The Critical Role of Crisis Receiving Centers in Urban & Rural Communities

CIT International Conference Seattle – 2019
Introductions

- **Law-Enforcement**
  - Regions
  - Urban/Rural
  - Perspective of Program Status

- **Family, Consumer, Advocate**

- **Behavioral Health**
  - Regions
  - Urban/Rural
  - Crisis or Outpatient
  - Funder
The 5 “Legs” Of a CIT Program

- Law Enforcement Training
  - 40 Hour Advanced/Voluntary Students
  - Community Instructors
- Community Collaboration
  - Law Enforcement, Providers & Consumers/Families
- Vibrant Accessible Crisis System
  - “No Wrong Door” Approach
  - Expedient – Quick & Certain Responses
- Behavioral Health Provider Training
- Education for Family, Consumers, Etc.
Effective Crisis Response for Police
Remove the Barriers!

3 Main Elements
Services & Accessibility based on “Customer Service” as defined by the needs of the Cops

1. **No Wrong Door Philosophy** (They can enter anywhere, and Behavioral Health Providers can move amongst their system)
   - MH/SA/T19/N-T19, etc.
   - Not too 390 or not 390 enough, STO, “Ping-Pong” (i.e. don’t “U.M” them)
   - Need Medical Clearance, etc.

2. **Expedient – Quick Turn Around**

3. **If Mobile Response – Quick & Certain Responses (not “triage“)**
“Big Picture/Lasting Effects”
We’re encouraging philosophy shift & far reaching consequences

Annual Phoenix Metro PD Handoffs to the Crisis System

![Bar Chart]

Average Annual Hand-offs

- Detox/Voluntary Psych Eval
- Mobile
- Pysch Center - Involuntary

23,635!
“Receiving Centers”
“Receiving Centers”

- Receiving Centers Serve a Vital Role in Vibrant CIT Programs
- 24/7 Accessibility
- Requires an Organizational “Culture” to Operate Effectively as a “No-Wrong Door”
- Diversion & alternative for Law Enforcement, local Hospitals & Urgent Cares
- Options for friends, families, and Community.
Some Advantages

1. Community Based
2. Designed Specifically to work with clients with Behavioral Health Needs
3. Built on Welcoming & Trauma Informed Care Environment
4. Designed with goal of rapid stabilization and (re)connection to ongoing services vs lengthy stays
5. Increased opportunities to connect individuals to ongoing “outpatient” care, etc.
CBI’s Statewide System of Care

- 1,500+ Employees, 30 Locations
- Peer Support & Outreach (600 Peers)
- Access Point / Transition Point (x2) (Crisis Entry Point)
- Crisis Stabilization & Inpatient Psychiatric (x1)
- Crisis Stabilization & Medical Detoxification (x3)
- Residential Treatment/BIP (x5)
- Rural Stabilization & Recovery Units (SRU’s) (x2)
- Psychiatric Services (Telemed to all locations)
- Medically Supervised Treatment
- Tele-med Statewide (Hard-wired at each location)
- Housing the Homeless (300 units available)
- Veterans Outreach (3 programs)
- Patient Centered Medical Centers (11 locations)
- Outpatient Opioid Medical Detox Co-locations (including Prescription Medication)
- Permanent Supportive Housing for Women (3 fourplexes; 500 vouchers)
- Women’s and Children’s Programs (Transitional and Supportive Housing)
- Prevention & Community Education
CBI Programs FY 18/19

- Crisis Observation (5)
- Inpatient Facilities (9)
- Residential/TP (9)
- PCMH (9)
  - MAT/OTP (6)
  - ACT Teams (2)
  - FACT Teams (4)
- Housing Units (600+)

Crisis Beds/Chairs – 155
Inpatient Beds – 142
Residential/TP Beds – 164
• Front door to the behavioral health system – **Hand-off**
• Assess for ongoing services, provide brief intervention, group and individual sessions, as needed
• Provide support and resources
• Coordinate ongoing care through formal and natural supports
CBI Facilities that Serve as Front Door of Crisis System

Community Psychiatric Emergency Center (CPEC)
50 crisis chairs
16 inpatient beds

Central City (CCARC)
32 crisis beds 16 detox beds

East Valley (EVARC)
11 crisis beds
16 detox beds

West Valley (WVAP/TP)
26 crisis chairs
41 transition point beds

Tucson Toole
40 crisis chairs
32 inpatient beds
28 transition point beds

Total 2017 Crisis Admissions: 56,699
Community Bridges Total Law–Enforcement Drop Offs

- 2016 – 8,116 Drop–Offs
- 2017 – 8,988 Drop–Offs
- 2018 – Averaging Over 700 a month

- Average PD turn–around time is under 3 minutes.

- How Many were declined???
What is your Program Mission?
- Voluntary?
- Involuntary?
- Co-Occurring?
- Co-Morbid Physical Health Care?

Goals
- Person
- Police/First Responders
- Community
- Payers
# Receiving Centers

## Services

- **What services will be provided**
  - Evaluation/Assessment
  - Treatment
  - Medications
  - Seclusion/Restraint
  - Licensing required for services
  - Covered services (payor implications)

## Considerations

- **Criteria for services**
  - No wrong door philosophy
  - No Authorization needed
  - Dedicated Law-Enforcement Entrance

- **Patient Flows**
  - Admissions
    - How do people get to the center
    - What happens when a person gets to the center
  - Treatment
    - What happens while a person is at the center
  - Discharge
    - How do people leave the center
Receiving Centers
Funding Considerations

- Who will pay for services
  - Medicaid
  - Commercial

- Funding/Reimbursement methodology

- Licensure/Accreditation
  - State regulations
  - Medicaid/Medicare requirements
  - Accreditation

- Stakeholders/Customers
  - Who are the customers?
    - Law enforcement/First Responders
    - Hospitals/EDs
    - MCOs (funders)
    - City
    - Community/Neighbors
    - County
Receiving Centers
Staffing Considerations

- 24/7 staffing – Various Shifts & types
- Professional Staff
  - Medical practitioners (e.g. MD/DO, NP, PA)
  - Nurses
  - Social Workers
  - Telemed
- Paraprofessional staff
  - BH Technicians (milieu management)
  - Peers
- Administrative staff
  - Phones, Registration, Billing
- Management
  - Medical Director
  - DON
  - Quality, Compliance, Administration
  - Clinical/Social Services
How to Operationalize

1. Get leadership to believe it
2. Change operations to meet it
3. Train people
Integrated Services

- Psychiatric Services–NP, Psychiatrists, RN
- Substance Use Treatment–Medical detoxification, Counseling, MAT Services
- Medical–Physical health treatment and PCP services.
Discharge Planning

Considerations

- ASAM Criteria
- Natural Support Involvement
- Outpatient / WRAP services
- Medical Needs
- Bridge Scripts
- Transportation
- Housing – Recovery Homes, Family, Independent Living, Residential, etc.
- “Impact” on surrounding Community
Importance of Collaboration

- Regular meetings and collaboration i.e.
  - Police
  - Funders
  - Stakeholders
  - Partner Agencies
  - Etc.
Rural Considerations

- Community Needs
  - Distance
  - Population Density

- Access to Services
  - Medical
  - Behavioral Health

- Transportation

- Cultural
Rural Considerations

Stabilization and Recovery Unit Overview

*Front Door for Rural Communities*
Staffed 24/7 with an EMT and a Peer Support Specialist
- Withdrawal Monitoring and supported by 24/7 Triage RNs–Reviews medical and withdrawal symptoms for each admission
- Follow-up for behavioral and physical health with a qualified Medical Practitioner
- Outpatient Treatment Center co-located for behavioral health support and ongoing care
- Tribal supports in place for specific programming
- Peer Support Services - Utilizes Living in Balance curriculum to address substance abuse, physical health and wellness, vocational, and recovery skills
- Access to inpatient behavioral health services for medical detoxification and other services in geographic area, when needed.
- Transportation and ongoing outreach
Telemedicine Capability

- 24/7:
  - Medical Screenings – Immediate Treatment
  - Urgent Psych Assessments
  - Ambulatory Detoxification
  - Bridge Scripts
  - Routine Treatment
  - Addiction Medicine
The Power of Peers in Crisis Services

CBI Peers help to navigate the “Recovery Journey”

Crisis Peers transform despair into hope...
Peer Support

- Peer Support are Integral to every stage
- Serve as a guide during intervention
- Critical role reducing anxiety and building “therapeutic alliance”
- Filling critical community gap
- Advocacy
- Discharge Planning & Coordination of Care
- Integrating Peers throughout Programs
- Integrating Peers throughout our Community
Questions?
Gabriella Guerra, Chief of Programs
- Community Bridges, Inc.
- Gguerra@cbridges.com

Jamie Pothast, Sr. Director of Crisis
- Community Bridges, Inc.
- jpothast@cbridges.com

Nick Margiotta, President
- Crisis System Solutions
- Margiotta.nick@gmail.com