Crisis Stabilization: Effective Strategies for Reducing Hospitalizations within a Community Residence Setting

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Overview of Today's Session

- Introductions & a little about RSS

- What is CDSS?

- What has worked?

- Obstacles & how we overcame them

- Interventions used to reduce hospitalizations

- Our Outcomes

Our History & Services

- Founded in 1979

- Provide community-based mental-health and substance abuse services for children and adults

- 13 counties throughout NYS

- OMH Licensed group homes, Supportive and Transitional Apartment Programs

- PROS Services

- Clinic

- Supported Employment

- Affirmative Businesses

Counties Where We Provide Services
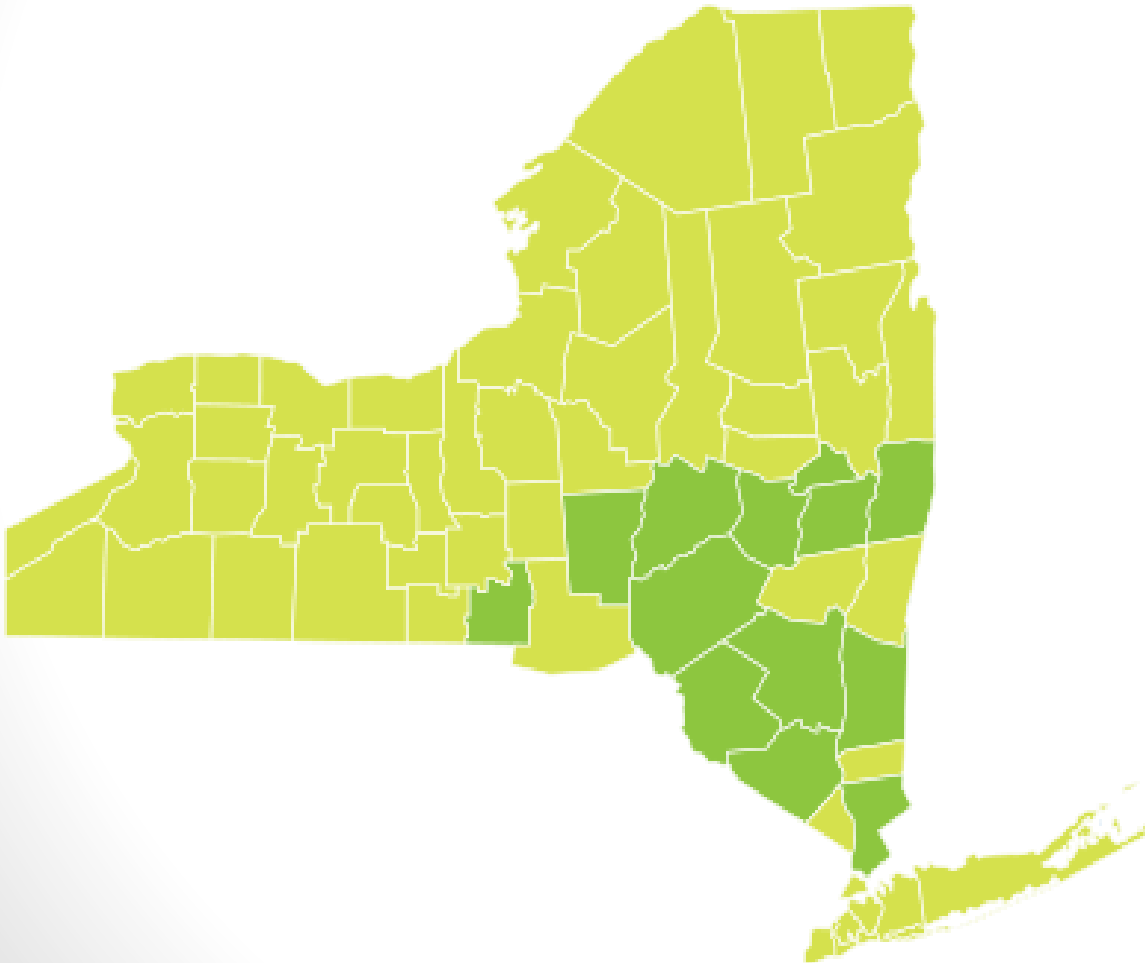
- Albany
- Chenango
- Delaware
- Dutchess
- Orange
- Otsego
- Rensselaer
- Schenectady
- Schoharie
- Sullivan
- Westchester
- Tioga
- Ulster

How did CDSS begin?

- Grant funded from OMH with MRT dollars

- A recognized need to divert individuals from the hospital/Crisis/ER when possible

- Acknowledgement that hospitalizations are preventable at times

- The need for an environment where individuals can safely manage their symptoms with increased supports

- CDSS opened officially on 3/16/15

What is CDSS?

- A short-term stabilization program
- Services are available to 9 different counties within NY:
  - CDPC's catchment area: Albany, Schenectady, Rensselaer, Saratoga, Warren, Washington, Columbia, Greene, Schoharie
- Staffed 24/7
- Supervised by a Licensed Mental Health Counselor
- Hospital/Crisis/ER Diversion
- Hospital Step-down services
- Peer support available on-site
- Intensive interventions

The Environment:

- Prior to opening, RSS had to convert a 10 bed +1 CR (South Lake) to an 8 bed CR

- Redesigned 2 beds into our 94 bed TAP program

- Renovations were minor, but had to create two distinct offices.

- CDSS is operational within the South Lake Community Residence

  - 8 Beds belong to South Lake CR

  - 3 Beds belong to CDSS

The Environment (cont..):

- "Bed & Breakfast"

- Clients are called "guests"

- Guests can prepare meals for themselves or staff can this for them

- The ability to eat in their rooms if needed

- Calming environment

- Shared spaces with CR residents

Eligibility

- Adults 18 and over

- Individuals who are able to return to their permanent residence

- Individuals with a situational crisis or with exacerbated symptoms they are struggling to manage in their current setting

Staffing

- CDSS is staffed by 5 Residence Counselors (3 of FT & 2 of PT staff) and 1 Professional Clinician who oversees the program.

- 4 Residence Counselors are peers

- Peers are not pre-identified to guests prior to arrival. Peers are trained on appropriate self disclosure and use their lived experience. In all other aspects, peers are RSS employees and not identified any differently than that on an operational level.

- Scheduling of staff:
  - The Professional Clinician works Mon-Fri with flexible hours to accommodate referrals and quick access to care
  - Residence Counselors are scheduled so that there is a 3:2 guest staff ratio as much as is possible

Training of staff:

- Monthly Relias trainings on important topics
- WRAP training via Relias
- ASIST
- Strengths-based
- Trauma-Informed Care
- Motivational Interviewing
- Safety training
  - De-escalation techniques
  - Warning signs that a person is becoming a risk to self/others

Admission Process

1) Referrals are accepted Monday – Friday from 8:00 am to 4:00 pm.

2) Assessment by Professional Clinician done in a timely manner to ensure quick access to care

3) Admission decision made by Professional Clinician

4) Same day admission done as often as is possible

5) Minimal referral information is requested to keep it as easy as possible on referral source

Concept of Quick Access to Care:

- No "red tape" to cut through to get someone the services they need

- Minimal referral documentation

- The quicker a person receives support services, the quicker the crisis begins to stabilize

- Real-time prevention of emergency services

Day to Day Operations

- Breakfast, lunch, dinner and snacks provided for guests

- Medication Supervision

- A daily routine is encouraged (i.e. attention to ADLs, 2-3 nutritious meals per day, attending groups and 1:1)

- Clinician offers 1:1 for each day of admission

- Groups run by staff offered throughout the day

Referral Sources

- In 2016 a total of 75 referrals and accepted 65 of them

Referral Source	Total Referrals
Outpatient MH Clinic	23
Residential Programs	15
Inpatient Units	11
PROS Programs	8
Care Management	4
Other	4

Primary Diagnosis Information 2016 of 65 Individuals Served

DIAGNOSIS
PTSD
Major Depressive Disorder
Generalized Anxiety Disorder
Bipolar Disorder
Schizophrenia
Schizoaffective Disorder
Borderline Personality Disorder
Anxiety Related Disorder
Substance Use Related Disorder

- Primary diagnosis in order of most commonly admitted at CDSS

Discharge Follow Up

- Upon discharge, each guest is assigned to a peer for follow-up:

    - Follow-ups are done on 30, 60 and 90 day intervals (at minimum). We are actually reaching out within the first 7 days post discharge and offering weekly follow ups in the first month after being discharged from CDSS.

    - Guests are provided with the CDSS phone number at discharge and are encouraged to reach out as needed.

    - Follow-ups are offered via phone or in-person.

    - On the day of discharge, we complete "Discharge Outcomes." This is repeated each time a peer makes contact with a former guest.

    - Progress notes are written for each follow-up interaction.

    - Welcomed back to the house in a planful way for drop ins as needed (i.e. weekends, holidays, difficult times, etc.)

    - Re-admission is welcomed if appropriate

Challenges

- Coexisting in an existing community residence with residents who live there full time
- Coexisting with two sets of staff
- Stable housing requirement
- Not a locked facility
- Frequent requests to determine appropriate level of care
- Serious Medical Concerns
- Lack of community "connectedness"
- Space challenges (offices, meeting spaces, groups, etc.)
- Determining the appropriateness of a referral
- Safety in a less-restrictive environment than a hospital

Overcoming the Challenges… Coexisting in one House

The Issues

- Residents residing with short term guests
- A house that is regularly in crisis
- Triggering one another
- Residents may have a past history with guests
- Controlling the environment

Solutions

- Constant communication amongst managers and staff regarding observations and concerns
- Regular check ins with S. Lake residents
- Encourage residents to speak up if they feel uncomfortable
- Take each issue on a case by case basis
- Involve clinical where appropriate
- Encourage group participation and activities within the house
- Staff work "on the floor" (i.e. not in offices)

Overcoming the Challenges... Coexisting with two sets of staff.

The Challenges

- Shared house maintenance
- Confusion of who works where?
- Shared overnight staff

The Solutions

- "In the moment" feedback and supervision
- Regular staff training on Trauma Informed Care, Motivational Interviewing
- Staff are expected to know and understand both "sides" of the house
- Ensuring staff redirect clients to their team of staff members
- It's been a great benefit to have extra "hands" when needed in the midst of a crisis!
- Staff trained to communicate serious concerns to overnight staff as well as a plan to manage any concerns

Overcoming the Challenges… Stable Housing Requirement

The Challenges

- Prior to admission everyone must have stable housing to return to

- Often times individuals may be "on hold" or moving in "soon" to their new housing placement and we are asked to admit them in the interim

The Solutions

- Working with SPOA and other community providers to come up with a solid housing plan

- Requesting, in writing, that someone has someplace to return once they are considered stable at CDSS

Overcoming the Challenges… CDSS Is Not a Locked Facility

The Challenges

- Risk of elopement
- Individuals become agitated and may leave the residence
- Difficult to locate or reach individuals once they leave
- Concern that an individual in a crisis situation is alone in the community
- Potential access to items that can be used for self-harm and/or harm of others

The Solutions

- Set the rules up front about leaving the residence and make sure that the guest agrees with this
- Communicate with providers
- For a pre determined amount of time, individuals are asked not to leave the residence without staff
- If someone chooses to leave without staff, a safety assessment is conducted and plan in place regarding time of return
- If someone leaves and there is a concern of harm to self or others, they are flagged at crisis and BOLO is done immediately
- Implementation of a safety checklist completed upon admission

Overcoming the Challenges…
Level of Care Determinations

The Challenges

- Many people may live independently, with family, or in a treatment apartment program
- Concern about a person's well being is often that they do not have enough support
- Since CDSS is within a CR it is enticing to "test" a person there to see how they do in a group setting or with 24 hour support
- Level of Care Determinations do not result in a stabilization that remains following discharge from CDSS
- CDSS is not the same as a CR and cannot be equated to what it may look like in another CR
- Discovering while a guest is admitted that they require a higher level of care unbeknownst to current providers

The Solutions

- Communication with referral sources about what is being stabilized
- What will stabilization look like when someone returns to their home?
- Provider meetings
- Daily communication with housing programs/providers
- Setting limits or saying no to accepting referrals that seem to more about level of care than stabilizing in their current housing setting
- Completing residential referrals as needed to assist with long-term stabilization

Overcoming the Challenges… Serious Medical Concerns

The Challenges…

- No medical staff on site

- Some individuals are very medically compromised- how does this fit into psychiatric stabilization?

- Refusal to follow medical recommendations

The Solutions…

- Increased communication with specialists

- Linkages to PCP or specialists

- Introduced to Urgent Care

- Referral to Care Management

- Discussion about how medical concerns may be impacting psychiatric stabilization

- Improved routine

- Expectations are set at admission

- Use of monitoring forms or checklists to accompany medication supervision

- Safety contracts to ensure compliance with medical recommendations

Overcoming the Challenges…
Lack of Community "Connectedness"

The Challenges

- May only have one provider or family member who made referral

- Determination that increased support in the community could help maintain stability

- Living in an unhealthy or chaotic situation

The Solutions

- Refer! Refer! Refer!

- Follow up on referrals

- Reach out post discharge to ensure there was follow through

- Have a plan in place prior to discharge for how stability will be maintained as new services are put in place

- Work with family or providers about how situations may be handled differently

- Provide training

Overcoming the Challenges... Space

The Challenge

- Two programs converging into one house

- Shared community living space

- Office space

- Having space to run groups

- What happens when a crisis occurs?

The Solutions

- Evolving approach-started with shared managers' office and moved into individuals program offices

- Groups for CDSS are held during the day when the house is "quiet"

- Evening groups or activities are open to the entire house

- Staff communication and shared staff meeting as needed

Overcoming the Challenges… Determining the Appropriateness of a Referral

The Challenges:

- Often thought of as "respite"
- Stable housing requirement…
- Is the client willing or do they know the referral was made?
- What will we actually stabilize?
- Level of care issues
- Many referrals have so many layers and pieces to them, it is hard to get a full picture

The Solutions:

- Speak with the referral source
- Speak with the client
- Call other providers
- Be direct during the assessment and intake process
- Lay out all of the expectations and rules up front to make sure everyone is on the same page
- Be open to assessing referrals to make a determinations

Interventions Used to Reduce Hospitalization

- Flexibility post discharge to receive support
  - Follow up procedures
  - Visits
  - Holidays
  - Re-admission
- Specific and detailed safety planning
- Strong suggestions of remaining on site initially
- Steps taken to be reintroduced to daily routine over time
- Provider meetings
- Provider trainings

Interventions Used to Reduce Hospitalization (cont.)

- Mediations
- Linkage to community resources
- Medication organizers
- 2:3 staff:client ratio
- Relaxing and calm atmosphere
- Guest led recovery
- 15 minute rounds

Strengths-Based Approach

- People can have strengths in different areas:

    - Interpersonal/character strengths, everyday living skills, etc.

- Sometimes it is difficult to see a person's strengths because he/she has such severe functional deficits or life challenges.

- It is OUR RESPONSIBILITY to identify the many strengths of all consumers and to support the use of and development of strengths

Strengths-Based Approach:

- Specific Training to assist staff with understanding:
  - What it is NOT:
    - Ignoring the problem
    - Giving compliments so a person will feel good
    - Reframing misery
    - Allowing people to evade responsibility
    - Getting people to "like you"
    - Condoning the problem
    - Treating people nicely without holding them accountable

Strengths-Based Approach:

- And what it IS:
  - Developing a therapeutic relationship with the consumer
  - Having a primary focus on the person's strengths and maintaining a sensitivity to what their hardships have been
  - Seeing the glass as half full not half empty
  - Being able to approach nearly every situation and find the positive in it
  - Keeping in mind the many strengths of a person, no matter what is happening
  - Never losing faith in each person's positive qualities

Foundation for ALL staff skills

Trauma-Informed Care

Trauma IS the central problem, not PART of the problem!

Physical/Emotional Effects of Trauma:

- Difficulty forming relationships
- Hypervigilance: overly reactive to situations, often perceiving actions of others as threatening, unfair, spiteful
- Rigid/Unable to make changes
- Responding to situations they view as threatening with self-defeating responses
- Appear to want to stir up a crisis
- Frequently feel out of control
- Hopelessness/Helplessness
- Appear as disconnected, cold, uncaring, unfeeling
- Resist new ways of coping

Trauma-Informed Care:

- Specific training to assist staff with:
  - Extinguishing statements that express control-replace with collaborative statements
  - Offering choices
  - Identifying triggers & responding with a collaborative and gentle teaching approach
  - Use of empathy
  - Understanding trauma by recognizing that many behaviors and responses are ways of adapting to and coping with past traumatic experiences
  - Ensuring staff responses are consistent, predictable, and respectful
  - *Promoting safety* by establishing a safe physical and emotional environment where basic needs are met through ensuring that what we do as providers does not add new traumatic experiences

Outreach:

- Ongoing outreach is SO important:
  - Detailed presentations are offered by the Professional Clinician to a variety of providers across counties:
    - Examples:
      - Clinics
      - Hospitals
      - Care Management Programs
      - Crisis Inpatient/Mobile Crisis Teams
      - PROS Programs
      - Dual Recovery Task Force

Hospitalization Reduction 2016 Data

- 25 people had been in the ER/admitted for psychiatric reasons three months prior to admission

- Post Discharge-14 out of the 25 had been re-hospitalized psychiatrically

- 37 people had been in the ER or inpatient units for medical reasons three months prior to admission

- Post Discharge- 22 had been re-hospitalized in the three months following their admission

- Overall, the total number of preadmission ER visits and hospitalizations (psychiatric and medical combined) went from 62 hospitalizations three months prior to admission at CDSS to 36 three months post discharge.

Days in the Hospital Data

- Days Hospitalized 6 months pre admission to CDSS and 6months post discharge from CDSS:

  - 1191 days prior to admission to CDSS

  - 553 days post discharge from CDSS

  - 53.6% reduction in days hospitalized

  - Prior to admission days of ER/Hospital visits ranged from 0 to 441

  - Post discharge days of ER/Hospital visits ranged from 0 to 242

Length of Stay Data
Diabetes & Medication Data

- In 2016:

  - 14% increase in diabetes monitoring and screening for clients on antipsychotic medications.

  - 21% increase in Medication Adherence.

- 2016 Average LOS- 10.2 Days

- 2016 Longest Stay-28 days

- 2016 Shortest Stay- 3 days

Case Review #1

- Jane Doe:
  - History of long-term hospitalization
  - History of chronic use of the hospital and crisis services, a developed dependency on feeling safe in these settings
  - Difficulty maintaining safety in the community (i.e. serious history of self-harm and suicide attempts
  - Dx: PTSD, Borderline Personality Disorder

Case Review #1:

- Goals:
  - Reduce use of Crisis services and inpatient admissions to the hospital by offering diversion services at CDSS
  - Reduce incidences of self-harm
  - Reduce suicidal ideation
- Services utilized:
  - Collaboration with Transitions Team, clinical provider, Crisis, and housing program to develop a comprehensive response plan
  - Safety Planning
  - Boundaries
  - 1:1 sessions and groups at CDSS
  - Ensuring consistency in the responses of all providers involved
  - Ongoing support following discharge from CDSS
- Outcome:
  - Individual now understands there is an alternative to Crisis and is working diligently on avoiding the use of Crisis
  - The individual has not engaged in self-harm in over 6 months
  - The individual has been able to avoid re-hospitalization for the most part (aside from a few very short admissions to CIP)

Case Review #2

- John Doe:

  - Extended hospitalization following loss of job and apartment due to difficulty maintaining employment because of depressive symptoms

  - Discharge planning at the hospital became difficult as this would cause pt. to report suicidal thoughts

  - History of serious plan to complete suicide with means to do so

  - Extreme anxiety regarding reintegrating into the community following hospitalization

  - Lack of linkages to services

Case Review #2

- Goals:
  - Linkages to necessary services
  - Reduce depression, anxiety and suicidal thoughts
  - Prevent re-hospitalization
- Services utilized:
  - Linkages to housing, clinical, PROS and care management services
  - Groups on-site
  - 1:1 therapy services
- Outcome:
  - Discharged to Equinox Diversion Apartment, linked to a clinical provider with a psychiatrist to prescribe medications, linked to PROS program, linked to a care manager
  - No re-hospitalization!
  - Eventual admission to a CR level of care to support long-term stability
  - Ongoing management of anxiety and depression by clinical provider
  - Well-linked to services needed