OHIO BH CRISIS SERVICES DATA COLLECTION

LOCAL REPORT ON CRISIS SERVICES AND SYSTEMS

OCTOBER 2021

Submit Responses to kris@healthcareperspective.com

Responses Due November 19th

INTRODUCTION

This form is designed to facilitate reporting of crisis system capacity, service delivery, funding, and future planning for each ADAMHS Board. This form also includes legislatively mandated reporting on how state crisis funds are being utilized, so that a separate survey will not be required.

OMHAS views this report as an opportunity for each Board to demonstrate the full range of capacity currently in place, as well as where OMHAS, ODM, 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 is an important source of data for the work of the Ohio Crisis Task Force, in which multiple stakeholder partners are represented. All partners are supportive of efforts to collect this information and recognize that we expect, and Boards will need to work collaboratively with service providers, first responders, hospitals and other community partners to gather as much of this data as possible.

We understand that Boards will not, at present, have access to all the data requested. When there is an item for which you do not have data available, simply let us know. We expect that our collective capacity to make the right data available will have to evolve over time. In the meantime, we hope you do the best you can to share the progress that you are making as well as your plans for further development.

Should you have any questions about how to complete this data collection tool, please outreach Kris Vilamaa (kris@healthcareperspective.com) or Steven Hedgepeth (steven@healthcareperspective.com)

INTERIM DEFINITIONS

This data collection survey uses a set of "interim definitions" to facilitate reporting of various types of crisis services in a flexible and accurate manner. The interim definitions provide guidance as to inclusiveness of crisis services for children and adults, for individuals with MH and/or SUD crises and describe MH/SUD (behavioral health) crisis services for specific subpopulations such as individuals experiencing I/DD, homelessness, or domestic violence. The interim definitions also provide language to facilitate reporting of state "crisis stabilization center" funds utilization, as that term is intended to be used inclusively of many categories in

this survey. The full "interim definitions" document is accessed through this LINK. It is recommended that this document be reviewed thoroughly before completing this survey. However, key sections of the document are also repeated in relevant sections of this survey for convenience.

Please provide your responses in blue, if possible

REPORTER INFORMATION

ADAMHS Board Reporting:

Person/People Completing Form:

Date Completed:

Please keep track of the data sources you use so that we can come back later and ask if there are questions.

REPORTING ON LOCAL PLANNING AND ACCOUNTABILITY

1. **Is there a formal collaborative that meets regularly to discuss planning, implementation, and/or performance of BH crisis services in each of your county/counties?**

   Yes

   No

   a. **If yes, please describe.**

   b. **If no, is one being planned or contemplated?**

2. **Are there other partners that work with the ADAMHS Board to share responsibility for designing, implementing, and overseeing performance of the BH Crisis System in your county/counties?**

   Yes

   No

   a. **Please describe the current state of planning and oversight.**

   b. **If no, please indicate what other entity might be participating in that role.**

3. **Is there an identified person in the role of BH Crisis System Coordinator for your county/counties?**

   Yes

   No

   a. **Please describe.**

4. **Is there any involvement of Medicaid MCOs, commercial insurers, or business leaders in BH crisis system planning in your county/counties?**

   Yes

   No

   a. **Please describe.**

5. **Is there any capacity at present to collect performance data and/or monitor quality performance metrics for the entire BH Crisis System in your county/counties?**

   Yes

   No

   a. **If yes, please describe what is in place.**

   b. **Also, please describe any performance metrics that have been identified as important measures of success for your communities.**

   c. **Also, please describe what is being planned or contemplated.**

6. **Have you as a Board or any portion of your service area adopted a particular crisis <u>system</u> "model" or approach?**

   _____ Crisis Now
   _____ Roadmap to an Ideal Crisis System
   _____ Ohio Crisis Roadmap
   _____ None
   _____ Other_____

REPORTING OF BASELINE NEED

Crisis systems are best coordinated and implemented locally within state standards that provide guidance and flexibility for local decision-making. Our goal as a state is to iteratively develop a crisis system that is responsive to all Ohioans in every community. 988 implementation will further drive the importance of that effort. Therefore, we need to start with understanding baseline need. The following data elements are indicators of current volume of need.

Please report to the best of your ability:

BH 911 calls per year (ambulance, fire, police)

7. **Do you have access to BH 911 call data for any of your county/counties?**

   Yes

   No

   a. **How many of the calls were for adults in each county?**

   b. **How many of the calls were for Youth in each county?**

   Additional Comments:

   Please provide sources for this data, if possible:

BH Emergency Room visits

8. **Identify the hospital emergency rooms (ERs) in your communities which are common sites for serving emergency BH patients.**

9. **Do you have data for the emergency BH patients in MEDICAL emergency rooms?**

   Yes

No

a. **If yes, provide as much of the following data as is available (copy table as needed for different facilities):**

TABLE 1. EMERGENCY BH PATIENTS IN MEDICAL ERS

Facility	
MH Visits	
SUD Visits	
Visits for Adults	
Visits for Children/Youth	
Individuals brought by police or EMS	
Payer Mix	
Disposition of Individuals after Service	

10. **Are there one or more psychiatric ERs in your county/counties?**

Yes

No

(Additional information is requested in the Crisis Centers section)

a. **If yes, please describe.**

Additional Comments:

Arrest Data

11. **Some law enforcement agencies (LEAs) identify BH related arrests that may have been avoidable: If you have data from one or more LEAs in your county/counties reporting on the volume of adult arrests and juvenile detentions that are behavioral health related, please include that information here. (No more than 5 LEAs should be provided)**

TABLE 2. ARREST DATA BY LEA

LEA Jurisdiction 1	
BH Arrests/Jail Bookings	
BH Juvenile Detention Bookings	
LEA Jurisdiction 2	
BH Arrests/Jail Bookings	
BH Juvenile Detention Bookings	
LEA Jurisdiction 3	
BH Arrests/Jail Bookings	
BH Juvenile Detention Bookings	
LEA Jurisdiction 4	
BH Arrests/Jail Bookings	
BH Juvenile Detention Bookings	
LEA Jurisdiction 5	
BH Arrests/Jail Bookings	
BH Juvenile Detention Bookings	

Additional Comments:

Please provide sources for this data, if possible:

Boarding or Waitlist Data

An important marker of need and capacity issues relates to ER boarding, where individuals remain in ERs or other settings for extended periods of time because they need hospitalization or other crisis service, and none is available.

12. **Please describe in as much detail as you can whether this is an issue in your county/counties and provide data (including quantitative, if available) that indicate the degree to which it is an issue for adults and youth.**

13. **For hospitals where boarding is an issue, are they boarding in the ER, observation unit, or are they using general medical beds with sitters? Please describe.**

Any Additional Data

14. **If you have any additional data that speaks to baseline need (e.g., Crisis Now Calculator's prediction of volume of adult crisis episodes), please provide.**

    Please provide sources for this data, if possible:

REPORTING OF CURRENT CONTINUUM OF SERVICES

This section is organized according to the major categories of the Ohio Crisis Roadmap. As noted above, terminology reflects a set of "interim definitions" that have been developed in partnership with Peg's Foundation, but more accurate description of services and programs is encouraged, to assist with making the terminology used in the state more accurate.

The goal is to identify service capacity, service utilization, sources of funding, as well as potential needs for further expansion.

Many ADAMH Boards have received and utilized state funds dedicated to "Crisis Stabilization Centers". We also understand there is a "crisis stabilization unit" defined in Ohio Administrative Code. This survey is designed, in part, for Boards to report on how those funds are being used currently and plans for future use. This is to reduce the need for separate reporting to OMHAS and to put the use of these funds in a larger context with other funding streams. All the following can be reported: facility-based crisis services, which include Behavioral Health Walk-In Urgent Care, Crisis Center with Observation, and Residential Crisis Services. However, some communities may have appropriately used the funding for implementation or expansion of community-based crisis services, including, but not necessarily limited to, Mobile Crisis Intervention with Clinical Staff or Intensive Community Based Crisis Intervention. Please report all utilization of Crisis Stabilization Center funding by your Board in one or more of these categories.

Call Centers and Warm Lines

These services are not defined in the Interim Definitions, so please use the brief definition provided here.

The definition here is NOT restricted only to National Suicide Prevention Lifeline (NSPL) services that will be included initially in 988 responses. The services to be included here are ANY call centers, hot lines, or warm lines designed to be available to the general public (as opposed to just for existing clients of an agency) and designed primarily for helping people who are experiencing a mental health and/or SUD crisis. These services may vary in hours of operation and can be staffed by paid staff, volunteers, clinicians, and/or peers. The services to be included here should NOT include those that are primarily information and referral lines, those that are primarily to help identify resources (e.g., how to locate an SUD provider), or services primarily for other needs (e.g., housing crisis, domestic violence crisis, child abuse hotline, crisis for people with I/DD) even though those needs may include a BH component.

Many boards partner have crisis call centers/hotlines/warm lines in their communities of service. Please report on your partners in helping people access MH and/or SUD crisis care, as opposed to the routine potential call-in entry points for services or need in your communities.

15. **Please list all BH crisis call centers, hot lines, or warm lines that are designed to serve residents of your county/counties. (Note: We know that people can call anywhere. Please focus on those that are specific to your region) If there are none, please say NONE.**
    For EACH one in the list, provide the following information:
    (Copy Table 3 and 4 as needed for EACH)

Table 3. Call Centers and Warm Lines

	Answer/Comments
Name of service	
Location	
Operating Entity	
Phone Number	
Type of Service	
Staffing Composition	
Hours of Operation	
Annual Operating Budget for the previous FY	
Annual Operating Budget for the current FY (SFY 22)	
Voice Call?	
Video Call?	
Text?	
Chat?	
NSPL Certified?	
Planning to be a 988 Provider?	
Client Tracking? (If yes, please describe)	
How many individuals were served in the last FY?	
How many individuals are you planning on serving in the current fiscal year (SFY 22)?	

Additional Comments:

Please provide sources for this data, if possible:

Table 4. Funding for Call Centers and Warm Lines

Source of funds	Previous FY %	Current FY %	Previous FY $	Current FY $
Local Funds				
Levy				
Local Hospital Support				
County Government				
City Government				
Non-Levy Other				
Medicaid				
Third Party Insurance				
Foundations				
State Funds				
Mental Health Block Grant				
SAPT Block Grant				
Crisis Stabilization – MH				
Crisis Stabilization - SUD				
Crisis Flex				
Crisis Infrastructure				
Other State Funds (including State awarded Federal funds)				

First Responder Crisis Intervention Team

Any organized program or team offering BH crisis response by trained law enforcement personnel, emergency medical personnel, or other generic first responders without routine involvement of behavioral health clinical or peer support specialist staff.

This definition is not intended to include only having CIT trained law enforcement officers on patrol, but rather intentional and planned response to behavioral health crises by a trained cohort of law enforcement personnel or other first responders. If clinicians are involved periodically, but not routinely, that would be described here. Examples may include having a designated response team of CIT officers or specially trained EMTs or may include a more targeted response such as a law enforcement homeless outreach team for individuals on the street who have serious MH and/or SUD.

16. **Please list all First Responder Crisis Intervention Teams that are designed to serve residents of your county/counties.**
    For EACH one in the list, provide the information in Tables 5 and 6
    (Copy Tables 5 & 6 as needed for EACH)

    Remember – provide as much information as you can, but if you don't have it let us know.

TABLE 5. FIRST RESPONDER CRISIS INTERVENTION TEAM

	Answer/Comments
Name of service	
Location	
Operating Entity	
Phone Number	
Adults? Children/youth? If both, is there one team that responds to both populations or two different teams? If different teams, please describe each one separately.	
Type of Service	
Staffing Composition	
Hours of Operation	
Annual Operating Budget for the previous FY	
Annual Operating Budget for the current FY (SFY 22)	
How are calls dispatched? Sources of referral: Call centers, 911, ED, crisis center, outpatient providers, other	
How many individuals were served by these teams in the last fiscal year?	
How many individuals are you planning on serving in the current fiscal year (SFY 22)?	

Additional Comments:

Please provide sources for this data, if possible:

TABLE 6. FUNDING FOR FIRST RESPONDER CRISIS INTERVENTION TEAM

Source of funds	Previous FY %	Current FY %	Previous FY $	Current FY $
Local Funds				
Levy				
Local Hospital Support				
County Government				
City Government				
Non-Levy Other				
Medicaid				
Third Party Insurance				
Foundations				
State Funds				
Mental Health Block Grant				
SAPT Block Grant				
Crisis Stabilization – MH				
Crisis Stabilization - SUD				
Crisis Flex				
Crisis Infrastructure				
Other State Funds (including State awarded Federal funds)				

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. Mobile response and stabilization service is a structured intervention and support service provided by a mobile response and stabilization service team that is designed to promptly address a mental health and or substance use disorder crisis situation. 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.

Examples must be primarily for crisis response and not mainly for routine service provision, and include, but are not limited to:

- *Organized mobile crisis service, even if it has limited hours or only responds to selected locations, such as schools, emergency rooms and/or jails. Include mobile response services that utilize telehealth. Community Support Network (CSN) can also be included.*
- *MRSS response to community locations for children (Clinician or Peer Response)*
- *Prescreening teams going to ERs, primary/urgent care settings, jails, etc.*
- *School crisis intervention services*
- *Co-responder teams with law enforcement and/or EMS (Cahoots model, RIGHT Care)*
- *Outreach intervention services for individuals experiencing opioid overdose or public intoxication*
- *Outreach intervention services for individuals who are both homeless and experiencing acute BH crises*

17. **Please list all mobile crisis intervention services with clinical staff that are designed to serve residents of your county/counties.**
    For EACH one in the list, provide the following information
    (Copy Tables 7 & 8 as needed for each)
    Remember – provide as much information as you can, but if you don't have it let us know.

Table 7. Mobile Crisis Intervention with Clinical Staff

	Answer/Comments
Name of service	
Location	
Operating Entity	
Phone Number	
Adults? Children/youth? If both, is there one team that responds to both populations or two different teams? If different teams, please describe each one separately.	
Type of Service	
Staffing Composition	
Hours of Operation	
Annual Operating Budget for the previous FY	
Annual Operating Budget for the current FY (SFY 22)	
Is mobile co-response with law enforcement provided? What percentage of calls involve law enforcement?	
How are calls dispatched?	
Sources of referral: Call centers, 911, ED, crisis center, outpatient providers, other	
How many individuals were served in the last fiscal year?	
How many individuals are you planning on serving in the current fiscal year (SFY 22)?	
Dispositions after service, with percentages or volume data if possible: ER, inpatient, other crisis services, routine outpatient, etc.	

Additional Comments:

Please provide sources for this data, if possible:

Table 8. Funding for Mobile Crisis Intervention with Clinical Staff

Source of funds	Previous FY %	Current FY %	Previous FY $	Current FY $
Local Funds				
Levy				
Local Hospital Support				
County Government				
City Government				
Non-Levy Other				
Medicaid				
Third Party Insurance				
Foundations				
State Funds				
Mental Health Block Grant				
SAPT Block Grant				
Crisis Stabilization – MH				
Crisis Stabilization - SUD				
Crisis Flex				
Crisis Infrastructure				
Other State Funds (including State awarded Federal funds)				

BH Walk-In Urgent Care

Behavioral health urgent care centers are non-ER 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.

For this definition, note that walk-in urgent care services may provide evaluation over a period of a few hours but do NOT include more extended observation (usually defined as up to 23 hours or more, as in the next category).

Examples must be primarily for crisis response and not mainly for routine service provision, and include, but are not limited to:

- *Free standing BH urgent care*
- *BH urgent care provided in the context of a medical urgent care setting*
- *BH urgent care provided in a hospital, in a space outside of the ER*
- *BH urgent care walk in service in a BH clinic, available to the public (may serve existing clients, but not only existing clients)*

18. **Please list all BH walk in urgent care centers that are designed to serve residents of your county/counties.**
    For EACH one in the list, provide the following information
    (Copy Tables 9 & 10 as needed for each)
    Remember – provide as much information as you can, but if you don't have it let us know.

TABLE 9. BH WALK-IN URGENT CARE

	Answer/Comments
Name of service	
Location	
Operating Entity	
Phone Number	
Adults? Children/youth? If both, is there one center that responds to both populations, or two different ones? If different locations or teams, please describe each one separately.	
Type of Service	
Staffing Composition	
Hours of Operation	
Annual Operating Budget for the previous FY	
Annual Operating Budget for the current FY (SFY 22)	
Other State Funds (including State awarded Federal funds)	
Is the service available for law enforcement drop off of voluntary clients? What percentage of visits are brought by law enforcement?	
Sources of referral: Self, Call centers, 911, ED, crisis center, outpatient providers, law enforcement,	
How many individuals were served in the last fiscal year?	
How many individuals are you planning on serving in the current fiscal year (SFY 22)?	
Dispositions after service, with percentages or volume data if possible: ER, inpatient, other crisis services, routine outpatient, etc.	

Additional Comments:

Please provide sources for this data, if possible:

TABLE 10. FUNDING FOR BH WALK-IN URGENT CARE

Source of funds	Previous FY %	Current FY %	Previous FY $	Current FY $
Local Funds				
Levy				
Local Hospital Support				
County Government				
City Government				
Non-Levy Other				
Medicaid				
Third Party Insurance				
Foundations				
State Funds				
Mental Health Block Grant				
SAPT Block Grant				
Crisis Stabilization – MH				
Crisis Stabilization - SUD				
Crisis Flex				
Crisis Infrastructure				
Other State Funds (including State awarded Federal funds)				

Crisis Center with Observation

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 emergency departments, 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.

Examples include, but are not limited to:

- *Non-hospital crisis centers with 23-hour observation*
- *Specialized psychiatric emergency services units*
- *Crisis respite or drop-in centers*
- *Crisis diversion centers (like Oriana House)*
- *Walk-in overnight sobering centers*
- *Beds in Recovery Housing that are used for individuals to walk in and "sleep it off"*

NOTE: *A key distinction between these services and residential crisis services (next bulleted definition) is that Crisis Center services' primary purpose is to provide immediate initial evaluation with the option of extended observation (designed for a preferred maximum stay of 23 hours) to anyone who comes in, whereas residential crisis services are accessed AFTER an evaluation to determine service appropriateness and are designed for lengths of stay ranging from a few days to a few weeks. Sometimes both types of services are in a single site, and individuals in crisis move smoothly from one setting to the other.*

19. **Please list all Crisis Centers (including Psych EDs) that are designed to serve residents of your county/counties.**

    For EACH one in the list, provide the following information

    (Copy Tables 11 & 12 as needed for each)

    Remember – provide as much information as you can, but if you don't have it let us know.

TABLE 11. CRISIS CENTER WITH OBSERVATION

	Answer/Comments
Name of service	
Location	
Operating Entity	
Phone Number	
Adults? Children/youth? If both, is there one center that responds to both populations, or two different ones? If different locations or teams, please describe each one separately.	
Type of Service	
Staffing Composition	
Hours of Operation	
Annual Operating Budget for the previous FY	
Annual Operating Budget for the current FY (SFY 22)	
Is the service available for law enforcement drop off of involuntary clients? What percentage of visits are brought by law enforcement?	
Sources of referral: Self, Call centers, 911, ED, crisis center, outpatient providers, law enforcement,	
How many individuals were served in the last fiscal year?	
How many individuals are you planning on serving in the current fiscal year (SFY 22)?	
Dispositions after service, with percentages or volume data if possible: ER, inpatient, other crisis services, routine outpatient, etc.	

Additional Comments:

Please provide sources for this data, if possible:

TABLE 12. FUNDING FOR CRISIS CENTER WITH OBSERVATION

Source of funds	Previous FY %	Current FY %	Previous FY $	Current FY $
Local Funds				
Levy				
Local Hospital Support				
County Government				
City Government				
Non-Levy Other				
Medicaid				
Third Party Insurance				
Foundations				
State Funds				
Mental Health Block Grant				
SAPT Block Grant				
Crisis Stabilization – MH				
Crisis Stabilization - SUD				
Crisis Flex				
Crisis Infrastructure				
Other State Funds (including State awarded Federal funds)				

Residential Crisis Services

Residential crisis services provide short term non-hospital crisis treatment for people experiencing MH and/or SUD crises, usually on referral from a location or service that has provided an initial evaluation to determine that the residential service is the appropriate level of care. Services are commonly voluntary, and lengths of stay generally range from 2-14 days. Residential crisis services may be accessed from a community crisis evaluation service, or stepdown from an acute inpatient setting. Within the broad category of residential crisis services, there are many variations based on level of medical or nursing care, level of peer support, and availability of programming. Residential crisis settings may also be more MH focused or more SUD focused, with the latter including residential withdrawal management services (ASAM Level 3.1D-3.7D).

This definition does NOT include residential services that are not routinely available to people in crisis or that are designed for longer term services. For example, this definition would not include step down services for long term state hospital patients, non-crisis residential placements for children, or residential SUD treatment that requires prior detox or usually has a waitlist.

Examples must be primarily for crisis response and not mainly for routine service provision, and include, but are not limited to:

- *Crisis residential units for adults, adolescents, or children, which may include a variety of service models with varying levels of medical, nursing, or peer support*
- *Crisis apartments staffed when needed, as in rural settings with less consistent volume*
- *Residential withdrawal management services (ASAM Level 3.1 D – 3. 7 D)*

20. **Please list all Residential Crisis Services that are designed to serve residents of your county/counties.**
    Please distinguish programs serving adults from those serving children and youth.

    For EACH one in the list, provide the following information

    (Copy Tables 13 & 14 as needed for each)

    Remember – provide as much information as you can, but if you don't have it let us know.

TABLE 13. RESIDENTIAL CRISIS SERVICES

	Answer/Comments
Name of service	
Location	
Operating Entity	
Phone Number	
Adults? Children/youth? If both, is there one center that responds to both populations, or two different ones? If different locations or teams, please describe each one separately.	
Type of Service	
Staffing Composition	
Hours of Operation	
Medical, nursing, and peer support staffing coverage. Please provide enough detail to help distinguish the type and intensity of services that the residential crisis program provides.	
Annual Operating Budget for the previous FY	
Annual Operating Budget for the current FY (SFY 22)	
Sources of referral: Self, Call centers, 911, ED, crisis center, outpatient providers, law enforcement,	
How many individuals were served in the last fiscal year?	
How many individuals are you planning on serving in the current fiscal year (SFY 22)?	
Dispositions after service, with percentages or volume data if possible: inpatient, other crisis services, routine outpatient, etc.	

Additional Comments:

Please provide sources for this data, if possible:

TABLE 14. FUNDING FOR RESIDENTIAL CRISIS SERVICES

Source of funds	Previous FY %	Current FY %	Previous FY $	Current FY $
Local Funds				
Levy				
Local Hospital Support				
County Government				
City Government				
Non-Levy Other				
Medicaid				
Third Party Insurance				
Foundations				
State Funds				
Mental Health Block Grant				
SAPT Block Grant				
Crisis Stabilization – MH				
Crisis Stabilization - SUD				
Crisis Flex				
Crisis Infrastructure				
Other State Funds (including State awarded Federal funds)				

Intensive Community Based Crisis Intervention

Intensive community-based crisis intervention services are organized home-based and/or office-based services that can be available more often than once a week and that provide continuing crisis services following an initial evaluation or following an acute episode of care at a higher level (e.g., following hospitalization or residential crisis). Length of service is commonly for a period of weeks, with the goal of facilitating connection to continuing routine care. These services are designed for routine access by people in crisis, not just designed to serve existing clients (such as on an ACT team). These services may be provided during MH and/or SUD crises.

For this definition, only include services designed for people in crisis. Do not include, for example, routine SUD IOP programs that are provided for individuals who may be court referred.

Examples include, but are not limited to:

- *Crisis partial hospitalization (diversion or step down)*
- *Crisis intensive outpatient group programs (diversion or step down)*
- *Any planned program that provides access to intensive crisis response in a BH clinic, designed for either crisis diversion, or as follow up to mobile crisis, crisis center, residential crisis, or inpatient services.*
- *Crisis home-based child/family stabilization services (e.g., MRSS pilot)*
- *Continuing crisis intervention by clinical staff that provides ongoing intervention after the initial evaluation*
- *Intensive outreach and continuing care for individuals with recent opioid overdose*

21. **Please list all Intensive Outpatient Crisis Services that are designed to serve residents of your county/counties. Please distinguish programs serving adults from those serving children and youth.**

    For EACH one in the list, provide the following information

    (Copy Tables 15 & 16 as needed for each)

    Remember – provide as much information as you can, but if you don't have it let us know.

TABLE 15. INTENSIVE COMMUNITY BASED CRISIS INTERVENTION

	Answer/Comments
Name of service	
Location	
Office-Based or Mobile?	
Operating Entity	
Phone Number	
Population Served	
Type of Service	
Staffing Composition	
Hours of Operation	
Medical, nursing, and peer support staffing coverage. Please provide enough detail to help distinguish the type and intensity of services that the residential crisis program provides.	
Annual Operating Budget for the previous FY	
Annual Operating Budget for the current FY (SFY 22)	
Sources of referral: Self, Call centers, 911, ED, crisis center, outpatient providers, law enforcement	
How many individuals were served in the last fiscal year?	
How many individuals are you planning on serving in the current fiscal year (SFY 22)?	

Additional Comments:

Please provide sources for this data, if possible:

TABLE 16. FUNDING FOR INTENSIVE COMMUNITY BASED CRISIS INTERVENTION

Source of funds	Previous FY %	Current FY %	Previous FY $	Current FY $
Local Funds				
Levy				
Local Hospital Support				
County Government				
City Government				
Non-Levy Other				
Medicaid				
Third Party Insurance				
Foundations				
State Funds				
Mental Health Block Grant				
SAPT Block Grant				
Crisis Stabilization – MH				
Crisis Stabilization - SUD				
Crisis Flex				
Crisis Infrastructure				
Other State Funds (including State awarded Federal funds)				

Acute Inpatient Psychiatric Care

Acute psychiatric inpatient units are appropriate for individuals who are acutely in need of close and continuous medical, nursing and staff treatment intervention and monitoring over more than a 23-hour period, where safety risk remains unclear and when adequate evaluation or treatment cannot be achieved safely or effectively in a less intensive crisis or community-based setting. These units are licensed under Ohio Administrative Code Section 5122-14, and can be located in a freestanding psychiatric hospital or in a general hospital. These include general psychiatric units for adults or children/adolescents, as well as geriatric units that can safely treat older adults with medical and cognitive impairments, medical-psychiatric units that treat individuals of any age with combinations of acute psychiatric needs and acute medical illness and/or severe medical disability, specialized units for co-occurring serious mental illness and addiction, and specialized units for co-occurring psychiatric illness and intellectual/developmental disability or brain injury. State psychiatric hospital capacity for acute civil admissions can also be included within this service setting. Forensic units and long-term rehabilitation units, however, are excluded.

22. **Please list all Acute Inpatient Psychiatric facilities that commonly serve residents of your county/counties. Please distinguish programs serving adults from those serving children and youth.**

    Begin with listing inpatient facilities that are located within your Board's service area, and then describe your Board's utilization of acute state hospital beds. Then, understanding that people are often sent all over the state, just list the hospital units outside your Board region that you work with regularly.

For EACH one in the list, provide the following information

(Copy Tables 17 & 18 as needed for each)

Remember – provide as much information as you can, but if you don't have it let us know.

TABLE 17. ACUTE INPATIENT PSYCHIATRIC CARE

	Answer/Comments
Name of service	
Location	
Operating Entity	
Phone Number	
Type of Unit	
Volume/# of Beds	
Proportion of Volume Used by your Board	
Type of referrals that the unit does or does not accept (e.g., voluntary vs involuntary)	
Hours of Operation	
Medical, nursing, and peer support staffing coverage. Please provide enough detail to help distinguish the type and intensity of services that the acute inpatient psychiatric service provides.	
Annual Operating Budget for the previous FY	
Annual Operating Budget for the current FY (SFY 22)	
Sources of referral: Self, Call centers, 911, ED, crisis center, outpatient providers, law enforcement	
How many individuals were served in the last fiscal year?	
How many individuals are you planning on serving in the current fiscal year (SFY 22)?	

Additional Comments:

Please provide sources for this data, if possible:

TABLE 18. FUNDING FOR ACUTE INPATIENT PSYCHIATRIC CARE

Source of funds	Previous FY %	Current FY %	Previous FY $	Current FY $
Local Funds				
Levy				
Local Hospital Support				
County Government				
City Government				
Non-Levy Other				
Medicaid				
Third Party Insurance				
Foundations				
State Funds				
Mental Health Block Grant				
SAPT Block Grant				
Crisis Stabilization – MH				
Crisis Stabilization - SUD				
Crisis Flex				
Crisis Infrastructure				
Other State Funds (including State awarded Federal funds)				

Crisis Transportation

Transportation of people in crisis is a significant issue in Ohio, whether transportation TO a location for evaluation, or transportation FROM an evaluation location, such as an ER or Crisis Center, to another location for ongoing stabilization.

23. **Please describe the status of crisis transportation services in your Board region. Include the usual modes of transportation TO and FROM crisis evaluations and describe specific challenges in as much detail as possible. If you have identified any creative solutions that to address crisis transportation needs, please describe those solutions, including how they are funded, and how you have overcome any operational challenges.**

BH Crisis Services for Individuals with I/DD

24. **If not already discussed elsewhere in this survey, please describe any challenges and/or unique BH crisis services solutions for individuals with I/DD (or acquired brain injury) who are experiencing behavioral health crises.**

Other BH Crisis Services

25. **If there are other BH crisis services that are provided in your Board region that for whatever reason do not fit into any of these categories, please describe them here. If possible, please include the specific information listed above (location, description, staffing, funding, referral sources, disposition, etc.)**

BH Crisis Workforce

26. **We recognize there are incredible challenges with workforce in the current environment. Everyone is having challenges filling positions and retaining staff. We are open to learning more about unique aspects of your situation that are important to share with relation to the crisis service delivery system. Please provide any unique workforce challenges or successes that we should know about your county/counties.**

Clarification of Definitions and Terminology

27. **Are there definitions, terminology or other aspects of this tool that need clarification in the future?**

REPORTING OF PLANS FOR THE COMING YEAR

For each section of this table, identify your planning and funding targets for the coming year. For services, identify intended expansion of capacity, development of new services, anticipated funding sources and amounts, and any other relevant information to identify your objectives for the coming year.

Plans for Upcoming Year					
	Choose One				
	No Changes	**Expansion**	**Reduction**	**Comments**	**If Expansion, what funds are being used?**
Call Centers and Warm Lines					
First Responder Crisis Intervention Team					
Mobile Crisis Intervention with Clinical Staff					
BH Walk-In Urgent Care					
Crisis Center with Observation					
Residential Crisis Services					
Intensive Outpatient Crisis Services					
Crisis Transportation					
BH Crisis Services for Individuals with ID/DD					
Other BH Crisis Services					