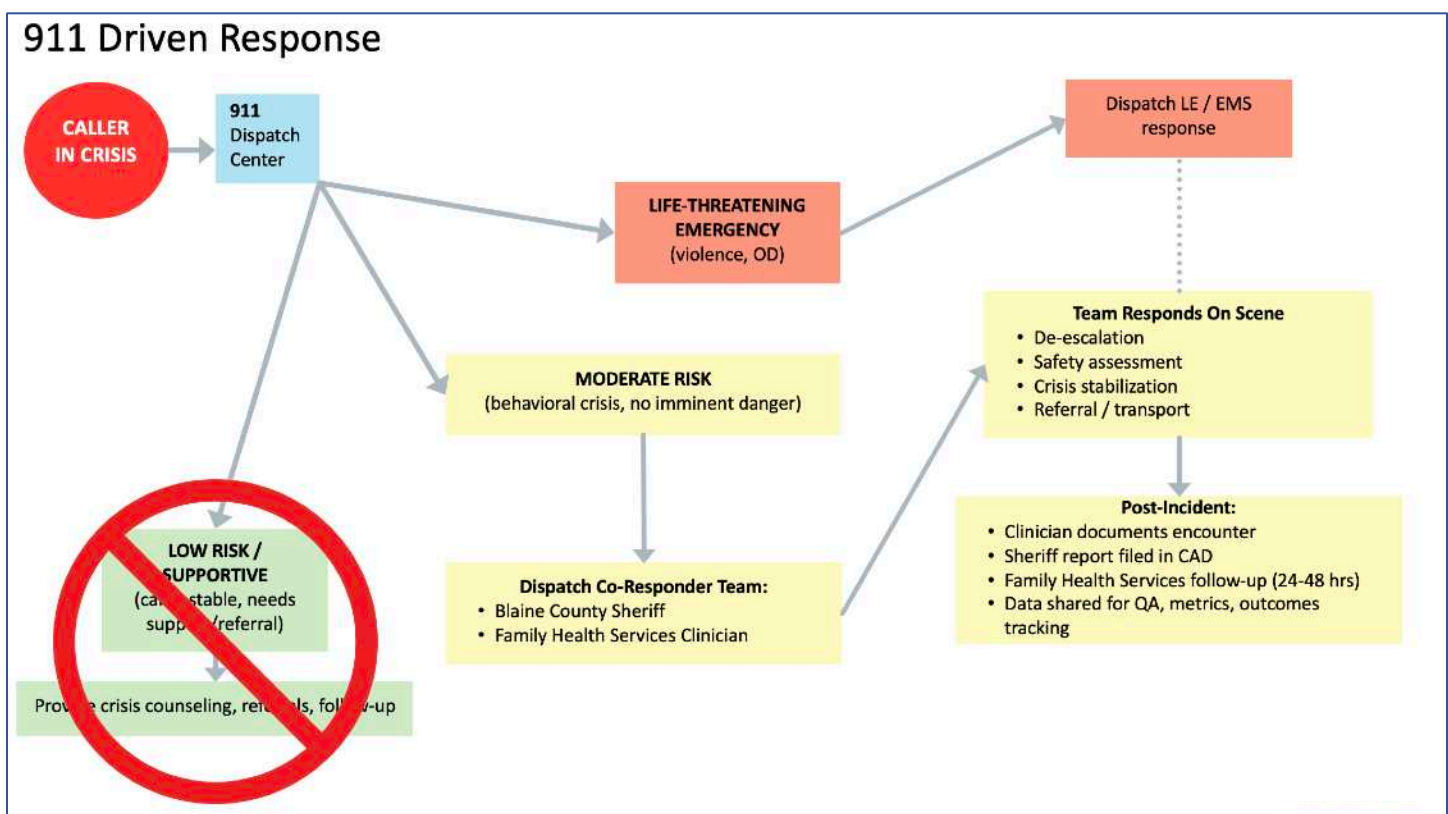
When responders arrive on scene, they provide de-escalation, safety assessment, crisis stabilization, and referral or transport as needed. After the incident, the clinician would document the encounter, the sheriff would file a CAD report, Family Health Services would conduct follow-up within 24–48 hours, and data would be shared for quality assurance, metrics, and outcomes tracking.

Participants discussed that, unlike the 988-driven model or local hotline entry point, 911 does not have the capabilities to resolve behavioral health crises on the phone or route low-risk or supportive calls for counseling or referral. There were also concerns expressed about asking people to call 911 for mental health issues, when

local hotlines and 988 were created in part to help reduce law enforcement involvement and non-life-threatening engagement of first responders.

At the same time, the group acknowledged that in rural mountain areas, response times and available resources make 911 a practical entry point for some calls, if it is complemented by adequate behavioral health supports and not left solely to law enforcement to resolve. Given the Blaine County Sheriff Department's involvement in the co-response team, the local call center in Blaine County would be able to deploy the team, making this the most feasible option in the short term. Protocols will need to be developed to better define "moderate risk" and to establish appropriate situations to deploy the team. The group discussed nuances around safety, such as how the presence of a gun may not automatically equate to imminent danger. Participants emphasized the importance of engaging the person in crisis collaboratively, allowing them to choose their own resources or support pathways.

Figure 12 Scenario: 911 Driven Response

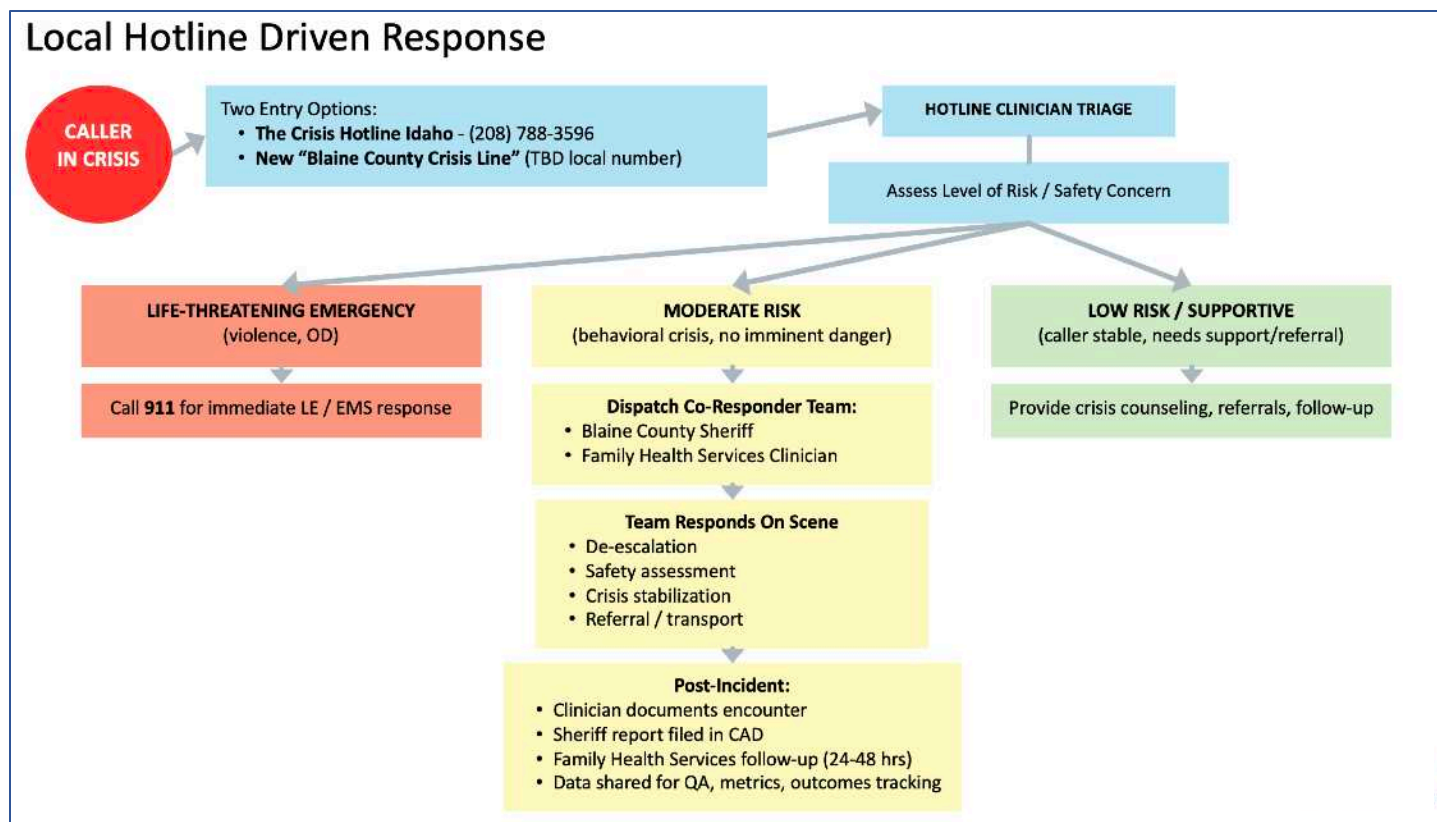


C. Local Hotline Driven Response

In a local hotline-driven response, a caller in crisis would enter the system through the Crisis Hotline Idaho (or a new Blaine County crisis line could be established). A hotline clinician conducts triage and assesses the caller's level of risk and any safety concerns. Low-risk callers who are stable and primarily need support or referral receive crisis counseling, referrals, and follow-up directly from the hotline. If the situation is life-threatening, the hotline may direct the call to 911 for an immediate law enforcement or EMS response. For

moderate-risk situations, where a behavioral crisis is present without imminent danger, the hotline would connect the caller to the co-responder team, ideally through a warm hand-off. The team would then provide on-scene support, including de-escalation, safety assessment, crisis stabilization, and referral or transport. After any on-scene response, the clinician documents the encounter; the sheriff files a CAD report; Family Health Services conducts follow-up within 24–48 hours; and data is shared for quality assurance, metrics, and outcomes tracking.

Figure 13 Scenario: Local Hotline Driven Response



Participants discussed that the Crisis Hotline Idaho is very open to deploying the co-response team, and may require some additional technology to be capable of warm handoffs.

Stakeholders described the local hotline-driven response as both a practical necessity and an opportunity to strengthen community-specific crisis care. Since rural areas face technology gaps and inconsistent access to statewide systems, local hotlines remain essential even as broader networks like 988 evolve. The group discussed the hotline's interest in aligning local hotline standards with 988. They emphasized that callers should receive clear options and a "no wrong door" entry into the system, supported by outreach that explains how response pathways differ and what callers can expect. Stakeholders also emphasized the importance of follow-up services and case management as essential components of the local response, particularly given community feedback that these supports are often inadequate.

Moving forward, the group emphasized the need to work closely with local 911 dispatch, Family Health Services, and the sheriff's office to define clear protocols and lines of questioning that will guide when the co-response team should be deployed. There was interest in exploring the pilot underway in Caribou County that is considering transferring callers to 988, with the understanding that earlier local involvement in such efforts could offer greater control over implementation. Stakeholders also discussed adding the co-response team as an available option for individuals who contact 988, ensuring that the crisis system presents multiple pathways for support. Similarly, the local call line should be able to connect callers to the co-response team when appropriate. A key next step will be determining the most effective method for making that connection, such as directly contacting the clinician on duty. Additionally, maintaining concurrent pathways is essential to upholding a "no-wrong-door" approach, allowing callers to access the right level of support regardless of how they enter the system. Alongside operational planning, the group recognized the importance of collecting data to track effectiveness, call volume, and outcomes. Once the co-response team launches in January, time will be needed to fully embed its processes within the broader crisis system. Finally, it will be essential to define how local wrap-around support is accessed and utilized by the co-response team to ensure that individuals receive coordinated and continuous care beyond the immediate crisis response.

Recommendations

Third Horizon recommends the formation of an ongoing workgroup to continue developing and refining protocols for coordination. Utilization and outcome data from the co-response program should be collected and reviewed by the workgroup to assess referral and deployment pathways over time.

Based on the meeting discussion, the firm advises a "no wrong door" approach to deploying the co-response team. This should include:

- 988—providing a consumer option for callers from Blaine County to have the co-response team deployed when indicated
- 911—adopting a behavioral health crisis call screening protocol that could result in the immediate deployment of the co-response team as appropriate
- The Crisis Line—implementing a warm hand-off protocol to the co-response team when indicated
- Replicating the pilot initiated by Magellan in Caribou County to bridge 988 and 911 with a warm-handoff option/protocol.

It will be vital that each of the call centers, referral organizations, other providers, and the community as a whole understand how and when the co-response team can be reached. Third Horizon recommends a robust marketing and outreach campaign to launch the program. Furthermore, as additional behavioral health and crisis services are expanded in Blaine County, the MWBI and its partners should facilitate strong coordination and collaboration across the entire system.

Third Horizon recommends formalizing protocols, memoranda of understanding, and, when funding is involved, contractual arrangements in writing. The workgroup, along with other critical partners such as Family Health Services, should strive for consensus in defining what constitutes "moderate" risk and an appropriate cause for deploying the co-response team.



“Someone to Respond”

The MWBI requested that Third Horizon prioritize the development of a “structured recommendation for designing, staffing, and implementing a Mobile Crisis Response (MCR) team in Blaine County, ensuring a 30-minute crisis response time.” The “Co-Response Team Operational Plan” was submitted as Third Horizon’s first deliverable in July 2025. It is included in the appendix of this report, and is summarized here. The MWBI, Blaine County Sheriff’s Department, and Family Health Services are in the process of implementing a Clinician-Led Co-Response Team, which will be operational in the first quarter of 2026.

Third Horizon used a mixed-methods methodology, including a literature review of SAMHSA’s updated 2025 Behavioral Health Coordinated System of Crisis Care guidance, focus groups with community partners, direct interactions with MWBI leadership, and analysis of four years of local crisis data to inform Blaine County’s strategy to define, structure, and implement a mobile crisis response strategy.

Like contact centers, there are many different mobile crisis teams (MCTs) and outreach models. The three most common models are behavioral health practitioner-only, co-responder models involving law enforcement, and services provided through mobile response and stabilization programs. The guidance recommends identifying model types that best match the community’s needs. SAMHSA specifies four key components a mobile crisis team needs to meet its definition.

- MCTs must be on-demand and rapid once a request is accepted.
- MCTs must be mobile and meet the individual in the community instead of being limited to a specific location.
- MCTs must include at least one crisis staff person providing crisis services to the individual face-to-face.
- An MCT response must include engagement with a licensed or credentialed provider (this engagement may be virtual).

The SAMHSA guidance outlines best practices for staffing and service delivery for each model. Regardless of the model, special attention must be given to children and youth mobile crisis systems. Youth models should follow SAMHSA’s Systems of Care values and principles. A key difference between youth and adult services involves families and prioritizing keeping children in their current living environments whenever possible. MCT teams serving children and youth should receive specialized training in areas such as child development, family systems, crisis intervention with LGB Youth, child abuse reporting, and other relevant topics to serve this population best.

Third Horizon’s analysis of local crisis data shows that behavioral health crisis activity in Blaine County has been steadily rising across multiple indicators, including crisis dispatch calls, SLWR mental health encounters, and emergency department visits. Researchers found that across both the 911 dispatch data and SLWR ED data specifically for suicidal ideation/self-harm, crises peaked in the evening hours, particularly between 7 p.m. and 10 p.m. These trends suggested that the MWBI and its partners should prioritize mobile crisis resources during high-demand evening periods as they design and scale the county’s crisis response system.

Stakeholders, including community partners, providers, local government, and St. Luke’s, expressed strong interest in strengthening Blaine County’s behavioral health crisis system by developing a mobile response.

Based on research and best practices, as well as feedback from various community stakeholders and an assessment of Blaine County's needs and available resources, Third Horizon recommended a phased approach to building mobile crisis services in Blaine County.

In the short term, the firm recommended that the MWBI launch a clinician-led co-response pilot in partnership with the Sheriff's Office. Here, a licensed behavioral health clinician and a Crisis Intervention Team (CIT)-trained deputy would respond together during peak evening hours, with the clinician leading the assessment and the deputy ensuring safety. The deputy would operate in plain clothes and an unmarked vehicle to reduce stigma, and both team members would be expected to provide trauma-informed and culturally responsive services. Additionally, housing the clinician within Family Health Services would support clinical supervision and long-term financial sustainability. Third Horizon recommended that clear deployment protocols, community education, and strong data tracking systems be essential components of the pilot.

In the midterm, Third Horizon recommended that the MWBI evaluate pilot performance, including utilization, response times, case outcomes, and impacts on ED use and criminal justice involvement, to determine whether to expand services, adjust staffing or hours, or transition toward a mobile crisis team that operates independently of law enforcement. This team could also pair the clinician with a peer, case manager, or paramedic and may be dispatched through a local hotline.

For the long term, Third Horizon recommended that the MWBI collaborate with the Idaho Department of Health and Welfare and Magellan to enhance and expedite state mobile crisis team operations and advocate for improved response times. The MWBI would also support Idaho's potential participation in the CCBHC Medicaid Demonstration or adoption of CCBHC as a State Plan option, which would create a sustainable funding model for crisis services and enable long-term expansion of community-based behavioral health care in Blaine County.

The county is moving forward with establishing its first clinician-led co-response team to provide immediate mobile response and de-escalation, as well as follow-up and coordination services. The co-response team is expected to be fully operational by the first quarter of 2026, with a new office planned in Bellevue. In preparation for implementing this model, both the clinician and deputy positions have been posted, recruitment is underway, and the memorandum of understanding between Family Health Services, the Sheriff's Department, and the MWBI is nearing completion.

As "somewhere to go" for behavioral health needs is developed within Blaine County, Third Horizon recommends the clinician-led co-response team closely coordinate and, if room allows, physically be co-located there. While as a mobile unit, the team should primarily work on the road, a home base for follow-up and documentation will also be needed. Third Horizon recommends that the MWBI establish key performance indicators and an evaluation plan to assess the impact of the clinician-led co-response team.

Third Horizon recommends that the MWBI establish key performance indicators and an evaluation plan to assess the impact of the clinician-led co-response team.

Third Horizon recommends that the following data points and key performance indicators be evaluated after six months and again after one year:

- Utilization and demographics of people served
- Response time
- Case disposition
- Reductions in avoidable emergency department utilization
- Reductions in criminal justice involvement
- Cost impacts (e.g., comparing the program's cost to the cost of deploying first responders or utilizing emergency departments)
- Number of individuals provided short-term post-crisis case management services.

If warranted, the pilot program could be made permanent, and the number of hours or the number of teams could be expanded.

Additionally, over time, the MWBI may want to explore the feasibility and need for a clinician-led mobile crisis response that does not involve law enforcement. This could be in addition to, or instead of, the co-response program. The clinician could be paired with a peer support specialist, case manager, or paramedic.





“Somewhere to Go”

“Somewhere to go” under SAMHSA’s behavioral health crisis guidance refers to a safe, dedicated crisis-stabilization setting where individuals experiencing a mental-health or substance-use crisis can receive immediate, compassionate support, observation, and short-term care. These facilities are intended as an alternative to the emergency department or jail. SAMHSA describes a range of models that exist across the country, including crisis centers, also known as crisis receiving and stabilization facilities, behavioral health urgent care, crisis residential, peer respite, and crisis stabilization units. Because communities and populations vary widely, the form a ‘place to go’ takes can look very different depending on local resources. While it may be ideal to have somewhere to go available 24/7, this may not be feasible in a rural community with a smaller population and lower volume of encounters.

When the MWBI first enlisted Third Horizon, a traditional crisis center had been the initial concept model for “somewhere to go” or “a place to go”, as the community referred to it. However, as the project team dug deeper into the community needs, available resources, and Idaho’s financing and policy, it became apparent that alternative scenarios should be explored. Stakeholders highlighted that, beyond thinking about people in crisis, there are concerns about individuals with behavioral health needs being able to access services that help prevent them from getting into crisis in the first place, and support them after a crisis.

Through its stakeholder engagement and data analysis, Third Horizon consistently identified three key themes that highlighted what was most needed in the community. The first theme is the need for case management, particularly during care transitions. This type of case management ensures that individuals experiencing a crisis can access follow-up resources after immediate intervention and are not dropped during their care journey. The second theme is access to same-day care for both mental health and substance use-related needs. Currently, the only access point for same-day care is the emergency room, which is not always the most appropriate level of care based on individual needs. The last theme raised was navigation of services. A desire for a more transparent and streamlined means to access care and navigate the system was greatly emphasized in the community.

Notably, Idaho lacks a statewide system for outpatient behavioral health services, such as a network of community mental health centers. This is unlike some of its neighboring states or those in the Mountain West. For example, Colorado has [“comprehensive safety net providers,”](#) while Wyoming has [“community mental health centers,”](#) and WA state is [actively working to develop a statewide CCBHC model](#). This service gap also informed Third Horizon’s research into a potential model for Blaine County.

Key Themes From the Case Studies

Third Horizon gathered publicly available information and conducted four interviews with crisis service providers, including three in rural, mountain communities that share characteristics with Blaine County, and one in Chicago, selected because of its strong reputation and “living room” model. These interviews, featuring the Aspen Hope Center (CO), Mountain House in Jackson Hole (WY), Axis Health (CO), and Thresholds (IL), highlight diverse approaches to creating accessible, community-based crisis services. For more details, see Appendix C.

Third Horizon developed the case studies to explore model innovations, strategies for establishing and sustaining services in resource-limited settings, as well as challenges and pitfalls that may inform Blaine County's planning. By capturing lessons learned and other information on funding models, staffing structures, and community partnerships, these insights helped to inform a localized vision for what "a place to go" could look like in Blaine County, aligned with its local needs and context.

Several common themes emerged:



Funding diversification: each organization relies on a complex blend of state allocations, Medicaid and/or commercial insurance billing, county contributions, hospital partnerships, grants, and philanthropy to sustain operations.



Staffing models: The programs use a mix of licensed clinicians, bachelor's-level staff, and, in some cases, peer specialists. In all cases, the organizations have defined security measures, not security guards.



Care continuum: Each of the programs is part of a larger behavioral health provider organization, which helps ensure continuity of care and follow-up after a crisis.



Community partnerships: Interviewees identified collaborations with law enforcement, schools, hospitals, and local governments as vital.



Standardized screening: All programs utilize the Columbia Suicide Severity Rating Scale. Some use additional screening and collect data on key performance indicators.

Taken together, these insights offer Blaine County practical lessons and robust guidance, particularly in starting with scalable, community-anchored approaches and integrating crisis care within a more comprehensive framework of behavioral health services.

Facility Model Scenarios and Feasibility

Third Horizon synthesized lessons from the case studies, applied the firm's direct experience working in behavioral health systems, and used its qualitative research and data findings to envision what "a place to go" for might look like in Blaine County. The project team defined four potential scenarios, rooted in the county's unique geography, population, and service landscape.

On November 12, 2025, Third Horizon presented the four models to stakeholders from St. Luke's, St. Luke's Wood River Foundation, Family Health Services, Blaine County government, and MWBI staff and board members. The scenarios included potential staffing models, service offerings, operational considerations, and cost and revenue implications.

The following section summarizes the scenarios, options, and stakeholder feedback from November 12.

1	2	3	4
Crisis Center	Behavioral Health Hub	Diffuse Model	CCBHC Model

Scenario 1: Crisis Center

The first scenario posed by Third Horizon was a crisis center as defined by [Idaho legislation](#). In Idaho, a crisis center must comply with all provisions of state and federal laws, rules, regulations, policies, standards, and guidelines. Crisis centers are separate for adults and children. Both are places to go for people experiencing a behavioral health crisis, such as suicidal thoughts or withdrawal from drugs, to get help. Clients may remain at the facility for up to 23 hours and 59 minutes.

Facilities must have accreditation from an external party (e.g., The Joint Commission or CARF) and a capacity for 10 male and 10 female beds, totaling 20 beds. Additionally, the center must comply with staffing model requirements, which include a clinical supervisor, two staff members always on site (one of whom must be a medical staff member), and a staffing ratio of one direct care staff member for every three clients.

Magellan contracts the state-wide crisis center network, which currently consists of seven adult centers and four youth centers. Representatives from Magellan indicated that there were no plans currently to expand the number of crisis centers; however, if one were to be added, it would likely be a youth center. While behavioral health providers may bill fee-for-service and offer some comparable services, only facilities that meet the State of Idaho crisis center guidelines and are contracted by Magellan may access the per diem rate.

Upon reviewing this model, stakeholders identified that the capacity requirements and resources required to operate a crisis center in Blaine County are not aligned with the community's needs. Therefore, a crisis center is not a feasible option at this time.

Rather, participants identified that better transportation options should be developed to support community members in accessing the adult and youth crisis centers operated by [the Crisis Center of South Central Idaho](#) in Twin Falls.

The financial implications of building a crisis center include the startup costs of a new brick-and-mortar facility. This may require construction or renovation, as well as new furnishings, IT equipment, and medical equipment. Personnel costs may be higher in the crisis center model than in other models due to the state staffing requirements. If accepted into the Magellan network, the crisis center may receive a per diem reimbursement rate for services provided to Medicaid beneficiaries. Services would not be reimbursable for those who are uninsured, and commercial contracted rates for crisis services for those with private insurance may vary. More financial implications details can be found in the “Financial Analysis of ‘Place to Go’ Models” section of this report.

Scenario 2: Behavioral Health Hub

The second scenario, a behavioral health hub, is a homegrown model designed based on the needs identified by the community to increase access to same-day outpatient behavioral health triage, treatment, and care coordination services.

Third Horizon conceptualized the behavioral health hub as an option that may be more feasible in the short term than developing a full CCBHC or other more comprehensive model, given the current policy and financial environment. The hub would provide a physical location for community members to visit during specified hours, offering screening, triage, appropriate interventions, and case management. As a homegrown model, the hub would provide flexibility to meet the community’s needs. Stakeholders and the entity providing clinical services at the hub would need to make some decisions about the operating model, including space requirements, operating hours, and connectivity to other behavioral health services, such as the clinician-led co-response team.

The hub would offer an array of services, including triage, intake, and level of care assessment (In Idaho, the comprehensive diagnostic assessment (CDA) is required), case management, care navigation, crisis psychotherapy, psychotherapy, and peer support. Third Horizon recommended the following should be considered in the model:

- Licensed BH Clinician (ideally able to address both mental health and SUD)
- Case Manager
- Front desk staff (can be dual role)
- Care Navigator and/or Peer Support Specialist
- On-call Counselor(s) at specified hours

On November 12, stakeholders identified this model as a strong opportunity to personalize a model that meets the unique needs of Blaine County. Over time, the model could remain as a hub offering a limited service set or expand its service offerings to achieve a CCBHC or incorporate partnerships with other community health or human services providers. Family Health Services emphasized an ability to operate many elements of the hub

model and would apply learnings from its operations in other counties. Stakeholders were highly interested in moving forward with the hub model, as it meets a critical need identified for same-day and next-day services and complements the co-response team, providing timely post-crisis services.

Like the crisis center model, the financial implications of building a crisis center include the startup costs of a new brick-and-mortar facility. However, the space requirements are more flexible than those of the crisis center model, meaning the costs may be lower if there is less offered capacity. Other start-up expenses, such as furniture and IT, are required for a new site. Personnel costs would vary based on service offerings and desired capacity. Certain services may be reimbursable by Medicaid or private insurance, while grants or philanthropic opportunities may support other operating costs. In all models, there will likely be a need to braid multiple funding sources to offer an array of services that meet the community's needs. More financial implications details can be found in the “Financial Analysis of ‘Place to Go’ Models” section of this report.

Scenario 3: Diffuse Model

Third Horizon presented a third scenario, a “diffuse model,” in response to members of the MWBI work groups three and four, identifying the multiple spaces in the community that already exist and may be able to offer enhanced services if resources were available. This model would provide screening, triage, appropriate intervention, and case management services across various settings. The approach could enable the addition of new service capacity to existing programs or clinics, thereby enhancing the system of care.

Similar to scenario two, the diffuse model would allow Blaine County flexibility in developing the service offerings and navigating the operational considerations. Unlike facility-based options, this approach would not require new real estate, front desk staff, or greeters. A diffuse model, therefore, offers efficiencies in administrative and operational costs.

The stakeholders found that this approach may lead to greater confusion among consumers and complexity among operations. Additionally, participants expressed concern about the county's existing infrastructure, particularly the limited space in the clinical spaces currently operating.

The diffuse model may have the lowest start-up expenses among the other options, as it leverages infrastructure resources from other facilities. The staffing may also be lower depending on the services offered. However, this model may be more challenging to attract philanthropic or local funding, as it is not a new location and may be more difficult to explain to the public. Capital campaigns are generally more appealing to the public than general fundraising due to their tangible, specific, and time-limited nature, which makes the impact of a donation clearly visible and creates a sense of excitement and shared purpose. More financial implications can be found in the “Financial Analysis of ‘Place to Go’ Models” section of this report.

Scenario 4: Certified Community Behavioral Health Clinic

The fourth scenario presented by Third Horizon involves operating a CCBHC in Blaine County. A CCBHC must operate in accordance with [federally prescribed criteria defined by SAMHSA](#). It must provide services to anyone seeking help for a mental health or substance use condition, regardless of their place of residence,

ability to pay, or age. Also, CCBHCs are required to meet SAMHSA-defined criteria for access standards, staffing, scope of services, data, quality measures, and governance.

CCBHCs are required to offer nine core services, which are crisis services, screening, assessment, and diagnosis, treatment planning, outpatient mental health and SUD, primary care screening and monitoring, targeted case management, psychiatric rehabilitation, peer support and family/caregiver services, and community care for uniformed service members and veterans. CCBHCs can contract with a designating collaborating organization (DCO) to perform up to 49% of these services if they are unable to operate specified services or determine it is in the community's best interests to contract with a DCO. The staffing model must also meet federal requirements, which include a CEO or other project director, a psychiatrist as medical director (there is a rural allowance for this to be filled by a psychiatric nurse practitioner), licensed clinicians (MH and SUD), peer support specialists, a medically trained behavioral health care provider who can prescribe FDA-approved medications used to treat opioid, alcohol, and tobacco use disorders, and other staffing as determined by the required community needs assessment.

Stakeholders expressed a strong interest in establishing a CCBHC in Blaine County. For states participating in the CCBHC Medicaid Demonstration or implementing CCBHC through a State Plan Amendment (SPA), CCBHCs are a sustainable option. In these states, CCBHCs receive a clinic-specific cost-based reimbursement, or "[prospective payment system \(PPS\)](#)". SAMHSA also offers CCBHC expansion grants, which are \$4 million over 4 years, for clinics to implement and expand on the CCBHC model. As a SAMHSA CCBHC Expansion grantee, Family Health Services operates a CCBHC in Twin Falls and is in its final year of grant funding.

To date, Idaho has not pursued joining the CCBHC Medicaid Demonstration or a SPA. The [Bipartisan Safer Communities Act of 2022](#) provides for the expansion and extension of the CCBHC Demonstration, allowing the selection of ten additional states to participate in the CCBHC Demonstration program, beginning July 1, 2024, and every two years thereafter. This means there will be further opportunities to join, should the state of Idaho opt to. However, in the short term, this scenario requires start-up investment via community-based or philanthropic funds. Participants expressed concerns for the long-term if Idaho does not implement CCBHC at the state level. Additionally, concerns were raised about creating a model that requires a significant investment in infrastructure, staffing, and operations, given the lack of a guaranteed long-term funding source. Stakeholders expressed interest in a strategic and phased approach, beginning with the behavioral health hub, which may eventually evolve into a CCBHC.

The cost implications of the CCBHC model are more substantial than those of the other models due to the federal criteria. Startup and infrastructure costs may be similar due to the acquisition of new space or the renovation of existing space. Personnel costs will also be higher due to the requirement of a psychiatric practitioner on staff. CCBHCs are reimbursed based on a cost reporting model; therefore, the revenue opportunity when serving Medicaid patients may be more accretive than billing individual behavioral health services under a fee-for-service model. More financial implications can be found in the "Financial Analysis of 'Place to Go' Models" section of this report.

Development and Funding Strategy

Understanding of the Current Policy and Funding Environment

It is essential to note that the MWBI crisis system planning process is occurring during a period of significant volatility in the behavioral health field, driven by changes at the federal and state levels. These changes involve organizational restructuring and downsizing of federal agencies that address substance use and mental health (e.g., SAMHSA, HRSA, CDC), as well as shifting grant requirements to comply with [executive orders](#) and align with the current administration's priorities. Most importantly, there are imminent changes to Medicaid.

Federal changes under H. R. 1, the "One Big Beautiful Bill Act," are scheduled to take effect beginning in 2026 and 2027, introducing more frequent eligibility redeterminations, new work requirements, and higher cost-sharing for adults on Medicaid. According to reporting in the [Idaho Capital Sun](#), over the next decade, the "One Big Beautiful Bill Act" is expected to cut federal funds for Idaho Medicaid \$4.3 billion and reduce Idaho Medicaid's enrollment by as much as 40,000 people.

Idaho's [House Bill 345](#) already contains work-requirement language for Medicaid expansion recipients, which means the state is positioned to adopt some of these federal provisions more quickly and stringently than many other states once the federal rules are finalized.

Additionally, at the state level, Idaho has implemented additional changes that may further narrow access to care. According to Idaho Reports and the Department of Health and Welfare, the state enacted a 4% statewide Medicaid provider rate cut on September 1, 2025. Behavioral-health services are facing significant reductions. Magellan of Idaho — the contractor managing Medicaid mental health benefits — is instituting reimbursement cuts of 4% to 15%, with the steepest reductions applied to intensive services, such as partial hospitalization programs. Magellan is also discontinuing adult peer-support services and ending per diem payment for the Assertive Community Treatment (ACT) model, while maintaining child and family peer support, according to [Magellan's provider news](#).

These fiscal, structural, and policy adjustments could have a profound impact on the system's ability to meet current and future demand for care. Third Horizon approached its work with the understanding that sustainability must be top of mind when developing new behavioral health services in Blaine County, balancing the need to ensure access for the community's most vulnerable populations with long-term financial viability.

Financial Analysis of "Place to Go" Models

Third Horizon considered the financial implications for sustainability for each of the four potential "place to go" scenarios. The firm projected likely expenses and revenues, as well as the differences between them across the models. The financial analysis was intended to inform the selection of an approach for Blaine County. It did not reach the level of specificity necessary to include in a more detailed pro forma.

Expenses

For the analysis, Third Horizon categorized anticipated expenses into two broad categories: capital expenses and personnel expenses. Capital expenses are often one-time expenses with occasional maintenance or renewal fees. The expenses identified by the project team in the analysis were categorized as follows: facility

and construction, furnishing, fixtures, and other office supplies; IT and telehealth infrastructure; medical equipment; licensing and permits; and other expenses, including marketing. These expenses vary based on the model. For instance, not every scenario would require medical equipment if the services required do not involve taking vitals or managing medication. Capital expenses may be reduced due to sharing resources, for instance, in the diffuse model, where space is shared, or if the operating provider can utilize existing infrastructure.

The other large expense category considered is personnel. Like capital expenses, personnel costs will depend on the model deployed and the services offered. For example, the CCBHC would require a psychiatrist or psychiatric nurse practitioner, while the behavioral health hub model may not. Personnel-related staffing would include salaries, as well as fringe and other related costs, such as recruitment and retention efforts. Stakeholders mentioned reimbursement for housing is also common when hiring in Blaine County due to the high cost of living. Aside from clinical roles, depending on the chosen model, there may be requirements to employ administrative staff or data analysts to fulfill the required operational tasks.



Revenues

Third Horizon reviewed three revenue streams to determine the feasibility of the different models for “a place to go” and assess future sustainability. Some revenue streams have longer-term sustainability than others, while some may provide the initial infrastructure or seed funding required to start the program.

The most material revenue stream for ongoing sustainability is the ability to collect reimbursement from insurance. Potential clients may have insurance coverage under commercial plans, Medicaid, Medicare, Tri-Care, or be uninsured. Third Horizon looked specifically at the largest commercial plan in Idaho (Blue Cross) and Medicaid. Depending on the service offerings of the “place to go,” there may be a variety of eligible billable services. Reimbursement rates vary widely based on factors such as insurance type, carrier type, service type, and practitioner type. Potential covered services and billable rates may include:

CPT Code	Service	<u>Commercial Range</u> <u>Blue Cross of Idaho</u>	<u>Medicaid as of 11/2025</u>
90832	Psychotherapy w/ patient, 30 min	\$82.49 - \$304.00	Psychologist: \$63.38 Master's Level: \$56.77
90834	Psychotherapy w/ patient, 45 min	\$171.53 - \$304.00	Psychologist: \$95.10 Master's Level: \$85.17
90837	Psychotherapy w/ patient, 60 min	\$114.49 - \$304.00	Psychologist: \$112.95 Master's Level: \$101.16
90839	Psychotherapy for Crisis, initial 60 minutes	\$155.32 - \$304	\$143.64
90840	Psychotherapy for Crisis, additional 30 minutes	\$77.03	\$68.72
T1017	Case Management, Behavioral Health w/ or w/o Care Coordination Activities; per 15 min	Not Found	\$17.17
H2011	Crisis Intervention; per 15 minute	Not Found	Psychologist: \$38.59 Master's Level: \$34.55
H0030	Crisis response (telephonic); per call	\$23.00 - \$60.00	Psychologist: \$39.96 Master's Level: \$35.78
H0038 HA	Youth Support; per 15 min	Not Found	Individual: \$14.15 Group: \$7.08
S9485 <i>Only available for Crisis Centers</i>	Crisis intervention mental health services on a per diem basis	Not Found	\$390 per 24 hours

While offering a potentially sustainable funding source, insurance reimbursement rates are variable and do not always cover the actual cost of care. Medicaid-covered services and rates for behavioral health services in Idaho have been changing over the past several months, reflecting budget pressures resulting from shifts in federal and state policies. As of November 1, 2025, Medicaid rates were decreased by 4%, with additional notice that rates may be further reduced by up to 15%. Additionally, adult peer services will no longer be reimbursed by the state effective December 1, 2025 (though youth peer support will remain a covered Medicaid service). Blue Cross also does not pay for peer support. Therefore, alternative funding streams may be needed if adult peer services are built into the “place to go” model in Blaine County.

The number of clients enrolled in insurance may also vary and should be considered when identifying funding model options. Due to federal changes to Medicaid in H.R. 1, there will likely be fewer eligible beneficiaries and higher rates of enrollment and disenrollment from the Medicaid program. Furthermore, the Affordable Care Act subsidies are still in question, and if not renewed, will likely result in more people becoming uninsured. Services provided to uninsured clients will not be reimbursable through insurance.

Philanthropy and other federal, state, and local funds can offer financing for a “place to go.” The St. Luke’s Wood River Foundation has continually prioritized mental health as a key issue in the county and has directly supported the MWBI. Philanthropic funding is advantageous for program start-up and some ongoing costs, as it can be flexibly used for capital or infrastructure requirements, depending on donors’ limitations. However, funding amounts may vary and are only available at certain times. As a newly formed 501 (c) (3), the MWBI can pursue other private grant funds. Given the MWBI’s critical role as a “backbone” organization, it will also need to be sustainable so that it can continue to provide robust convening and service-enhancing activities.

Local funding opportunities furnished through Blaine County may be material in creating “a place to go.” Local funding opportunities are contingent upon voter approval or approval by the county. For example, the county has used a tax Levy or bond in the past to fund community priority capital projects. The County Commissioner identified that an existing tax bond is set to expire in 2027, presenting an opportunity for a new capital ballot initiative. This initiative would need to be acted on by the county, but the MWBI can submit a proposal for consideration.

Smaller funding amounts are available through community service agreements (CSA), which allocate limited funding to community partners. Behavioral health-focused initiatives have been funded by the county in FY 2026, such as an award to NAMI Wood River Valley to provide *Certified Crisis Intervention Training for Law Enforcement Officers, Dispatch, and EMS First Responders*. At the November 12th retreat, a Blaine County commissioner indicated these funds could potentially support a “place to go” model or augment the clinician-led co-response team, such as by providing funding for providers to hold times for next-day appointments.

State and national funds may also be available for a “place to go model.” Most notably, the MWBI should continue to monitor state and federal activities related to the Rural Health Transformation Program (RHTP). CMS plans to announce award amounts by December 31, 2025. Idaho DHW will likely then post competitive solicitations for the proposed activities that have been approved for funding. Similar to local and grant opportunities, the funding amounts are variable, may have limitations, and are competitively awarded.

National funding opportunities must also align with the current administration's priorities, as outlined in the ["Improving Oversight of Federal Grantmaking"](#) executive order.

In 2026, 2028, and 2030, Idaho will have additional opportunities to [apply to join the CCBHC Medicaid Demonstration](#). Alternatively, Idaho could seek to add CCBHC at the state level through a Medicaid State Plan Amendment. The MWBI should continue to actively monitor the progress of these initiatives and engage in advocacy efforts when appropriate. The MWBI should also monitor for other funding opportunities nationally through SAMHSA, HRSA, or the CDC, as well as at the state level through the Idaho Department of Health and Welfare. FY2026 SAMHSA grants, including CCBHC, are listed on [SAMHSA's FY 2026 NOFO Forecast Dashboard](#).

Final Recommendation for "A Place to Go"

Based on Third Horizon's analysis and the stakeholder consensus reached at the November 12 meeting, the firm recommends that the MWBI and its partners pursue the development of the Behavioral Health Hub model, with an eye to evolving the hub into a CCBHC should long-term funding become available. Family Health Services offered and is the ideal entity to operate the hub, given its experience as a CCBHC in Twin Falls, its strong reputation in the community, expertise in billing and compliance, and collaborative philosophy.

Third Horizon advises the following as the project's next steps:



The MWBI should continue to serve as a convener, while exploring more formalized partnerships and an advisory board for the Hub. This may be modeled after the Center for Community Health Consortium, in which Family Health Services, St. Luke's, and Twin Falls municipal and county entities participate.



The MWBI, in close collaboration with Family Health Services, should develop a detailed operating plan and pro forma.



The Blaine County community should employ a multi-pronged fundraising approach, leveraging potential resources from Blaine County, the St. Luke's Wood River Foundation, the broader community, and any available state or federal grant opportunities.



The MWBI should define key performance indicators and a data collection and analysis plan to support both continuous quality improvement and behavioral health and crisis system-level analysis.

Stakeholder Collaboration and System Integration Plan

The MWBI was formed to serve as a “backbone” organization, convening over 50 community partner organizations working together to create the conditions that allow all people in Blaine County to thrive. Over the past year, the MWBI has become a 501 (c)(3) organization with a staff, a Board of Directors, and dedicated, though time-limited, funding. As crisis care and other behavioral health services are developed in Blaine County, the MWBI should continue to serve as the primary convener promoting multi-stakeholder collaboration.

Third Horizon recommends that the MWBI continue to convene smaller, initiative-focused workgroups focused on each of the three crisis system areas (someone to call, someone to respond, and somewhere to go) while also working across the system to provide an integrated approach. The “place to go” workgroup may replicate the Center for Community Health consortium model. While the smaller workgroups might meet more frequently, the three workgroups should be brought together at least biannually to review system-level developments, utilization data, and performance against key indicators.

This aligns with the MWBI’s strategic goal #5: Provide strategic leadership and data-driven collaboration. Here, the MWBI aims to advance a coordinated and data-informed approach to improving community mental well-being by aligning partners and funding around shared priorities, unified communication, and measurable impact.

To ensure the success of multi-agency efforts, the MWBI should provide technical assistance and facilitation to guide the development of the necessary advisory or governance structures, written agreements, and protocols. When it comes to data sharing, multiple levels warrant further exploration. The first is the sharing of aggregate data for evaluation purposes, including utilization, demographic, and outcome data. This will be essential to gauging the impacts of the new interventions and assessing community needs on an ongoing basis.

The second is more complex, in terms of sharing protected health information (PHI) for care coordination and tracking a client's progress longitudinally across various systems. This may require engaging an attorney well-versed in health and behavioral health care privacy laws (e.g., HIPAA, 42 CFR Part 2); however, the larger providers in Blaine County are well-acquainted with developing Business Associate Agreements and Memoranda of Understanding.

It will be vital for the long term that community fundraising efforts to build the behavioral health infrastructure in Blaine County consider the needs of the MWBI as an ongoing backbone structure. As a 501 (c) (3) organization, the MWBI can now pursue other philanthropic, private, or government funding streams while being mindful of not creating new competition with direct service providers. There may also be opportunities for earned income such as charging dues for MWBI “members”, providing data and evaluation, or offering other fee-based services.



Conclusion

The MWBI has bold yet imperative goals to increase the accessibility of behavioral health services (Goal 3) and expand behavioral health crisis response (Goal 4). From April through December of 2025, Third Horizon provided research, data analytics, stakeholder engagement, and behavioral health subject matter expertise to support the MWBI in building and strengthening the crisis system infrastructure in Blaine County.

The firm's study found that there has been a steady increase in behavioral health crises, with peak hours of both 911 crisis calls and emergency department visits between 7 and 10pm. Beyond crisis needs, Third Horizon found that there are gaps in behavioral health services – particularly same-day access for treatment, care management/care transitions for follow-up care after a crisis, and navigation for community members with mental health or substance use-related needs who don't know how to access services.

This strategic planning process has resulted in the early stages of development of a coordination strategy for "Someone to Call", a new, Clinician-Led Co-Response Team for "Someone to Respond", and the selection of a homegrown model, the Behavioral Health Hub, for "Somewhere to Go." Although substantial work remains to be done, given the current policy and funding environment, these crucial steps should be recognized as substantive achievements.

Throughout the nine-month project, the level of engagement of Blaine County community members was exceptional. The MWBI has collaboration at its core, demonstrating fidelity to the collective impact approach guided by a framework of five conditions: a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and a backbone support organization.

The recommendations outlined in this report provide a solid framework for continued development. The MWBI's role as a "backbone" organization is vital to maintain the community's momentum and highly collaborative approach to improving the well-being of all Blaine County residents.



Appendices

[Appendix A: MWBI Strategic Vision Document](#)

[Appendix B: Co-Response Team Operational Plan \(Interim Report\)](#)

[Appendix C: “A Place to Go” Case Studies](#)

[Appendix D: In-Person Meeting Notes and Presentation Slides](#)



Our Community's Strategic Vision for Mental Well-Being in Blaine County

Blaine County's Mental Well-Being Initiative (MWBI) reflects our community's shared commitment to building an integrated mental health and well-being network that supports every resident. Powered by more than 50 partners across government, healthcare, education, nonprofits, businesses, and faith communities, we are working together to create the conditions that allow all people in Blaine County to thrive.

This Strategic Direction emerged from an 18-month process of community engagement, partner refinement, and analysis of local data sources. The result is a shared set of five community goals that chart our collective path toward increased protective factors, improved access to care, and a resilient behavioral health system that works for everyone.

Designed as a living guide for the next five years, this plan provides a shared framework that allows partners to identify annual actions, metrics, and improvements that keep us aligned and responsive. Through shared leadership, collaboration, and data-informed decision-making, Blaine County is building a behavioral health system where everyone has the opportunity to feel connected, supported, and well.

GOAL 1: Increase community connectedness and belonging.

Foster belonging and connection by creating inclusive, substance-free spaces and opportunities that strengthen relationships, reduce isolation, and enhance community well-being.

GOAL 2: Strengthen and expand evidence-based prevention practices.

Align, strengthen, and expand evidence-based prevention strategies to improve behavioral health outcomes, reduce substance misuse, and promote healthy, resilient communities.

GOAL 3: Increase accessibility of behavioral health services.

Increase access to affordable, culturally responsive, and coordinated behavioral health services by reducing barriers, expanding local provider capacity and improving care navigation.

GOAL 4: Expand behavioral health crisis response.

Build a coordinated, 24-hour crisis response and stabilization system that provides timely, compassionate, and effective support for individuals in crisis.

GOAL 5: Provide strategic leadership and data-driven collaboration.

Advance a coordinated, data-informed approach to improving community mental well-being by aligning partners and funding around shared priorities, unified communication, and measurable impact.

Community Prevention

Blaine County fosters a connected, resilient community where everyone feels a sense of belonging and purpose. Through inclusive, substance-free spaces and coordinated, evidence-based prevention strategies, we empower residents and organizations to promote mental well-being, prevent substance misuse, and strengthen lifelong protective factors.

Goal #1: Increase community connectedness and belonging

Foster belonging and connection by creating inclusive, substance-free spaces and opportunities that strengthen relationships, reduce isolation, and enhance community well-being.

OBJECTIVE 1A- Inclusive Spaces & Activities

Create and sustain inclusive, substance-free spaces and pro-social activities that foster belonging and cross-generational connection, with a focus on after-school and evening opportunities throughout the valley.

OBJECTIVE 1B- Promotion & Marketing

Strengthen collaborative, promotion of community events and prosocial opportunities so residents can easily engage, connect, and participate.

OBJECTIVE 1C- Purposeful Opportunities

Connect the community with meaningful, purpose-driven volunteer or paid opportunities that build belonging, purpose, and connection, specifically among teens and young professionals.

OBJECTIVE 1D- Community Connectors

Activate a network of community members to host pro-social opportunities that build cross-generational relationships, and serve as trusted guides who can connect people to mental health resources.

OBJECTIVE 1E- Inclusive Outreach

Expand inclusive outreach to populations identified through local data such as teens, LGBTQ+ residents, non-native English speakers, and low-income households by fostering stigma-free, affirming environments.

Goal #2: Strengthen and expand evidence-based prevention practices

Align, strengthen, and expand evidence-based prevention strategies to improve behavioral health outcomes, reduce substance misuse, and promote healthy, resilient communities.

OBJECTIVE 2A- Shared Framework

Align efforts to a unified vision and coordinated approach for implementing a comprehensive menu of evidence-based prevention strategies that amplify impact, promote shared language, and reduce duplication.

OBJECTIVE 2B- Target Key Populations

Support, promote, and measure the impact of evidence-based prevention programs that strengthen resiliency and mental health awareness, prioritizing populations identified as high priority such as youth, youth-serving adults, frontline professionals, non-native English speakers, and low income populations.

OBJECTIVE 2C- Accessible Training

Expand access to prevention training by bringing them to workplaces and community settings and integrating participation into paid time whenever possible.

OBJECTIVE 2D- Coordinated Awareness Efforts

Increase community-wide mental health awareness and reduce stigma through coordinated messaging, prevention-focused outreach, and promotion of mental health trainings.

OBJECTIVE 2E- Harm Reduction

Advance coordinated community strategies that prevent substance misuse and suicide by promoting safe storage firearms and disposal of medications, reducing alcohol-related harm, and encouraging healthy, substance-free behaviors.

Behavioral Health Care

Blaine County is a place where everyone can access compassionate, coordinated behavioral health care—when and where they need it. By strengthening our local workforce, expanding affordable and culturally responsive services, and building a 24-hour crisis response system, we ensure residents receive timely, connected support from prevention through recovery.

Goal #3: Increase accessibility of behavioral health services

Increase access to affordable, culturally responsive, and coordinated behavioral health services by reducing barriers, expanding local provider capacity and improving care navigation.

OBJECTIVE 3A- Behavioral Health Center

Support the establishment of a community behavioral health center to provide integrated, sustainable, and comprehensive behavioral health services in Blaine County.

OBJECTIVE 3B- Access & Affordability

Increase affordability and access to behavioral health services by expanding financial supports, strengthening insurance and Medicaid participation, improving transportation to care, and addressing critical service gaps such as psychiatric services and youth supports.

OBJECTIVE 3C- Language Access & Equity

Expand culturally and linguistically appropriate behavioral health services— including Spanish-language care—along with targeted outreach and care-navigation support for underserved populations to ensure equitable access to timely, effective care for all residents.

OBJECTIVE 3D- Care Coordination & Navigation

Strengthen care coordination and navigation by expanding bilingual liaisons and peer supports, improving referral and data-sharing systems, and ensuring clear, accessible information that guides residents to the right care at the right time.

OBJECTIVE 3E- Workforce Expansion

Strengthen and grow Blaine County's behavioral health workforce by supporting current providers, expanding local career pathways, and offering incentives that attract, train, and retain professionals committed to serving our community.

OBJECTIVE 3F- Support Groups

Expand and strengthen support groups and recovery resources for community members, youth and families, behavioral-health professionals, and first responders to promote long-term resilience.

Goal #4: Expand behavioral health crisis response

Build a coordinated, 24-hour crisis response and stabilization system that provides timely, compassionate, and effective support for individuals in crisis.

OBJECTIVE 4A- Hotline Coordination

Improve coordination among crisis lines by aligning data tracking, reducing redundancies, and establishing clear pathways to connect callers with appropriate local resources and follow-up care.

OBJECTIVE 4B- Co-Response Team

Implement and evaluate a clinician-led co-response program pairing a CIT-trained officer with a licensed behavioral health professional to respond to behavioral health crises.

OBJECTIVE 4C- Postvention Community Loss Response

Sustain and strengthen the Community Loss Team to provide compassionate, coordinated support after suicide or sudden loss.

OBJECTIVE 4D- Same-Day Services

Develop a Behavioral Health system that offers same-day crisis assessment, brief therapy, and resource navigation to reduce emergency department utilization and connect individuals quickly to ongoing support.

OBJECTIVE 4E- System Performance Monitoring

Establish shared performance metrics for crisis response and regularly review outcomes to strengthen system accountability, coordination, and timely access to care.

Leadership & Collaboration

By fostering collaboration across sectors, securing and stewarding funding to strategy, and grounding decisions in data, MWBI provides the leadership, communication, and coordination needed to create lasting, measurable improvements in mental well-being for all residents.

Goal #5: Provide strategic leadership and data-driven collaboration

Advance a coordinated and data-informed approach to improving community mental well-being by aligning partners and funding around shared priorities, unified communication, and measurable impact.

OBJECTIVE 5A- Strategic Facilitation

Lead and align community partners across sectors, including schools, local government, healthcare, and businesses, around a shared vision for mental well-being. Facilitate collective strategic planning, strengthen systems for accountability, and maintain structures that sustain long-term, coordinated action.

OBJECTIVE 5B- Data-Driven Approach

Build and sustain a shared behavioral health data system that guides decision-making, tracks outcomes, and identifies service gaps. Maintain a centralized dashboard that supports partner accountability and continuous improvement across the community.

OBJECTIVE 5C- Communication

Develop and implement inclusive, bilingual communication strategies that improve awareness, visibility, and engagement in mental health and substance use resources, programs, and events. Coordinate messaging and outreach to normalize mental health conversations and expand equitable access to information.

OBJECTIVE 5D- Funding

Secure and steward public and private funding to target the highest community needs, directing investments toward priorities identified in the strategic plan.

OBJECTIVE 5E – Sustainable Infrastructure

Strengthen and maintain the organizational systems and capacity needed to sustain coordinated action, shared accountability, aligned funding, and continuity across the mental well-being ecosystem.



Deliverable 1: Co-Response Operational Plan

Prepared for:
Blaine County Mental Well-Being
Initiative

Prepared by:
Third Horizon

July 7, 2025

Table of Contents

Background	3
Methodology	3
Research Findings	4
Substance Abuse Mental Health Services Administration (SAMHSA) Best Practices	4
Co-Responder and Mobile Crisis Team Models	6
Crisis Data Analysis	9
Summary of Key Data Findings	13
Stakeholder Input	13
Focus Group Findings	13
Additional input from staff and Workgroups 3 and 4	15
Third Horizon Recommendations	15
Short-Term: Develop a Clinician-Led Co-Response Model	16
Service Hours	16
Required Staffing	16
Host Organizations	17
Deployment of the Co-Response Team	17
Community Education and Training	18
Mid-Term Recommendations	18
Long-term Recommendations	19
Conclusion and Next Steps	21
Appendices	22
Definitions Memo	22
Admissions Data Memo	22
MWBI Co-Responder Research Memo	22
Presentation Slides	22

Background

The Blaine County Mental Well-Being Initiative (MWBI) is working to develop a sustainable, outcomes-focused behavioral health crisis system that reflects national best practices while addressing the community's unique needs. MWBI has contracted Third Horizon, a strategic health care advisory firm with deep behavioral health systems design and implementation expertise, to support this effort. Third Horizon will work with the MWBI throughout 2025 to build and strengthen the crisis system infrastructure. This includes exploring the feasibility of developing a mobile response, a place to go for crisis stabilization, and improved behavioral health system-level coordination.

MWBI requested that Third Horizon provide an interim report, addressing a structured recommendation for designing, staffing, and implementing a mobile crisis response strategy in Blaine County. The project team was asked to consider how the community could ensure a 30-minute crisis response time, including an assessment of the Blaine County Sheriff's "Co-response" concept of adding a mental health staff person alongside a potential new deputy as a "first step" prior to a full mobile crisis team buildout.

This report serves as the requested deliverable.

Methodology

Third Horizon used a mixed-method approach to research and prepare the recommendations. This included:

- **Discovery:** The project team examined historical MWBI documents and had extensive dialogue with MWBI leadership and staff.
- **Literature review:** Third Horizon reviewed publicly available information on evidence-based practices for different co-responder models and provider examples from across the country. Researchers then selected a few illustrative examples to investigate further and highlight. Third Horizon also conducted an internet search on relevant job descriptions and job types to help inform local decision-making.
- **Stakeholder engagement:** The project team facilitated four focus groups with behavioral health providers, partner organizations, St. Luke's staff, and county government, including law enforcement. Additionally, Third Horizon met regularly with MWBI leadership and staff, participated in MWBI workgroup meetings, presented its research findings and preliminary recommendations, and obtained input from workgroups 3 and 4.
- **Crisis data analysis:** Researchers analyzed crisis data from public safety and St. Luke's to assess the current state of behavioral health crisis response.
- **Analysis of operational feasibility:** Third Horizon applied its behavioral health system-level expertise and experience. The team considered feasibility given community needs, available resources, political will, and level of readiness to adopt behavioral health crisis response models.

Research Findings

Substance Abuse and Mental Health Services Administration (SAMHSA) Best Practices

Third Horizon sought the most recent and widely accepted guidance on best practices for behavioral health crisis delivery systems. In January 2025, SAMHSA released [updated guidelines](#) for a Behavioral Health Coordinated System of Crisis Care (BHSCC). These updated guidelines build upon the foundation of best practices published by SAMHSA in 2020, and the children's guidelines published in 2022. They have been used to implement models nationwide over the past five years. The national guidelines assert 11 overarching principles that outline how BHSCC services should be implemented and integrated into the broad care delivery system. The principles are specific, yet not prescriptive, emphasizing the need for a community to develop a BHSCC that meets its unique needs. The principles also focus on operating a systems-based model through integration and coordination, while tailoring services to meet the needs of the individual, such as tailored services based on the level of crisis or age range.

SAMHSA's principles specify that crisis services should be:

- Comprehensive, Integrated, Coordinated, and Developed Utilizing a Systems-Based Approach
- Person-Centered, Family Focused, and Provide the Right Level of Care at the Right Time
- Prioritizing Safety
- Equitably Accessible and Responsive to the Diverse Needs of Populations
- Prioritizing Quality and Effectiveness
- Developmentally Appropriate
- Resiliency- and Recovery-Oriented
- Trauma-Informed
- Providing Continuity of Care from Onset of Crisis Until Stability and Include Follow-Up Care and Linkage
- Evidence-Based, Evidence-Informed, and/or Reflect Best, Promising, and Emerging Practices; and
- Responsive to Individuals' Wholistic Needs.

SAMHSA guidance outlines best practices for designing, implementing, and sustaining a BHSCC. The guidance emphasizes assigning an accountable entity to provide high-level oversight and coordination of services across the BHSCC. The primary functions of the entity include conducting community assessment and planning activities, managing multiple funding sources to support the continuum, and establishing performance benchmarks. The accountable entity will help manage the key components of a BHSCC infrastructure, including:

- Administrative Structure, Oversight, and Policy;
- Communications and Community Engagement;
- Equitable Behavioral Health Crisis Care;

- Evaluation and Data Collection;
- Optimizing Crisis Systems Through Technology;
- Financing and Fiscal Sustainability; and
- Behavioral Health Crisis Workforce Recruitment, Retention, and Support.

SAMHSA considers a best-in-class BHSCC to include the three essential elements: Someone to Contact, Someone to Respond, and A Safe Place for Help. The services offered within these elements may vary by the community's infrastructure and needs, but all models should abide by the overarching principles.

Someone to Contact: 988 Lifeline and Other Behavioral Health Lines

Contact centers offer free and safe options for individuals in a crisis. Several call center models can be integrated into a BHSCC, such as the 988 suicide & crisis lifeline, other behavioral health crisis hotlines, peer-operated warmlines, and additional behavioral health emotional support lines. Regardless of the type of call line, crisis workers should be trained to support people with various behavioral health issues and age groups. For example, mandated reporting training should be required for serving children and youth. The contact center should also provide training on de-escalation techniques, which vary for adults and youth.

The call lines must also coordinate with other services in the care continuum. This integration may involve other existing crisis lines or 911. Effective coordination requires clear guidance on each call line's roles, particularly when engaging law enforcement through 911. Additionally, ongoing data collection, evaluation, and quality improvement initiatives should occur within the crisis lines. The SAMHSA guidance provides a list of sample metrics to track and monitor for a call line. Lastly, equity is highlighted as a best practice, and the line must be accessible to everyone, including offering services in multiple languages or using translation services. There might also be a preference for a video option for individuals who are hard of hearing or a chat feature for those who prefer text communication.

Someone to Respond: Mobile Crisis and Outreach Services

Like contact centers, there are many different mobile crisis teams (MCTs) and outreach models. The three most common models are behavioral health practitioner-only, co-responder models involving law enforcement, and services provided through mobile response and stabilization programs. The guidance recommends identifying model types that best match the community's needs. SAMHSA specifies four key components a mobile crisis team needs to meet its definition.

- MCTs must be on-demand and rapid once a request is accepted.
- MCTs must be mobile and meet the individual in the community instead of being limited to a specific location.
- MCTs must include at least one crisis staff person providing crisis services to the individual face-to-face.
- An MCT response must include engagement with a licensed or credentialed provider (this engagement may be virtual).

The SAMHSA guidance outlines best practices for staffing and service delivery for each model. Regardless of the model, special attention must be given to children and youth mobile crisis systems. Youth models should follow SAMHSA's Systems of Care values and principles. A key difference between youth and adult services is involving families and prioritizing keeping children in their current living environments whenever possible. MCT teams serving children and youth should receive specialized training in areas such as child development, family systems, crisis intervention with LGB Youth, child abuse reporting, and other relevant topics to serve this population best.

Mobile crisis and outreach services should emphasize coordination with other BHSCC services, data evaluation, and quality improvement initiatives. Due to the urgency of an intervention with an MCT, data may be more complex to track. Therefore, demographic data should be prioritized for collection, and processes to collect data post-intervention may be required.

A Safe Place for Help: Emergency and Crisis Stabilization Services

Across all emergency and crisis stabilization service models, individuals should have a safe space to receive support and care that addresses their behavioral health crisis. One model type is no-barrier or low-barrier, which requires no criteria for admission. These models can be structured to support individuals in high-intensity or moderate-intensity crises, provide availability for a short-term or extended stay, or be located in a hospital or the community. No or low barrier spaces differ from referral-based crisis residential services, as these require a referral and typically offer more extended lengths of stay (between several days and a couple of weeks).

For youth and children, the ideal approach to providing a safe space for help focuses on de-escalation and stabilization within their home or current living environment. In-home stabilization services can act as a bridge to help transition youth from a moderate crisis to community-based care. It is essential to involve family members or support providers in stabilization and care planning for youth. If in-home services are not possible, respite services, crisis stabilization, or residential crisis facilities should be designed explicitly for the needs of youth.

Coordination among contact lines, MCTs, and follow-up care is essential for emergency and crisis stabilization services. For example, referrals for referral-based services are often made from contact centers. If the location allows law enforcement to drop off individuals, a mutually determined process with law enforcement is also vital.

Co-Responder and Mobile Crisis Team Models

Informed by SAMHSA's best practices, Third Horizon researched program models for co-response and mobile crisis. The research aimed to describe different approaches that could be used to inform local decision-making for Blaine County. The following is a summary of a memorandum provided to the MWBI in May 2025, which is also included in the Appendix.

Historically, emergency responses have relied heavily on 911 call centers, which dispatch police as primary responders, with fire and emergency medical services (EMS) providing support when needed. In this traditional model, police officers are responsible for assessing safety and initiating interventions. While this structure benefits from existing emergency infrastructure and well-defined command chains, it often results in a security-driven response to behavioral health emergencies. Research has shown that this approach may lead to unnecessary arrests, use-of-force incidents, and increased emergency department visits. Although many jurisdictions have adopted Crisis Intervention Team (CIT) training to better equip officers, the core model continues to position law enforcement as the default responder, which may inadvertently escalate mental health crises.

In response to these limitations, co-responder models have emerged as a critical innovation in crisis intervention. These models involve law enforcement officers working alongside behavioral health professionals, such as clinicians, counselors, or peer support specialists, during crisis calls. This collaborative approach aims to de-escalate situations, minimize unnecessary arrests and hospitalizations, and ensure individuals receive appropriate care. Including behavioral health professionals introduces expertise and lived experience into the response process, promoting more compassionate and effective outcomes. Successful implementation of co-responder models requires more than shared deployment; it necessitates structured joint training, clear protocols, and ongoing inter-professional communication to ensure coordinated and effective crisis management.

Co-responder models offer a transformative alternative to traditional police-led responses for behavioral health crises. By combining the strengths of law enforcement and clinical professionals, these programs enhance public safety, reduce unnecessary criminalization, and connect individuals in crisis to the services they need. The most effective models are those that build strong inter-agency partnerships, invest in collaborative training, adhere to clear operational protocols, and embed equity and evaluation into every stage of their design. Figure 1 summarizes different types of co-response models and other options for operational and structural variations for a model.

Figure 1: Summary of Co-response model types and structural variations

Police-Led Co-Responder Models	Clinician-Focused and Hybrid Co-Responder Frameworks	Behavioral Health Practitioner-only Mobile Crisis Teams (MCT)
Law enforcement officer paired with a behavioral health clinician An officer must be present; ensures safety of the person in	Emphasizes a balanced partnership or clinician leadership, prioritizing health-centered responses	Typically, has at least one licensed clinician and other non-licensed support staff (peers/case managers)

crisis, and the clinician, if present	Maintains law enforcement presence for safety when needed	
Operated through police departments, using existing emergency infrastructure Officers often receive specialized training, e.g., Crisis Intervention Training (CIT)	Operated by police departments Allows either the clinician or officer to take the lead based on the situation, contingent upon the need for clinical assessment or safety intervention	Operated by an independent agency SAMHSA emphasizes that co-responder models may complement, not replace MCTs May respond to calls to 988 calls, an MCT hotline, or 911 calls assessed as not requiring police response
The presence of uniformed officers may be seen as stigmatizing or criminalizing The model may be more viable in communities with safety concerns	Studies show community members often favor clinician-led teams, highlighting the impact of program structure on trust and effectiveness	Eliminates police response for most scenarios
Operational Variations		
Ride along: Embeds a mental health professional with law enforcement for faster, coordinated response and improved team cohesion Ride Support: Dispatches clinicians as needed, maximizing resource efficiency but possibly delaying intervention and complicating de-escalation	Service delivery Modality: Telehealth Expanding clinical reach, especially in rural or resource-limited areas Effectiveness may be reduced by tech issues, limited situational visibility, and challenges in building rapport Better supplement than replacement	Team composition may include: Paramedics/ Emergency Medical Technicians (EMTs) Peer Support Specialists

While co-responder programs offer significant benefits, their success depends on careful planning and coordination across multiple areas. Establishing strong, formal partnerships among law enforcement, behavioral health providers, and community organizations is essential, supported by memoranda of understanding (MOUs) that clearly define roles, responsibilities, data-sharing protocols, and sustainable funding arrangements. Ongoing joint training is also crucial, covering topics such as crisis intervention, de-escalation, trauma-informed care, cultural responsiveness, legal considerations, and informed by individuals with lived experience. Clear protocols should guide all stages of the response process, from dispatch to follow-up, to ensure consistency and safety. Comprehensive data collection is necessary from the beginning to evaluate outcomes, improve service quality, and support program sustainability. Engaging the community throughout design and implementation fosters equity and trust. Additionally, long-term success requires stable funding and a strong commitment to ethical standards, including informed consent, confidentiality, and addressing potential biases. When implemented thoughtfully, co-responder models can be a cornerstone of a more humane, effective, and integrated crisis response system.

Crisis Data Analysis

Third Horizon sought to understand demand for and utilization of crisis services in Blaine County. Researchers analyzed available crisis data as follows:

- SLWR Mental Health Encounters (January 2020 – September 2024)
- SLWR Mental Health Emergency Department Visits (December 2020 – June 2024)
- Blaine County Dispatch Calls for Mental Health Crises (January 2021 – May 2025)
- Crisis Hotline Call Volume (January 2022 – June 2024)
- Idaho Crisis Suicide Hotline FY2024 Q1 and Q2 Reports

Encounters, ED Visits, and dispatch data were provided at the individual line level, with all cases scrubbed of personally identifiable information.

Utilization Trends

Figures 2 and 3 show month-over-month counts for 911 dispatch calls for crisis response and SLWR mental-health emergency department visits, respectively. The red line is a trailing 12-month average intended to show the general trend while smoothing over some of the monthly variance.

Figure 2: Crisis response calls over time

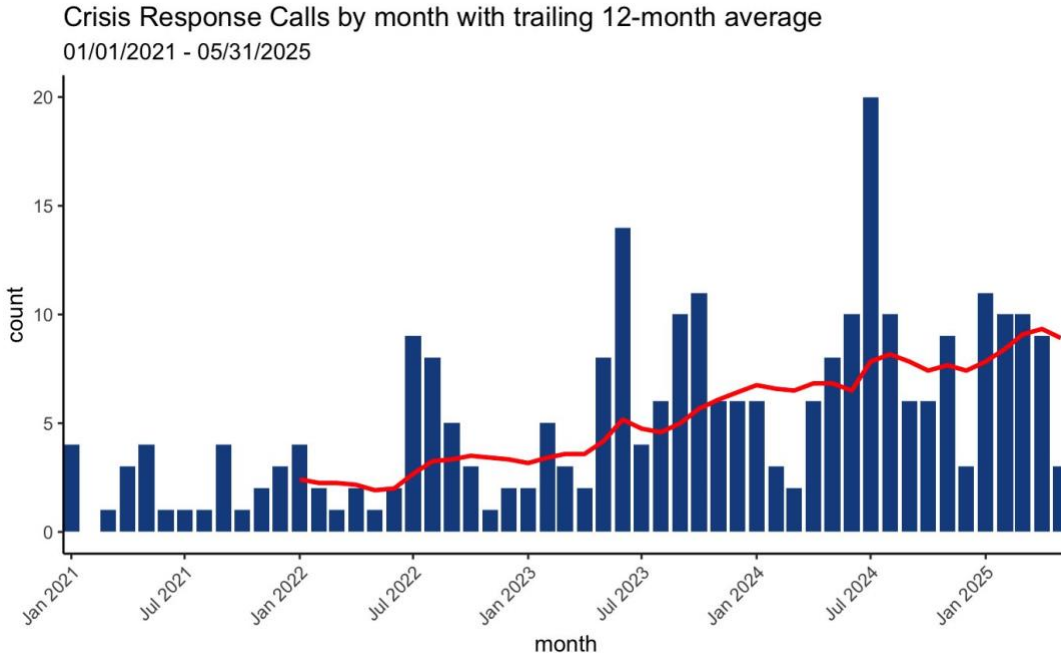
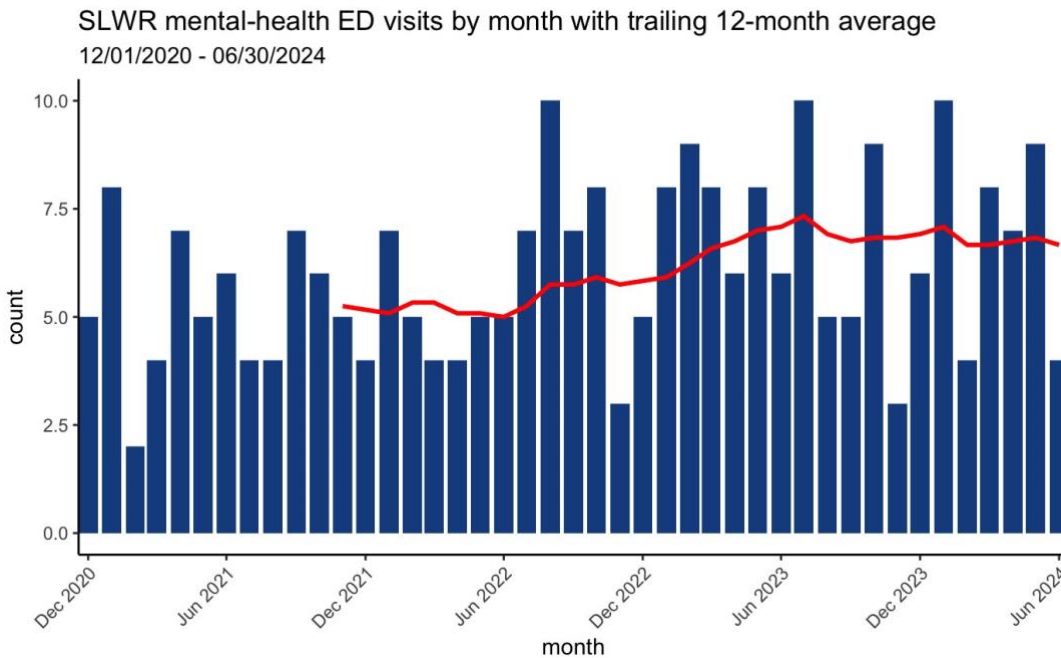


Figure 3: SLWR mental-health ED visits over time



Crisis hotline calls and utilization of mental health services also increased over the same period.

One of the primary goals of a coordinated crisis system is to lower emergency department visits. The SLWR emergency department visit data contained 262 mental health ED visits over a 3.5-year period. There were 21 distinct diagnosis codes in the data—diagnoses could be broadly bucketed into two categories: 1) ideation, and 2) those containing a component of self-harm

(e.g., intentional drug overdose, suicide attempt). Seventy-three percent of admissions were for suicidal thoughts/ideation, while 27% involved a component of self-harm.

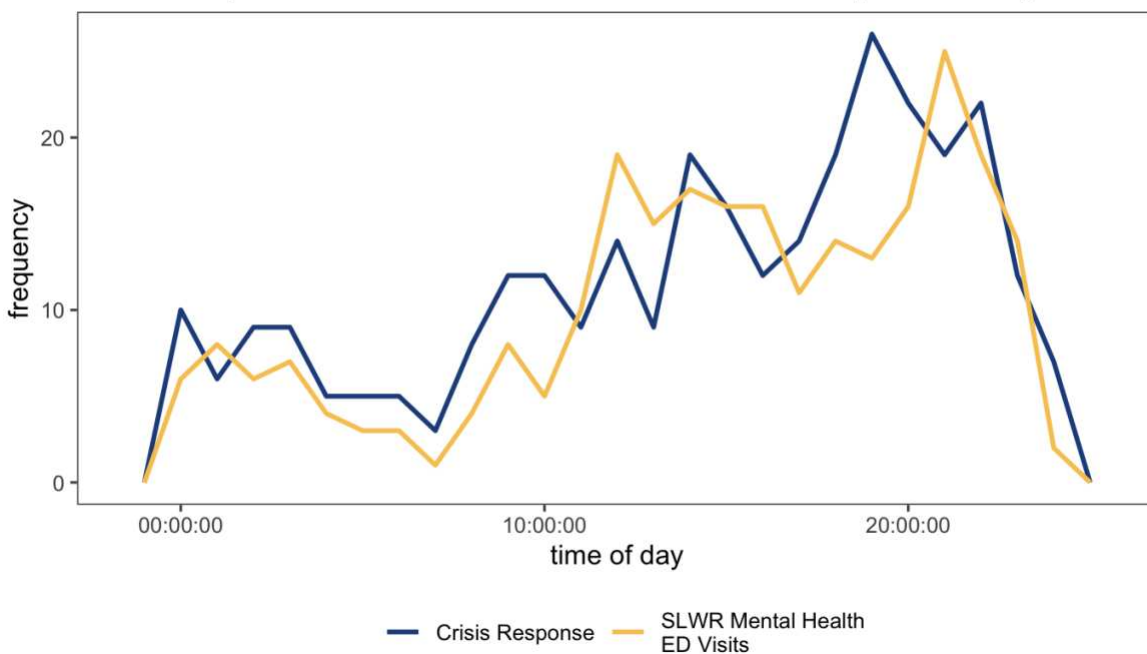
Crisis dispatch data included details about the type of transportation provided to help resolve the incident. Thirty-six percent of dispatches were resolved with transportation by ambulance, while approximately half required no transportation at all. Fifteen percent of cases included a transportation component by law enforcement.

Figure 4. Crisis Dispatch Transport Share

Transport	Share (%)
Ambulance	36%
Law Enforcement	13%
Both	2%
Neither	49%

Both crisis dispatch data and SLWR ED visit data included timestamps for each case. Figure 5 shows the frequency of cases by time of day. Both crisis dispatches and ED visits track closely together by time of day. Most mental health crisis calls and ED admissions occur in the second half of the day, with peak hours between 7pm and 10pm. This information can be useful for staffing decisions, but it must be balanced with other factors such as the availability of behavioral health professionals and law enforcement.

Figure 5: Crisis Response and SLWR mental-health ED visits by time of day
Crisis Response and SLWR mental-health ED visits by time of day



Crisis Client Demographics

Third Horizon analyzed demographic data where available. Figure 6 shows the breakdown of services by gender and median age.

Figure 6. Available Gender and Age Data

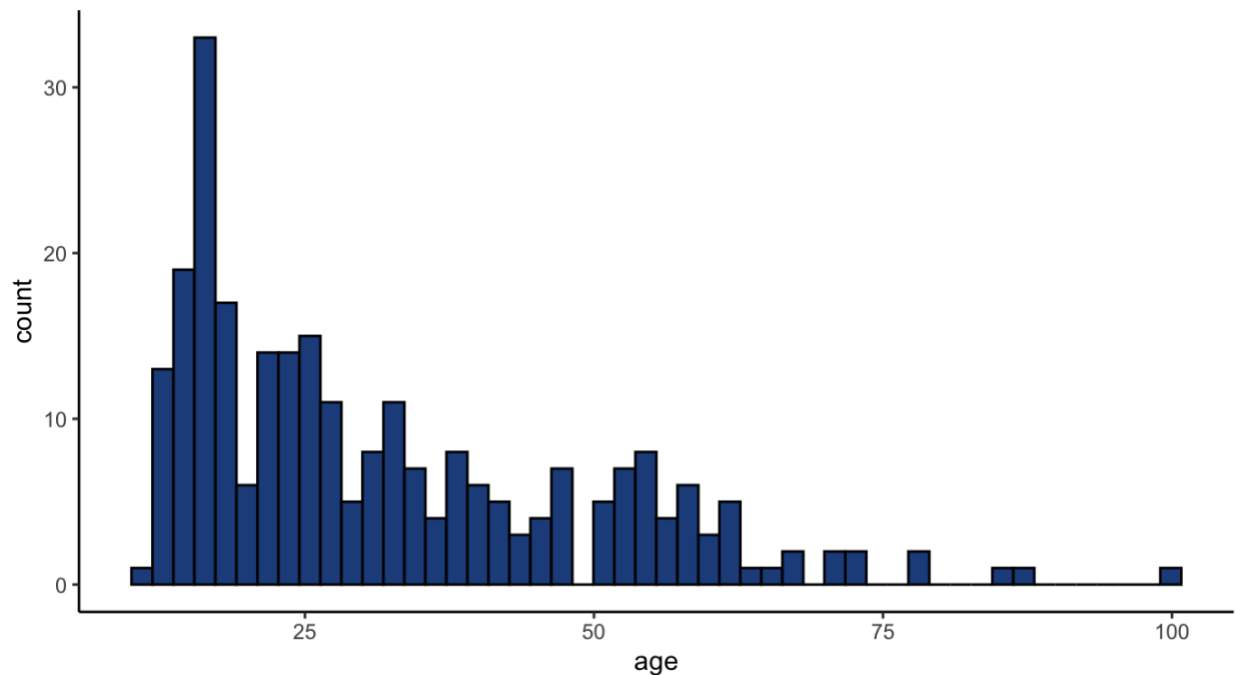
Source	Male	Female	Median Age
Crisis Response Data	46%	54%	36
Crisis Hotline Call Data	43%	57%	n/a
SLWR Mental Health Encounter Data	40%	60%	38
SLWR Mental Health ED Visits	40%	60%	26

Utilization by gender is relatively consistent across all datasets. The median age is significantly lower for the emergency department cohort. Figure 7 shows a histogram of the age distribution for emergency department visits. The lower median age is driven by increased ED utilization from adolescents.

Figure 7. SLWR Mental Health ED Visits by Age

SLWR mental health ED visits by age

12/01/2020 - 06/30/2024



Limitations and Next Steps

The data provided likely does not present a comprehensive view of crisis services for the county. Dispatch and hospital data are for mental health-related incidents and do not include all SUD. SLWR ED data were filtered using primary mental health crisis diagnostic codes. While this may be the best available method, it could be overly restrictive in identifying relevant events.

As a next step, Third Horizon will analyze community and provider survey responses from the Katz Amsterdam Foundation survey, compare responses to those from other Mountain West communities, and use them to inform the strategic direction of Blaine County MWBI's crisis services.

Summary of Key Data Findings

Third Horizon's analysis found:

- Crisis response dispatch calls, SLWR mental health encounters, and SLWR ED visits data all show increasing utilization trends over time.
- On average, dispatch responds to nine behavioral health crisis calls per month (most recent available trailing 12-month average).
- On average, the ED receives seven individuals in mental health crisis per month (most recent available trailing 12-month average).
- The median age for ED visits (26) is significantly lower than for crisis response (36) or mental health encounters (38). This reflects a higher prevalence of mental health-related ED visits among adolescents.
- Thirty-six percent of all crisis response calls involved transportation by ambulance.
- Most mental health crisis calls and mental health ED visits occur in the second half of the day, with peak hours between 7pm and 10pm.

Third Horizon and the MWBI can collaboratively use this data to help inform the development of behavioral health crisis services in Blaine County. One primary implication of the data is that the need for mobile crisis response may be most significant in the evening hours.

Stakeholder Input

Focus Group Findings

In May 2025, Third Horizon facilitated four virtual focus groups with community partners, behavioral health providers, local government representatives, and the St. Luke's team. Facilitators used a structured discussion guide to gather input on key questions aligned with Goal 4 of the Blaine County Mental Well-Being Initiative.

Focus Group Participation:

Cohort	Number of Participants	Date
--------	------------------------	------

Local Government including law enforcement	9	May 12
Partners	9	May 28
Providers	5	May 27
St. Luke's	10	June 3

Focus group participants shared various perspectives on how best to respond to behavioral health crises in the community. Opinions were mixed regarding the role of law enforcement. While some expressed concern about the historical inconsistency and heavy-handed nature of police responses, others noted improvements through recent CIT training and supported co-response models, particularly for safety during late-night incidents. Many emphasized that, if pursued, co-response should involve plain-clothes officers in unmarked vehicles paired with behavioral health professionals. Those who favored a mobile crisis team acknowledged that law enforcement may sometimes need to be involved if there are safety concerns.

There was a strong interest in developing a local mobile crisis team, which many saw as a feasible and needed option, especially with potential support from the Sheriff and available funding. Participants valued the ability of mobile teams to focus on de-escalation, connection to ongoing care, and the inclusion of peer or non-clinical supports. A local hotline was also suggested as an alternative to 911, allowing emergency resources to be reserved for more appropriate calls. Some participants noted concerns about the responsiveness of existing crisis services and suggested that a mobile team could help alleviate pressure on the emergency department, which is currently functioning as the default crisis center.

Still, questions remain about the level of local demand, with some wondering whether the community can sustain both a co-response model and a mobile crisis team, especially on a 24/7 basis. Many pointed out that crises often arise during evenings, weekends, and holidays, and that behavioral health needs among children and youth are becoming more acute. Participants cited a shortage of child therapists and service gaps for children under 14, who local inpatient providers do not currently serve. Suggestions included developing a drop-in facility for teens and ensuring more robust support for parents navigating crises.

Operational considerations also surfaced, including the need for clear leadership structures in co-response models, creative staffing solutions in light of workforce shortages, and thoughtful service hours aligned with community needs. Participants also called for closed-loop systems to ensure individuals receive follow-up care, and stressed the importance of outreach and education, both to the broader community and to referral sources.

More detailed findings and stakeholder input are available in the Appendix.

Additional Input from MWBI Staff and Members of Workgroups 3 and 4

After reviewing the focus group findings, a group of local stakeholders provided feedback on preliminary recommendations for improving crisis response in Blaine County. Overall, participants supported the direction of the recommendations while highlighting key logistical and funding challenges.

Sheriff Ballis noted that while commissioners are aligned with the long-term vision, the county funding a whole crisis response team may not be feasible until FY27 due to budget timelines. The most likely scenario is that the county would approve a new deputy position in the Sheriff's office, which could be paired with a behavioral health clinician funded by the MWBI. Several stakeholders supported a clinician-led model as the ultimate goal but acknowledged that a hybrid approach may be needed in the interim. Concerns were raised about Magellan's current mobile crisis team response time to 988 calls. Participants discussed whether a local hotline might be a more effective dispatch point, unless Blaine County and Magellan can establish a formal agreement to reroute calls to a local team or shorten the response time.

Participants expressed interest in staffing around high-need hours. Stakeholders emphasized the need for better data on EMS and 911 calls to inform planning. The importance of law enforcement and clinicians training together and building rapport before the co-response launch was also raised.

Participants agreed that even a phased or partial implementation represents progress toward longer-term goals for an effective crisis system in Blaine County.

Third Horizon Recommendations

Based on research, analysis, and stakeholder feedback, Third Horizon recommends that Blaine County MWBI take the following phased approach to implementing mobile crisis services.

Short-Term: As soon as possible, develop a clinician-led co-response model, pairing a licensed behavioral health clinician with a deputy. This should be implemented on a pilot basis. Additional details and considerations for the implementation plan are described below.

Mid-Term: Assess the model and determine whether further expansion, contraction, or service redesign is needed. Explore the feasibility and need for a clinician-led mobile crisis response that does not involve law enforcement.

Long-Term: Collaborate with Magellan and the Idaho Department of Health and Welfare to expand mobile crisis teams and reduce response time. Advocate with the department and the legislature for Idaho to apply for a planning grant and/or to join the CCBHC Medicaid

Demonstration. While these are long-term recommendations, the MWBI could pursue them concurrently with implementing the short—and mid-term steps.

Short-Term: Develop a Clinician-Led Co-Response Model

Third Horizon recommends that Blaine County MWBI partner with the Sheriff's department to implement a co-response model as soon as possible. The program would initially be funded by county resources supporting the new deputy position and the MWBI supporting a licensed behavioral health clinician.

Service Hours

Recognizing that the level of demand and available resources may not be sufficient for 24/7 services, Third Horizon recommends that the program be piloted to align with the second shift at the Sheriff's department and include the peak crisis times of 7 p.m. to 10 p.m. The MWBI should track utilization, response time, and place of service data over time to gauge the effectiveness of the program and the need to expand or contract service hours.

Required Staffing

Third Horizon recommends pairing 1 FTE licensed behavioral health clinician with 1 FTE deputy who would work as a team and respond to a crisis call together. Third Horizon sought and found seven sample job descriptions for mobile crisis and co-response behavioral health clinicians. Almost all of them (5/7) require a master's degree and appropriate licensure (either in counseling or social work). Many require at least 2-3 years of professional field experience. An alternative to a licensed clinician would be a master's-level clinician pursuing licensure, provided they can have the appropriate level of supervision and support. Third Horizon also recommends that the clinician be trained in and have experience with crisis intervention and de-escalation, triage, and assessment. Furthermore, the clinician should be comfortable working with both adults and youth.

Third Horizon recommends that the deputy position be filled by someone with CIT training and a commitment to serving people with behavioral health needs through the least restrictive setting possible.

Given the evidence base and stakeholder feedback, Third Horizon strongly recommends that the co-response deputy be in plain clothes and an unmarked vehicle. This will help mitigate stigma and anxiety and promote an appropriate and trauma-informed response. Using an unmarked car and plain clothes helps reinforce that the situation is a health issue, not a law enforcement problem. This approach will breed community trust, decrease the risk of escalation, and encourage voluntary engagement.

The behavioral health clinician should lead the assessment of the person in crisis. However, the deputy should retain discretion to assert authority if safety becomes a concern. Part of the deputy's role will be to ensure the behavioral health clinician and the person experiencing a behavioral health crisis remain out of harm's way.

The deputy and the behavioral health clinician should be trained in culturally relevant care and have access to translation services if it is not possible to include a bilingual team member. This will be important to help reach the Hispanic community in Blaine County. Additionally, on-call support should be available when a team member is on leave. Over time, the community may want to grow the program to have a cadre of contractors who can provide co-response to help increase overall coverage.

Host Organizations

The deputy position would be under the auspices of the Blaine County Sheriff's Department.

Third Horizon recommends that the Family Health Services employ the behavioral health clinician. They may be housed at the Bellevue clinic, out of their home, or in a hybrid scenario. Since 1982, Family Health Services has served southern Idaho with primary and preventive care, oral health, and behavioral health services. Family Health Services is a federally qualified health center and operates a grant-funded CCBHC in Twin Falls. By housing the clinician within a provider organization, the MWBI will increase the likelihood that these services can be sustained through reimbursement or absorbed into either the FQHC prospective payment system (PPS) or a future CCBHC PPS if the state of Idaho joins the Medicaid Demonstration. Family Health Services would also offer efficiency in terms of administrative costs, given their pre-existing infrastructure. Furthermore, a provider organization would be best suited to offer clinical supervision and quality assurance for the co-responder services. Lastly, Family Health Services has been an active participant in the MWBI since its inception and shares the vision and mission of the organization.

Deployment of the Co-Response Team

In the near term, the co-response team should be deployed through law enforcement/public safety. Written protocols, memoranda of understanding, and processes will need to be developed. This will help ensure all relevant parties have a shared understanding of when it is appropriate to send the co-response team rather than other law enforcement, how community members can request the team, and expectations for the response time. Public safety/911 should be able to triage and assess calls to determine if first responders are needed, or if the co-response team is appropriate.

The MWBI requested that Third Horizon develop recommendations for a 30-minute response time. This should be the stated expectation for the team, but with the recognition that it may not always be feasible with only one team available. For example, if they are on a call in the field and another request for co-response comes in, or if there is a snowstorm or road closures. It will be critical for the MWBI to monitor the success of the co-response team in meeting the 30-minute response time guidelines and rationale if there is a delay, to help inform needed modifications after the initial pilot phase of the program.

Community Education and Training

As co-response will be a new approach for Blaine County, the MWBI and its partners should invest in extensive community education and training about the services. A well-crafted communication and marketing plan can raise awareness about the co-responder program and its goals, educate the public about how it works and its benefits, and encourage appropriate use. Further, community education and training about co-response can help reduce stigma around mental health and substance use disorders while building public trust in law enforcement and behavioral health partnerships.

Referral organizations such as human services, health care, behavioral health providers, schools, and community-based organizations should be well informed about requesting the co-response team and have reasonable expectations for the response time.

Third Horizon recommends that the MWBI and its partners use some combination of the following tactics:

- Press release/PSAs announcing the program launch
- Op-eds or guest columns in local newspapers
- Website page with FAQs, partner info, and how the program works
- Social media
- Town halls or community forums
- Print Materials (e.g., brochures/flyers for clinics, grocery stores, libraries, police stations, and community centers)
- Presentations and meetings with referral organizations.

Data Collection

The MWBI, Family Health Services, and the Sheriff's department should establish systems to collect and monitor data during the pilot phase. This will be a critical step to gauging the effectiveness of the co-response program. See the Mid-Term Recommendations for suggested key performance indicators. Family Health Services has an electronic health record, but this may or may not be the best platform for data tracking. A separate shared database or Excel tracking tool should most likely be developed.

Mid-Term Recommendations

Following the initial pilot period, MWBI and its partners should review the effectiveness of the co-response program and evaluate the need to expand or contract service hours or pivot to a different approach. Third Horizon recommends that the following data points and key performance indicators be assessed after one year:

- Utilization and demographics of people served
- Response time
- Case disposition
- Reductions in avoidable emergency department utilization
- Reductions in criminal justice involvement

- Cost impacts, e.g., comparing the program's cost to the cost of deploying first responders or utilizing emergency departments.

If warranted, the pilot program could be made permanent, the number of hours or the number of teams could be expanded.

Additionally, over time, MWBI may want to explore the feasibility and need for a clinician-led mobile crisis response that does not involve law enforcement. This could be in addition to, or instead of, the co-response program. The clinician could be paired with a peer support specialist, case manager, or paramedic. The local suicide prevention hotline could be used to deploy this team.

Long-term Recommendations

For the long term, the most feasible or sustainable approach to mobile crisis response in Blaine County would be for the MWBI to partner with the Idaho Department of Health and Welfare and Magellan (the Medicaid managed care organization in Idaho) to expand Magellan's mobile crisis response teams (MRTs) and reduce the response time. This would not preclude the need for co-response; as previously noted, these approaches are not mutually exclusive; SAMHSA emphasizes that co-responder models may complement, not replace MCTs.

Partnering with Magellan will ensure a more sustainable funding source (e.g., Medicaid) for mobile crisis services in Blaine County. However, changes to the existing program will be needed to achieve the MWBI's goal of a 30-minute response time.

The contract between the state and Magellan specifies requirements for administering crisis services in the state. The publicly available version of the contract has redacted sections that may include greater detail on Magellan's scope of work and requirements. The publicly available information on the scope of work includes establishing, maintaining, and promoting a crisis system for all Idahoans, comprised of a crisis call center, MCTs, and crisis stabilization facilities. The contract requires the program to adhere to the [IDHW Crisis System Standards](#) and SAMHSA best practices when operating the crisis delivery system.

The contract states that the mobile response strategy must establish and maintain MRTs to meet projected crisis needs across the seven IDHW regions. The MRT must respond without law enforcement support unless exceptional circumstances exist and should follow IDHW-approved protocols when engaging law enforcement. The contract states MRTs are required to respond on site within 60 minutes of receiving a crisis call and to follow up with the person in crisis within 24 hours of initial contact. Magellan may offer incentives to MRTs who respond to crisis calls within 45 minutes. During the TH-facilitated focus group with partner organizations, a representative from Magellan indicated that the state required MRT response time to be one hour but allowed up to two hours for rural areas and up to three hours for frontier areas. While Third Horizon could not verify this in the publicly available contract, it may be reflected in a redacted section. This extended response time concerns stakeholders and may pose risks to the safety of the person in crisis and the community.

Magellan must track performance measures for the MRT teams. Three reports are listed in the contracts: a performance report, an available MRT report, and a template for field reporting.

These measures include a monthly performance report that include:

- 1) Total number of crisis contacts in which an MRT was indicated
- 2) Total number of times an MRT was dispatched
- 3) Distribution of response times from initial contact to arrival on site
- 4) Total number of transports made to the following as a result of the MRT:
 - a) Crisis stabilization units
 - b) Inpatient hospitals
 - c) Other facilities
- 5) Total number of designated examinations initiated as a result of the mobile crisis response
- 6) Total number of coordinated responses with law enforcement, fire or ambulance, or other first responders
- 7) Distribution of insurance coverage for members receiving mobile crisis response, by coverage type.

Third Horizon also reviewed the Idaho Behavioral Health Transformation Waiver, which was approved in April 2020 by CMS under Section 1115 authority. The waiver aims to provide various behavioral health services for Medicaid beneficiaries. Over the last five years, the state has reported improvements in access to inpatient behavioral health care and substance use disorder treatment. The current waiver will expire in September 2025. The State Medicaid department submitted an [application for a five-year extension](#) in March, which is awaiting approval as of this report.

One of the demonstration goals described improved crisis service availability, including call centers and mobile crisis units. To achieve this goal, the state proposes the following:

- Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability;
- Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
- Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine the appropriate level of care and length of stay.

The waiver extension does not indicate changes to the goals and strategies for increasing access to crisis services. Therefore, the state seems to remain committed to building capacity to improve access to crisis services for the Medicaid population. MWBI should continue to monitor state activity, including Medicaid-covered services and funding streams, as they build their long-term crisis system.

Finally, Third Horizon recommends that the MWBI continue to advocate with the IDHW and the Idaho legislature to apply to participate in the Certified Community Behavioral Health Clinic (CCBHC) Medicaid Demonstration, authorized under section 223 of the 2014 Protecting Access to Medicare Act (PAMA) (P.L. 113-93). Under the demonstration, states receive an enhanced federal match from CMS to enable them to pay clinics that meet federal and state certification criteria as CCBHCs with a prospective payment system (PPS). The Bipartisan Safer Communities Act authorized adding 10 new states to the CCBHC Medicaid Demonstration program every two years, starting in 2024 and continuing through 2030. Idaho would have opportunities to apply to join the demonstration in 2026, 2028, and 2030. Idaho may also have opportunities to apply for a planning grant from SAMHSA in advance of applying to join the demonstration.

Alternatively, Idaho could add CCBHC to its Medicaid State Plan. On March 9, 2024, the Consolidated Appropriations Act (CAA) of 2024 (Pub. L. 118-42) was signed into law and contains a provision under section 209 that makes the CCBHC program permanent as an optional state plan benefit under Medicaid.

Idaho's participation in the Medicaid Demonstration would benefit Blaine County's MWBI by creating a sustainable funding mechanism (the PPS) for robust crisis services at the community level. CCBHCs must offer a comprehensive range of services to all people in need, including crisis services, regardless of payer source, and coordinate care with other providers and systems.

While Family Health Service has grant funding to operate as a CCBHC in Twin Falls, it is time-limited. A more permanent funding stream for CCBHC would enable Family Health Services (or another provider) to expand and sustain CCBHC into Blaine County.

Conclusion and Next Steps

The Blaine County MWBI is working to develop a sustainable, outcomes-focused behavioral health crisis system that reflects national best practices while addressing the community's unique needs. Third Horizon conducted research, data analysis, and stakeholder engagement to assess the best approach for a mobile response in Blaine County. Creating a co-response model that pairs a licensed behavioral health clinician with a CIT-trained deputy in the Sheriff's department is a realistic and critical first step to addressing immediate crisis needs in the community. It will be vital that the MWBI and its partners build out the program in accordance with the recommendations contained in this report and gauge the impact of the pilot against key performance indicators.

In the next phase of work, Third Horizon will work closely with the MWBI and community stakeholders to assess the need for a crisis stabilization facility or other behavioral health center that offers people experiencing a behavioral health crisis a "place to go", as an alternative to the emergency department or jail.

Appendices

[Definitions Memo](#)

[Admissions Data Memo](#)

[MWBI Co-Responder Research Memo](#)

[Presentation Slides](#)



TO: Jenna Vagais, Blaine County Mental Well-Being Initiative (MWBI)
FROM: Mindy Klowden, Managing Director for Behavioral Health, Third Horizon
DATE: May 9, 2025
SUBJECT: Behavioral Health Crisis Services: A Primer and Definitions

Background

The Blaine County MWBI contracted with Third Horizon to help Blaine County build a sustainable behavioral health crisis system infrastructure rooted in national best practices and tailored to the community's needs. This memo aims to provide a primer and help distinguish between different terminology and levels of care associated with behavioral health crisis services. Third Horizon included in this memo only those services discussed to date in stakeholder meetings. This is not a comprehensive overview of all behavioral health services.

Broad Overview of the Behavioral Health Continuum

The continuum of care for mental health and substance use disorder services includes prevention, crisis services, outpatient treatment, intensive outpatient treatment, residential treatment, inpatient/hospitalization, and recovery supports. Having access to all levels of behavioral health care helps ensure that individuals can receive appropriate care in a timely manner, which helps keep people from getting into crisis and supports people after experiencing a crisis. Third Horizon, therefore, considers the extent to which the full continuum or service array is available in a community as part of strategic planning around crisis systems.

Behavioral Health Crisis Services

[SAMHSA's 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care](#) states, "A behavioral health crisis system represents a key set of services that includes someone to contact, someone to respond, and a safe place for help." This includes crisis contact centers, mobile crisis teams (MCTs) and outreach services, and crisis stabilization services that work together to coordinate care. These services address the acute behavioral health needs of people in crisis; are consistent with goals to improve well-being; decrease psychological distress/substance use and prevent suicide and overdose; and are linked to sub-acute and outpatient services that support ongoing engagement, harm reduction, treatment, and supports that foster recovery and resilience."

The revised guidelines introduce some new terminology that has not yet been fully adopted in the field. Third Horizon crosswalks the language used in the 2025 guidelines with some other terminology used to help delineate between different models and approaches.

Someone to Call: Crisis Contact Centers

These include 9-8-8 call centers contracted by Vibrant Health, as well as suicide prevention and other hotlines that are not part of the 988 Lifeline network.

Someone to Respond: Mobile Crisis and Outreach Services

Mobile crisis and outreach services aim to de-escalate situations and help link individuals with behavioral health issues to appropriate services. There are multiple models of these services. Third Horizon is preparing a more in-depth memo comparing approaches, to help inform local efforts in Blaine County with pressing timelines. In this memo, the firm only provides definitions to help ensure consistency in language. It is important to note that these models need not be mutually exclusive and can be complementary approaches to meet different needs in a given community.

- **Co-Response:** Co-response models vary significantly across communities but generally pair specially trained law enforcement officers or other public health first responders (e.g., fire, emergency medical services (EMS)) with behavioral health professionals to respond to calls involving individuals experiencing a behavioral health crisis. Benefits of a co-responder model include that first responders may have the ability to travel distances or terrain more quickly than a mobile crisis team, or intervene in a situation in which safety is a concern. Co-response teams are often deployed through 9-1-1 or utilize a "beat" or geographic area structure, assigning mental health professionals or social workers to specific zones or areas where they work alongside police officers.
- **Mobile Crisis Teams (MCT):** SAMHSA recommends in its 2025 guidelines that communities have mobile crisis services available that do not involve law enforcement, recognizing the potential harm and stigma associated with police involvement in behavioral health crises. The key components of MCT are that they are on-demand services that can be deployed quickly, they are mobile and able to go to where the person in crisis is, and they provide in-person services. Licensed mental health clinicians lead MCTs, while in some communities, peers and non-degreed trained crisis workers may also be on a team. MCTs may work in partnership with a crisis call center or operate their own, and be deployed based on those calls.
- **Community Outreach Teams (COTs):** Community Outreach Teams (COTs) do not provide on-demand crisis services but crisis prevention and postvention services. These teams help community members access needed behavioral health, social services, and other supports. COTs may focus their outreach on targeted populations such as people who are homeless.

Somewhere to Go: Emergency and Crisis Stabilization Services

SAMHSA's 2025 guidelines state, "Emergency and crisis stabilization services reflect a range of models and care to support individuals through emergent and urgent behavioral health needs. Emergency and crisis stabilization services include facility-, home-, and

community-based services that provide access to care and stabilization for adults and youth in crisis.”

The phrase “somewhere to go” has been associated with many labels. Terms such as “crisis center,” “crisis walk-in center,” “crisis stabilization center,” “crisis receiving center,” and “crisis receiving and stabilization center” are sometimes used interchangeably. Per [Idaho statute Title 39, Health and Safety, Chapter 91](#), in Idaho, these facilities are termed “Behavioral Health Community Crisis Centers” or simply “crisis centers.”

Additionally, other types of crisis facilities, such as “behavioral health urgent care”, and “crisis stabilization units,” differ from crisis centers in some core program characteristics. Each of these facility types are distinct from hospital-based care, though hospitals may also operate behavioral health emergency units.

- **Crisis Centers:** Crisis centers help people in the midst of a behavioral health crisis by de-escalating, stabilizing, and providing access to community-based services or referrals. Because crisis centers are not considered residential or inpatient facilities, client stays are limited to 23 hours and 59 minutes (e.g., less than 24 hours). Clients may access crisis centers voluntarily through self-referral, or by referral (and often transport) by mobile crisis teams, or first responders. Services typically include triage, screening, assessment, immediate intervention and referrals to longer-term services. The setting is often a less clinical environment, or “living room model” in which clients can relax in recliners or couches and sometimes refreshments, clothing, or other supportive services are available on site.
- **Behavioral Health Urgent Care (BHUC):** The purpose of a BHUC is similar to that of a traditional urgent care facility in that it is for non-life-threatening behavioral health issues that need attention quickly but are not emergent. Examples would include anxiety or depression flare-ups, medication management needs, or other behavioral health issues not requiring more intensive crisis services or hospitalization. These facilities are NOT typically 24/7 but may have extended hours beyond a typically outpatient clinic, and have same-day, walk-in access. As stated on SAMHSA’s 2025 guidelines, BHUC “provides time-limited, targeted services and supports that is not meant to be a routine or ongoing source of care.”
- **Crisis Stabilization Unit (CSU):** CSUs may or may not be attached to or share a campus with crisis centers or hospital-based programs. The intent of a CSU is for individuals in a serious psychiatric crisis who need short-term intensive care but don’t require full psychiatric hospitalization. Length of stay in a CSU is typically up to 72 hours. The setting is often secure, with rooms and beds that are more hospital-like than a crisis center but less restrictive than an inpatient psychiatric hospital. In terms of staffing, a CSU will generally have more medical team members present (psychiatrist, nurse) than would be required in a crisis center.

Third Horizon will work collaboratively with Blaine County MWBI to further flesh out these facility types and discern the most appropriate “somewhere to go” model to meet local community needs.

Assertive Community Treatment (ACT)

ACT is an evidence-based practice that features intensive, community-based services provided by a multidisciplinary group of professionals to individuals with serious mental illness (SMI)—often those who have difficulty engaging in traditional outpatient treatment. ACT is generally not considered a crisis service per se. The primary goals of ACT are to help individuals with serious mental illness live successfully in the community, reduce hospitalizations, and improve their quality of life.

ACT Teams typically comprise a team lead or supervisor, mental health and substance use disorder clinicians, a psychiatric consultation (psychiatrist or psychiatric nurse practitioner), an RN, peer specialists, and a vocational support specialist with expertise in supported employment. An ACT team typically serves a small caseload—around 1:10 staff-to-client ratio—allowing high-intensity, personalized care.

ACT teams can be challenging to sustain in rural communities. Some payers require fidelity to the ACT model as measured by the [Dartmouth ACT Scale](#).

Certified Community Behavioral Health Clinic (CCBHC)

A Certified Community Behavioral Health Clinic (CCBHC) is an outpatient, community-based clinic that provides a comprehensive range of mental health and substance use services. CCBHCs are required to serve anyone who walks through the door, regardless of their diagnosis, age or insurance status. The [Excellence in Mental Health and Addiction Treatment Act](#) established a federal definition and criteria for CCBHCs. These criteria were [updated by SAMHSA in 2023](#).

CCBHCs must offer nine core services, either directly or through a contracted “Designated Collaborating Organization” or DCO. Services include:

- Crisis services;
- screening and assessment;
- person-centered treatment planning;
- outpatient mental health and substance use services;
- outpatient primary care screening and monitoring;
- targeted case management;
- psychiatric rehabilitation services;
- peer support and family support; and
- Intensive community-based mental health care for veterans.

For crisis services specifically, CCBHCs must ensure clients have access to emergency crisis intervention services, mobile crisis services, and crisis receiving/stabilization services. It is important to note that the CCBHC criteria promote collaboration with existing state and local crisis systems. For example, CCBHCs are not required to operate as the 9-8-8 call center but rather coordinate with it.

States can apply to join the CCBHC Demonstration authorized under section 223 of the 2014 Protecting Access to Medicare Act (PAMA) (P.L. 113-93). Under the demonstration, states receive an enhanced FMAP from CMS to enable them to pay clinics that meet federal and state certification criteria as CCBHCs with a prospective payment system, which is similar to how federally qualified health centers are paid.

SAMHSA has also operated CCBHC expansion grant programs, offering up to four years of grant funding for clinics to develop, implement, or expand on the CCBHC model. Idaho has four clinics that received SAMHSA CCBHC grants in the fall of 2022. These included Heritage Health (based in the Coeur d'Alene area), Community Health Association of Spokane (expanding into the Lewiston area), Terry Reilly Health Services (clinic will be located in Caldwell), and Family Health Services (based in Twin Falls).

In April, 2023, [Idaho Governor Little recommended, and the Idaho Legislature appropriated, \\$12 million](#) over two years for Certified Community Behavioral Health Clinics (CCBHCs) to improve access and the quality of behavioral health services in Idaho.

The Bipartisan Safer Communities Act authorized adding 10 new states to the CCBHC Medicaid Demonstration program every two years, from 2024 through 2030. Idaho would have opportunities to apply to CMS and SAMHSA to join the Demonstration in 2026, 2028, and 2030.

Additionally, on March 9, 2024, the Consolidated Appropriations Act (CAA) of 2024 (Pub. L. 118-42) was signed into law and contains a provision under section 209 that makes the CCBHC program permanent as an optional state plan benefit under Medicaid.

Conclusion

This memo aims to help the Blaine County MWBI and its stakeholders align around terminology and definitions. This information may be beneficial for both planning purposes and stakeholder education. Third Horizon will be happy to expand on the information or insert additional terms as needed.

About Third Horizon

Third Horizon is a boutique advisory firm focused on designing integrated health and social systems so that all communities, families, and individuals can thrive. Through its work across five advisory services, the firm offers a 360° view of complex challenges across three horizons – past, present, and future – to help industry leaders and policymakers interpret signals and trends and develop upstream innovations, strategies, and structural changes that maximize the value of the yearly spend on health care. Learn more at www.thirdhorizon.co.



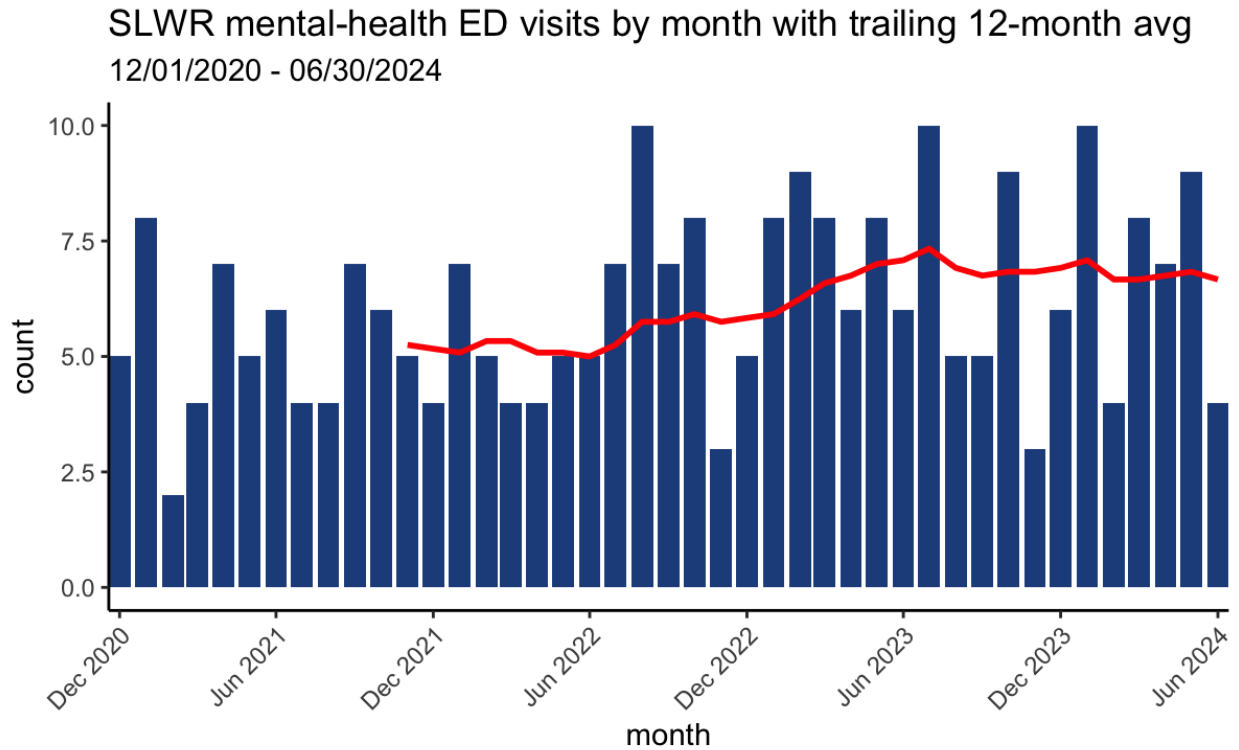
TO: Jenna Vagias, Blaine County Mental Well-Being Initiative (MWBI)
FROM: Mindy Klowden, Managing Director, Third Horizon and
Alex Hryhorczuk, Senior Director of Data Services and Analytics, Third Horizon
DATE: May 7, 2025
SUBJECT: St. Luke's Wood River Medical Center Mental Health Emergency Department
Admissions Data

Background

The Blaine County MWBI contracted with Third Horizon to help Blaine County build a sustainable behavioral health crisis system infrastructure rooted in national best practices and tailored to the community's needs. Third Horizon has begun analyzing local crisis-related data to understand current utilization patterns better and inform the planning process. MWBI provided emergency department data, which the firm then used to build some data visualizations that may be beneficial for both planning purposes and stakeholder education.

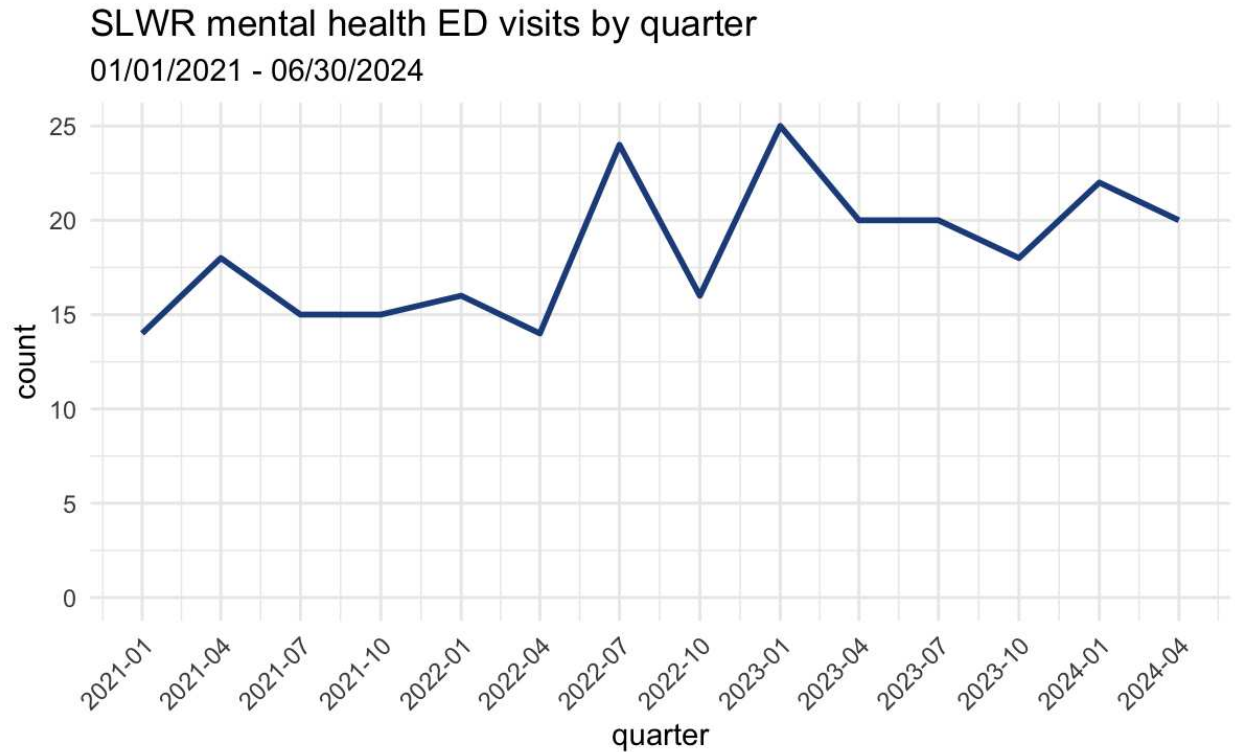
Third Horizon's analysis found that the data contained 262 mental health ED visits over a 3.5-year time window, including fields for age, sex, diagnosis, and date/time. There were 21 distinct diagnosis codes in the data—diagnoses could be broadly bucketed into two categories: 1) ideation, and 2) those containing a component of self-harm (e.g., intentional drug overdose, suicide attempt). 73% of visits were for suicidal thoughts/ideation, while 27% involved a component of self-harm.

Utilization by Date and Time



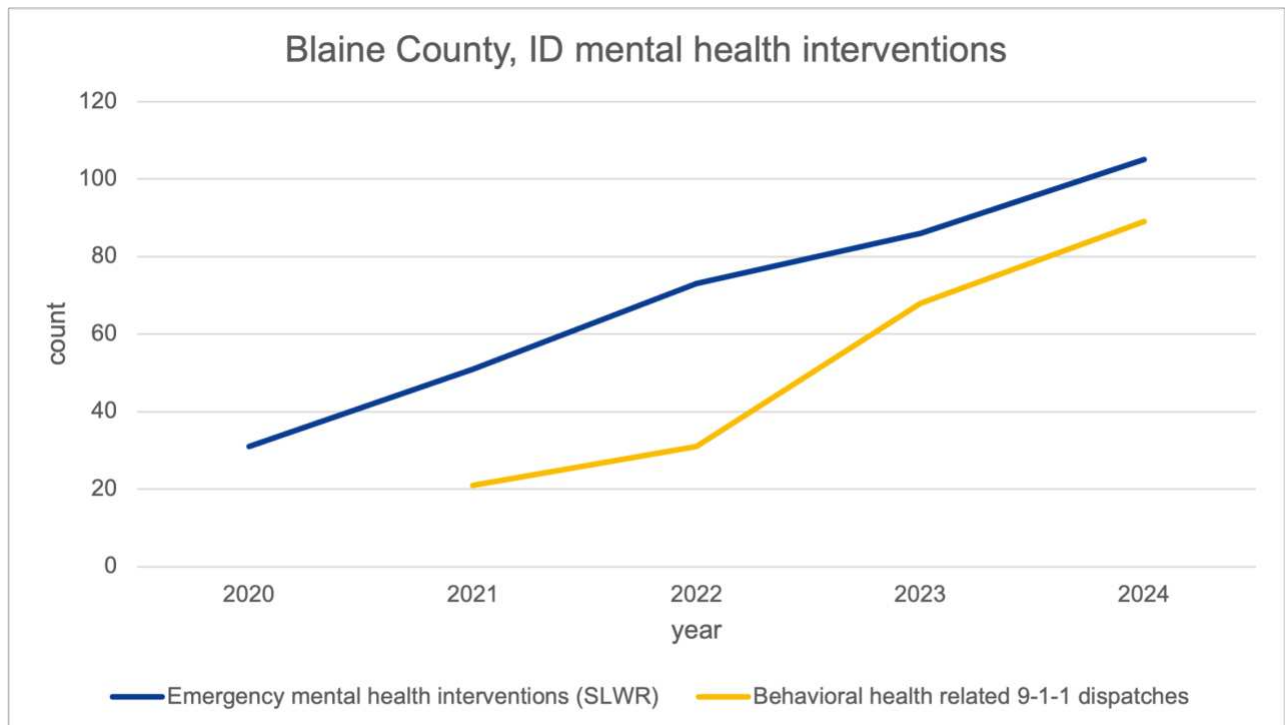
The data show there was an average of six mental health ED visits per month, with a minimum of two and a maximum of 10.

To more clearly see if there is an increasing trend, visits were next depicted by quarter.



The quarterly data shows visits increasing over time.

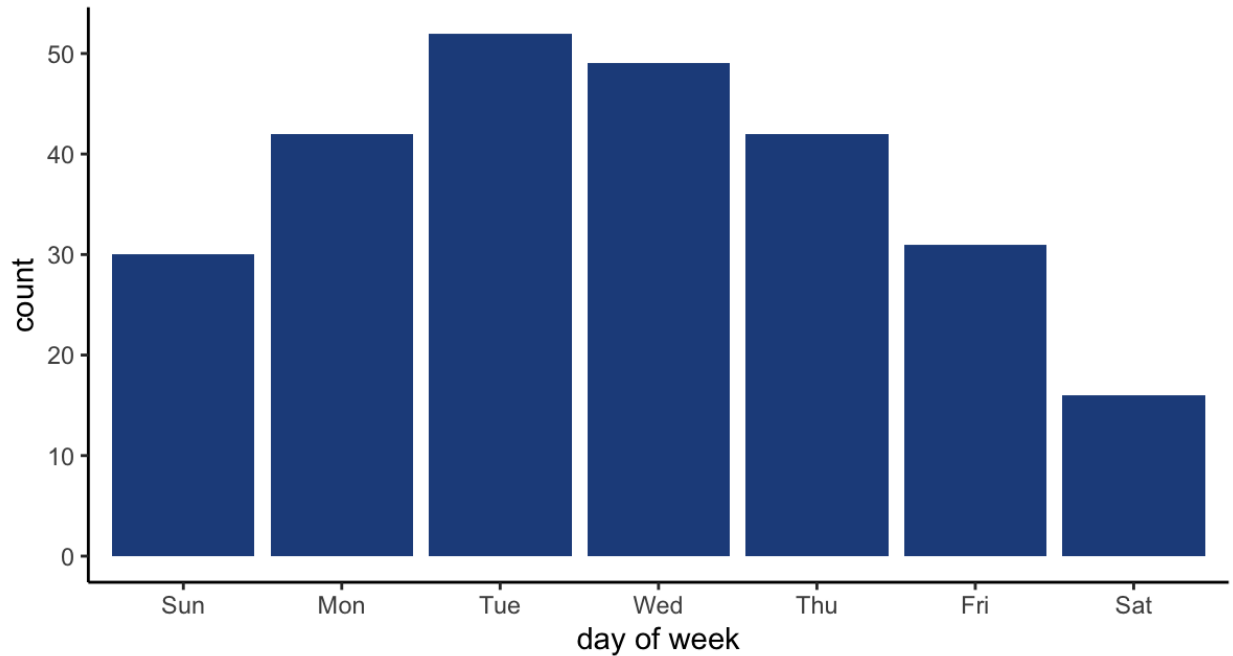
Data from “Youth & Mortality Data Blaine County.xlsx” shows yearly counts of SLWR mental health interventions and behavioral health 911 dispatch calls on a slightly longer timeline. Both clearly show an increasing trend over time.



Next, Third Horizon looked for any trends related to days or hours of admission. This information could potentially be useful in thinking through how to allocate staffing and other resources in crisis services.

SLWR mental health ED visits by day of week

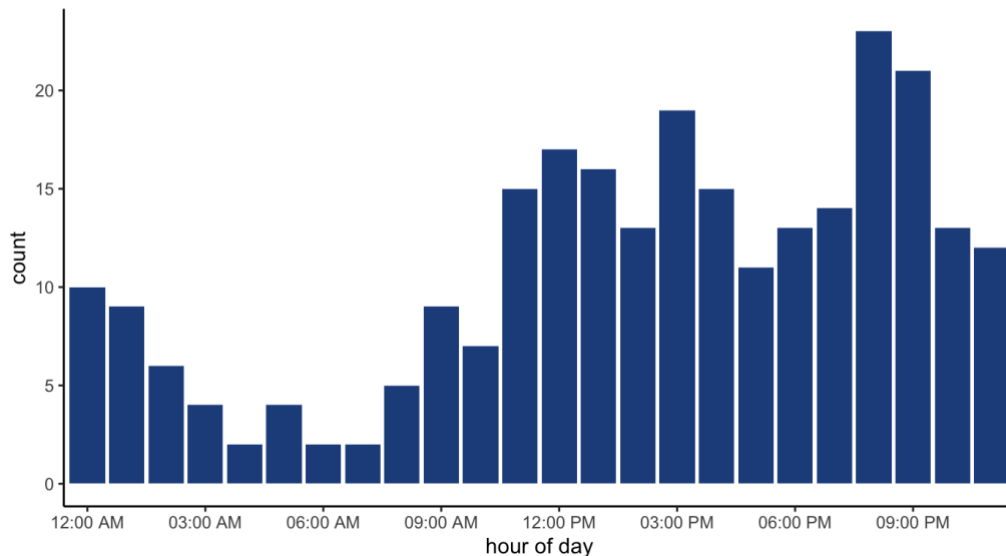
12/01/2020 - 06/30/2024



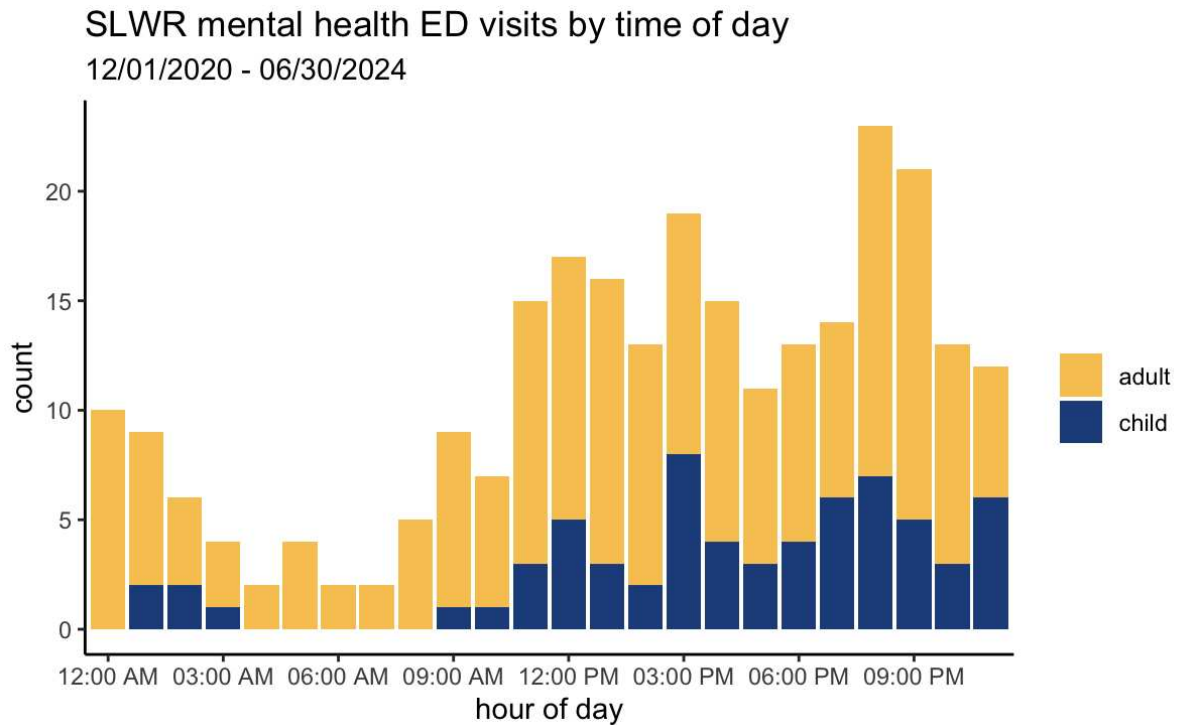
The plot shows ED visits are more common during the middle of the week, and less common on weekends.

WRMC Mental Health ED Admissions by time of day

12/01/2020 - 06/29/2024



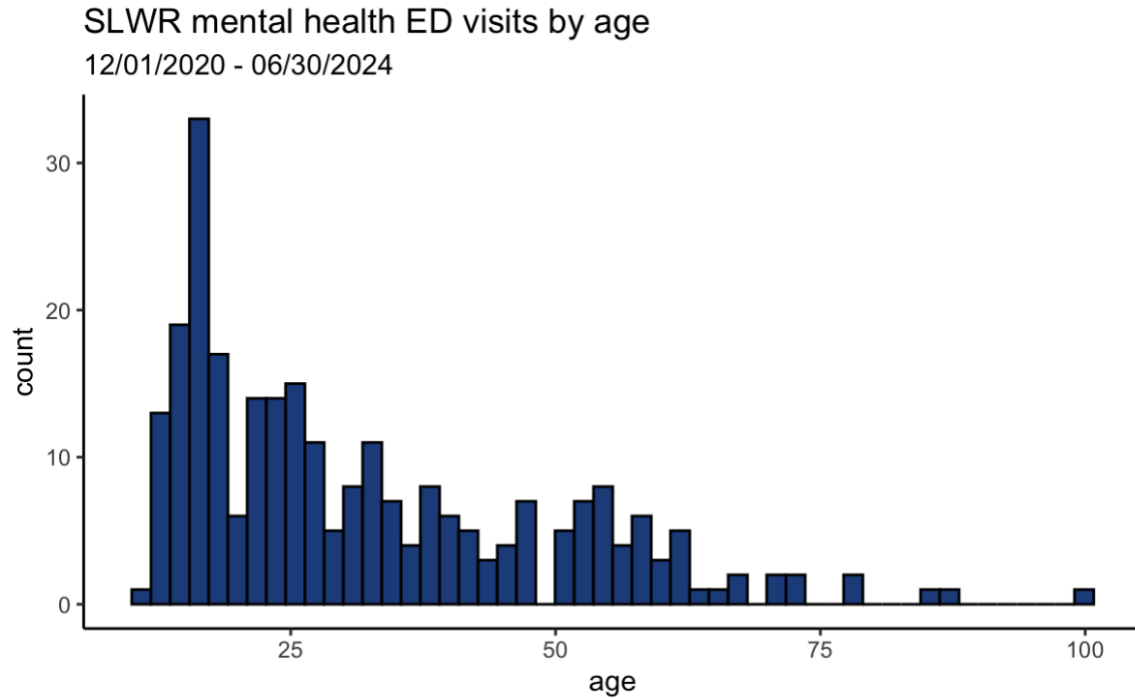
Most visits occur in the second half of the day, with peak hours between 8-10PM. Researchers also checked to see if there were any meaningful differences in times between children under 18 and adults. None were found.



Demographics

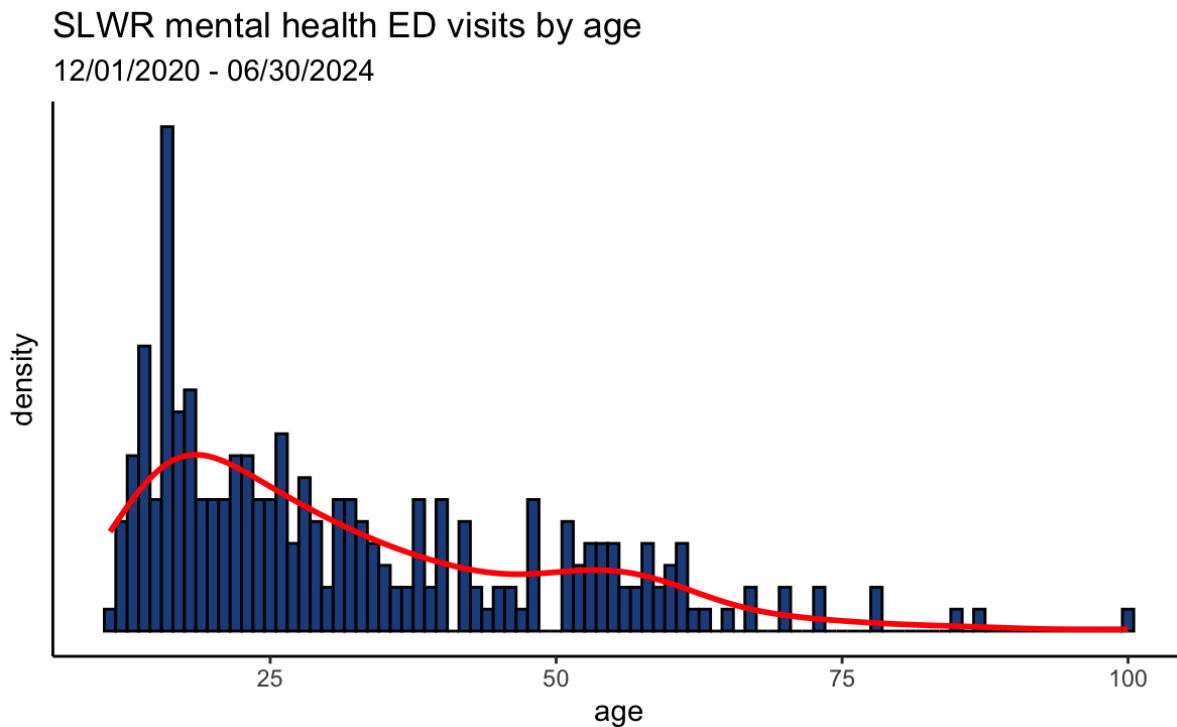
Sixty percent of ED visits were female. It was also more likely that females would self-harm. 67% of visits for self-harm were female.

The median age for the population was 26, meaning half of all ED visits were under 26 years old.



As illustrated in the histogram (above), the data show ED visits are much more prevalent among adolescents. The highest prevalence is among 16-year-olds.

A density diagram allows Third Horizon to draw a trend line through the data (below).



Conclusion

Third Horizon and the MWBI can collaboratively use this data to help inform the development of behavioral health crisis services in Blaine County. Additional crisis-related data that would be beneficial to review, if available, includes 9-8-8 call line data, first responder data and behavioral health provider data.

About Third Horizon

Third Horizon is a boutique advisory firm focused on designing integrated health and social systems so that all communities, families, and individuals can thrive. Through its work across five advisory services, the firm offers a 360° view of complex challenges across three horizons – past, present, and future – to help industry leaders and policymakers interpret signals and trends and develop upstream innovations, strategies, and structural changes that maximize the value of the yearly spend on health care. Learn more at www.thirdhorizon.co.



TO: Jenna Vagais, Blaine County Mental Well-Being Initiative (MWBI)
FROM: Mindy Klowden, MNM, Managing Director for Behavioral Health
Elveena Fareedi, Manager, Behavioral Health Research and Projects
DATE: 05/21/2024
SUBJECT: Crisis Co-Responder Models

Background

The Blaine County MWBI contracted with Third Horizon (TH) to help Blaine County build a sustainable behavioral health crisis system infrastructure rooted in national best practices and tailored to the community's needs. Sheriff Morgan Ballis has proposed developing a co-responder model in the county, while stakeholders are also exploring a mobile crisis team. This memo aims to inform the planning process by providing research on various co-responder models and evidence-based practices. Third Horizon also offers samples of comparable job descriptions from across the country to inform local decision-making.

Methodology

TH conducted a literature review of publicly available information on evidence-based practices for different co-responder models and selected a few examples from across the country to highlight. TH also conducted an internet search on relevant job descriptions and job types to help inform local decision-making.

Introduction

Historically, traditional crisis response funnels all emergencies through 911 centers that dispatch police as primary responders, with fire and emergency medical supports (EMS) as needed. Officers are tasked with safety assessment and initial intervention. This model relies on existing emergency infrastructure and clear command structures but often results in a primarily security-oriented approach to behavioral health emergencies. Research indicates that this has led to unnecessary arrests, use of force incidents, and emergency department transports¹. While many jurisdictions enhance this model through Crisis Intervention Team (CIT) training for officers, the fundamental approach still positions law enforcement as the default crisis responder, which may often escalate tensions for individuals experiencing mental health emergencies.

Co-responder models have become a pivotal innovation in emergency response systems, especially as communities seek alternatives to traditional law enforcement-led interventions during behavioral health crises. As defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), co-responder models involve pairing trained first responders, typically police, with behavioral health specialists such as clinicians, counselors, or peer support professionals². These models represent a collaborative framework in which law enforcement officers and behavioral health professionals respond together to crisis calls in order to de-

escalate situations, reduce unnecessary arrests and hospitalizations, and connect individuals to appropriate care. The behavioral health professional on the team may be a licensed clinician, a social worker, a counselor, or a peer support specialist who brings lived experience to the interaction. Effective co-response requires more than simply placing two professionals together; it demands intentional efforts to bridge these divides through comprehensive joint training, clearly articulated protocols, and continuous inter-professional communication.

SAMHSA also recommends in its 2025 guidelines that communities have mobile crisis services available that do not involve law enforcement, recognizing the potential harm and stigma associated with police involvement in behavioral health crises. These are referred to as Mobile Crisis Teams (MCT). The key components of MCT are that they are on-demand services that can be deployed quickly, they are mobile and able to go to where the person in crisis is, and they provide in-person services. Licensed mental health clinicians lead MCTs, while in some communities, peers and non-degreed trained crisis workers may also be on a team. MCTs may work in partnership with a crisis call center or operate their own, and be deployed based on those calls.

In 2021, authorized under the American Rescue Plan Act (ARPA), states were given a new option for supporting community-based mobile crisis intervention services for individuals with Medicaid.³ These services must be provided to individuals who are Medicaid eligible, either through the state plan or through a CMS-approved waiver, and who are experiencing a mental health or SUD crisis, outside of a hospital or medical setting. The team should include at least one behavioral health care professional qualified to provide an assessment and other professionals or paraprofessionals with expertise in behavioral health or mental health crisis intervention. These additional community-based mobile crisis intervention services team members may include nurses, social workers, trained peer support specialists, and others with relevant experience and expertise identified by the state in its state plan, waiver, or section 1115 demonstration. These services must be available 24 hours a day, every day.

The ARPA mobile crisis services require states to ensure that the multidisciplinary mobile crisis team can provide screening and assessment, stabilization and de-escalation, and coordination with and referrals to health, social, and other services and supports, as needed, and health services as needed. CMS recommends that telehealth be used at the outset of the crisis as part of screening, assessment, and stabilization, or for follow-up to the crisis with the individual regarding coordination and referrals.

Model Types and Structural Variations

Co-responder programs differ significantly across jurisdictions but can be broadly classified into several typologies. Below is a brief description of several types of co-responder models:

A. Police-Led Co-Responder Models (e.g., Officer-Clinician Pairings)

The most traditional and widely recognized co-responder model involves a law enforcement officer paired with a mental health clinician responding jointly to emergency calls suspected of having a significant behavioral health component⁴. In this configuration, the law

enforcement officer's primary role is to ensure the safety of all individuals on scene, including the person in crisis, the clinician, and the public. The clinician provides specialized mental health expertise, conducts assessments, and employs de-escalation techniques. These models are typically housed within and dispatched through police departments, leveraging existing emergency response infrastructure. Officers participating in these programs are often, though not always, required to have specialized training, such as Crisis Intervention Team (CIT) certification. However, this structure may also lead to perceptions within the community that the response is primarily a law enforcement one. SAMHSA guidance suggests that co-response teams involving law enforcement can sometimes be stigmatizing and may inadvertently reinforce the criminalization of mental illness.⁵ The presence of a uniformed officer, even alongside a clinician, might affect the willingness of some individuals or communities to engage with the team, particularly those with prior negative experiences with law enforcement.

B. Clinician-Focused and Hybrid Co-Responder Frameworks

Some jurisdictions have developed clinician-focused or hybrid co-responder frameworks to address some of the concerns associated with strictly police-led models. These models may place greater emphasis on the clinician's role or strive for a more visibly balanced partnership in the field. In these models, police officers and a designated clinician may collaborate on calls. A key feature is that officers first evaluate the nature of the call and determine if a law enforcement action is appropriate before the full co-response engagement.⁶ Clinician-focused or hybrid models may represent a deliberate design choice to prioritize a health-centered approach while still ensuring law enforcement presence for safety when deemed necessary. This allows for a flexible, needs-based leadership within the co-response team, where the professional with the most relevant expertise for the immediate situation, be it clinical assessment or safety assurance, can guide the intervention.⁷

SAMHSA guidelines acknowledge this variability, noting that key considerations for co-responder models include the entity that operates or manages the program (e.g., law enforcement agency or a behavioral health provider) and the degree to which the team is embedded within the community versus a clinical setting.⁵ One study found that individuals who had previously used mobile crisis services and their families generally preferred co-response teams led by a clinician rather than responses involving only law enforcement.⁸ This preference was based on the belief that clinicians' training, expertise, and empathy are crucial in effectively de-escalating situations and encouraging voluntary engagement with treatment. These structural choices can significantly influence the program's operational dynamics and public perception.

C. Behavioral Health Practitioner-only Mobile Crisis Teams (BHP-only MCT, or more commonly, MCT): Distinctions and Potential Overlaps with Co-Response

Distinct from co-responder models that inherently include law enforcement in the dispatched team, community responder programs typically involve health professionals, social workers, or other trained civilian staff serving as first responders to certain 911 calls, often without an accompanying police officer⁹. SAMHSA describes this model as the "Behavioral Health

Practitioner-only Mobile Crisis Teams (BHP-only MCT)². The Crisis Assistance Helping Out on The Streets (CAHOOTS) program¹⁰ in Eugene, Oregon, is a well-known example, dispatching a medic and a crisis worker to non-violent calls with a behavioral health component.¹¹ It is important to note, that police although not primarily present as part of the core team, may be called if deemed necessary. Recently, and despite its long-standing success, CAHOOTS services in the City of Eugene were discontinued effective April 7, 2025, reportedly due to financial capacity issues, though services continue in the neighboring city of Springfield¹². This highlights the critical need for sustainable and robust funding for such programs. SAMHSA guidance underscores that co-responder teams should be viewed as an additional service option within a broader crisis care continuum, not as a replacement for MCTs.² This positions co-response as one of several tools, with MCTs preferable for situations where a law enforcement presence is not indicated.

The emergence of community responder models highlights a critical debate regarding the necessity and appropriateness of law enforcement involvement in behavioral health crises. While co-responder models integrate police into the crisis team, community models aim to minimize or eliminate police presence for many scenarios. The threshold for police involvement is a key differentiator. However, the distinction is not always absolute. Some programs designated as "co-response" might operate with protocols where the clinician makes initial contact if the scene is deemed safe, with the officer staging nearby. A comprehensive crisis system may strategically deploy a co-responder or an MCT, triaging calls to the most appropriate and least intrusive response based on available information.

Operational Variations in Co-Response Models

Beyond the overarching model type, co-responder programs exhibit several operational variations:

1. **Ride-Along vs. Ride-Separate Support:** The ride-along model pairs a mental health professional with a law enforcement officer in the same vehicle for an entire shift, enabling faster, coordinated responses and stronger team cohesion¹³. In contrast, the ride-separate model dispatches clinicians only when needed, making more efficient use of limited resources but potentially delaying intervention and complicating de-escalation. The choice between models depends on factors like call volume, staffing, geographic area, community preferences, and the program's priorities.
2. **Remote/Telehealth Co-Response:** An increasingly utilized variation involves mental health professionals providing support remotely via video conferencing, telephone, or radio to officers in the field.⁹ This approach, sometimes termed tele-co-response or virtual co-response, allows clinicians to offer consultation, assessment, and de-escalation guidance without being physically present. Telehealth can significantly expand the reach and immediacy of clinical expertise, particularly in geographically large or rural areas with limited clinician availability and other resources. However, its effectiveness can be constrained by technological limitations such as network connectivity, access to and availability of a smart device, the clinician's inability to observe the full range of environmental dynamics, and

potential challenges in establishing therapeutic rapport with individuals in crisis.¹⁴ This model may be best suited as a supplementary tool or an interim solution when in-person co-response is not feasible, rather than a complete replacement.

3. Team Composition and Diversification

While the core pairing typically involves a law enforcement officer and a mental health professional, many programs incorporate other professionals to broaden their intervention capabilities (*See Table 1 in Appendices for a summary of roles, descriptions, and skills/qualifications for each of these roles*):

- a. **Paramedics/ Emergency Medical Technicians (EMTs):** Recognizing the frequent co-occurrence of physical health issues with behavioral health crises, or the need for medical assessment and clearance, some models include paramedics or EMTs on the team.
- b. **Peer Support Specialists:** There is a growing recognition of the value of including peer support specialists, otherwise understood as individuals with lived experience of mental health conditions or substance use recovery, on co-responder teams **Error! Bookmark not defined..** Peers can often establish rapport more effectively with individuals in crisis due to their shared understanding and ability to empathize on a personal level.

SAMHSA recommends that a comprehensive crisis system may strategically deploy both co-responder and community-led teams, triaging calls to the most appropriate and least intrusive response based on available information and need ⁵. Communities that choose to deploy any variation or composition of a co-response model should do so in accordance with community needs and available resources. For example, areas with high rates of substance use and overdose might prioritize teams that include paramedics and peer specialists with addiction recovery experience. The ideal team composition is responsive to local needs.

Best Practices

Third Horizon's literature review identified several best practices when implementing crisis services. While co-responder programs offer many advantages, building an effective and responsive model requires thoughtful planning and coordination across several key areas. Strong partnerships between law enforcement, behavioral health providers, and community organizations are essential. They should be formalized through memoranda of understanding and shared agreements that clarify roles, responsibilities, processes for data and information sharing, and financial arrangements.¹⁵

Ongoing joint training is also critical. These may include but are not limited to crisis intervention, de-escalation, trauma-informed care, cultural responsiveness, and legal issues, with scenario-based learning and input from those with lived experience¹⁶. Having clear protocols that guide all phases of the response, from dispatch to on-scene collaboration and follow-up, will help ensure consistency and safety¹⁷. Programs like Johnson County's (model example highlighted under "Local Examples"), which have demonstrated success in reducing repeat calls, often have strong, dedicated follow-up components. In addition, robust data collection from the outset is necessary to measure impact, improve quality, and secure ongoing support. Meaningful community



involvement throughout program design and implementation helps ensure equity and builds trust¹⁵. Finally, sustainable funding and careful attention to ethical concerns, such as informed consent, confidentiality, and bias, are vital to the long-term success and integrity of the program.

18

Local Examples

Third Horizon identified examples of models around the country that fit within categories 1-3, including several in rural areas, and some in mountain west communities as well as more urban models.

Category 1: Police-Led Co-Responder Models

Johnson County, Kansas: Mental Health Co-Responder Program

This program, initiated in 2011 with the Olathe Police Department and since expanded, embeds mental health clinicians from the Johnson County Mental Health Center (JCMHC) within most local police departments throughout the county.¹⁹ Co-responders (clinicians) respond on scene with law enforcement officers when behavioral health is identified as a contributing factor in a call for service.²⁰ Their role includes not only immediate crisis intervention but also conducting outreach and follow-up with individuals who have had police contact due to a behavioral health crisis. The aim is to connect these individuals to appropriate services and thereby reduce future interactions with law enforcement. These clinicians often work closely with officers who have received Crisis Intervention Team (CIT) training. Proactive follow-up, performed by the co-responding clinicians is a critical factor for achieving long-term positive impacts. This moves the intervention beyond immediate crisis stabilization to facilitating pathways to sustained care, addressing underlying issues that might otherwise lead to future crises.

Harris County, Texas: A Model for Clinical Support Embedded in Dispatch Centers

The Crisis Call Diversion (CCD) program in Harris County, Texas, launched in 2016, is a collaborative effort between the Houston Police Department, Houston Fire Department, Houston Emergency Center, and The Harris Center for Mental Health and IDD. Although not fully integrated yet, current 988 center is also housed under the Harris Center for MH and IDD and calls from 988 are often reroute to The Crisis Call Diversion²¹. This initiative integrates trained behavioral health counselors into the 911 dispatch system to manage non-emergency mental health-related calls. When a call is identified as non-violent and non-criminal, it is redirected to a Harris Center crisis counselor who provides immediate assessment, de-escalation, safety planning, and referrals to appropriate community resources, thereby reducing the need for police or EMS response. The program began as a pilot funded by grants from the Houston Endowment, the Episcopal Health Foundation, and the Bureau of Justice Assistance.²² Its success led to continued support from the City of Houston and Texas Health and Human Services. Since its inception, CCD has diverted thousands of calls from first responders, saving significant resources. Between March 2016 and March 2021, over 7,400 calls were diverted from law enforcement, equating to more than 11,000 police hours and over \$2 million in savings. Similarly, more than 3,000 calls were diverted from the fire department, saving nearly \$4.5 million. **Error! Bookmark not defined.** In 2021, the program expanded to include the Mobile Crisis Outreach

Team (MCOT), allowing for in-person assistance when phone-based interventions are insufficient. This addition further enhanced the program's ability to provide appropriate care and reduce the burden on emergency services.²³

Category 2: Hybrid/Clinician Focused Models

Franklin County Pennsylvania: Mental Health Co-Responder/Community Liaison

In 2017, Franklin County, Pennsylvania, took a proactive step to address the intersection of mental health challenges and law enforcement by launching the Mental Health Co-Responder Program. This initiative embeds mental health professionals within police departments to collaboratively respond to individuals in crisis, aiming to provide timely interventions that divert individuals from the criminal justice system and connect them to appropriate behavioral health services. Co-responders work closely with various county agencies, including the Department of Emergency Services, adult and juvenile probation departments, the county jail, and a network of human service organizations. When police encounter situations where an individual's behavior does not necessitate custody, co-responders conduct on-scene assessments to determine the appropriate level of care, facilitating connections to community resources and services. The effectiveness of the program is evident in its early outcomes. Within the first 13.5 months, the program made 233 individual referrals to local services, significantly surpassing the initial two-year goal of 80 referrals.²⁴ This success underscores the program's ability to address mental health crises effectively and reduce the burden on emergency services and the criminal justice system. Funding for the program was initially secured through a grant from the Pennsylvania Commission on Crime and Delinquency (PCCD). However, ongoing support comes from the Office of Mental Health and Substance Abuse, contributions from local police departments, and other federal and local support.

Island County, Washington State: Co-Responder Program

Island County, Washington has implemented a Co-Responder Program that pairs law enforcement with behavioral health professionals to respond to mental health crises. Its rural setting and limited resources had historically made traditional crisis response challenging. To address this, the county launched a field-based model where clinicians respond alongside deputies to assess, de-escalate, and connect individuals to care. The county's Human Services Department runs the program in partnership with the Sheriff's Office and local police. It aims to reduce unnecessary arrests and hospitalizations while supporting officers with clinical expertise. While formal outcome data isn't yet published, the model aligns with successful rural co-response programs elsewhere, helping reduce repeat 911 calls and improving care continuity.

Pitkin County, Colorado: Pitkin Area Co-Responder Teams

The Pitkin Area Co-Responder Team (PACT) in Pitkin County, Colorado, is a collaborative program designed to respond to mental health and substance use crises with a team-based approach. Launched in 2019, PACT serves the rural mountain communities of Aspen, Snowmass Village, and surrounding areas by pairing law enforcement officers with behavioral health clinicians to provide immediate, compassionate crisis intervention in the field. The program is a partnership



between Pitkin County Public Health, Mind Springs Health, and local law enforcement agencies, including the Aspen Police Department, Snowmass Village Police Department, and the Pitkin County Sheriff's Office. The team includes mental health professionals embedded with law enforcement, a dedicated case manager, and peer support specialists who offer follow-up care grounded in lived experience. When a 911 call involves a behavioral health concern, a clinician either responds alongside officers or follows up shortly after. The team works to stabilize the individual, de-escalate the crisis, and connect them to services, avoiding unnecessary arrests or hospitalizations. Follow-up support, often led by peer specialists and the case manager, helps ensure continuity of care. In 2023, PACT responded to 148 calls with a clinician on scene, served 288 individuals, and conducted over 1,700 follow-ups.²⁵ These outcomes reflect a strong commitment to diverting individuals from the criminal justice system and reducing strain on emergency services. PACT is funded by state-level grants from the Colorado Behavioral Health Administration's Co-Responder Program and the Colorado Department of Public Health and Environment's Harm Reduction Grant Fund. This funding supports personnel, operations, and training, ensuring the program remains sustainable and responsive to community needs.

Davidson, North Carolina: A Hybrid Co-Responder Program

Implemented in May 2023, the Town of Davidson's Co-Responder Program operates as a hybrid model. It involves collaboration between the Davidson Police Department and a designated mental health clinician (holding an MSW, LCSW) who is directly employed by the town and housed within the police department.²⁶ Police officers initially evaluate the nature of a call and determine whether a law enforcement action is appropriate. The co-responder team then collaborates to address the situation. The program's goals are to ensure a proper response tailored to the crisis, provide targeted services to individuals, reduce the need for future 911 calls, lower barriers to accessing treatment, and break the stigma associated with mental health and substance abuse. The clinician is responsible for conducting on-scene assessments, utilizing de-escalation techniques, connecting individuals to resources, and providing proactive follow-up. The Davidson model's explicit "hybrid" structure, where police officers conduct an initial assessment to determine the necessity of law enforcement action before the co-responder clinician fully engages, suggests a pragmatic approach to titrating the level of law enforcement involvement based on immediate needs. This could be particularly suitable for smaller towns or municipalities aiming to balance limited specialized resources with the desire for a mental health-informed crisis response.

Category 3: MCTs

Flathead County, Montana: Crisis Assistance Team

The Crisis Assistance Team (CAT) is Flathead County's behavioral health mobile crisis team, operating within the Flathead City-County Health Department in partnership with the Flathead County Sheriff's Office, Kalispell Police Department, Whitefish Police Department, and Columbia Falls Police Department.²⁷ Established in August 2020, CAT aims to decrease the frequency and intensity of 911 behavioral health calls by linking individuals in crisis to mental health services. Since its inception, the team has responded to over 1,000 calls, supporting emergency

department and justice system diversion. The team employs a client-centric, systems approach to provide on-site therapeutic services to community members experiencing behavioral health crises.²⁸ CAT comprises two Co-Responder Crisis Therapists and two Crisis Care Coordinators operating in two independent teams. Co-Responders assess and counsel individuals in crisis within the community, performing field mental health evaluations and providing recommendations to law enforcement officers on scene. They are dispatched through 911 or 988 and conduct assessments at various locations, such as homes, schools, parking lots, and grocery stores. Care Coordinators serve as contact points, advocates, and informational resources for Co-Responders, law enforcement, and community members in crisis, working to assess unmet health and social needs and developing care plans that include referrals to social service programs and treatment facilities. The program is partially funded through a Montana Department of Public Health and Human Services (DPHHS) grant supporting behavioral health initiatives, as well as through a partnership between Flathead County and the City of Kalispell using National Opioid Settlement Agreement Funds.²⁹ The CAT Program can also bill Medicaid for client services. In December 2023, Flathead County and the City of Kalispell entered an agreement to fund the Crisis Assistance Team using funds from the National Opioid Settlement Agreement. Both entities received settlements totaling approximately \$100,000 and decided to combine these funds to support the CAT program, recognizing the need for alternative behavioral health services in response to certain 911 calls. This funding is expected to sustain the program for the next twenty years.

Other Models and Variations

St. Louis, Missouri: A Model of Virtual Assistance

In late 2016, Behavioral Health Response (BHR) in St. Louis launched the Virtual-Mobile Crisis Intervention (V-MCI) program to enhance crisis response and reduce unnecessary emergency room visits and jail detentions.³⁰ In partnership with the St. Louis County Police Department, officers use iPads to connect directly with BHR behavioral health specialists for real-time assessments and referrals. The process begins with a BHR crisis clinician taking the initial call and coordinating support with on-scene officers. BHR also provides follow-up case management until individuals are successfully connected to community mental health services. By leveraging its 24/7 crisis infrastructure, BHR aims to improve outcomes for people in crisis while reducing costs across the healthcare and justice systems. BHR's program also included follow-up case management to ensure continuity of care. In its first year, the initiative diverted over 81% of individuals from hospital emergency departments, demonstrating substantial cost savings and improved outcomes for those in crisis.³¹ BHR was funded by the Missouri Foundation for Health to create and implement the Virtual Mobile Crisis Intervention program.

Colorado Springs, Colorado: A Multidisciplinary Team Approach

The Colorado Springs, Colorado's Police Department (CSPD) and the Colorado Springs Fire Department (CSFD) collaborated with AspenPointe (now DiverusHealth)³², a local behavioral health organization, to form a specially staffed mobile integrated mental health emergency response team. The program is designed to adapt to each community's specific needs, with team structure variations based on factors like population density and available resources. Generally,



it follows one of two models: either a dedicated team of officers and behavioral health specialists who respond together to behavioral health calls, or a model where officers can request a behavioral health specialist to join them on-scene as needed. Some teams also include paramedics. Regardless of the structure, the goal is to de-escalate crises, conduct behavioral health assessments, and develop a plan for next steps. This strategy has greatly lowered emergency room visits by guiding individuals in crisis toward community-based options such as the Crisis Stabilization Unit or county detox center. Additionally, the local 9-1-1 call center supports this effort by routing appropriate calls directly to the Community Response Team (CRT), easing the workload on standard EMS, fire, and police dispatch services.³³

Considerations for Blaine County MWBI

As Blaine County MWBI explores options to develop behavioral health crisis services, Third Horizon recommends carefully considering the advantages and challenges of different co-responder models. Given the recent expansion of Crisis Intervention Training in Blaine County, new opportunities may exist to maximize trained officers in new ways. Important considerations include whether the level of Blaine County's needs related to behavioral health crisis warrants having both a co-responder and a mobile crisis team, the degree of safety concerns, and the desires and beliefs of community members.

Third Horizon will work with Blaine County MWBI staff and leadership, obtain stakeholder input through focus groups, and formulate more specific recommendations.

Appendix

Table 1: Summary of Roles, Role Descriptions, and Requirements in Co-response Models

Role	Typical Responsibilities	Common Educational/Licensure Qualifications	Essential Skills/Competencies
Mental Health Clinician/ Crisis Worker	On-scene crisis intervention & de-escalation, mental health & risk assessments, safety planning, resource navigation & referral to services (MH, SUD, housing), collaboration with LE/EMS, follow-up care, documentation	Master's degree in social work, Counseling, Psychology (MSW, MA, MS) or related field. State licensure (LCSW, LPC, LMFT) often required/preferred. Bachelors with extensive experience in some cases.	Clinical assessment & diagnosis, advanced de-escalation, crisis management, trauma-informed care, cultural responsiveness, strong communication (verbal & written), collaboration & teamwork, knowledge of community resources & systems, ethical judgment
Law Enforcement Officer	Ensure scene safety for all parties, secure individual, if necessary (per policy), collaborate with clinician; initial de-escalation (if CIT trained), assist with transport/referrals, documents law enforcement aspects of call	Sworn law enforcement officer certification. Crisis Intervention Team (CIT) certification (typically 40 hours) or equivalent specialized crisis response training.	Tactical assessment & safety protocols, de-escalation techniques (especially CIT), cultural responsiveness, communication with individuals in crisis, understanding of mental health signs/symptoms, knowledge of legal criteria for emergency detention/holds
Peer Support Specialists	Support during and after crisis, rapport and trust building, system and resource navigation, advocacy,	Lived experience, experience and understanding of the behavioral health system and trauma informed care, often state required certifications, and state clearances	Cultural responsiveness, active listening, empathy, basic documentation skills for any required paperwork, knowledge of community and resources
Paramedics/ EMTs	Medical assessment and stabilization, emergency care, transport coordination	Certification (EMT), state required licensing, field experience, agency specific requirements (for example, background clearance)	Cultural responsiveness; basic behavioral health and trauma informed care knowledge; communication

References

- ¹ Responding to Behavioral Health Crises | Mental Health America (2025). Retrieved from: <https://mhanational.org/position-statements/responding-to-behavioral-health-crises/>
- ² 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care. (2025). Retrieved from: <https://library.samhsa.gov/sites/default/files/national-guidelines-crisis-care-pep24-01-037.pdf>
- ³ New Medicaid Option Promotes Enhanced Mental Health, Substance Use Crisis Care. Centers for Medicare & Medicaid (2021). Retrieved from: <https://www.cms.gov/newsroom/press-releases/new-medicaid-option-promotes-enhanced-mental-health-substance-use-crisis-care>
- ⁴ Co-Response Initiative – Mental Health America. (n.d.). Retrieved from: <https://www.mhainspire.org/co-response-program/>
- ⁵ 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care. (2025). Retrieved from: <https://library.samhsa.gov/sites/default/files/national-guidelines-crisis-care-pep24-01-037.pdf>
- ⁶ Co-Responder Program | Davidson, NC. (n.d.). Retrieved from: <https://www.townofdavidson.org/1559/Co-Responder-Program>
- ⁷ Co-Responder Model of Criminal Justice: A Deep Dive in Officer & Clinician Collaboration. (n.d.). Retrieved from: <https://www.julota.com/news/co-responders-what-is-it-like-for-an-officer-and-a-clinician-to-work-together/>
- ⁸ Pope, L. G., Patel, A., Fu, E., Zingman, M., Warnock, A., Ellis, S., Oluwaytoyin Ashekun, Watson, A. C., Wood, J., & Compton, M. T. (2023). Crisis Response Model Preferences of Mental Health Care Clients with Prior Misdemeanor Arrests and of Their Family and Friends. Psychiatric Services. Retrieved from: <https://psychiatryonline.org/doi/10.1176/appi.ps.20220363>
- ⁹ Responses to People with Mental Health Conditions.(2025). <https://leknowledgelab.org/mental-health-crisis-response/mhcr-responses-to-people-with-mental-health-conditions/>
- ¹⁰ What is CAHOOTS?- White Bird Clinic. (n.d.). Retrieved from :<https://whitebirdclinic.org/what-is-cahoots/>
- ¹¹ CAHOOTS Updates. (2025). Retrieved from: The Community Responder Model- Center for American Progress. <https://www.americanprogress.org/article/community-responder-model/>
- ¹³ Legal Considerations and the Co-Responder Model. (2023). Retrieved from: <https://www.julota.com/news/legal-considerations-and-the-co-responder-model/>
- ¹⁴ Center for Crisis Response and Behavioral Health: Research Hub- William James College. (2025). Retrieved from: <https://www.williamjames.edu/centers-and-services/crisis-response-and-behavioral-health/research-hub.html>
- ¹⁵ The Best Practices For Implementing A Co-Responder Program – Julota. (n.d.). Retrieved from: <https://www.julota.com/news/the-best-practices-for-implementing-a-co-responder-program/>
- ¹⁶ Co Response Teams: A New Approach to Mental Health and Law Enforcement Collaboration. Julota. (n.d.). <https://www.julota.com/news/the-co-response-team-a-new-approach-to-mental-health-and-law-enforcement-collaboration/>
- ¹⁷ The Best Practices For Implementing A Co-Responder Program – Julota. (n.d.). Retrieved from: <https://www.julota.com/news/the-best-practices-for-implementing-a-co-responder-program/>
- ¹⁸ . Developing and Successfully Implementing Your Co-Responder Program. NAMI Tennessee. (2020) <https://namitn.org/wp-content/uploads/sites/359/2020/12/CoResponder-Brief.pdf>
- ¹⁹ Mental health and Criminal Justice System – Johnson County Case Study. National Association of Counties. (2015): Retrieved from: https://www.naco.org/sites/default/files/documents/Johnson%20County%20Mental%20Health%20and%20Jails%20Case%20Study_FINAL.pdf
- ²⁰ Emergency Services. Johnson County, Kansas. (n.d.). Retrieved from: <https://www.jocogov.org/departments/mental-health/our-services/emergency-services>
- ²¹ The Crisis Call Diversion Program. The Harris Center. (n.d.). Retrieved from: <https://www.houstoncit.org/ccd/>
- ²² Embedding Crisis Response in Harris County's 911 Dispatch Center. (2021). retrieved from: <https://talk.crisisnow.com/embedding-crisis-response-in-harris-countys-911-dispatch-center/>

-
- ²³ Diverting 911 calls: Lessons from early adopting urban jurisdictions. *Criminology and Public Policy*. (2024). retrieved from: <https://onlinelibrary.wiley.com/doi/10.1111/1745-9133.12680>
- ²⁴ Data, Police and Mental Health: How a Pennsylvania County Helps People in Distress. *Route Fifty*. (2018). <https://www.route-fifty.com/management/2018/06/mental-health-pennsylvania-county/149154/>
- ²⁵ Pitkin County Public Health celebrates co-responder program. *The Aspen Times* (2024). <https://www.aspentimes.com/news/pitkin-county-public-health-celebrates-co-responder-program/>
- ²⁶ Co-Responder Program | Davidson, NC. (n.d.). Retrieved from: <https://www.townofdavidson.org/1559/Co-Responder-Program>
- ²⁷ Crisis Assistance Team. Flathead County, Montana. (n.d.). <https://flathead.mt.gov/departments-directory/health/crisis-assistance-team>
- ²⁸ Crisis Assistance Team Rerouted More Cases to Mental Health Resources in January. *Flathead Beacon*. (2025). <https://flatheadbeacon.com/2025/02/20/crisis-assistance-team-rerouted-more-cases-to-mental-health-resources-in-january/>
- ²⁹ Flathead Crisis Assistance Team Secures 20 Years of Funding. *Flathead Beacon*. (2023). <https://flatheadbeacon.com/2023/12/18/flathead-crisis-assistance-team-secures-20-years-of-funding/>
- ³⁰ Virtual Mobile Crisis Intervention. *ScatterGood*. (2017). Retrieved from: https://www.scattergoodfoundation.org/award_submission/virtual-mobile-crisis-intervention
- ³¹ Virtual Mobile Crisis Intervention. *ScatterGood*. (2017). Retrieved from: https://www.scattergoodfoundation.org/award_submission/virtual-mobile-crisis-intervention/
- ³² Up close with Colorado Springs Community Response Team. (n.d.). Retrieved from: <https://www.hmpgloballearningnetwork.com/site/emsworld/article/219668/close-colorado-springs-community-response-team>
- ³³ Mobile Integrated Healthcare Program Changing How EMS Responds to Behavioral Health Crises. (2016). *Journal of Emergency Medical Services*. Retrieved from: <https://www.jems.com/mobile-integrated-health-and-community-paramedicine/mobile-integrated-healthcare-program-changing-how-ems-responds-to-behavioral-health-crises/>



Island County
Co-Responder Case Manager ***INTERNAL APPLICANTS ONLY***

SALARY	\$27.32 Hourly	LOCATION	Coupeville Campus, WA
JOB TYPE	Full Time Regular	JOB NUMBER	2024-067
DEPARTMENT	Human Services	OPENING DATE	07/24/2024
CLOSING DATE	8/7/2024 4:30 PM Pacific		

Summary

**** This position is open to internal candidates only ****

The Co-Responder Program Case Manager will provide direct, field-based services to individuals who may have extensive history of psychiatric hospitalizations, are homeless, have co-occurring substance use disorders, mental health disorders or issues, medical problems, or are involved in the criminal justice system. Services might include helping individuals with housing, parenting, benefits, symptom management, medical care, behavioral health treatment and employment, all performed where those in need are located.

The Co-Responder Case Manager will respond to referrals made by the Co-Responders with the Island County Sheriff’s Office and the Oak Harbor Police Department. The Co-Responder Case Manager provides outreach, long-term engagement, and supportive services for participants through intensive case management activities and collaboration with existing services available through Island County and all other service providers in the county.

Resume and Cover Letter are required. Please attach.

Job Duties

- Provide outreach and intensive case management services for participants referred by Co-responders for the Island County Sheriff’s Office and the Oak Harbor Police Department.
- Work closely with law enforcement, hospitals, Designated Crisis Responders, Mobile Crisis Outreach Team members, and other community partners coordinating referrals.
- Develop and implement, with the participant’s input, a recovery-oriented stabilization plan as the means for implementing appropriate services. Update this plan periodically with participant to reflect movement toward or attainment of articulated goals and the emergence of new needs.
- Responsible for coordinating services being provided; arranging resources, advocating for needed services, intervening in crises, and making appropriate referrals.

- Establish communication with appropriate community services for benefits such as DSHS, Social Security and behavioral health treatment to initiate and facilitate the completion of application and enrollment.
- Develop and maintain a working relationship with crisis stabilization facilities, crisis responders, evaluation, and treatment facility staff, DSHS workers, behavioral health treatment providers, health care providers, shelter providers, landlords, detox centers, protective or representative payees, and other community programs which may support participants.
- Accompany participants to appointments as needed.
- Identify gaps and barriers in available community resources and advocate for systemic changes.
- Attend stakeholder work groups and committees to represent the experiences of program participants.
- Document all contacts in a timely manner, including face-to-face interviews, collateral and networking contacts, counseling appointments, and correspondence. Maintain case records in accordance with standards and requirements. Prepare reports by collecting, analyzing, and summarizing treatment and results data.
- Provide follow-up services when appropriate and necessary.
- Communicate participant progress by attending weekly interdisciplinary meetings and supervision in compliance with agency policies and procedures. Collaborate and work with other community agencies and law enforcement.
- Update job knowledge by participating in educational opportunities, reading professional publications, maintaining personal networks, and participating in professional organizations.
- Perform other duties as assigned by the supervisor and Co-Responders that are consistent with the position.
- Follow policies, procedures, and protocols for this program as a member of the Co-Responder Team.

Knowledge, Skills & Abilities

- Ability and willingness to work independently under general supervision in a self-directed manner and the ability to work collaboratively with other team members and/or service providers or professionals.
- Ability to quickly grasp new techniques, deal with rapid changes in events, remain calm in stressful situations, relate to various personality styles in a calm, professional manner.
- Effectively communicate, both orally and in writing with others for purposes of gathering and relaying information.
- Ability to identify community resources and services for clients and coordinate provision of services, to establish effective working relationships with internal agency staff and relevant community organizations.
- Understand the need for maintaining confidentiality of sensitive information.
- Familiar with record documentation requirements and service plan development and implementation.
- Possess time management and organizational skills.
- Fluent in computer office programs with good data entry skills.

Education, Experience & Certifications

- Bachelor's degree in Social Work, Psychology, Human Services, or related field required.
- Valid Driver's License.
- Two years of experience in providing crisis mental health and/or case management services preferred.
- Possess or be willing/able to complete training to obtain a Community Health Worker certification from a State-approved training program.
- Satisfactory criminal history background check results are a condition of employment.
- Willingness to take part in familiarization with law enforcement policies and procedures.

ISLAND COUNTY IS AN EQUAL OPPORTUNITY EMPLOYER

* Candidates must be legally authorized to work in the United States. Island County does not provide visa sponsorship.

*

Employer

Island County

Address

1 NE 7th Street

Coupeville, Washington, 98239

Website

<https://islandcountywa.gov>

[Skip to main content](#)

This website uses cookies to customize and improve your experience. If you are a California resident, you may be entitled to certain rights regarding your personal information. Additional information about our data collection practices and location specific notices is available on our privacy policy.

X

[Accept Cookies](#)

Job Details

Job Location
MONTROSE, CO
Position Type
Full Time
Education Level
4 Year Degree
Salary Range
\$18.50 - \$23.72 Hourly
Travel Percentage
Up to 50%
Job Category
Health Care

Description

Co-Responder Case Manager – Full Time – Montrose, CO

Commitment to Pay Standards: We are committed to fair and equitable hiring with salaries based on relevant factors, such as work experience, education, and certification/licensure (rather than wage history).

Position Summary: The role of the **Co-Responder Case Manager** is to work in collaboration with a law enforcement officer or emergency medical technician to respond to community members whose need for urgent intervention was reported through the Emergency Communication Center (911). The team(s) specialize in de-escalation, problem-solving, risk assessment, and community resource linkage. Co-responder teams have demonstrated improved interactions between law enforcement, first responders, and the people they serve. Communities have also recognized savings by connecting people to appropriate services and resources, rather than using more costly, higher-level interventions.

It is the role of the behavioral health provider to act as a first responder to issues related to behavioral health crises which may include mental illness, substance use, and social determinants of health. The case manager will utilize a working knowledge of crisis intervention approaches to provide intervention, support, risk evaluation and triage services for all populations utilizing the 911 system within the jurisdictional limits of the partner agency and program specifications. They will actively participate in patient continuity of care, brief counseling, referral, and prompt documentation. This includes an intense focus on community resourcing and linkage, requiring strong interpersonal skills and collaboration.

Our ideal candidate for our **Co-Responder Case Manager** position will have bachelor's degree (Master's degree is preferred), in one of the recognized mental health professions. They will also have experience in an emergency service setting or demonstrated competency. Crisis intervention experience preferred.

Driver's License: Must have current driver's license and ability to be commercially insured and maintain a driving record that allows insurability with Axis Health System commercial insurance agency.

They must also be able to complete and apply training with law enforcement agency including basic tactical intervention, scene safety, basic firearm safety, defensive driving, use of CAD and radio systems.

Salary:

- Co-Responder Case Manager: Base Rate \$19.50 (\$18.50 + Locale \$1.00) - \$23.72, per year (non-exempt/hourly)

Benefits:

- | | |
|--------------------------------|-----------------------------|
| • Medical (HDHP or PPO) | • Long Term Disability |
| • 401k offering up to 6% match | • Short Term Disability |
| • Health Savings Account | • Dental |
| • Flexible Spending Account | • Vision |
| • Dependent Care Account | • Pet Insurance |
| • Life Insurance | • College Invest plans |
| • Annual Wellness Benefits | • Personal Days |
| • Loan Repayment Programs | • (9) Company Paid Holidays |

- (3) weeks of All Paid Leave (APL) for first 2 years with full-time employment.
- On-going training & educational opportunities for professional development are also available.

Physical demands: This community-based position functions in partnership with first responders on patrol or at a dispatch location. The employee will spend most of a workday in a vehicle issued by the first responder partner. The employee must be able to sit for longer periods of time in a vehicle and tolerate the movement of driving. Office space is available as needed for administrative activities.

Employee may occasionally be required to exert moderate levels of physical energy when response conditions require self-defense, ambulation assistance, or physical safety intervention.

Employee must occasionally lift and/or move up to 25 pounds. Employee is frequently required to walk, sit, stand, or kneel and occasionally required to climb or balance and stoop.

May be exposed to stressful situations that involve enraged, distraught and/or intoxicated individuals with possible mental health issues.

Possible potential exposure to communicable disease.

The noise level in the work environment is usually moderate.

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Required Skills:

- Must be knowledgeable regarding patient health information and HIPAA compliance.
- Must be organized and demonstrate the ability to follow guidelines.
- Must demonstrate excellent interpersonal and communication skills.
- Must demonstrate the ability to be self-directed.
- Must demonstrate the ability to follow the organization's confidentiality and security rules.
- A working knowledge of crisis intervention approaches and their applications to clients with emotional, behavioral, and substance abuse problems.

- Working knowledge of Brief Solution Focused Therapy, Motivational Interviewing and DBT coaching skills.
- Ability to perform mental status evaluations, differential diagnosis, and service coordination duties.
- Ability to assess level of risk and treatment approaches and their applications to clients with emotional, behavioral, and substance abuse problems. Make appropriate clinical judgment for resolution of client emergencies to a safe outcome.
- Ability to deliver services in various community locations.
- Working knowledge of involuntary mental health holds (27-65), and alcohol and drug Emergency Commitments (EC) and Involuntary Commitments (IC).
- Working knowledge of HIPAA and 42 CFR, Pt. 2.
- Knowledge of community health and behavioral health resources and their eligibility criteria.
- Working knowledge of Windows based computer applications to include MS Word, MS Excel, MS Outlook, and Internet access.
- Ability to operate standard office equipment including calculator, copy machine, fax, and multi-line telephone. Interpersonal and communication skills to develop and maintain effective working relationships with all internal and external customers.
- Ability to organize and prioritize workload in a sometimes-hectic environment with frequent interruptions.
- Ability to follow established universal precautions and report potential exposure to a communicable disease immediately
- Must have current driver's license and ability to be commercially insured and maintain a driving record that allows insurability with Axis Health System commercial insurance agency.
- Travel required

Additional eligibility requirements: Annual Flu immunization, Annual TB screening, CPI training within 90 days of hire, BLS PRO certification required within 90 days of hire.

About our Axis Health System: We are the leading provider of behavioral health and integrated (primary, dental, and behavioral health) care on the Western Slope of Colorado. As a therapist in our clinic, you'll have access to a wide range of resources for your patients. We have recovery groups, Medication Assisted Treatment (MAT), specialized mental health outpatient programs, primary care, diabetes education, crisis services, resource navigators, insurance enrollment specialists, tele-video systems to access our locations across the region and more. We work to make sure you have what you need at your fingertips to be successful in your position and support your patient in their road to recovery.

Please visit our website at <http://www.axishealthsystem.org> , to apply for this position and for more information about our organization. All qualified applicants will receive consideration for employment, transfer, or promotion opportunities.

About Montrose/Delta/Hotchkiss:

If you're interested in archaeology, hiking, biking, boating, rafting, hunting, exploring, or kayaking – Montrose is the place for you!

Montrose and the surrounding area are perfect for an outdoor enthusiast. Black Canyon National Park, just east of the San Juan Mountains is just minutes away and to the west, the Uncompahgre Plateau is waiting to be explored. Here, you are surrounded by the many opportunities and adventures waiting to happen. From hiking and biking to kayaking and rafting with breath taking views of our majestic landscape. When in Hotchkiss you can explore their vineyards and museums or find you self at the art center appreciating all the creativity or taking an art class yourself! Montrose has an airport within 10 minutes from our Montrose locations, which has daily service to Denver, Dallas and Phoenix (including several other major US cities). Learn more about our area here: [Visit Montrose, CO](#).

Apply Now

Legal First Name*

Legal Last Name*

Email*

Confirm Email*

Phone*

 +1 *arrow_drop_down*

ATTACH RESUME/CV*

Start Application

chevron_left

Sign In

Welcome ! It looks like you have an account with this email. Please enter your password to complete your application.

Password*

[Back to topics](#)

LONGMONT COLORADO CO-RESPONDER CLINICIAN POSITION

[Show latest replies on top](#) [Subscribe to topic](#)

31 Mar 2025 11:51 AM

Message # [13481228](#)

[Quote](#)

[Anonymous member](#)

Job Announcement

20250123 Co-Responder Clinician III

CLOSING DATE: Open Until Filled

APPLY ONLINE AT LONGMONTCOLORADO.GOV/JOBS

Department: Public Safety (Police)

Division: Collaborative Services

Hiring Range: \$40.79 - \$45.32/hour

Varied Schedule, Shift work required.

Regular Full-time with Benefits

Benefits include: Medical, Dental, Vision, Flex Spending, Defined Benefit Pension Plan, 401(a) Money Purchase Plan, Life & Survivor, Term Life & AD&D, Long Term Disability, Bereavement, Jury & Witness Duty, FMLA, Military Leave, Parental and Caregiver Leave, Sick, Vacation at start of employment, Holiday pay, EAP, Tuition Assistance.

Other benefits: Optional, employee elected, voluntary benefits are available.

Open Until Filled positions may close without advance notice. To be considered, please apply as soon as

possible.

Definition:

Act as first responder to mental health emergency calls for service with Public Safety personnel (interdisciplinary team including a paramedicine professional and a law enforcement Officer - CORE Team). Provide primary de-escalation tactics and clinical crisis interventions to high-risk, high-acuity behavioral health emergencies.

Provide expert clinical judgement in the field to inform police and paramedicine action and provide the most appropriate intervention at the time of Public Safety contact. The Crisis Outreach Response and Engagement (CORE) Clinician engages in dynamic field contacts that can be rapidly changing and require immediate evaluation and intervention. CORE Clinicians can be responsible for resource navigation, preparing legal documents for transport to appropriate levels of care, including mental health holds, court ordered psychiatric evaluations, emergency commitments, and involuntary commitment petitions (court ordered substance use treatment). Expectation is to rely upon community resources and engagement to facilitate health and increase continuity of care. Will serve as a liaison to other community serving agencies. The Co Responder program is a flexible, dynamic system that will adapt to the community's needs.

Principal Duties:

Respond to behavioral health calls for service with other Public Safety personnel (e.g., law enforcement, fire and paramedicine professionals) and provide clinical crisis intervention services, biopsychosocial evaluations, problem identification, scaffolding of skills, and referrals to appropriate resources. Responsible for brokering of services for clients in order to have a robust referral network that attends to the needs of our client population.

Engage in follow-up care (within 72-hours) to help build relationships, solidify skill building, and advocacy for ongoing services.

Execute appropriate mental health holds (to include M1 and M3), if applicable.

Occasionally responsible for providing short-term case management.

Maintain accurate and timely clinical records.

Participate in team/department meetings, in-service trainings, clinical supervision and supervisory sessions as required.

Perform outreach activities to members of our community that are struggling with behavioral health concerns.

Perform training activities and engage in outreach events to inform community at large of CORE service offering

Broker services with community agencies and stakeholders to ensure appropriate service offerings for community members in need.

Transport clients as needed to appropriate destinations.

Collaborate with other case management staff and agencies to support client progress.

Working Environment:

Operating out of a police vehicle with other team members including an assigned CORE Officer and Paramedic, to emergencies in the local area. Including but not limited to; Active Shootings, stabbings, major traffic accidents (fatal), menacing, SWAT team calls, armed suicidal calls, child abuse, domestic violence, serious medical emergencies, infectious disease exposure risk (scabies, bed bugs, hepatitis, etc.) narcotics related calls (overdose) and many other. Wear tactical/ Bullet-Proof body armor during shift due to inherent safety risks in responding to 911 emergencies with police officers. Actively utilize "scene safety" and personal safety (defensive tactics) training tools to maintain physical safety amidst 911 emergencies (often in unpredictable environments). Initial and follow-up contacts will occur in a variety of community environments including homes, emergency rooms, community partners, jail settings, parks, greenways etc.

Often works off site and in the community, including homes, community agency sites, hospital emergency rooms, psychiatric units, nursing homes, jails and juvenile detention facilities. General office environment. Regularly works with people in acute distress or crisis. May require travel to several sites throughout Boulder County to attend meetings. Co Responder Clinicians are stationed at the Longmont Department of Public Safety.

Qualifications:

Minimum of two years' experience in clinical settings with experience performing clinical crisis interventions. Minimum of Master's degree in social work, psychology, or similar field. Current license as a LSW/LPCC in the State of Colorado or above. Special Qualifications: Bilingual (English/Spanish) Intermediate/Advanced proficiency preferred. Must have valid Colorado Driver's License and good driving record.

We're committed to building a team that reflects the diversity of the communities we serve. The City may consider an equivalent combination of knowledge, skills, education, and experience to meet minimum qualifications, and encourages all candidates to apply and help us achieve our goal of creating an inclusive and equitable workplace.

Selection:

The selection process will include complete job description review, personal interview, background investigation, criminal background check, and substance screening. Unescorted Security Clearance Required.

DEADLINE: Open Until Filled

An ONLINE APPLICATION is required. This job is Open Until Filled. The online application process is available for this position on our website at www.longmontcolorado.gov/jobs. Resumes will be accepted in lieu of the full City Application; however, they must be submitted via the City application site for consideration. Open Until Filled positions may close without advance notice. To be considered, please apply as soon as possible. For more information, call (303) 651-8609.

The City of Longmont is an equal opportunity employer. The City affirms its commitment to diversity and to complying with all applicable federal, state, and local laws regarding nondiscrimination in employment. The City will not discriminate against any person in recruiting, examining, appointing, hiring, training, placement, termination, layoffs, recall, transfer, leave of absence, promoting, compensating, retaining, disciplining, or any other personnel action on the basis of age, race, color, creed, religion, sex, sexual orientation, gender identity or expression, national origin, ancestry, genetic information, marital status, veteran status, status with regard to public assistance, physical or mental disability, or any other characteristic protected by federal, state, or local law, except when any of these categories constitutes a bona fide occupational qualification (i.e., an actual qualification for performing a job). If you need special assistance in the selection process, please contact the Human Resources Department in advance to make arrangements.

AN EQUAL OPPORTUNITY EMPLOYER

ALL CITY OF LONGMONT FACILITIES ARE SMOKE FREE

<https://longmontcolorado.gov/careers/>

[Back to top](#)

[Home](#) » [Longmont Colorado Co-Responder Clinician Position](#)

[CR CHAT Home](#)

[CoRCon Chat](#)

[Join ICRA Email List](#)

[All jobs \(https://recruiting.pa...](https://recruiting.pa...) Crisis Intervention Specialist Law Enforcement Co-Responder



Crisis Intervention Specialist Law Enforcement Co-Responder

Alma, MI (<http://maps.google.com/maps?q=608+Wright+Ave+Alma+MI+USA+48801-1617>)



[Apply \(/Recruiting/jobs/Apply/3180515\)](#)

Description

Gratiot Integrated Health Network (GIHN) has an immediate opening for a grant funded full-time, salaried position to provide Crisis Intervention Law Enforcement Co-Responder services to adults, children and families residing in Gratiot County.

With one of our strategic priorities focused on becoming a leading employer of choice in Mid-Michigan, GIHN offers competitive salary, benefits and paid time off, all of which begin on your first day of employment. Here are just a few reasons why you should consider GIHN as your next, and last, employer:

- Flexible working conditions
- Ongoing Professional Training opportunities
- Medical insurance you can trust with BCBS of Michigan. Low employee contribution and employer funded HSA.
- Delta Dental and EyeMed Vision at low, to no, employee cost.
- Student Loan Forgiveness options with Public Service Loan Forgiveness program
- 182 hours of paid time off which increases with longevity plus 13 paid holidays
- Corebridge financial planning manages our social security opt-out program, along with 401a, 457b and an annual employer contribution of 7.5%.
- Employer paid life insurance.
- Employer paid short term disability
- On-site pharmacy for employee convenience

SALARY RANGE: \$51,001 to \$71,968

EMPLOYMENT CLASSIFICATION: Regular, Full-Time, Exempt/Salary Status

Requirements

Summary/Objective.

The Crisis Intervention Specialist Law Enforcement Co-Responder will work in collaboration with law enforcement agencies to provide mental health assessments, crisis intervention, and resource referrals to individuals in the community. This position is designed to assist law enforcement officers by providing an immediate mental health response during calls that involve individuals experiencing mental health crises or behavioral health challenges. The clinician will provide on-scene evaluations, de-escalation, and intervention, ensuring that individuals are connected to appropriate mental health services.

Essential Functions.

To ensure equal employment opportunities to qualified individuals with a disability, GIHN will make reasonable accommodations for the known disability of an otherwise qualified individual, to allow them to perform the essential functions of a job, unless doing so causes undue hardship on the operation of the Agency.

1. Performs emergency assessments of individuals with a mental health and/or substance use disorder, to determine the level of required service, and will make appropriate referrals to meet the identified needs.
2. Provides crisis intervention and access screen services to individuals on-scene during law enforcement response in the community.
3. Respond to 911 calls and other emergency situations where behavioral health crises are suspected.
4. Exhibits a solid understanding of the legal process and the criteria governing involuntary psychiatric hospitalization and subsequent legal proceedings.
5. Partner with law enforcement officers to assess individuals in the community who are experiencing mental health emergencies.
6. Utilize crisis de-escalation techniques to manage individuals in distress, ensuring safety for all parties involved.
7. Educate law enforcement officers on behavioral health symptoms, resources, and intervention strategies.
8. Assist in referrals to appropriate community-based mental health services, shelters, or emergency resources.
9. Maintain thorough documentation of all interactions, assessments, and interventions in accordance with department and regulatory standards.
10. Participates in staff conferences, consumer reviews and in-service training sessions as part of the clinical services team.
11. Provides consultation, linking and advocacy, with referral sources such as physicians, schools, community professionals, hospitals, courts and families, as required, to meet the needs of the consumer and ensure the provision of services.
12. Provides support for Intensive Crisis Stabilization and Support team as needed.
13. Advocates to obtain the least restrictive community placement based on the individual consumer needs.
14. Involved in organized, on-going, collaborative efforts that involve individuals with co-occurring mental health and substance use disorders which may require services from multiple systems.
15. May serve as a member of the emergency services team that provides on-call, 24 hour crisis intervention to Gratiot County residents, utilizing a "no-wrong door" philosophy for both mental health and substance use disorders.
16. Protects the security, confidentiality and integrity of all protected health information in a manner that is consistent with HIPAA, MDHHS and GIHN policy and procedure.
17. Assures consumers' rights are protected and recipient rights procedures are followed throughout GIHN and its provider network.

18. Attends and actively participates in GIHN required training for both mental health and substance use disorders, as well as seeks external education opportunities for professional growth and development.
19. Abides by all applicable GIHN policies and procedures.
20. Maintains a safe and clean work environment.
21. Performs work and other duties as assigned by the supervisor.

Competencies.

Must demonstrate sensitivity, knowledge and use of appropriate approaches, skills and techniques which reflect an understanding and awareness of trauma and social, cultural and economic diversity of the target population served. GIHN employees will actively support the goal of person centered planning and integrated care through the recovery process. GIHN employees will acknowledge and develop competencies to support the understanding of the complexities of the human condition and the manner in which physical health, substance use disorders and physical and/or emotional trauma are interrelated to the need for mental health services. Must demonstrate computer skills, including entering and retrieving data. Must be able to read and interpret statistical data. Must demonstrate high level of interpersonal skills to handle sensitive and confidential situations and documentation and the ability to maintain a high level of confidentiality. Must exhibit strong spelling, grammar and both oral and written communication skills.

Supervisory Responsibility.

This position has no supervisory responsibilities.

Work Environment.

This job operates in a professional office environment and may also operate in satellite locations such as the local hospital, local law enforcement offices, county jail or consumer's home. This role routinely uses standard office equipment such as laptop computers and smartphones.

Physical Demands.

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job.

While performing the duties of this job, the employee is occasionally required to stand; walk; sit; use hands to finger, handle or feel objects, tools, or controls; reach with hands and arms; climb stairs; balance; stoop; kneel, crouch or crawl; talk or hear; and taste or smell. The employee must occasionally lift or move up to 20 pounds

Position Type/Expected Hours of Work.

This is a full-time, salaried, exempt position. Some flexibility in hours is allowed but the employee is expected to be available during the core works hours of assigned shift and work 40 hours each week to maintain full-time status, unless an adjusted schedule is pre-approved (a minimum of 30 hours per week is required to maintain full time benefit status). Some evening hours and weekends may be required.

Travel.

Limited travel within Gratiot County is expected for this position.

Required Education and Experience.

Bachelor's degree in Social Work is required with Michigan licensure appropriate to professional degree, (i.e. LLBSW, LBSW), OR be a designated Mental Health Professional (MHP) and Child Mental Health Professional (CMHP) or a Registered Nurse. Must also be designated as a Crisis Professional. Must have experience in the provision of services to individuals and families with mental health illness, developmental disabilities, substance use disorders and co-occurring disorders in a mental health or other human services agency.

Preferred Education and Experience.

Bachelor Degree in Social Work Preferred. Bachelor degree in Human Services accepted. Michigan licensure appropriate to professional degree, i.e., LLMSW, LMSW, LLPC, LPC, RN, preferred. Three years of work in the mental health field with crisis intervention experience preferred.

EEO Statement.

GIHN provides equal employment opportunities to all employees and applicants for employment without regard to race, color, religion, sex (including pregnancy, gender identity and sexual orientation), parental status, national origin, age, disability, genetic information (including family history), political affiliation, military service, or any other characteristic protected by local, Michigan or federal law. Equal opportunity applies to all terms and conditions of employment, including hiring, placement, promotion, termination, layoff, recall, transfer, leave of absence, compensation and training. GIHN expressly prohibits any form of unlawful employee harassment or discrimination based on any of the characteristics mentioned above, or any other protected status. Improper interference with the ability of other employees to perform their expected job duties is absolutely not tolerated.

Other Duties.

Please note this job description is not designed to cover or contain a comprehensive listing of activities, duties or responsibilities that are required of the employee for this job. Duties, responsibilities and activities may change at any time with or without notice. The above functions will also incorporate knowledge about and actively support culturally competent recovery based practices, person-centered planning and a trauma informed culture of safety to aid consumers in the recovery process, as applicable to the work performed.

Salary Description

\$51,001 to \$71,968

[Apply \(/Recruiting/jobs/Apply/3180515\)](/Recruiting/jobs/Apply/3180515)

[↩ View All Jobs \(/Recruiting/Jobs/All/8672153e-ed3f-4189-8a6b-2fcf71e87ff4\)](/Recruiting/Jobs/All/8672153e-ed3f-4189-8a6b-2fcf71e87ff4)

Powered by  paylocity

Privacy Policy (<https://www.paylocity.com/privacy/>) Payroll & HR Software (<https://www.paylocity.com/>)

MENTAL HEALTH CO-RESPONDER CLINICIAN

🔗 Apply Now!

⬅ Back to search

Location:	Dumont, Colorado
Department:	Emergency Medical Ser
Posted:	4/2/2025
Location Name:	3400 Stanley Road: EMS Building
Wage Max:	96,800.00 Annual
Wage Min:	78,700.00 Annual
Position Type:	Full Time Benefits Eligible (> 30 Hours Per Week)
Shift:	Regular - 40 Hrs Week

JOB SUMMARY FOR MENTAL HEALTH CO-RESPONDER CLINICIAN:

The Community Crisis and Health Assistance Team (CCHAT) is Clear Creek County's Alternate and Co-responder program serving vulnerable populations throughout the county. functions: 1 - Provide alternate response (without other emergency service providers) to appropriately screened 911 calls offering trauma-informed, client-centered responses to individuals in crisis. 2 - Provide co-response to calls for service that require LE presence and have a mental health or other crisis related component. 3 - Through a Community Integrated Health Care Services (CIHCS) team, provide care coordination, and resource navigation, to help resolve issues that affect a person's health and safety for medically fragile vulnerable populations. In all functions, the team provides follow-up, care coordination, and resource navigation, to help resolve issues that affect a person's health and safety for medically fragile vulnerable populations. The clinician thinks critically, demonstrates safety, and works well in a multi-disciplinary team environment. The clinician is experienced, creative, and adaptable to provide unique solutions to each client.

Benefits: Retirement, Health, Vision, Dental, Retirement, Voluntary Life, Critical Illness, Accident and Hospital), Life & AD&D Ins, Short-term & Long-term Disability, PTO, Sick Leave

PRINCIPAL JOB DUTIES FOR MENTAL HEALTH CO-RESPONDER CLINICIAN:

- Respond to mental and behavioral health-related 911 calls to provide crisis de-escalation, on-scene risk, and needs assessments to identify the problems and appropriate interventions.
- Collaborate with on-scene personnel to identify the best disposition for a call while advocating for the client's mental/behavioral health needs.
- Understand the criteria and procedures for Emergency Mental Health Holds within Colorado, assess a person's risk of harm to self or others or grave disability, and arrange for appropriate cases.
- Respond to referrals from EMS/Fire/LE/Community Partners via phone and/or in person; Enroll appropriate clients in CIHCS services for ongoing care.
- Provide ongoing resource navigation in the days and weeks following a client contact.
- Coordinate care for clients' ongoing bio-psycho-social needs with local and regional providers as part of crisis resolution and CIHCS enrollment.
- Assist community paramedics by providing social/mental health assessments for all clients enrolled in CIHCS services and responding to scheduled visits.
- Assist in developing/maintaining community partnerships by attending community meetings, events, etc.
- Maintain accurate and timely clinical records consistent with standards.
- Participate in team/department meetings and trainings.
- Maintain licensure if applicable, including necessary CEs.
- Maintain a trauma-informed environment of well-being.
- Performs other related duties and responsibilities as required.

MINIMUM JOB REQUIREMENTS:**REQUIRED EXPERIENCE / EDUCATION FOR MENTAL HEALTH CO-RESPONDER CLINICIAN**

- Master's degree in Clinical Mental Health Counseling, Social Work, or a closely related degree from an accredited program.
- Preferred License as an LCSW/LPC/LMFT/LAC or another appropriate licensure in Colorado.
- Minimum two years of experience in crisis intervention and verbal de-escalation, working with individuals experiencing moderate to severe and persistent mental illness and/or substance use.

CERTIFICATIONS & SPECIAL LICENSES:

LAC or CACIII preferred

KNOWLEDGE, SKILLS & ABILITIES FOR MENTAL HEALTH CO-RESPONDER CLINICIAN

- Knowledge or ability to learn and practice trauma-informed principles and practices.
- Knowledge of methods of psychotherapy
- Knowledge of community resources
- Ability to always demonstrate good clinical judgement
- Ability to assess crises and intervene appropriately.
- Familiarity with the DSM V and diagnostic techniques
- Practical written and verbal communication skills
- Ability to work flexible hours, including weekends

NECESSARY SPECIAL REQUIREMENTS:

- Must have a valid Colorado Motor Vehicle Drivers' License, and proof of automotive insurance
- Must pass a background check: Criminal & Traffic
- Required legal authorization to work - United States citizenship or legal authorization to work in the United States

SUPERVISORY:

None

PHYSICAL REQUIREMENTS AND WORK ENVIRONMENT FOR MENTAL HEALTH CO-RESPONDER CLINICIAN:

The physical requirements described here represent those that an employee must meet to perform the essential functions of this job successfully. While performing the duties of this job, the employee is required to stand for long periods, use hands and fingers to handle or feel, and reach with hands or arms. The employee is required to stand, walk, bend, twist, stoop, or kneel. Must be able to coordinate—dexterity of hands and fingers to operate a computer keyboard, mouse, and other devices and objects. The employee must frequently lift and/or move objects in vision, distance vision, color vision, peripheral vision, depth perception, and the ability to adjust focus. Must possess the mental and emotional resilience to handle potentially stressful situations an employee encounters while performing essential functions of this job. When appropriate, work is performed in either an office environment or a client's home. This role routinely uses fax/scan machines. Possible exposure to conditions relating to loud noise, all types of weather and non-weather conditions, extreme temperatures, fumes, odors, dirt, and dust. Extensive travel may be necessary. Work can be a stressful environment during peak operations.

POSSIBLE HEALTH RISKS SPECIFIC TO THIS POSITION

N/A

The above statements are intended to describe the general nature and level of work. They are not intended to be an exhaustive list of requirements, duties and responsibilities. (C)

The above statements are intended to describe the general nature and level of work. They are not intended to be an exhaustive list of requirements, duties, and responsibilities. Clear Creek County provides reasonable job-related accommodations for disabled persons.

Equal Opportunity Employer/Protected Veterans/Individuals with Disabilities.

The contractor will not discharge or in any other manner discriminate against employees or applicants because they have inquired about, discussed, or disclosed their own pay or the pay of another employee or applicant. However, employees who have access to the compensation information of other employees or applicants as a part of their essential job functions cannot disclose the pay of other employees or applicants to individuals who do not otherwise have access to compensation information, unless the disclosure is (a) in response to a formal complaint or charge, (b) in furtherance of an investigation, proceeding, hearing, or action, including an investigation conducted by the employer, or (c) consistent with the contractor's legal duty to furnish information. 41 CFR 60-1.35(c).

[Home](#) > [Government](#) > [Departments](#) > [Human Resources](#) > [Employment](#)

Employment with the Village of Gurnee

The Village of Gurnee is an Equal Opportunity Employer and complies with all applicable federal, state, and local laws regarding employment. The Village encourages qualified candidates who share our commitment to diversity and non-discrimination to apply for available positions.

Full-time employees that are not part of the Police or Fire pensions become members of the Illinois Municipal Retirement Fund (IMRF), a link to their website is posted [here](#).

Applicants for employment can view the FMLA poster [here](#).

Applications are accepted only in response to posted vacancies. If there is a position you would like to apply for, please review the job advertisement and follow the application instructions. Unless otherwise indicated, the qualifications listed are guidelines. Other combinations of education and experience, which could provide the necessary knowledge, skills, and abilities to perform in the job position, may be considered at the Village's discretion when

appropriate. Please note during high volume recruitments, Village staff may contact only candidates under consideration for a position. Questions? Email the [Human Resources Department](#).

-

Current Openings

POLICE SOCIAL WORKER - APRIL 2025

Summary:

The Village of Gurnee is looking for a passionate, motivated, and experienced individual who is ready to join our team in the newly created position of Police Social Worker.

Requirements:

Click [Here](#) to Apply - Candidates are encouraged to apply as soon as possible for consideration for this position. First review of applications will occur May 9th, 2025. Position is open until filled.

This is an excellent opportunity to advance your career while making a direct impact in the community.

Key Responsibilities: In this role, you will partner with Law Enforcement Officers to bring compassion and crisis intervention to the front lines of public safety.

Responsibilities include but are not limited to the following:

- Partner with Officers to respond to mental health, substance use, and crisis situations
- Provide immediate support, de-escalation and referral services in the field
- Review and assess all Police incident reports to determine if social service follow-up is needed
- Provide mental health and other related training to Officers
- Consult with department Peer Support Officers as needed to promote Officer wellness
- Provide emergency social service assistance after working hours to Officers in the field as needed

Key attributes: The ideal Police Social Worker will be a non-sworn experienced professional who is calm under pressure and confident working alongside law enforcement. Someone that is passionate about community wellness and has the ability to work independently to follow up on cases. An organized, detail oriented individual with strong written and verbal communication skills.

Pay Range:

The Salary range: \$104,160-126,607 annually (+/- DOQ): plus, a generous benefit package including health, dental, and vision benefits, employer-paid life insurance and other ancillary benefit options. Retirement benefits through the Illinois Municipal Retirement Fund (IMRF), retirement health savings plan through

Mission Square with bi-weekly Village contributions along with the option to participate in a 457(b) deferred compensation plan. Paid time of and tuition reimbursement assistance.

Work Schedule: This is a full-time, 40-hour per week, exempt position. Typical work hours are Monday through Friday, with shifts generally falling between 8:00 AM – 6:00 PM. Flexibility is required, as evening and/or night hours will be necessary to collaborate with night shift officers, respond to critical incidents, or meet the needs of the community.

Minimum Qualifications:

Education/Experience:

- Master's degree in Social Work, Counseling or Psychology or related field is required
- Minimum 3 years of related experience, within a law enforcement agency is preferred
- Illinois certification as a Licensed Clinical Social Worker (LCSW), preferred or Licensed Social Worker (LSW)

[Return To Job Postings](#)

[Careers](#)[Pay
Online](#)[For Residents](#) [For Businesses](#) [County Services](#)[Newsroom](#) [Contact Us](#) [Search](#)[Returning Candidate? Log back in!](#)

Mental Health Co-Responder (Licensed Crisis Clinician)

US-KS-Mission

2025-2770

Category Healthcare, Welfare, and Social Services**Benefits Category** Full Time - Regular (Full Benefits) **Remote** No**Salary Min** USD \$32.93/Hr. **Salary Max** USD \$49.40/Hr.**Organizational Unit** Mental Health**Work Schedule** Schedule: Sunday-Wednesday 8am-6pm, varies as needed by community needs.**Driving Status** Primary (25% or more)

Overview

A career with Johnson County Government is more than just a job, it is an opportunity to serve a diverse and expanding community in meaningful ways. We challenge ourselves to be a different kind of government because we care deeply about our community and each other. Committed to our shared values, we provide excellent public service, seeking always to improve ourselves and our organization. We offer wonderful benefits, retirement plans, wellness incentives, a great organizational culture, and much more! If you're searching for something more than just a job, something akin to a calling, then consider the challenge and opportunity of being a member of Johnson County Government!

Johnson County has implemented a skill-based pay plan of up to \$4200 annually for staff who have obtained licensure by the BSRB at the Clinical Level.

Johnson County Mental Health Center (JCMHC) is looking for qualified candidates who are interested in working alongside law enforcement to fill the position of **Mental Health Co-Responder (Licensed Crisis Clinician)**. These positions will work as a member of JCMHC's Emergency Services Division but will office within the assigned police department. The Co-Responder positions are perfect for clinicians who like working in fast paced environments, resolving crises, and improving the intersection between law enforcement and behavioral health. The goals of the program include decreasing unnecessary trips to the emergency rooms, avoiding preventable arrests and reducing repeat behavioral health calls for the police department by connecting people to the appropriate resources. The co-responder will respond to behavioral health 911 calls alongside their respective police department, provide interventions at various locations in the community, and provide outreach by phone or in person to determine if the crisis is resolved and if additional services or resources are needed. All in person interventions will be accompanied by a law enforcement officer.

Open Positions

- The schedules below may include meetings and trainings outside of normal work hours, so flexibility is necessary.
- *This position is eligible for a shift differential specific to weekday overnight hours(\$2.00/hr), weekend hours (\$4.00/hr), and weekend overnight hours (\$6.00/hr).*

Overland Park Police Department

- Schedule: Sunday-Wednesday 8am-6pm.
- We offer four 10-hour shifts with a working lunch.

Leawood/Prairie Village

- Schedule Options: Choice between Sunday-Thursday or Tuesday-Saturday
- This position is for evening coverage, however the police department has offered flexibility with hours and applicants may choose from 2p-10p, 3p-11p, or 4p-12a

Olathe Police Department

- Schedule: Wednesday-Saturday 2pm-Midnight
- We offer four 10-hour shifts with a working lunch.

Position will remain open until filled.

Job Description

Responds in person to 911 behavioral health calls alongside law enforcement to conduct an assessment to recommend appropriate level of care, including assessing individual risk for suicide and other safety related concerns, and determining the need for resource referrals.

- Completes **in person or phone outreach** to support individual's post-crisis with connecting to necessary services; this could also be after other 911 calls, like domestic violence, fatalities or traumatic experiences.
- May complete **State Hospital Screenings** for involuntary commitments to assist with keeping individuals safe and getting critical services.
- **Reviews police reports** and determines appropriate next steps, including follow up needs after the initial call to ensure the crisis has resolved and/or if additional resources are needed. Follow up is conducted by phone or an in-person outreach alongside a law enforcement officer.
- **Collaborates** with JCMHC teams and other community agencies to advocate and partner for individuals' needs.
- Submits **clinical documentation** regarding services provided and makes necessary referrals to internal and external resources.
- **Facilitates trainings** for police department regarding co-responder role and mental health related topics; participate in presentations in the community regarding the co-responder program.

Job Requirements

Minimum Job Requirements:

Master's degree in Social Work, Counseling, Psychology, or other Human Services field and Kansas Behavioral Sciences licensure* at the master's level in the area of focus are required. May require a KS/MO driver's license, depending on department or agency.

*Applicants who meet Kansas licensure requirements may be considered if Kansas licensure is obtained by time of an employment offer and licensure is pending confirmation at the time of employment application. Candidates must be able to meet REJIS/KCJIS requirements (for law enforcement positions) and will be required to successfully complete a background investigation, including post-offer polygraph and drug screen, as a condition of employment.



County Administration Building

111 S. Cherry St.,
Olathe, KS 66061

Meetings and Events

ADA Accommodation Request

Contact Us

Legal Disclosures

For Residents

For Businesses

County Services

Newsroom

Contact Us

Department Directory

Facebook

Twitter

Instagram

YouTube

Social Media Directory

Copyright © 2024. All rights reserved



Blaine County Mental Well Being Initiative Crisis System Planning

June 4, 2025



Copyrights © 2025 | Third Horizon

1

1

Third Horizon



Third Horizon is a boutique advisory firm focused on designing integrated health and social systems so that all communities, families, and individuals can thrive. Through its work across three advisory services, the firm offers a 360° view of complex challenges across three horizons – past, present, and future – to help industry leaders and policymakers interpret signals and trends and develop upstream innovations, strategies, and structural changes that maximize the value of the yearly spend on health care. Learn more at www.thirdhorizon.co.

Copyrights © 2025 | Third Horizon

2

2



Behavioral Health



Enhancing behavioral health prevention, treatment, and recovery systems of care to **improve access and quality**

Analysis



Conduct environmental scans, data analytics, focus groups, and key informant interviews to ascertain gaps, demand, and opportunities to enhance mental health and substance use prevention, treatment, and recovery

Delivery System Redesign



Facilitate robust stakeholder engagement processes and research, evaluate care models, and provide recommendations and implementation support to improve publicly and privately funded behavioral health services and crisis care

Strategy & Technical Assistance



Provide strategic planning and leadership development on change management for organizations, help providers navigate and improve programs and services, and advise private philanthropy on behavioral health grantmaking strategy

Policy



Host convenings to inform and advance policies, conduct analyses on budget implications, service delivery, and payment reform efforts at the local, state, and national level; assist providers in navigating complex regulatory and licensing processes

3

Project Overview



Blaine County's Mental Well-Being Initiative released a Request for Proposals in February 2025 to secure consulting services to support their strategic plan *Goal #4: Create a 24-hour mobile mental health crisis response system and crisis stabilization options.*

While the MWBI has already done extensive research and planning, the Initiative seeks external guidance to ensure the development of a sustainable, outcomes-focused crisis system rooted in national best practices but tailored appropriately to meet the needs of the Blaine County community.

Third Horizon will:

Develop a comprehensive mobile crisis response operational plan incorporating the county's existing emergency response framework

Assess the feasibility of crisis stabilization settings that complement the mobile response system, ensuring seamless transitions for individuals in crisis.

Design a coordinated care model that enhances continuity of care beyond the initial crisis intervention.

4

Presentation Goals



Share findings from Third Horizon's initial crisis data analysis, qualitative research and literature review



Describe a range of models and approaches that could be used to implement mobile crisis response



Obtain additional stakeholder input to help inform Third Horizon's recommendations

Copyrights © 2025 | Third Horizon

5

5

Project Timeline



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Project Management	[Timeline bar]								
Phase 1: Discovery	[Timeline bar]								
Kick-off Meeting	[Timeline bar]								
Review of Existing Documents	[Timeline bar]								
Key Informant Interviews		[Timeline bar]							
Phase 2: Data Analysis and Planning Process				[Timeline bar]					
Case Studies Development				[Timeline bar]					
Collect and Analyze Crisis Emergency Data				[Timeline bar]					
First Planning Retreat				[Timeline bar]					
Interim Report (due July 7)				★					
Strategic Vision Document (due September 1)						★			
Phase 3: Development of Final Recommendations and...							[Timeline bar]		
Financial Analysis							[Timeline bar]		
Second Retreat							[Timeline bar]		
Report Writing and Production								[Timeline bar]	
Final Report									★

Note: Strategic Vision Document deadline has been extended to accommodate holding the first planning retreat in September

Copyrights © 2025 | Third Horizon

6

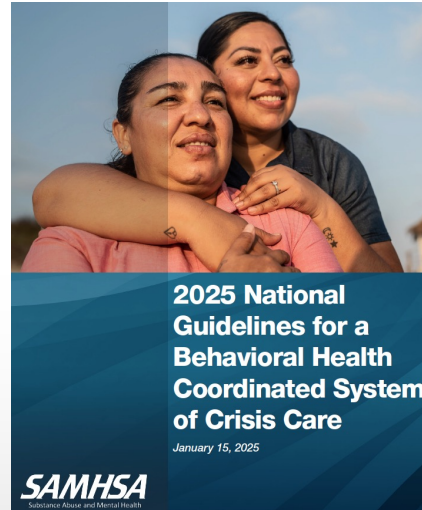
6

Behavioral Health Coordinated System of Crisis Care Overarching Principles



Crisis Services Should Be...

- Comprehensive, integrated, coordinated, and developed utilizing a systems-based approach
- Person-centered, family-focused, and provide the right level of care at the right time
- Prioritizing safety
- Equitably accessible and responsive to the diverse needs of populations
- Prioritizing quality and effectiveness
- Developmentally appropriate
- Resiliency and recovery-oriented
- Trauma informed
- Providing continuity of care from the onset of crisis until stability, including follow-up care and linkages
- Evidence-based, evidence-informed, and/or reflect best, promising, and emerging practices
- Responses to individuals' holistic needs



Copyrights © 2025 | Third Horizon

7

7

Behavioral Health Coordinated System of Crisis Care Essential Elements



Someone to Contact: Services like the 988 Lifeline and other behavioral health hotlines provide immediate, accessible support



Someone to Respond: Services like mobile crisis teams deliver rapid, on-site interventions to de-escalate crises and connect individuals to care and other community-based supports that provide crisis prevention and postvention care



A Safe Place for Help: Emergency and crisis stabilization services that support on-demand crisis care and crisis-related supports in a variety of community settings.

*To realize the vision of a robust, high-quality BHSCC, communities should ensure that **individuals have access to each of the three essential elements of behavioral health crisis care**. In addition, providers, system partners, and payers should **collaborate to ensure coordination of services** and that **system components are accountable** for effective crisis response in communities.*

Copyrights © 2025 | Third Horizon

8

8

Co-Responder and Mobile Crisis Team Models

9

Model Comparisons

Police-Led Co-Responder Models	Clinician-Focused and Hybrid Co-Responder Frameworks	Behavioral Health Practitioner-only Mobile Crisis Teams (MCT)
• Law enforcement officer paired with a mental health clinician • An officer must be present; ensures safety of the person in crisis, and the clinician, if present	• Emphasizes a balanced partnership or clinician leadership, prioritizing health-centered responses • Maintains law enforcement presence for safety when needed	• Typically, has at least one licensed clinician and other non-licensed support staff (peers/case managers)
• Operated through police departments, using existing emergency infrastructure • Officers often receive specialized training, e.g., Crisis Intervention Training (CIT)	• Operated by police departments • Allows either the clinician or officer to take the lead based on the situation, contingent upon the need for clinical assessment or safety intervention	• Operated by an independent agency • SAMHSA emphasizes that co-responder models may complement, not replace MCTs • May respond to calls to 988 calls, an MCT hotline, or 911 calls assessed as not requiring police response
• The presence of uniformed officers may be seen as stigmatizing or criminalizing • The model may be more viable in communities with safety concerns	• Studies show community members often favor clinician-led teams, highlighting the impact of program structure on trust and effectiveness	• Eliminates police response for most scenarios

10

Operational Variations and Compositions



Ride-Along vs. Ride-Separate Support

Ride along: Embeds a mental health professional with law enforcement for faster, coordinated crisis response and improved team cohesion

Ride Support: Dispatches clinicians as needed, maximizing resource efficiency but possibly delaying intervention and complicating de-escalation



Remote/Telehealth Co-Response:

Expanding clinical reach, especially in rural or resource-limited areas

Effectiveness may be reduced by tech issues, limited situational visibility, and challenges in building rapport

Better supplement than replacement



Team Composition and Diversification

Paramedics/ Emergency Medical Technicians (EMTs)

Peer Support Specialists

Model Formulation =
Least Intrusive + Responsive to Community Needs + Sustainable Based on Available Resources

Copyrights © 2025 | Third Horizon

11

11

Model Examples



Johnson County, Kansas: Mental Health Co-Responder Program

- Partnership between Olathe Police Department and Johnson County MH Center
- Officers receive mandatory CIT
- Clinicians provide on scene support, crisis intervention, outreach and follow up
- Clinicians and officers respond to the scene together
- Dispatched through 911

Pitkin County, Colorado: Pitkin Area Co-Responder Teams (PACT)

- PACT serves the rural mountain communities of Aspen, Snowmass Village
- Partnership between DPH, Mindsprings Health, multiple local PDs, and the sheriff's office
- Clinician-led response alongside LE
- Team includes mental health counselor, peer support, case manager, law enforcement officer
- Clinician either responds together with law enforcement or after the fact
- Dispatched through 911 or the Aspen Hope Centers' 24/7 "Hopeline"

Flathead County, Montana: Crisis Assistance Team (CAT)

- Operated within Flathead City-County Health Department and in Partnership with multiple local PDs
- 2 CAT Therapists + 2 CAT Care Coordinators in 2 independent teams
- Therapists provide on scene crisis services, assessment, and recommendations to law enforcement. Care coordinators engage in outreach, follow-up case management, and resource navigation
- Dispatched through 911 or 988

Copyrights © 2025 | Third Horizon

12

12



Crisis Data Findings

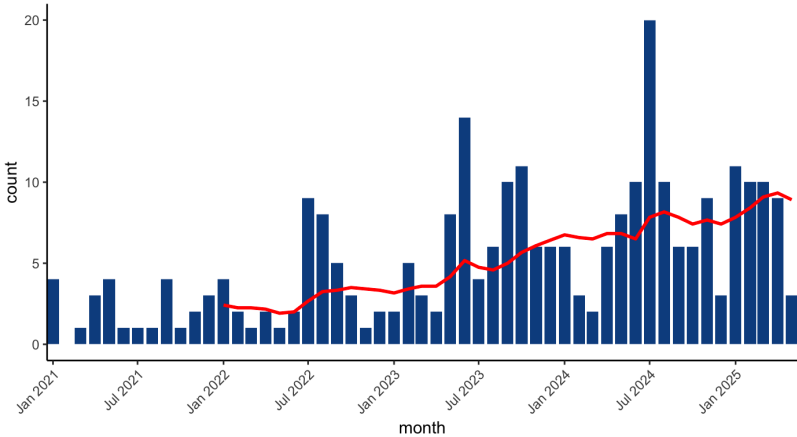
Analysis of 9-1-1 Dispatch, Wood River Medical Center
Emergency Department, and St. Luke's Mental Health
Encounter Data

13

Crisis Response Data (Jan. 2021 – May 2025)



Crisis Response Calls by month with trailing 12-month average
01/01/2021 - 05/31/2025

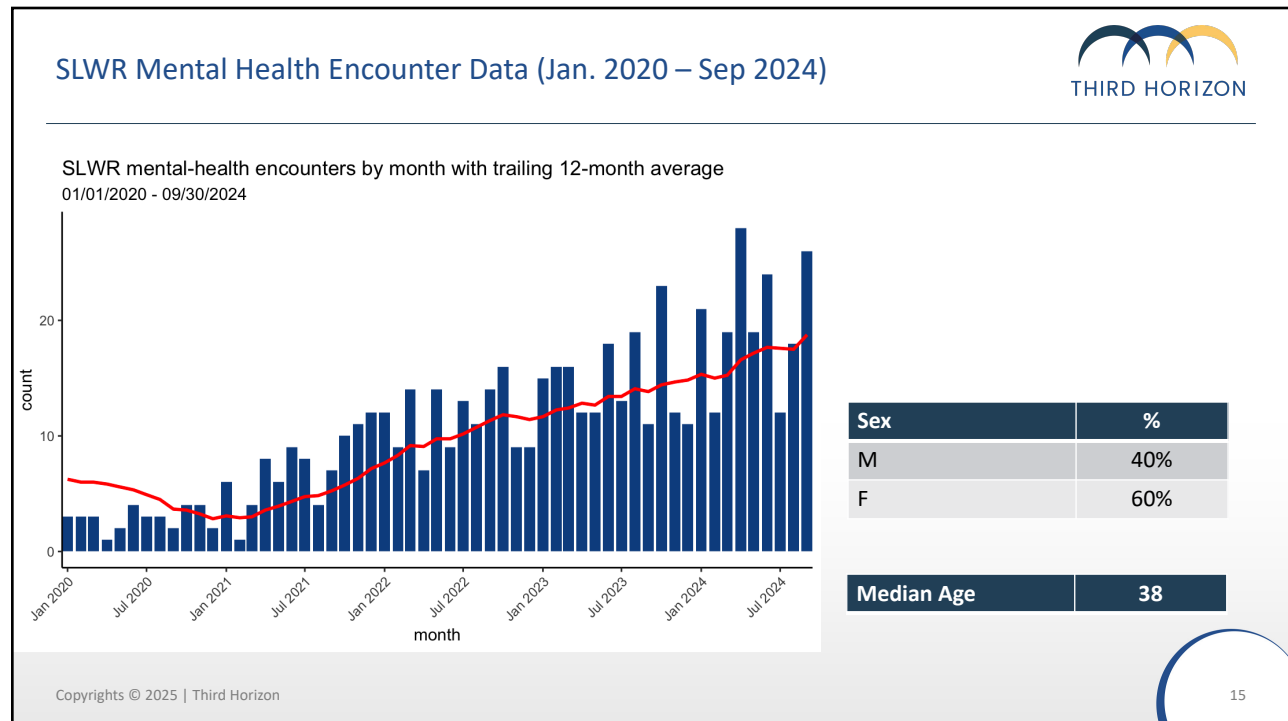


Transport	Share (%)
Ambulance	36%
Law Enforcement	13%
Both	2%
Neither	49%

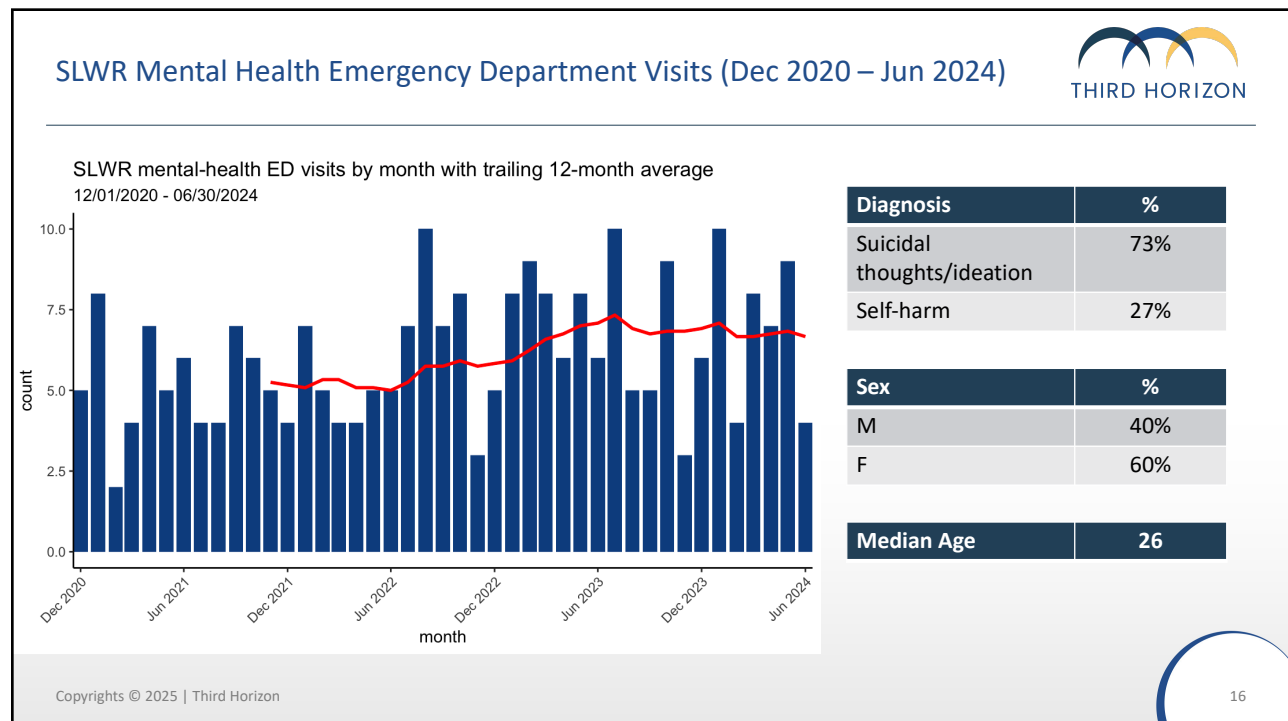
Sex	%
M	46%
F	54%

Median Age	36
------------	----

14

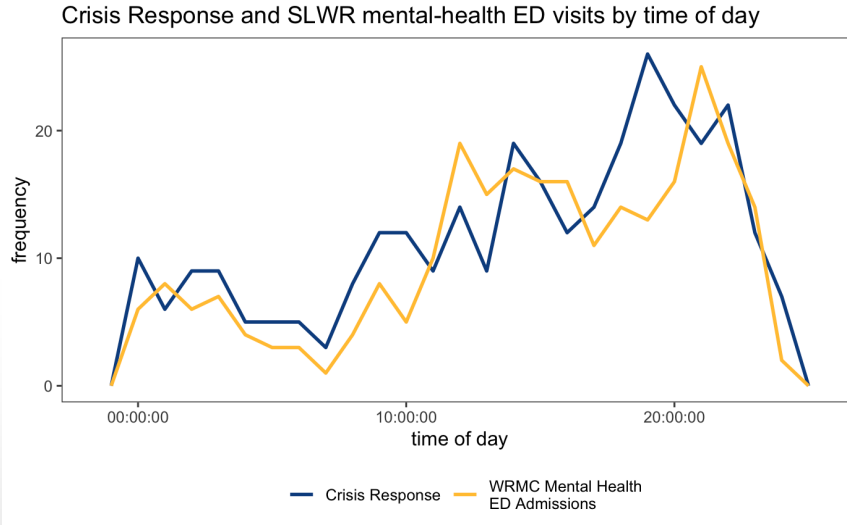


15



16

Crisis Response and SLWR ED Visits Time of Day



Copyrights © 2025 | Third Horizon

17

17

Key Takeaways



- Crisis response dispatch calls, SLWR mental health encounters, and SLWR ED admissions data all show increasing utilization trends over time
- On average, dispatch responds to nine behavioral health crisis calls per month (most recent available trailing 12-month average)
- On average, the ED receives seven individuals in mental health crisis per month (most recent available trailing 12-month average)
- The median age for ED visits (26) is significantly lower than for crisis response (36) or mental health encounters (38). This reflects a higher prevalence of mental health-related ED visits among adolescents
- Thirty-six percent of all crisis response calls involved transportation by ambulance
- Most mental health crisis calls and mental health ED admissions occur in the second half of the day, with peak hours between 7pm and 10pm



Copyrights © 2025 | Third Horizon

18

18



Focus Group Findings

Copyrights © 2025 | Third Horizon

19

19



Focus Group Process

- In May 2025, Third Horizon facilitated four virtual focus groups with community partners, behavioral health providers, local government representatives, and the St. Luke's team.
- Facilitators used a structured discussion guide to gather input on key questions aligned with Goal 4 of the Blaine County Mental Well-Being Initiative.

Cohort	Number of Participants	Date
Local Government	9	May 12
Partners	9	May 28
Providers	5	May 27
St. Luke's	10	June 3

Copyrights © 2025 | Third Horizon

20

20

Gaps and Priorities



- **There is a need for case management**, including follow-up care post-crisis and for family members impacted by suicide.
- **Linguistic and cultural barriers** reduce Spanish-speaking residents' access to services.
- **Stakeholders indicated the crisis system should adopt a more proactive approach**, addressing needs before crises escalate rather than responding only after they occur.
- **Transportation can be a barrier to access**, even when services are technically available.
- **Current crisis response timeframes are inadequate**—for example, Magellan's 2 to 3-hour response window under its state contract does not align with urgent needs.
- **There are limited resources to address SUD** (especially alcohol).
- **Stakeholders would like to see a “place to go”**, and/or transportation assistance for individuals and families to access crisis centers in other counties.



Copyrights © 2025 | Third Horizon

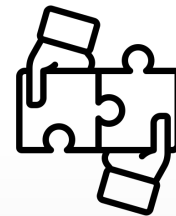
21

21

Co-Responder Proposal Considerations



- **There are mixed opinions about the need for police involvement.**
 - Some participants expressed that law enforcement's response to behavioral health crises has historically been inconsistent and, at times, heavy-handed.
 - Others emphasized that recent CIT training is preparing police to address crises better
 - Several felt that co-response was preferable to ensure the safety of everyone involved, particularly late at night.
 - Many participants indicated that if a co-responder program is implemented, it should include a plain-clothes officer in an unmarked vehicle paired with a behavioral health professional.
 - Participants who prefer a mobile crisis team approach indicated there may still be times law enforcement need to be brought in.
- **It may be a realistic starting place** given the Sheriff's support and potential funding opportunity



Copyrights © 2025 | Third Horizon

22

22

Mobile Crisis Team Considerations



- **Many participants expressed an interest in seeing a local mobile crisis team developed, now or eventually.**
 - Concerns about Magellan's response time were raised
 - Many expressed a desire to see an alternative to co-response focused on crisis de-escalation and connection to ongoing care
 - A mobile crisis team could utilize peers or other non-clinical supports, which may not be available in co-response
 - The emergency department is currently serving as the "defacto" crisis center; a mobile crisis team may reduce inappropriate utilization
 - A local hotline could serve as an alternative to calling 9-1-1, allowing public safety resources to be used where most needed
- **The community is uncertain about what to anticipate in terms of the level of demand**
 - Questions were particularly raised about whether both a co-response model and a mobile crisis team are warranted
 - Some questioned whether there would be enough crisis volume to justify a dedicated team 24/7, much less two dedicated teams
 - However, crises often happen during evenings, weekends, and holidays.



Copyrights © 2025 | Third Horizon

23

23

Considerations for Children & Youth



- **Behavioral health needs may be growing in acuity for children and youth**
- **There is a critical shortage of child therapists** in the community, contributing to long wait times and unmet need.
- **Current age restrictions at St. Luke's**, which only serves individuals 14 and older, leave younger children without access to care. (A child psychiatrist is expected to join the St. Luke's team later this year.)
- **A drop-in facility was suggested as a valuable resource for teens**, offering a safe and accessible space to seek help.
 - There is one in a neighboring county, but transportation is an issue for families
- **Parents of children in crisis need more support**, including warm handoffs and clear guidance when accessing services.



Copyrights © 2025 | Third Horizon

24

24

Operational Considerations



- **Accurate triage will be very important** for the success of any model to ensure that people get the correct services and to respect patient concerns around anonymity, no police involvement, and avoiding ER visits.
- **Clarity is needed about** who holds authority over the deputy and clinician in a co-response model, and where the positions are physically housed
- **Workforce issues** may necessitate creativity, such as on-call clinicians or shared staff
- **Service hours** should be designed to address unmet needs, if 24/7 is not feasible
- **A closed-loop system may be needed** to confirm whether individuals receive follow-up care after a crisis interaction.

Copyrights © 2025 | Third Horizon

25

25

Community Awareness



- Participants expressed the need for increased awareness of services and programming in the community
- However, stakeholders also note that sometimes people don't show up even when the best efforts are made to market services or educational programs and eliminate barriers
- Whatever crisis services are implemented, it will be critical to do outreach and education to referral sources and diverse community groups

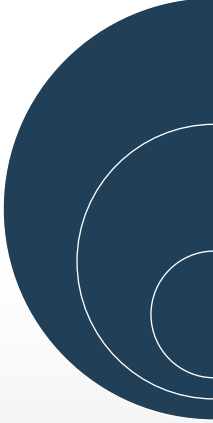


Copyrights © 2025 | Third Horizon

26

26

New Developments in the Community

St. Luke's will be adding two psychiatrists in September, including one specializing in child psychiatry.
CIT (Crisis Intervention Team) training for police officers began in December, with the first cohort already completed and additional sessions planned.
St. Luke's staff will be embedded in schools during the upcoming academic year to support student mental health needs.

Copyrights © 2025 | Third Horizon

27

27



Preliminary Recommendations and Facilitated Discussion

Copyrights © 2025 | Third Horizon

28

28

Preliminary Recommendations- For Discussion



Short Term

- Evaluate if the Blaine County Commissioners are willing to invest in an MCT or hybrid model, or only in a co-response model
- If only a co-response, ensure the assigned deputy has completed CIT and shows up in plain clothes and an unmarked vehicle
- Ensure the deputy and the behavioral health clinician are trained in culturally relevant care
- Pilot a co-response unit with limited hours (e.g., peak crisis)
- Gauge crisis call volume, disposition, and outcomes; evaluate the need to expand and/or for a separate MCT

Mid Term

- Establish a local MCT, clinician-led and paired with a peer specialist
- Triage and coordinate with law enforcement and/or other first responders when safety is a concern
- Ensure all staff are trained in culturally relevant care; invest in bilingual or translation services
- Pilot with limited hours (may or may not overlap with co-response hours)
- Utilize the local suicide prevention hotline to deploy
- Gauge crisis call volume, disposition, and outcomes; evaluate the need to expand or contract services

Long Term

- Advocate with Magellan, Idaho Department of Health and Welfare (IDHW), and legislators to expand MCTs and reduce the response time
 - This will ensure a more sustainable funding source (e.g., Medicaid)
- Aim for 24/7 crisis coverage
- Advocate with the Idaho Department of Health and Welfare (IDHW) and legislators for Idaho to apply to participate in the CCBHC Medicaid Demonstration in 2026

Copyrights © 2025 | Third Horizon

29

29

Discussion



Copyrights © 2025 | Third Horizon

30

30

Thank you!

Contact: Mindy Klowden, MNM
303-884-2670
Mindy@thirdhorizon.co



THIRD HORIZON

Copyrights © 2025 | Third Horizon

31



Introduction

The Blaine County Mental Well-being Initiative (MWBI) engaged Third Horizon to support strategic planning around Goal 4 of its framework: “A Place to Go.” To inform this effort, Third Horizon conducted four case study interviews with crisis service providers working in rural, mountain communities and one urban setting. These interviews, featuring Aspen Hope Center (CO), Mountain House in Jackson Hole (WY), Axis Health (CO), and Thresholds (IL), highlight diverse approaches to creating accessible, community-based crisis support. Third Horizon sought information on the program models, challenges and lessons learned, and funding sources. These insights are intended to inform a localized vision for what “a place to go” could look like in Blaine County, aligned with community needs and resources.

Several common themes emerged.

- **Funding diversification:** each organization relies on a complex blend of state allocations, Medicaid and/or commercial insurance billing, county contributions, hospital partnerships, grants, and philanthropy to sustain operations.
- **Staffing models:** The programs use a mix of licensed clinicians, bachelor’s-level staff, and, in some cases, peer specialists.
- **Care continuum:** Each of the programs are part of a larger behavioral health provider organization, which helps ensure continuity of care and follow up after crisis.
- **Community partnerships:** Interviewees identified collaborations with law enforcement, schools, hospitals, and local governments as vital.
- **Standardized screening:** All programs utilize the [Columbia Suicide Severity Rating Scale](#). Some use additional screening and collect data on key performance indicators.

Across the case studies, there were some key challenges that were highlighted as well included. For example, low and variable service demand in rural settings, workforce shortages, liability concerns (particularly around detox services), and the difficulty of scaling intensive programs with limited population bases. Despite these obstacles, the programs demonstrated that tailored crisis response models, whether through living room-style drop-in centers, mobile crisis response, or short-term stabilization units, can divert individuals from emergency departments and law enforcement while fostering recovery in less restrictive settings.

These insights provide Blaine County with practical lessons and robust guidance. Particularly around starting with scalable, community-anchored approaches, avoiding

duplicating existing billable services, and remaining adaptable to shifting local needs. These case studies form a foundation for envisioning what “a place to go” for crisis services might look like in Blaine County, rooted in the county’s unique population health needs, geography, and service landscape.

Case Study: Aspen Hope Center

Person interviewed: Erin Mitchell, Executive Director

Introduction/Background

The Aspen Hope Center is based in Aspen, Colorado, and serves Pitkin, Garfield, and a portion of Eagle County. It was founded in response to an acute community need of high suicide rates and a lack of mental health resources beyond the hospital. Originally launched as a crisis hotline, the center has since evolved into a comprehensive mental health service provider, including mobile crisis response, school-based programming, and intensive stabilization services. Aspen Hope Center is a stand-alone organization that is not affiliated with a hospital or Federally Qualified Health Center (FQHC). It does not have status as a Certified Community Behavioral Health Clinic (CCBHC).



How the Program Works

The Aspen Hope Center provides multiple pathways for individuals in crisis. Community members connect with the organization primarily through its crisis response phone line or referrals. Mobile crisis clinicians respond in the community, while co-response units operate alongside law enforcement. Clinicians conduct an initial clinical assessment and use standardized assessment tools, particularly the [Columbia Suicide Severity Rating Scale](#) (C-SSRS). After evaluation, if an individual is deemed high-risk and safety is in jeopardy, they may enter the Intensive Stabilization Program. This program is an alternative to inpatient hospitalization. Individuals who undergo ISP must have a trusted adult with them 24/7 and meet three times each day with a therapist for ten days. These meetings can occur in the person’s home or Aspen Hope Center’s clinical office. For individuals who are not experiencing suicidal ideation but still need support, there is a Community Stabilization Program (CSP) that is a less intensive, 12-week pathway. For this program, clients may be seen in community settings. Aspen Hope Center has also placed school-based clinicians in 20 schools to provide crisis support and prevention services directly to students.

Aspen Hope Center does not operate a walk-in crisis facility. This is due to several factors, including funding constraints and licensing issues. Additionally, the organization does not operate a detox center, nor is one available in the local region; these prompt liability concerns. Aspen Hope Center outsources clinicians to a local hospital emergency department and offers follow-up care as an alternative to a walk-in crisis center.

Staffing & Operations Model

Staffing includes master's-level clinicians, some licensed and some in the process of obtaining licensure. A Colorado statute permits bachelor's-level clinicians for crisis response, though Aspen Hope generally prioritizes hiring staff with experience in crisis work. Peers are not directly employed due to concerns about triggering experiences, though peer contractors are used through partnerships. Clinicians often hold dual roles, supporting multiple parts of the crisis continuum.

Funding Model

The organization has a blended funding model. Colorado has dedicated funding for crisis services, which is administered through Behavioral Health Administrative Services Organizations (BHASOs) that operate on a regional basis. Aspen Hope Center receives support from Rocky Mountain Health Plans (the local BHASO) specifically for its mobile crisis team. Additionally, the organization has funding from hospital contracts, fundraising, private pay, Medicaid, and commercial insurance billing. In the near future, Pitkin County is expected to provide funding for the crisis stabilization programs.

Performance/Utilization

The Center serves just under 1,000 people annually, primarily adults aged 25–55. In recent years, there has been an uptick in youth aged 12–18 accessing services.

Aspen Hope Center's [2024 Annual Report](#) highlights the following numbers for services provided:

- 551 intakes
- 1,2590 telephone calls
- 10 cases of Peer support for first responders
- 2,814 follow-ups/progress notes
- 607 evaluations
- 1,137 individuals received crisis services

Challenges & Lessons Learned

Challenges include aligning diverse stakeholders, avoiding duplication of billable services, and managing liability issues around detoxification and psychiatric emergencies. Leadership advises starting small, focusing on preventing crises rather than creating new facilities that may not address root causes.

Recommendations for Other Communities

Aspen Hope advises communities to carefully evaluate whether a crisis walk-in center is truly necessary. In many cases, a strong co-response model can address most needs without requiring a new facility. Communities should also avoid duplicating billable services already offered by existing providers, as this can dilute funding and undermine

established programs. It is also important to have a strong board governance structure with the right people at the table.

Case Study: Mountain House Therapeutic Outreach

Person interviewed: Deidre Ashley, Executive Director

Introduction/Background

Mountain House is an initiative of Mental Health & Recovery Services of Jackson Hole. The organization provides a continuum of mental health and recovery services, including medication management, therapy, crisis services, peer support services, and case

management, but does not have CCBHC status. Mountain House serves as both a drop-in center and a crisis stabilization program. It is designed to provide wraparound services, foster community, and serve as an alternative to hospitalization or incarceration.



How the Program Works

The drop-in center is located in the basement of the Mental Health & Recovery Services Clinic and is a classic “living room model”. The center resembles a large living room with amenities such as a kitchen, shower, laundry, computers, and clinical offices. It provides case management, prescriber services, and social activities to help individuals build community. Crisis services are integrated, with Mountain House contracted to conduct assessments for involuntary hospitalization at the local hospital. Law enforcement can also bring people directly to Mountain House. The center operates five days a week between the hours of 9 a.m. to 4 p.m. After hours, a crisis line staffed by therapists is available. Staff utilize the Columbia Suicide Severity Rating Scale (C-SSRS) when receiving intakes at the center.

Staffing & Operations Model

The team includes five therapists (licensure preferred), three specialized case managers, and a drop-in center coordinator. While there are no dedicated peer specialists for the drop-in center, Mental Health & Recovery Services’ peers who focus on substance use services collaborate. Security measures include infrastructure controls, such as secure doors separating clinical areas.

Funding Model

Wyoming pays for many mental health and substance use services for people earning at or below 200% of FPL who fall into the state’s priority populations. Services are provided through a network of community behavioral health centers, including Mental Health and Recovery Services. The state’s funding comes from federal block grants and state-dedicated quality-of-life funds. Wyoming has not expanded Medicaid, but the organization bills traditional Medicaid when serving eligible beneficiaries. Teton County also provides some funding to the organization. Grants supplement program activities.

Performance/Utilization

Utilization varies, with peaks in the early morning and late afternoon. Most attendees are also enrolled in clinical services. Demand fluctuates with the local economy and population shifts, including seasonal workers and visitors.

Challenges & Lessons Learned

Mountain House faces challenges related to geographic isolation, high cost of living, and seasonal demand. Staffing evening hours has not been prioritized, and crisis services are stretched due to unpredictable utilization. Limited population size makes implementing intensive outpatient programs difficult.

Recommendations for Other Communities

Mountain House advises communities to assess needs carefully, balance drop-in services with crisis stabilization, and plan for the realities of geographic isolation. Partnering with hospitals, law enforcement, and youth organizations is critical for effective crisis response.

Case Study: Axis Health

Person interviewed: Molly Rodriguez, Director of Residential and Crisis Services

Introduction/Background

Axis Health is an FQHC, and is recognized by the state of Colorado as a comprehensive mental health safety net provider. The organization also has a CCBHC grant for its clinic in Durango. It operates walk-in crisis centers in Durango and Montrose, Colorado, offering crisis response, withdrawal management, and stabilization. Montrose operates 24/7 with secure facilities, while Durango functions primarily during business hours but allows off-hours interventions when necessary. Both sites aim to divert individuals from emergency rooms and provide stabilization in the least restrictive environment.



How the Program Works

The Montrose campus includes the crisis walk in center as well as crisis stabilization units (CSUs) for both adolescents and adults, integrated with withdrawal management in one building. Durango serves as a regional crisis center, where clinicians operate 24/7, but the building is only open during business hours unless a crisis requires intervention. Both centers conduct intake assessments using the Columbia Suicide Severity Rating Scale (C-SSRS), provide comfort items, food, and harm-reduction resources, and connect individuals to appropriate next steps.

Staffing & Operations Model

Axis employs bachelor 's-level behavioral health technicians (BHTs), peers (primarily during daytime hours), and both licensed and master 's-level clinicians, with at least two clinicians per 12-hour shift. Supervisors triage cases during peak hours, with additional staff available after hours. Axis uses robust clinical intake and assessment, including state-mandated tools, C-SSRS, PHQ-9, GAD-7 and CCAR for CCBHC clients.

Security protocols include panic buttons, cameras, and key-entry systems, but no armed security to avoid a punitive environment. Axis is also contracted to provide E.D. follow-up services to four hospitals in Durango.

Funding Model

Axis has a complex funding mix, with regional differences across sites. As an FQHC in Durango, it is paid using a prospective payment model (PPS) but this does not address behavioral health crisis services. The organization has a separate PPS as a comprehensive mental health safety net provider. Since it is only grant funded by SAMHSA, it does not have a CCBHC PPS rate. Crisis services specifically are funded in part by Medicaid, and contracts with Rocky Mountain Health Plans/United for Montrose. Additionally, Axis has

intergovernmental agreements and receives support from a number of counties in its service area.

Performance/Utilization

Utilization averages 2–5 visits per day, with higher-acuity substance use crises and greater law enforcement involvement occurring later in the day. The Durango walk-in center is open from 7:30 a.m. to 5:00 p.m. and sees the highest number of individuals presenting with crisis between 8:00 a.m. and 11:00 a.m. The hours were set to be aligned with the availability of other resources and community programs. Axis follows a “treated and placed” model, meaning individuals are quickly stabilized and then connected to the most appropriate next level of care rather than remaining in the walk-in area for extended periods. Demand often rises during seasonal shifts and school transitions, and follow-up contacts are conducted to support continuity of care.

Challenges & Lessons Learned

Challenges include managing translation services for Spanish-speaking clients, balancing low walk-in volume with hospital contracts, and addressing safety concerns when individuals present with contraband items such as weapons or drug paraphernalia. Workforce stress is mitigated through supervision and peer support. Data tracking is robust, with Axis using Tableau dashboards to monitor crisis activity and outcomes.

Recommendations for Other Communities

Axis recommends leveraging SAMHSA’s crisis guidelines, avoiding duplication of services, and tailoring staffing models to the local workforce pool. Strong partnerships with law enforcement and robust safety protocols are essential. Flexibility and creativity are critical in adapting to community needs. Axis also has a robust data dashboard and recommends crisis providers track progress against key performance indicators. A sample image of the dashboard is included in the appendix of this case study document.

Case Study: Thresholds

Person interviewed: Manuel Meza, Area Director of Clinical Operations

Introduction/Background

Thresholds is a nonprofit organization that provides services and resources for persons with serious mental illnesses and substance use conditions in Illinois. It has received two SAMHSA CCBHC grants and is in the process of becoming certified by the State of Illinois as a CCBHC. Thresholds launched its crisis programs in 2022 as part of the state's effort to expand alternatives to police intervention. The organization had already established a peer-led Living Room model, offering a 24/7 drop-in space, which became the foundation for its mobile crisis program. Both programs emphasize peer support and community-based care.



HOME | HEALTH | HOPE

How the Program Works

The Living Room model allows individuals to stay for up to 23 hours, offering immediate assessment, peer connection, and basic needs such as food and clothing. Mobile crisis teams also deploy into the community to provide peer and clinical support. The Living Room is intentionally co-located with one of Thresholds CCBHC clinics, enabling seamless hand-offs to therapy, Assertive Community Treatment (ACT) teams, or case management.

Thresholds implements several safety measures. Upon arrival, individuals are asked to store their belongings in a secure locker, and screening assessments include questions about weapons. Panic buttons connect staff directly to emergency responders, and staff are trained to respond to overdoses in bathrooms, including administering Narcan when necessary. Thresholds' full written safety protocols are provided in the appendix of this case study document.

Staffing & Operations Model

Thresholds emphasizes peer staffing, with most shifts covered by at least two peers and one non-identified peer. Clinicians are also trained in peer support. Three team leaders cover AM, PM, and overnight shifts. Staff follow a 1:1 staff-to-client ratio to maintain safety and quality of care. The mobile crisis team which operates 24/7 is available for back-up staffing.

The organization prioritizes workforce well-being, with "wellness week" programs offering self-care activities, generous PTO, therapy provided by external therapists, incident debriefings, and Employee Assistance Programs (EAP).

Funding Model

Initially funded through Illinois' 590 initiative, Thresholds now sustains its crisis services through CCBHC Prospective Payment System (PPS) reimbursement. Its budget supports staffing, operations, marketing, and training. Donations supplement food and clothing for clients.

Performance/Utilization

Thresholds maintains a strict 1:1 staff-client ratio, meaning capacity is capped at three clients at a time. Utilization peaks from noon to 8pm, with overnight services less busy but available. Follow-up care includes walk-in therapy hours and three follow-up calls for each client. Services are available for adults 18+, while youth are served by the mobile crisis team.

Challenges & Lessons Learned

Challenges include building community trust and awareness of the program to encourage people to access services, recruiting and retaining certified peer staff, and addressing workforce vicarious trauma. Thresholds supports staff well-being and reduces burnout through supervision, structured wellness programs, and active leadership engagement. Comprehensive safety protocols, along with external screenings, help manage potential risks.

Thresholds utilizes the Columbia Suicide Severity Rating Scale (C-SSRS) upon intake. The intake screenings are a crucial step in determining the level of de-escalation required. Staff have found that completing the screening assessment outside the entrance before individuals enter the facility significantly reduces potential issues. Staff are also trained to provide intervention over the phone, which is particularly helpful in many cases, especially during bad weather.

Recommendations for Other Communities

Thresholds emphasizes the importance of deep community integration, consistent outreach, and strong peer leadership. Programs should budget resources for ongoing community engagement, prioritize staff wellness, and build strong connections with partner organizations to ensure success.



Blaine County Mental Well-Being Initiative (MWBI) Prevention Workgroups 1 & 2 – September Planning Meeting

Date: Wednesday, September 10, 2025

Participants:

Laurie Strand, Resilience Rising	Amanda Chase, Hailey Fire Department
Megan Smith, Communities for Youth	Megan Robinson, Sun Valley Company
Jane Lopez, The Hunger Coalition	Darrel Harris, The Advocates
Jessica Obenauf, 5B Suicide Prevention Alliance	Aaron Bronson, The Space
Donna McGourdy, NAMI Wood River Valley	Becky Lopez, The Alliance of Idaho
Cara Bartlett, Higher Ground	Bruce Shahbaz, 5B Suicide Prevention Alliance
Sarah Cox, Blaine County	Anna Nielsen, YMCA Wood River Valley
Brittney Shipley, 5B Suicide Prevention Alliance	Benson Blair, Wood River High School,
Sarah Seppa, Center for Community Health	Paige Redman, Flourish Foundation
Sarah Verst, Community Member and Coach	Monica Reyna, The Space
Amber Perks, Blaine County SD	Kirstin Emerson, MWBI
Emily Olson, JustServe	Tammy Davis, The Crisis Hotline
Taylor Bybee, SCPHD	Heather Wesley, Wood River Interfaith Counsel
Tom Poole, Light on the Mountain	Jovita Pina, The Senior Connection
Lilianna Bridge, The Community Library	Matt Leidecker, The Sage School
Judd Efinger, Love Like Ky Foundation	Jenna Vagais, MWBI
Cody Orchard, SCPHD	Phil Sheridan, MWBI
Chloe Lichtenberg, The Hunger Coalition	Mindy Klowden, Third Horizon
Jim Foudy, Blaine County SD	Ashley DeGarmo, Third Horizon
Natalie Postles, The Argyros	Jessica Casebolt, Third Horizon

Meeting Summary

The objectives of the retreat were for Third Horizon to present on their research and analysis, and facilitate discussion on the short- and long-term goals and objectives to improve behavioral health prevention efforts in Blaine County. The workgroup reviewed data, discussed gaps in services, and considered priorities for the MWBI over the next 1–2 years. The meeting ended with an activity to help participants identify and prioritize key focus areas to help inform decision-making.

Several key themes emerged in the meeting. These included:

- The importance of clarifying goals and focusing efforts on perhaps fewer priorities. Some of the items on the vision document may have already been implemented and could be moved to “monitor”.

- There was strong interest in addressing youth AND adults, and targeted efforts to reach the most at-risk populations (e.g., immigrants, LGBTQ, very low-income, and elderly).
- Based on the data, participants expressed serious concerns for the need to include a focus on addressing alcohol and substance use among both youth and adults.
- Participants emphasized the importance of leveraging existing community resources, educating providers, stakeholders and community members about services, and engaging the broader community.

Notes

Welcome and Introductions	Jenna opened the meeting with remarks that set the stage, recognizing the new starting point the Mental Well-Being Initiative (MWBI) has reached following two years of foundational work. • Evolution over the last 2 years and collective impact: ○ St. Luke’s recognized two years ago the rising trend in crisis-related issues in Blaine County and identified the need for action, understanding that addressing it would require a collective impact approach. ○ The collective impact approach is centers around the question, “What can I do as an individual, or organization to align with the community’s vision for mental well-being, and then what can we do together?” • MWBI created goals through gathering insights through stakeholder and community engagement. The goals focus on: ○ Crisis response ○ Care access & capacity ○ Mental health training and learning ○ Community connection • St. Lukes has committed \$4.43M to support the collaborative effort by creating a non-profit that will facilitate toward solutions, bring vision to reality, and align with real data showing what the community needs. • The non-profit will lift up whatever the workgroups come up with as a plan. It can also fund those solutions. Jenna discussed how the infrastructure for the MWBI has evolved and where things are currently. • As a newly formed 501 c 3 nonprofit organization, the MWBI has a board of directors and newly expanded team. This well help facilitate the collective impact work by serving as a “backbone” structure.
----------------------------------	--

	• Kirstin Emerson is new prevention program manager who will be the point of contact for all of this work. • Phil Sheridan is the new behavioral health program manager and has a career in building mental health systems. • Jessica Obenauf oversees communications and operations of the 5B Suicide Prevention Alliance which has been brought in as part of MWBI. • Jenna framed the meeting around refining the two prevention goals and the vision document, highlighting that with staffing now in place, the team can move forward with collaborative actions. • Third Horizon was contracted in April to help design a crisis response system. MWBI was pleased with their work so asked them to expand their contract to help refine prevention goals.
Introductions and level-setting	Mindy reviewing meeting agreements and facilitated an icebreaker activity around the question “how have you learned about resiliency in your life?” • In the response from the group there were common themes and unique thoughts. • Mindy related this to the meeting objectives noting that the group is thinking of solutions that meet the needs of many but also will address unique circumstances that require more specialized attention.
Survey Data Analysis	Ashley reviewed Third Horizon’s process of reviewing disparate data sources and pulling together common themes and key takeaways. See slides for full details around data. • The data sources that were used to pull out key findings for this group to consider include: ○ Communities for Youth Survey (C4Y) ○ PRC community engagement and behavioral health survey ○ PRC mental health provider study • Ashley reviewed key highlights from the data. ○ Responses to the survey are representative of community demographics. • The greatest stressors that impact mental health are finances/cost of living and family stress. • Adults and youth reported high levels of social isolation/loneliness • In Sun Valley the reports of excessive drinking among adults and youth were higher than what has been reported across the state or compared to Boise.

- The data is not broken down by payer source. Third Horizon recommends that MWBI suggest to Katz Amsterdam that they do a breakdown of payer source in future surveys.
- Top 3 biggest gaps providers see in the community for people in crisis:
 - Crisis response, stabilization, and follow-up care
 - Inpatient mental health treatment
 - Intensive outpatient treatment
- The biggest gap/barrier reported by youth is “feeling awkward”
- Data collected from St Lukes Wood River Emergency Department and 911 dispatch were analyzed and presented to the group. Third Horizon has requested an expanded data set for analysis which is currently being processed.
 - There is a spike for mental health ED visits for youth that are 16 years of age.
- Third Horizon shared high-level recommendations based on the data sources for the prevention workgroups.
 - Prevention efforts should include a significant focus on activities that foster social connection while also directly targeting alcohol use and other substances among youth and adults (adults were added due to group feedback)
 - Targeted efforts and interventions are needed to meet the needs of younger residents, those with lower incomes, Hispanics, and those who identify as LGBTQ+
 - Continued training in the community such as Mental Health First Aid, QPR and ASIST, as well as ongoing community education, may be beneficial to mitigate stigma and ensure people in need know how to access care

Questions & Discussion

- Would the survey responses/data look different depending on what time of year the survey was administered?
- Who sets the levels for what is considered “excessive drinking”?
- Was there a question about people seeking care for children? This is often what impacts people responding that it takes them a long time to get care.; Sara Seppa said that the St. Luke’s Survey captured that question, so she can get the data on this.
- It was flagged that language barriers were not a response option for gaps/barriers to seeking care.
- Under the 911 data, is there information on the trend of suicide mortality (not just interventions)?
- Jenna responded that MWBI does have this data and that the Wood River Valley is at 2.5 times the national rate for suicide mortality.

	• From the perspective of the Crisis Hotline, call volume has increased and the demographics of callers has expanded. ◦ That is actually good and makes sense because there have been efforts to promote the hotline and divert callers from 911. • There was concern about the prevention goals and Third Horizon’s recommendations specifically targeting youth for alcohol/substance use interventions when the data shows such high usage among adults. Adults model the behavior to youth, so adult interventions are equally as important if not more so. Rather than “intervention”, there needs to be a change in the social norms around alcohol. • Third Horizon will update the recommendation slide accordingly. • Other mountain communities have had success with “booze less” (not abstinence) campaigns. • It would be interesting to know how incomes impact youth substance/alcohol use. • The concept of “lower-income” in the Wood River Valley is evolving. What does it mean today? Future surveys should ensure that middle-income households aren’t overlooked. Many parents note that systems exist to support lower-income families, and those with higher incomes have opportunities, but what about middle-income families? • This should be part of the discussion around goals and objectives and how this group wants to define things.
Breakout Discussions and Report Back	The workgroup had small table discussions around the following questions, and then shared out their key takeaways: <u>Discussion Questions:</u> • What surprised you, if anything in the data? • Directionally, how does this information shift the MWBI’s goals? • What goals and objectives may no longer be relevant in the strategic vision document? • What is missing or needs to be added? • MWBI wants to be both bold in vision and realistic in its strategic plan. Third Horizon will be recommending SMART goals. What should the MWBI focus on in the next 1-2 years? <u>Group Debrief and Report Back</u> • Clearer language is needed for goal 1. • An intermediate space exists between primary prevention and crisis response that needs to be considered. • People don’t want to go to more trainings.

	• The “booze less” approach is seen as an effective strategy rather than complete sobriety. • Service/volunteer is missing and is a key factor. • Populations are missing in the survey data (i.e. older Spanish-speaking individuals who aren’t going on to do an online survey). ◦ Need more grassroots efforts such as knocking doors. • Physical space is needed to achieve the goal of creating “welcoming spaces.” The Church of the Big Woods has offered a downtown location. ◦ This space should not operate in isolation but instead involve other organizations for staffing, particularly during after-school hours. • Community education is needed to know how to access resources. • Community trainings on foundational resiliency and mindfulness skills are needed. These should begin with members of this workgroup, who can then serve as role models for the broader community. • Goal 2 should include language emphasizing outreach to low-income workplaces, such as landscaping businesses or hair salons. • Sober spaces in the community should be identified as part of the strategy. • To shift the culture around alcohol, stigma, and related issues, local government should be included in the conversation, as they can implement policies that support a healthier community culture. • Since financial and family stress were the top reported stressors, strategies should focus on reducing these pressures and supporting economic stability—for example, through programs like the Hunger Coalition that assist the highest-risk families. • A question was raised about whether Goal 2 is necessary, as community stakeholders are already heavily engaged in this work. It may not need to remain a focus of the Well-Being Initiative. ◦ Goal 2 reads: <i>Build a robust, comprehensive community training and education program focused on resiliency, self-regulation, healthy communication, and crisis de-escalation.</i> ◦ Alternatively, under Goal 2, focus only on the most at-risk populations. ◦ Consider how to phrase the goal so it aligns with a collective impact strategy. ◦ Another option is to emphasize stronger connections to existing resources. • Regarding goal 2, consider how a person’s environment affects their behavioral and mental health. It’s not just about education or training—while those have been implemented, they haven’t
--	--

	produced significant change. The approach may need to be more expansive. ○ Several people made comments in support of either removing goal 2 or reframing it. ○ Note that goal 5 does already have language about how to coordinate around resources, so modifying goal 2 similarly might be redundant. ● Does addressing SUD among adults have a trickle-down effect for youth? Does that mean that there needs more emphasis on welcoming in the community for adults? ● More separating of the data is wanted to see how things play out among different demographics. ● It would also be interesting to see data pulled out around alcohol use and if suicide rates or other negative mental health issues are higher among people using alcohol. ● A lot of the stress concerns reported may be very different now than when the survey was administered – especially for immigrant population. ● Blaine County relies on the immigrant population and their role in the community. It's important to convey that message to them. ● In goal 1, the phrase “educate teens on community expectations and appropriate behavior” could be changed to convey a more supportive approach. ● Goal 1 mentioning teens should be changed to say “youth” to be more inclusive of more ages. ● The same group of people shows up to these meetings and events. This is not best use of efforts and funds. ○ For goal 2 objective C, instead of creating a whole center, it would be more effective to build off what exists. ● For parents, classes feel shameful rather than supportive. A better approach is to first offer a service to help their child and then offer classes as a follow-up. ● Prevention strategies should find a way to engage the broader community and have them actively participate in protective factors. ○ Consistent marketing and messaging (under goal 5). ○ Also goes back to connection to resources and shared communication. ○ Raising awareness about why we are doing these surveys. ○ Get outside the echo chamber of same group of people that show up. ● There were comments about improving how communication and how information is shared. Jenna said this will be part of the communication hub/website that will soon be available.
--	--

Parking Lot	Mindy noted that some discussion items fell outside the meeting's objectives but recorded them for follow-up, recognizing their importance. • St. Luke's survey question on childcare services for kids • Marketing and communication
--------------------	---

Sticky Note Activity

After the breakout group report-outs, participants identified their top priorities on sticky notes and posted them on three flipcharts, each labeled with a different discussion question. They then used sticker dots to “upvote” the ideas they supported. It is important to note that several participants left early and therefore did not have an opportunity to upvote. Mindy noted that the exercise was not binding or decision-making, but rather just a facilitation strategy to gauge where stakeholders are in their thinking. The results, summarized below, are organized into thematic categories.

Flipchart #1:

What should the MWBI and its members/partners focus on in the next 2 years?

****The number in parentheses at the end of a bullet indicates number of dots added to the sticky note*

- Immigrants
 - Immigrant community support (6)
 - Create a Latino-Hispanic-Immigrant liaison group to act as a resource and communication medium (1)
- Alcohol
 - Pro-social activities without alcohol (4)
 - Addressing alcohol consumption in a resort community through marketing and celebration of non-alcoholic choices “normalize this!”
 - Ask every business that services alcohol to have multiple NA options
- Narrowing focus
 - Focus! Too many goals and objectives. Prioritize (4)
 - Build sub-committee structure based around goals to spur action (1)
- Policy
 - Government policies that support a protective community (3)
- Social/community
 - Adult sense of belonging (3)
 - Future of community campus (3)
 - Community center for kids here – community capacity (3)
 - Get out of echo chamber (2)
 - Greater community involvement in MWBI (2)
 - Helping build capacity/support to engage Latin, LGBTQ, youth (1)
 - Teen connection space, community arts Still need: #3 increased access to behavioral health access (1)
- Outreach strategies/resource navigation

- Training/education to navigate care resources (2)
- Education about how benefits of service/volunteering (1)
- Engage the broader community in the work and mental health work (1)
- How we continue to support and education about substance use (1)
- Stand up a local navigator program or peer support specialists or chaplain (1)
- Create a messaging program that helps each organization recognize and promote the bi-directional relationship between what they do and how it impacts mental health (1)
- Proper marketing that there are other options to care than just “go to counseling” (1)
- Other
 - How do we all have Friday, Saturday, Sunday off (2)
 - Upstream protective factors (digital wellness, resource access, sleep) (1)
 - 1 or 2 providers, local vs virtual, care EAP insurance by companies (1)
 - Grassroots survey efforts for specific populations – seniors, Spanish-speaking (1)
 - How can we pull the data points together to make it effectively measurable (1)
 - Community school model – work hours vs school hours (1)
 - Emotional and physical safety for people and children (1)
 - Focus on the aging population (1)
 - Cost of care and how it impacts health and stress
 - Implement moments of mindfulness in our meetings/daily work lives
 - Streamline – training info across kids to parents – more of the same messaging
 - Lack of supervision at home

Flipchart #2

What is missing or needs to be added?

*** The number in parentheses at the end of a bullet indicates number of dots added to the sticky note

- Demographic targeting
 - Name the groups: parents, youth, LBGTQIA, Low-income, Hispanic, Latino (6)
 - Immigrant community support (4)
 - Target parents in goal #2 – name them specifically as key players to the community education goal
 - Add language to goal 2, objective A, #4, offer trainings to working class/low-income employers (i.e. hairdressers, construction)
- Community education and social support
 - Teaching skills – prevention models for mental health skills (2)
 - SVSEF and other sports organizations having more “recreation” style opportunities – middle ground opportunities (2)
 - Prevention models – teaching skills (1)
 - Robust community center – after school (1)

- Goal #1 objective C (time) – How do we give people time to engage in the spaces, connection, engagement
- Goal #1 doesn't have population most affected outlined/prioritized
- Missing: connections and opportunities to serve others
- Community meals or dinner delivery to families in need
- How service opportunities can help with mental health
- Training youth and older adults on how to get help – navigate finding resources
- Do less. Hustle cultures in teens. Pressure on kids. (4)
- Advocacy for youth to be able to access mental health services on their own
- Alcohol/sober living
 - Add language to goal #1 that specifies sober spaces to address drug/alcohol use
 - Sober ski days/hockey games – Ketch'em Alive, Hailey Rocks (1)
 - Cultural shift not to drink clubs that support sober living
 - Booze less capitalizes "I want more out of life" (8)
 - Get creative around messaging re: drinking and not just its "its them" – the alcoholic. How do we do this different?
- Data
 - More detail from dispatch, overdoses (2)
 - Where is the data from kids left home alone and mental health crisis? (2)
 - Still no data from the physicians. Medications, who is being treated? How many private patients being treated? (2)
 - Active using vs sober w/ mental health stress (1)
 - Nexu Study to be included from BCHA housing (1)
 - Data around availability for transportation
 - Teacher data & health
 - Data around availability for transportation
 - Define and analyze data and needs around seasonal residents compare with year-round residents
 - Ways to measure success for each objective
 - How many therapists actually taking insurance (1)
 - Lack of CANS, ANSA, and CDA assessors in Blaine County which are needed for BH services with Magellan (1)
 - Who is missing from the data and how do we capture them? older adults? People with disabilities? (1)
- Other
 - Employee Assistance Program vs in person (1)
 - Substance use disorders – prevention vs post-vention (1)
 - Understanding of Jeff D. lawsuit and youth/families' rights to access children's mental health services which are provided by Medicaid regardless of family's income (1)
 - Housing Authority (both)
 - Lack of ability to deal with bullying
 - What's the support between upstream response/intervention?

Flipchart #3

What is no longer relevant or should come off?

*** The number in parentheses at the end of a bullet indicates number of dots added to the sticky note

- Do we need goal 2? (6)
- Goal 2, Objective C #2 – support existing career exploration and expand them not build center (i.e. Advocates, Far and Wise, etc) (2)
- Goal 1, objective B, remove “educate teens on community expectations and appropriate public behavior (3)
- Goal 2 while important should consider that trainings are often attended by the same group of us, does not mean deprioritize, but keep in mind
- Edit goal #1, objective B, #2 how to connect teens – business owners to build mutual respect. (1)
- “Anti-stigma” campaigns can cause harm in youth populations – so be careful and thoughtful (2)

Next Steps

Jenna closed out the meeting by thanking the participants for their hard work and engagement. Mindy shared that Third Horizon would synthesize the input for consideration as the firm revises the guiding vision document with Jenna and her team.



Blaine County Mental Well-Being Initiative (MWBI) Prevention Workgroups 3 & 4 – September Planning Meeting

Date: Thursday, September 11, 2025

Participants:

Muffy Davis, Blaine County Commissioner	Jim Foudy, Blaine County SD
Cate Wood, St. Luke's Wood River Foundation	Sarah Cox, Blaine County Courts
Sonya Wilander, Men's Second Chance Living	Donna McGourdy, NAMI Wood River
Jessica Obenauf, 5B Suicide Prevention Alliance	Tod Guenter, Hailey Elementary
Judd Efinger, Live Like Ky Foundation	Niel Crosun, Higher Ground
Aaron Houston, Family Health Services	Tammy Davis, The Crisis Hotline
Sarah Seppa, Center for Community Health	Lisa Efinger, St. Luke's Wood River Foundation
Amanda Chase, Hailey Fire Department	Paige McNeil, The Community School
Bruce Shahbaz, 5B Suicide Prevention Alliance	Daniel Rothman
Dr. Michael Walton, St Luke's Health System	Shannon Nichols, The Advocates
Sheriff Morgan Ballis	Jasmine Easterday, The Crisis Hotline
Steve England, Hailey Police Chief	Naomi Spence, The Hunger Coalition
Julie Carney, St. Luke's	Daniel Rothman, Alpine Integrative Wellness
Brittney Shipley, 5B Suicide Prevention Alliance	Neil Crowson, Flourish Foundation
Matt Hardin, Magellan of Idaho	Jenna Vagais, MWBI
Rene Smey, Community Member	Phil Sheridan, MWBI
Kirstin Emerson, MWBI	Mindy Klowden, Third Horizon
Michelle Ross, MWBI	Ashley DeGarmo, Third Horizon
Megan Tanous, St. Luke's Wood River Foundation	Alex Hryhorczuk, Third Horizon
Amanda Deaver, MWBI	Jessica Casebolt, Third Horizon

Meeting summary

The objectives of the retreat were for Third Horizon to present their research and analysis and facilitate discussion on the short- and long-term goals and objectives to improve behavioral health prevention efforts in Blaine County. The workgroup discussed gaps in services, priority goals, and the concept of “a place to go” for behavioral health support. The meeting ended with an activity to help participants identify and prioritize key focus areas to help inform decision-making.

Several key themes emerged, including:

- The need to address substance use among youth and adults

- An interest in refining the data to better understand the availability of services by level of care, and source of coverage (e.g., Medicaid, uninsured, vs. commercially insured)
- There is a need for increased awareness of existing resources, even among providers
- Transportation continues to be a significant challenge in the community. Reliable transportation to and from St. Luke’s Canyon View Behavioral Health Services in Twin Falls is needed to fully leverage available services.
- General care coordination, and particularly care transitions, are needed to help support people after a crisis.
- There was strong interest in addressing youth AND adults, and targeted efforts to reach the most at-risk populations (e.g., immigrants, LGBTQ, very low-income, and elderly).
- Some participants emphasized using existing community facilities and building on existing resources (which they referred to as a “scaffolding approach”) rather than creating entirely new centralized locations.
- The importance of gauging the impact of the new co-response program over time to help inform other planning efforts.

Notes

Welcome and Introductions	Jenna provided opening comments and reviewed collective impact. Jenna discussed how the infrastructure for the MWBI has evolved and where things are currently. • Collective impact involves aligning dispersed actions toward common solutions. In practice, however, developing a strategic plan to drive systems-level, population-wide change is more complex. • When MWBI engaged stakeholders at the beginning of this work, the feedback contributed to the initiative’s goals around the following areas: ○ Crisis response ○ Care access & capacity ○ Mental health training and learning ○ Community connection • As a newly formed 501 c 3 nonprofit organization, the MWBI has a board of directors and newly expanded team. This will help facilitate the collective impact work by serving as a “backbone” structure. • St. Lukes has committed \$4.43M to support the collaborative effort. • This meeting is focused on refining the treatment/crisis goals.
----------------------------------	---

	• Third Horizon has been contracted to help with this work and to help define what the co-response model and/or “a place to go” should look like for Blaine County. Third Horizon has analyzed data from various sources to gather themes and highlight important considerations. Mindy reviewed the goals of the retreat and meeting agreements, then facilitated an icebreaker activity, asking participants to comment on a time when they achieved a significant personal or professional goal.
Survey Data Analysis	Alex provided a review of key data insights, followed by group questions and discussion. • In Blaine County, 73% of respondents said that alcohol is important to social life, and rates of excessive drinking are higher than the state and national averages. • In Blaine County, alcohol use is more prevalent among younger age groups than in Boise, with initiation beginning as early as 8th to 10th grade. • The biggest gaps in the community for people in crisis are: ○ Crisis response, stabilization, follow up care ○ Inpatient mental health treatment ○ Intensive outpatient treatment • Third Horizon shared high-level recommendations for the crisis response workgroups. ○ Crisis response, stabilization, and follow-up care is perceived as the largest service gap in Blaine ○ Targeted efforts and interventions are needed to meet the needs of younger residents, those with lower incomes, Hispanics, and those who identify as LGBTQ+ ○ Crisis walk-in or other intensive services may best be piloted on a limited basis to gauge utilization and impacts Questions and Discussion • What is the demographic breakdown for youth substance use? (gender, ethnicity, etc.) • Is there a way to compare youth substance use to previous years? ○ This was the first survey to include that question, so no comparison is currently available. The upcoming survey will include it again for the second time, making comparison possible in the next analysis.

	• Providers know that substance use data is always under-reported, so it's likely higher than the data even shows. • It seems there is a disconnect between what providers reported availability in the survey, and actual patient experience. • 77% of providers are accepting new patients, but that likely doesn't apply to youth referencing a gap in the community. • Of the 91 respondents, 33 reported seeing children ages 5-12. However, participants in the room questioned how this broke down by specialty • Is there data around homicidal ideation? ○ Alex will follow up about. • Third Horizon will also be getting more data for the ER visits.
Case Studies	Mindy shared case studies from Third Horizon on four programs offering crisis walk-in or living room models, providing insights that may inform what the workgroup could implement in Blaine County. See the meeting slides for more details. • Case study sites ○ Aspen Hope Center, Colorado ○ Axis Health, Colorado ○ Thresholds, Illinois ○ Mountain House, Wyoming • Common themes from the case studies: ○ Importance of funding diversification ○ Staffing models use a mix of licensed clinicians, bachelor's-level staff, and peers ○ All four case studies were of behavioral health provider organizations offering crisis services that are directly connected to their larger care continuum ○ Community partnerships ○ Use of standardized screening Questions and Discussion • Is there more information on Aspen Hope Center's budget? ○ This is available in the annual report. The total income for 2024 was \$4.9M and the total expenses were \$4.7M. • How does jail diversion work? Police can drop off an individual in crisis to a crisis walk in center, rather than taking them to jail or the E.D. • What is the benefit to being a CCBHC (Certified Community Behavioral Health Clinic)? ○ In states where they have the Medicaid demonstration, there is an enhanced federal match that comes to the state.

	The provider receives a PPS (Prospective Payment System) rate that covers their actual costs, creating more sustainable and comprehensive services. ○ The provider must meet 9 service requirements, which includes robust reporting and clinical quality measures. This is important because historically, the behavioral health field has not had uniformity in data collection, so CCBHC increases quality of care through standardized data reporting and analysis. ○ Aaron Houston highlighted that CCBHC would serve Medicaid and self-pay patients almost exclusively in Blaine County. ○ CCBHCs serve anyone who walks in the door, regardless of their ability to pay, their resident status, etc. ● What types of patients can these facilities serve, and what level of mental health needs can they accommodate? ○ For Blaine County, the key question is: what type of facility do we want to establish that meets the unique needs of this community, and what should its service parameters be based on those unique needs? ○ From the case studies, one example was being able to accept an inebriated individual only if a withdrawal management was on site (setting parameters based on infrastructure and resources). ○ These are operational details that would be worked out once the community determines if a physical place to go is needed and what it should look like to best meet local needs.
Table discussion & report outs	The workgroup had small table discussions around the following questions and then shared out their key takeaways. What's missing or needs to be added? ● Older populations are currently underrepresented, and additional Medicaid resources may be needed to support them. ● Primary care data on behavioral health. ● There is a need to identify individuals with dual diagnoses. ● Transportation support is missing and should be addressed. ○ This includes transportation for drug court, mental health court, and access to services in Twin Falls, as well as picking up patients and returning them home. ○ Family Health Services, as a CCBHC, along with telehealth and pharmacy services, may be able to assist with transportation.

	• Family and social support networks should be explicitly included in the goals. • Mental health court is not included in the current goals and objectives. • Additional therapists are needed, and more detailed data is required to determine the types of therapists in demand, such as Spanish-speaking providers, child specialists, and addiction counselors. • Aftercare support is limited for patients who detox in hospitals and are then discharged. Peer support or volunteer chaplains could help fill this gap. • Jail in-reach programs are needed to ensure that individuals leaving jail have appointments scheduled, resources available, and peer support to help them stay on track. • There is a lack of sober living houses for women. • Patients discharged from Canyon View may face delays of several weeks before local appointments are available; co-response teams could serve as a touchpoint during this gap. • Intensive outpatient programs (IOP) could potentially be offered virtually, or St. Luke's could adapt its model to include this type of service. • Youth services are insufficient, especially IOP. This is addressed in the plan but it's not currently being addressed in the community. While youth IOP is included in the plan, it should be emphasized. What is no longer relevant? • Instead of creating centralized locations, it may be more effective and resource-efficient to add "scaffolding" to existing locations—that is, enhance or expand current community resources rather than starting from scratch. • Rather than having goals about creating CIT training or mobile response, since these are already up and running the MWBI should focus on tracking the impact of the programs. A monitoring system is needed to track progress made. • The preventative paramedicine program in goal 4 objective B is not realistic at this time. What are the priority goals? • Educate service providers and practitioners about the information shared in this meeting so they can help address gaps and connect people to resources. • Consider the benefits of a centralized location for community access, while using a "scaffolding" approach to build toward that based on community needs.
--	--

	• Explore a decentralized model that leverages existing trusted community spaces, such as The Advocates and The Hunger Coalition, which people already see as safe places to go. • Increase the number of child therapists to better meet demand. • Raise awareness of available services and funding, noting that resources like the scholarship fund are often underutilized. • Support volunteer transportation for drug court, mental health court, psychiatric appointments, and trips to Twin Falls for services. ○ Provide strategies such as gas cards or fuel reimbursement to support volunteers. ○ Consider safety requirements for vehicles; barriers may be necessary depending on circumstances. • Promote career development and support for behavioral health professionals in the valley. ○ Focus especially on younger individuals to build a pipeline and expand career options. ○ Include initiatives under Goal 3, items #4 and #5. ○ Highlight the importance of loan forgiveness programs. ○ Advocate for increased reimbursement rates; while this is happening at the state level, it takes time for effects to reach the local level. Based on the data presentation and discussion, what should “a place to go” look like? • There are concerns that the space could be perceived as a homeless shelter rather than serving its intended purpose. ○ It is beneficial for individuals experiencing homelessness to cycle through a crisis center, as it can help them reach a point where they want and are willing to accept treatment, while keeping them out of the criminal justice system. • Teenagers have the highest hospital visits for suicidality, so strategies are needed to address this population specifically and proactively. • Resources already exist, but the key challenge is improving collaboration and communication to connect people to those resources effectively. • Key areas to emphasize/focus on include: ○ Transportation ○ Educating providers ○ After care • In reference to Goal 4, Objective C, some resources are already available, including in Twin Falls. Would it make sense to filter down to a smaller pilot space to provide services that meet less
--	---

	acute needs and can provide case management and follow up? Resource center rather than a crisis center. ○ Goal 4, Objective C states: <i>Build crisis care and stabilization capacity by assessing needs, exploring interim solutions, and developing short-term crisis care stabilization services.</i> ● The construction and service industry population hasn't been captured in data collection efforts. These populations have high SUD and mental health issues. ● A potential barrier to co-response is that it can tie up officers who may be needed for other duties. There is a benefit to having a crisis responder handle situations instead of, or alongside, law enforcement. ○ It was emphasized to watch the impact of co-response. ● Instead of a single central location, it may be more effective to use existing program centers across the valley. This approach can make transportation easier and provide separate spaces—for example, if a family situation requires all the beds at one center, other locations can accommodate additional individuals, maintaining both availability and separation. ● A big consideration is legalities of patient transfers. Protocols must be in place otherwise the facilities can't be used even if they exist. ● Mid-level support is needed in the goals such as peers and sober space. ● How can behavior be changed so that people call 988 instead of 911? What system-level changes could be implemented to re-route appropriate calls to 988 based on specific criteria? ● The St. Luke's Community Center already exists as a drop-in resource center. Its hours are limited and it is severely understaffed, but the community is aware of it. Expanding hours, increasing funding, and adding staff could make it a highly effective solution.
--	--

Implications for MWBI vision document

Mindy facilitated the previous discussion organizing feedback into actionable recommendations for adapting the vision document, which are captured in the following three columns. Anything marked with an asterisk () was emphasized by multiple participants.*

No Longer Relevant	Missing	Focus: Goals
Monitor CIT	Older populations ● Medicaid BH resources	Volunteer transport (appointments, etc.)

Mobile response paramedic program may be unrealistic *Watch impact of co-response* Get more granular on BH provider capacity Goal 3AB Community paramedicine program	Dual diagnosis Family and social supports Primary care provider data on behavioral health Mental health court • Telehealth and pharmacy Sober Homes Construction and services industry Data Prevention Promote 988 but needs system	*Educate service providers* Staged approach to “a place to go” Decentralized approach More child therapists *Awareness of resources* Pipeline – loan forgiveness Advocate for reimbursement *After-care and peer support* • Volunteer chaplains • Jail in-reach • Canyon View – IOP, start small Youth focus • 15 suicidal ideation 3C connection to resources Drop-in resources center (not acute care) including walk in or same day therapy appointments Multiple drop in crisis centers Middle level support (not AA or substance use abstinence but rather services for people who want to drink less) St. Luke’s drop-in hours
--	---	---

Straw poll/ Gut check on “A place to go”	Mindy asked participants if based on the data and discussions they think there is a need for a new crisis walk in center or other facility-based program, or if they would advocate instead for a decentralized set of services such as increased care coordination. Judd suggested a third option, which would be to build on existing resources and infrastructure with some centralized coordination. Third Horizon will build out some scenarios and work with Jenna and her team to refine a recommendation related to a “place to go”.
Parking lot	Mindy noted that some discussion items fell outside the meeting’s objectives but recorded them for follow-up, recognizing their importance. • Diversion versus prosecution tactic ○ This came up in relation to a question on number of days youth reported being drunk • Youth survey data by income, race, and ethnicity • Emergency Department visits by age

Next Steps

Jenna closed out the meeting by thanking the participants for their hard work and engagement. Mindy shared that Third Horizon would synthesize the input for consideration as the firm revises the guiding vision document with Jenna and her team.



THIRD HORIZON

Mental Well-Being Initiative (MWBI)

Blaine County, ID
September 10-11, 2025



Copyrights © 2025 | Third Horizon

1

1

Retreat Goals





Present Third Horizon's Phase 2 Research and Analysis



Facilitate discussion on short—and long-term goals and objectives for improving behavioral health prevention (groups 1&2) and crisis services (groups 3&4) in Blaine County



Provide vital feedback for Third Horizon to consider as they review and refine the MWBI Strategic Vision document.

Copyrights © 2025 | Third Horizon

2

2



Agreements

We will start and end on time

We will be present and focused (laptops closed and cell phone ringers on vibrate)

We will be inclusive and strive for equitable participation

We will be respectful even when we disagree

We will actively listen, be curious, validate, and seek first to understand then be understood

We will be outcome-oriented and forward-thinking

What else?

Copyrights © 2025 | Third Horizon



3

3



Project Overview

Blaine County's Mental Well-Being Initiative released a Request for Proposals in February 2025 to secure consulting services to support their strategic plan *Goal #4: Create a 24-hour mobile mental health crisis response system and crisis stabilization options.*

While the MWBI has already done extensive research and planning, the Initiative seeks external guidance to ensure the development of a sustainable, outcomes-focused crisis system rooted in national best practices but tailored appropriately to meet the needs of the Blaine County community.

Third Horizon will:

Develop a comprehensive mobile crisis response operational plan incorporating the county's existing emergency response framework

Assess the feasibility of crisis stabilization settings that complement the mobile response system, ensuring seamless transitions for individuals in crisis.

Design a coordinated care model that enhances continuity of care beyond the initial crisis intervention.

Copyrights © 2025 | Third Horizon



4

4

Strategic Vision Refinement: Prevention Focused (Work Groups 1 & 2)



Third Horizon was asked to support MWBI in refining its strategic visioning document related to community connections (Goal 1) and training and education (Goal 2).

Third Horizon will:

Use existing data from the Communities for Youth survey, the Behavioral Health Community and Provider surveys (Katz Amsterdam Foundation), and other relevant data sources to refine the goals, objectives, and strategic roadmap as outlined by the Mental Well-Being Initiative.

Facilitate a half-day retreat in September with workgroups 1 & 2 to present data analysis and gain community input on strategic vision refinement

Copyrights © 2025 | Third Horizon

5

5



Survey Data Analysis

Copyrights © 2025 | Third Horizon

6

6

Survey Data Sources



GOAL: As part of the Communities for Youth Blaine Initiative, measure risk and protective factors associated with youth well-being.

Most recently in **November 2024**, a total of 1196 students from grades 6-12 from Blaine County School District participated, which is **68% of students**.



2025 PRC Community Engagement & Behavioral Health Survey

GOAL: To measure community engagement and behavioral health needs for individuals who live or work in Blaine County, Idaho.

1169 total responses. 200 surveys completed through a random selection of households over the phone or online. 969 surveys completed through an online version driven by various forms of community outreach including press releases, social media, and posting on websites.



2025 PRC Mental Health Provider Study

GOAL: To engage mental health providers in the community and assess needs and challenges.

Over three weeks, solicited responses from mental health providers serving Blaine County, ID. **Received 91 completions out of 161 eligible (56.5%)** response rate.

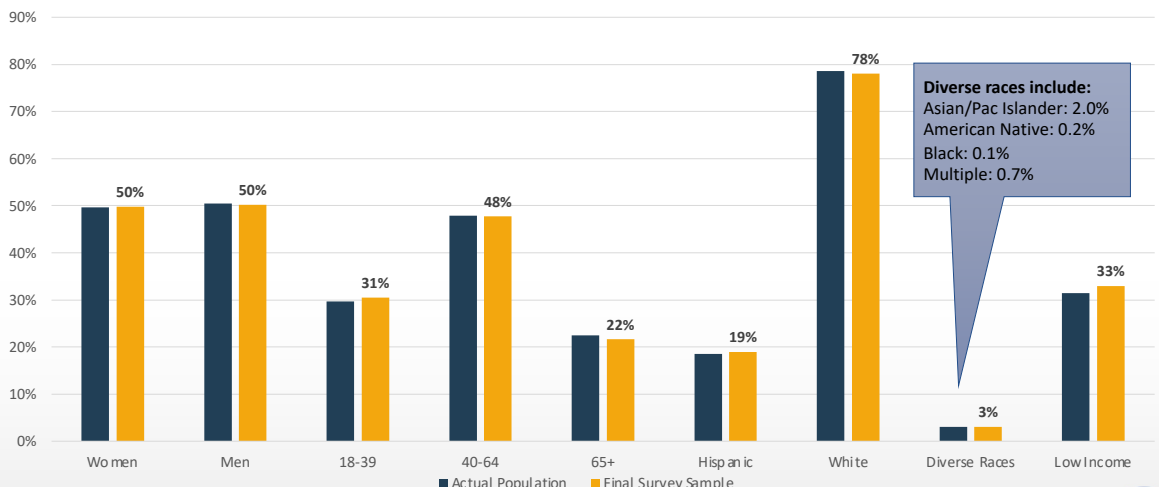
Copyrights © 2025 | Third Horizon

7

7

Community survey responses are representative of community demographics





Demographic	Actual Population (%)	Final Survey Sample (%)
Women	50%	50%
Men	50%	50%
18-39	31%	31%
40-64	48%	48%
65+	22%	22%
Hispanic	19%	19%
White	78%	78%
Diverse Races	3%	3%
Low Income	33%	33%

Diverse races include:
 Asian/Pac Islander: 2.0%
 American Native: 0.2%
 Black: 0.1%
 Multiple: 0.7%

Copyrights © 2025 | Third Horizon

2025 PRC Community Engagement & Behavioral Health Survey

8

8



Community Life

Copyrights © 2025 | Third Horizon

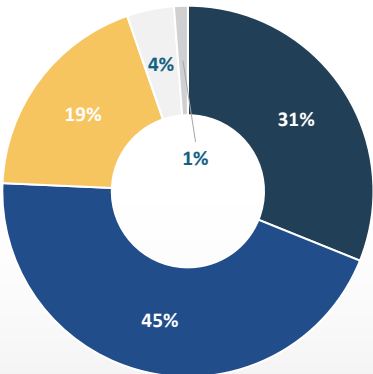
9

9

Residents of Blaine County are engaged in their community and rate it as a good place to live



Rating of the Community as a Place to Live



Rating	Percentage
Excellent	31%
Very Good	45%
Good	19%
Fair	4%
Poor	1%

- Excellent
- Very Good
- Good
- Fair
- Poor

- The majority (76%) of responses perceive the community as an excellent or very good place to live
- Older residents, those with higher incomes, and White respondents rate the community higher than very low-income, Hispanic, and younger residents.

Copyrights © 2025 | Third Horizon

2025 PRC Community Engagement & Behavioral Health Survey

10

10

Mental Health Needs and Challenges

"We need to continue to develop community support for pre-teens and teens to reduce depression, anxiety, academic stressors, sense of disconnection."

"The community needs to become more educated and thoughtful in shifting how we show up for one another..."

Copyrights © 2025 | Third Horizon

11

11

Self- Reported Mental Health Days



Question: *"In an average week, I feel mentally healthy..."*

- **22%: 2 days or less**
- **20%: 3 to 4 days**
- **58%: 5 to 7 days**



2025 PRC Community Engagement & Behavioral Health Survey

Question: *Days Per Month in Which Respondent Felt Their Mental Health Was Not Good*

- 37%: 1 day or less
- 29%: 2 to 4 days
- 14%: 5 to 7 days
- 20%: more than 7 days



2025 PRC Mental Health Provider Study

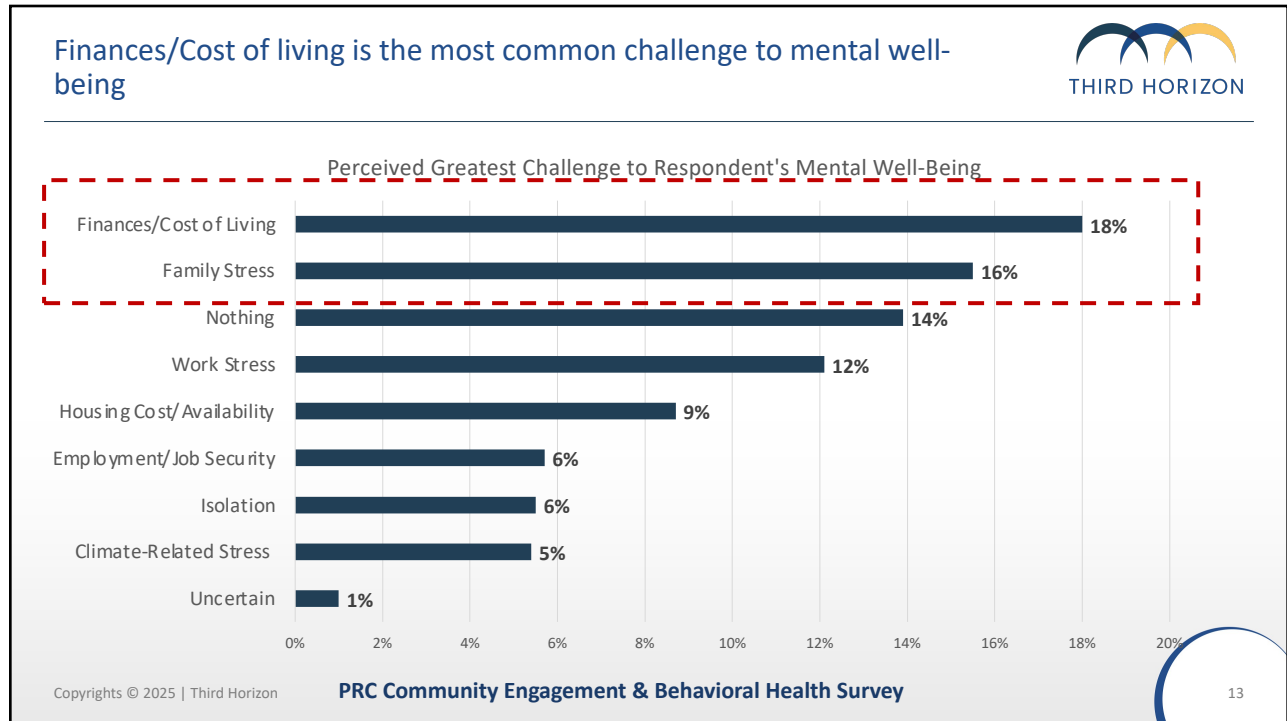
Question: *Days Per Month in Which Respondent Felt Their Mental Health Was Not Good*

- 40%: 1 day or less
- 32% : 2 to 4 days
- 13%: 5 to 7 days
- 15%: more than 7 days

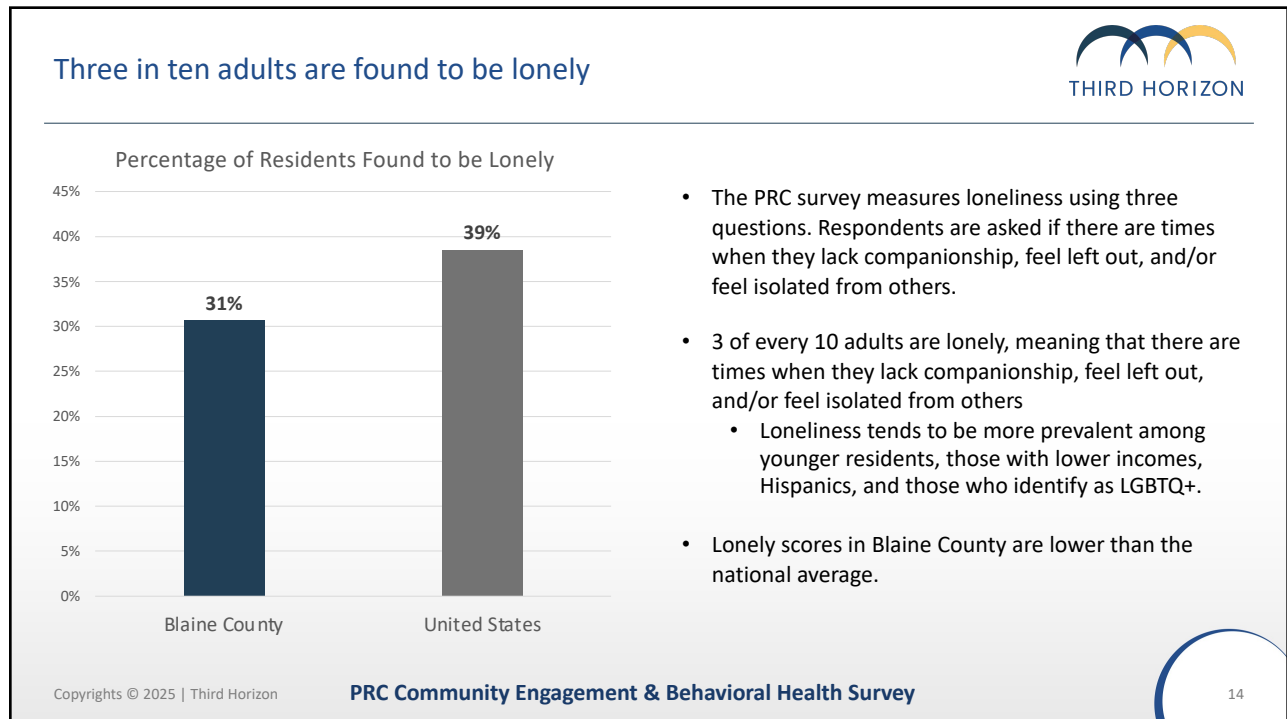
Copyrights © 2025 | Third Horizon

12

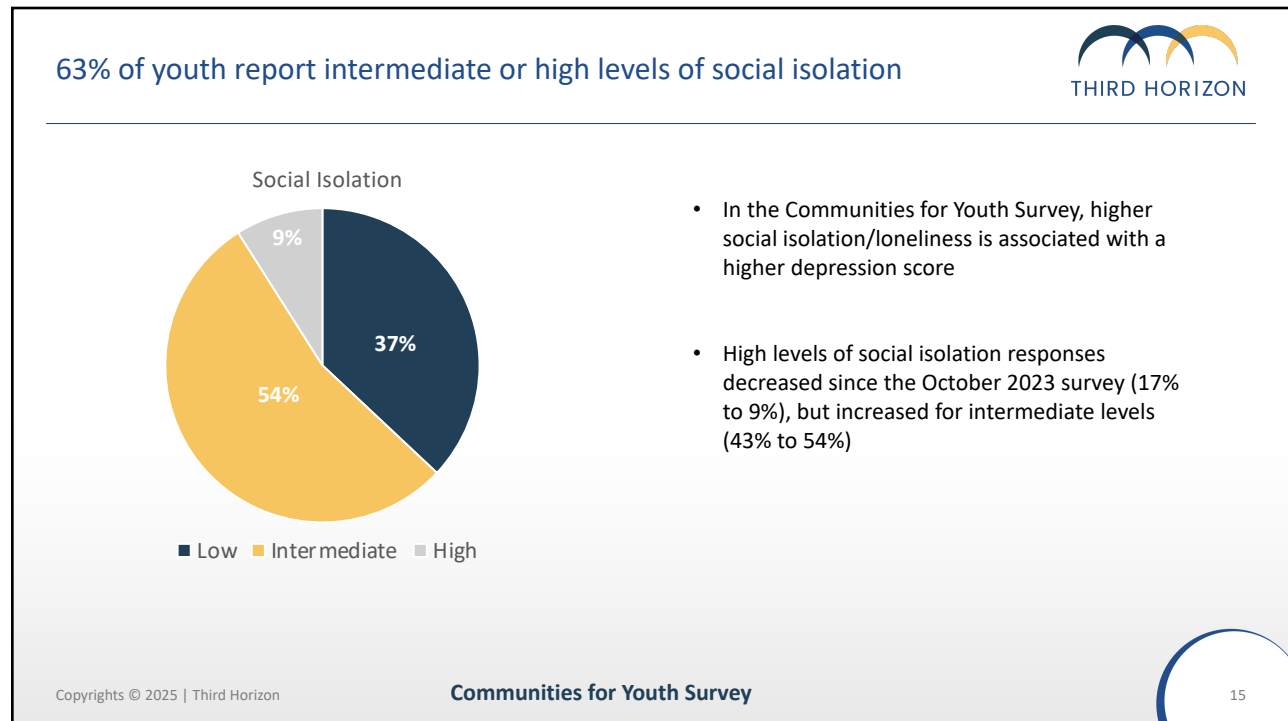
12



13



14



15

THIRD HORIZON

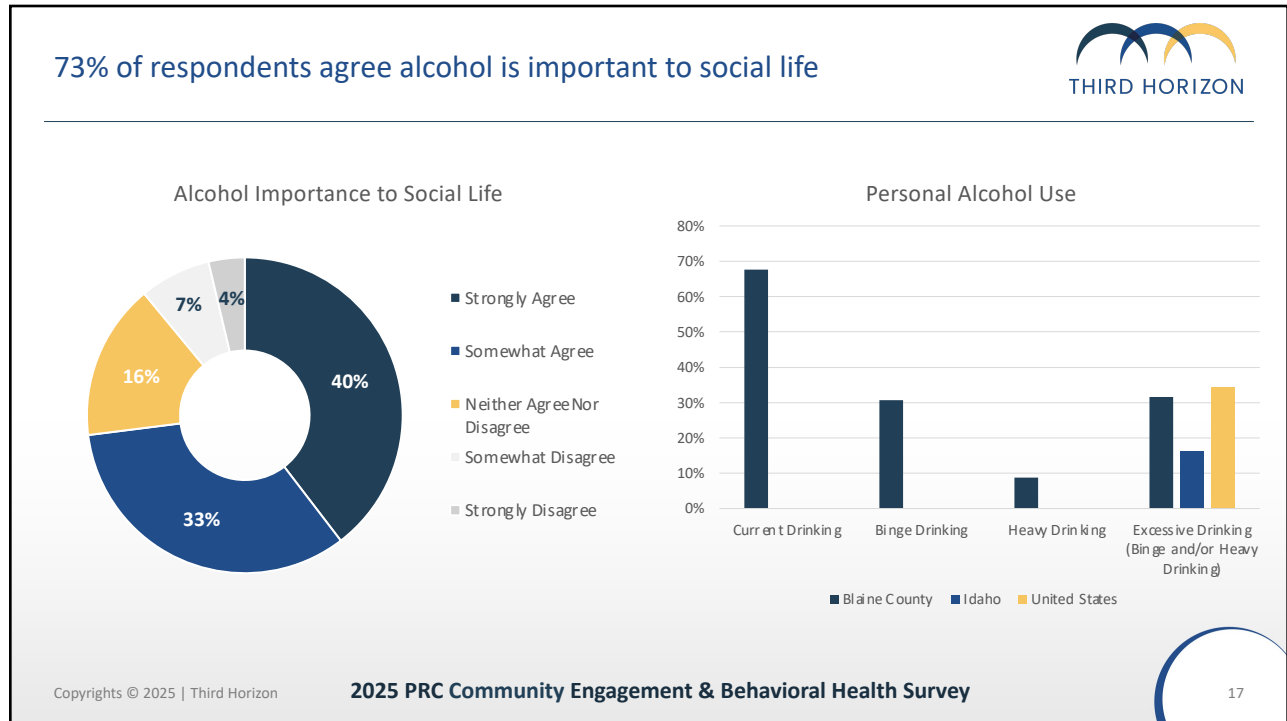
Substance Use

"I'd like there to be more normalizing of the challenges of drug and alcohol abuse that affects adults in a resort community"

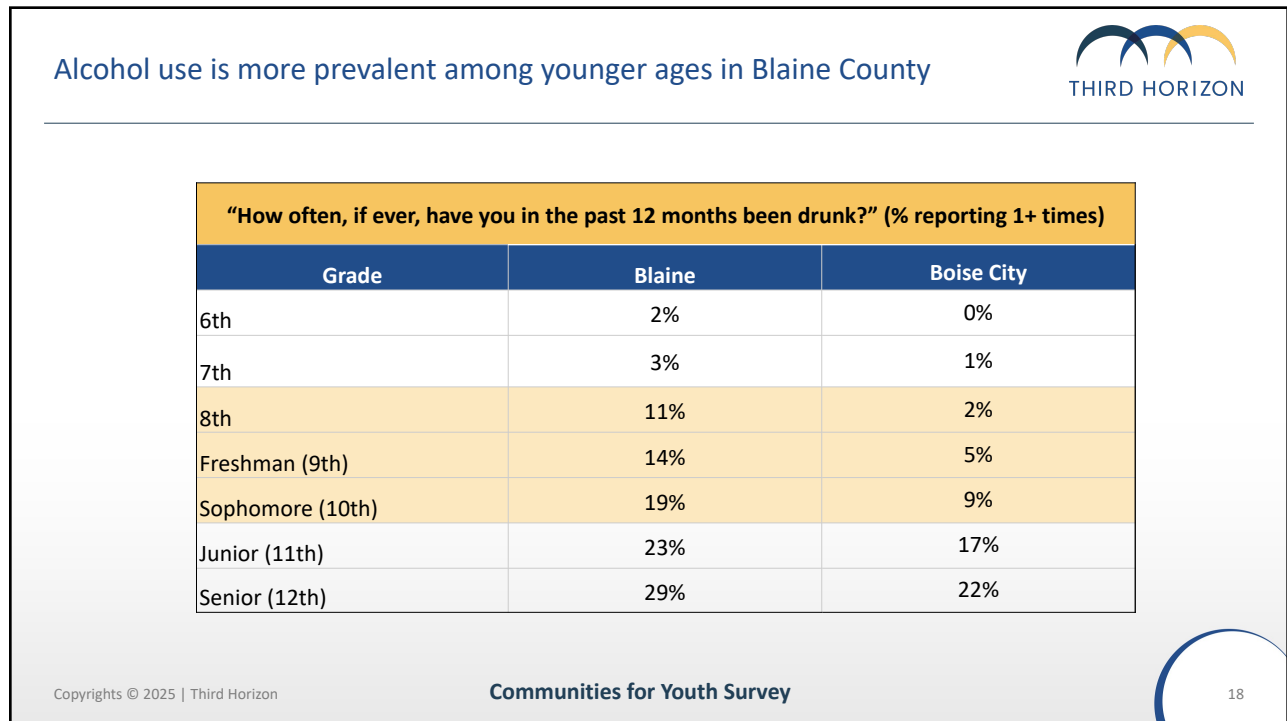
Copyrights © 2025 | Third Horizon

16

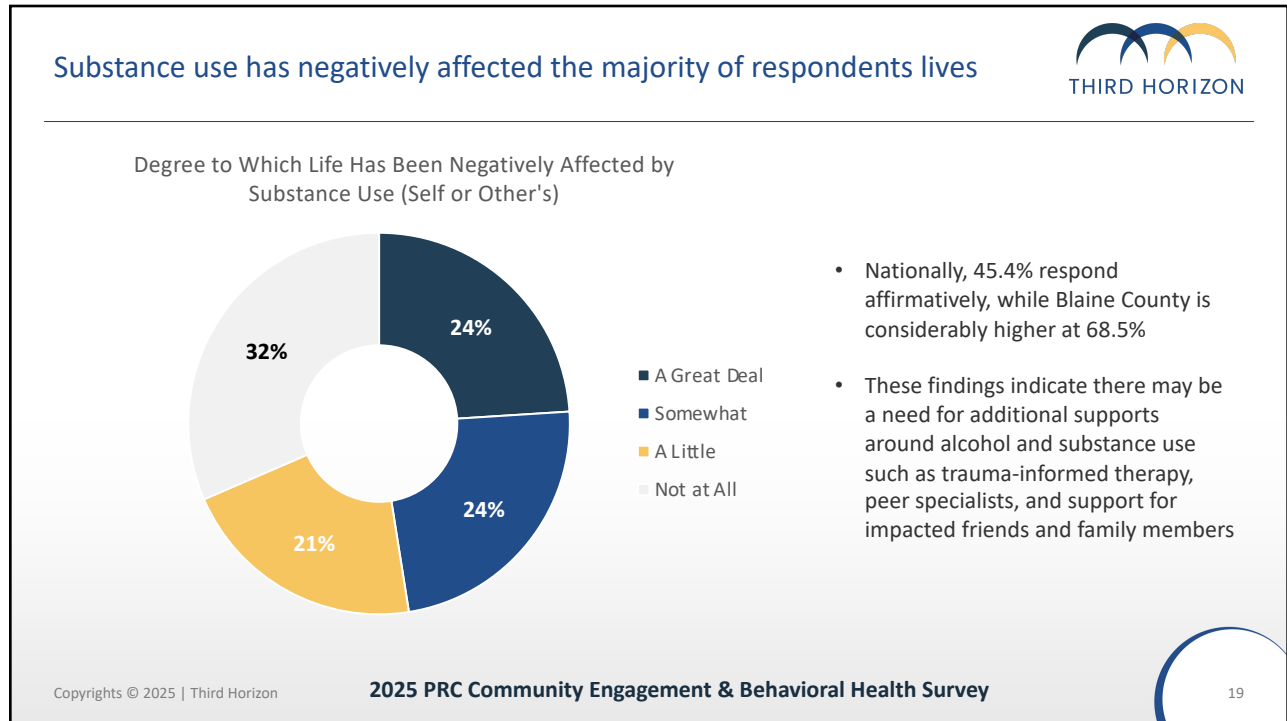
16



17



18



19

Behavioral Health Service Landscape, Gaps, & Access

THIRD HORIZON

"Our community lacks AFFORDABLE mental health therapists"

Copyrights © 2025 | Third Horizon

20

20

Wait times for mental health services may vary



- 77% of providers responded that they are accepting new patients
- 65% of providers can see new clients within one week
- 9% of providers have a greater than 30-day wait time for new clients
- 62% of providers responded the availability of preventative mental health programming for children and adolescents in the community is "fair" or "poor"
- Findings are based on aggregated data. The PRC Survey data is not broken out by level of care or insurance status, which would provide greater context

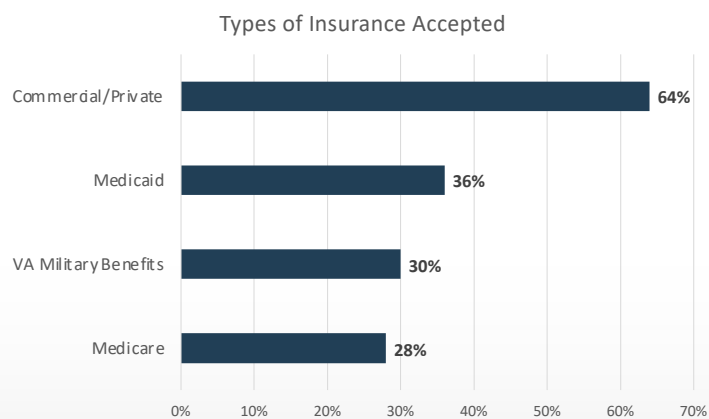
Copyrights © 2025 | Third Horizon

2025 PRC Mental Health Provider Survey

21

21

Two thirds of providers accept commercial/private insurance, but only slightly more than one third accept Medicaid



Additional Payment Information

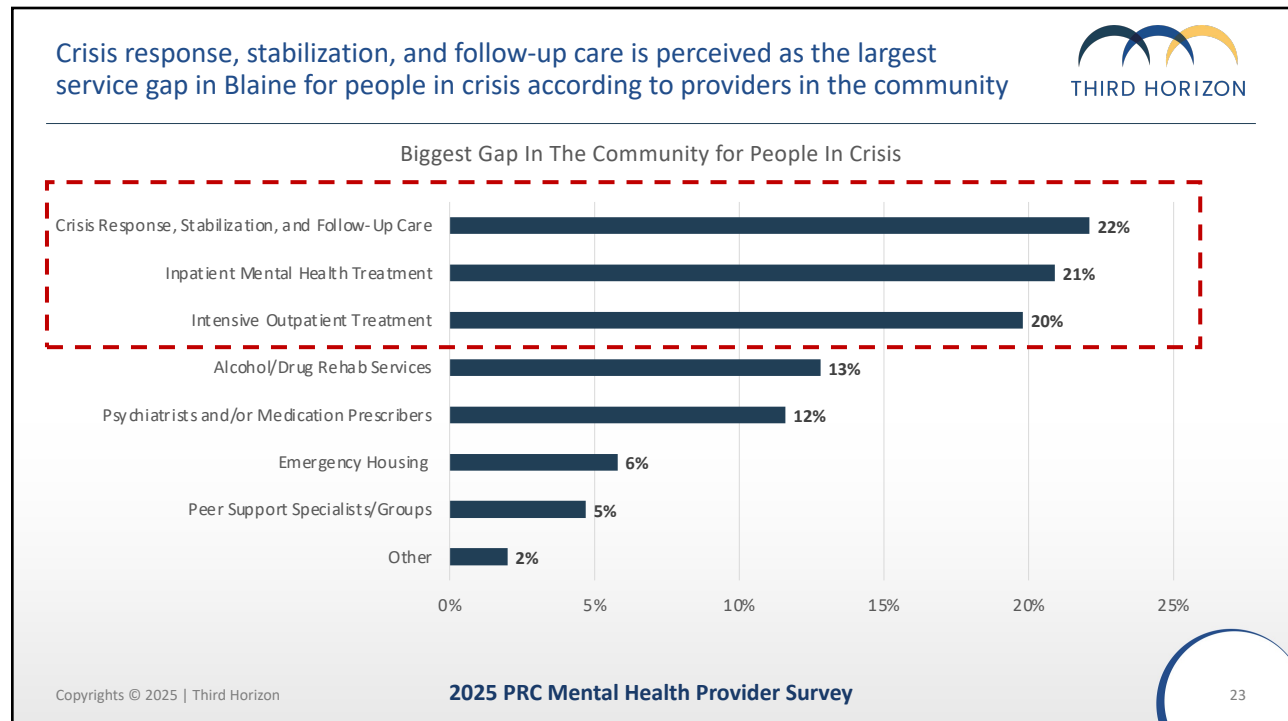
- Of those accepting commercial insurance, 98% accept Anthem BCBS. United Healthcare (72%) and Humana (61%) were the next most accepted payers.
- 32% responded that they accept clients on employee assistance programs (EAPs).
- 61% responded that they offer a sliding scale for clients paying out-of-pocket.

Copyrights © 2025 | Third Horizon

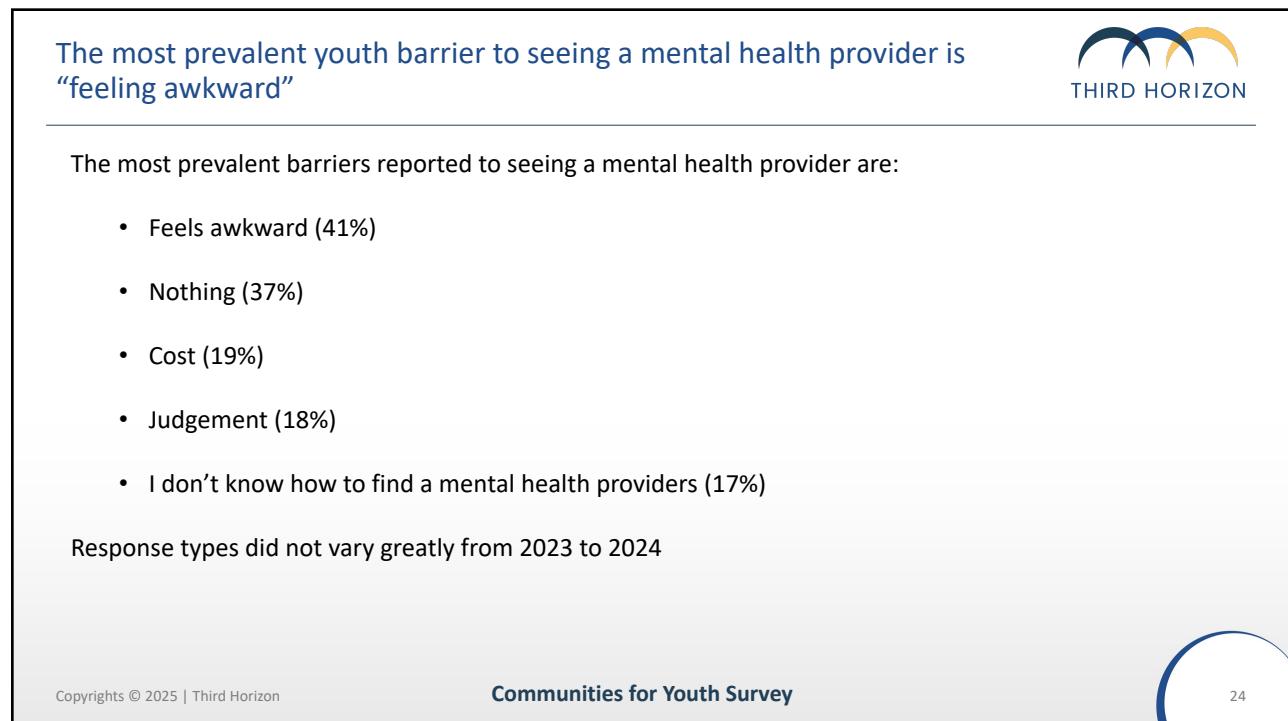
2025 PRC Mental Health Provider Survey

22

22



23



24

Cost and treatment availability are the primary reasons people do not get needed services



36% of respondents to the community survey said they needed mental health services in the last year.

Of those needing services, **21%** responded that they did not get the services they needed.

Top reasons for not getting needed services	
Cost	26%
Treatment not available	21%
Don't know where to go	11%
Health insurance doesn't cover	8%
No time	6%
Long waits	5%
Confidentiality concerns	4%
Lack of / no transportation	4%
Various other	<3%

Copyrights © 2025 | Third Horizon

2025 PRC Community Engagement & Behavioral Health Survey

25

25

Awareness of local mental health resources and stigma around seeking help



- 75% of adult residents are aware of local mental health resources, and most say that they would be likely to seek mental health services locally if needed.
- Awareness levels are lower among men, those living below the federal poverty level, Hispanic residents and LGBTQ+ community.
- While 70% of residents agree with the statement that people in the community are generally caring and sympathetic to people with mental health concerns, only 54% agree that it is easy for residents to talk about mental health challenges.

Copyrights © 2025 | Third Horizon

2025 PRC Community Engagement & Behavioral Health Survey

26

26

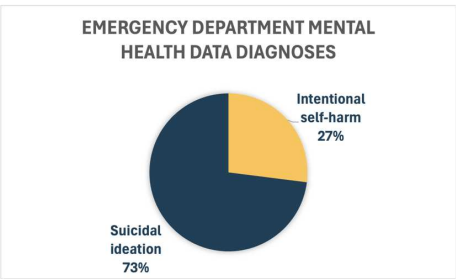
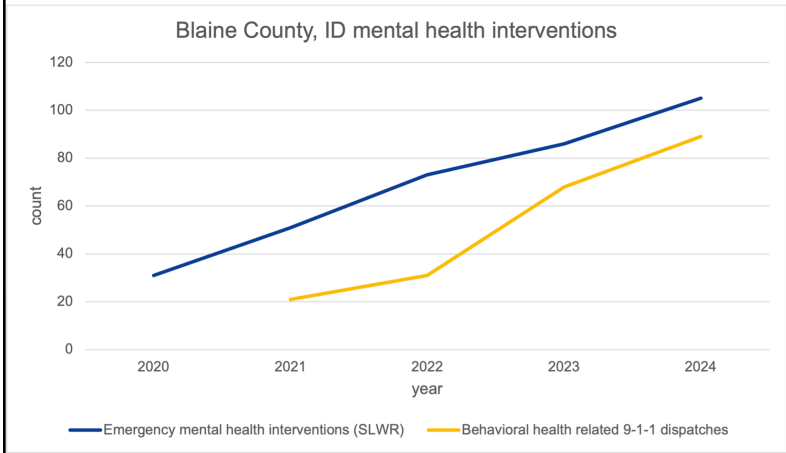


911 Dispatch and Emergency Department Data

"There is a need for crisis intervention without patients having to be transported to in-patient facilities. There needs to be follow-up with patients who are transported to in-patient facilities as to how they were treated within the process." - Provider Survey

27

Emergency mental health interventions and behavioral health related 9-1-1 dispatches are increasing over time.



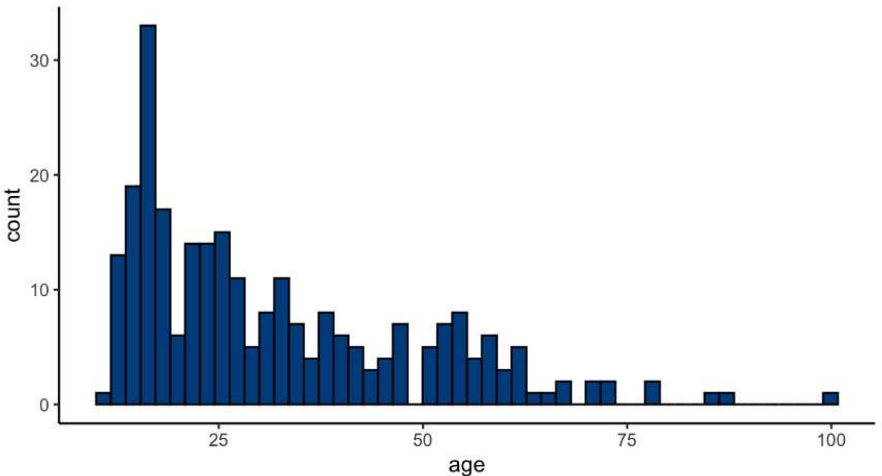
For ED visits, diagnoses could be broadly bucketed into two categories: 1) ideation, and 2) those containing a component of self-harm (e.g., intentional drug overdose, suicide attempt).

28

ED visits involving intentional self-harm and/or suicidal ideation disproportionately involve youth



SLWR mental health ED visits by age
12/01/2020 - 06/30/2024



Copyrights © 2025 | Third Horizon

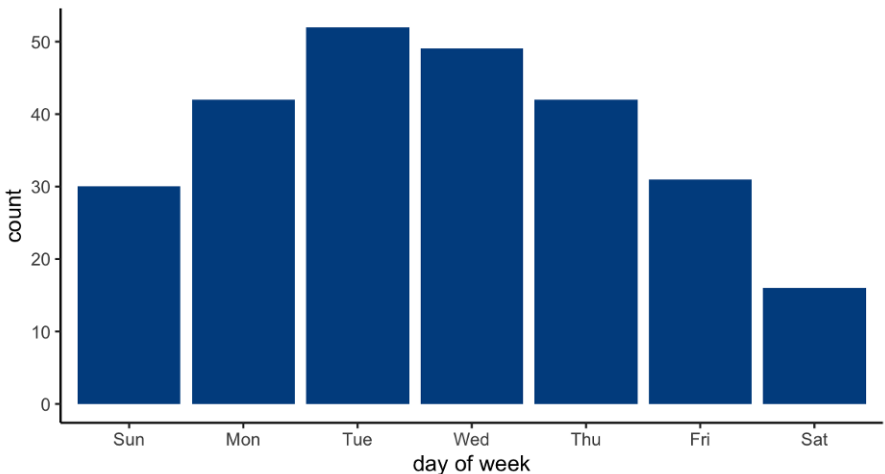
29

29

ED visit and dispatch data could provide insights into crisis response staffing needs



SLWR mental health ED visits by day of week
12/01/2020 - 06/30/2024



Copyrights © 2025 | Third Horizon

30

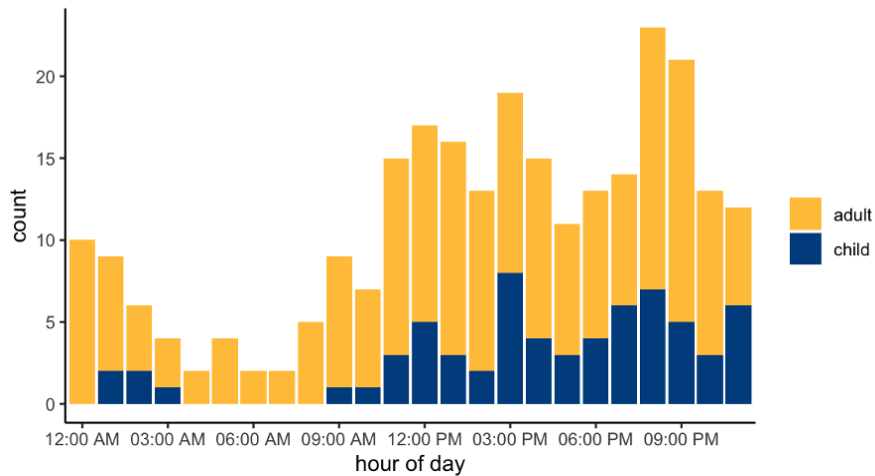
30

ED visit and dispatch data could provide insights into crisis response staffing needs



SLWR mental health ED visits by time of day

12/01/2020 - 06/30/2024



Copyrights © 2025 | Third Horizon

31

31

Key Takeaways



- Crisis response dispatch calls, SLWR mental health encounters, and SLWR ED visits data all show increasing utilization trends over time
- On average, dispatch responds to nine behavioral health crisis calls per month (most recent available trailing 12-month average)
- On average, the ED receives seven individuals in mental health crisis per month (most recent available trailing 12-month average)
- The median age for ED visits (26) is significantly lower than for crisis response (36) or mental health encounters (38). This reflects a higher prevalence of mental health-related ED visits among adolescents
- Thirty-six percent of all crisis response calls involved transportation by ambulance
- Most mental health crisis calls and mental health ED visits occur in the second half of the day, with peak hours between 7pm and 10pm



Copyrights © 2025 | Third Horizon

32

32



Implications and Recommendations for Blaine County

"I hear so much about how we need more therapists - we have A LOT of therapists in this valley...but the vast majority do not serve our most vulnerable population. Peer support, crisis triage and stabilization, good ol' fashioned outreach and engagement are our gaps. " - Provider Survey

33



Biggest Takeaways and Recommendations for the MWBI

Prevention

- Prevention efforts should include a significant focus on activities that foster social connection while also directly targeting alcohol use and other substances among youth and adults
- Targeted efforts and interventions are needed to meet the needs of younger residents, those with lower incomes, Hispanics, and those who identify as LGBTQ+
- Continued training in the community such as Mental Health First Aid, QPR and ASIST, as well as ongoing community education, may be beneficial to mitigate stigma and ensure people in need know how to access care

Crisis

- Crisis response, stabilization, and follow-up care is perceived as the largest service gap in Blaine
- Targeted efforts and interventions are needed to meet the needs of younger residents, those with lower incomes, Hispanics, and those who identify as LGBTQ+
- Crisis walk-in or other intensive services may best be piloted on a limited basis to gauge utilization and impacts

34



Aligning Local Goals with State Initiatives

Crosswalk of State and Local Behavioral Health Response Plans

35



Crosswalk Overview

Third Horizon compared MWBI's strategic goals and objectives with two state planning documents and a regional plan to identify areas of alignment and note any key differences.



IBHC 2024 – 2028
Strategic Action Plan



IBHC Scope of Work -
Primary Prevention
Programs and
Protective Factors
Scope of Work (SOW)



South Central Behavioral
Health Board Strategic
Priorities

36

Plan Similarities



Overall, MWBI's approach is well-coordinated with broader state efforts, with differences largely reflecting the distinct scopes and responsibilities of state-level versus local-level planning. Key themes and similarities include:



Community Connection: MWBI's Goals 1 & 2 align well with state priorities around community connection in IBHC's Prevention SOW.



Expand Access: The State Action Plan, SCBHB priorities, and MWBI Goals 3 and 4 align closely in recognizing the need to expand access to behavioral health care.



Crisis Response: All of the strategic plans prioritize accessible, robust crisis response, including mobile teams and crisis stabilization options.



Data Infrastructure: Both the IBHC SOW and MWBI plan have goals around developing data collection tools.

Copyrights © 2025 | Third Horizon

37

37

Key Differences



Children & Youth: The state plan places greater emphasis on primary prevention for children and youth.



Jail Diversion: The State Action Plan and Prevention SOW are more explicit in their goals for diverting individuals from the criminal justice system, with strategies to provide a continuum of behavioral health care for incarcerated individuals.



Case Management: Both the state plans and MWBI's plan address case management, but their approaches differ. The state plans focus on system-level care coordination, while MWBI emphasizes strategically placing case managers within the community to connect people directly to resources.



Recovery Support: The State Action Plan explicitly includes goals for recovery support. MWBI's plan is less direct in addressing long-term recovery support needs, though it does outline objectives for inventorying community programs and sharing information with partners.



Plan Structure: The state plan organizes objectives and strategies as SMART goals, assigning specific action items and responsibilities. By contrast, the Blaine County plan presents more of a strategic vision than an operational roadmap.

Copyrights © 2025 | Third Horizon

38

38



“A Place to Go”

Case Studies



39

39

Behavioral Health Crisis Centers



The phrase “somewhere to go” has been associated with many labels. Terms such as “crisis center,” “crisis walk-in center,” “crisis stabilization center,” “crisis receiving center,” and “crisis receiving and stabilization center” are sometimes used interchangeably. **Per Idaho statute Title 39, Health and Safety, Chapter 91, in Idaho, these facilities are termed “Behavioral Health Community Crisis Centers” or simply “crisis centers.”**

- Crisis centers help people in the midst of a behavioral health crisis by de-escalating, stabilizing, and providing access to community-based services or referrals.
- Because crisis centers are not considered residential or inpatient facilities, client stays are limited to 23 hours and 59 minutes (e.g., less than 24 hours).
- Clients may access crisis centers voluntarily through self-referral, or by referral (and often transport) by mobile crisis teams, or first responders.
- Services typically include triage, screening, assessment, immediate intervention, and referrals to longer-term services.
- The setting is often a less clinical environment, or “living room model,” in which clients can relax in recliners or couches. Refreshments, clothing, or other supportive services are sometimes available on site.



Copyrights © 2025 | Third Horizon

40

40

Aspen Hope Center, Aspen Colorado



- Nonprofit behavioral health provider serving mountain resort and rural communities in Pitkin, Garfield and Eagle Counties
- Offers a crisis hotline, mobile crisis, school-based services, outpatient behavioral health, and intensive stabilization services. Does not operate a walk-in crisis facility.
 - Intensive Stabilization Program
 - Community Stabilization Program
- Serves about 1,000 people annually
- It uses a blended funding model, including Colorado's crisis system funding, hospital contracts, fundraising, private pay, Medicaid, and commercial insurance billing. In the near future, Pitkin County is expected to provide funding for the crisis stabilization programs.



Copyrights © 2025 | Third Horizon

41

41

Mountain House, Mental Health and Recovery Services, Jackson Hole, Wyoming



- Nonprofit behavioral health provider serving mountain resort and rural communities in Teton County Wyoming
- The organization provides a continuum of mental health and recovery services, including medication management, therapy, crisis services, peer support services, and case management, but does not have CCBHC status.
- Mountain House is a drop-in center and a crisis stabilization program. It is designed to provide wraparound services, foster community, and offer an alternative to hospitalization or incarceration.
- Wyoming pays for many mental health and substance use services for people earning at or below 200% of FPL who fall into the state's priority populations. Services are provided through a network of community behavioral health centers, including Mental Health and Recovery Services. The state's funding comes from federal block grants and state-dedicated quality-of-life funds. Wyoming has not expanded Medicaid, but the organization bills traditional Medicaid when serving eligible beneficiaries. Teton County also provides some funding to the organization. Grants supplement program activities.



Copyrights © 2025 | Third Horizon

42

42

Axis Health System, Durango Colorado



- Nonprofit, Federally Qualified Health Center (FQHC), comprehensive mental health safety net provider, and CCBHC grantee (for Durango location only) serving multiple counties in Southwest Colorado
- Axis operates two crisis walk-in facilities, in Montrose and Durango.
 - The Montrose campus includes the crisis walk in center as well as crisis stabilization units (CSUs) for both adolescents and adults, integrated with withdrawal management in one building. It is open 24/7
 - The Durango walk-in center is open from 7:30 a.m. to 5:00 p.m. and sees the highest number of individuals presenting with crisis between 8:00 a.m. and 11:00 a.m.
- Axis is also contracted to provide E.D. follow-up services to four hospitals in Durango.
- Axis has a complex funding mix, with regional differences across sites (FQHC PPS, comprehensive provider PPS, Colorado state allocated crisis funding, intergovernmental agreements and county support, local hospitals)



Copyrights © 2025 | Third Horizon

43

43

The Living Room, Thresholds, Chicago Illinois



- Nonprofit organization, certified by Illinois as a CCBHC and grant-funded by SAMHSA, offering comprehensive outpatient services, mobile crisis, and the Living Room crisis drop-in center
- The Living Room model allows individuals to stay for up to 23 hours, offering immediate assessment, peer connection, and basic needs such as food and clothing. It is intentionally co-located with one of Thresholds CCBHC clinics, enabling seamless hand-offs to therapy, Assertive Community Treatment (ACT) teams, or case management
- Staffing model utilizes peers with clinical services available on same campus
- Initially funded through Illinois' 590 initiative, Thresholds now sustains its crisis services through CCBHC Prospective Payment System (PPS) reimbursement. Its budget supports staffing, operations, marketing, and training. Donations supplement food and clothing for clients.



HOME | HEALTH | HOPE

Copyrights © 2025 | Third Horizon

44

44

Common Themes



Funding diversification: each organization relies on a complex blend of state allocations, Medicaid and/or commercial insurance billing, county contributions, hospital partnerships, grants, and philanthropy to sustain operations.



Staffing models: The programs use a mix of licensed clinicians, bachelor's-level staff, and, in some cases, peer specialists. In all cases, the organizations have defined security measures, not security guards.



Care continuum: Each of the programs is part of a larger behavioral health provider organization, which helps ensure continuity of care and follow-up after a crisis.



Community partnerships: Interviewees identified collaborations with law enforcement, schools, hospitals, and local governments as vital.



Standardized screening: All programs utilize the Columbia Suicide Severity Rating Scale. Some use additional screening and collect data on key performance indicators.

Copyrights © 2025 | Third Horizon

45

45

Discussion Prompts



- What surprised you, if anything in the data?
- Directionally, how does this information shift the MWBI's goals?
- What goals and objectives may no longer be relevant in the strategic vision document?
- What is missing or needs to be added?
- MWBI wants to be both bold in vision and realistic in its strategic plan. Third Horizon will be recommending SMART goals. What should the MWBI focus on in the next 1-2 years?



Copyrights © 2025 | Third Horizon

46

46

SMART Goal Sample





Mental Well-Being Initiative SMART Goals

Goal 1:	Objectives	Key Performance Indicators	Action Steps	Timeline	Person Responsible
Goal 2:	Objectives	Key Performance Indicators	Action Steps	Timeline	Person Responsible
Goal 3:	Objectives	Key Performance Indicators	Action Steps	Timeline	Person Responsible

Copyrights © 2025 | Third Horizon

47

Thank you!



THIRD HORIZON

Copyrights © 2025 | Third Horizon

48



Blaine County Mental Well-Being Initiative (MWBI): Crisis Call Centers Meeting

Date: Tuesday, November 11, 2025

Participants: Jenna Vagias, MWBI
Phil Sheridan, MWBI
Tammy Davis, Crisis Hotline
Matt Hardin, Magellan
Brian Knight, Idaho Crisis and Suicide Hotline
Andrew Rigby, Crisis Hotline
Kathy Thomas, Blaine County Emergency Communications
Mindy Klowden, Third Horizon
Ashley DeGarmo, Third Horizon
Jessica Casebolt, Third Horizon

Meeting Summary

Third Horizon presented opportunities to improve coordination and potential dispatch scenarios for the co-response team, which is currently being developed and plans to begin operations in January. The group discussed the feasibility of various options, including short- and long-term goals, and explored how to integrate the co-response team into existing workflows. Next steps include defining protocols within 911 for how and when the co-response team is deployed, exploring the Caribou County pilot with Magellan, integrating the co-response team as an option to be provided to 988 callers from Blaine County and callers to the local hotline, collecting data, and continuing to improve coordination through an ongoing workgroup.

Meeting Notes

Meeting objectives and framing the conversation	<i>The group did a round of introductions and then Jenna, Phil, and Mindy provided opening comments to frame the discussion around coordination among the call centers to explore gaps, assess current systems, and identify approaches for timely and effective deployment of the co-response team.</i> - Jenna provided a brief refresher on the background of the MWBI, noting that Third Horizon was contracted to help assess the crisis system in Blaine County and determine what “a place to go” should look like to meet the community’s need. The purpose of this meeting is to talk about the piece for “who to call.” - The MWBI is a solutions-oriented, neutral party that works to identify gaps and develop strategies to address them. - Phil gave opening comments about the goals for the meeting:
---	--

	○ Mindy will walk through possible models for coordination among the call centers. ○ The goal is to reach a preliminary agreement about what model will enable timely and effective dispatch of the co-response team when someone calls for help. ● The co-response team is still in development, with plans to have the team fully operational and an office in Bellevue established by the first quarter of 2026; job descriptions and the MOU between Family Health Services, the Sheriff's department and MWBI are in the process of being finalized. ● Mindy ○ The work this group is involved in occurs within a broader state and federal context, so it's important to consider both current realities and what an ideal future system might look like. ○ Mindy suggested starting the conversation by evaluating how current phone lines are functioning, identifying gaps and redundancies, and exploring opportunities to improve coordination across systems. Some improvements may be addressed locally, while others may require action at the state level. ▪ When the co-response team begins operations in 2026, what is the best way to deploy that team? ○ Third Horizon recommends forming a dedicated workgroup to advance this work, ensuring ongoing conversations and improved coordination, as these goals cannot be fully addressed in a single 90-minute meeting.
Potential scenarios for Blaine County	<i>Mindy reviewed the national landscape for crisis call centers, highlighting issues related to care coordination, and presented possible scenarios for Blaine County with those considerations in mind. (See slides for presentation details)</i> <u>National Landscape</u> ● SAMHSA provides guidance for best practices around care coordination. To translate best practices into Idaho, Mindy reviewed the current landscape for these services in the state, which has a very centralized approach with a single statewide contract with Magellan for behavioral health and crisis services. <u>Discussion</u> ● Kathy asked whether the mobile response team is the same as the clinician-led co-response team. Mindy clarified that the clinician-led team is being established locally because the Magellan-operated mobile crisis team cannot always respond quickly enough. The sheriff is particularly interested in this approach to reduce justice involvement in behavioral health crises. Many communities have both approaches. ● Brian added that at 988, there is daily communication with dispatch centers and public answering points; only about 1% of contacts involve law enforcement for imminent suicide, and there is consistent statewide coordination with law enforcement.

	• A more formal process linking 911 directly to 988 is considered the next step at the state level for Magellan. <u>Scenarios (see slides for full details)</u> • 988 driven response ○ The advantage of this approach is that low-risk issues can be solved on the phone with follow-up as needed. ○ Brian said this is true for 89% of calls. ○ It is important to note that due to the way Idaho funds crisis services, Magellan’s mobile crisis response teams are funded by the state while other interventions would not be. • 911 driven response ○ This approach does not allow for resolution over the phone. However it may be the most direct way to send out the co-response team. • Local hotline driven response ○ <u>This option may be time effective, but there is no direct way to connect callers. It would need to be a referral or warm handoff if the technology could be in place to facilitate this.</u>
Discussion of scenarios	<i>The group discussed what is feasible, what would be ideal in the long term, and any gaps or considerations not addressed in the three proposed scenarios.</i> • Kathy asked if the co-response team will operate 24/7. ○ No, that team will operate under a 40 hour work week, with hours adjusted as much as possible to cover peak times of day. There is commitment to expand coverage as the team/program develops. • Matt noted that in Scenario 1, a response can still occur if a gun is present on the premises, as it is not necessarily considered life-threatening or dangerous. Key considerations include the gun’s location, whether it can be safely secured or removed, and the distinction between merely having a gun versus “brandishing” it. • Brian noted that the process should involve collaboration with the person in crisis—asking if they want referrals, community resources, or a mobile response team. Sometimes individuals call for a welfare check, and after risk evaluation, their preferences for services may change. ○ A large percentage of dispatches are for third-party calls. ○ Many requests come from law enforcement seeking mobile response support. ○ The goal is to support law enforcement in crisis situations that are better addressed by mobile response; for 988-driven responses, the communication flow should be bi-directional with 911. • Kathy conveyed the need for warm handoffs between 911 and 988, rather than giving someone a number to call and then hanging up. • Jenna emphasized that the co-response team is not solely for crisis calls; there is a case management and follow-up component. Community feedback and data indicate gaps in follow-up services, and there are not enough crises alone to keep the team fully occupied.

	• Tammy highlighted that while the Crisis Hotline could become a remote provider through 988, it's important not to retrain people to call 911 for mental health issues. Law enforcement shouldn't be the first point of contact. Rural areas and technology gaps make a local hotline still necessary, even if it's eventually integrated into a larger network. • Tammy has promoted 988, but call logs show local lines are still needed. The local hotline is interested in meeting the same standards as 988. • Brian raised questions about communication between the co-response clinician and the officer, and how the sheriff and Family Health Services envision this. ○ This is still being determined, but currently dispatch is through 911. There could be multiple ways to dispatch the co-response team. ○ There is a concern about pushing the community to call 911 for behavioral health situations. This should be avoided. ○ There is a need for co-messaging between 911 and 988 to ensure timely responses. Local teams may respond more effectively than 988 team which sits hours away. ○ Brian noted that some 988 contacts can wait for Mobile Crisis Teams (MCT), but coordination becomes challenging if multiple counties operate independent systems. • Mindy and Brian discussed whether 988 could directly dispatch co-response rather than routing through Magellan. ○ The process presents options to the person in crisis, who may adjust their choice after evaluating available resources. ○ Teams are familiar with unique resources in different communities. ○ Tammy noted that 988's geo-location is accurate for most callers, though 5% may have carriers that do not report location correctly. ○ The 988 team could be trained to offer co-response as an option ○ Tammy is open to participating. • Phil emphasized that any call line should ideally be aware of the co-response option. • Community outreach is needed to explain the system, highlight "no-wrong-door" access, present options to clients, and clarify response times and responders. • Regulatory/contractual considerations for dispatching the co-response team: ○ Teams could only be sent in lieu of other qualified MRTs, but currently Magellan is the only option. Even the new co-response team would not be a directly comparable option. ○ Matt is not sure if Magellan would be able to promote the co-response team as a substitute. They are two different types of interventions. MRT is specifically a clinician and a peer. ▪ Brian emphasized Matt's point that co-response involving a police officer and clinician is very different than MRT. ○ Mindy explained that practical factors such as existing resources (county funding and the sheriff's interests) and community needs for a more timely response drove the choice of co-response for Blaine County rather than MCT.
--	--

	• Kathy outlined current dispatch procedures, which use determinants and questioning protocols to cover liability. ◦ Integrating the co-response team would require reconfiguring training and establishing a clear call chain. ◦ First steps include working with Dr. Koplin (Medical Director) to review call protocols and determine how the co-response unit is contacted, followed by programming implementation. • Matt highlighted a pilot in Caribou County that is exploring transferring 911 callers to 988. Kathy supports doing something like this.
Next steps	• Work with local 911 dispatch, FHS, and the sheriff to define protocols and lines of questioning for when the co-response team should be deployed. • Explore replicating the pilot in Caribou County; earlier involvement may provide greater control over implementation. • Add the co-response team as an option for callers to 988. • Ensure the local call line can connect to the co-response team when appropriate; next step is to determine the connection method (e.g., directly calling the clinician). • Maintain concurrent pathways to support a “no-wrong-door” approach. • Collect data to track effectiveness, volume, and outcomes. • Plan for integration: once the co-response team launches in January, allow time to fully embed processes. • Define how local wrap-around support will be accessed and utilized by the co-response team.
Workgroup	Mindy closed the meeting by asking participants to commit to participating in an ongoing workgroup to continue refining the ideal approach, protocols, and coordination processes. The group will reconvene in January.



THIRD HORIZON

Optimizing the Crisis Call System:
Opportunities for Coordination and
Deployment of the Blaine County
Clinician-Led Co-Response Team

Mental Well-Being Initiative
November 11, 2025



Copyrights © 2025 | Third Horizon

1

1

Objectives





Assess the “current state” of 988 (Idaho Crisis and Suicide Hotline), 911 and the Crisis Hotline Idaho (local hotline)

Evaluate current gaps, redundancies, and opportunities for improved coordination.



Determine the optimal process for dispatching the Blaine County clinician-led co-response team

This may include short-term approaches and long-term solutions



Form and define next steps for the working group

Copyrights © 2025 | Third Horizon

2

2

SAMHSA 2025 National Guidelines for a Behavioral Health Coordinated System for Crisis Care Best Practice Guidance for Coordination



Clearly identified protocols/decision points and processes for transferring calls between entities

Joint/collaborative planning

A dedicated local leader and champion *{and convener}*

Formal agreements to strengthen collaboration

"Warm transfer" e.g., 911 staff staying on the line with a caller until the 988 crisis counselor answers and is briefed on the reason for the transfer

Coordination with local hotlines and warm lines

Established protocols with local Mobile Crisis Teams and Co-Responder teams to allow for dispatch, referrals, and information sharing while complying with privacy laws

In rural communities, must account for long response times, and limited mobile crisis capacity, often requiring virtual clinical consultation models or shared regional protocols

Copyrights © 2025 | Third Horizon

3

3

Current Landscape: Idaho



- Idaho's Idaho Behavioral Health Plan (IBHP), administered by Magellan Healthcare, centralizes behavioral health and crisis services under a single statewide contract
- The Idaho Crisis & Suicide Hotline (ICSH), is part of the Vibrant approved network and answers all 988 calls and coordinates dispatch with Magellan's network of Mobile Response Teams (MRTs)
- Magellan subcontracts primarily with Benchmark Human Services and Community Bridges, Inc.—to provide MCT coverage across broad geographic regions
- Local or community-based organizations that are not part of Magellan's network cannot currently be deployed directly through 988, even if they operate qualified crisis teams (financial constraints, regulatory and contracting issues)
- Magellan is at the very initial stages of exploring possible state level coordination between 911 and 988
- Blaine County Sheriff's Department, Family Health Services and the Blaine MWBI are standing up a new Clinician-Led Co-Response Team
- The Crisis Hotline Idaho - (208) 788-3596 is NOT in the Vibrant/988 network

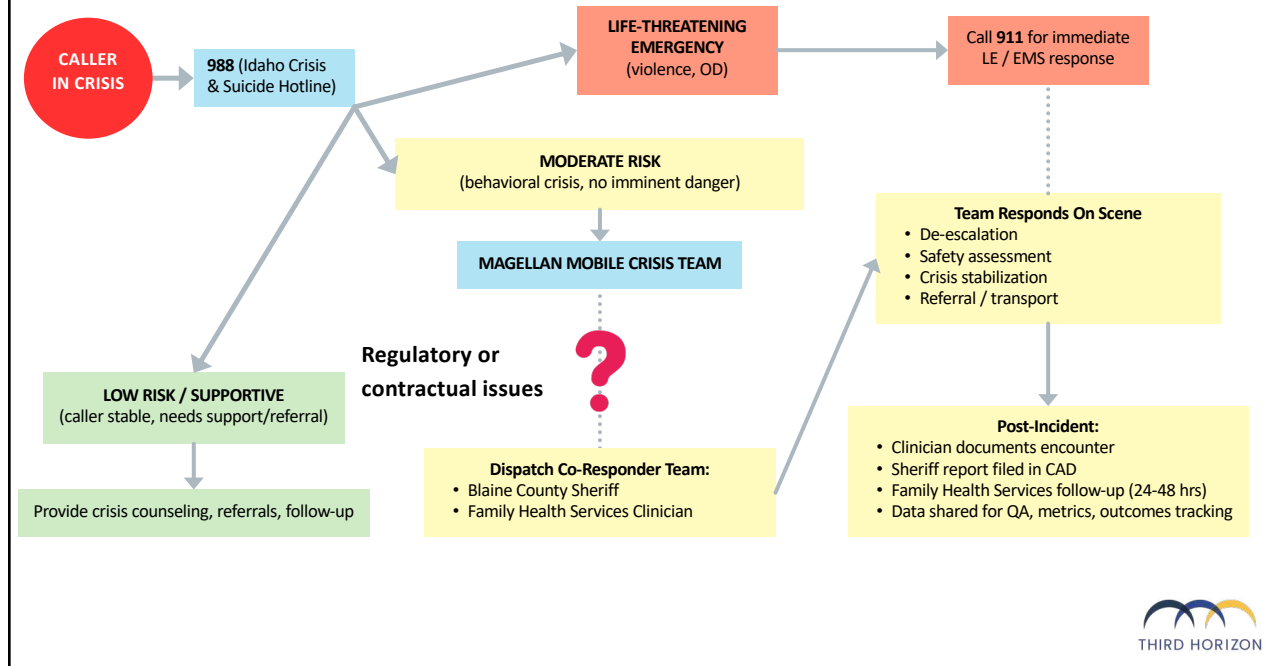


Copyrights © 2025 | Third Horizon

4

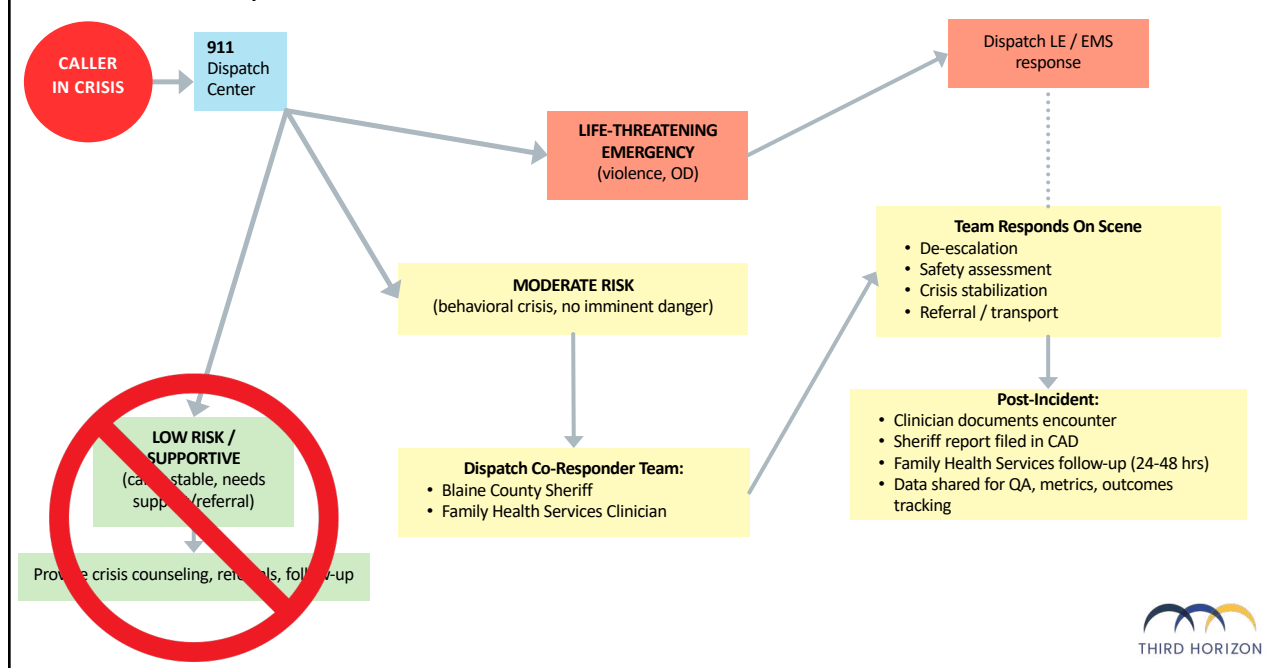
4

988 Driven Response

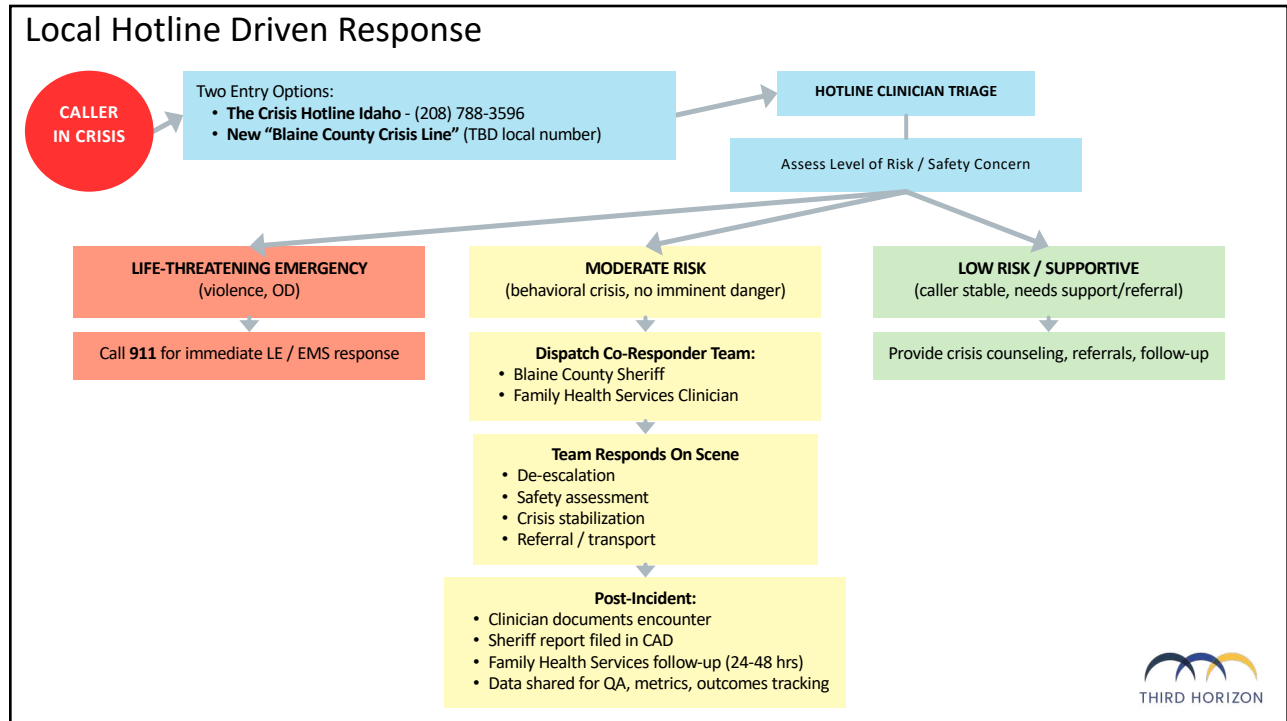


5

911 Driven Response



6



7

Discussion

Copyrights © 2025 | Third Horizon

8

8

Thank you!

Mindy Klowden, MNM, Managing Director
Mindy@thirdhorizon.com
(303) 884-2670



THIRD HORIZON

Copyrights © 2025 | Third Horizon

9



Blaine County Mental Well-Being Initiative (MWBI): Place-to-Go Feasibility Retreat

Date: Wednesday, November 12, 2025

Participants: Aaron Houston, Family MWBI
Almita Nunnelee, St. Luke's Wood River
Amanda Deaver, MWBI
Deborah Robertson, St. Luke's
Jenna Vagias, MWBI
Megan Tanous, St. Luke's Wood River Foundation
Michelle Ross, St. Luke's Health System
Muffy Davis, Blaine County Commissioner
Phil Sheridan, MWBI
Sarah Seppa, Center for Community Health
Tori Torgrimson, Family Health Services
Ashley DeGarmo, Third Horizon
Mindy Klowden, Third Horizon
Jessica Casebolt, Third Horizon

Meeting Summary

The group reviewed community needs and model options for establishing a “place to go” for behavioral health crises. Third Horizon walked through four potential approaches—a crisis center, behavioral health hub, diffuse model, and Certified Community Behavioral Health Clinic (CCBHC)—along with operational, financial, and staffing considerations. After extensive discussion, the group reached consensus to eliminate the crisis center and diffuse models, focusing instead on strengthening the emerging co-response team with next-day appointments and developing a “behavioral health hub” operated by FHS to provide same-day access to outpatient services, which could potentially later evolve into a CCBHC. Key next steps include refining the hub model and its phased development, defining governance (likely through a consortium), identifying space and partnership needs, exploring funding opportunities, and incorporating these insights into Third Horizon’s forthcoming final report.

Meeting Notes

Welcome	<i>Jenna welcomed the group and provided context for the meeting.</i> Jenna provided background on the St. Luke's Wood River Foundation's investment to launch the Mental Well-being Initiative
---------	--

	(MWBI) as a new nonprofit to support ongoing behavioral health work, serving as a backbone for coordination and implementation. • Overwhelming community feedback indicated that there was a need for “a place to go” for people when in crisis. • Megan added that the nonprofit emerged from concerns about the burden on emergency rooms and the need for better solutions.
Setting the stage	<i>Mindy reviewed possible options for a “place-to-go,” flagging key considerations and facilitating discussion around each option.</i> • Mindy outlined that Third Horizon would present potential scenarios for “a place to go” and facilitate discussion to inform the final report. • Jenna reiterated that the initial “crisis center” concept evolved into a focus on case management, same-day access, and care navigation. <u>Place to go Options:</u> 1. Crisis Center a. Walk in 23-hour crisis center offering the services required by Idaho state guidelines 2. Behavioral Health Hub a. Walk in same day access for outpatient services with distinct operating hours 3. Diffuse Model a. Diffused or non-centralized model placing new positions into existing programs or clinics 4. CCBHC Model a. Seed grant for a CCBHC with continuous state advocacy <i>**See slides for details, including definitions, operating considerations, staffing requirements, and service offerings</i> • Mindy highlighted that any of these models would need to consider how care is being coordinated across systems/multiple organizations. <u>Questions/Discussion</u> Option 1: Crisis Center • What is the medical staffing requirement under the crisis center? ○ 2 staff required on site at all times ○ Staffing requirements are governed by the state

	• Are the centers in surrounding areas like in Twin Falls currently sustainable? ○ Matt indicated that they are generally operating at 60-80% full. • Can the county move forward with this model without Magellan's buy-in? ○ Yes, but it wouldn't be eligible for the per diem rates. It would require piecing together fee-for-service rates. • Is there flexibility on the 20-bed count? How would the model navigate kids and adults since they cannot be in the same space? ○ The county/MWBI can create whatever the community needs, however to be designated a crisis center by the state and qualify for the per diem it would need to follow the state guidelines. • Are state guidelines informed by standards of care? ○ Yes, they are informed by SAMHSA crisis care guidelines. One distinction Third Horizon has observed is that in Idaho they are using beds, whereas crisis centers in some other states use recliners since it is not intended as a residential facility. Recliners may not encourage people to stay as long. • Is anything in the Rural Health Transformation Program (RHTP) targeted at behavioral health? ○ It includes some access to mental health funds, starting in 2027 (from what is published so far). ○ The state will likely put out competitive requests for proposals for RHTP funding. Option 2: Behavioral Health Hub • Tori flagged that Idaho requires a Comprehensive Diagnostic Assessment(CDA) to be able to access case management, peer support, etc. Tori recommends adding ASAM for intake to determine level of care. ○ These kinds of details would need to be laid out in an operational plan. • This model would not be intended as a crisis center but could be a safe place for someone to be while next steps are determined. • Is there data to show how the upstream prevention would impact the downstream (i.e. ER visits)? ○ Jenna said that St. Luke's hospital data shows approximately 70% of emergency department crisis visits were for suicide ideation rather than attempts, so in theory, those could be diverted from the emergency department if there were an appropriate alternative.
--	--

	○ As the co-response team begins operating in January, data will start to be collected that can hopefully add insights to the concept. ● In this model would there be opportunity to have volunteers/peers that could enhance the program and add sustainability? ○ As long as things are within clinical guidelines. It depends on how the program is set up if it would include or preclude volunteers. ○ Adult peer support will not be paid for by the state of Idaho as of December 1. Option 3: Diffuse model ● How do the diffuse sites manage elements like HIPAA? ○ It may be that a position is added for St. Luke's that is for care follow up, and an outpatient clinician is added to FHS, and a case manager is added to a third organization. Then there will be a need to look at how to coordinate care across providers. It's more about adding capacity in the community to meet needs. ● Would the approach under this model focus on community organizations or stay within the medical realm? ○ Clinical services have to be provided by clinical organizations that are licensed but non-clinical services might be provided by other community based organizations. ● How does this solve for a place to go when people have a situation and need to determine where to get help? ○ It depends on where someone walks in. This model is not that different from what exists now - there are people going to community organizations not knowing where to get help. Option 4: CCBHC ● How does payer mix in the community impact sustainability for this model? ○ The Bellevue clinic sees 80% uninsured. FHS indicated the hub would need to serve a larger proportion of Medicaid beneficiaries. ○ The approach may be to have seed money from the community to stand up the CCBHC and continue to advocate with the state to eventually get sustainable funding through the CCBHC Medicaid Demonstration or a State Plan Amendment.
--	---

	○ There is also a chance that SAMHSA grants could become available. ○ There is a chance that RHTP could be a source of funding. ● Would this be a brand new organization? ○ It could be an expansion of something that already exists (such as FHS) or another provider organization ● In a CCBHC, could medication management be fulfilled by a contracted entity? ○ Yes, through a “designated collaborating organization” (DCO). ○ The requirement is that a majority of services be provided directly by the CCBHC.
Cost Implications	<i>Ashley walked through some of the capital and personnel expenses under the different models, noting that this is a preliminary review and there will be more questions and vetting to do as MWBI moves forward with a model or in the process of determining the ideal model. (See slides for details)</i> ● As questions arose about more specific details such as square footage, Mindy noted that Third Horizon was not contracted to provide a pro forma and also couldn’t do so until the operating model was defined. Getting deeper into those financials will be a significant next step in this process. ● Other personnel expenses were flagged to be considered – such as housing and other fringe benefits to attract/retrain staff, as well as malpractice insurance and workers compensation. Discussion around funding streams/revenue: ● The prospective payment system (PPS) rate might help carry some of the self-pay clients. ● Mindy noted that as MWBI and partners think about the options, they should consider what is going to be appealing to the community that would garner financial and other support. ● Muffy noted that the public appeal is also important if pursuing a ballot initiative. ● Aaron flagged the importance of the pharmacy program for financial sustainability. Through the 340B program, this program makes medication affordable for self-pay patients, and brings in revenue. Therefore, it would be crucial to have tele-pharmacy and a prescriber embedded to get the pharmacy revenue. This strategy offsets and pays for the psychiatric nurse practitioner.

Discussion	<i>The group discussed the pros and cons of the different models. There was group consensus to remove the crisis center and diffuse models from consideration.</i> Crisis Center ~~• State won't fund~~ ~~• 20 beds is excessive for this community~~ ~~• Group agreed that this isn't the model and can remove~~ <i>The Crisis Center option was removed by consensus, as it was determined that the demand is insufficient to support a program of this scale.</i> Behavioral Health Hub • The hub could address some of the immediate concerns expressed by the community for same day access to triage, outpatient treatment and case management and navigation services. • The concern with the hub approach is that it doesn't have 24/7 capability. • The hub could offer transportation such as to the crisis center in Twin Falls • The hub should have direct connection with the co-response team; however, this will also not be operating 24/7 at least in the first year. • This model could be set up so that it easily transitions to CCBHC in the future, and if the funding never comes to fruition you are not at a loss because it wasn't a full investment into that model. Diffuse Model ~~• No 24/7~~ ~~• This is effectively what already exists so also not really the option~~ <i>The diffuse model was removed by consensus because it largely reflects the county's existing crisis infrastructure and, therefore, does not sufficiently address gaps or improve service delivery.</i> CCBHC • No 24/7 walk in services (CCBHCs are required to have on-call services) • Next day appointments could be contracted • It would provide more data • Can do CDA/CANS
-------------------	---

Additional discussion and defining next steps	<i>When the group reconvened after the lunch break, Mindy reflected that the group is moving toward adding onto the co-response model by building in next day appointments and also fleshing out the behavioral health hub model with the potential for that to transition to CCBHC further down the line.</i> <i>Mindy reviewed again the slide with the details for the behavioral health hub model and the group continued discussion.</i> Discussion/questions • What is the difference between a navigator and case manager? ○ The navigator would help generally provide information and referral services, including to non-clinical services in the community. Whereas the case manager would be working with clients receiving clinical services and may support a client over time and those services would be billable. • Phil suggested that the early phase of the behavioral health hub should not include a prescriber and services like medication management as doing so would add very complicated layers. These could be added later on but including that component in the beginning would add so much complexity that it would slow the launch. • The group agreed to not to include other community providers in the hub model for now while keeping them in consideration for a later phase as the hub is further developed—either during a transition to CCBHC status or as the hub expands over time. • Operator of the hub ○ Not currently in St. Luke’s scope/capacity ○ It makes sense for FHS to take it on – a lot of experience in this area and mission alignment. ▪ FHS might need some additional administrative support. ▪ Aaron shared about the Center for Community Health which is operated under a consortium that has been set up through a legal agreement as an advisory board. (FHS is technically the owner) ▪ The consortium determines budget and is directive to FHS. ▪ Aaron thinks this kind of structure would work well for the hub model. There are different players that have a say in it and not just FHS.
--	---

Next Steps	• Further define the hub model and direction (phase 1, 2, +), with FHS as the operator. • Define the consortium model and role of MWBI. • Identify opportunities for other partner organizations in the same space (for Phase 2). • Identify needs for building/space. • Prepare for/consider county CSA funding application. • Third Horizon will be providing a final report, which will provide a recommendation and include the process and input which informed it.
Parking Lot	• Role for volunteers • Pharmacy revenue • Need better payer projections • How to market to Medicaid clients • Liability concerns



"A Place To Go" Feasibility Retreat

Blaine County Mental Well-Being
Initiative

November 12, 2025



Copyrights © 2025 | Third Horizon

1

1

Retreat Goals



Present options for "A Place To Go" in Blaine County with financial and operational considerations



Facilitate discussion to gather feedback on the financial analysis, programmatic, and system recommendations



Create alignment between MWBI's Board and key partners before final recommendations are delivered

Copyrights © 2025 | Third Horizon

2

2

Agreements



We will start and end on time

We will be present and focused (laptops closed and cell phone ringers on vibrate)

We will be inclusive and strive for equitable participation

We will be respectful even when we disagree

We will actively listen, be curious, validate, and seek first to understand then be understood

We will be outcome-oriented and forward-thinking

What else?

Copyrights © 2025 | Third Horizon

3

3

Project Overview



Blaine County’s Mental Well-Being Initiative released a Request for Proposals in February 2025 to secure consulting services to support their strategic plan *Goal #4: Create a 24-hour mobile mental health crisis response system and crisis stabilization options.*

While the MWBI has already done extensive research and planning, the Initiative seeks external guidance to ensure the development of a sustainable, outcomes-focused crisis system rooted in national best practices but tailored appropriately to meet the needs of the Blaine County community.

Third Horizon will:

Develop a comprehensive mobile crisis response operational plan incorporating the county’s existing emergency response framework

Assess the feasibility of crisis stabilization settings that complement the mobile response system, ensuring seamless transitions for individuals in crisis.

Design a coordinated care model that enhances continuity of care beyond the initial crisis intervention.

Copyrights © 2025 | Third Horizon

4

4



Place-to-go Scenarios

Copyrights © 2025 | Third Horizon

5

5



Informing Research and Limitations

- Emergency Department and 911 Call Center Data Analysis
- Communities for Youth, Community Survey and Provider Survey Data Analysis
- Stakeholder Inputs: Workgroups 3&4, virtual meetings, and in-person work sessions
- Case study review
- Key Informant Interviews focused on finance and funding streams

Limitations:

- Rapidly changing federal and state policy and funding environment
- Awaiting more comprehensive emergency department data
- Project did not involve claims analysis, service utilization analysis outside of crisis data, or proforma development

Copyrights © 2025 | Third Horizon

6

6

Behavioral Health Crisis Centers



The phrase “somewhere to go” has been associated with many labels. Terms such as “crisis center,” “crisis walk-in center,” “crisis stabilization center,” “crisis receiving center,” and “crisis receiving and stabilization center” are sometimes used interchangeably. **Per Idaho statute Title 39, Health and Safety, Chapter 91, in Idaho, these facilities are termed “Behavioral Health Community Crisis Centers” or simply “crisis centers.”**

- Crisis centers help people in the midst of a behavioral health crisis by de-escalating, stabilizing, and providing access to community-based services or referrals.
- Because crisis centers are not considered residential or inpatient facilities, client stays are limited to 23 hours and 59 minutes (e.g., less than 24 hours).
- Clients may access crisis centers voluntarily through self-referral, or by referral (and often transport) by mobile crisis teams, or first responders.
- Services typically include triage, screening, assessment, immediate intervention, and referrals to longer-term services.
- The setting is often a less clinical environment, or “living room model,” in which clients can relax in recliners or couches. Refreshments, clothing, or other supportive services are sometimes available on site.



Copyrights © 2025 | Third Horizon

7

7

Case Study Themes



Funding diversification: each organization relies on a complex blend of state allocations, Medicaid and/or commercial insurance billing, county contributions, hospital partnerships, grants, and philanthropy to sustain operations.



Staffing models: The programs use a mix of licensed clinicians, bachelor's-level staff, and, in some cases, peer specialists. In all cases, the organizations have defined security measures, not security guards.



Care continuum: Each of the programs is part of a larger behavioral health provider organization, which helps ensure continuity of care and follow-up after a crisis.



Community partnerships: Interviewees identified collaborations with law enforcement, schools, hospitals, and local governments as vital.



Standardized screening: All programs utilize the Columbia Suicide Severity Rating Scale. Some use additional screening and collect data on key performance indicators.

Copyrights © 2025 | Third Horizon

8

8

What we Heard





Case Management (Care Transitions)



Same Day Access to Care



Navigation

Copyrights © 2025 | Third Horizon

9

Place to Go Options



1

CRISIS CENTER

Walk in 23-hour crisis center offering the services required by Idaho state guidelines

2

BEHAVIORAL HEALTH HUB

Walk in same day access for outpatient services with distinct operating hours

3

DIFFUSE MODEL

Diffused or non-centralized model placing new positions into existing programs or clinics

4

CCBHC MODEL

Seed grant for a Certified Community Behavioral Health Clinic (CCBHC) with continuous state advocacy

All models require service coordination across the community

Copyrights © 2025 | Third Horizon

10

1

Crisis Center



Definition: In Idaho a crisis must comply with all provisions of state and federal laws, rules, regulations, policies, standards, and guidelines. The purpose of a center is to provide 24/7 accessibility for patients

Operating Model Considerations

- Operating Hours 24/7
- Independent Space
- Magellan contract; per diem rate
- Accreditation requirements
- Adult Crisis Centers must have capacity for ten male/female beds for a total of twenty beds
- Most run at 60-80% capacity

Staffing Model

- A clinical supervisor
- One medical staff always on site
- Two staff always on site
- Required staffing ratios: 1 direct care staff for every three 3 clients
- Ability to provide 1:1 supervision as needed

Service Offerings:

- Individual, group and family counseling
- Parent/guardian education
- Relapse prevention
- Case management/care coordination
- Referral services
- Aftercare planning
- Safety planning
- Meets general facility requirements

Copyrights © 2025 | Third Horizon **Source:** [Idaho Medicaid Crisis Center Minimum Requirements](#)

11

11

2

Behavioral Health Hub



Definition: A walk-in center open specified hours offering screening, triage, appropriate intervention and case management.

Operating Model Considerations

- Operating Hours
- Facility
- Reimbursements
- Connectivity with mobile co-response model
- Assumes 30 visits per week

Potential Staffing Model

- Licensed BH Clinician (ideally able to address mental health and SUD)
- Case Manager
- Front desk staff (can be dual role)
- Care Navigator or Peer Support Specialist
- On-call Counselor(s) at specified hours

Service Offerings:

- Intake / Level of care assessment
- Case management
- Care navigation
- Crisis psychotherapy
- Psychotherapy
- Peer support

Unknowns: Operator roles and responsibilities (i.e., charting, billing, etc.)

Copyrights © 2025 | Third Horizon

12

12

3

Diffuse Model



Definition: Screening, triage, appropriate intervention and case management services located in different settings. This model could enable new service capacity added to existing programs or clinics to enhance the system of care.

Operating Model Considerations

- Operating Hours
- Shared Space
- Reimbursements
- Connectivity with mobile co-response model
- Assumes 30 visits per week

Potential Staffing Model

- Licensed BH Clinician (ideally able to address both MH and SUD)
- Case Manager
- Care Navigator or Peer Support Specialist
- On-call Counselor at specified hours

Service Offerings:

- Intake / Level of care assessment
- Case management
- Care navigation
- Crisis psychotherapy
- Psychotherapy
- Peer support

Unknowns: Operator roles and responsibilities (i.e., charting, billing, etc.), other service offerings

Copyrights © 2025 | Third Horizon

13

13

4

Certified Community Behavioral Health Clinic



Definition: A certified community behavioral health clinic must provide services to anyone seeking help for a mental health or substance use condition, regardless of their place of residence, ability to pay, or age. They must offer a defined set of services and staffing requirements as outlined by SAMHSA.

Operating Model Considerations

- Federally prescribed criteria for access standards, staffing, scope of services, data and quality measures, and governance

Staffing Model

- A CEO or other Project Director
- A Psychiatrist as Medical Director
- Licensed clinicians (MH and SUD)
- Peer support specialists
- A medically trained behavioral health care provider who can prescribe FDA-approved medications used to treat opioid, alcohol, and tobacco use disorders
- Other staffing determined by community needs assessment

Service Offerings:

- Crisis services
- Screening, assessment, and diagnosis
- Treatment planning
- Outpatient mental health and SUD
- Primary care screening and monitoring
- Targeted case management
- Psychiatric rehabilitation
- Peer support and family/caregiver services
- Community care for uniformed service members and veterans

Copyrights © 2025 | Third Horizon **Source:** [Team Based Care for CCBHC](#), [CCBHC Certified Criteria](#)

14

14



Cost Implications

Copyrights © 2025 | Third Horizon

15

15

Expenses





Capital Expenses



Personnel Expenses

Copyrights © 2025 | Third Horizon

16

16

Capital Expenses



Expenses	Description	Cost Type
Facility and Construction	Expenses to acquire, construct, or renovate a new space for a place to go	One-time with occasional maintenance
Furnishing, Fixtures, and other Office Supplies	Furniture such as chairs and desks required for staff and patient use	One-time with occasional maintenance
IT and Telehealth	Hardware and software required for EHR access, internet connectivity, and other virtual care	One time investment for hardware purchases with ongoing investment for software, additional licenses and IT support
Medical Equipment	Clinical or medical emergency equipment such as medication storage, blood pressure cuffs, etc.	One-time with occasional maintenance
Licensing and permits	Regulatory approvals if required	One-time with potential renewal fees
Other	Translation services, marketing materials, contingency capital placeholder, data and quality improvement	One time or ongoing

Copyrights © 2025 | Third Horizon

17

17

Scenario capital expenses



	1 Crisis Center	2 Behavioral Health Hub	3 Diffuse Model	4 CCBHC Model
Facility and Construction	New or Renovation	New or Renovation	N/A	New or Renovation
Furnishing and Fixtures	All new	All new	Potential use of existing resources	All new
IT and Telehealth	All new	All new	Potential use of existing hardware resources	All new
Medical Equipment	Required	May not be required	May not be required	Required
Licensing and Permits	Required	Required	May not be Required	Required
Other	Some costs required	Some costs required	Some costs required	Some costs required

Copyrights © 2025 | Third Horizon

18

18

Personnel expenses



Position Based on Bureau of Labor & Statistics Titles	Estimated Salary Range
All Models	
Clinical and Counseling Psychologist	\$64,020 - \$128,050
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	\$48,210 - \$75,920
Mental Health and Substance Abuse Social Workers	\$46,820 - \$83,170
Social and Human Services Assistant (i.e., Peer Support Specialist)	\$36,780 - \$53,100
Community Health Worker (i.e., Case Manager)	\$38,750 - \$74,640
Crisis Center or CCBHC	
Registered Nurse	\$79,130-\$97,200
EMT (Crisis Center Only)	\$21,640- \$48,880
Psychiatrist (CCBHC)	\$73,280 - \$124,070

Copyrights © 2025 | Third Horizon Sources: Estimated salaries from 2024 South Central Region Idaho or Idaho State Data , or National BLS listings based on availability

19

19

Illustrative Staffing Model Costs



	2 Behavioral Health Hub		
	FTE	Estimated Salary per Hour	Estimated Annual Personnel Cost Salary Only
Behavioral Health Counselor	1	\$36 (annual \$75k)	\$75,000
Peer Support Specialist /Front Desk	.5	\$25 (\$53k)	\$26,500
Case Manager/ Front Desk	.5	\$35 (\$74k)	\$37,500
On-call Counselors	.3	\$36 (\$75k)	\$22,500
Total	2.3		\$152,000

- Assumes a behavioral health counselor is always on-site during operating hours
- Assumes a peer and a care navigator play dual roles, seeing patients and front desk responsibilities
- Assumes dedicated on-call support
- Assumes a 40 hour work week with 20 visits per week for the counselor in scheduled visits with availability for walk-ins
- Assumes salary at the high end of the reported BLS Range

Copyrights © 2025 | Third Horizon

20

20

Personnel expenses



Other Considerations:

- Additional personnel related staffing costs may include but are not reflected recruitment and retention efforts, fringe benefits, etc.
- Other positions not listed may be necessary to support the clinical services (e.g., data analysts)
- Staffing FTE ratios will vary based on census, capacity, and service offerings
- Higher rates may be needed for Blaine County cost of living or bilingual staff

21

Funding Streams



Public and Private
Insurance Reimbursement



Philanthropy



Federal, State, and Local
Funds

22

Public and Private Insurance Considerations



- Rates may continue to fluctuate; As of November 1, Idaho Medicaid experienced a 4% rate cut with potential to continue to cut up to 15%
- Not all services may be covered under private or public insurance
- Services provided to uninsured individuals will not be reimbursable
- Due to federal changes to Medicaid in H.R., 1 it is likely there will be less eligible beneficiaries, higher rates of churn, and reduced federal match
- Affordable Care Act subsidies are still in question and, if not renewed, will likely also result in more people becoming uninsured
- Licensure, clinician type, or place of service requirement may exist within an insurance construct
- Reimbursement rates vary by provider type for certain services
- FQHC PPS rate does not include behavioral health crisis services
- Prior authorizations or other administrative tasks may be required for certain services or certain payers

Copyrights © 2025 | Third Horizon

23

23

Public and Private Insurance Reimbursement Rates



Code	Description	Commercial Range Blue Cross of Idaho	Medicaid as of 11/2025
90832	Psychotherapy w/ patient, 30 min	\$82.49 - \$304.00	Psychologist: \$63.38 Master's Level: \$56.77
90834	Psychotherapy w/ patient, 45 min	\$171.53 - \$304.00	Psychologist: \$95.10 Master's Level: \$85.17
90837	Psychotherapy w/ patient, 60 min	\$114.49 - \$304.00	Psychologist: \$112.95 Master's Level: \$101.16
90839	Psychotherapy for Crisis, initial 60 minutes	\$155.32 - \$304	\$143.64
90840	Psychotherapy for Crisis, additional 30 minutes	\$77.03	\$68.72
T1017	Case Management, Behavioral Health w/ or w/o Care Coordination Activities; per 15 min	None Found	\$17.17

Copyrights © 2025 | Third Horizon *Source: Medicaid, BC of Idaho*

24

24

Public and Private Insurance Reimbursement Rates



Code	Description	Commercial Range Blue Cross of Idaho	Medicaid as of 11/2025
H2011	Crisis Intervention; per 15 minute	Not found	Psychologist: \$38.59 Master's Level: \$34.55
H0030	Crisis response (telephonic); per call	\$23.00 - \$60.00	Psychologist: \$39.96 Master's Level: \$35.78
H0038	Adult Peer Support; per 15 min	Not found	\$14.15
H0038 HB	Adult Peer Support Group; per 15 min	Not found	\$7.08
S9485*	Crisis intervention mental health services on a per diem basis	Not found	\$390 per 24 hours

*Only available for Crisis Centers

Copyrights © 2025 | Third Horizon *Source: Medicaid, BC of Idaho*

25

25

Philanthropy



OPPORTUNITIES

- St. Luke's Wood River Foundation has continually raised mental health as a priority issue in the county
- Blaine MWBI, now as a 501 c 3, can pursue other private grant funds

CONSIDERATIONS

- Strong marketing and stakeholder communication needed for community or funder buy-in
- Funding may be flexibly used for capital or infrastructure requirements dependent on the limitations of the donors
- Funding amounts may be variable and only available at certain times
- Blaine MWBI plays a critical role as a "backbone" organization and will also need to achieve sustainability

Copyrights © 2025 | Third Horizon

26

26



Local Funds

OPPORTUNITIES	CONSIDERATIONS
• Tax Levy or bond has been used in the past to fund community priority capital projects • Community services agreement allocate small funding amounts to community partners	• Requires ballot initiatives initiated by the board of county commissioners • Funding amounts may be variable and only available at certain times

Copyrights © 2025 | Third Horizon

27

27



Federal and State Funds

OPPORTUNITIES	CONSIDERATIONS
• Rural Health Transformation Funding • CMS will announce awards by December 31, 2025 • Idaho DHW will post competitive solicitations for the proposed activities under the five initiatives • CMS/SAMHSA CCBHC Medicaid Demonstration • SAMHSA CCBHC Grants • Other federal funding for behavioral health such as through SAMHSA, HRSA, or the CDC • Idaho Department of Health and Welfare behavioral health grants	• Funding amounts may be variable and only available at certain times • Grants are competitively awarded • Grants must align with current administrations priority with accordance to the <u>"Improving Oversight of Federal Grantmaking"</u> executive order • There are currently no FY2026 grants listed on <u>SAMHSA's grants dashboard</u>

Copyrights © 2025 | Third Horizon

28

28

Considerations for Utilization



Scenario Modeling	Estimate Blaine County Population	Utilization Rate	Average Visits/Person /Year	Annual Visits	Weekly Visits
Low	25,000	3%	1.7	1,275	25.5
Medium	25,000	4%	1.7	1,700	34
High	25,000	5%	1.7	2,125	42.5

Notes

- Utilization rates are for planning estimates. The 2023S SAMHSA Uniform Reporting Summary identified a community utilization rate of 6.11 per 1,000 people in Idaho. The estimate can continue to be refined as more data is received.
- There is limited published data on visits/user/year in rural walk-in BH access settings; assumption reflects conservative estimate based on fewer outpatient visits in rural settings. The average visits per person per year is based on the annual behavioral health visits per patient at a FQHC which was 3.4 in 2019.

Copyrights © 2025 | Third Horizon

29

29

Thank you!

Discussion



Copyrights © 2025 | Third Horizon

30

30