

Meeting Purpose and Participants

The Safe Place for Help subgroup met on September 3, 2026, to continue its work to improve coordination and continuity of care across Nevada's crisis response system. The discussion focused on how 988, and other crisis services connect people to crisis stabilization and inpatient behavioral health care, where referral and placement processes break down, and what practical resources may help agencies make more effective warm handoffs.

Representatives participated from inpatient behavioral health facilities, crisis stabilization centers, 988 and crisis contact services, Medicaid, state and local government, rural behavioral health partners, hospitals, community-based organizations, and advocacy groups. Inpatient and crisis-service representatives included Northern Nevada Adult Mental Health Services (NNAMHS)/Dini-Townsend Hospital, Carson Tahoe Behavioral Health, Renown Crisis Care Center, UMC Crisis Stabilization Center, Rural Nevada Counseling, Carelon Behavioral Health, and Crisis Support Services of Nevada.

The meeting was designed as an open discussion, encouraging member participation. Participants were asked to describe current referral and placement practices from both the crisis service and inpatient-provider perspectives, identify system gaps, review early experiences with the new closed-loop referral platform, and recommend priorities for future subgroup meetings.

Current Connections Between Crisis Services and Inpatient Behavioral Health Care

Crisis service providers described inpatient placement as a process that generally works best when referral teams have current information about facility capabilities, accepted insurance, admission criteria, and available points of contact. Participants also emphasized that the placement experience varies considerably by geography, time of day, staffing, the person's clinical presentation, and the availability of appropriate step-down or residential resources.

Participants identified several groups for whom appropriate inpatient admission, residential placement, or safe discharge planning can be especially difficult:

- Children and adolescents with significant behavioral needs, particularly when they will require residential treatment or another intensive level of care following inpatient stabilization
- Older adults who require geriatric behavioral health services or who have co-occurring medical and behavioral health needs
- People with intellectual or developmental disabilities, autism, traumatic brain injuries, or other disabilities whose needs may be mistaken for a primary psychiatric crisis

- People on a legal hold, especially when insurance limitations, acute psychosis, or the complexity of the hold reduce the number of facilities able to accept the referral
- People with chronic behavioral health conditions who need inpatient support but do not meet legal-hold criteria
- People whose histories include sex offenses or arson, which can substantially limit licensed residential and housing options because of program eligibility or insurance restrictions

Carson Tahoe Behavioral Health reported that placement challenges are most pronounced at the two ends of the age spectrum: youth with complex behaviors and older adults requiring geriatric care. UMC's Crisis Stabilization Center similarly identified people with developmental disabilities as difficult to place, particularly when responders or referring partners have difficulty distinguishing behavioral manifestations of a disability from an acute psychiatric condition.

Renown noted challenges placing people on legal holds, while Carson Tahoe described the converse problem of finding care for people with chronic conditions who are not on a legal hold.

Insurance, Housing, Transportation, and Workforce Barriers

Insurance remains a major practical barrier. Referring providers may not know which plans a facility accepts, and that uncertainty can delay placement while staff verify eligibility, seek alternative facilities, or help a person enroll in coverage.

UMC noted that its case-management partners complete much of this verification and placement work, but the broader system would benefit from clearer, current information about facility insurance requirements.

Housing and step-down placement were repeatedly identified as system-wide challenges. Facilities may be able to stabilize a person clinically but remain unable to discharge the person safely because appropriate supportive housing, licensed residential homes, or specialized placements are unavailable. This contributes to longer inpatient stays, reduced bed availability, and repeated cycling through hospitals and crisis services.

Transportation can create another break in the placement chain. Rural providers described situations in which a bed becomes available, but transportation cannot be arranged quickly enough, causing the receiving facility to release the bed. Workforce shortages also restrict capacity: a physical bed may exist, but the facility cannot open it without sufficient qualified staff.

NNAMHS and Dini-Townsend Hospital Referral and Discharge Practices

Julie Lindesmith, Agency Manager for Northern Nevada Adult Mental Health Services (NNAMHS), explained that Dini-Townsend Hospital serves as a safety-net inpatient provider. The hospital is relatively small, and construction is temporarily reducing its capacity further. Because demand exceeds available space, referrals are prioritized according to need and the availability of other placement options.

Dini-Townsend Hospital generally gives first priority to people who are uninsured, followed by people who are underinsured, including individuals with coverage that many private hospitals do not accept. Referrals from rural hospitals receive the next level of priority because those hospitals often have very limited capacity to hold patients safely. Insured individuals who may be served by another hospital are generally considered after these higher-priority groups. As a result, a facility may not be able to provide a fixed position on the waiting list because a newly referred, higher-priority patient may need to be placed first.

NNAMHS is currently receiving referrals through fax and email. It is not yet participating in the Carelon closed-loop referral system because its agreement remains under legal review. Once participation is approved, NNAMHS expects the platform to improve the speed and consistency of communication with referring hospitals.

NNAMHS also experiences extended lengths of stay because many admitted individuals have cycled repeatedly through emergency and inpatient care. Rather than discharging someone to homelessness or another setting that has repeatedly failed, the team attempts to develop a more sustainable discharge plan. NNAMHS uses multidisciplinary team meetings and other collaborative planning approaches to identify longer-term solutions.

State funding can only be used for placement in licensed homes, but Washoe County has very few licensed residential homes. NNAMHS has developed a flyer explaining how prospective providers can become licensed and contracted with the State and encouraged partners to help distribute it.

For placement questions or current wait-time information, providers may contact NNAMHS at 775-688-0522. The main admissions nurse, Coral, may be contacted directly at 775-688-0533. Julie Lindesmith may also be reached at jlindesmith@health.nv.gov, although email responses may not be immediate.

Improving Communication Between Referring and Receiving Facilities

Participants agreed that effective referral coordination depends on both accurate clinical information and reliable communication. Receiving facilities may request a direct provider-to-provider or physician-to-physician conversation to clarify the person's presentation and determine whether the facility can safely meet the person's needs. Delays occur when a referral is submitted but the referring organization is not responsive to follow-up questions.

Several participants noted that staff do not always know the correct number or role to contact at another facility. A nursing-station number may be available, but nurses may be engaged with patients and unable to answer promptly. Members discussed whether facilities should identify an alternate contact, such as a quality or risk-management representative, who could receive time-sensitive placement calls and connect the caller with the appropriate clinical staff.

The discussion highlighted the need for a more dependable communication pathway between referring and receiving organizations. Participants suggested that this issue may require both an updated contact resource and additional training so staff understand whom to contact, what information must accompany a referral, and how to escalate a time-sensitive request when the primary contact is unavailable.

Closed-Loop Referral System: Early Implementation Feedback

The group reviewed the transition from OpenBeds to Carelon's closed-loop referral system. The platform is intended to allow 988 crisis counselors and participating partners to identify appropriate services, submit referrals, and receive information about whether a referral was accepted. Participants emphasized that the system is still in an early implementation stage and that the current experience is based on a small number of participating providers and referrals.

UMC's Crisis Stabilization Center reported that it had used the system for approximately two weeks. They receive referral notifications by email and had observed approximately three or four notifications on some days. Based on this limited early experience, the process was functioning reasonably well, but they recommended allowing more time and collecting more referral activity before drawing broader conclusions.

The current group of receiving providers is composed largely of organizations that had previously participated in OpenBeds. Some rural organizations and other referral partners were not OpenBeds users and therefore are not yet active in the new system. Carelon and State partners are developing a plan to enroll additional receiving providers. A later phase will expand participation to other referring organizations.

Carelon encouraged each enrolled provider's system administrator to review the organization's profile and confirm that listed services, eligibility requirements, and referral capabilities are accurate. Some information was updated during onboarding, but gaps remain.

- Providers needing assistance or corrections should contact the Nevada Crisis Safety Platform help desk at Nvcsphelpdesk@carelon.com. Amber Allen may also be contacted at a.allen@health.nv.gov.

Warm Handoffs Between 988 and Facilities

Members discussed when and how a warm handoff should occur between 988, crisis stabilization services, inpatient facilities, and other community resources. Crisis-contact representatives explained that there is not a single procedure that applies to every situation. The appropriate response depends on the help seeker's needs and consent, the services available in the person's location, the time of the call, facility operating hours, staffing, transportation, and the clinical urgency of the situation.

A warm handoff attempted during normal business hours may be substantially different from one attempted overnight. Participants therefore cautioned against defining a successful handoff only as a standardized step or script. At a minimum, staff need enough knowledge about available services and referral procedures to make an informed connection, and whenever possible the handoff should directly connect the person with the next provider rather than merely giving the person a telephone number or written resource.

Carelon previously presented information to the Coalition explaining how warm handoffs and resource referrals occur within 988. Mai Tran agreed to locate and send that presentation to Brent Andriese so it can be redistributed with this meeting summary as a refresher for new and returning Coalition members.

Bojana Vujeva shared that Washoe County partners developed a warm-referral matrix identifying contact numbers, hours, procedures, and the circumstances under which different agencies should initiate referrals. Although the matrix itself does not complete a warm handoff, it provides staff with a practical first step by clarifying whom to call and what process to follow. The matrix was recommended as a potential model for other regions and will also be shared with this meetings summary report.

Education, Awareness, and Facility Familiarity

Participants emphasized that staff are more likely to make appropriate referrals when they understand what each component of the crisis response system actually provides. UMC encouraged Coalition members and frontline personnel to tour the Crisis Stabilization Center so they can better understand its environment, eligibility considerations, workflow, and role as a safe place for help.

For future subgroup work, Christian Raymer recommended moving beyond general discussion of warm handoffs and identifying concrete ways participating agencies can extend crisis-system education within their own organizations and communities. This could include selecting a priority audience, agreeing on the most important information that audience should understand, developing consistent language, and assigning partners to distribute or present the information.

Members agreed that shared language is important. Consistent messaging about 988, mobile crisis response, crisis stabilization, and inpatient care can reduce confusion, improve referral quality, and help community partners understand the distinct role of each service within the crisis continuum.

Potential Priorities for Future Subgroup Meetings

The discussion identified several issues that may warrant focused work during future meetings:

- Examine communication gaps between referring and receiving facilities and identify reliable primary and alternate contacts
- Use the Washoe County warm-referral matrix as a possible model for documenting regional contacts, hours, referral conditions, and escalation procedures
- Develop shared educational messages and identify specific audiences that would benefit from greater understanding of crisis stabilization and other safe-place-for-help services
- Explore how transportation delays affect placement, particularly for rural communities
- Continue discussion of housing, specialized residential care, and discharge barriers for people with complex needs
- Identify manageable system gaps that the subgroup can address through incremental, clearly assigned action steps

Participants acknowledged that many of these barriers have existed for years and cannot be resolved through a single meeting. The subgroup can add value by documenting where the system chain breaks, selecting a limited number of priority issues, and working on practical improvements over time.

Meeting Cadence Schedule

Members provided support for continuing the Safe Place for Help subgroup's current meeting structure in 2027, continuing with quarterly meetings held on Thursdays for 90 minutes. Coalition staff will develop the 2027 meeting cadence based on that direction.

Next Steps

- Mai Tran will send the prior Carelon warm-handoff presentation to Brent Andriese for distribution with the meeting summary.
- Brent Andriese and Bojana Vujeva will locate the Washoe County warm-referral matrix for distribution as a resource and potential template.
- Coalition coordinators will include the warm-handoff presentation, referral matrix, and captured follow-up items with the final meeting materials.
- Administrators for organizations enrolled in the closed-loop referral system should verify that their service descriptions and referral information are accurate and request corrections when needed.

- Participating providers should report closed-loop referral problems directly to Carelon or Amber Allen so issues can be tracked and addressed.
- Carelon and State partners will continue planning for enrollment of additional receiving providers and, during the second phase, other referring organizations.
- Coalition coordinators will use the identified communication, education, transportation, housing, workforce, and placement gaps to shape future subgroup agendas.
- Coalition staff will develop the subgroup's quarterly Thursday meeting cadence for 2027.

The next Safe Place for Help subgroup meeting will be held on Thursday, December 3, 2026, from 1:00 to 2:30 p.m.