Ohio's Behavioral Health

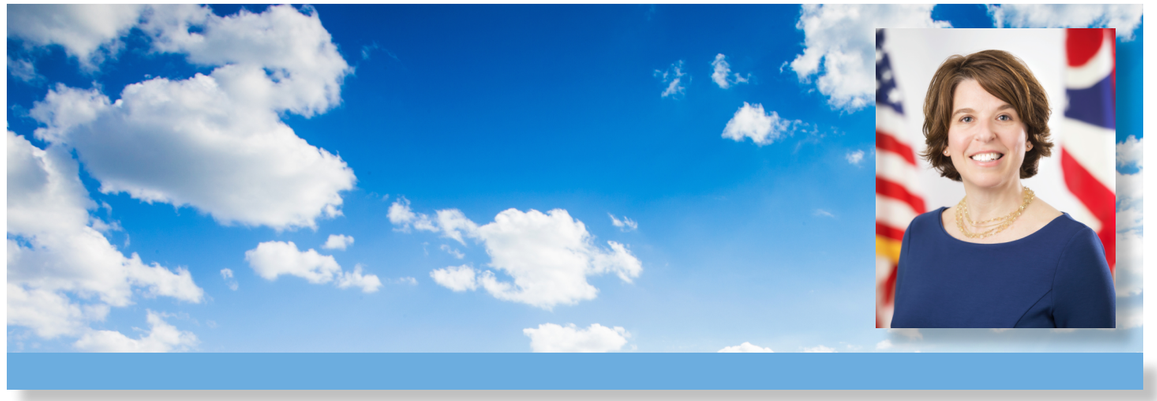
CRISIS SYSTEMS

LANDSCAPE ANALYSIS

2023

"And now, every day in Ohio, we have families in crisis. They need immediate help. And too often, they have nowhere to turn, no idea where to go, so their loved ones suffer -- and sometimes, these individuals — our friends, our family members — die needlessly. ***We can change this.****"*
Governor Mike DeWine

MENTAL HEALTH & ADDICTION SERVICES | Ohio



FROM THE DIRECTOR

Across Ohio, people of all ages and their families are seeking care in record numbers for substance use disorder and mental health concerns. A quality crisis services system provides needed assistance to Ohioans and their families before an emergency occurs, rapidly responds to and stabilizes the person while they are in crisis, and makes strong connections to community-based treatment services and needed supports after a crisis occurs. It is a critical part of our overall continuum of care.

Under the leadership of Governor Mike DeWine and his RecoveryOhio initiative, the Ohio Department of Mental Health and Addiction (OhioMHAS) and its partners are working to develop a supported quality crisis response system to serve as a timely and appropriate alternative to arrest, incarceration, unnecessary hospitalization, or placement in a setting with insufficient resources to address the acute nature of the situation a person is experiencing.

In his 2022 State of the State Address, Governor DeWine shared his vision for building the system of care that has never been fully built in Ohio. Achieving this includes learning from our successes, identifying gaps and barriers, and pressing forward urgently on the work needed to realize an Ohio where fewer families face the unimaginable grief of losing a loved one to suicide or overdose; where shame, fear, stigma, and embarrassment are erased; and where mental illness and substance use disorders are treated as health issues, not as crimes, ensuring the dignity of all those who are seeking to get and stay well.

At the center of this work are the Ohioans we serve. It is important to keep their faces and voices in front of us as we walk down this path. The Ohio way means listening to their needs, acting with urgency to provide a continuum of care that delivers healing and hope, and centering our focus on the dignity and worth of each person.

There are four principles of building Ohio's crisis services system. **Connect**: We are working to make help and connections to care visible and accessible in local communities for all who need it. **Respond**: When a call isn't enough to help, we are building out Ohio's mobile response to provide families with supports during and after a crisis to avoid emergency department (ED) use and criminal justice involvement. **Stabilize**: We want to ensure there are places to go in communities that are specifically designed to respond to mental health and addiction crises in a culturally competent way. **Thrive**: Our goal is to build community capacity to ensure any Ohioan who experiences a mental health or addiction crisis is connected to the services they need to get well and stay well for their lifetime.

We are very grateful to the many Ohioans who informed this report and join with us in our ongoing work to build a healthy, hopeful Ohio.

Lori Criss

Lori Criss, Director
Ohio Department of Mental Health and Addiction Services

How to Use this Report

This report is a landmark assessment of Ohio's crisis services and reflects the input of hundreds of people involved with the state's behavioral health system. As such, this report will be read from many unique vantage points, and we encourage you to review the report from your lens while also considering and learning from others' perspectives and experiences.

This report is designed to encourage evaluation and reflection on the information being shared -- how it could impact the work that your organization does and how your organization can contribute to elevating Ohio's behavioral health system of care and building the system that has never been fully built. Consider how your organization fits into the full crisis continuum: Connect, Respond, Stabilize, and Thrive.

Each of us can play a role in the support of people and families experiencing a crisis by providing direct/indirect care or developing access roads to care. Ohio's local ADAMH Boards and providers are currently planning for the crisis continuum in their communities, and we urge you to stay closely connected to these organizations as implementation plans are developed.

As we continue this journey together, OhioMHAS will conduct listening sessions following the release of this report, and the Ohio Crisis Task Force will be leading the development of a statewide strategic implementation roadmap. OhioMHAS is here to listen, support, and act with urgency on our shared priority to make sure crisis services are visible, accessible, and effective for all Ohioans in need, and we encourage you to stay in touch with us.

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BACKGROUND

Ohio has put tremendous energy and focus into the behavioral health (BH) crisis system over the last several years, including the investment of millions of additional dollars focused on the expansion of available services across the state. The Ohio Department of Mental Health and Addiction Services (OhioMHAS) provided a vision for the behavioral health crisis services system in its initial Crisis Services Report in July 2021:

The vision is for every Ohioan to have access to a visible and accessible crisis continuum of services and supports that are person-centered, quality driven, and focused on ensuring people are stabilized and thriving in the community.

As part of the process of operationalizing this vision, OhioMHAS contracted with HealthCare Perspective and ZiaPartners, Inc. to lay out the current state of the behavioral health crisis system, create a vision for the future state, and lay out considerations to make progress from the current state toward that envisioned future.

OhioMHAS and its stakeholder groups agree that there has been great progress made in recent years advancing the behavioral health crisis service delivery system, but there are still opportunities to do more for people with behavioral health challenges who are in crisis in Ohio. The process of developing this analysis has brought together the various partners and constituencies to create a common set of principles and approaches to focus and help achieve that improvement.

OhioMHAS has taken a collaborative approach throughout this process that has allowed for widespread buy-in and confidence of the stakeholders that the results of this process will produce concrete action steps that will improve the lives of people with behavioral health challenges in Ohio and deliver a better continuum of care.

This analysis includes the background necessary to understand the origins of this work, a discussion of the methods and framework used throughout the process of developing the analysis, the results obtained through the process, and a synthesis of the considerations and concluding remarks.

Achieving the Ohio Vision for BH Crisis Services

Achieving Ohio's vision will require stakeholders and partners working in concert to develop systems at both the state and local levels that support individuals and families involved in substance use- or mental health-related crises in Ohio. OhioMHAS envisions a compassionate and competent system of statewide crisis services that values personal safety, delivers services in a person-centered manner, and focuses on preventing future crises. Crisis services should also connect people with treatment and interventions within the community that support recovery. The crisis continuum should be easily visible, accessible, available to the entire community, and address the diverse needs of people in a behavioral health-related crisis. OhioMHAS envisions a system where everyone who experiences a crisis, everywhere in the state, regardless of circumstances, has access to crisis services where and when they need them.

The vision of how the system should work is built on these four pillars: ***Connect, Respond, Stabilize,*** and ***Thrive***. ***Connect*** refers to the ability to connect people to services when they are in a crisis. ***Respond*** refers to the ability to respond to individuals with services that go to them or that they can get to with minimal burden. ***Stabilize*** refers to the ability for individuals in crisis to have places to go to stabilize over a more extended period. ***Thrive*** refers to providing the necessary long term treatment and supportive services necessary that will reduce the chance of a future crisis.

Critical to the vision is also addressing diversity and equity concerns across the continuum. This requires data collection that recognizes the diversity of individuals being served and identifies the disparate outcomes, comprehensive involvement of diverse members of the community in the planning of services, culturally competent staff to provide services across the continuum, and tracking of financial resources in a manner that ensures equitable access and targeted closing of gaps in care when resources are available.

To realize Ohio's vision, OhioMHAS and its partners in all sectors are deeply invested in continuing to see changes in the system that will improve the response to people in behavioral health crisis throughout Ohio. Building on the energy that was evident throughout the crisis planning, 988 implementation process, the Mobilization Response and Stabilization Services (MRSS) development process, and the Crisis Task Force process will allow Ohio the greatest opportunity for success in continuing to move closer to its vision.

Crisis planning at work in Ohio

The Lorain County ADAMH Board and the Nord Center are providing a long-term lease for the land on which a new crisis center will be built. This facility will offer a "no wrong door" approach to people with mental health and substance use disorders in crisis. It will include detoxification and dual diagnosis services. It will feature 23-hour observation beds and quick screenings.

METHODS AND FRAMEWORK

Various methods were used throughout the process of developing this document: a collaboration of 200 stakeholders; conducting a survey of the Ohio Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards in Ohio; collecting other data from OhioMHAS, the Ohio Department of Medicaid (ODM) and other partners; developing the Crisis Task Force to review the current state of the system and develop considerations for change; establishing the values and principles to guide the crisis system; building a lexicon to define how Ohio talks about its crisis system; and capturing the voice of a people primed for change.

Stakeholder Meetings

To develop the basis for the considerations and process for the behavioral health crisis system, meetings were held with a wide variety of stakeholders to receive the widest possible input in understanding the current state and future needs of the crisis continuum in Ohio. Regional focus groups were held within each of the hospital regions to understand how each region manages planning and disbursing dollars that have been distributed on a regional basis. There were focus groups held with ADAMHS Boards of common size and structure (large, medium, and small, with levies and without levies) to further understand challenges with the development of cohesive behavioral health crisis continuums. Regular meetings were held with the Ohio Council of Behavioral Health and Family Services Providers (Ohio Council) and the Ohio Association of County Behavioral Health Authorities (OACBHA) throughout the process to receive ADAMHS Board and provider feedback and incorporate it into the ongoing work of the development of the analysis. There were also separate discussions held with NAMI (National Alliance on Mental Illness) Ohio, the Ohio Hospital Association, managed care organizations, crisis service provider organizations, and peer support organizations in Ohio to give each their own forum to get questions answered and provide additional input to the process.

ADAMHS Board Surveys

As part of this process, a data collection tool that covered the full crisis continuum of services and would allow for analysis of services currently available across the State of Ohio was distributed to all ADAMHS Boards. Responses were received from all of the ADAMHS Boards. The tool used a set of interim definitions for crisis services, developed in partnership with Peg's Foundation, categorizing crisis services into broad categories. This set of definitions resulted in the Lexicon discussed in Appendix C. The interim definitions were used for the collection tool to allow for consistency in reporting and broader education about the definitions across the state.

The data collection was distributed to ADAMHS Boards in October 2021. The tool was designed to facilitate reporting of crisis system capacity, service delivery, funding, and future planning for each ADAMHS Board.

OhioMHAS viewed this project as an opportunity for each ADAMHS Board to demonstrate the full range of capacity currently in place, as well as where OhioMHAS, ODM, health plans, ADAMHS Boards, providers, and other funders need to work collaboratively to meet community needs in providing the full-service array in the Ohio Crisis Roadmap. This survey was an important source of data for the work of the Ohio Crisis Task Force. All partners were supportive of efforts to collect this information and recognized that ADAMHS Boards would need to work collaboratively with service providers, first responders, hospitals, and other community partners to gather as much of this data as possible.

It was understood that ADAMHS Boards would not have access to all the data requested at the time of the survey. When there was an item for which data was not available, the ADAMHS Board was asked to simply respond as such. The expectation was that the collective capacity to make the right data available would have to evolve over time.

The survey questions addressed multiple aspects of the crisis services continuum, including:

- Reporting on local planning and accountability
- Reporting of baseline need – BH 911 calls, ED visits, arrest data, boarding data
- Reporting of current continuum of crisis services
  - Call centers and warm lines
  - First responder crisis intervention
  - Mobile crisis intervention
  - BH walk-in urgent care
  - Crisis center with observation
  - Residential crisis services
  - Intensive outpatient crisis services
  - Acute inpatient psychiatric care
  - Crisis transportation
  - BH crisis services for individuals with intellectual disability/developmental disability
  - BH crisis workforce
- Reporting of plans for the coming year

Each element was then deconstructed and sent to each committee to allow it to work with the information that was relevant to its deliberations.

Data Limitations

It is important to understand the limitations of this mode of data collection. ADAMHS Boards are most aware of services that are available to individuals with Medicaid or services that are paid from the funds available to the ADAMHS Boards. There are additional services available only to individuals who have third-party insurance (which is approximately 56% of the population in Ohio) or are able to pay for services themselves, especially in the Stabilize portion of the continuum, that may not be as clearly identified in these survey results. There is also no uniform data collection strategy among ADAMHS Boards, making consistency in data reporting a challenge. Finally, similar state-wide data collection strategies were nonexistent, so this survey served as a baseline.

Other Data Collection

Additional information sessions were conducted with Centers of Excellence, hospitals, managed care organizations and other partners suggested by OhioMHAS and its partners. A complete list of informants is provided in an Appendix to this report. Deep dives were conducted with three ADAMHS Board areas in Ohio that are described in a later section of this report.

The survey responses, focus group sessions, other interviews and information from the deep dives were compiled and analyzed along with data from a variety of other data sources (e.g., OhioMHAS, ODM, 988 Implementation Team, MRSS, the Substance Abuse and Mental Health Administration (SAMHSA), and others) to assist with understanding the current strengths and gaps of the behavioral health crisis system in Ohio, highlighted throughout this analysis.

Figure 1. SAMHSA Core Elements of a Crisis System

Someone to talk to: Regional or statewide crisis call centers in coordinating in real time	Regional 24/7 clinically staffed hub/crisis call centers that provide crisis intervention capabilities (telephonic, text and chat). Such a service should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide and offer air traffic control (ATC) - quality coordination of crisis care in real-time.
Someone to respond: Centrally deployed, 24/7 mobile crisis	Mobile crisis teams available to reach any person in the service area in their home, workplace, or any other community-based location of the individual in crisis in a timely manner.
A place to go: 23-hour crisis receiving and stabilization programs	Crisis stabilization facilities providing a short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.
Essential crisis care principles and practices	Includes addressing recovery needs, significant role for peers, trauma-informed care, Zero Suicide/Suicide Safer Care, safety/security for staff and people in crisis, and crisis response partnerships with law enforcement dispatch and emergency medical services (EMS).

SAMHSA Guidelines for BH Crisis Care

The Substance Abuse and Mental Health Services Administration (SAMHSA) released its National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit in 2020. The toolkit is intended to advance national guidelines in crisis care that support program design, development, implementation, and continuous quality improvement efforts. The guidelines call for crisis services to be designed for anyone, anywhere and anytime. There is also a call for transformation in the approach to crisis behavioral health care in this country.

Roadmap to the Ideal Crisis System

Ohio has gone beyond the SAMHSA Core Elements to incorporate elements of the Roadmap to the Ideal Crisis System, released in 2021 by the National Council for Mental Wellbeing, into its planning and design. The Roadmap delineates how implementation of successful systems requires three interacting design elements, along with measurable indicators for the components of each. These three interacting design elements provide the structure for the Roadmap report:

- Accountability and finance
- Crisis continuum: basic array of capacities and services
- Basic clinical practice

The Roadmap also provides multiple examples of system level progress for crisis services that can help aid in future state and local planning Ohio. Examples include:

- Communities that have organized to develop excellent behavioral health crisis systems: Pima County (Tucson), Arizona
- Statewide legislation to define a crisis system vision: Iowa's crisis access standards
- Statewide efforts to establish best practices: Michigan's guidelines for medical screening
- National efforts to expand resources and expectations for community crisis systems: Certified Community Behavioral Health Clinics (CCBHCs)

Analysis on Building a Sustainable Behavioral Health Crisis Continuum

Another analysis that was released during the time this work was being undertaken was part of the USC-Brooking Schaeffer Initiative for Health Policy on "Building a Sustainable Behavioral Health Crisis Continuum." This analysis identifies several best practices for mobile crisis, including CAHOOTS (Crisis Assistance Helping Out on the Streets) in Eugene, Oregon; a Connecticut youth mobile crisis program with a 25 percent reduction in ED use and the Denver Support Team Assisted Response (STAR) program which was expecting to reduce police responses to calls by nearly three percent. The Brookings analysis also

discussed the Tucson model for crisis stabilization but pointed out that while Medicaid can be used by states to cover and pay for these services, "such initiatives have been quite limited and less federal policy activity has been devoted specifically to advancing access to these services relative to immediate crisis response." The analysis points out that infrastructure investments are needed to build an effective crisis response continuum, pointing to $90 million that was invested by New York City to build two receiving facilities and Georgia's investment of $256 million to build up its overall crisis response system. Finally, the report identifies how states address the significant ongoing costs for the crisis continuum.

Building a Partnership for Change: The Crisis Task Force Process

OhioMHAS established the Ohio Crisis Task Force in June 2021 to support the department in its efforts to improve the crisis services delivery system in the state. The Task Force originally consisted of twenty members representing various state departments, ADAMHS Boards, provider agencies, foundations, centers of excellence, payers and stakeholder groups from around the state, and grew to thirty over the course of the project. There was also active participation from peer and advocacy organizations throughout the process, with active participation on all the committees and subcommittees, including representation from Ohio Citizen Advocates for Addiction Recovery, Ohio PRO (Peer Recovery Organizations), National Alliance on Mental Illness, and Mental Health and Addiction Advocacy Coalition. The Task Force met monthly, receiving updates from the consultants and providing input to the process.

A committee and subcommittee structure was added to enhance the Crisis Task Force advisory process in October 2021. There were five new committees proposed, along with incorporating the work of the previous 988 Advisory Committee into this work as the "Connect" Committee. The five new committees were the service focused committees of "Respond" and "Stabilize & Thrive" and the boundary spanning committees of "Community Crisis Coordination", "Performance Metrics & Data," and "Financing the Continuum". Each committee then developed its own subcommittee structure to address key questions that were provided by the consultants to the committees. These subcommittees developed recommendations that form the basis of considerations for improving the behavioral health crisis system in Ohio.

In addition to the monthly Crisis Task Force, committee and subcommittee meetings, the consultants met with:

- Regional focus groups
- ADAMHS Board focus groups based on their size and levy status (large boards, medium boards with and without levies, small boards with levies and without levies)
- Ohio Association of Community Behavioral Health Authorities (OACBHA) monthly
- Ohio Council of Community Behavioral Health and Family Services Providers monthly
- A group of behavioral health crisis providers from around the state quarterly
- The Stepping Up Initiatives leadership
- Peg's Foundation and their Clear Pathways team
- The Ohio Hospital Association
- Aging Committee of OhioMHAS
- PIRE – the consultants for the 988 implementations
- Ohio Association of Health Plans
- CareSource
- Leaders of the OpenBeds implementation for Ohio
- Central Ohio Hospital Council
- Ohio Department of Public Safety

Figure 4. Stakeholders and Partners in the Taskforce, Committees and Subcommittees

Consensus Values and Principles Recommended by the Task Force

Over the course of this effort, seven values and principles came up repeatedly in the discussions among Task Force, committee, and subcommittee members. These principles can serve as valuable guideposts to future work in the development of Ohio's behavioral health crisis services continuum.

Principle 1:
Ohio's BH Crisis System is for Ohioans experiencing a mental health (MH) and/or substance use disorder (SUD) crisis.

- Diversity and equity concerns should be at the center of every element of the continuum and planning for services in every community in Ohio.
- No matter your insurance coverage/ability to pay.
- No matter where you live: adaptation as needed for different geographies.
- No matter your age: adaptation as needed for children, adolescents, adults, and older adults.
- No matter your race, culture, language, immigration status, sexual orientation, or gender identity.
- No matter the other challenges you may face: intellectual/developmental disabilities, acquired brain injury, neurodiversity, physical illness/ disability, homelessness, justice/protective service involvement, or challenges faced by older adults.

Principle 2:
Ohio's BH Crisis System ensures services are welcoming, safe, hopeful, person and family-driven, empowering, trauma-informed, and culturally competent.

- The voice of a diverse array of people with lived experience is included in all aspects of system design, implementation, and service delivery.
- Equity and inclusion for all populations is a priority for system performance.
- Crisis services welcome people with co-occurring MH and SUD and provide appropriately matched integrated crisis intervention in all crisis settings.

Principle 3:
Ohio's BH Crisis System is designed to help every person and family experiencing a crisis to get the right help in the right place at the right time, and to get help not only to stabilize but also to thrive.

Principle 4:
Ohio's BH Crisis System is forward thinking, looking beyond our current service and funding models to design the services needed for Ohioans in accordance with our values.

Principle 5:
Ohio's BH Crisis System belongs to everyone and requires collaboration, contribution, and partnership from everyone, both locally and statewide.

- Individuals and families with lived experience
- First responders
- Community BH service providers
- Community human service agencies and providers
- Hospitals and health systems
- ADAMHS Boards
- Communities (counties, cities)
- Community foundations
- Business leaders
- Faith leaders
- Justice system leaders (judges, sheriffs, district attorneys' offices, etc.)
- Medicaid and commercial health plans
- State agencies: OhioMHAS, Ohio Departments of Medicaid, Insurance, Public Safety

Principle 6:
Ohio's BH Crisis System should be in parity with the system of services for individuals who experience any other type of physical health crisis.

- Individuals who experience a behavioral health crisis should receive services regardless of their ability to pay, just like physical health emergencies.
- Services should be reimbursed in a similar fashion for behavioral health crisis services as they would be for the same individual receiving services in a physical health emergency.
- Documentation required for behavioral health crisis services should be no more burdensome than it is for a physical health emergency.

Principle 7:
Ohio's BH Crisis System uses data for continuous quality improvement to be in better alignment with the needs of people with behavioral health needs and the needs of communities.

Lexicon: How We Talk About Crisis Services in Ohio

It is difficult to work toward progress on any complex issue without a common terminology or lexicon. A set of interim definitions was developed at the outset of the project to set the framework for discussion of crisis services in Ohio and allow for data to be collected about existing and planned services in a meaningful way. That lexicon was enhanced through the work of the Task Force, its committees and subcommittees and a working version was adopted by the Taskforce and is included as part of this analysis as Appendix C.

NOTE: *All key terms are further defined in Appendix C: Full Set of Committee Considerations.*

Crisis Triage	A process whereby a BH crisis responder in any service setting (including phone, text, chat or in-person) quickly (within a few minutes) determines the level of severity and urgency of the BH crisis situation in order to determine the right next step. The next step can be categorized according to the speed and intensity of response, as follows:
Emergency Crisis Response	Response within **minutes** due to immediate risk of physical harm to self or others, usually warranting a 911 law enforcement response, and/or immediate risk of medical harm (as due to overdose), warranting a 911 EMS response. This response can result in the person being brought to a Crisis Center, ED, or a "rapid" Mobile Crisis Team response once the immediate risk is stabilized in the field.
Rapid Crisis Response	Response within **30-90 minutes (one hour average)** due to BH crisis requiring rapid attention to engage the person in crisis and stabilize the situation. This response can occur through Mobile Crisis Team or through walk-in at or transport to a BH Urgent Care or a Crisis Center.
Urgent Crisis Response	Response within **a few hours, no longer than 1-2 days.** This can occur after the initial contact (e.g., phone call referred to walk in the next day at Urgent Care) or after a more intensive crisis episode (e.g., referred from a Crisis Center with Observation to Intensive Crisis Intervention within one to two days after discharge from the Crisis Center.
Call/Chat/Text Only Response	This applies only to Connect services. This refers to a crisis that is resolved by the initial call/chat/text only, with referral for routine follow-up.
Crisis Intervention	This term is defined in OAC 5122-29-10. **The definition applies to crisis intervention that can occur in any setting** and is used to inform the application of psychotherapy billing codes with crisis modifiers. The definition in OAC includes a definition for 23-hour observation, which is referenced elsewhere in this Lexicon.
988 Member Centers	These include current NSPL/988-certified member centers.
Non-988 Member Centers	These include other call centers, crisis lines, warmlines and hotlines, some that will be maintained based on need post-full 988 implementation and some that will not.
Mobile Crisis Team	Mobile crisis team services are 24/7 "clinical" services that coordinate with first responders. Mobile crisis teams provide rapid response to BH crises at any location in the community served - mobile response stabilization services (MRSS) is one example for children, but not the only example.
Mobile Co-Responder Teams	These programs are a version of mobile crisis that involves routine pairing of teams of crisis clinicians and first responders, either paramedics or CIT trained law enforcement. Such programs are not common in Ohio.
Targeted Mobile Crisis Response	Does not meet criteria for mobile crisis team because of restrictions on function, population, timing, or location of response.
Crisis Center (or Crisis Center with Observation)	**Definition of 23-hour observation in OAC 5122-29-10(B)**: 23-hour observation bed means face-to-face evaluation, for up to twenty-three hours duration under close medical/nursing supervision, of an individual who presents an unpredictable risk of adverse consequences due to intoxication, withdrawal potential and/or co-existing disorders for the purpose of determining the appropriate treatment and plan for the next level of care.
Residential Crisis Services – eligible for Crisis Stabilization Center funds	**Adult MH Residential Crisis Services:** medically intensive, medically supported, clinically supported, peer-operated non-medical (peer respite) **Child MH Residential Crisis Services:** medically intensive, medically supported, clinically supported **Adult SUD Residential Crisis Services**** (American Society of Addiction Medicine (ASAM) Level 3 withdrawal management (WDM)): ASAM 3.7: medically monitored**, ASAM 3.2: socially supported**, Option to consider: Sobering Centers **Adolescent SUD Residential Crisis Services**** (ASAM Level 3 WDM): ASAM 3.7: medically monitored**, ASAM 3.2: socially supported**
Community-Based Crisis Intervention Programs	**Structured Group Programs for MH Crisis Intervention:** partial hospital programs (PHP): (using Medicare definitions), intensive outpatient programs (IOP): (using Medicare definitions) **Structured Group Programs for SUD Intervention:** partial hospital programs (PHP): (ASAM 2.5) **, intensive outpatient programs (IOP): (ASAM 2.1) ** **Intensive Crisis Intervention Team (may include individuals with MH and/or SUD):** MRSS is one example for children and families, but not the only example, IHBT is one example, but not the only example. **Intensive Crisis Intervention specifically for SUD:** ambulatory withdrawal management programs, rapid initiation and continuation of medication assisted treatment for SUD (buprenorphine programs and methadone programs)
Thrive	In addition to defining the components of the full continuum of "Thrive" services (which are NOT enumerated in this lexicon) the Thrive subcommittee recommended definition and provision of specific types of high intensity continuing community-based services for high need populations who may be frequently in crisis without continuing intensive support.

Crisis Triage	Emergency Crisis Response Rapid Crisis Response Urgent Crisis Response Call/Chat/Text Only Response
Crisis Intervention*	Urgent Evaluation Crisis Plan
Connect	988 Member Call Centers Non-988 Member Call Centers
Respond	Mobile Crisis Team (for adults and children - MRSS** is one for children) Mobile Co-Responder Teams Targeted Mobile Crisis Response BH Urgent Care (for adults and children)
Stabilize	Crisis Center (or Crisis Center with Observation) Residential Crisis - Adult and Child MH, Adult and Adolescent SUD** Community-Based Crisis Intervention Programs
Thrive	Continuing Community-Based Services for High-Need Populations

*This service has a current OhioMHAS definition.
**These services have an OhioMHAS definition and is billable through Ohio Medicaid.

RESULTS

To best understand the strengths, challenges, and opportunities within the behavioral health crisis system in Ohio, the Results section begins with a system overview "score" based on two national report cards. This is followed by a discussion of the core elements of the crisis continuum: Connect, Respond, Stabilize, Thrive, Special Populations, Transportation, Designing the Local Continuum, Workforce, Planning and Coordination, Performance Metrics, and Financing of the Continuum. Each of these elements are presented within a framework:

- **Where is Ohio?** - Description of the current state
- **Where do we want Ohio to be?** – The goal
- **How do we get there?** - Recommendations

Ratings on NAASP/Crisis Now Scale

The National Action Alliance for Suicide Prevention (NAASP) has offered a framework for State/Regional Self-Assessment through Crisis Now that was endorsed in SAMHSA's Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit (2020). Note that this Self-Assessment focuses only on a subset of the crisis continuum and is less comprehensive than what was proposed in the subsequent Roadmap to the Ideal Crisis System (2021), or the range of services included in Ohio's vision. Nonetheless, it can be used as a quick reference for partial understanding of the current baseline.

Five Levels

There are five levels in the Crisis Now scale (Minimal, Basic, Progressing, Close, and Fully Integrated.) There are five corresponding indicators that can be achieved by a state or regional system. Table 1 outlines the assessed rating based on the Crisis Now scale for Ohio's crisis system elements.

Level 1	**Minimal**
Level 2	**Basic**
Level 3	**Progressing**
Level 4	**Close**
Level 5	**Fully Integrated**

Figure 5. Framework for State/Regional Self-assessment (Crisis Now and NAASP)

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

How Does Your Crisis System Rate?

What makes Level 5 different?	Call Center Hub	Mobile Outreach	Sub-acute Stabilization	Crisis Now System
	Real time access valve mgmt	Meets person at home/apt/street	Direct law enforcement drop-off <10 minutes	Equal partners, 1st Responders
Level 5: FULLY INTEGRATED	Air traffic connectivity	Adequate access statewide	Adequate access statewide	Adequate access statewide Plus
Level 4: CLOSE	Data sharing (not 24/7 or real time)	Statewide access but reliant on ED	Statewide access but reliant on ED	Integrated system w/ diversion power
Level 3: PROGRESSING	Formal partnerships	Adequate access <1 hour response	Adequate access <50% bed available	Adequate access major payers Incl.
Level 2: PROGRESSING	Shared MOU/ protocols	Some availability limited to urban	Some availability limited to urban	Limited state/ county support
Level 1: MINIMAL	Agency relationships	None or very limited availability	None or very limited availability	Fragmented status quo

Level 5 System also conforms to four modern principles

1. Priority focus on safety and security
2. Suicide care best practices, e.g., systematic screening, safety planning and follow-up
3. Trauma-informed, Recovery Model
4. Significant role for peers

Table 1. Ohio Ratings on NAASP Framework

Crisis System Element	Rating	Notes
Call Center Hub	LEVEL 3 – PROGRESSING	Ohio has an established crisis call center structure, has invested significant effort into its 988 implementation, and is progressing its formal partnerships in local communities throughout the state. To achieve Level 4, the model requires data sharing, which is not currently occurring on a statewide basis, but is certainly envisioned as the 988 roll out continues.
Mobile Outreach	LEVEL 2 – BASIC	While some areas of the state have moved beyond this level, on a statewide basis, the main metric offered in this framework for Level 3, namely that there is adequate access to mobile services that meet people in behavioral health crisis where they are, has not yet been achieved. With the addition of MRSS, Ohio is working towards a response time of one hour or less, which is a target for the standard in the recommendations from the task force later in this report. There is the opportunity to move rapidly from Level 3 to Level 5 as the current strategy does not rely on EDs, so as the availability of mobile outreach continues to expand, and the response time reduces to one hour, there will be the opportunity to move to Level 5 faster than if the strategy did rely on the EDs as the primary response.
Sub-Acute Stabilization	LEVEL 2 – BASIC	This area meets the definition offered for Level 2, that there is some availability of sub-acute stabilization, limited to urban areas. To be able to advance to Level 3, there would need to be adequate access, which is defined as 50% of the beds that are needed being available in the state. The biggest deficit here is around mental health residential crisis services, as substance use disorder withdrawal management appears to meet this 50% metric currently.
Crisis Now System	LEVEL 2 – BASIC	Level 2 for this area means that there is limited support for the crisis system, coming from state and county funding sources. A significant finding of the Finance Committee of the Crisis Task Force was the need for more support from all major payers for behavioral health crisis services, which is the requirement for Level 3.
Conformance to Modern Principles	N/A	1. Priority focus on safety and security for individuals in behavioral health crisis. This is certainly a priority in Ohio in many pockets of the state but ingraining that statewide is still a work in progress. 2. Ingrain suicide care best practices, including systematic screening, safety planning, and follow-up. The biggest challenge in Ohio with meeting this principle is the post-crisis follow-up. The Care Coordination Subcommittee recommended better tracking and follow-up for people in behavioral health crises. 3. Robust trauma-informed, recovery model, which is becoming more ingrained in Ohio and is strong in pockets, but following the recommendations by the Taskforce could certainly strengthen the statewide application of this principle. 4. Significant role for peers, which is an area for improvement found in the recommendations across all service areas.

Roadmap to the Ideal Crisis System Scorecard:

The Report Card in the Roadmap to the Ideal Crisis System (Group for the Advancement of Psychiatry, 2021) provides a framework for scoring each of the "measurable indicators" within the Roadmap.

There are three sections in the Roadmap, and the Report Card covers all three. There are a total of 76 items, with 19 in Section 1 (Accountability and Finance), 32 in Section 2 (Capacities and Services), and 25 in Section 3 (Clinical Practices). For scoring Ohio's state and local crisis system in this report, we have selected 10 of the 76 items that are particularly relevant, 3 in Section 1, 4 in Section 2, and 3 in Section 3. The items are selected to be different from the items in the Crisis Now Scorecard. These items are scored on a Likert Scale from 1-5, shown above.

Roadmap Section 1: Accountability and Finance

Item 1A: Accountable entity (for community crisis systems) identified and established
Score: 4

Ohio has indicated that the ADAMHS Boards are intended to be the accountable entities for community BH crisis system planning for all populations. This role needs to be further clarified and defined, with clearer expectations for participation by important provider and funder partners who may not be directly in relationship with the ADAMHS Board.

Item 1E: Multiple payers contribute to financing services and capacity in the continuum
Score: 3

Ohio has created a partnership between OhioMHAS state funds and local ADAMHS Board funds (e.g., levies) to support the development of crisis services, and commercial insurance contributions are negligible. Some communities have engaged significant contributions from foundations and health systems partners, but this is not routine.

Item 1J: Quality metrics are established and measured for each service and for the crisis continuum as a whole
Score: 2

Current contracted services have performance metrics within ADAMHS Board contracts, but those metrics are not consistent, except for MRSS and 988 Centers, which are meeting state-level requirements, and most crisis services in the continuum are not defined or measured consistently in state data systems. Recommended performance metrics for the continuum have been suggested by the Crisis Task Force, but not yet adopted or implemented. This is another opportunity to ensure that OhioMHAS's commitment to diversity and equity can be evidenced through establishment of metrics that identify potential areas for improvement.

Roadmap Section 2: Crisis Continuum: Basic Array of Capacities and Services

Item 2B: Services address the continuum of crisis experience from pre-crisis to post-crisis
Score: 2.5

Ohio has done exceptional work readying availability of 988 crisis call centers (and non-988 centers) in advance of the launch of 988. A few ADAMHS Boards have implemented continuing post-crisis intervention, and continuing crisis intervention is built into MRSS. However, limited data that is available shows that services addressing the full continuum of crisis are still only available to less than half of the people in Ohio who experience BH crisis. Ohio Medicaid is the predominant funder of "crisis" services across Ohio for the Medicaid population with commercial insurance coverage being negligible.

Item 2L: Clients are tracked through the continuum
Score: 2
Systems for routine care coordination and client tracking for people in crisis are starting to be developed across the state. Some clients may have connection to care, such as OhioRISE. However, much more work needs to be done to develop routine client tracking for individuals experiencing BH crises and moving rapidly through multiple types of services.

Item 2V: Residential crisis services for mental health
Score: 2.5

Residential crisis services for adults and children are available in several communities, but there is much less capacity than is needed. There is no program definition or adequate funding model for residential crisis services for people with mental health challenges. Adult residential services are more available than children's residential crisis services, but neither is available to half the population in need, which would be needed to score 3 on this item.

Item 2FF: Peer support throughout the continuum
Score 2.5

Peer support is highly valued, and there has been significant effort to train peer supporters to work in the behavioral health field. Mobile crisis teams and crisis center services across the state have recognized the value of including peer supporters as essential team members. However, the availability of peers to work in all components of the crisis continuum is still limited. Fewer than half the people experiencing a behavioral health crisis in Ohio will have the opportunity to receive peer support during their crisis episode.

Roadmap Section 3: Basic clinical practices

Item 3F: Basic core competencies for call center staff and first responders
Score: 4

Ohio has identified call center core competencies and associated curricula. Ohio has also made considerable progress over many years in dissemination of crisis intervention team (CIT) training for first responders and has some models of well-trained first responder staff. Continuous quality efforts are underway for the 988 centers, as well as to continue dissemination of CIT training.

Item 3I: Suicide risk screening and intervention
Score: 3

Suicide prevention is a high priority in the Ohio system. There has been wide dissemination of knowledge of the utilization of best practice suicide risk screening tools such as the Columbia Suicide Screening Scale. Many crisis programs have organized protocols for addressing suicide risk. Although there is still a gap in having uniform program standards and practice guidelines for crisis services, there is considerable progress that would support the feasibility of the goal of having universal standards for suicide screening and continuing protocols for suicide intervention and risk reduction throughout the crisis system.

Item 3Q: Practice guidelines for co-occurring mental health and substance use disorder (crisis response) and medication assisted treatment start up
Score: 3.5

Ohio has made considerable progress in promoting engagement of high-risk opioid users through the dissemination of quick response team (QRT) services and has supported broader availability of medication assisted treatment. Access to medication assisted treatment initiation in EDs and crisis settings remains variable. For people with co-occurring mental health and substance use disorders, most crisis providers are aware of and capable of providing guidelines to staff for integrated crisis response. However, because current program certification standards separate crisis response for people with mental health and substance use disorders, and do not provide guidance for how to respond to people with co-occurring needs in each setting, full dissemination of such guidance is less than what it otherwise might be.

TOTAL SCORE: 29

AVERAGE SCORE: 2.9

The background data for these findings is obtained from ADAMHS Board surveys and stakeholder interviews, as will be described in the following sections. In addition, there are recommendations to address and improve these scores that have been derived from the surveys and the work of the Crisis Task Force and its Committees.

Connect - Where is Ohio?

On July 16, 2022, the National Suicide Prevention Lifeline (NSPL) transitioned to the three-digit dialing code 988. This transition is designed to better connect crisis care services with individuals and families experiencing a mental health or addiction crisis. Increasing levels of crisis service utilization and an increasing volume of phone, text, and chat contacts to the Lifeline highlight the importance of the Lifeline and 988 as an entry point into Ohio's crisis care system. Further, Ohio data and a landscape analysis suggest that the need for crisis care, and related supports will remain at high levels in the years to come. These challenges are not limited to specific areas of the state.

The 988 Implementation Plan that OhioMHAS developed under its grant requirements addresses the eight core areas identified in Figure 4 provides a comprehensive roadmap for Ohio's transition to 988. Top priorities identified for Ohio include building the system's capacity to ensure that 90% of Lifeline calls and 50 percent of Lifeline chats and texts can be answered in state; ensuring service quality is maximized through ongoing training and support as well as through the development of a shared web-based resource directory; and ensuring that all Ohio Lifeline providers have adequate high-speed Internet access and up-to-date communication, documentation, and other technology systems.

Per the 988 implementation plan, the Lifeline provides a critically important entry point into Ohio's crisis care system. During the thirteen-month period from July 2020 to July 2021, a total of 54,602 contacts were made to the Lifeline via call, chat, or text. Of those contacts, 45,773 were answered by a certified Lifeline provider in Ohio, for an overall answer rate of 84 percent. Most of the contacts to the Lifeline by Ohioans occurred via phone with a smaller proportion of chats and texts. Overall contact volume and answer rates fluctuated over the thirteen-month period but remained stable.

To prepare for the implementation of 988, Ohio expanded the number of NSPL-qualified call centers from 12 to 19, ensuring Ohioans in all 88 counties have access to coverage and support. Because of this careful planning, Ohio has successfully increased the percentage of Lifeline calls being answered in-state; in August 2022, 87% of calls were answered in-state, marking a 25% increase for the same period one year prior.

The work to connect individuals in need to services needs to encompass not only the 19 NSPL-approved call centers, more than any other state, but the additional eighty-five hotlines/helplines operating throughout the state and how this vast system will interact to support Ohioans in crisis. To round out the access points, Ohio also has approximately 180 911 call centers across the state or Public Service Answering Points (PSAPs). The importance of connections with and among 911s, 988s, 211s, and other call centers cannot be minimized.

The survey indicated that crisis lines/hot lines/warm lines are quite prevalent, with every county in the state reporting having some number for people to call who are in behavioral health crisis. The types of lines ranged from warmlines that connect people to services in their area to 24-hour crisis hotlines intended for to prevent suicide or overdose to lines that are intended for children to access needed services. At least forty-three of the fifty ADAMHS Board areas reported at least one line as operating 24/7. Over $13.8 million is currently budgeted for the crisis lines that were reported in the survey. These financial resources are a combination of Medicaid, state and local dollars, with the highest percentage coming from local levies ($9.5 million).

Coordination between the Lifelines/988 Providers and the existing crisis lines/hot lines/warm lines will be critical to the success of the transition from the existing environment for places that people in Ohio in crisis can connect to the services they need and the envisioned future where most of that connection will funnel through the Lifelines/988 with other needs being met by other connection points.

1. Ensure statewide coverage for 988 calls and texts.
2. Secure adequate, diversified, and sustained funding streams for Lifeline Member Centers.
3. Expand and sustain capacity for target in-state answer rates on current and projected calls, text, and chat volume.
4. Support crisis centers in meeting operational standards, requirements, and performance metrics.
5. Convene a coalition of key stakeholders to advise on 988 planning and implementation.
6. Maintain a comprehensive, updated listing of resources, referrals, and linkages.
7. Ensure all Ohio centers can provide best practice follow-up to 988 callers/texters/chatters.
8. Plan and implement marketing for 988 in Ohio.

"Connect" at work in Ohio

- OhioMHAS is implementing "Open Beds" in multiple regions in the state to help people in need find available services more quickly. Visit Treatment Connection.com.
- The Central Ohio Hospital Association has implemented a "bed board" that helps providers identify available resources for people in crisis quickly and efficiently.

Connect - Where Does Ohio Want to Be?

Ohio has engaged in exceptional 988 planning, has engaged the largest number of certified 988 call centers of any state, and was well-positioned for the 988 "soft launch" in July 2022. However, the journey of 988 implementation, in Ohio and elsewhere, is just beginning. Just like full implementation of the 911 system required decades of steady progress, so will full implementation of 988.

The vision of CONNECT and 988 is that all Ohioans will utilize 988 as the "go to" number for all MH and SUD crises that does not require an immediate 911 response (e.g., due to immediate threat of violence or immediate medical emergency).

Goals for the future vision of Ohio's 988 system include:

1. **Fully operational 988 call, text, and chat within Ohio.** The Ohio 988 system is striving towards the goal of having all Ohio calls, chats, and texts to 988 answered within the state of Ohio. Ohio has seen a 109% increase in calls answered by Ohio's Lifeline providers, a 201% increase in chat demand, and a 603% increase in text demand (August 2021 to August 2022).

2. **Fully operational linkage between 988 calls and other elements of the BH crisis response system.** These linkages are currently being developed and involve clear handoffs to both non-988 crisis centers when appropriate for callers in those counties, as well as direct handoff to mobile crisis response or other crisis services when needed by the caller, regardless of the caller's originating county.

3. **Access to a comprehensive online resource manual.** The resource manual development contract has been awarded and is intended to be operational by June 2023.

4. **Interconnected response between 988 and 911 systems.** This will require future technological capacity to create rapid handoffs between 911 calls and 988 response systems, and vice versa, when appropriate. The 988 system needs to promote accurate geolocation regardless of the area code of the caller's cell phone. Federal partners are leading this development.

5. **Certification of call center performance and call center staff competency.** Ohio is training and supporting all call center staff to achieve required competencies, as well as to monitor Ohio call center performance in the context of national NSPL standards.

6. **Consistent performance metrics for call centers, including tracking callers to ensure that they have been appropriately connected to help, as well as a statewide data system for performance monitoring.** This is currently in the early stages of planning and development.

7. **Statewide marketing and dissemination.** Following the "soft launch" and troubleshooting existing system improvement requirements, Ohio will continue to follow SAMHSA's national guidelines to increase universal "988 awareness" for calls for help in a BH crisis.

8. **Sustainable funding model beyond the startup federal funds.** Considerations for sustainable funding models have been articulated and are pending action.

Connect - Considerations

To continue the positive momentum that has been built by the successful roll out of 988 and bring broad connection to crisis care services, integration with the rest of the existing crisis response system should be achieved.

The following are considerations to support the Ohio crisis system to achieve full linkage between 988 and other elements of the BH crisis response system and begin the work of setting foundational quality standards across the call center network.

Additional considerations are provided to support marketing initiatives to bring broad community awareness to the presence of 988 and other crisis call lines.

Considerations were derived based on input from the Connect Committee of the Crisis Task Force, the 988 implementation plan, OhioMHAS guidance documents, as well as national best practices.

Connect - Linkages Considerations

To realize the goal of an integrated crisis response system with linkages between 988, 911, and existing call lines, there should be a concerted effort to ensure cooperation amongst ADAMHS Boards, NSPL/988 call centers, and other local hotlines. While the planning is a crucial step, the implementation of technology that allows for call, text, chat and warm handoffs across the various lines is present. Finally, all these lines should be supported by a statewide online resource directory that supports the sharing of quality referrals. The considerations below support these goals and should be considered in conjunction with the 988 implementation plan.

1. The state and local communities value all the crisis lines (988, 911, 211, warmlines, etc.) as a crisis safety network working collaboratively as a team to address crisis calls/texts/chats across the state. As such, each crisis line is a key partner in creating a crisis system that saves lives, gets people into treatment, and links callers to resources.

2. Local ADAMHS Boards, in collaboration with the OhioMHAS 988 Administrator, should convene meetings with NSPL/988 call center agencies, other local warm/hot lines, 211s, 911s and other crisis providers. These collaborative meetings should be a regular occurrence. The crisis stakeholders should have formal agreements that delineate the expectations of each stakeholder, the data that will be shared, and an agreement to work cooperatively to meet the needs of persons in crisis regardless of entry point.

3. Technology should be implemented that allows for the efficient exchange information, including directly transferring and referring calls to the best resources, training programs, sharing of statistics and outcomes, caller resource guides, budgets, etc. This flow of information and timely reporting should occur regardless of the funding source.

4. Systems should be developed to support callers who have ported their phone numbers from other Ohio counties and from other states. The 988 call centers should work with any community call center, if needed, to ensure that warm handoffs take place. Additionally, to seek to close any potential gaps in service accessibility geolocation of 988 calls and texts should be implemented.

5. The current Online Resource Directory development project should be completed and available to all call lines to support the sharing of quality referrals. The directory should be updated to ensure that all 988 and other call lines have a reliable and current statewide list of all local crisis contacts. This guide should also be available to the national NSPL/988 back-up call centers to support anyone who has moved into Ohio with another state's area code.

Connect - Quality Considerations

The implementation of quality standards should provide consistency across call centers, ensure satisfaction for those who use the lines, and promote increased access to the broader community. The implementation of 988 provides an opportunity to identify quality benchmarks that keep the focus on serving those who are impacted. These benchmarks should be applicable to all call centers, not just 988. To achieve the desired state, summary considerations are provided below. Additional detailed quality standards can be found in Appendix C.

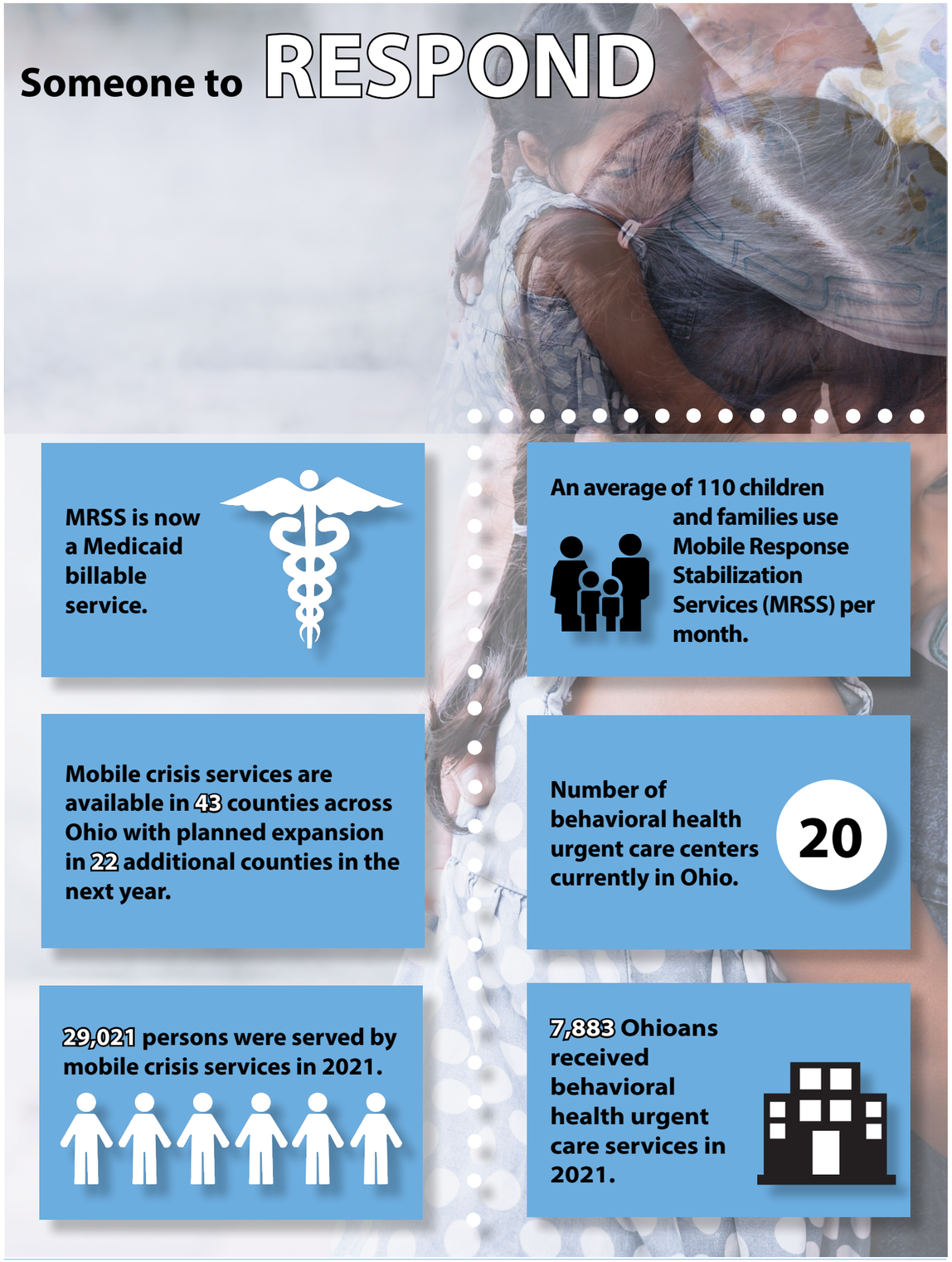
1. The Connect Committee should continue to guide state efforts as the state's 988 and other crisis call center infrastructure continues to evolve. Stakeholders should include:
   - Call center programs – both 988 and other crisis call centers
   - OhioMHAS
   - ADAMHS Boards
   - Law enforcement
   - 911/public safety centers
   - Youth and Adult Mobile Response, including Mobile Response and Stabilization Services (MRSS) for youth
2. Call center certification standards should be developed for all crisis call centers. These standards should be grounded in national quality models and, to the greatest extent possible, not introduce additional administrative burden.
3. The system should adopt a core set of trainings that are accessible to all call center staff. The current CARELINE Training series is a foundational element which could be enhanced through additional core staff onboarding, population-specific and best practice model trainings and on-demand webinars.
4. A core set of quality metrics should be developed that seek to assess each call center's level of service, access, quality, and satisfaction. At a minimum, these metrics should include call center utilization, post-call disposition, number of calls that resulted in law enforcement intervention, and caller satisfaction.

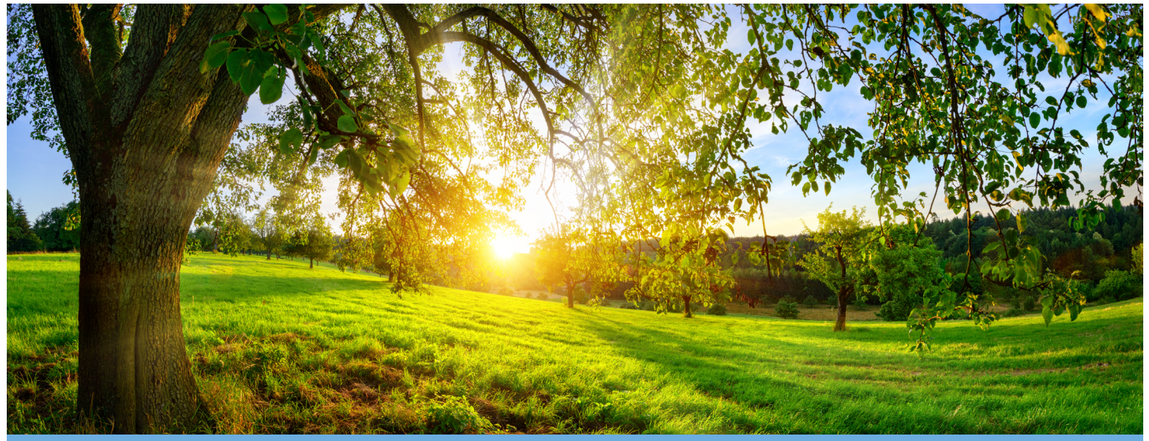
Connect - Marketing Considerations

Marketing efforts for 988 call centers and others are critically important as call centers serve as the main entry point into the state's larger crisis services system for Ohioans experiencing a suicide-related, mental health or addiction crisis. Effective marketing will help Ohioans learn about and remember 988 as the dialing code for mental health and addiction crisis support. Marketing work in preparation for 988 implementation in Ohio has begun to identify key audiences for marketing 988, dissemination channels, strategies for using guidelines and toolkits from SAMHSA, the CDC and Vibrant, state-level assets, and region-specific needs.

SAMHSA, Vibrant, and the National Alliance for Suicide Prevention have released marketing and communication tools designed to educate all the stakeholders in the crisis response systems regarding the launch of 988. The federal government has requested that states hold off on public messaging campaigns until July 2023 to allow for the new 988 system to be tested and revised to ensure quality access points for those in need. To prepare for the official launch date and integrate 988 marketing efforts with a broader dissemination of community information on existing BH crisis lines, the following should be implemented rapidly.

1. Continue the marketing workgroup for OhioMHAS and crisis system partner representatives to create a robust, comprehensive marketing and funding plan. This workgroup should work to formalize a public relations plan, engage target audience focus groups, and develop messaging materials to support the implementation of 988 as well as bring awareness to the crisis line network.
2. Develop a messaging plan to support the official launch of 988 in July 2023. The work should focus on key goals of the 988 messaging campaign, prioritize audiences for messaging efforts, identify themes for focus audiences and channels for distribution.





Respond - Where is Ohio?

A core responsibility in an ideal crisis system is the expectation that crisis response is timely and provides for appropriate intensity and triage to higher and lower levels of care.

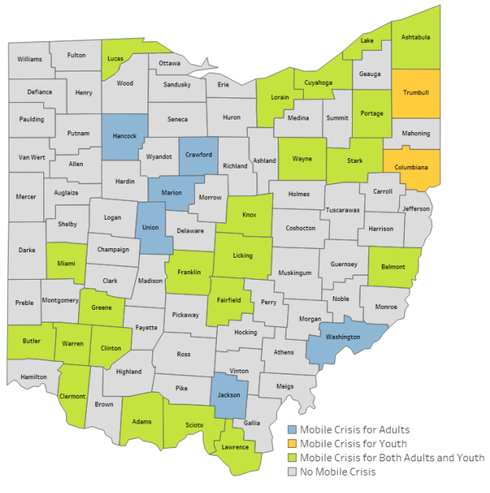
Ohio's crisis system consists of two distinct services: 1) Mobile Crisis Services for both adults and children and 2) BH urgent care. Both services seek to provide initial interventions to prevent repeat crises.

OhioMHAS and ODM have worked collaboratively to implement MRSS as a Medicaid funded mobile crisis model for children and families under OhioRISE (which went into effect July 1, 2022). MRSS started in Ohio as a pilot with a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2017 in two regions: Northwest and Southwest Ohio. The department has implemented MRSS in the Northwest (Lucas, Wood, Hancock, Allen, Auglaize, Hardin, Putnam, and Paulding counties); and Southwest (Butler, Warren, Clinton, Preble, and Clermont counties).

State data on MRSS for the last quarter indicate over 200 children/families per month statewide that received an MRSS intake, of which approximately two-thirds were in "immediate" need. MRSS therefore is still very limited in reach. Further, many counties report that they are unable to meet MRSS standards due to workforce requirements. In addition, some providers who are currently attempting to offer MRSS report that they are unable to meet all the expectations, especially in rural areas. To assist providers, OhioMHAS is providing MRSS readiness trainings as well as support with applications for MRSS certifications.

Service descriptions from current mobile crisis providers indicate a great deal of variability in the design and implementation of mobile crisis services from county to county. This is not to say that variability in design means variability in quality. There is clear commitment by all providers to offering the best possible quality of services. However, local variation in geography, population, workforce, and funding has led to significant variation in creative approaches to meeting the needs of people in those communities.

Figure 6. Mobile Crisis Services in Ohio



Mobile Crisis Teams

The survey specifically requested data using the interim definition of "mobile crisis intervention with clinical staff."

Any organized program or team in which BH crisis response includes specialists in behavioral health – licensed or unlicensed clinicians and/or peer support staff – brought to the location of the person in crisis. Mobile crisis units may offer face-to-face, pro-active intervention to individuals where they present, including home, work or anywhere else in a community a person is experiencing crisis. This may include clinician only or co-responder (with law enforcement or EMS) programs. This may include mobile intervention services for people with SUD as well, such as outreach interventions for individuals who have overdosed on opioids. Some services may be provided by telehealth; the key is that the services are brought to the location where the person is in crisis rather than the person needing to go to a specific BH crisis location. Mobile crisis units may be integrated within and dispatched from community behavioral health settings, crisis facilities, crisis hotlines, and 911 response systems (PSAPs, sheriff's offices, etc.). Note that mobile crisis response limited to existing clients in an ongoing program, such as ACT or supported housing, would NOT be included.

The ADAMHS Board survey indicated that every ADAMHS Board is providing some level of service under this definition, but for most ADAMHS Boards also have provision for mobile services in schools and juvenile justice settings. Mobile crisis services for adults beyond that baseline, which serve individuals anywhere in the community, were reported by ADAMHS Boards in 26 counties (24 serve both adults and children, 2 serve adults alone). Six additional counties have mobile crisis only for children (30 total). Note that the availability of these services in these counties does not mean that they meet fully recommended standards of availability and response.

Table 2. Data from ADAMHS Board Surveys on Mobile Crisis Services

Item	Result
Total number of mobile crisis teams (MCTs) in Ohio	43
Number of MCTs that serve both children/adolescents and adults	27
Number of MCTs that serve only children/adolescents	7
Number of MCTs that serve only adults	9
Number of individuals served by MCTs in last year	29,021
Number of children who were served by MCTs in last year	21,157
Total budget for MCT services in last year	$18,934,538
Average annual costs to operate a team	$540,986

Arrests/Behavioral Health Crisis Encounters in Jails

While only limited jail data were submitted by ADAMHS Boards in response to the survey for this Landscape Analysis, there was a consistency in the data that could lend itself toward establishing a valid benchmark for what a community that does not have available data could assume for planning purposes. The counties represented in Figure 8 had limited obvious commonalities, however, they were able to provide the data due to data sharing collaborations with local law enforcement partners. The counties ranged in size from 98,000 to over 380,000, but all had behavioral health related arrests consistently in the 300-400 range per 100K population.

Bowling Green State University conducted research for Ohio's Stepping Up Initiative, published in December 2021, that also informed this analysis. They concluded that two areas needed improvement: (1) individual support upon jail release, including housing, access to treatment, community-based support and (2) courts, specifically tracking of offender populations, specialized courts, and probation departments. There was also discussion of the need for more consistent data collection on behavioral health related law enforcement encounters and arrests.

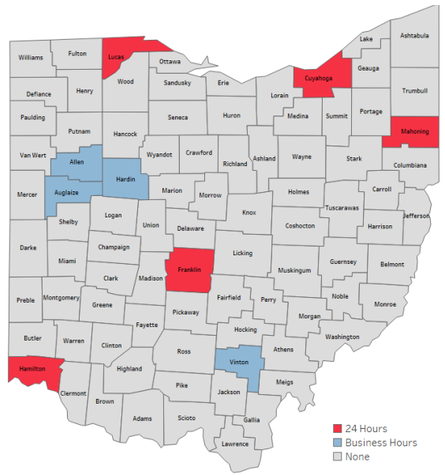
They were able to find that at least 31 counties have an active crisis intervention team (CIT) program, with twenty-one counties reporting that law enforcement or their CIT program collects data on the number of people identified as having a mental illness who were diverted to non-jail settings. This aligns with the findings from the ADAMHS Board survey conducted for this report.

Figure 7. Findings from Stepping Up of Crisis Continuum Services ADAMHS Boards identified for development and enhancement

Service on Crisis Continuum to Develop/Enhance	Number of Counties
Crisis residential facility	7
Mobile response	12
Crisis stabilization unit*	4
Receiving and evaluation center	9
Enhancement of existing system	1
Increase co-response to mental health calls	1
**One county noted a youth-only facility*	

First Responder Crisis Intervention Teams

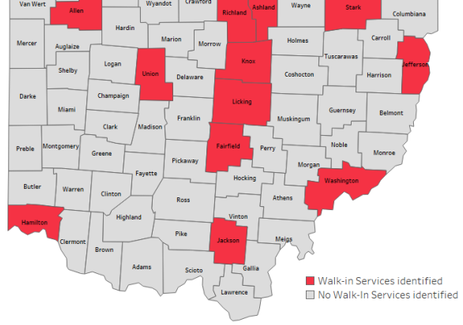
Figure 8. First responder crisis Intervention Services in Ohio



In the ADAMHS Board survey, information was requested on first responder crisis intervention teams. While significant time and resources have been invested in training officers in CIT training, which is certainly resulting in more informed and safer engagement of first responders with people in behavioral health crises, the teams that were being requested in the survey are defined as intentional and planned response to behavioral health crisis by a trained cohort of law enforcement personnel or other first responders. Very few communities outside of the three largest metro areas have such a response in Ohio, with notable exceptions being Franklin County's multiple partnerships between clinical resources and the Columbus Fire Department, Columbus Police Department and Franklin County Sheriff's Office, Cuyahoga County's Community program which involves up to 25 law enforcement agencies in the county, the University Hospital program in Cincinnati, and a full-time behavioral health deputy in Vinton County.

NAMI Northwest, covering Seneca, Ottawa, Sundusky and Wyandot Counties, began running three-person mobile crisis units in August 2021, initially only in Sandusky County and expanding to the other counties the following summer, to support local law enforcement by handling nonviolent 911 calls that involve behavioral health situations, following up on calls occurring outside of operating hours, providing home wellness checks, linking and transporting people to treatment services, and providing case management. Hopewell Health Centers, serving Athens, Hocking, Vinton, Gallia, Jackson and Meigs Counties, operating 24 hour a day crisis intervention teams that evaluate and pre-screen callers, visitors and ED patients for crisis services, reducing the number of people in a behavioral health crisis who are taken to jail. Hubbard City also has interesting program that involves up to 6 chaplains who, when invited, work with individuals who have experienced trauma. Data was relatively limited on these programs, though Franklin County ADAMHS Board was able to report that its community served over 3,000 individuals between their multiple programs. Budgets for the teams ranged from $75,000 to over $2.2 million.

Figure 9. Behavioral Health Walk-In Services in Ohio



Behavioral Health Urgent Care

In the ADAMHS Board Survey, BH urgent care centers were defined as:
Non-hospital based walk-in locations (analogous to medical urgent care) that provide easy access for individuals requesting or accepting assistance with a behavioral health crisis. Individuals may be brought to urgent care walk in locations by others, including law enforcement, but the services are voluntary. For the purposes of this definition, include only walk-in services that are available to the public, not just walk in services restricted to existing clients. Also, only include services whose primary purpose is crisis response, NOT "open access" primarily for routine assessment or intake. Hours of operation for this setting may vary depending on community needs or geographic location.

Seventeen ADAMHS Boards reported at least one BH urgent care center which are being provided by fifteen providers across the state:

- Alternative Paths
- Appleseed Community Mental Health Center
- Behavioral Healthcare Partners of Central Ohio
- Catalyst Life Services
- Coleman Health Services
- Community Counseling Center
- Hopewell Health Centers
- Life & Purpose Behavioral Health
- Maryhaven at Mill Center
- Mental Health Services of Clark & Madison Counties
- New Horizons Mental Health Services
- Oriana House
- Ravenwood Health
- The Children's Home
- Upper Valley Medical Center – Premier Health

Table 3. Data from Surveys on BH Urgent Care

Item	Result
Total number of BH urgent cares in Ohio	19
Number of BH urgent cares that serve both children/adolescents AND adults	17
Number of BH urgent cares that ONLY serve children/adolescents	1
Number of BH urgent cares that ONLY serve adults	1
Number of individuals served by BH urgent cares in last year	7,883
Number of counties indicating additional support for BH urgent cares in the next year	3
Total budget for BH urgent care services in last year	$7,595,961

Respond - Where Does Ohio Want to Be?

Ohio has recognized the importance of not only having "someone to call" (988) but having "someone to respond" urgently to people in need. The implementation of mobile crisis teams across Ohio including MRSS is an important first step. There are three components to "Respond": 1) mobile crisis teams where clinical staff and peers (sometimes in partnership with other first responders) go to the person in crisis, wherever they are; 2) behavioral health urgent care walk in services, where people who need help can have easy access to timely response; and Transportation, where people in behavioral health crisis can have an easy time moving between different locations of crisis response in order to get what they need. Transportation is an important feature of stabilize and thrive services as well.

The vision of "Respond" is that every person experiencing a behavioral health crisis in Ohio will receive the right response in the right place every time, through having access to a timely urgent response, whether through mobile crisis or through walk in services, 24 hours a day, 7 days a week. Consequently, unnecessary use of medical EDs and unnecessary arrests for people experiencing behavioral health crises will be reduced or eliminated. Everyone experiencing a behavioral health crisis who needs transportation from one location to the next to receive the right response will have access to a comprehensive array of appropriately matched and funded transportation options, commensurate with the diversity of options available to people with medical conditions and disabilities.

Outlined below are some of the goals for the future vision of Ohio's crisis response system:

1. **Mobile crisis teams, including both clinicians and peers, are available for adults and children 24/7 in every county in Ohio.** 988 calls would have the capacity to dispatch the closest mobile team to the point of crisis, and 988 and 911 dispatchers would work collaboratively to ensure that law enforcement and/or EMS were available on scene as indicated to collaborate with the mobile crisis providers. MRSS is a desirable option for communities that have the capability to implement that service package, but other mobile crisis services for children and families can be implemented as well.

2. **BH urgent care walk-in services are available for walk-in response in every county in Ohio.** These services can be provided in combination with crisis centers with observation, as discussed further in the Stabilize section, in combination with medical urgent care, community mental health centers or other services, or in freestanding locations, and in larger communities will be available 24/7 for people of all ages. These services represent easily accessible response for individuals with an urgent need that do not require an ED visit and usually do not require a higher level of care.

3. **Service definitions and certification standards, along with sustainable multi-payer funding for both mobile crisis teams for adults and children, and BH urgent care.** The goal is for policy guidance and support to promote adequate and sustainable program funding for the full array of critical and cost-effective respond services.

4. **Comprehensive array of crisis transportation options that are safe and appropriate for people in behavioral health crisis are available in each county in Ohio.** This requires defining behavioral health specific medical necessity criteria for various transportation options, so that they can be provided and funded appropriately, as well as facilitating other local transportation options to fit local need.

Respond - Considerations

Respond – Mobile Crisis Team Considerations

Mobile crisis services for adults and children are a core component of the Ohio BH crisis system. To achieve the desired future state of statewide implementation of mobile crisis services to scale, a standard service definition with accompanying service standards specific for Ohio should be adopted. This definition and standards should guide consideration of options for adequate financing as well as guidance for developing implementation steps.

The considerations are derived from the SAMHSA *National Guidelines for Behavioral Health Crisis Care (2020)*, the CMS guidance for mobile crisis services that are eligible for enhanced FMAP (2021), and the Mobile Crisis Subcommittee of the Crisis Task Force. The considerations summarized here are included in a more detailed form in the Mobile Crisis Subcommittee Report that is included in the Appendix. The SAMHSA and CMS documents define the broad goals and objectives of mobile crisis and identify core required elements and areas where states can have individual flexibility in service design within their own Medicaid plans and waivers. The mobile crisis subcommittee used these documents as a base and supported the development of the detailed service standards that consider the geographic and resource variation present across Ohio.

Service Definition

Mobile crisis team services are behavioral health (MH and/or SUD) crisis response services provided by clinically trained staff who are dispatched to the site of the crisis anywhere in the community and are commonly available 24/7. Mobile Crisis Services are designed to provide rapid response to the crisis location, assess the individual child or adult in crisis, and develop a plan to resolve the crisis.

- The main objective of mobile crisis teams is to reduce psychiatric hospitalizations, including hospitalizations that follow psychiatric ED admission. (SAMHSA *National Guidelines for Behavioral Health Crisis Care*).

- Additional objectives may include:
  - Linking people to needed services and engaging hard-to-reach individuals.
  - Diversion from unnecessary ED visits and unnecessary law enforcement involvement and arrest.

The above definition and the accompanying core services and service standards below are designed to align with national guidance from SAMHSA, CMS, and other sources regarding state-of-the-art mobile crisis response. Adoption of a standard definition allows the community to understand the goals of mobile crisis services and positions mobile crisis teams as key components in the crisis system, as that of a first responder. Within a final service definition, it is important that broad goals and core services are delineated. As shown below, SAMHSA and CMS have delineated goals and required core services that should be present in a high performing mobile crisis program.

Goals of Mobile Crisis Team Services (SAMHSA Guidelines for Behavioral Health Crisis Care)

1. Helps individuals experiencing a MH or SUD crisis event to experience relief quickly and to resolve the crisis when possible.

2. Meets individuals in an environment where they are comfortable.

3. Provides appropriate care/support while avoiding unnecessary law enforcement involvement, ED use and hospitalization.

Core services: (CMS)

- Mobile crisis team services should be strengths-based, person-centered, trauma informed, culturally competent, coordinated and focused on outcomes (e.g., service engagement, decreases in arrest and ED boarding, etc.).

- Mobile crisis team services should be integrated into a full community-based continuum of crisis services.

- Mobile crisis teams must be on the ground in the community served and should be provided where the person is experiencing a crisis (home, work, park, etc.) and not be restricted to select locations within the region or to particular days/times.

- Mobile crisis teams should connect people to facility-based or ongoing community-based care as needed, through supported linkage and coordinating transportation only if situations warrant transition to other locations.

- Mobile crisis teams should have the capability to make referrals to outpatient care and to follow up to ensure that the individual's crisis is resolved, or they have successfully been connected to ongoing services.

- Mobile crisis services should be designed and measured with attention to diversity, equity, and inclusion. A crisis continuum that functions well is intentionally inclusive of all residents of a community, including those from under-resourced areas and populations with disparate outcomes.

- Mobile crisis team services are available 24/7 and can be provided in the home or any setting where a crisis may be occurring.

Service Standards

Development of specific service standards for mobile crisis team services in Ohio should clearly balance delineation of the core expectations of each program with flexibility to accommodate the needs of diverse communities. The initial service standards described below were developed to align with national best practices and ensure consistency in service provision. They also provide suggested areas where it may be appropriate to have flexibility as described above. Final service standards should provide regulatory guidance for permissible variations due to rural versus urban geography, adults versus child populations served, type of staffing, variation in services at different times of day, and scope of services offered.

Triage/screening, including explicit screening for suicidality. The triage system (911, 988, & non-NSPL call centers) needs to identify when mobile crisis response is needed, versus a response that is either more intensive and rapid, or less intensive and rapid.

24-hour timely access. The goal of mobile crisis team services is always to have 24/7 availability. However, there may be a need for ramp up or start up phases, where the initial program may have 12- or 16-hour coverage to begin.

Assessment. The standard should include the expectation of having a clinician available who is "capable by scope of practice of performing an assessment under the state Medicaid plan". Further, options should include availability of a licensed clinician via telehealth.

Cultural/Linguistic Access. All mobile crisis teams should be trained, including triage staff, to have cultural humility. In addition, it is critical to make provision for linguistic barriers, including American Sign Language.

De-escalation/resolution. The service should prioritize de-escalation in the field, with follow up efforts to promote continuing crisis resolution and linkage to ongoing treatment.

Peer support. Having adult and youth peer supporters as regular members of the mobile crisis team provides dramatic advantages to engaging people with BH and/or SUD crises.

Coordination with physical health services, behavioral health services, and other service systems. Mobile crisis team services are part of a community's emergency response system, but also need to have ongoing relationships with existing continuing services and support systems, for evaluation, coordination of crisis response, and continuing care planning.

Mobile crisis services should be provided by teams. Community-based mobile crisis team services should use face-to-face professional and trained peer intervention, deployed in real time to the location of the person in crisis to achieve the best outcomes for that individual.

Team-based service policies and procedures. All mobile services should be designed (as MRSS already is designed) with specific standards that support team-based responses, including billing and documenting team members providing services in the same location to the same client at the same time.

Crisis planning and follow-up. Mobile crisis teams should have embedded capacity to develop crisis plans as well as to provide continuing short term follow up services to ensure that the person or family is stabilized and engaged in continuing care.

Considerations for Financing for Mobile Crisis Services

Adequate funding for key services is essential to ensure 24/7 availability ("firehouse capacity"), appropriate distribution in the geography to ensure timely response, and adequate payment to incentivize recruitment and retention of well-trained staff. In most states, mobile crisis teams have a significant component of their funding through Medicaid and/or Medicaid managed care organizations (MCOs).

To ensure mobile crisis team services are available to all persons who may need them in Ohio the following should be considered.

1. Mobile crisis team services should be defined in regulation, in alignment with nationally recognized evidence-based treatment standards by SAMHSA and CMS and should be mandated for funding by ALL third-party payers.

2. Payment methodologies should be based on funding the "firehouse model" of capacity, as well as service volume. Costs should cover the true cost of recruiting staff to be on call and mobile 24/7. As a result, cost could vary in less well-resourced and more geographically dispersed communities.

3. For mobile crisis service costs that are not supported by third party payment in Ohio, funding responsibility by ADAMHS Boards should be shared equally with, and adequately funded by, OhioMHAS.

4. Support mobile crisis team structures that use single and multiple sites as bases of operation.

5. Recently published national best practices for mobile crisis team funding should be considered by Ohio.

6. Rural counties may need higher per capita funding due to smaller size.

7. Incentive payments should be considered for meeting certain benchmarks, such as response timeliness.

8. Hospitals are natural partners in funding mobile crisis team services that may relieve pressure on their EDs. If there are community hospitals experiencing challenges with boarding, and absorbing associated costs for security they should be brought to the table to help fund mobile crisis services as an alternative.

Implementation Considerations

In addition, to the service definition, service standards, and financing, there are additional implementation considerations that should be contemplated to enhance the ramp up of services as well as provide local flexibility to aid program development.

1. Regulations should be flexible enough to accomodate mobile crisis teams that may specialize in serving adults or children, but other factors enumerated below will guide the practicality of supporting multiple teams in a given locale.

a. Consideration for the best option should be based on service volume, available resources, and potential economies of scale. Variables include:

   i. Size of county or ADAMHS Board region

   ii. Type and amount of available funding

   iii. Availability of appropriate staffing

   iv. Access to appropriate staff training

2. Regulation should be flexible enough to accommodate mobile crisis teams that may specialize in serving adults or children but other factors as enumerated below will guide the practicality of supporting multiple teams in a given locale.

   a. Communities also should have the option of keeping these services separate but complementary and collaborative.

   b. QRT could also be used to provide follow up (peer, clinical staff, or other) after determination is made by mobile crisis team to maintain client in the community.

Respond - BH Urgent Care Considerations

BH urgent care services should be a core component of the BH crisis system in Ohio. BH urgent care is analogous to physical health urgent care in providing walk-in services for people in crisis who generally do not require involuntary intervention nor to be seen in a physical health ED. BH urgent care may be an appropriate alternative response for individuals and families who may prefer to be seen outside their home, and therefore would not choose a mobile crisis response.

To achieve the desired future state, a service definition with accompanying service standards should be developed. This definition and standards should guide consideration of options for adequate financing as well as guidance for developing implementation steps.

Service Definition

BH urgent care centers are community-based options to stabilize individuals experiencing BH crises in a way that reduces unnecessary trips to the ED, hospitalizations, and even incarcerations. These walk-in centers are designed to provide assessment, stabilization, and psychiatric and SUD intervention for persons in crisis by a multidisciplinary team of professionals. The goal is to ensure people are stabilized and linked to the least restrictive and most appropriate level of care that promotes their continued recovery.

The above definition provides for the inclusion of a range of different services and resources that can be included in BH urgent care and ensures that the services are tiered with essential, desirable, and potential services (must, should, may). This should allow communities flexibility to develop baseline BH urgent care capability and then work toward a more ideal or comprehensive BH urgent care service as resources allow.

Service Standards Considerations

The service definition should also include service standards that clearly delineate the services and intervention expected of each program. The standards described below include national best practices and provide flexibility given the variation in geography and resources in Ohio. The "must have" services for all BH urgent cares should consider:

- Behavioral Health Triage and Crisis Screening: The triage system (911, 988, & non-NSPL call centers) needs to identify when the needs/wants of the caller can be more appropriately met at a BH urgent care as opposed to mobile response.
- Physical health triage and basic medical screening. A brief screening to ensure people are medically stable, to reduce ED use.
- Rapid access to higher levels of intervention. The program should have existing agreements and contacts to rapidly transfer to higher levels of physical health, mental health, and substance use disorder services, where needed.
- MH and SUD crisis evaluation and intervention.
- Safety planning. Completion of a brief safety plan to identify crisis warning signs, coping strategies, and family and professional supports.

- Continuing care planning. Ensuring linkage to needed ongoing BH services and other community resources, as well as to recovery support services.
- Managing appropriate utilization. Providing interventions for "familiar faces" for those that are frequent persons served.
- Access to prescriber consultation. Availability of prescribers in-person or via telehealth to support bridge prescriptions.

Considerations for Financing BH Urgent Care Services

As a key first intervention point in the Ohio crisis system, adequate funding is essential to ensure 24/7 availability ("firehouse capacity"), appropriate distribution in the geography to ensure timely response, and adequate payment to incentivize recruitment and retention of well-trained staff. Since BH urgent care programs can be funded through a multitude of existing services, it is most imperative that funding methodologies and rates are sufficient to ensure program capacity and required of all third-party payers. Further, justification for funding should include the value brought by avoiding unnecessary ED utilization.

To ensure behavioral health urgent care services are available to all persons who may need them in Ohio the following should be considered.

1. BH urgent care, like physical health urgent care, should be supported by third-party funding mechanisms that correspond to the value of minimizing expensive and unnecessary ED care (often only to existing clients), and the 24/7 availability of the ED for anyone who has an urgent or emergent need.
2. Maximizing sustainability through third party revenue generation minimizes the need for other types of funding support and can occur through one or more of the following location-based strategies:

   a. Accessible and on/near public transportation lines

   b. Near other high-volume settings or frequently accessed services

   c. Locations that have potential for growth through the addition of other enhanced services

3. Rate structures should be considered with the idea of diversion from ED visits. Rates should recognize that BH urgent care services are not routine outpatient mental health care.
4. Consider funding models that support a multidisciplinary team approach to BH urgent care that will meet the varied needs of people experiencing a crisis without undue administrative burden on any of the crisis system partners.

Other Implementation Considerations

In addition, to service definition, service standards, and financing, there are additional implementation considerations that should be contemplated to enhance the ramp up of services as well as provide local flexibility to aid program development.

1. Behavioral health urgent care regulations should allow for a variety of set-ups and locations. These could be freestanding locations or co-located with and/or embedded in other service settings. Telehealth can be used, as clinically appropriate, to help reduce access issues for difficult to staff services such as prescriber consultation. These could include, but are not limited to:

    a. Embedded in an existing physical health urgent care.

    b. Being in or proximal to a hospital near the ED (for example, with staff that can come to the ED to escort appropriate individuals to urgent care).

    c. Combined with a crisis center with observation.

    d. Embedded in an outpatient MH and/or SUD service setting.

    e. Co-located with a peer drop-in or respite center.

2. Services may be separated among adults, young adults, and youth and/or may be a service for all without delineation. For instance, there is a BH urgent care program specifically for children in Hamilton County.

3. BH urgent care can be offered separately from BH emergency services that might be provided in a crisis center with observation, or as a component of such services.

    a. Communities should have the flexibility to determine the design and distribution of BH urgent care depending on community needs and services.

    b. Consider the potential for services in some communities to be offered under a federally qualified health center umbrella, as well as CCBHCs.

Crisis innovation at work in Ohio

- Hamilton County has opened a behavioral health urgent care center for children.
- Nationwide Children's Hospital in Columbus has a comprehensive walk-in service for childen in crisis.

Stabilize - Where is Ohio?

Once people connect to services and someone is there to respond, there must be a place for people in BH crisis to go to stabilize.

According to the interim definitions that were used in the ADAMHS Board Survey and guided the Crisis Task Force process, crisis centers with observation are "places to go" where individuals in crisis can present for immediate assessment and intervention. These facilities provide an opportunity for 23-hour (or sometimes longer) observation in order to promote stabilization and connection to the next best service, maximizing the opportunity to divert from hospitalization.

Ohio has invested considerable state resources and energy into the development of "Crisis Stabilization Centers." Crisis centers with observation are one important type of "Crisis Stabilization Center." Because the use of the term Crisis Stabilization Center in Ohio has acquired so many diverse meanings, this term has been set aside in this process to be more precise about what is being described and developed. The ADAMHS Board Survey data and other sources have identified several major subtypes of crisis centers with observation: Hospital-based psychiatric emergency services (of which there are three reported, one of which is at Sisters of Charity Health System - St. Vincent Charity Health Campus in Cuyahoga County), non-hospital crisis centers (of which there are a few in operation, and several in planning and development), and peer respite services (of which there is one identified, operated by Foundations of Canton). (Note: the crisis center in Akron is named "Psychiatric Emergency Services", but it is non-hospital based. Therefore, the term "psychiatric emergency services" should not be used as a descriptor for hospital-based services.)

The survey asked about crisis centers and observation, defined as:

A crisis center and observation setting provide no wrong door access for individuals in acute mental health and/or substance use crisis with capacity for ongoing evaluation (including prescreening for hospitalization), observation, and intervention. This setting usually accepts walk-ins, referrals from mobile crisis teams and transfers from EDs, as well as police, ambulance, and fire department drop-offs. Some settings may accept individuals on involuntary status. Observation commonly may be extended to 23 hours, but at times individuals need to be kept for longer periods (up to 72 hours) before disposition.

There is better coverage provided by existing crisis centers with observation than was recognized as this process began. While not available in most counties in the state, there are existing 24/7 crisis centers in five geographically diverse communities in the state (Lima, Cleveland, Cincinnati, Columbus, Zanesville). Mapping these centers with a 50-mile radius shows that there are still several significant geographic gaps in the state, in the northwest/north central, south central and far eastern regions, where people with BH crises are not within a reasonable distance of this type of service. There are also centers planned for Montgomery, Franklin and Lorain Counties that will expand capacity and have involuntary access that is not currently available. While this is encouraging, it is important to remember that having one crisis center with observation (some of which have limited capacity relevant to need, or only take voluntary admissions) is not the same as having adequate capacity for adults and children in BH crisis or people who are being served involuntarily and voluntarily.

Figure 10. Map of existing 24/7 crisis centers with observation within 50-mile radius mapped

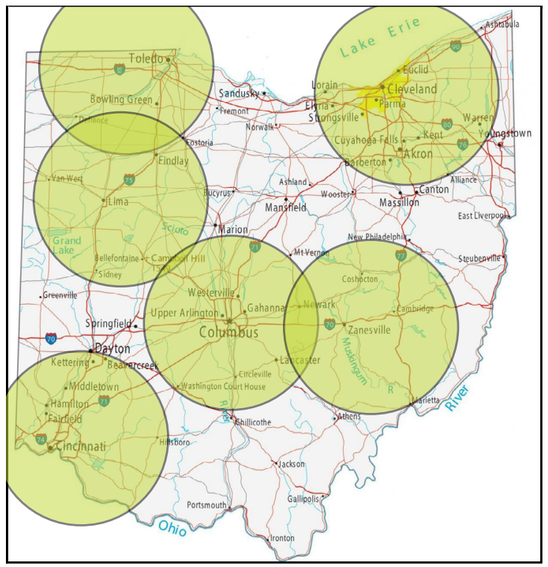


Table 4. Data from Surveys on Crisis Centers with Observation

Item	Result
Total Number of crisis centers with observation in the state	10
Number of crisis centers with observation for children/ adolescents	0
Total number of crisis centers with observation for adults	9
Number of Ohioans served by crisis centers with observation in last year	7332
Number of counties indicating additional support for crisis centers with observation in the next year	2
Total budget for crisis centers with observation in last year	$7,815,377

For residential crisis services, while there are many short-term residential beds in the state for those in crisis, the majority are residential withdrawal management programs for substance use disorders. There are very limited residential crisis services for adults with MH crises, and even fewer for children. Further, it is important to note the significant population centers that reported not having any residential crisis services. Butler County was the largest county that reported not having any residential crisis services, followed in population size by six additional counties with more than 100,000 in population: Lake, Delaware, Medina, Fairfield, Clark, and Miami Counties.

Figure 11. Crisis Residential Facilities

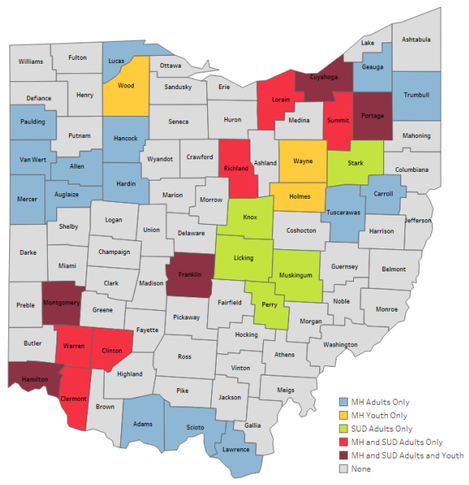


Table 5. Data from Surveys on Crisis Residential Services

Item	Result
Total number of crisis residential programs in Ohio	48
Number of crisis residential programs that serve both children/adolescents and adults	1
Number of crisis residential programs that only serve children/adolescents	2
Number of crisis residential programs that only serve adults	45
Number of children/adolescents served by crisis residential programs in last year	807
Number of adults served by crisis residential programs	16,319
Number of Ohioans served by crisis residential programs in last year	17,126
Number of counties indicating additional support for crisis residential programs in the next year	10
Total budget for crisis residential programs in last year	$35,511,444

There are numerous hospital-based partial hospitalization programs and intensive outpatient programs that fall under the definition used for intensive community crisis but were not often captured on the survey because they are not generally relied on or contracted with by the ADAMHS Boards. Hospital partners were indicated in some communities, but not all where they are available. Larger communities have multiple inpatient facilities which draw from multiple counties, and smaller communities often send their patients to multiple facilities a significant distance away.

Some mobile crisis teams provide (usually with ADAMHS Board support) continuing follow-up for 30-90 days after the initial contact, but this is not a consistent practice outside of the MRSS which includes stabilization services for up to six weeks." Quick Response Teams (QRTs) exist in almost every county in the state but not necessarily in every town and city. Generally, their purpose is to prevent death from opioid overdose; they can't always offer the follow-up that some people who experience crisis might need. On the other hand, QRTs are a critical building block to a more comprehensive system in many Ohio communities as it indicates a recognition from law enforcement and across the broader community that follow up for those in crisis is an important and valuable component of the system.

There is limited availability from state hospitals for non-forensic patients. Acute inpatient psychiatric services are available through both general hospitals and a significant dispersion of freestanding psychiatric facilities. Children in crisis have fewer inpatient resources outside of general hospitals and Children's Hospitals in large metropolitan areas.

Stabilize - Where Does Ohio Want to Be?

Ohio is well on its way to broad dissemination of some of the stabilization elements of the BH crisis system, which include crisis centers with observation, residential crisis services (adult, children, MH, SUD), inpatient psychiatric treatment, and intensive community-based crisis intervention. Significant progress has been made in starting up brand new stabilization crisis services all over the state, and Ohio is ready to take this implementation to the next level.

The vision of "Stabilize" is that every community will have access to a full array of stabilize services to scale, either locally or in a neighboring county, so that every person experiencing BH crisis will get what they need, in the right place, at the right time, without unnecessary arrests or ED visits.

Outlined below are some of the goals for the future vision of Ohio's crisis system, using Crisis Now figures:

1. **Crisis centers to scale serving all communities, accepting involuntary and voluntary clients.** With the goal of 16 "crisis observation chairs or beds" for adults for a population of 500,000 and roughly one-fourth to one-half that number for children, the goal is to have an appropriate crisis center in each large county (or ADAMHS Board region), and almost all medium-sized counties, with collaborations between larger and neighboring smaller counties to provide both ED consultation and crisis center access.

2. **Residential crisis services for MH to scale for both adults and children.** Scaling these services requires recognition that fewer individuals need residential crisis services (whether for hospital diversion or stepdown) than need crisis center services, but the lengths of stay are longer (3-14 days), so the consideration is 16 residential MH beds for 250,000 adults and no less than half that for children. Again, this means planning for adequate capacity in all large and medium counties or ADAMHS Board regions, plus collaboration with smaller counties to ensure nearby access.

3. **Service definitions and certification standards, along with sustainable multi-payer funding for both crisis centers and residential crisis services for MH.**

4. **Continued expansion of access and capacity for residential crisis services for SUD (withdrawal management services)**. Although these services are more widely available, there are still counties which do not have adequate access to these American Society of Addiction Medicine services.

5. **Expansion of rapid access to inpatient services for those who have the greatest needs.** Although there has been an increase in the number of psychiatric inpatient beds, there continue to be barriers to access for those (especially children) with highest acuity and complexity, as well as those without insurance. Open Beds, Multi-System Adult, and indigent funding have helped, however, there continues to be programs that require collaborative problem solving.

6. **Intensive crisis intervention to scale serving all clients in need, in all communities.** This also requires development of service definitions, certification standards, and funding mechanisms for different types of intensive crisis intervention programs in different settings.

7. **Partnering with hospital systems to include hospital-based crisis services in planning the continuum.** Currently, these services have significant capacity that need to be included in community planning efforts to achieve the goal of taking crisis intervention services to scale.

Stabilize - Considerations

Stabilize – Crisis Centers with Observation Considerations

Governor DeWine has invested considerable state resources and energy into the development of crisis services. Building on that investment and recognizing that there is significant deviation in each of these existing programs, a standard service definition with accompanying service characteristics should be developed. This definition and standards should guide consideration of options for licensure regulation revisions, adequate financing as well as guidance for developing implementation steps.

The considerations provided are derived from the SAMHSA Guidelines for Behavioral Health Crisis Care (2020) and the Crisis Center with Observation Subcommittee of the Crisis Task Force.

Service Definition

A "**crisis center with observation"** is a facility where people in MH and/or SUD crisis can go (or be brought) without requiring prior assessment, and at which they can receive a range of interventions. People may stay 23 hours (and on occasion up to 48 or 72 hours) to be assessed, have the crisis addressed, and to connect them with ongoing services that best meet their needs, in the best possible setting, avoiding arrest, criminalization, hospitalization, ED boarding, and other unnecessary, costly and/or restrictive interventions to the greatest extent possible.

The department should either edit the current crisis intervention service definition or adopt the above definition for crisis centers with observation that supports service design and funding of these services. The definition should allow for several program "levels" or "subtypes" that may possess different service capacities and payment rates. These program options should include:

1. **Non-hospital crisis center with observation; accepts voluntary and involuntary individuals.** Ideally, has 24/7 operation, serves all ages, incorporates peers and medical capacity at all hours.

2. **Non-hospital crisis center with observation; accepts voluntary people only.** Ideally, has 24/7 operation, serves all ages, incorporates peers, with prominent Living Room, and has medical capacity at all hours.

3. **Hospital Based crisis center with observation; accepts voluntary and involuntary, plus those with severe medical needs.** Ideally, has 24/7 operation, serves all ages, incorporates peers, with prominent living room, and has medical capacity at all hours.

Service Standards

Since crisis centers with observation are capital intensive and may require service and staffing adjustments based on the geographic region and resources available, the service definition should ensure that each program has specific standards that normalize service provision and seek to achieve the desired future state. The final standards should allow for different levels of program capability, with associated variation in program requirements and funding rates. While all programs may not initially be able to accept the full range of MH and SUD diagnoses or involuntary clients, this should be the goal and regulations should allow for this opportunity to serve all clients.

The standards described below were developed by the Crisis Center with Observation Subcommittee and include national best practices as described in the SAMHSA Guidelines for Behavioral Health Crisis Care.

1. **Welcoming, recovery-oriented, and trauma-informed.** The center should adopt a "yes, first" posture. Unless there are clear needs that cannot be met at the facility, it should be accepting of all.

2. **Person and family-centered.** Services are designed to accommodate the diverse needs of the person served.

3. **Safe for people served and for staff providing service.** Safety is maximized through welcoming engagement, not through punishing and controlling practices or armed and uniformed security.

4. **Accessible to diverse populations.** Equitable access and response for all racial, ethnic, linguistic, and cultural groups, significant subpopulations (children, I/DD, older adults, veterans, LGBTQ+), and rural versus urban populations.
5. **Accessible to all people in crisis.**

   - Minimal criteria for diversion and a policy approach that accepts all.
   - Welcomes individuals who may be actively using substances.
   - Law enforcement and other first responders are preferred customers, with rapid turnaround time for drop off (15 minutes or less).

- Access for both walk-ins and drop offs. A crisis center with observation may be co-located or integrated with a BH urgent care center.

6. **Capacity to provide restraint and seclusion.** The expectation should be that the crisis center operates with a philosophy of "no force first", maximizes engagement (including with peers) before control, and meets a standard where use of restraint, including chemical restraint and seclusion is minimized and occurs at lower frequency than in hospital settings.

7. **Accessible 24/7.** Note. There may need to be provision for ramping up to 24/7 operation when crisis centers first open. There may be also a need to permit flexibility in the face of extreme staffing shortages.

8. **Accessible geographically.** People should be served as close to home as possible. Individuals should have access to a crisis enter no more than two counties away and no more than 60 minutes from their home. These time frames should be at parity with access to higher levels of emergent medical care, such as a Level 1 Trauma Center.

9. **Comfortable Setting.** Individuals should be served in congregate settings (with recliners or chairs) with minimal visual obstruction to facilitate safe observation, while maintaining an environment that is comforting and non-stimulating, with opportunities for privacy when needed and appropriate.

10. **Capability to access clinical consultation.** Utilization of telehealth to support clinical staffing gaps.

11. **Access to medical screening and basic intervention.** On site nursing, as well as capacity for basic medical screening and triage, on site or through telehealth should be an expectation.

12. **Capacity to meet demand.** Facilities should be designed with enough capacity to meet the anticipated need for the population. It is recommended to establish a recommended number of adult and child "beds" or "chairs" per population served, using Crisis Now figures as a starting place:

    - 16 beds-20 beds or chairs for adults per 500,000 population is an approximate benchmark

    - Child/youth beds may be approximately 25% of that number

13. **Timely access to a full range of MH and SUD services from an interdisciplinary team.** Staffed by an interdisciplinary team that includes licensed clinicians, peers, paraprofessionals, nursing staff, and prescribers, along with program leadership and clinical/medical leadership. Peers are ideally available 24/7. Access to certain disciplines may occur through telehealth.

14. **Crisis assessment, crisis intervention and rapid through-put.** The program team initiates rapid assessment, crisis intervention, and transition planning to help persons served routinely stabilize and connect to the next appropriate service within 24 hours in almost every instance.

15. **Service for co-occurring disorders.** Regulatory guidance must be clear that co-occurring MH and SUD are an expectation in a crisis center with observation, and there should be one set of guidelines that allow the crisis center to serve individuals with any combination of issues and conditions.

16. **Care coordination and continuity.** Functions as part of a continuum of crisis services and works collaboratively with both lower levels of care (e.g., mobile crisis) and higher levels of care (hospitals) to get people to the right place. The program has relationships with continuing care BH providers of all types, as well as with human service programs such as homeless services, housing programs, schools, aging services, etc., to facilitate bidirectional connection in the community.

Licensure Regulations

The current definition of 23-hour observation (OAC 5122-29-10(B)) should be revised to align the facility regulations with the new service definition for crisis center with observation. Current programs are certified with multiple waivers under the "residential treatment facility" definition. This inhibits implementation, limits guidelines for defining flexibility in staffing or regional variances and makes it more difficult to create sustainable funding methodologies. There was an example given that crisis centers are usually designed to permit observation of multiple individuals in crisis simultaneously for short periods of time, whereas residential treatment standards require separate bedrooms because they are applied to permanent living situations. Addressing this scenario will assist in aligning policy and practice.

Considerations to revisions to licensure standards should align to a variety of location options to support sufficient distribution of these centers. Location options should include:

1. **Non-hospital crisis centers with observation are the most common model nationally, and in Ohio.** These settings are both less costly and more likely to be successful in diverting from hospitalization. They are often located in sites that are convenient both for people served and first responders, as well as reasonably close to emergency medical facilities.

2. **Hospital-based crisis centers with observation.** They may be freestanding under a hospital license but are usually affiliated with or a component of a larger ED.

3. **Co-location.** For economies of scale and continuity of flow, crisis centers with observation may be co-located with, and share some staff and resources with, other types of crisis services, including residential MH crisis services, withdrawal management programs, BH urgent care services.

Financing Crisis Center with Observation

Adequate funding for key services is essential to ensure 24/7 availability ("firehouse capacity"), appropriate distribution in the geography to ensure timely response, and adequate payment to incentivize recruitment and retention of well-trained staff. In most states, crisis centers with observation have a significant component of their funding through Medicaid and/or Medicaid MCOs. Importantly, 23-hour observation is reimbursable in Ohio by third-party payers when the service is provided in a hospital ED. However, there is no reimbursement category currently for crisis center with observation as defined herein.

To ensure crisis center with observation services are available to all persons who may need them in Ohio the following should be considered.

1. **Crisis centers with observation should be supported by ALL types of third-party payers.** Just as third-party payment supports physical health EDs and urgent care, reimbursement commensurate to the value of crisis services would minimize expensive and unnecessary ED utilization should be available.

2. **Funding models should consider the service and facility cost.** Funding methodologies should consider base funding that supports required services and all-inclusive of services, capacity, and facility needs (as in an ED), with options for increased funding for higher service intensity or complexity, as in EDs.

3. **Start-up funding will be necessary.** To support the planning and design, capital acquisition and renovations, coverage of uninsured individuals, and additional non-medical service provision, OhioMHAS, ADAMHS Boards, and city/county funders should consider additional funding.

4. **Develop statewide roadmap for development of crisis centers.** Given the need for a statewide plan for distribution of these crisis centers, OhioMHAS could consider convening stakeholders to develop a roadmap to help not only with start-up investment but also to identify start-up operational funds and stimulate multi-board planning for the continuing operation in the multi-county service area that will be supported by the Crisis Center that is being developed.

5. **Funding methodologies should support co-occurring disorders.** As service of people with co-occurring MH and SUD is an expectation, there should be clear instructions for MH crisis services for how to bill for persons with co-occurring SUD services; conversely there should be clear instructions for SUD services for how to bill for persons with co-occurring MH services.

Implementation considerations

"Regional" crisis centers with observation: As previously noted, some rural counties or ADAMHS Board regions may be too small to support a crisis center with observation in their community. Therefore, statewide dissemination of crisis centers may need to include planning for how crisis centers in certain "hub" counties can serve additional counties in the surrounding area. To support this planning, the following are recommended:

1. Geo-mapping: Looking at natural geography to determine priority crisis center location, and planning capacity based on the population of the surrounding ADAMHS Board regions is a recommended approach to create statewide coverage. Note that the geomapping for Crisis Centers may involve different geographic partners than the current State Hospital regions. Those regions can remain the same, but Crisis Centers should be designed to serve counties that are physically closest. Areas where relevant regional collaborations (e.g., Level 1 trauma centers, ADAMHS Board collaboratives, opiate task forces, regional jails, etc.) already exist could be a starting point.

2. Virtual support: In addition to direct services, a 24/7 crisis center "hub" can provide virtual support to providers serving individuals in BH crisis throughout its assigned geography. This allows it to efficiently project capacity (e.g., clinical consultation to first responders, psychiatric consultation to EDs) through telehealth, while remaining accessible to transporting those individuals that are most in need of the crisis center with observation setting. This model could support ongoing workforce challenges as well provide expertise in specific clinical service areas.

Stabilize - Residential Crisis Services Considerations

"Residential crisis services" is a broad category described in the interim definitions that guided the Crisis Task Force and are distinguished from crisis centers with observation in that they are services that are accessed following an assessment to determine level of care need. These services may be available as both direct admission from the community or by stepdown from a higher level of care such as a hospital or 23-hour crisis center with observation, and provide for crisis intervention in a residential setting for a period of days or weeks. These services are also distinguished from longer term residential settings such as transitional housing, supported housing, recovery housing, and residential treatment centers such as qualified residential treatment programs (QRTPs) and psychiatric residential treatment facilities (PRTFs).

The following considerations seek to expand the availability of MH crisis residential services. SUD residential services, withdrawal management services, seem to have significant capacity currently. This derivation is primarily a result of the licensure and funding methodologies that support SUD services more readily than MH residential services.
The considerations provided are derived from the national models of MH crisis residential service and the Crisis Residential services Subcommittee of the Crisis Task Force.

Service Definition

Crisis residential services are facilities that provide short-term (30-90 days) residential setting to serve individuals who are experiencing acute psychiatric crisis and whose adaptive functioning is moderately impaired. The facilities provide short-term, intensive and supportive services in a home-like environment and are designed to improve the lives and adaptive functioning of those they serve.

The final definition should define the optimal guidelines, as described, but provide flexibility for different program "levels" that may still be valuable but may have different service capacities and payment rates. An example of these levels can be found in the Roadmap to the Ideal Crisis System (National Council, 2021, p. 111-112). The report defines the four levels:

- Residential crisis programs with higher medical/ nursing involvement
- Residential crisis programs with moderate medical/ nursing involvement
- Residential crisis programs with low medical/ nursing involvement
- Peer operated crisis respite programs

Each of these can and should incorporate peer supporters and aspire to creating a living room environment. The more highly resourced and more costly programs will be able to manage individuals at higher acuity, and thus divert more people from hospitalization. The less costly programs can provide a valuable resource for people in earlier stages of crisis and can provide cost-effective support that prevents further decompensation and assists people to reconnect with their existing supports more rapidly. In Ohio, communities should be allowed to choose different options depending on their local needs and resources. Many communities may choose to have multiple options and may even combine options in a single location for more efficiency.

Service Standards

The final service definition should ensure that each program has specific standards that normalize service provision and seek to achieve the desired future state. The final standards should allow for different levels of program capability, with associated variation in program requirements and funding rates. The standards described below were developed by the Crisis Residential subcommittee and include national best practices as described in the SAMHSA Guidelines for Behavioral Health Crisis Care.

1. **No Wrong Door Admissions Policy.** Admissions can occur either directly from the community or as a step down from higher levels of care.

2. **Adults and children must have separate physical locations.** However, these locations may be contiguous for more efficient staffing coverage.

3. **Length of stay may vary from a few days to a few weeks or more.**

4. **Staffing should be interdisciplinary, including medical, clinical, and peer professionals, as well as other crisis workers.** Staffing ratios and composition may vary, according to the service level provided. Staffing levels and composition may be specified for each of the different levels described above.

5. **Services are voluntary and the admission process should ideally occur 24/7.** There should be defined admission protocols that include appropriate medical and behavioral triage to ensure that people's medical needs, BH clinical needs, and care needs can be met on site with the level of staffing available.

6. **SUD service supports.** Because co-occurring SUD is an expectation for individuals presenting with MH crisis, MH residential crisis services should be able to provide for sobering support and mild/ moderate withdrawal management, as appropriate to their medical and nursing capabilities.

7. **Individual and group crisis intervention programming should be routinely available.** Such programming does not have to be conducted by independently licensed clinicians. All staff, including peer supporters, may participate in providing these services.

8. **The program must have provision for helping clients access and take medication.** This should include access to medications from collaborative pharmacies, and ability to self-administer prescribed medications under supervision. More highly medically staffed programs will have more capacity to prescribe medications and adjust medications.

9. **The program must meet basic residential safety and client rights standards, as appropriate for individuals in shared rooms.** These standards are described in current residential standards but need to be adapted for individuals in short-term environments. For example, short-term residential crisis services do not require rental agreements and have different requirements for client rights.

10. **The program must provide for clients' nutrition appropriately.** There are many mechanisms by which programs can do this that are cost effective, ranging from contracting for prepared meals, offering prepared meals once per day and having self-preparation for breakfast and lunch, engaging in joint meal preparation, etc. More meal service is required for programs serving children.

11. **The discharge planning process must include a connection to continuing BH treatment, other community resources, and natural/peer supports, as well as include developing crisis plans and safety plans as appropriate for the individual and family.**

Licensure Regulations

The current efforts to adapt residential regulations to residential crisis services are complicated, as it disconnects the facility standards from the service provision. In contrast, the current regulatory design and per diem funding model for withdrawal management services should be the precedent for MH residential crisis services. To bring licensure regulations into alignment with the desired future state of the service, the following should be considered.

1. Develop a licensure classification that defines MH crisis residential facilities as a separate and distinct facility type from non-crisis residential facilities.

2. Permit local flexibility in the design of crisis residential facilities, to facilitate cost-effective operation.

Financing Residential Crisis Services

The current regulatory design and per diem funding model for withdrawal management services could be used as a guide for the MH residential crisis services.

SUD withdrawal management services are paid for by a Medicaid per diem rate, and most of these services report that a substantial percentage (approximately 70%) of their funding comes through Medicaid. MH residential crisis services however are funded differently, with an expectation that third party revenue requires billing individual service contacts.

The following considerations seek to ensure MH residential crisis services are reimbursed in a way that supports increased capacity and program excellence.

1. Develop a reimbursement methodology that ensures broad and adequate payor support, to include ALL third-party public and private payors.

2. Rates should be sufficient to support community capacity, robust clinical staffing, and administrative overhead.

Stabilize - Intensive Crisis Follow-up Considerations

The Intensive Crisis Follow-Up Subcommittee was assigned the responsibility for addressing the need for service descriptions and standards related to the provision of intensive community-based crisis follow up services for individuals and families that have experienced a mental health crisis episode, a substance use disorder crisis episode, or both, and whether that episode is a mobile crisis visit, urgent care visit, ED encounter, crisis stabilization center visit, hospitalization, or residential crisis admission. The subcommittee's focus was on recognizing that people may need help for an extended period to transition from the disruption of a crisis episode to continue in routine services to maintain stabilization and progress to thrive. The following are the summary considerations.

Intensive Crisis Follow-Up Considerations:

1. Intensive crisis follow-up services should be a defined component of the BH crisis system in Ohio. A new service definition for "intensive crisis follow-up services" could support service design and funding of this service. MRSS is a current model that could be adopted for other populations.

2. The service definition should clearly define:
   a. Target population
   b. Service goals
   c. Service availability and location
   d. Service interventions
   e. Requirements for community integration
   f. Required staffing and training

3. A reimbursement methodology that ensures broad and adequate payor support, to include third-party public and private payors, should be developed.

Thrive

1,488
Peer Recovery Supporters were certified from 2020-2021.

Number of agencies in Ohio certified for Individual Placement and Support (IPS) employment:

23

From 2020-2021, more than 4,700 Ohioans received IPS employment services.

$108,165,816

State and federal funding allocated to housing for Ohioans with behavioral health disorders.

Thrive - Where is Ohio?

Ohio has a variety of important building blocks in the crisis continuum to improve the state's ability to connect every person who experiences a BH crisis in Ohio to the right resources for them in the community, keeping them healthy and thriving. Key components of the "Thrive" component of the continuum that were identified include:

- Support from foundations in the state for behavioral health crisis continuum development.
- Involvement by peer support specialists in the identification and connection for individuals who have experienced behavioral health crisis.
- New models of care coordination – epitomized by the implementations of OhioRISE and MRSS, which will serve as models and provide lessons learned for future care coordination work.
- Implementation across systems, including child protection, I/DD, and Medicaid systems, of the CANS for identification of needs in children, as part of OhioRISE.
- Strong partnerships between ADAMHS Boards and other partner agencies in the community like universities, schools, criminal justice, and transportation resources that can be built on to provide more opportunities for people in crisis to thrive.
- A focus on local planning and the importance of local partnership – the closer planning efforts are to the individuals in need, the greater the likelihood that service needs for thriving will be identified and addressed.

Thrive - Where Does Ohio Want to Be?

Ohio has uniquely and appropriately emphasized that the goal of all BH crisis services is not to merely stabilize individuals, but to address multisystem needs and to help connect them to continuing opportunities to thrive – to make progress in their lives and achieve their full potential for a happy, hopeful, successful, and meaningful life. "Thrive" has been defined in the Crisis Task Force, and specific steps articulated for progress.

The vision of "Thrive" is that every person or family in BH crisis in Ohio is connected to person- or family-centered services to help them make progress toward achieving their full potential. Thrive services include a full array of supports for housing, employment, education, social connection, meaning, and joy, as well as appropriate continuing treatment for BH and medical conditions.

Delineating all the components of this is beyond the scope of this analysis. Outlined below are important goals that are directly relevant to the BH crisis system:

1. Crisis intervention success is uniformly defined and measured as connection to "Thrive" services. This means that performance measures for the outcome of a crisis are not only hospital diversion and outpatient follow-up appointment but ensuring continued connection to appropriately matched "Thrive" services for each individual and family, based on their needs and preferences.

2. Continuing intensive crisis intervention for a few weeks to a few months to "bridge" between a brief crisis episode and connection to continuing services is an expectation for all people in crisis. The current system commonly has a gap between a few days in a hospital and the expectation of resuming "routine" weekly or monthly care, without any provision for the level of engagement and inspiration needed to help people build hope, connection, and trust.

3. Peer support is a routine feature of all BH crisis services, ranging from mobile crisis to inpatient care and is available to be an inspiring element of the bridge between "Stabilize" and "Thrive." Peers are essential team members everywhere.

4. Continuing care coordination to ensure those connections are a routine feature for all clients in crisis, regardless of ADAMHS Board region or payer source.

5. For people who experience frequent crises, the goal is to have uniform access to intensive service models that are built around the goal of "thriving" from the beginning, and help people move from despair to hope. Examples of these service models exist in Ohio, such as assertive community treatment; intensive in-home services; intensive outreach, integrated health care, and supportive housing for homeless populations; and other examples need to be taken to scale.

Thrive - Considerations

To reinforce the importance of individuals in crisis being connected to a service continuum that supports everyone's ability to make progress toward their own self-defined goals for a happy, hopeful, and meaningful life, a set of considerations were developed that seek to draw on national best practices and the capabilities and resources that currently exist in Ohio. Within the purview of the Crisis Task Force, the defining Thrive Subcommittee's most important task was to indicate the broad components that are needed to support the ability for people of all ages to thrive, and to focus specifically on what is needed to ensure that individuals in crisis are connected to continuing supports that enable them to thrive. These components include the need to develop a vision, define a continuum of thrive services, and ensure funding and system coordination mechanisms support persons who have experienced crisis.

Vision

To further the goal of establishing a thrive continuum, a vision and framework for thrive must be developed. This vision is the lens that the system should utilize when making the connection between crisis support services and community services that support continued wellness and recovery. The following should be core components of that vision.

1. Hope for thriving is fundamental.
2. Thriving is defined by the most important elements of human experience. Thriving also includes opportunities for joy, fun, creativity, and personal growth.
3. Thrive services are person- and family-driven.
4. Thrive services are about people and should be similar regardless of whether people experience MH challenges, SUD challenges, or both.
5. Thriving requires a network of support for each individual and family to help them on their journey.
6. Thriving belongs to the whole community.
7. Thriving is local.
8. Development of a continuum of thrive services requires community planning.

Defining a Continuum of Thrive Services

The following are services that should be available in every community to help those persons who have experienced a crisis to continue a path to wellness and recovery. Each community may have varying levels of each of these services but the availability and ease of access to each is crucial to ensuring people continue to thrive. Feedback from stakeholders reflected the importance of providing services and supports to individuals and families that go well beyond "treatment" and "case management" needs, with a particular focus on housing, educational supports, and employment/vocational supports.

1. Peer support services
2. Employment support services
3. Education support
4. Housing retention supports
5. Social connectedness
6. Integration with faith-based communities
7. Transportation supports
8. Supports for parents and family members of adults and children who are engaged in the BH system
9. Engagement with schools, colleges, and universities
10. Other social services: income assistance, food assistance, disability payment assistance, etc.
11. Connection to community BH professional services
12. Connection to primary care services and wellness supports

Implementation Considerations

Implementation of the defined vision, framework, and continuum of thrive services should be supported by a robust funding environment and care coordination system. The additional considerations noted below are intended to set the stage for connection to the thrive services that will support recovery.

1. **Diverse payer engagement.** Engagement of payers as important partners in connecting people to services for thriving, both through funding connection, navigation, and peer support services, and through using their data sources to promote linkage and care coordination is fundamental to supporting people.
2. **Care coordination is imperative.** Investment in care coordination and intensive community-based crisis intervention is important, including peer bridgers, care navigators, hospital liaisons, and so on.
3. **Connectivity.** Building the expectation of "connectivity" into existing crisis services, whether mobile crisis, crisis centers, or hospitals, is critical for the success of people served.
4. **Transportation must be accessible.** Transportation can and should be funded through multiple sources and multiple modalities, including:
   a. Case manager transport
   b. Peer transport
   c. Public transport
   d. Uber/Lyft
   e. Van transport: RIDE Services
   f. Reimbursement for peer ride along on any of the above

Transportation - Where is Ohio?

Crisis transportation through the whole crisis continuum includes transportation from the person's home to a place to be seen, transportation from an initial crisis contact (as in urgent care, crisis center, ED) to a place to receive further stabilization (crisis center with observation, residential crisis services, hospital), and then, after stabilization, transportation to the next level of care as indicated (e.g., step down from a hospital to a residential crisis setting).

Transportation of individuals in BH crisis was reported as a significant concern by every ADAMHS Board. Issues reported included the lack of availability of ambulances to travel long distances, the lack of adequate reimbursement for ambulance transport leading some EMS providers to refuse or avoid MH transport, the need to use law enforcement for transport often in handcuffs, and the need for BH clinicians on the scene to negotiate for extended periods to find any transport for a client in acute distress. People in BH crisis may have to walk or take public transportation to a BH Crisis Center because an EMS transport is not available. Some ADAMHS Board areas have identified successful workaround solutions, such as contracts with individual EMS companies to use ambulettes for transport, contracting with off duty or retired law enforcement, or using peers. However, these solutions are localized and dependent on local relationships and resource availability, being systematized across the state.

Transportation - Considerations

BH Crisis Transportation should be treated as a parity issue. That is, individuals in BH crisis should have equivalent assurance of access to a full range of transportation services in every community as would be available to those with physical health crises. To support this goal, the following considerations have been developed based on national best practices, comparable state initiatives, and input from the transportation subcommittee of the Crisis Task Force.

1. Develop a set of standards or guidelines defining a BH crisis transportation system for the state of Ohio, with a combination of minimal expectations for each community, but with the ability for local flexibility regarding how to meet those expectations.

2. BH crisis transportation services should be reimbursed to EMS providers and other transportation providers to the greatest extent possible by Medicaid, Medicare, and third-party payers, with supplementation by ADAMHS Boards for those who have no insurance or for supplemental transportation services that are provided outside the medical transportation system.

3. All third-party payers should be expected to pay for BH emergency transportation at parity with payment for emergency physical health transportation.

4. Establish a statewide standard of care that ensures each community has at least one EMS company that can provide a full range of medically necessary BH emergency transportation services adequate in scale for that community.

5. The Emergency BH Transportation System should be designed to be coordinated with the existing County Administered Non-Emergency Transportation System funded by Medicaid (and matched with federal dollars) that is administered through Department of Job and Family Services in all eighty-eight counties.

6. Additional transportation options should be defined as part of developing a set of standard descriptions of BH emergency transportation services and provided as options (but not requirements) for supplemental local funding. These may include:

    a. Contracting with off duty law enforcement to transport.

    b. Contracting with peer support specialist or peer organizations to provide transport.

    c. Contracting with EMS companies to provide customized transportation services that may supplement those that are available through the third-party funded BH Crisis Transportation System.

Workforce - Where is Ohio?

Every ADAMHS Board indicated that there were significant challenges with recruitment and retention of the BH crisis workforce. Existing BH workforce shortages are exacerbated when hiring individuals to work in crisis services, where there are more emotional demands and requirements for after hours and weekend schedules. There are shortages in all disciplines: prescribers, particularly for children; peer supporters (especially MH peers); and independently licensed providers. There is also a lack of career pathways that bring people into the field early and provide for appropriate ongoing training and internship opportunities to prepare for work in "real world" settings, as well as to provide ongoing career ladders and professional development. Along with the concerns around shortages, there is also a recognition that a more diverse, inclusive, culturally, and linguistically competent workforce is desired as we continue to build the crisis continuum in Ohio. Many responders commented on the lack of adequate payment for staff, particularly for crisis work, connected to lack of adequate reimbursement mechanisms for the crisis services provided. Individual ADAMHS Boards or provider agencies have reported some success with recruitment initiatives (bonuses, tuition reimbursement, loan forgiveness, discounts, etc.), and emphasize the importance of creating a positive internal work culture with great teamwork, sensitivity to providing a trauma-informed environment for staff in "high burn-out" jobs (including Wellness Rooms with snacks, music, massage chairs, etc.), high quality supervision and support so that staff don't feel "alone" in the work, exposure to positive outcomes and recovery stories, and access to meaningful job structures (pay, benefits, hours) that provide BH crisis workers an appropriate quality of life.

Workforce - Considerations

The following considerations are organized to identify actionable changes that can create improvements in BH crisis workforce recruitment, retention, and quality of life more generally throughout the continuum of crisis services, building on creative ideas that have been implemented locally to provide direction for more systemic change. Many of these initiatives are already being considered by the department's workforce task force.

1. To attract and retain a quality BH workforce to support crisis services, the following may need addressed:

    a. Improving payment for BH Crisis Services and, by extension, improving payment and benefits for BH Crisis Staff, including access to differential payments for crisis work itself.

    b. Improving flexibility and inclusiveness of credentialing requirements.

    c. Expanding categories of staff who can participate in BH Crisis service provision.

    d. Facilitating efficiency of staffing and service delivery through telehealth.

    e. Expanding career opportunities via specialized training and/or certification in BH crisis work.

    f. Reducing administrative burden for BH crisis workers.

2. Additional recommendations to address BH workforce needs more generally include:

    a. Marketing: Elevating the BH field and reducing social stigma.

    b. Enhanced recruitment efforts.

    c. Allow for more flexible scheduling.

    d. Support for initial and continuing education.

    e. Implementation of incentives such as student loan forgiveness.

Regional Planning and Coordination

The Community Crisis Coordination committee was tasked with identifying the opportunities for state/local collaboration in crisis system planning at every level.

For the Ohio BH crisis services continuum to reach its full potential, there must be close collaboration between OhioMHAS, ODM, other state agency partners, the ADAMHS Boards, the BH provider community, hospitals, first responders, representatives of people with lived experience and so many other partners throughout communities across the state. OhioMHAS and the Ohio Department of Medicaid can set the parameters, standards, guidelines, and payment structures for building successful systems, but the work to construct these comprehensive systems of care should and must happen as close to the people with BH challenges as possible.

There was a desire for additional guidance to be offered to local ADAMHS Boards and regions in planning for crisis services because of the information that was collected during the development of this analysis. The use of the current state hospital regions for crisis planning was also an area of discussion throughout the process that is analyzed further here before going into considerations and guidance for local boards and regions in future crisis service planning efforts.

Regional Planning - Where is Ohio?

The review of local and regional continuums brings up another area of focus that came out of many discussions during this process. While funding has traditionally flowed through state hospital regions for various BH initiatives, the recommendations of several committees through the Task Force as well as discussions with various regional groups organized in different manners indicates that it would be worth exploring organizing regional crisis efforts around existing structures and hubs to ensure as much coverage for needed services as possible. The state hospital regions serve a necessary purpose for multiple reasons but may not be the ideal structure moving forward to think about the BH crisis services continuum in the state.

The regions outlined in Figure 12 are used to discuss the current state of BH crisis services around the state. There is more significant population in the Northeast, Central and Southwest regions of this map, with lower populations for the Northwest and Southeast. Along with assigning regions, ADAMHS Boards have also been defined as Large, Medium or Small based on population:

- 23 Small Board regions (populations of 50,000-150,000)
- 17 Medium Board regions (populations of 150,000-300,000)
- 10 Larger Board regions (populations of 300,000)

Using both classifications, the available services and status of the crisis continuum for each board area are summarized in Appendix B.

Figure 12. Current and planned Crisis Centers with Observation with surrounding counties

Figure 12 maps out current and planned crisis centers with observation and surrounding counties that may be able to benefit from being close to those centers. Centering planning efforts around existing infrastructure and determining ways that infrastructure can be supported and leveraged even further is worth exploration and discussion among the partners.

Regional Planning - Considerations

These are considerations for individual counties (both single-county ADAMHS Boards and counties with multi-county ADAMHS Boards), multi-county ADAMHS Board regions, and multi-ADAMHS Board "regional" planning. "Region" is used here as it relates to "functional geography" – population within a certain distance of a population hub – rather than to the existing State Hospital Regions.

There is no national template for this checklist. To create this list, three guides for population planning were used:

1. Crisis Now Calculator, which predicts 200 adults needing BH crisis response (beyond just a call center) in each month, per 100,000 population. Estimates for children may be as little as 10-15% of that number.

   However, some models indicate that the estimate may be as much as 50% of that number, since children in crisis present in much more diverse locations. We will use 25% for this checklist.

2. Arizona system flow data indicating that 70-80% of crises are resolved "in the field" (through mobile or walk in services) and only 20-30% need a 23-hour crisis center or ED (and only a percentage of those need inpatient or residential services, but those who do need them for a longer period).

3. Estimates of crisis center capacity based on Arizona data, which are also recommended by the Ohio Crisis Center Subcommittee: 16 observation beds for adults per 500,000 population. There are no clear guidelines for how many residential crisis beds are needed. For this purpose, we assume 16 adult MH beds per 250,000, 16 adult SUD beds per 250,000, and 16 child MH beds per 250,000. (This is based on an analysis computed for Michigan.)

The checklist is divided into the following categories:

- Small counties or ADAMHS Board regions (populations of 50,000-150,000)
- Medium counties or ADAMHS Board regions (populations of 150,000-300,000)
- Larger ADAMHS Board or multi-Board regions (populations of 300,000 or more)

The considerations are based on the input from the Basic System Service Array Committee, which indicated that as many services should be close to home (inside a small county) as possible, but for those services where there was not sufficient volume to develop services there should be multi-county collaboration to plan a full array of services within approximately one hour drive from all parts of the multi-county "region".

Crisis System Planning

Small County or Board Region Planning Estimates

Figure 13. Small County or ADAMHS Board Region Services Checklist

Service	Need
Call center (988 or non-988) – linkage to receive handoffs from a 988 center	**YES**
Mobile crisis team (multiple teams needed, some may be child specific)	**YES** – Note: in an ADAMHS Board region with multiple small counties, there may need to be a team in each county.
BH urgent care capacity (both business hours and after hours)	**YES** – Note: In an ADAMHS Board region with multiple small counties, there should be walk-in BH urgent care in each county and can be built into and onto other services (medical urgent care; CMHC).
Crisis center with observation	**NO** – Volume too small. *
Residential crisis services for adults (MH and SUD) and children (MH)	**NO** – Not enough volume to sustain a freestanding program for each. **
Intensive crisis intervention follow-up	**YES** - This should be developed for both adults and children so it can happen on a case-by-case basis when needed. Multiple options, including building it into mobile crisis. MRSS is one option for children, but there are other approaches for adults, as well as for children.

*** Modification to consider:** *Build organized capacity into local ED so that there is ability for mobile crisis to work with the hospital for intervention and disposition. Ideally, it should be a safe, welcoming location within the ED. Availability of consultation regularly from a 24/7 crisis center in a neighboring ADAMHS Board region should be considered. If needed, transportation to the neighboring crisis center (within one hour by ambulance) should be made available.*

**** Modications to consider:** *Combine crisis and non-crisis residential into a single program (e.g., Adam and Amanda). Combine SUD and MH into a single location. Work with a neighboring program in a larger county. Minimum for MH: use a local apartment or other available site for adults on a case-by-case basis with wraparound staff for overnight supervision, as needed, with follow-up the next day. Minimum for SUD: manage withdrawal in hospital setting with wraparound consultation.*

Small County or ADAMHS Board Region Planning Estimates	
Anticipated total crisis episodes (beyond calls) based on Crisis Now Calculator	Adults: 100-300/month; 5.5-10/day Children: 25-75/month; 1-2.5/day
Total episodes that can be managed with only mobile crisis or urgent care	Adults: 75-225/month; 2.5-7.5/day Children: 18-54/month; .5-2/day
Total "chairs" needed for crisis center with observation (based on 16 beds for 500,000)	Adults: 1.6-5 Children: 0.4-1.25

Medium County or Board Region Planning Estimates

Figure 14. Medium County or ADAMHS Board Region Services Checklist

Service	Need
Call center (988 or non-988) – linkage to receive handoffs from a 988 center	**YES**
Mobile crisis team (multiple teams needed, some may be child specific)	**YES** – Note: in an ADAMHS Board region with multiple small counties, there may need to be a team in each county.
BH urgent care capacity (both business hours and after hours)	**YES** – Note: In an ADAMHS Board region with multiple small counties, there should be walk in BH urgent care in each county and can be built into and onto other services (medical urgent care; CMHC).
Crisis center with observation	**MAYBE** – The projected need for 5-10 chairs is on the cusp of feasibility for a non-hospital-based crisis center. Some communities may be able to implement; others may have the ability to create a hospital-based crisis center. For others, partnering with other ADAMHS Board regions may be needed.
Residential crisis services for adults (MH and SUD) and children (MH)	**YES** - The need for these services will usually support one of each type of program. Even for populations of 150,000, smaller size programs may be feasible, or the modifications suggested in the small county ADAMHS Board checklist can be considered. Some ADAMHS Boards may elect to partner with neighboring ADAMHS Board regions if a suitable location for residential crisis services that is accessible in a timely fashion to both ADAMHS Board regions is available.
Intensive crisis intervention follow-up	**YES** - This should be developed for both adults and children so it can happen on a case-by-case basis when needed. Multiple options, including building it into mobile crisis. MRSS is one option for children, but there are other approaches for adults, as well as for children. In multi-county regions, there should be provision for intensive crisis intervention in each county.

Note: *For multi-county ADAMHS Board regions, there may be a combination of planning county-specific services using the Small County Checklist, plus some regional services that cover all the counties in the ADAMHS Board region.*

Medium County or ADAMHS Board Region Planning Estimates	
Total crisis episodes (beyond calls) based on Crisis Now Calculator	Adults: 300-600/month; 10-20/day Children: 75-150/month; 2.5-5/day
Total episodes that can be managed with only mobile crisis or urgent care	Adults: 225-450/month; 7.5-15/day Children: 54-108/month; 2-3.5/day
Total "chairs" needed for crisis center with observation (based on 16 beds for 500,000)	Adults: 5-10 Children: 1.25-2.5

Large County or Board Region Planning Estimates

Figure 15. Large County or ADAMHS Board Region Services Checklist

Service	Need
Call center (988 or non-988) – linkage to receive handoffs from a 988 center	**YES**
Mobile Crisis Team (multiple teams needed, some may be child specific)	**YES** – Note: in a Board region with multiple small counties, there may need to be a team in each county. Further, in a large county, there may need to be teams focused on different geographic regions within the county.
Behavioral Health Urgent Care capacity (both business hours and after hours)	**YES** – For larger population centers, can be free standing, but also can be built into other services (Medical Urgent Care; CMHC). In a Board region with multiple small counties, there should be walk in BHUC in each County. Large counties will need multiple BHUCs serving different geographies.
Crisis Center with Observation	**YES** – Even the "smallest" large counties have feasibility for a non-hospital crisis center, that can also support surrounding smaller counties. The largest counties will need multiple crisis centers (2-3) to serve different geographies and may have both hospital and non-hospital crisis centers.
Residential Crisis Services for Adults (MH and SUD) and Children (MH)	**YES** – Should have at least one of each type of program. The largest counties will need two-four of each type of program.
Intensive Crisis Intervention Follow-Up	**YES** – This should be developed for both adults and children so it can be provided whenever needed. Multiple options, including building it into mobile crisis. MRSS is one option for children, but there are other approaches for adults, as well as for children. In multi-county regions, there should be provision for intensive crisis intervention in each county. In the largest counties, there will need to be intensive crisis intervention programs for different regions in the county.

Note: *(1) For multi-county board regions, there may be a combination of planning county-specific services using the small county or medium county checklists, plus some "regional" services that cover all the counties in the board region. (2) Large counties should routinely expect to partner with neighboring small counties, even those in other board regions or other state hospital regions, to use their 24-hour capacity (in a crisis center especially) to support those counties.*

Large County or ADAMHS Board Region Planning Estimates	
Total crisis episodes (beyond calls) based on Crisis Now Calculator	Adults: 600-2,000/month; 20-65/day Children: 150-500/month; 5-17/day
Total episodes that can be managed with only mobile crisis or urgent care	Adults: 450-1,500/month; 15-50/day Children: 108-375/month; 3.5-12.5/day
Total "chairs" needed for crisis center with observation (based on 16 beds for 500,000)	Adults: 10-32 Children: 2.5-8

Crisis System Planning - Where is Ohio?

OhioMHAS has been working diligently and strategically on crisis system planning. The Crisis Learning Academy has developed a stronger relationship between partners and local communities, including individuals and families who have experienced a BH crisis in the design of the crisis continuum. Ohio has undertaken a number of Medicaid initiatives related to coverage of behavioral health services. A major structural change that has set the table for increased coordination of mental health, substance abuse treatment, and primary care is the consolidating coverage of behavioral and physical health care under Medicaid managed care and an increased focus on coordination of behavioral and physical health care. As of July 1, 2022, the Ohio Department of Medicaid launched the OhioRISE (Resilience through Integrated Systems and Excellence) program which provides specialized services to help children and youth with behavioral health needs and help coordinate care for those who receive care across multiple systems. Related to the implementation of the OhioRISE plan is the newly introduced and covered mobile response and stabilization service (MRSS) for children/youth and their families which is available across all Ohio Medicaid managed care plans and fee for service.

As you would expect, some local communities that have more resources have been able to build more comprehensive systems of collaboration because they have more to offer their partners in terms of financially sustaining the needs for their community. In addition, there are pockets of very successful collaborations in areas where the combination of strong leadership, strong interest from the community and creative solutioning have allowed some communities to build strong continuums. The goal will be to take this hit-and-miss success to scale through more comprehensive shared strategies and support from the state to local communities with clear direction and strategies for success.

The collaboration between all the partners in the delivery of BH crisis services was notably positive throughout the development of this analysis. All the critical partners were eager to participate and provided significant effort to the ultimate development of considerations for strategies to move the system forward. It will be critical to find ways to maintain the momentum created by this effort to continue to foster the bonds of partnership and collaboration between the various partners on issues of shared concern.

Crisis System Planning - Considerations

The goal of designing crisis services that serve people in BH crises in Ohio requires the development of comprehensive systems of BH crisis care in every part of the state. These systems could look different in every community, but what will be the same is the collaboration between the state and local partners that is required for success. Whether it is a large county developing a crisis center with observation that also incorporates a call center, mobile response, intensive community-based crisis services and BH urgent care all in one facility or a regional collaborative that has created a full continuum of services through a less straightforward, but just as effective community collaborative of ADAMHS Boards, providers and services, the support from OhioMHAS and ODM as strong partners must be part of that success.

It is the role of OhioMHAS to set the expectations for local systems and what should be available to people in Ohio who are in BH crises, then work with those local systems to implement comprehensive systems of care with flexibility and understanding of local challenges and restrictions, whether they be financial, personnel, provider-based, or otherwise.

Consistently throughout this process it has been articulated that there are many ways to achieve the desirable future state and there should be flexibility in the expectations set for HOW goals are achieved, if the result for people in BH crises is that they have access to the quality services they need at the time that need presents.

ADAMHS Board Responsibilities - Where is Ohio?

OhioMHAS intends for the ADAMHS Boards to perform an important role as local partners in convening stakeholders in their board regions to plan, fund, and implement such a crisis continuum. In the Board Survey responses, however, although a few boards had organized comprehensive BH crisis system planning processes in partnership with other funders and with community partner organizations that were not directly contracted with the board, most Boards reported that their crisis system planning, and coordination was limited to their directly contracted providers and (usually) law enforcement. Some boards indicated that key potential partners (e.g., local hospitals) did not view themselves as partners with the board at all. Many potential partners did not share their de-identified client data with the board for completion of the board survey. This information from the surveys raises the question about whether Ohio should define a clearer expectation of the role of the boards and other entities in crisis system planning and coordination, and if the answer to that question is "yes," how to go about doing so.

ADAMHS Board Responsibilities – Considerations

Providing clarity on the role of ADAMHS Boards and community partners who should be engaged in the community crisis planning process is foundational to ensuring local coordination, identifying service gaps, and appropriate system funding. The following have been developed utilizing national best practices and direction from the ADAMHS Board Responsibilities Subcommittee of the Crisis Task Force. These seek to identify the basic framework for the ADAMHS Boards and other partners to work collaboratively to plan a continuum of BH crisis services to serve the whole community.

ADAMHS Boards should have formal responsibility for convening partners and stakeholders for planning and coordinating the BH crisis continuum for ALL persons who may require crisis services in their ADAMHS Board regions. This responsibility should be in the form of clear written instruction and direction from state leadership that delineates the importance of community crisis planning in each ADAMHS Board region, the role of ADAMHS Boards and other partners, and the expected deliverables. Further statutory changes could be made later, if needed, to formalize these expectations.

While ADAMHS Boards should be the conveners of the local crisis planning process, a wide range of stakeholders should be considered for invitation and participation in the process. Stakeholders that have a necessary relationship with the crisis care continuum in each ADAMHS Board region should be required to participate. There should be an expectation that each stakeholder shares de-identified data for purposes of community planning. These partners include:

- People with lived experience, peers representing the recovery community
- NAMI or other representation of families with lived experience
- Hospital systems serving the community (EDs and/or inpatient units)
- Law enforcement
- Courts
- Emergency medical services
- MCOs
- Call centers
- Aging services
- Community MH/SUD crisis providers, both community-based and residential
- Other community MH and SUD providers
- Homelessness/housing services providers

For children's planning:

- Schools
- Juvenile justice
- Child Protective Services

Department directives should include an expectation of specific deliverables that are developed collectively by the ADAMHS Board and its partners. Potential deliverables on an annual basis may include providing a publicly available report including:

1. Baseline analysis of needs and capacities for the whole community.
2. Gathering information and data about current services.
3. Delineating the intersections between Board funded services and other services in the community.
4. Strategies to address identified problems.
5. A plan for implementing a proposed crisis continuum for the Board region.
6. A resource plan for how Board resources, other local resources, OhioMHAS funds, Medicaid and other insurers, and other funding sources will be used to implement the plan.

Basic System Service Array - Where is Ohio?

In the Board survey responses, and in information provided in focus groups with Boards with different levels of resources, it was clear that there is currently little, if any, consistent set of expectations or standards for BH crisis services in any county or Board area, other than the requirements for Health Officers to be available to conduct pre-screenings. As a result, there is great variation from Board to Board about which crisis service elements are available for their communities. Smaller rural Boards and the 10 Boards with no levies are particularly limited in their resource capabilities for developing a local crisis service continuum. Certain services, like residential MH crisis services for youth and child inpatient beds, are in particularly short supply. At the same time, several Boards in smaller communities reported that they had identified creative approaches to crisis service design that allowed them to develop cost-effective options for their communities. One notable example is a board that has only an occasional need for residential MH crisis services, so while it is unable to sustain a typical residential crisis services program in its community, it has instead rented an apartment which is available for overnight crisis stays with on call staffing. These creative approaches inform what might be possible in smaller communities.

Basic Service Array - Considerations

It is the intent of the department to ensure consistent standards, service availability, and funding for all crisis services across all board regions. To achieve this goal, a basic system framework and standards, guidance on minimum service availability, and fundamental performance metrics must be delineated. The following were derived from national best practices as well as the basic system service array subcommittee of the Crisis Task Force. To guide its work, the subcommittee reviewed background data from the OhioMHAS whitepaper, SAMSHA's National Guidelines for Behavioral Health Crisis Care Best Practices Toolkit, data from the board survey, and committee member shared experience with physical health and BH emergency services.

1. There should be standards for a BH crisis system service array that is available to all people who experience a BH crisis in all communities. These standards for the system should be based on developing a local continuum of crisis services to the greatest possible extent.
2. Standards should be developed with principles that are both aspirational and realistic. Aspirational means that the standards should identify a desired future state and provide a bridge from the current state to the end goal. Realistic means that the standards are achievable in a reasonable time frame with appropriate funding, even if they are not immediately achievable now.
3. A minimum service array should be available to every person experiencing a BH crisis in Ohio. Each county should have services that connect, respond, and stabilize everyone in crisis. In addition, there should be access to transportation options, a robust peer support network, and care coordination to support system navigation.
4. There should be a defined set of services that may be available in large counties which may serve smaller neighboring counties "regionally". These services should be accessible within one hour's drive from individuals in crisis.
5. Each Board region should have the basic capacity to collect performance data on its crisis continuum that is aligned with the statewide recommendations for minimal metrics.

6. Planning for sustainable financing of the BH Crisis Continuum should rely on all partners (state, Boards, Medicaid, other insurers, and local communities including health systems) to fund the appropriate crisis continuum in each county and region.

7. Financing approaches should be inclusive of peer supports as part of the service team. Staffing regulations and training should incorporate peers in each service, where appropriate.

Care Coordination - Where is Ohio?

In the Board survey responses, ADAMHS Boards consistently described mechanisms by which they work with contracted providers, and often with law enforcement and other first responders, to attempt to coordinate care for individuals that are receiving Board funded services. All Boards have mechanisms by which they coordinate with State Hospitals for those clients that access those facilities. A few Boards identified specific care coordination activities that they fund directly or through contracted providers, such as "hospital liaison" positions, care navigators, or ongoing follow up and coordination provided by the contracted mobile crisis provider. These more extended care coordination services are not at all universally or systematically present. Multi-system youth and adults are a designated population that may receive enhanced care coordination. As of July 1, 2022, the Ohio Department of Medicaid launched the OhioRISE (Resilience through Integrated Systems and Excellence) program which provides specialized services to help children and youth with behavioral health needs and help coordinate care for those who receive care across multiple systems.

Input provided by Subcommittee members, as well as in other information gathering meetings with consultants, indicated that there are additional care coordination services provided by hospitals, providers and, MCOs. At present administrative, fiscal, and clinical responsibility for care coordination is fragmented so that while some individuals and populations (children on Medicaid having the best system so far) have designated responsibility for receiving care coordination in crisis, most individuals and families do not.

Care Coordination - Considerations

Care Coordination is the hub in a well-designed crisis service system. The ability to maintain contact with people who are in or have experienced crisis events prevents recurrence, connection to community resources, and reduced utilization of more expensive service alternatives. The current care coordination leaves the people vulnerable to having recurring crisis episodes. A singular crisis care coordination system could bring together the variety of funders and crisis service providers; delineating a basic framework by which payers, providers, and other partners can routinely provide care coordination for individuals and families experiencing a BH crisis, with a particular focus on those who are moving through multiple service types and service locations (e.g., mobile crisis, crisis center, inpatient unit, intensive community crisis intervention, etc.) during a crisis episode. The following were derived from national best practices, states with similar funding and regulatory environments as well as the care coordination subcommittee of the Crisis Task Force.

1. Client specific care coordination for people in BH crisis should be a routine component of the community crisis system in every Board region.

2. Ohio should develop a coordinated system where all the partners (Boards, MCOs, providers, hospitals, others) work together to ensure that all people in crisis have a clear mechanism for receiving the care coordination services they need.

3. The care coordination system should establish a locus of accountability supported through an organized partnership between the partner entities such as Boards, MCOs/insurers, community crisis providers, and hospitals.

4. Care coordination systems for clients in crisis should work toward developing protocols for information sharing that are in place ahead of time, as well as technology solutions that make it easier to keep track of where people are being served.

5. Care coordination systems involving Boards, MCOs, providers, and hospitals will function best if the structure, processes, expectations, and deliverables are embedded in contracts between ODM, Ohio MHAS, Boards, MCOs/hospitals/providers as appropriate.

Performance Metrics and Data

The planning, operation and management of BH crisis services all require the collection and use of data to make decisions about how, when and where crisis services are provided. The continuous quality improvement process desired for BH crises services also requires that the data be available in a timely manner, to be actionable. The National Association of State Mental Health Program Directors has provided guidance to states on using data to manage state and local-level mental health crisis services that is informative here.

Performance Metrics and Data - Where is Ohio?

Like many states and communities, Ohio struggles with collecting and reporting data on the provision of BH crisis services, separate from the broader provision of BH services, and in a way that is timely enough to be actionable.

Ohio's vision for its BH crisis system, as articulated in the OhioMHAS Crisis whitepaper, indicates that the system should address the needs of "all Ohioans." This implies that performance measurement should apply to the whole population as well. However, responses to Board surveys and information from key informants, including Centers of Excellence related to sequential intercept mapping and CIT implementation, illustrate that there is no easy way for Board regions in Ohio to collect and analyze meaningful population data. Board data systems may track Board funded services, and different Boards and providers may use different systems. There is no consistent BH data collected from law enforcement or EMS that would guide measurement of diversion efforts. Hospital data sharing regarding ED utilization for BH services, inpatient utilization, or ambulatory crisis services is not consistently available for Board-level planning.

The board surveys revealed that certain counties have developed collaborative relationships in which the Boards were able to obtain detailed data on BH ED visits and/or BH related law enforcement and/or 911 response through collaboration. Based on these survey responses, the consultants prepared a "model" for the current baseline of BH crisis system functioning in Ohio, comparing Ohio's data on BH ED visits, BH arrests, and BH diversion programming to what might be predicted using the Crisis Now Calculator prediction of two hundred/emergency adult encounters per month per 100,000 population. This modeling showed that the total Crisis Now calculator prediction was close to what Board data indicated, with most encounters occurring in the local ED (1,500-2,000 per 100,000 per year), a much smaller percentage in law enforcement (200-400) and a similar percentage (variably) in diversion programs such as mobile crisis. This data can be used for predictive modeling of progress and success as more crisis services are implemented statewide.

Additional examples of "local" models for data sharing include the criminal justice-BH grant-funded collaborations in Huron and Summit Counties, and the Central Ohio Hospital Association (Franklin County) ongoing data driven improvement of ED Boarding (25-hour "wait time" reduction to 5-hour average over the past ten years). The OpenBeds project also has some data about the positive impact on access to inpatient services in a small number of counties.

Aggregate state Medicaid data on BH services is available, by county and zip code, in an online platform, and additional data are available on request from ODM. Individual MCOs may have their own data. However, "crisis services" data are not captured in a way that reflects specific type of program (mobile crisis, residential crisis, crisis center), but instead by service code, as there are no program categories for MH crisis diversion that allow for that collection. Data are available for BH hospitalization (freestanding and general hospital), SUD services (due to the SUD waiver delineating American Society of Addiction Medicine-specific program categories), MRSS, and OhioRISE. Data for utilization and cost of MH crisis services in the full continuum need to be better categorized and tracked.

Several boards have nonetheless embraced ambitious targets for measurement of performance of individual services (crisis centers with observation in particular) and their potential impact on the community. Equity is an important concern in these aspirational measurement targets but is also not routinely and easily measured. None of the boards identified specific benchmarks for these metrics.

Performance Metrics and Data - Considerations

The Performance Metrics and Data Committee was designated to address issues regarding measuring performance of the BH Crisis System and its components, both at the state and local level, including identifying key targets for success at the community or population level, and identifying the types of data that are (or could be) available for demonstrating progress and supporting continuous quality improvement of BH crisis services for Ohioans. There were three Subcommittees whose work has been integrated.

- The Principles Subcommittee delineated general principles for Performance Metrics and Data Collection
- The Data Collection Subcommittee identified existing data sets that could simplify performance measurement.
- The Access Metrics Subcommittee identified specific program metrics for service access.

The following are the summary considerations.

1. The state should adopt of a set of overarching principles for performance metrics and methods for data collection that are grounded in developing and collecting meaningful, usable, and relevant data for/from stakeholders.
2. The state should consider adopting the recommended metrics from the Roadmap to the Ideal Crisis System.
3. Data categories that match the recommended proposed crisis services lexicon should be developed by OhioMHAS and ODM. These categories should be used to collect cost and utilization data from all payors.
4. Convene a workgroup to review current data sets, design a desired future state for state level data, and develop an implementation plan.
5. Implement the recommended program-specific access metrics for mobile crisis services as well as crisis center with observation.

Financing - Where is Ohio?

Significant investments have been made by Governor DeWine and the Ohio Legislature in the development of the BH crisis services continuum in recent years. These dollars disseminated through OhioMHAS have made significant improvements in access to these needed services in many communities across the state. The addition of the MRSS benefit and financing by OhioMHAS and the Ohio Department of Medicaid has been a critical step to expanding mobile response for children on Medicaid in the state. There are currently program specific bundled rate Medicaid benefits for residential crisis services for people with substance use disorder (withdrawal management services). Some services within crisis centers with observation and BH urgent care are reimbursable under the current Medicaid structure.

Financing Overview

The Ohio Crisis whitepaper outlines a vision that requires a statewide set of program standards and financing policies that permit definition of the full continuum of services required to fulfill the vision. It also includes methodologies for attracting multiple payers (including, but not limited to, public and private health insurers) to support the start-up and sustainable financing and regulation of the envisioned system. Current data gathered from the state landscape analysis (Board surveys) and other state sources indicates that while there has been progress in this area, there is still a lot of work to be done.

Crisis Services Definitions and Standards. As information from other committees and subcommittees has indicated, there does not exist a comprehensive set of crisis services definitions and standards for the key recommended elements of the BH crisis system continuum.

Crisis Services Start-Up Funding. Governor DeWine has made a strong commitment to the development of a BH Crisis System in Ohio and has committed significant resources through OhioMHAS to help new programs get off the ground. These new funds are in multiple funding categories and have been used for a variety of purposes to facilitate the startup and operation of new crisis services. Federal funds (much of which is time-limited) coming through the state (e.g., Mental Health Block Grant set asides for crisis, 988 planning and implementation, ARPA funds) help contribute to the state's capacity to provide startup funding. Crisis centers with observation and residential MH and SUD crisis services that are currently being planned, as well as some that have recently opened, have utilized the new crisis stabilization center funds to help them either launch or create a viable startup plan. In focus group meetings, many Boards have expressed concerns about how to utilize one-time funding when there is uncertain availability of sustainable funding in the foreseeable future for ongoing operations after initial investment.

Crisis Services Sustainable Funding. As noted above, the vision of a BH Crisis System serving all people in Ohio experiencing BH crisis implies that access to the BH crisis system, as for the physical health emergency system, would be supported by all health care payers, as well as other local health partners such as health systems, not just by OhioMHAS, Medicaid, and ADAMHS Boards. Funding capacity and therefore the capacity of the BH crisis continuum may depend significantly on the availability and size of the local levy.

Crisis Services Data Collection. As described in detail in the report from the Performance Metrics and Data Committee, the availability of crisis services data across the state is very limited and inconsistent across jurisdictions. The lack of available service definitions and standards is a major contributor to this deficit. This limited availability of consistent information applies to data on services in physical and BH settings, as well as services provided in law enforcement, justice and child or adult protective services. Further, there is little or no policy guidance to support the facilitation of data sharing between partners at the state or local level, even guidance for how such data sharing can be facilitated, rather than impeded, by the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2. Policy guidance is needed to plan, fund, and sustain services as well as to coordinate effective care.

Crisis Services Administrative Regulations. Current administrative regulations that govern crisis service payment are associated with administrative requirements for reimbursement that may be more suitable for routine care. Examples include treatment planning documentation requirements that may be more suited for routine care than for a mobile crisis encounter or crisis center visit and creation of shadow billing to meet the separate needs of Board funders.

Financing - Where Does Ohio Want to Be?

Efficient start-up and sustainable funding are the hallmark of a well-designed crisis system. Funding methodologies exist that attract multiple payers (including, but not limited to, public and private health insurers) to support the start-up and sustainable financing and regulation of the envisioned system. The system is built on the following fundamentals:

- Start-up Funding: Investment available for both services and capital projects that support the creation of key foundational components of the crisis system.
- Innovative Financing Strategies: Financing strategies and policies, as well as payment methodologies and rates, and universal coding (payment) mechanisms, designed to be applied in an innovative manner across multiple funders, and modified or developed to achieve sustainable funding for the visioned system.
- Participation of Multiple Funders: Sustainable funding is achieved through the engagement of multiple sources of funding include OhioMHAS, Medicaid, Medicare (including Medicare Advantage) Medicaid MCOs, commercial third-party payers, Boards, and other federal, state, local and private funders.
- Parity: The principle of parity is essential to the funding of an ideal crisis system. Parity ensures access to a "core set of services" and a universal "standard of care" for all payers and all who access the crisis system in Ohio. Parity also includes an approach to funding a continuum of BH crisis response that is on par with funding for physical health crisis response, including having a consistent standard of care across Ohio.

- Technology Facilitated: Facilitating and encouraging appropriate financing of technology, including, but not limited to telehealth capacity and technology-based consumer applications for crisis support for the delivery of services.

- Data-Driven: Financing policy is aligned with mechanisms for tracking and reporting on utilization and cost of crisis services in the continuum to facilitate both quality improvement and demonstration of cost-effectiveness. Whenever possible, required documentation should satisfy and shed light on both financial and quality improvement metrics at the system and program level.

- Efficient: Administrative, clinical, and associated financing requirements are designed to maximize efficient use of limited resources (including staff time) and minimizes unnecessary administrative burden that may negatively affect the quality of care.

Financing - Considerations

To meet the desired future state for the Ohio crisis system, clearly delineated policies for start-up and sustainable funding of each of the system services is needed. At a minimum, service regulations should be designed to allow for reimbursement by all third-party payers. The following are divided in the same manner as the above discussion of the current state:

- Crisis service definitions and standards
- Crisis services financing
- Start-up and sustainable financing
- Crisis services data and administrative regulations

The Financing the Continuum Committee was designated to address issues regarding financing the BH crisis system and its recommended components, including transportation services, as well as addressing other overarching policy and regulatory issues that might facilitate implementation of the recommended services. The Financing Committee was intended to align its overarching financing and policy considerations with the program considerations from the service specific committees and subcommittees. The service-specific subcommittees considered how each program could be sustainably funded across the state; the Financing Committee's goal was to provide more detail for how to fund the whole continuum of recommended services.

Assumptions

The Committee based its considerations on a set of assumptions. The overarching assumption is using shared available resources to produce better outcomes and more successful lives for people in Ohio experiencing BH crises. This is accomplished by minimizing the use of expensive services that may not be appropriately matched (such as inappropriate use of EDs or law enforcement) and instead expanding the funding of services that produce better results.

Crisis Service Definitions and Standards

1. Develop OhioMHAS certification regulations for ALL the crisis services recommended through the Crisis Task Force process to comprise the crisis continuum. Regulations should define how services are provided by best practice interdisciplinary service teams, including peers, to support payment for the service provided by the team, not to try to replicate payment models used for individual therapy, group therapy, or medication visits.

2. OhioMHAS can initiate a process with other partners to develop adaptations of current medical transportation definitions and standards for application to individuals in BH crises.

Crisis Services Financing

1. OhioMHAS and other state agency partners should consider convening a formal Crisis System Collaborative Funding Workgroup to engage multiple payers and other partners in the step-by-step process of designing and implementing the financing of the envisioned BH Crisis System.

2. Develop policy language or funding instructions for ADAMHS Boards to delineate that any startup funds can and should include both capital costs and startup operations to facilitate eventual sustainability.

3. The required 50% Board match for capital funds could be waived to facilitate the implementation of Crisis Centers and Residential Crisis Services to meet statewide need.

4. Both in the near term and over time, one-time funding of developing, building, start-up operations of Crisis Centers should be primarily supported by OhioMHAS. Current one-time federal funding, such as ARPA funding and 988 implementation funding, are potential sources of this start up investment.

5. Where possible, utilize existing options and experiences to focus on initial planning and eventual (longer term) implementation of payment methodologies for each specific type of crisis service that is recommended for contribution to the full continuum.

6. Initiate identification of appropriate payment methodologies and planning for the implementation of those methodologies for the sustainable funding of the full continuum of crisis services as defined in the Crisis Services Standards. Include attention to disparity, equity, and inclusion in the design of these methodologies.

7. Establish the intention that rate-setting methodology for crisis services, should consider the most recent experiences of other states to develop payment approaches that support the true cost of BH crisis services, including the true cost of recruiting and retaining skilled staff.

8. Initiate collaborative planning for state regulatory and payment changes to ensure and maximize third-party reimbursement for the full continuum of crisis services across all public and commercial insurance plans. Longer term provide state guidance on recommendations for expected coverage of the BH crisis continuum by all insurance plans under parity is necessary, even though many plans are not under jurisdiction of ODI.

9. In addition to the recommendations for call center sustainability provided by the Sustainability Subcommittee to the Connect Committee, explore other payer options for coverage of Call Center services, including clinical, support, and administrative services associated with Call Center operations.

10. Support integrated care models that provide comprehensive, coordinated, and person centered care.

11. Articulate the primary role of OhioMHAS and local board funding is to pay for the portion of BH crisis services that are provided to uninsured or underinsured populations, as well as paying for services and infrastructure (call centers and call center technology) that cannot be attributed to individual service payments.

Crisis Services Data and Administrative Regulations

1. The implementation of the recommended Service Definitions and Standards for OhioMHAS Certification for crisis services will create the basis for much more useful data collection across all payers statewide.

2. Develop guidance on minimizing administrative burden for obtaining payment, by reducing or eliminating unnecessary documentation.

3. The performance metrics and data that inform the delivery of BH crisis services should be clear, consistent statewide, and measuring both performance of the overall crisis continuum and the individual services within the continuum. The metrics should be built on data that is clearly understood and validated by the partners within the service continuum.

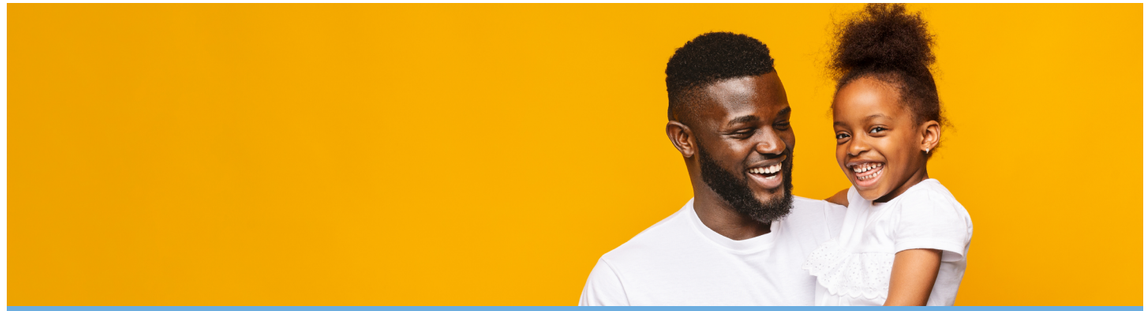
SYNTHESIS OF THE CONSIDERATIONS

Ohio has improved its crisis continuum significantly in the last several years through concerted work and investment of resources at both the state and local level. There is a tremendous vision for where Ohio can take its crisis service delivery system. The entities who are at the table working on these issues are the necessary partners to do the work that will be needed going forward. Taking the policy, regulatory, funding, and planning frameworks to the next level can be accomplished by taking the considerations outlined here from documentation to action. The implementation of 988 and MRSS are just the two most recent examples of partners coming together in Ohio to make meaningful improvements in the crisis continuum. Crisis centers are being developed in multiple communities across the state.

OhioMHAS is committed to improving the continuum and will continue to engage with the partners at both the state and local level to support the next steps of this process. A broad policy and funding framework is needed to support the next steps of implementing the vision. Key elements for that framework include definitions and standards for all the necessary components, emphasizing quality, flexibility for different geographies, diversity and equity, disseminating checklists for boards of different size and geographies within the state, seeking all available funding incentives, and engaging funding partners to develop appropriate funding models to support those services.

There are dozens of actionable steps outlined throughout this analysis that can be considered for action within local systems to strengthen their continuums in partnership with OhioMHAS and other state and local partners. The success of Ohio's crisis continuum is not just about what state agencies do, but the work that their partners in local communities are doing to build their systems together through local planning and partnership and providing feedback to the processes necessary to address the needs of people in BH crisis in their community.

OhioMHAS' redesigned community assessment and planning process creates a new opportunity for data-driven community planning with common key performance indicators. ADAMHS Boards lead this process and convene partners for community buy-in.



No single element of the system can do this alone, but everyone has a role to play in advancing the ability of the system to respond to people in BH crises in Ohio. The most important element is to continue to work together to move forward. There are many ongoing drivers to this work, including the continued implementation of 988, MRSS and local efforts to establish new crisis centers with observation, BH walk-in services and other crisis services.

Implementation of the considerations outlined will also assist Ohio in progressing on the two scorecards discussed early in this analysis. For example, as the system looks to make progress on the criteria outlined in the *Roadmap to the Ideal Crisis System*, moving from a score of 2 to a score of 5 on Item 1J (regarding quality metrics) will require developing a full set of quality metrics for every service in the continuum, and for the continuum. This can be achieved in both local systems and at the state level, but will take concerted effort from the partners to complete. Another example is Item 2L related to client tracking: with the implementation of OhioRISE, there may be a pathway established for improvement in client tracking across the various service delivery systems, but it will take focus and effort among the partners to ensure Ohio can demonstrate that all individuals in crisis can be tracked no matter where they go within the service continuum.

Collaboration at work in Ohio

There are multiple ADAMHS Boards working on comprehensive crisis planning efforts for their communities, including Franklin County, Lorain County, Montgomery County, and Paint Valley. These communities have created strong local partnerships, combined resources, leveraged state and local dollars, and are set up to implement key services that will significantly improve the crisis continuum.

CONCLUSION

OhioMHAS is deeply grateful to the partners who have worked to advance the behavioral health crisis services continuum in the state and who continue to partner to improve care every day. Ohio has made tremendous progress with the significant investments to date, and additional resources are being rolled out statewide to continue to ensure that the system will be as responsive as possible to those in Ohio who are experiencing mental health and substance use disorder crises in the future. We know the ADAMHS boards, call centers, crisis providers, advocates, hospitals, managed care organizations, peers, and family advocates and others who care deeply about these issues will continue to work with OhioMHAS to take the next steps in this important journey together.

Ohio's Behavioral Health

CRISIS SYSTEM LANDSCAPE ANALYSIS

2023

Mike DeWine, Governor
Lori Criss, Director
Ohio Department of Mental Health and Addiction Services

30 E. Broad Street
Columbus, OH 43215
mha.ohio.gov

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