Webinar #3: Facility-Based Crisis Stabilization
Meeting Notes
Tuesday, June 30, 2020
9:00-10:30am

The third session in the Nevada Crisis Response System Virtual Summit webinar series once again drew over 100 attendees representing all of Nevada's 17 counties. The following panelists participated in the Webinar: Jamie Sellar, Chief Strategy Officer, RI International; Mary Hoefler, Manager, Crisis Services, Colorado Office of Behavioral Health; Megan Lee, Manager, Crisis Services Adult Treatment and Recovery, Colorado Office of Behavioral Health; Theresa Carsten, Chief of Managed Care Compliance, Division of Health Care Financing and Policy; and Michelle Sscot, who provided a lived experience perspective.

Kelly Marschall with Social Entrepreneurs, Inc. (SEI), welcomed participants to the third session in the webinar series and shared the objectives for the webinar, which included a review of the key components of facility-based crisis stabilization and Colorado's and Maricopa County's approach to this, a discussion of the rural and urban differences in implementing facility-based crisis stabilization, and how facility-based crisis stabilization is used in a crisis care system.

The first panelist was Jamie Sellar, who presented on facility-based crisis stabilization and programming in Arizona. He explained that there are various terms used in different states for "crisis" services and that in a Crisis Now model, it's important to be clear that you are operating under a "no wrong door approach" that accepts anybody, anytime. More specifically, this means there is an ability to admit 24/7, accept direct referrals from the community, and the goal should be diversion away from emergency departments and jails. The "no wrong door" approach also means that guests are admitted regardless of an involuntary status, substance use disorder (SUD) issues, potential for violence, medical status, Intellectual or Developmental Disabilities (I/DD) issues or readmission status.

Mr. Sellar explained that the goal of a crisis center is to offer stabilization and support and noted that the majority of guests are stabilized within first the 24 hours and the rest are usually stabilized within two and a half to three and a half days. He noted that the current literature from SAMHSA generally supports that crisis residential care is as effective as other longer psychiatric inpatient care at improving symptoms and functioning, there is strong satisfaction among guests, and the overall costs for residential crisis services are less than traditional inpatient care.

He explained how crisis stabilization facilities should function as an integral part of a regional crisis system serving the whole population, and described how they should operate in a home-like environment as much as possible, utilizing peers as integral staff members. Another important factor is to have 24/7 access to psychiatrists, as this is a key component for achieving the short-term length of stay.

An essential practice for crisis stabilization facilities is direct law enforcement drop offs. Mr. Sellar shared that Maricopa County has accepted over 20,000 admissions out of the back of a police car since 2014, and have "said yes" 100% of the time. He noted that about two to four percent of the time they

will need to send a guest out for medical stabilization, but they do that following a screening. He reiterated why "no wrong door" is important, explaining that when you say "no" to a police officer, they will frequently take that as the facility is no longer an option to drop someone off and in the future will instead turn to the emergency department, jail, or leave the person in the community. This is why it is imperative to give a 100 percent guarantee and assurance that the crisis stabilization center will always accept the people that are dropped off.

Mr. Sellar explained that the Crisis Now model provides two levels of care side by side on the same campus, which may be separated by a hallway, but are under the same roof and licensed separately. The first component is comprised of a 23-hour observation unit, and is operated as an outpatient program and still has the ability for seclusion and restraint. This component utilizes recliners as opposed to beds for two reasons: 1) if the facility is licensed for a recliner, it's not as big of an issue if you go over capacity, and 2) it creates the optic for the guest you serve that you are here to work and the primary intervention isn't sleep and medication. He noted that the staffing variability is dramatic. For example, at their Peoria facility there are currently between 20-24 guests, but that will start to ramp up when the sun goes down and it's important to be able to staff appropriately.

The second component is a short-term psychiatric hospital with about 16 beds per unit (due to the IMD exclusion). There are firm limits on capacity and a predictable staffing model (often 85-100% capacity). He explained that this second unit is a transferred admission, so guests are triaged through the 23-hour observation unit.

Mr. Sellar shared that 70 percent of guests leave in the first day and the average length of stay is between 16-18 hours. If a guest is on an involuntary status, the goal is to convert them to become an active participant rather than a passive recipient. He explained that it's important to make it easier for police to drop off at a crisis stabilization center rather than an emergency department or jail, and therefore the drop off time needs to be under five minutes. The current average facility drop-off rate is three to four minutes.

He also explained that there has to be a different culture at crisis stabilization centers. One way this is achieved is through the utilization of certified peer support specialists. They emphasize a high-tech, high-touch approach with enough specialized staff to meet state requirements but use a peer workforce to make sure guests are served. In a true crisis receiving model, it is critical to start thinking of patients as guests, and have staff out engaging guests and creating a warm, welcoming living room style approach. Mr. Sellar shared a video demonstrating the fusion model of crisis facilities that further demonstrates the welcoming approach.

Webinar participants asked Mr. Sellar the following questions: Nancy Snyder asked, "What is your smallest successful site in terms of daily guests and staffing?" Mr. Sellar answered that one program in Delaware is only ten chairs, and the reality is that they can't accept everyone. He recommended a combination 16 chairs and 16 beds as the smallest option for business development. Webinar participant Amy Roukie asked, "Is there a license as a psychiatric hospital due to it being a secured/ locked setting?" Mr. Sellar answered that all states are different; in Arizona it is first licensed as an outpatient facility but they are certified to do secure and restraint. He noted that he had previously

provided testimony for Nevada's AB66, the goal of which was to create an avenue for a license to be created that had requirements to offer a facility-based crisis center.

Mary Hoefler spoke next on the implementation of facility-based crisis stabilization in Colorado, and shared that in the first five years, all of their walk-in crisis centers initially had to be open 24/7. However, they learned there's not a lot of activity between about 11pm and midnight until the morning, so for the next five-year period they asked for only one 24/7 walk-in center per region. Some walk-in centers are now closed from midnight to 7am, or have limited hours.

Ms. Hoefler shared some of the challenges Colorado has faced, including the standardization of procedures and policies, and workforce issues such as recruiting and retaining licensed staff. She explained that walk-in centers have to have access to a medical professional for a health screen when it's indicated, and there are nursing shortages in many regions. She emphasized that the walk-in centers are not a medical clinic and unlike their colleagues in Arizona that can provide seclusion and restraint, there is no way to force anyone to stay. Another challenge highlighted by Ms. Hoefler and Ms. Lee is in treating children and adolescents, with only one crisis stabilization unit in the state taking this age group.

A webinar participant asked: "For your walk-in center, how are you currently funded? It sounds like if you are able to take anyone, you must be supported by unrestricted state funds? Especially with the high level of staffing costs." Megan Lee replied that the centers are largely funded through state general funds with some supplemental funding of federal block grant dollars and other smaller grants. She explained that they will bill Medicaid and other insurance first and use Colorado funding as a last resort.

A slide was shown detailing walk-in center outcomes. The majority of people go home with a referral to outpatient behavioral health, and a very small number are admitted to a higher level of care. Webinar participant Megan Freeman asked what the "other" outcomes included and it was answered that it can include things that they don't identify specifically on their outcome form such as homeless shelter, law enforcement involvement, medical basic needs, etc. It was discussed that a data system showing that you can have more than one outcome would be helpful. Colorado's system only allows them to select one outcome, which provides a rough picture rather than a detailed look at what happens.

Webinar participant Travis Atkinson asked, "what steps do people have to go through in order to be admitted to respite/residential care?" Ms. Hoefler explained that for respite care there is no medical clearance and that respite facilities are sometime facility-based or are run in-home by peer support specialists.

The next panelist, Theresa Carsten, explained that Nevada Medicaid is moving toward a contract amendment with their health plans to cover residential crisis stabilization facilities that are SAPTA-certified 3.5 co-occurring and are also licensed by the Health Care Quality and Compliance (HCQC) within the Department of Health and Human Services. Webinar participant Kim Gilbert asked if this was only for managed care and if it excludes fee-for-service clients. Ms. Carsten answered that it would exclude fee-for-service clients. Ms. Marschall noted that this is something that could be discussed in more detail in the assets and gaps discussion in Webinar #7.

Michelle Sscot provided a lived experience perspective, sharing what was helpful and what was not helpful in her experience in inpatient settings. She explained that she had several hospitalizations and the most helpful thing was knowing that during every shift change, someone would come and check in with her. It also helped when staff would be respectful and acknowledge what she was saying so she felt heard. A staff member even worked to advocate with her insurance company for a longer stay and to help secure cloth scrubs that fit properly in a timely manner.

Ms. Sscot detailed how the Wellness Recovery Action Plan (WRAP program) helped, explaining that having a diverse selection of music and the ability to do art, decorate rooms and have outdoor access was beneficial.

She described an unhelpful visit where she was handcuffed and taken to the hospital for a blood test, even though she told them she hadn't taken a substance. She had to wait in jail for several hours for a bed to be available and was put in jail clothes and in a cell without even a toilet seat. She shared that she was transported from Gardnerville to Reno in handcuffs, and that the people who examined her upon arrival talked to each other about her cuts and injuries as if she weren't there. She explained that she didn't see a doctor for the first 24 hours, and was taken off her medications and became extremely agitated and suicidal. She noted that the staff would have conversations behind the counter and not interact with clients. She asked for anxiety medication and was told "no," so she went to her bedroom and without anyone noticing, tried to choke herself with a sheet, and punched a hole in the wall. The facility's response was to have a large man come and tell her to "stop it." She added that there were no notes about this given to her doctor in her chart. She was released the next day, even though she was suicidal.

Ms. Sscot suggested that it would be helpful for facilities to play a diverse range of music and engage with clients. She explained that calling clients by their name or whatever their preferred nickname is would be helpful as well as having staff check in with clients at the change of every shift. She also noted that giving clients something to help distract them while making it accessible to the level of attention of the person at that time is extremely helpful. She ended by saying that it's relationships and communication that builds trust.