OHIO CRISIS TASK FORCE SUB-COMMITTEE RECOMMENDATIONS

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RESPOND COMMITTEE

All Services mentioned below are designed to account for both adults and children, unless otherwise indicated. For certain community-based services, the needs of transition aged youth and their unique service needs should be considered when designing programming.

Respond Committee
URGENT CARE SUBCOMMITTEE
Recommendations
April 2022

Chair: Em Ribnik, Criminal Justice Coordinating Center of Excellence

Members: Meg Griffing (mgriffing@adamhfranklin.org), Michelle Allison Smith (michelle.smith@colemanservices.org), Alisia Clark (alisia.clark@mha.ohio.gov), Mark Johnson (mjohnson@MHARSLC.org), Molly O'Neill (moneill@oca-ohio.org), Angela Dugger (angeladugger@namiohio.org)

Consultant Support: Ken Minkoff, Kris Vilamaa

The subcommittee has had four meetings in February, March and April.

Committee Objectives and Questions:
The BH Urgent Care Subcommittee has been assigned the responsibility to develop recommendations for BH urgent care for the state of Ohio. Behavioral health urgent care is analogous to medical urgent care in providing walk-in services for people in crisis who generally do not require involuntary intervention nor to be seen in a medical emergency department. 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. Note that BH urgent care walk in services are commonly embedded in best practice Crisis Centers with Observation around the country, but those services are also provided in many locations independently of having observation capacity. The overarching goal for this subcommittee is to identify next steps for possible implementation that includes high quality standards of care, flexibility of implementation for various populations and geographies, and a broad framework for adequate financing. More details about financing are the domain of the Financing Committee.

Questions to be answered by this Subcommittee include:

Behavioral Health Urgent Care Questions

- **Should there be a service description for BH urgent care?**
- **If so, what are the elements to be considered in such a service description?**
- **Could BH UC be combined with medical UC? Could BH UC be provided in a hospital setting outside an ER?**
- **Could BH UC include telehealth medical screening?**
- **What arrangements might maximize revenue generation?**

Recommendations

1. **The Subcommittee recommends that BH Urgent Care services should be a component of the BH Crisis System in Ohio. Therefore, there should be a standard service description that supports service design and funding of these services.**
2. **General characteristics of BH Urgent Care services include:**
    a. Services may be separated between 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. **Note:** Designing services for youth as opposed as adults does not have to differentiate between ages. It possible to create services that are better designed for transition aged youth. Unlike residential services, community based services may be better designed to accommodate the needs of transition aged youth
    b. Behavioral Health 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. Communities should have the flexibility to determine the design and distribution of BH Urgent Care depending on community needs and services.
    c. The Subcommittee recommends that there is a service description that includes a range of different services and resources that can be included in BH Urgent Care, but that the services are tiered, with essential, desirable, and potential services (must, should, may), that 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.
    d. **Recommended Service Description:** *The complete tiered model and associated descriptions are still being revised and will be attached in a separate document. However, the following services are recommended as "must have" services:*
        i. BH Triage and Crisis Screening
        ii. Medical triage and basic medical screening to reduce ED use
        iii. Rapid access to higher levels of intervention for individuals with higher levels of medical, MH, and SUD needs
        iv. MH and SUD crisis evaluation and intervention
        v. Safety planning
        vi. Continuing care planning and linkage to needed ongoing BH services and other community resources, as well as to recovery support services.
            a. Communication and information sharing during and after visit
        vii. Managing appropriate utilization
            a. i.e. "Familiar faces" interventions for those that are frequent persons served
        viii. Access to prescriber consultation and bridge prescriptions are strongly encouraged, but the Subcommittee feels that the lack of availability of those capacities should not prevent the launch of a BH Urgent Care service. The appropriate utilization of resources, including OARRS and available medical records, is highly recommended when a community wants to have psychiatric services in their BH Urgent Care as part of their mental health/behavioral health services system.
    e. 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, and to help reduce access issues for difficult to staff services such as prescriber consultation. These could include, but are not limited to:

i. Embedded in an existing medical urgent care,
ii. 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 the Urgent Care),
iii. Combined with a Crisis Center with Observation
iv. Embedded in an outpatient MH and/or SUD service setting
v. Co-located with a peer drop-in or respite center

3. The subcommittee recommended that Behavioral Health Urgent Care must have access to medical screening to reduce the need for individuals to go to Emergency Departments simply for medical triage. BH Urgent Cares can vary in how such screening is provided, and whether it is provided directly or through collaboration, and whether it is provided on site or through telehealth. If through telehealth, it is recommended that this happens with identified medical urgent care partners through either MOU's or contracts, depending on the needs and resources of the community.

    a. Behavioral Health Urgent Care, like medical urgent care, must be supported by third-party funding mechanisms that correspond to the value of minimizing expensive and unnecessary emergency department utilization. BH Urgent Care fills the significant gap between scheduled appointment services plus periodic walk-in services provided during business hours (and often only to existing clients), and the 24/7 availability of the emergency department for anyone who has an urgent or emergent need. Revenue generation is enhanced by the capacity to bill at an appropriate rate, as well as the capacity to bill for the full spectrum of diagnostic and intervention services and providers that may be offered, just as in medical urgent care. 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 strategies:
        i. Location
            1. Accessible and on/near public transportation lines
            2. Near other high-volume settings or frequently accessed services
            3. Consider a location that has potential for growth for additional and enhanced services
        ii. Publicity
            1. Targeted advertising to the community and potential referral sources, potentially through the local ADAMHS board
            2. Consider untapped advertising avenues and unique marketing items (keychains, magnets, clings, etc.)
4. Collaboration with Service System Partners
5. MOUs with mental health and SUD providers to ensure a collaborative relationship (cross-referrals, information sharing, etc.)
    a. Partnership with call centers, first responders, mobile crisis, crisis centers to promote appropriate triage and referral
        i. Billing Staff and Services

1. Assistance with assessing/signing up individuals for benefits including availability of applications for presumptive Medicaid
2. Utilization as appropriate of multiple CPT billing codes in each single visit to account for multiple services occurring during a single visit
3. Encouragement of specific use of systems that allow for Incident To billing, where payers accommodate it, and appropriate variations to maximize revenue generation by an interdisciplinary team of service providers
4. Appropriate certifications and licensure of staff for services and billing
5. Billable services through third party payors
6. Rate structure needs to be based on the idea of diversion from ED visits and that BH UC is not routine outpatient mental health care. Rate structure should be developed as bundled/per diem rates that allow for a variety of service providers to meet varied needs of people experiencing a crisis.
7. Potential for services in some communities to be offered under an FQHC umbrella, which may permit an enhanced rate as well as CCBHCs, if an enhanced rate is adopted in the future.

RESPOND COMMITTEE

MOBILE CRISIS SUBCOMMITTEE

Recommendations – Final Draft

April 2022

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Consultant Support: Ken Minkoff, Kris Vilamaa, Hilary Hamlin

The subcommittee has had meetings on 1/12, 1/28, 2/11, 3/11, 3/25, & 4/8

Committee Objectives and Questions:

The Mobile Crisis Subcommittee has been assigned the responsibility to develop recommendations for mobile crisis services provided by clinical staff for the state of Ohio. Mobile crisis services include response to both adults and children and include response to both MH and SUD crises. The overarching goal is to identify next steps for statewide implementation that includes high quality standards of care, flexibility of implementation for various populations and geographies, and a broad framework for adequate financing. More details about financing are the domain of the Financing Committee. The Mobile Crisis Subcommittee includes representatives from a significant subset of the providers, Boards, and communities that are currently offering mobile crisis services in Ohio.

Questions to be answered by this Subcommittee include:

1. Review current service definitions (OHMAS and ODM) that apply to mobile crisis.
2. Should there be a standard service definition, or should there be a service description that allows for variability in coverage hours, time of response, urban vs. rural, adults vs children, etc.
3. In either case, what would be included in the service definition and service standards (bullet points)?
4. Are there other approaches to mobile crisis for children that can be developed besides or in addition to MRSS?
5. Should mobile crisis routinely permit including provision of mobile follow up crisis services?
6. Can mobile crisis and QRT services be combined on one team?
7. Should mobile crisis be supported by third party payment, or by Boards/OMHAS only?
8. What responsibilities should hospitals have to provide, fund, and/or coordinate (with Boards) services provided in their ERs?

Background data from Board Survey and other informants (including the Subcommittee members):

The Board surveys indicated that every Board is providing some level of “mobile” crisis services, but for most Boards that service is restricted to Health Officers providing state-mandated hospital pre-screening

in Emergency Departments and sometimes jails. A few Boards also have provision for mobile services in schools and juvenile justice settings. Mobile crisis services for adults beyond that baseline, that serve individuals anywhere in the community, are present in 26 counties (24 serve both adults and children, 2 serve adults alone). 6 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. More detailed data on the scope of these services is being analyzed currently.

OMHAS and ODM have worked collaboratively to implement MRSS as a Medicaid funded mobile crisis model for children and families, using grant funds to start a series of pilot programs. Many of the counties that provide mobile crisis for children are pilot counties for MRSS implementation; some are just starting up in the second phase of that pilot. State data on MRSS for the last quarter indicate an average of 110 children/families per month statewide that received an MRSS intake, of which approximately 2/3 were in "immediate" need. MRSS therefore is still very limited in reach. Further, many counties report that they are unable to meet MRSS standards as written and have proceeded to find other solutions to provide mobile crisis for children. 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, and that the current fidelity standards should be adjusted to recognize the service realities.

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.

Finally, one organization, Boundless, offers specialized mobile crisis services for individuals with I/DD including those with co-occurring BH needs. This specialized service is available in certain geographies but is an identified need statewide.

Mobile Crisis Recommendations:

The recommendations follow the assigned questions:

1. Review current service definitions (OHMAS and ODM) that apply to mobile crisis.

    a. **The Subcommittee noted that other than MRSS, there are no current service definitions for mobile crisis services. Therefore, OMHAS and ODM regulations need to be updated to include appropriate guidance language for adult and child BH (MH and SUD) mobile crisis services statewide. When new standards are developed, the process should include necessary changes to avoid conflict with existing rules/regulations (e.g. MRSS).**

    b. **The current MRSS standards are commendable but should not be the only type of mobile crisis service standards that are included in the regulations.**

c. **The regulations should be designed to align with national guidance from SAMHSA, CMS and other sources regarding state-of-the-art mobile crisis response.** Should there be a standard service definition, or should there be a service description that allows for variability in coverage hours, time of response, urban vs. rural, adults vs children, etc.

d. **The Committee recommends that there needs to be a standard definition for Mobile Crisis and the services that are included. Within that definition, there can be regulatory guidance – outside of the standard definition - 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.**

2. **In either case, what would be included in the service definition and service standards (bullet points)?**

The Subcommittee recommends reliance on national guidelines, including SAMHSA Guidelines for BH Crisis Care (2020) and the CMS Guidance for Mobile Crisis Services that are eligible for enhanced FMAP (2021). The former document defines the broad goals and objectives of mobile crisis; the latter document (See attached 3-page summary) identifies core required elements and areas where states can have individual flexibility in service design within their own Medicaid plans and waivers.

a. **Goals of Mobile Crisis Services: (SAMHSA Guidelines for Behavioral Health Crisis Care)**
   i. Helps individuals experiencing a MH or SUD crisis event to experience relief quickly and to resolve the crisis when possible.
   ii. Meets individuals in an environment where they are comfortable; and
   iii. Provides appropriate care/support while avoiding unnecessary law enforcement involvement, ED use and hospitalization.

b. **Objective of Mobile Crisis Services: (SAMHSA Guidelines for Behavioral Health Crisis Care)** "The main objectives of mobile crisis services are to provide rapid response, assess the individual, and resolve crisis situations that involve children and adults who are presumed or known to have a behavioral health (MH and/or SUD) disorder. Additional objectives may include linking people to needed services and finding hard-to-reach individuals. The main outcome objective of mobile crisis teams is to reduce psychiatric hospitalizations, including hospitalizations that follow psychiatric ED admission." (SAMHSA Guidelines for Behavioral Health Crisis Care). Additional objectives are to divert from unnecessary ED visits and unnecessary law enforcement involvement and arrest.

c. **Core services: (CMS)**

- Mobile crisis services should be strengths-based, person-centered, trauma informed, culturally competent, coordinated and focused on outcomes (e.g., service engagement, decreases in arrest and emergency department boarding, etc.).
- Mobile crisis services should be integrated into a full community-based continuum of crisis services.
- Mobile crisis services 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 services should connect individuals to facility-based or ongoing community-based care as needed, through warm hand-offs 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 marginalized populations.
- **Mobile crisis services are available 24/7 and can be provided in the home or any setting where a crisis may be occurring.**

Mobile crisis services are usually provided by teams. The response team may be comprised of professionals and non-licensed professionals (including trained peer support providers), who are trained in crisis intervention. Community-based mobile crisis services use face-to-face professional and trained peer intervention, deployed in real time to the location of the person in crisis in order to achieve the best outcomes for that individual.Most community-based mobile crisis programs utilize teams that include both professional and non-licensed professional staff. For example, a master's or Bachelor's level clinician may be paired with a trained peer support specialist and the backup of psychiatrists, psychologists or other Master's level clinicians who are on-call, as needed. Trained peer support workers often take the lead on client engagement and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis.

Mobile teams coordinate and co-respond with other first responders (law enforcement, EMS) in situations where physical or medical safety are at issue. In communities with fewer resources for BH mobile coverage, mobile clinicians may team up with other first responders (law enforcement, EMS) on a more routine basis. In situations where there is lower risk, mobile clinicians can at times respond individually, with telehealth back-up.

d. **Recommendations regarding components of Mobile Crisis Services: (Note**

that these recommendations are consistent with current MRSS standards but have broader and more flexible application.)

i. Triage/screening, including explicit screening for suicidality.

The Subcommittee emphasized the importance of a functional multi-factorial triage system. The system should use available call centers as well as 911 to triage possible requests for mobile crisis services. Triage can occur through 988 call lines but must be able to dispatch appropriately to the county in which the caller resides. Triage may need to occur through other call lines, as well as through the 911 system, where law enforcement and other first responders may receive the initial request and then themselves make the determination for involving mobile crisis. 911 & 988 systems, and non-NPSL call centers will ideally be interoperable in the future.

The triage system needs to identify when mobile crisis response is needed, versus a response that is either more intensive and rapid, or less intensive and rapid. ("Every fire does not require sending fire trucks.") Further, the triage system needs to identify the level of both medical risk (e.g., overdose requiring emergency room intervention) and behavioral risk (threat of violence, weapons) that may determine the need for a level of response that involves ambulance or law enforcement, and then to determine whether there should be a mobile BH response in addition or instead. Finally, the triage needs to determine whether the mobile BH response should occur immediately (within 60 minutes or so) or urgently (within 24 hours.) Triage also needs to evaluate client preferences for the timeframe of response and be able to accommodate those preferences. The goal of triage also to minimize unnecessary involvement of police or ambulances, while making sure they are available on scene when needed.

ii. 24-hour timely access.

The Subcommittee agreed that the goal of mobile crisis 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. Where there is only partial coverage, it is important to prioritize coverage for high volume time periods (usually late afternoon to midnight or 1 AM). Further, it is important for there to be provision for other best practice coverage during other hours, such as having Health Officers available 24/7 with some capacity to do mobile visits, and/or having CIT trained law enforcement available. Because 24-hour coverage is necessary to draw down enhanced FMAP for Medicaid, once Medicaid payment options are established, programs may have significant financial incentives to expand to 24 hour coverage over a relatively short time period.

Further, the Subcommittee agreed that for mobile crisis, 60 minutes is a reasonable access standard (expectation would be for 85-90% of contacts to meet this standard) in general, but that there should be options for longer time frames in more rural areas (e.g., 90 minutes), and options (and perhaps

incentives) for faster response in more urban areas (30-45 minutes.) Some mobile teams (e.g., Coleman in Stark) already attempt to meet the higher standard. **Note: These should be service provider standards and not impact reimbursement for services**
Important note: When more emergent response is needed in any location, EMS, LE, or other first responders could be utilized to provide the more immediate response. Mobile crisis response can arrive on scene as soon as possible to collaborate with first responders to manage the crisis, including providing support to involved family members of the person in crisis.

The Subcommittee also recommends that "time out the door" (15 minutes from dispatch instruction) is a helpful benchmark for mobile crisis response at the level of the provider, in addition to the overall timely access standard for being on scene. "Time out the door" is a variable that the provider can control, whereas arrival on scene may depend on the distance that needs to be travelled to get there. Further, investment in meeting the timely access standard requires a level of funding that permits adequate incentives for staff to cover the program and provision for duplication of coverage to minimize the number of times that the mobile team can't respond because they are involved with another crisis.

iii. 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". There is flexibility about how this can occur, however. The Subcommittee agreed that having independently licensed clinicians on site is valuable, but not always practical. The Subcommittee also agreed that current standards for documenting an assessment and treatment plan in a mobile crisis encounter to justify payment are not matched to the crisis nature of these services. Further, options for having other levels of staff on site with supervision available from a licensed clinician through telehealth should be an option, for all programs or perhaps just for programs in rural or underserved areas. In addition, the Subcommittee agreed that it is desirable for there to be responder "teams", including (but not necessarily limited to) licensed clinical professional plus unlicensed case manager, professional and peer, professional and paramedic (e.g., Columbus model), but also agreed that there are some agencies that have been successful with only having one clinician available with option to partner with law enforcement and/or with telehealth back up.

iv. Cultural/Linguistic Access: All mobile teams should be trained, including triage staff, to have cultural humility. In addition, it is critical to make provision for linguistic barriers, including ASL. Provisions should be made in the cost basis and rate setting methodology to account for this requirement.

v. **De-escalation/resolution.** The mobile crisis service should prioritize de-escalation in the field, with follow up efforts to promote continuing crisis resolution and linkage to ongoing treatment. Access to transportation to higher levels of care such as crisis centers with observation, residential crisis services, or hospitalization is critical for the subset of individuals who will require more intensive intervention.

vi. **Peer support.** The Subcommittee agreed that having adult and youth peer supporters as regular members of the mobile crisis response team provided dramatic advantages to engaging people with BH and/or SUD crises. Similar advantages are present for having family partners available for family crises involving children. The goal for the system should be to promote the expectation peer involvement in mobile crisis services by expanding availability of peers who are trained to provide crisis services so that they are available statewide. However, in the current system, there are limitations to the availability of peers that make it prohibitive to have peers a REQUIRED component of mobile crisis at present. A reimbursement structure that incorporates the cost of peers as part of the service team will be necessary.

vii. **Coordination with medical services, behavioral health services, and other service systems.** Mobile crisis 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. This clearly includes coordination with both medical emergency and urgent care services, and coordination with the full continuum of BH crisis and ongoing services (Stabilize and Thrive), but also responsive partnerships with homeless services, schools, juvenile justice, jails, courts, aging services, recovery community organizations, and so on, all of which may be at varying times customers of mobile crisis services as well as sites for warm handoffs to continuing support.

viii. **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.

ix. **Crisis planning and follow-up.** The Subcommittee agreed that it is always desirable for mobile crisis services to 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.

3. Are there other approaches to mobile crisis for children that can be developed besides or in addition to MRSS?

a. **The Subcommittee strongly recommends that Mobile Crisis Services for children <u>can</u> be defined and developed in accordance with service models that are different from and in addition to MRSS.** Licking Knox has one such model.

b. **The Subcommittee also recommends that local systems have flexibility about whether to have one mobile crisis team that serves both adults and children, or to have separate teams. Both options should be available under regulation and funding.**

c. **Consideration for the best option would be based on service volume, available resources, and potential economies of scale. Variables include:**
   i. Size of county or Board region
   ii. Type and amount of available Funding
   iii. Availability of appropriate Staffing
   iv. Access to Appropriate Staff Training

4. Should mobile crisis routinely permit including provision of mobile follow up crisis services?

   a. **As noted previously, the Subcommittee strongly recommends that best practice would include routine tracking and follow up.**

   b. **Staffing for follow up services may be more directly reliant on bachelor's level staff, unlicensed professionals and peers, compared to staffing for initial crisis assessment. It may be helpful as well to have access to bridge prescribing.**

   c. **Provision for staffing follow up services can occur in a variety of ways but should not create a barrier to timely initial mobile crisis response.**

   d. **The follow up services should be designed to have accountability for an extra level of both tracking and direct service to ensure client does not get lost.** For example, the mobile crisis program can simply track clients for up to 90 days to make sure they are remaining engaged with continuing care and provide focused direct services only when they see that the client is at risk of not getting connected to appropriate services to help them to thrive.

5. Can mobile crisis and QRT services be combined on one team?

   a. **The Subcommittee recommends that mobile crisis response of all kinds for individuals with MH and SUD crises, especially those with opioid overdose, be considered as equal priority.** This means that individuals with opioid overdose should have access to immediate engagement as soon as they revive with naloxone, as well as immediate connection to initiation of MAT on scene if possible. Similarly, individuals in MH crisis would benefit from peer engagement and follow up just as those with opioid use disorder.

b. **Therefore, it is recommended that communities have the option of achieving integration of crisis response as well as economies of scale by combining mobile crisis services (immediate and follow up) with their existing capacity for QRT.** At the same time, communities also have the option of keeping these services separate but complementary and collaborative.

c. **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.**

6. Should mobile crisis be supported by third party payment, or by Boards/OMHAS only?

   a. **Mobile Crisis Services should be defined in regulation according to these recommendations, in alignment with nationally recognized evidence-based treatment standards by SAMHSA and CMS and should be mandated for funding by ALL third party payers.**
   b. **If State of Ohio will not require third-party payors to fund Mobile Crisis then non-Medicaid funding, including for those who are insured, should be a responsibility of local Boards that is equally and adequately funded by the State of OH.**
   c. **Note that even with MRSS, there remains a significant gap, because many children and families in crisis have other insurance coverage and are not eligible for Medicaid.**
   d. **Support mobile response team structures that utilize single and multiple sites as bases of operation**
   e. **Payment methodologies must 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. Cost could vary in less well-resourced and more geographically dispersed communities. Payment cannot be based on usual FFS rates for encounters. Recently published national best practices for mobile crisis funding, including more modernized Medicaid payment methodologies and appropriate billing codes, should be adopted by Ohio. The Financing Committee can provide more detailed recommendations.**
   f. **Rural Counties may need higher per capita funding due to smaller size.**
   g. **Incentive payments should be considered for meeting certain benchmarks.**

7. What responsibilities should hospitals have to provide, fund, and/or coordinate with Boards, and service providers in their ERs?

   a. **Hospitals are natural partners in funding mobile crisis services that may relieve pressure on their EDs. If there are community hospitals that are experiencing challenges with Boarding, and absorbing associated costs for security and sitters, they should be brought to the table to help fund mobile crisis services that may take the pressure off. The community can adopt metrics of reduction in unnecessary BH ED visits as a target.**
   b. **Hospitals also may need to support the provision of adequate BH crisis intervention services <u>within</u> their EDs. This includes a range of "stabilize"**

options as part of the full continuum. Services should be routinely coordinated with Boards as part of monitoring community crisis system performance. This issue is being addressed in other Committees.

RESPOND COMMITTEE

TRANSPORTATION SUBCOMMITTEE

Recommendations – Final
April 2022

Co-Chairs: Joan Englund, MHAC and Michelle Smith, Coleman Health Services

Members: Alicia Bruce, Thom Craig, Emily Clegg (OMHAS), Meredith C (ODI), Shawna Deems (ODM), Rafiat Eshett (ODM), Grace Kolliesuah (OMHAS), Molly Mottram (ODI), Molly O'Neill, Deidre Palmer, Laura Payne (OMHAS), Richard Pozywak,, Em Ribnik, Jonathan Thomas.
Consultant Support: Ken Minkoff & Kris Vilamaa

The subcommittee has had three meetings, February 11, March 4, and April 1.

Committee Objectives and Questions:

The Transportation Subcommittee has been assigned responsibility of making recommendations for transportation of individuals in crisis. Although this subcommittee is within the Respond Committee, its mandate extends to crisis transportation through the whole crisis continuum. This 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, ER) 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.)

Questions to be answered by this Subcommittee include:

1. Should Ohio develop specific service standards or service definitions for transporting people experiencing BH crisis?
    a. What would be the pros and cons?
2. If such standards were developed, what might they include, and to what funders or providers would they apply?
3. What are existing examples of transportation solutions that might be taken to scale or applied more broadly across the state?
4. What types of transportation might be reimbursable by third party payers?

Background data from Board Survey and other informants:

Transportation of individuals in BH crisis was reported as a significant concern by almost every Board. Issues reported included the lack of availability of ambulances to travel long distances, the lack of adequate reimbursement for ambulance transport under Medicaid 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 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, rather being systematized across the state.

Response to Questions and Recommendations:

1. **The Subcommittee recommends that "BH Crisis Transportation" 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 medical crises.**

2. **Therefore, the Subcommittee recommends that there need to be 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.**

3. **Further, the Subcommittee recommends that BH Crisis Transportation services 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.**

4. **The first step would be to clarify the range of options that are CURRENTLY available through the payment system, and the expectations of EMS providers with regard to those options. Then, over time, the next steps would be to develop a more comprehensive continuum of transportation options, as described below.** The Subcommittee learned that EMS companies have a range of options for medical transportation, including Advanced Life Support, Basic Life Support, Chair cars, Ambulettes, and even vans. Individuals in acute BH crisis may not need medical accommodations, but do need provision for safe transport and observation, which can often be provided in modified vehicles. Reimbursement for emergency medical transportation is governed by medical necessity criteria that are designed for individuals with medical crises and physical disabilities. There is no set of BH specific medical necessity standards for provision of appropriate emergency transportation at the right level of security and intensity for individuals with BH crises, and therefore there is no systematized approach to designing and implementing that array of transportation services in every community. Additionally, there is varied understanding/application of the requirements for law enforcement officers to transport people in crisis when an involuntary admission is necessary. The intent is to minimize the need for law enforcement to transport persons in crisis.

5. **The Subcommittee recommends therefore that the state of Ohio establish a process by which current medical necessity criteria for provision and payment of emergency medical transportation be amended to include a comprehensive array of BH emergency transportation options, each with BH specific medical necessity criteria and appropriate payment. This should range from ambulance transport for those with acute medical needs as well as BH conditions, to appropriately secure ambulettes with observation for those who have primarily BH crises and need to be transported safely and securely, to lower intensity transportation for individuals that have emergent or urgent BH needs but are not a safety risk.**

6. **Emergency BH Transport below Advanced Life Support should be authorized to transport to non-hospital settings.** For example, current Medicaid regulations – 5160.15 – appears to state that a BLS provider in the field can transport to a Medicaid provider for intervention with additional Medicaid covered services and receive reimbursement accordingly. This should be accompanied by interpretive guidelines to illustrate how this might clearly apply to BH crisis services.

7. **Within the Medicaid system, application of payment standards for the full continuum of BH Emergency Transportation should be expected of Medicaid MCOs.**

8. **All third-party payers should be expected to pay for BH emergency transportation at parity with payment for emergency medical transportation.**

9. **ET3 Waivers to permit Medicare funding of EMS transport to non-hospital settings such as crisis centers with observation should be initiated in as many jurisdictions as possible statewide.**

10. **To establish a standard of care statewide, the Subcommittee recommends that 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. Response times and capacity should be equivalent to those for medical EMS. Standards should include:**
    a. Wait times: People should not have to wait hours for transportation in a BH crisis
    b. Provision for observation, security, and safety, in a welcoming atmosphere.
    c. Accommodations for geography: In rural settings, transportation needs to be provided to the closest resource that is designed for BH crisis evaluation or stabilization.
    d. Minimal expectations of BH capacity for all certified EMS providers.
11. **The Emergency BH Transportation System should be designed to seamlessly flow into 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 88 counties.** That is, given that BH emergency transport may have a range of acuity, security, and urgency, some of the existing non-emergency transportation system can be dedicated to facilitating components of the BH Emergency Transportation system, such as transportation post discharge from a psychiatric hospital, crisis center with observation, or residential crisis service.

12. **Non-emergency transportation options should include transportation from a crisis stabilization setting (Crisis Center with Observation, Residential Crisis Service for MH or SUD, Inpatient Hospital) to home, for individuals that have no other means of transport.** This can be a significant challenge for people with serious MH and/or SUD issues, particularly when the stabilization setting is far from where they are needing to go.

13. **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. Existing models may be used to inform these definitions.** 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 ultimately available through the third-party funded BH Crisis Transportation System.

RESPOND COMMITTEE

WORKFORCE SUBCOMMITTEE

Recommendations – First Draft

April 2022

Chair: Kay Spergel, Licking-Knox

Members: Alicia Bruce, Rick Oliver, noelled@crcwoodcounty.org, Meg Griffing, tshelton@adamhmedina.org, Shawna Deems, Soley Hernandez, Katie Cretella, Thom Craig Grace Kolliesuah, scook@oacbha.org

Consultant Support: Ken Minkoff, Kris Vilamaa

The subcommittee has had two meetings: February 15 and March 3.

Committee Objectives and Questions:

The Workforce Subcommittee has been assigned responsibility of making recommendations for alleviating BH crisis workforce shortages and improving recruitment and retention of the BH crisis workforce. Although this subcommittee is within the Respond Committee, its mandate extends to BH crisis workforce through the whole crisis continuum. Although there is clearly overlap between the BH crisis workforce shortage and the BH workforce shortage in Ohio generally, the Subcommittee was encouraged to focus primarily on recommendations specific to crisis workforce, as the broader workforce issues are being addressed by OMHAS in other venues. The Ohio Council's December 2021 Whitepaper entitled Breaking Point: Ohio's Behavioral Health Workforce Crisis provided important background for the Subcommittee. Recommendations in the Whitepaper were adapted in many instances with a specific focus on BH crisis workforce.

Questions to be answered by this Subcommittee include:

1. What are regulatory requirements or barriers that can be addressed to alleviate workforce shortages for Respond and other BH Crisis Services?
2. What is working to retain BH crisis clinical staff? Are there specific targeted strategies to improve recruitment and retention that can be implemented more widely?
3. Identify 5-10 ideas that might improve the BH crisis workforce situation in the relatively near future.

Background data from Board Survey and other informants (including the Subcommittee members):

Every Board indicated that there were significant challenges with recruitment and retention of BH crisis workforce. Existing BH workforce shortages, particularly in rural areas and in public sector vs private sector or VA jobs, 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 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.

The following recommendations 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.

BH Crisis Workforce Recommendations:

1. **The Subcommittee recommends changes in the following areas, specifically related to BH Crisis Workforce. Most of these recommendations can be implemented relatively quickly (over the next 1-5 years) and are complementary to longer term BH workforce strategies. These are also in addition to the more general recommendations for addressing the BH Workforce Shortage in Ohio that are outlined in the Breaking Point Whitepaper and other discussions.**
    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.

Each of these will be considered in turn.

2. **Payment: Best practice sustainable payment methodologies for crisis services are designed based on the <u>true cost</u> of recruiting and retaining BH crisis staff at all levels to do the work.** It is significantly easier to recruit and retain staff for on call work, mobile crisis service provision, and shift work for 24-hour coverage of crisis services if the payment rates for those services are based on competitive market rates for appropriate staffing. One-time grant funding may help get a program started but needed staff salaries may not be sustainable once grant funding ends. Current fee for service payment rates and methodologies in Ohio are not adequate to provide revenue to cover costs for adequate payment for crisis staff, thus leading to significant recruitment challenges and higher turnover. Other states have implemented alternative payment methodologies which have been more successful. These include, but are not limited to, the following examples: Cost based program payments (e.g., Arizona and Georgia), prospective payments (e.g., statewide CCBHC implementation as in Missouri), encounter payment rates that

are flexible based on cost of service provided, and case rates for crisis episodes. In addition, the more different funding sources that are engaged and aligned to support BH crisis services at true cost (including adequate payment and benefits for staff), the more revenue will be available to pay adequately for services and by extension, staff. The details of these funding models are in the domain of the Financing Committee, but it cannot be understated how important adequate financing is for promoting recruitment and retention of BH crisis staff.

3. **Differential payments for staff:** A related recommendation is to facilitate the provision of differential payments for crisis staff. This may include shift differential payments, differential types of on call payment and reimbursement, and so on, that create different types of payment structures and incentives for staff doing crisis work compared to staff who are on more regular schedules. This requires training for HR staff about how to implement such differential payments in a manner that is fair, transparent, and equitable for all staff. Note that differential payments are routine in medical acute care settings and BH inpatient settings, so this approach can and should be more routinely expanded to BH crisis settings.
4. **Credentialling flexibility:** Given the high need for BH crisis services, there should be increased flexibility for how providers are able to credential staff delivering crisis services to meet payment requirements for Medicaid or other third-party payers. Many commercial payers will not reimburse crisis providers who are not independently licensed, even though their members may benefit from publicly funded crisis services; this is a parity issue. Enabling crisis providers to both broaden the categories of staff who can be approved for reimbursement for crisis response and facilitate organizational credentialling rather than individual credentialling and "enrollment" would improve the ability to engage more staff more quickly in delivering BH crisis response.
5. **Expansion of categories of staff who can deliver BH crisis services:** While it is necessary to have crisis services delivered under the supervision and direction of highly qualified and licensed BH practitioners, expanding the ability of individuals to work as interdisciplinary teams under supervision will promote the availability of BH crisis personnel. Team members who work under supervision (on site, or telehealth; see below) might include unlicensed interns, bachelor's level case managers, certified peer supporters, BH trained emergency medical technicians or paramedics, and a range of nursing personnel. Note that in some parts of Ohio, and in many states, BH trained EMTs or paramedics function as valuable members of BH crisis response (mobile and site-based) because they are already well prepared to respond to emergency situations, have substantial medical knowledge, and can be trained relatively easily to have BH crisis response skills to work as team members with BH clinicians.
6. **Improving efficiency of coverage through telehealth:** Staffing BH crisis services, particularly in rural areas, can be substantially facilitated by maximizing the degree to which telehealth coverage can be leveraged in both mobile and site-based crisis response. This requires increasing training and comfort in using telehealth, but also can be a way of providing virtual support in more underserved areas that mitigates safety and quality concerns. Using telehealth by practitioners with "higher levels of licensure" to support individuals or teams on the ground (both BH clinical service teams and first responders) has been modeled in many settings. Reviewing existing telehealth regulations and program rules to maximize this capacity, particularly in rural areas, can be very valuable in improving efficiency of staff recruitment and deployment. For example, a licensed clinician can support an unlicensed intern and/or peer supporter on scene through telehealth. Another example is that 24 hour physician back up can be provided by a regional crisis center with observation in an urban hub to support services provided by mobile crisis teams or in medical ERs in nearby rural counties.
7. **Improving efficiency of crisis coverage through other mechanisms:** A challenge of staffing BH Crisis Services, particularly in rural areas, may be the need to provide separate 24 hour coverage

rosters for multiple different types of services. A common example would be a county that is trying to staff mobile crisis for adults, MRSS for children, and QRT for opioid overdoses. For residential crisis services, a rural area may be challenged to staff separate MH residential crisis services and an SUD W/M program. The more flexibility individual counties can have to integrate their crisis service provision into one team, and to consolidate staffing and coverage, the more ability they will have to recruit and retain adequate staffing. Conversely, if staff on call for mobile response are too likely to be overwhelmed with the volume of response, it is important to have the flexibility to have multiple people on call, and thereby to reduce the individual burden on each one. It may be paradoxically easier to recruit more than one person to be on call for adequate payment and a reasonable expectation of service volume, than to try to recruit people to perform a job function that is inherently overwhelming regardless of the pay. (This approach is used in Arizona.)

8. **Expanding career opportunities via specialized training and/or certification in BH crisis work.** In the same way that being an EMT/paramedic has become a heroic career path, it is appropriate to begin to "market" BH crisis work for all levels of service provider as a highly valued and important vocation. We need to challenge the current "stigma" associated with the work and the population served. Career opportunities can be provided in any community to people at any level, with access to BH crisis specific training, certification, and internships (paid jobs) at any level: high school, community college, college students, bachelor's level, medically trained paramedics, nurses (RNs, LVNs), master's level (licensed or unlicensed), and of course certified peer support specialists. Having career pathways that include special training and recognition of a skill in BH crisis intervention, with associated pay differentials and opportunities, will promote more individuals who want to build on their current skills and interests to engage in this work as part of their career path. State-led development of incumbent worker programs specific to BH crisis employers would be beneficial to expand the workforce and recruit new staff to crisis work.
9. **Expanding crisis training and partnerships with higher education academic programs to enhance the knowledge of crisis service delivery by those graduating from these programs. –** Having a workforce that is better prepared to address crisis services as part of their overall curriculum for behavioral health counseling, nursing and other academic specialties. Training experiences should include practicums or internships with good quality crisis provider environments.
10. **Reducing administrative burden for BH crisis work. C**urrent paperwork and documentation requirements in all BH work are disproportionately onerous compared to requirements in medical settings and other human service fields. This contributes to both burn out and to the difficulty of meeting "productivity" requirements needed to support payment for salaries. While this is a larger issue to address, there can be some immediate improvement by reviewing and simplifying necessary documentation for BH crisis work, particularly for providers in mobile settings or urgent care/crisis center settings. These documentation requirements should be comparable to those for medical urgent or emergent care in similar settings, so the focus of provider time is on direct service delivery rather than on excessive layers of documentation that contribute to job dissatisfaction and turnover.

Additional Workforce Recommendations:

In addition to providing specific recommendations focusing on BH Crisis Workforce needs, the Subcommittee identified the following additional ideas that are worthy of attention for addressing BH workforce needs more generally.

1. Marketing
    a. Elevate the field of BH and reduce stigma.
    b. Mission/service driven, but what are the benefits of a BH career
        i. Clearer understanding of degree pathways (i.e., what will a B.S. in Psych. allow one to do?)
    c. Create an attractive workplace culture of welcoming, safety, and teamwork, so that current staff market to new staff.

2. Recruitment Postings -
    a. Denote salary/range
    b. Transparency is needed
    c. Clearly note if the position allows for NO productivity requirements
    d. More structure around job duties
    e. All-inclusive "benefit" packet explanation
    f. Long-term goal: Consider BH workforce insurance pool for providers and Boards.
    g. Adapt recruitment for "newer generation"
    h. Train HR staff in putting together attractive recruitment approaches.

3. Flexible scheduling
    a. Support hybrid, shared, split shifts, and/or remote work
    b. Some current funds (i.e., ARPA) could support a 4-day work week
    c. Consider "summer" schedule
        i. Flexible time off, without depleting PTO

4. Education
    a. On-going business best practices training
    b. Paid internships
    c. Tuition reimbursement and other continuing education incentives.
    d. Education on the "why" behind shift differential, travel, on-call, premium pay to all staff
    e. More interim certificate programs to bridge gap between bachelor and master's degrees - collaboration with state licensing boards related to development of career ladders and alternative licenses for associate's and bachelor's level.
    f. Increased education for employers and the general public on MH insurance parity and how to file a complaint

5. Incentivization
    a. Student loan forgiveness - creation of a state-level ombudsman or similar idea related to helping BH workforce navigate state and federal scholarships, loan forgiveness, and/or tuition reimbursement opportunities. Community benefits such as discount at local restaurants/stores
    b. Recruitment bonuses with commitment for length of time in job.
    c. Training HR staff to implement incentives legally and transparently

STABILIZE & THRIVE COMMITTEE

Stabilize & Thrive Committee

CRISIS CENTER WITH OBSERVATION SUBCOMMITTEE

Recommendations – Final Draft

April 2022

Chair: Joe Caruso, Compass Family and Community Services

Members: Scott Osiecki – Cuyahoga County ADAMHS Board
Kate St. James – Behavioral Health Care Partners
Thom Craig – Peg's Foundation
Meg Griffing – Franklin County ADAMHS Board
Michelle Smith – Coleman Services
Molly O'Neil - OCAAR
Mike Biscaro – St. Vincent Charity Health System
Dianne Mang – Foundations of Canton

Consultant Support: Ken Minkoff, Steven Hedgepeth

The subcommittee has had four meetings, January 5, February 2, and March 2, and April 6

Committee Objectives and Questions:

The Crisis Center with Observation Subcommittee was assigned the responsibility for addressing the need for service descriptions and standards related to Crisis Centers with Observation. According to the Interim Definitions that were used in the Board Survey and have 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, with 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. Crisis Centers with Observation in this work are distinguished from MH and SUD Residential Crisis Services, where individuals are admitted for days or weeks following an initial assessment to determine appropriateness for that level of care. The focus of the Subcommittee was to determine the need for specific service descriptions for this type of program, and if so, to provide guidance on what those service descriptions should include.

Questions to be answered by this Subcommittee include:

1. **Review current service definitions (OHMAS and ODM) that apply to any service in this category, include Psychiatric Emergency Services.**
2. **Should there be a standard service definition, or should there be a service description that allows for variability in available hours, level of staffing, level of access for involuntary patients, urban vs. rural, adults vs children, etc? In either case, what would be included in the service definition and service standards (bullet points)?**
3. **What are the pros and cons of hospital vs non-hospital-based crisis center services?**
4. **Should/can crisis centers with observation routinely co-locate with walk in urgent care and/or residential crisis services?**
5. **Can crisis centers with observation utilize telehealth medical screening to reduce ER utilization?**

6. **Can crisis centers with observation initiate withdrawal management interventions? What services can be provided by telehealth?**
7. **Should crisis centers with observation be supported by third party payment, or by Boards/OMHAS only?**
8. **How can regional services be better designed to support wider geographies?**

Background data from Board Survey and other informants (including the Subcommittee members):

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 in order to be more precise about what is being described and developed. The 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 3-4 reported, one of which is at St. Vincent Charity Health System 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 Subcommittee was fortunate in having representation from all the above subtypes.

Crisis Center with Observation Recommendations:

This draft language is based on the Subcommittee's discussion of its assigned questions and has not yet been fully vetted and approved.

1. The Subcommittee recommends the development of program guidelines that define a regulatory and funding framework for Crisis Centers with Observation.

Rather than recommending one standard definition, the Subcommittee recommends the development of guidelines for the creation of optimal Crisis Centers with Observation, as well as creating service descriptions of Crisis Centers with Observation that may have different levels of capability, with associated variation in program requirements and funding rates. These guidelines, and recommended variations, will be described in more detail below.
This recommendation is derived from the Subcommittee's review of existing service definitions (Question 1). The Subcommittee's consensus response is as follows:

***Consensus answer**: There are no known current definitions that define the types of crisis center with observation services that exist in the community (Psychiatric Emergency Services/PES, Non-hospital crisis centers or diversion centers, peer respite). Current programs are certified with multiple waivers under the "residential treatment facility" definition. This "workaround" inhibits implementation, limits guidelines for defining flexibility in staffing or regional variances and makes it more difficult to create sustainable county/Medicaid/insurance 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. This mismatch must be corrected.*

Characteristics of an optimal Crisis Center with Observation:
The Crisis Center with Observation is a facility where individuals 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 for a period of up to 23 hours (and on occasion up to 48 or 72 hours) to assess and address the crisis, and to connect them with ongoing services that best meet their needs, in the best possible setting, avoiding arrest, criminalization, hospitalization, ER boarding, and other unnecessary, costly and/or restrictive interventions to the greatest extent possible. Individuals are often 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.

The following are **Basic Characteristics** of an optimal Crisis Center. Where there is recommended flexibility for those characteristics, that is noted.

- **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
- **Person and Family-Centered**
- **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.
- **Accessible to diverse populations:** Equitable access and response for racial, ethnic, linguistic, and cultural minorities, significant subpopulations (children, I/DD, older adults, veterans, LGBTQ+), and rural vs. urban populations.
    - Separate space must be developed for adults and children. Ideal Crisis Centers serve both populations, but some communities may begin with one population, usually adults, and then add the services for children later.
    - Each facility to ensure it has adequate staffing and/or community partners to address the needs of specialty populations to include older adults, persons on the Autism spectrum, LGBTQ+, etc.
- **Accessible to all people in crisis**
    - Minimal criteria for diversion and a policy approach that accepts all comers.
    - Welcomes individuals who may be actively using substances
    - Triage practices that identify individuals with emergency medical needs (e.g., overdoses) before arrival and welcome everyone else.
    - 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.
    - All payer access is important: Medicaid, Medicare, commercial payers, veterans, uninsured.
    - ***Note:*** *The Subcommittee had considerable discussion about whether Crisis Centers should always be able to accept people who are on involuntary status.*
        - *There is agreement that the goal is for every community to have Crisis Center capacity to accept involuntary status who might otherwise be hospitalized or arrested.*
        - *There would need to be a "runway" to help Crisis Centers that do not have that capacity to transition over time.*
        - *There is recognition that for Crisis Centers to accept individuals who may be on voluntary status as well as those who might have more severe agitation, the*

Crisis Center needs to have the capacity to provide restraint and seclusion. However, 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.

- **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 that may occur during a pandemic.*
- **Accessible geographically**
    - People should be served as close to home as possible, which requires making it easier to develop access to Crisis Center services for people in rural areas.
    - Individuals should have access to a Crisis Center 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. (For some more remote rural areas, there may need to be flexibility for a longer time frame)
    - *Crisis Centers in larger counties can provide consultation by telehealth to crisis locations (BH Urgent Care, Mobile Crisis, EDs) in smaller counties in their service areas, to facilitate decisions about who should be transported to the Crisis Center and who should be served in their own community.
- **Access to medical screening and basic intervention**
    - Crisis Centers with Observation should have access to on site nursing, as well as capacity for basic medical screening and triage, on site or through telehealth. The goal is to reduce the unnecessary use of medical emergency rooms simply for medical screening or for medical interventions that would not normally require an emergency room. At minimum, a CMA/LPN/EMT or other appropriately trained/credentialed staff is needed on-site to complete vitals and monitor medical status.
    - Crisis Centers with Observation should have access to basic laboratory services (phlebotomy on site, lab processing off site), pharmacy services (stock meds, and mechanisms for delivery of prescribed meds), and telehealth or on-site medical coverage as needed. This can often be provided through collaboration or subcontracting with emergency rooms or medical urgent care centers.
- **Capacity to meet demand:** Crisis Centers with Observation 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. Facilities may use "swing beds" to accommodate fluctuations in age mix.
- **Timely access to a full range of MH and SUD services from an interdisciplinary team:** The ideal Crisis Center has 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 but many communities are still growing their peer workforce. Access to certain disciplines may occur through telehealth.
    - Timely access to peer contact is recommended, including peers in welcoming and engagement at the point of admission.

- Timely access to nursing triage is important at admission, and prescriber assessment and intervention for both MH and SUD should be able to occur within one hour, whether on site or via telehealth. Interventions to manage mild/moderate withdrawal symptoms should be standard.
- It is recommended that Crisis Centers with Observation be able to use naloxone for overdose withdrawal when necessary, and immediately initiate medication treatment for OUD whenever appropriate.
- 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. This means that there are clear instructions for BH 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 BH services.
- ***Note:*** *The Subcommittee discussed the importance of peer presence in creating a welcoming and recovery-oriented environment. The peer driven Living Room is a recommended approach to be incorporated into all Crisis Centers to the degree possible, understanding that there may be variation in Crisis Centers that are more equipped for medical intervention and high acuity, and Crisis Centers that are more reliant on just peer intervention, with less acuity and medical capacity.*

- **Crisis Assessment, Crisis Intervention and Rapid throughput:** 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. All necessary services are provided flexibly as needed in a fast-moving environment.
- **Care Coordination and Continuity:** The Crisis Center with Observation is 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 and so on, in order to facilitate bidirectional connection in the community.

- **Location Options for Crisis Centers with Observation:**
  - **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 for people served and first responders, as well as reasonably close to emergency medical facilities.
  - **Hospital-Based Crisis Centers with Observation** are an important subtype of Crisis Centers with Observation. They may be freestanding under a hospital license but are usually affiliated with or a component of a larger Emergency Department. These settings can be an appropriate part of the service continuum in addition to non-hospital Crisis Centers, as they are able to provide appropriate services to individuals who DO need medical emergency interventions as well as BH crisis interventions. Some larger communities (e.g., Cuyahoga County) can support both non-hospital and hospital-based Crisis Centers with Observation. In smaller communities, economies of scale may necessitate adding a small hospital-based Crisis Center unit to the local ED rather than developing a freestanding non-hospital location. Those smaller services might be supported by telehealth consultation provided by a larger Crisis Center with Observation located in a neighboring county. If the community has limited transportation options

and no ET3 waiver, then ambulances may only be able to transport to a hospital. As a result, the Subcommittee recommends that even though non-hospital Crisis Centers with Observation are preferred in most instances, regulatory guidance should provide options for both hospital ED based and non-hospital based Crisis Centers with Observation, depending on the needs and circumstances of individual communities or Board regions.

- **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, and so on. Where regulations permit, non-hospital Crisis Centers can be located close to hospitals and medical EDs, which facilitates cross coverage and patient flow.
- **Multiple locations: Larger communities may have multiple Crisis Centers with Observation** associated with different population centers or transportation hubs.

- **Program Options:** The Subcommittee recommends that the guidelines for Crisis Centers with Observation define the optimal guidelines, as described, but provide flexibility for different program "levels" or "subtypes" that may still be valuable, but may have different service capacities and payment rates, as follows:
  - **Non-hospital Crisis Center with Observation, accepts <u>voluntary and involuntary</u> individuals.** Ideally, has 24/7 operation, serves all ages, incorporates peers and medical capacity at all hours.
  - **Non-hospital Crisis Center with Observation, accepts <u>voluntary</u> people only.** Ideally, has 24/7 operation, serves all ages, incorporates peers, with prominent Living Room, and has medical capacity at all hours.
  - **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.

- **"Regional" Crisis Centers with Observation:** As previously noted, some rural counties or 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. The Subcommittee recommends:
  - **Geo-mapping:** Looking at natural geography for designing where it is a priority to locate Crisis Centers, and planning capacity based on the population of the surrounding Board regions is a recommended approach to create statewide coverage. Note that the geo-mapping 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, Board Collaboratives, Opiate Task Forces, Regional Jails, etc) already exist could be a starting point.
  - **Virtual Support:** In addition to direct services, a "hub" 24/7 Crisis Center 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.

SPECIAL NOTE: Peer Respite Living Room: accepts voluntary people only, primarily peer staffed, with limited medical/nursing capacity (consultation only). The Subcommittee discussed this program model as representing an extremely important component of the optimal crisis continuum, whether available just for short-term drop in or for brief overnight stays, and whether people can just walk in or whether they need to be evaluated elsewhere first and then referred. **However, the Subcommittee recommended that this service model be included in Residential Crisis Services, rather than in Crisis Center with Observation.**

Funding Considerations:

The Subcommittee strongly recommends that Crisis Centers with Observation be supported by all types of third-party payers the same way that third party payment supports medical EDs and medical urgent care (Parity). In most states, Medicaid is the major funder for the most intensive Crisis Center with Observation programs.

For all third-party payers, it is necessary for there to be a base rate that is adequate for the required services and all-inclusive of services, capacity, and facility needs (as in an Emergency Department), with options for increased payment for higher service intensity or complexity, as in Emergency Departments. Payment by bundled rate assures available "firehouse" capacity for this important service.

The Subcommittee recommended that multiple options be considered, and ideally available, within the framework of a bundled rate. Options may include developing the bundled rate based on total service cost divided by projected utilization or based on formulas projecting per capita population need. The bundled rate payment may vary based on what constitutes an encounter (how many hours counts as "observation") or an episode of care (if the person leaves and then comes back within a few hours, is that one episode or two). The types of services that are included within a bundled rate, or that are billed outside of a (smaller) bundled rate may also vary, based on the type of service setting. For example, hospital-based services may include laboratory services and medication within the bundle, while freestanding non-hospital services may contract with outside providers who may need to bill separately. That flexibility in rate design will support more creative local solutions for sustainable funding of these programs.

Further, additional support by OMHAS, Boards, and city/county funders are often needed to support planning and design, capital acquisition and building, coverage of uninsured individuals, and additional non-medical service provision. Given the need for a statewide plan for distribution of these Crisis Centers, OMHAS may need to play an important role in partnering with stakeholders to help not only with start-up investment but 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.

STABILIZE & THRIVE COMMITTEE
RESIDENTIAL CRISIS SERVICES SUBCOMMITTEE
Recommendations – Final Draft
April 2022

Chair: David Schenkelberg, Hopewell

Members: Michelle Smith, Jeff DeLay, Mary Haller

Consultant Support: Ken Minkoff, Steven Hedgepeth

The subcommittee has had two meetings, February 15, March 15, and April 19.

Committee Objectives and Questions:

The Residential Crisis Services Subcommittee was assigned to provide recommendations concerning the array of adult and child MH and SUD residential crisis services (SUD residential crisis services are usually withdrawal management programs) that should be implemented as part of Ohio's Crisis System. Residential Crisis Services are a broad category described in the Interim Definitions that guide 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, they 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 residences (sober living), and residential treatment centers such as QRTPs and PRTFs.

Questions to be answered by this Subcommittee include:

1. Should there be an updated service description for residential crisis services? If so, what are the elements to be considered in such a service description?
2. Should there be different levels or models of residential crisis services included in the service description?
3. Should the service descriptions, regulatory requirements, and payment methodologies for withdrawal management services be more aligned with residential crisis? Pros and Cons
4. Would it be permissible to have both services provided in one location under one regulation? Pros and Cons
5. What level of programming is expected?
6. Should individuals need to attend programming to be eligible for reimbursement?

Background data from Board Survey and other informants (including the Subcommittee members):

The Board surveys indicated that there is a distribution of both adult MH and SUD residential crisis services across the state. However, the funding mechanisms for these services are quite different. 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. For that reason, the Medicaid contribution to these services is much less (30% or less) and some Boards have elected to fund the entire service rather than to deal with third party billing. Although adult MH crisis residential services are present in over 20 Board

regions, they are often described as being inconsistently available, especially to individuals who may present for crisis in neighboring counties, simply because of both problems with immediate access for people who are unstable and problems of transportation from one site to another, since ambulances cannot transport to residential crisis services and expect to be reimbursed. Access to SUD withdrawal management services appears to be less problematic (though certainly not without difficulties), perhaps because there are more options available for transportation of individuals who may need withdrawal but are not demonstrating acute behavioral risk. MH crisis residential services for youth are only available in three locations. This may contribute to greater reported barriers for access to higher levels of care for youth in crisis who are presenting in hospital EDs.

Recommendations

1. **The Subcommittee agreed that there needs to be a service definition, regulatory framework, and payment methodology for MH residential crisis services that is essentially analogous to that for SUD withdrawal management services.**

The Subcommittee notes: The current efforts to adapt residential regulations to residential crisis services is 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. The challenge with designing services to be "chasing" disparate service codes and rates (TBS, Ind and Group Counseling, Med Man, Day Tx) is that the revenue needed to fund the facility seems to drive treatment as opposed to creating a unified residential support and crisis intervention service model that accommodates individual client needs

2. **The Subcommittee agreed that there need to be core standards for MH residential crisis services, but that there will need to be variations in specific instructions (program consents, staff training, supervision protocols, meals) for youth services compared to adult services. PRTF facilities, while often for long term services could be adapted to support short term youth crisis services.**

- **The Subcommittee agreed that there may be variations in the types of MH residential crisis services provided and recommends that there are different "levels" of residential services that are options for implementation. This is analogous to the different ASAM levels of residential SUD services and SUD W/M services.** An example of defining these levels that the Subcommittee offers for consideration is presented in the Roadmap to the Ideal Crisis System report (National Council, 2021, p. 111-112). In that report, four levels are defined:
    - 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. Each of these levels can have value. 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 may 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.

- **The Subcommittee recommends that the following factors be considered in developing service descriptions for all MH residential crisis service types:**
    - **Admissions can occur either directly from the community or as a step down from higher levels of care.**
    - **Adults and children must have separate physical locations.** However, these locations may be contiguous for more efficient staffing coverage.
    - **Length of stay may vary from a few days to a few weeks.**
    - **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. There may be variation in staffing expectations based on the resource needs in the community. (For example, peers may be recommended but not required on as many shifts in communities that have less access to certified peers). The Subcommittee has not gone into detail on all possible staffing patterns.** Note that in the highest level of residential crisis services (which is the one most commonly provided in Ohio currently) there should be access to prescriber consultation daily, prescriber presence on site more than one day per week, 24 hour access to RN consultation, and 24 hour coverage of LVN, EMT, or other medically trained staff. Some services by more highly credentialed staff can be provided through telehealth. It is standard that a more highly resourced 12-16 bed program will have 2-3 staff present per shift. Some programs currently include peers in their staffing pattern more routinely than others.
    - **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 (e.g., are they medically fragile and unable to perform daily living skills?) can be met on site with the level of staffing available.** Programs should have access to appropriate consultation by nursing or other licensed staff as needed for questions that may arise at the point of admission.
    - **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, without having to obtain a separate W/M license. Each provider facility should have the ability to determine whether they have sufficient staffing and clinical resources to support a facility that serves co-occurring individuals.**
    - **Individual and group crisis intervention programming should be routinely available. The Subcommittee recommends 3 hours of group programming daily but emphasizes that such programming does not have to be conducted by independently licensed clinicians. All staff, including and especially peer supporters, may participate in providing these services.** Decisions about whether clients may or may not be required to attend groups or other programming should be made based on individual client need.
    - **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, adjust medications, and offer prn medications.

- **The program must meet basic residential safety and client rights standards, as appropriate for individuals in shared rooms.** These standards are reasonably 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.
- **The program must provide for clients' nutrition appropriately.** There are many mechanisms by which programs can do this in a way that is 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, and so on. More meal service is required for programs serving children.
- **The discharge planning process must be inclusive of connection to continuing BH treatment, other community resources, and natural/peer supports, as well as inclusive of developing crisis plans and safety plans as appropriate for the individual and family.**

- **The Subcommittee recommends that the design of residential crisis services permit local flexibility in design according to local needs, to facilitate cost-effective operation.** For example, a residential crisis program in a small county may have a mixture of beds designated for MH crisis and SUD W/M in a single location with a single staff. Similarly, another program may have a mixture of short-term crisis diversion admissions, with individuals who have longer stays because they are stepping down from extended state hospital admissions. The more that regulations provide for such flexibility without extensive barriers or need for unique waivers, the more readily services will be implemented and deployed.
- **The Subcommittee recommends that MH Residential Crisis Services be funded with a per diem rate based on the cost of providing the total service, both facility and staffing costs. Rates should be sufficient to support community capacity, robust clinical staffing, and administrative overhead.** Residential crisis services should be a standard benefit provided by all third-party payers. Board funding should be available for those individuals who are indigent or underinsured.

Appendix A.

Current Program Illustrations - Program Structure for Hopewell and Coleman

Current Program Offerings

Admissions can occur at any hour
Individual and group interventions
Medication management – could be self-assisted but managed by RN
Therapy, Day Treatment, TBS, PSR
Bed Day funding – not substantial
On-Call providers as necessary

Coleman

Avg: LOS 5 days
13 beds – serve approx. 50 clients/month
LPNs 24/7 – (Board specific contract requirement)
RN – 40 hrs week
LPN
Weekend contract Psychiatry – 4hrs and on call (Psychiatrist "orders" stay)
1 FTE – Clinical counselor
1 FTE – Clinician
2-3FTE – HS-level technicians

Each shift has 3 people

Hopewell

13 bed + 16 bed units

3 days/week RN
Full time LPN
8hrs/week of psychiatry
1FTE – Clinician
2.5 (3 for 16 bed) FTE – CMs and Peer
2 FTE - technicians

Medications can be prescribed by other provider docs and filled at local pharmacies or FQHC-linked pharmacy either same day or next day

STABILIZE & THRIVE COMMITTEE
INTENSIVE CRISIS FOLLOW-UP SUBCOMMITTEE
Recommendations – Final Draft
April 2022

Chair: David C. Ross

Members: Jeff DeLay, Molly O'Neill, David Schenkelberg, Tracey Stute, Cresta Rodesky, Shawna Deems, Meg Griffing, Michelle Smith, Michael Krause, Shirley Johnson.

Consultant Support: Ken Minkoff, Steven Hedgepeth

The subcommittee has had three meetings, January 13, February 10, March 10, and April 14

Committee Objectives and Questions:

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, emergency room 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.

Questions to be answered by this subcommittee include:

1. **Review any existing standards for intensive crisis follow-up (MRSS, IHBT, hospital liaison, etc.).**
2. **Should Ohio develop specific service standards or service definitions for intensive crisis follow-up, office, home-based, or both?**
3. **Should there be alternative models to MRSS or IHBT to permit or incentivize flexibility?**
4. **If so (to any of the above), what might be some elements of those standards?**
5. **What should the standards be for connecting people leaving acute inpatient or residential settings with "thrive services" through continuing crisis intervention when needed?**
6. **What are existing examples of transportation solutions that might be taken to scale or applied more broadly across the state?**

Background data from Board Survey and other informants (including the Subcommittee members):

Ohio has recognized the importance of providing routine intensive crisis follow-up services in designing the standards for MRSS for youth. In addition, IHBT is recognized as a mechanism for delivering intensive crisis follow-up services for selected populations. In the Board surveys, other than those programs that reported MRSS implementation and occasional references to referrals to IHBT, there was little systematic identification of intensive crisis follow-up. Several Boards reported that their contracted non-MRSS mobile crisis providers offered continuing follow-up for clients after the mobile crisis encounter. For example, one agency in Licking Knox serving both adults and youth with mobile crises routinely engages a peer organization as a partner in doing outreach for up to 90 days, checking on

whether clients have been successfully engaged in ongoing services, and intervening when they need further help to get connected. A few Boards noted that they had designated hospital liaison staff who worked with private hospitals to facilitate transitions back to the community. A few hospitals indicated that they offered partial hospitalization services to follow-up inpatient care. However, most Boards stated that they did not have an organized approach to delivering intensive crisis follow-up across the board to people moving through the crisis continuum.

The following recommendations are based on consensus discussion in response to the questions above, synthesized into a set of actionable steps.

BH Intensive Community Crisis Follow-up Recommendations:

This draft language is based on the subcommittee's discussion of its assigned questions and has not yet been thoroughly vetted and approved.

- **Intensive Community Crisis Follow-Up Guidelines or Definitions would be beneficial.** The subcommittee agreed that service standards should be defined that underscore the importance of providing intensive crisis follow-up services. Existing standards incorporate this expectation into MRSS, but not standards that apply more broadly. Such standards are needed. There are examples of intensive follow-up services around the state (e.g., Hospital Liaisons) but no definitions that support expanding those services to all populations in need. These services must cover all populations, including all payors and MH and SUD. Standards must be defined enough to support adequate payment but flexible enough to permit flexibility in implementing these services.

  Reference: *OAC Rule 5160-1-73* (Behavioral Health Care Coordination) as an existing guideline

- **Service definitions should emphasize the functional nature of these services while promoting flexibility for how those services might be operationalized in different communities.**

The following includes recommended service descriptions and guidelines, and opportunities for adaptation in local communities.

An intensive crisis follow-up service is intended to support people who have recently experienced an acute behavioral health crisis that requires a visit to a hospital emergency department, crisis stabilization facility, crisis diversion center, behavioral health urgent care, mobile crisis team, or any other crisis service point. The service is time-limited and should be available for at least 30 days, with an opportunity for extension to 60 or 90 days if needed.

Target Population
The population served includes the broad spectrum of people of all ages (and their families/supports) who are currently or have recently experienced an acute mental health crisis, an acute substance use crisis, or both. These persons may be imminently discharged from a crisis stabilization facility, have presented in the hospital emergency department, received a mobile crisis team visit, or assessed at a behavioral health urgent care site. The population should be defined as those at risk of further decompensation or continued instability without intensive transitional support over time to effectively engage with continuing routine treatment and support services that will help them both stabilize and

thrive. This may apply both to people in crisis who have been previously involved in services and need help to re-engage and those who are new to the system.
Important target populations may include

1. People who have been incarcerated or arrested with significant BH challenges transitioning back into the community and need to be reconnected to community BH resources. ODM works with MCOs to connect to the pre-release adult population
2. Persons who have been inappropriately incarcerated due to a BH or SUD crisis
3. Children and families in crisis who present in schools or are involved with the juvenile justice system, the child protection system, or both
4. Individuals and families in BH Crisis who are also experiencing homelessness

Service Goals

The immediate goal is to ensure a connection for people who have recently experienced a crisis event to ongoing care and support. Additionally, the service should seek to:

1. Keep people in the community where they live
2. Reduce recidivism
3. Act as an advocate for people who are in crisis
4. Have a person-centered, strengths-based focus
5. Assure that connection to the crisis system has no wrong door

Fundamental tasks include:

1. Outreach and engagement to transition people to the appropriate services/treatment
2. Continued Crisis Intervention and Stabilization
3. Assessment of current service needs to promote continuing stability and growth
4. Connection of people by warm hand-off to needed behavioral health, physical health, and human services and supports required to provide continuing stability and growth.
5. Provision of case management and care coordination to access and maintain a safe living arrangement, enroll in applicable benefit programs (e.g., Medicaid), and promote connection with essential support systems, such as schools and other human services.
6. Identification and engagement of natural supports that could support long-term recovery and wellness

Service Availability and Location

1. Intensive community follow-up services may be provided in various locations and service settings under the auspice of appropriately credentialed community providers. Services can be provided as an extension of mobile crisis, urgent care, or other “respond” crisis services, provided by distinct teams or provided in the context of more routine community behavioral health services. Availability for services are multiple times per week, as needed, and be available in the home/community, as well as by telehealth, based on the preference of the person and the capacity of the community. In addition, services can be created through partnering with other intensive community service providers, such as visiting nurse organizations. They can be conceptualized as a parity service to the types of bridging in-home services commonly available for people who have experienced medical crises.
2. Access to initiation of this service can occur through 24/7 access to a call center to arrange response, based on the preference of the person and the capacity of the community, ideally in-person within one business day for the initial contact. Initial contacts should occur at the time or

before people leave the crisis setting or current level of care. Additional case management activities may be made telephonically or in person.

3. Services can be restricted to only those who initiate crisis contact with the program (e.g., follow-up after mobile crisis contact by the mobile team) or be open to anyone needing to follow up with crisis services.
4. The service should not disrupt any current therapeutic relationship. For persons currently engaged with a treatment provider but experiencing an acute crisis, the service should be available to provide a bridge of intensive interventions until stable and regular connection to their current provider can take place.
5. To best support people's needs, the majority of contacts should be completed in the community. Community locations could include the person's home, crisis facility, hospital emergency department, or other community location.

Service Interventions

While a time-limited service, the intensive community crisis services seek to provide a robust set of interventions to prevent people from falling back into crisis, act as a bridge to ongoing care and recovery, and provide follow-up after making community service connections. Professionals, peers, or both can provide interventions, should be available both in-person and via telehealth, both in-home and in the office, and include individual and group contacts. The clinical interventions can consist of medications, therapeutic services, recovery coaching, skill-building, and case management. The care coordination interventions include, but are not limited to:

1. The Transition of care planning to begin as close to the start of crisis as possible
2. Coordination of care between levels of crisis service to include treatment plan sharing to ensure care continuity
3. Liaison between hospitals, residential settings (crisis centers, residential crisis services, withdrawal management programs), and community settings
4. Facilitation of warm hand-offs between levels of crisis and outpatient care
5. Engagement and support of the natural environment (family) and connection to requisite supports
6. Provision of education and support regarding benefits
7. Connection to primary health providers
8. Advocacy for people in crisis
9. Coordination of transportation between LOCs

These interventions will be supported by access to a robust, electronically available community resource guide.

Community Connection

Crucial to making this service successful for all people served is substantial provider connection to other community providers. Key partners in this effort should include, but are not limited to;

a) Local Hospital Systems
b) Boards
c) Crisis Service Providers
d) Outpatient Behavioral Health and Recovery Providers
e) Managed Care Organizations

f) Support services such as housing providers, schools, child protection, probation, and Aging Services

Staffing and Training

The service should be staffed by professionals who have the requisite education, experience, and background to support diverse needs. Supervision of an interdisciplinary team, including peers, is essential. Access to medication prescribing, either as part of the team or through affiliation, will be required, as many individuals will not be able to connect to ongoing prescribers in a timely fashion. Wherever possible, peers (adult, youth, family) should be members of the service team. As persons who have lived experience with crisis, peers can engage and support persons that other paid supports may not reach. In addition, peers should have sufficient training and knowledge of the community service system to support people's needs. The Ohio START initiative is an example of professionals and peers being paired in service delivery.

All staff should have the ability to rapidly engage with individuals and families served.

- Crisis Intervention (including a specialized crisis intervention track for OMHAS peer training)
- Motivational Interviewing
- Critical Time Intervention
- Trauma-Informed Care
- Supporting families of adults in crisis

Access to services for individuals of diverse cultural and linguistic backgrounds is essential.

Funding the service

1. Should create a funding model for Medicaid, other third-party payers, and the uninsured. Funding should support the service across all payers.
2. The service should be reimbursed at higher rates than routine outpatient services because it is intensive and involves both office-based and in-home services and significant care coordination and case management.
3. One funding model to consider is paying on a bundled case rate, perhaps with differentials for higher vs. lower intensity services. For example, higher intensity services can be designed for individuals who need to be seen 2-3 times per week; lower intensity services for those who need only weekly contact. The bundled payment model can be conceptualized as similar to funding a time-limited "ACT Lite" service model.
4. Funding must be designed to support service costs, including adequate pay and benefits for peers and clinical staff to provide a living wage.

STABILIZE & THRIVE COMMITTEE
DEFINING THRIVE SUBCOMMITTEE
Recommendations – Final Draft
April 2022

Chair: Michael Krause, OhioPRO

Members: Shawna Deems – ODM, Kate St. James, Emily Clegg -OHMAS, Lauren Thorp – TCMHRB, Meg Griffing – Franklin County, Christina Shaynak-Diaz – OACBHA

Consultant Support: Ken Minkoff, Steven Hedgepeth

The subcommittee has had three meetings, March 3, March 14, and April 5

Committee Objectives and Questions:

The Defining Thrive Subcommittee's objective was 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 live – in short, to thrive. Within the purview of the Crisis Taskforce, this subcommittee's most important task is 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.

Questions to be answered by this Subcommittee include:

1. **Should there be standards for connecting people leaving acute inpatient or residential settings with "thrive services" through continuing crisis intervention when needed? How do we define "connect"?**
2. **What are existing examples of transportation solutions that might be taken to scale or applied more broadly across the state?**
3. **What types of transportation might be reimbursable by third party payers?**
4. **Are there other services that help individuals thrive that should have standards or targets set at a county level to ensure capacity?**
5. **How do we ensure there is community capacity for necessary services for people to thrive?**
6. **How do persons served define services for themselves? How do we use that to drive system design and service delivery standards?**
7. **How do we ensure that the overall continuum is person-centered and focused on the true needs of persons served?**
8. **Are there specifics around recruitment, pay differentials, credentialing mechanisms, on-call coverage that would simplify service provision?**

   Note that "transportation" here is focused on routine transportation, as opposed to crisis transportation which is being addressed by one of the Respond subcommittees.

Background data from Board Survey and other informants (including the Subcommittee members):

The Ohio Crisis Whitepaper recognizes Thrive as a key element of the crisis continuum that includes Connect, Respond, Stabilize and Thrive. The Board survey for the landscape analysis only surveyed elements in the Connect, Respond, and Stabilize portions of the continuum, in order to have the survey be more focused and manageable for respondents. Many informants in focus groups and other meetings have 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. New initiatives such as OhioRISE and multi-system adult services are identifying mechanisms to provide person/family-driven individualized and flexible service packages to help people move from instability and recurrent crisis to stabilization and thriving.

The following recommendations are based on consensus discussion in response to the questions above, synthesized into a set of actionable steps.

Defining Thrive Recommendations:

This draft language is based on the Subcommittee's discussion of its assigned questions and has not yet been fully vetted and approved.

The Subcommittee recommended a vision and framework for defining a "Thrive continuum" in each Board region, and then outlined specific recommendations for how to help people in crisis get connected to that continuum of services.

The Vision:

Hope for thriving is fundamental: Everyone should be provided with a belief that they are going to be successful in achieving their vision of a successful life ("thriving") and that wellness and recovery for individuals and families are achievable.

Thriving is defined by the most important elements of human experience: This begins with a place to sleep, a place to find meaning, and meaningful community connections (supportive relationships).

Thriving also includes opportunities for joy, fun, creativity, and personal growth; it's not just about meeting concrete needs.

Thrive services are person and family driven: In every community, people with lived experience, including those with lived experience of crisis, must be involved in providing information about what services are important, including for people in crisis ("transition planning"), and designing those services to be responsive to the needs of the service recipients, not the convenience of providers. Further, thriving is individualized for each person and family. What is important and inspiring for one person may be just the opposite for someone else. Helping people connect to thriving involves partnerships with service navigators and adult/youth/family peer supporters that help those people connect to those opportunities that matter most.

Thriving services are about people and should be similar regardless of whether people experience MH challenges, SUD challenges, or both. There should be continuous effort to align the service continuum within adult and child MH with the service continuum within SUD.

Thriving requires a network of support for each individual and family to help them on their journey. The composition of this network will be based on individual needs and preferences, but will commonly include peer support, family support, professional supports, and other (paid or unpaid) natural community supports, including mechanisms to support service navigation, transportation, and both face-to-face and virtual connection.

Thriving belongs to the whole community: Recovery-oriented systems of care (ROSC) and Children's Systems of Care based on wraparound principles emphasize the role of the whole community in contributing services, supports, and resources to help everyone thrive, especially those who are most vulnerable and most in need. All payers should be partners in developing the System of Care vision.

Thriving is local. Each community should be expected to provide access to a baseline level of services to support people's ability to thrive, regardless of where that community is located. Those services should be available to all, regardless of insurance status. There should be expectations of access and quality, but accommodations for variations in local culture, population density, population diversity, and geography.

Thriving Continuum of Services in each community requires community planning coordinated at the Board level with partnerships from multiple funders to ensure adequate funding, ongoing state and local strategies to promote BH workforce recruitment and retention at all levels, and a comprehensive commitment to demonstrating the value to the whole community of helping those who are most in need be able to thrive.

The "Thrive" Services:

The following services are part of the continuum of "thrive" services that should be available in each community. In addition, there needs to be individualized connection and support (peers and others) to help people navigate these services, especially after a crisis. Further, individualized person-centered service, as noted above, means recognizing that "thriving" is about helping people find meaning and joy, and is not just a checklist of activities. Thriving always begins with what is important to the person served.

Note that the Subcommittee listed professional BH and health services last on the list. That is not because these services are not important, but rather because when services for thriving are viewed through the eyes of people with lived experience, professional services are seen as only a small part of their lives.

The Subcommittee recommends that Thrive Services be understood through the lens of what people need and want, by looking at real world examples.

Example: Mt. Carmel Health System Street Medicine Teams

Street medicine programs are excellent examples of how to turn usual service packages upside down to start with what is most important to the people served rather than starting by trying to fit people into

the service "boxes" we already have. That is because the people served by street medicine teams are persistently homeless, with significant health and behavioral health issues, who are often using lots of expensive health care services with very poor outcomes. The Mt. Carmel Street Medicine team (including MD, Nurse Practitioner, EMT, peers, case managers) has been in operation in Columbus for 10 years and starts not with medicine but with building relationships and connecting people to peers and other supports, bringing health care (through a mobile van) to the homeless camps where people congregate, and focusing on building services that provide access to housing, plus employment, education, and socialization, as well as to medical and BH services. Mt. Carmel has gotten progressively more intentional about engaging people served about their priorities, starting with housing, and collaborates with a 72-unit affordable housing site to provide a combination of housing access and wraparound supports.

The lesson to be learned is the following: Best practice services for this homeless population that is frequently in crisis STARTS with attention to the need to thrive, and then includes traditional medical and BH services as part of the package, rather than the other way around. LEAD is another example of this type of service.

This same lesson should be applied to services for individuals, even without having a "special program".

The Subcommittee recommends therefore that the list of Thrive Services below be understood as operating within the context of hopeful relationships that build meaning and joy, not simply as a checklist to be applied in a one-size-fits-all manner.

1. Peer Support Services
   - Engagement at the point of crisis, and throughout the continuum
2. Employment
   - Employment skills support (resume, training)
   - Supported Employment – Helping people maintain employment
   - Connection with employers
3. Education support
4. Housing retention supports
   - Supportive Housing that provides wraparound services
   - Emergency housing access, including vouchers
   - Recovery Housing
5. Social connectedness
   Establishing the network of support.
   - Family support
   - Recovery Community connection
6. Faith-Based Communities – can be connectors to other resources (eg; housing, food, transportation)
7. Transportation
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,
11. Connection to community BH professional services

12. Connection to Primary Care Services and Wellness Supports

The Connection to Thrive Services:

The Subcommittee recommends that there be standards for post-crisis connection defined in standards and provided in each Board region. Every Board region should have a mechanism for keeping in contact with people up to 3 months post crisis service experience to make sure that they are connected to services and supports to help them to thrive. (Example: BH Care Partners in Licking-Knox)

Other recommendations for connection to thrive include:

- 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.
- Investment in care coordination and intensive community-based crisis intervention (reference to other subcommittees' work) is important, including peer Bridgers, care navigators, hospital liaisons, and so on.
- Building the expectation of "connectivity" into existing crisis services, whether mobile crisis, crisis centers, or hospitals, is critical for the success of people served.
- Virtual connection is important and ensuring individuals in need have access to basic technology, like smartphones, is critical for thriving.
- Transportation can and should be funded through multiple sources (including MCOs) and multiple modalities, including:
    1. Case manager transport
    2. Peer transport
    3. Public transport
    4. Uber/Lyft
    5. Van transport: RIDE Services
    6. Peer ride along on the above

PERFORMANCE METRICS AND DATA COMMITTEE

Performance Metrics and Data Committee
Recommendations
April 2022

Chairs: Soley Hernandez, Ohio Council; Kraig Knudsen, OMHAS

Principles Subcommittee Members: Scott Rasmus, Chair: Tracy Campbell, Jonathan Myers, Soley Hernandez, Jessica Linley, Hattie Tracy, Melissa Knopp, Alisia Clark, Molly O'Neill

Existing Data Sets Subcommittee Members: Jennifer Riha, Chair: Jennifer Swartzlander, Fonda Freeman, Kraig Knudsen, Peggy Smith, Shirley Johnson, Andy White, Jeffrey Allen, Molly O'Neill, Michael Krause

Access Metrics Subcommittee Members: Don Schiffbauer, Chair: Susan Ballard, JJ Boroski, Geoff Collver, Laura Paynter, Jonathan Thomas, Joe Trolian, Molly O'Neill, David Frederick

Consultant Support: Ken Minkoff, Kris Vilamaa

Committee Objectives and Questions

This "overarching" 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.

The full Committee has met monthly since December 2021. There are three Subcommittees whose work has been integrated into this set of recommendations, as described below.

Questions to be answered by this Committee include:

System Performance Metrics

- Review examples of performance metrics used by Boards and by systems outside Ohio.
- What is the difference between system level (state, county, or Board region) crisis system performance metrics and individual crisis program performance metrics?
- Should performance metrics apply to the whole community, or to just a subset of the population
- (indigent, Medicaid, etc.)?
- Should performance metrics or benchmarks vary by population? (for example child vs. adult, rural vs. urban, etc.?)
- Identify performance metrics to recommend for statewide application.
- Recommend possible benchmarks for those metrics.

Equity Metrics

- In addition to general performance metrics, it is important to attend to issues of equity.
- What types of metrics should be reviewed within each Board region to assess for socioeconomic/cultural/linguistic/racial equity?
- What types of metrics should be reviewed across the state to assess for equity across
- rural/suburban/urban Board regions?

- Is equity important for adults vs. children receiving BH crisis services? For SUD vs MH presentations?
    - If so, how to address?

Data sources

- What types of data sources are currently available to measure the metrics suggested for system performance and equity?
- What types of data sources need to be available to measure the metrics suggested for system performance and equity?
- Are there mechanisms for improving the ability of Boards, providers, and other community partners to collect the data that would help measure and improve performance?
- What are the current barriers in data collection and sharing?

Performance Metrics for Crisis System Subcomponents and Programs

- Review examples of existing performance metrics for various crisis system subcomponents. Consider guidance from the below sources:
    - SAMHSA National Guidelines for Behavioral Health Crisis Care (page 51)
    - National Council for Behavioral Health Roadmap to the Ideal Crisis System (page 51-55)
- To achieve system performance metric benchmarks, all the crisis system components need to perform individually as well as in connection with other components. This requires metrics for program performance and for inter-program collaboration.
- What are some of the metrics that are relevant for success for the different services within the Connect, Respond, Stabilize, and link to Thrive continuum?
- Where are there opportunities for metrics to improve program linkage and continuity?
- How or should performance metrics be used to guide performance incentives?
- Where are there risks for metrics to have unintended negative consequences?
- Identify a range of performance metrics that can guide further progress.

Background data from Board Survey and other informants (including the Subcommittee members)

Ohio's vision for its BH crisis system, as articulated in the OMHAS Crisis White Paper, clearly 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. (**See Appendix A, referenced below in the section on Existing Data Sets Subcommittee findings.)** Hospital data sharing regarding emergency department utilization for BH services, inpatient utilization, or ambulatory crisis services (e.g. partial hospitalization) 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 reasonably detailed data on BH Emergency Department visits and/or BH related law enforcement and/or 911 response through the 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 200/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 the vast majority of encounters occurring in the local ED (1500-2000 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. These data can be used for predictive modeling of progress and success as more crisis services are implemented statewide. (See modeling examples in **Appendix B).**

Additional examples of "local" models for data sharing include the CJ-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 Open Beds project also has some data about 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 ASAM specific program categories), MRSS (coming on line), 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. The consultants have provided recommendations for performance data to be considered, based on the work on the Roadmap to the Ideal Crisis System report and the proposed CRISES metrics for crisis center with observation performance published by Margaret Balfour, MD. These recommendations are considered a starting place for prompting further discussion. The NASMHPD TA Paper (No. 10, 2021) entitled Using Data to Manage State and Local Mental Health Crisis Services is another useful background reference.

The Roadmap to the Ideal Crisis System recommendations, the CRISES metrics, and aspirational metrics recommended by three Boards are included respectively in Appendices C, D, and E.

Predictive Analytics – Although the data collection methods and metrics could be improved, the committee recommended utilizing data for predictive analytics. The predictive measures could be used to identify and flag individuals prior to a crisis, overdose event, or other
Predictive analytic models are currently being test and piloted in multiple communities across the country

Committee Process

The Committee proceeded to address its questions through the following activities:

- The Principles Subcommittee, chaired by Scott Rasmus of Butler County, formed to delineate general principles for Performance Metrics and Data Collection
- The Data Collection Subcommittee, chaired by Jennifer Riha of Boundless, formed to address one of the principles, which was to identify existing data sets that could simplify performance measurement.
- The Access Metrics Subcommittee, chaired by Don Schiffbauer of Nord Center, formed to identify specific program metrics for service Access.
- The Committee as a whole met to build on the subcommittee work and the proposed recommendations from the consultants to identify overarching system performance metrics, and to delineate the importance of identifying metrics relevant to diversity and equity.

Overarching Principles for Performance Measurement and Data Collection Subcommittee

Recommendations

Overarching Principles for Performance Metrics

- Performance metrics should be meaningful, usable, and relevant to all stakeholders.
- Performance metrics should be both quantitative and qualitative, but the importance of reliable quantifiable metrics that can be applied statewide cannot be understated.
- Performance metrics should be actionable for quality improvement
- Performance metrics should be focused on quality, utilizing national best practice standards for BH crisis services for individuals, families, and communities
- Performance metrics should be able to identify both strengths and accomplishments, as well as gaps in care and community needs for improvement.
- Performance metrics must address experience and outcomes for primary and secondary customers (e.g., families, first responders), as well as efficiency of resource utilization (minimizing use of expensive services that are not well matched for individual needs).
- Performance metric principles must apply to collection and analysis of billing, claims, and revenue data from multiple payers
- Performance metrics should have consistent definitions so that they can be applied consistently statewide. (For example, if reducing ED Boarding is a performance metric, there should be clear definition of the number of hours that is considered boarding.)
- Performance metrics should be designed to recognize that there is variability in resources, population, and culture across Ohio Board regions, so that performance measures and improvement targets may need stratification based on key variables.
- Performance metrics should routinely attend to potential issues of equity and disparity for potentially underserved populations.
- Performance metrics should distinguish experience and outcomes of children, adolescents, adults, and older adults.
- Performance metrics should be continuously evaluated and improved over time, including discarding metrics that are no longer relevant.

Overarching Principles for Data Collection for Performance Measurement

- Data collection should be efficient, and guided by the principle of return on investment: is the relevance and value of the data collected worthy of the effort required to collect it?

- Data collection should not add undue administrative burden, minimize duplication, require minimal extra manual effort, and build as much as possible on existing data collection efforts and systems.
- Data collection should avoid collecting data that is not used: No “black hole” data.
- Data collection should increasingly be designed to be able to include data on diversity, equity, and inclusion for all key metrics for all relevant population variables, such as age, gender identify, payer status, race, language, culture, geography, etc.
- Data collection should be developed based on a comprehensive analysis of existing metrics, outcomes, data sources & databases to integrate, reduce, align, and promote uniformity across all state stakeholders. Create uniform data system with uniform reporting. There should be an effort to identify how multiple data systems can collect and report on common data metrics.
- Data collection principles should apply to billing, claims, revenue data from multiple payers.
- Data collection should identify metrics that are easy to track and quantify, as well as relevant for performance. For example, “avoidable” ED BH visits is hard to quantify, but ED BH visits with no medical diagnosis who came in voluntarily (no EMS, no law enforcement) is more readily quantifiable and already collected.
- Data collection should maximize contribution from existing technologies and Health Information Exchanges but should not create barriers by requiring expensive new technologies or hard-to-implement new data systems.
- Data collection processes and specific indicators should be continuously evaluated and improved over time, including discarding data points that are no longer relevant.
- Data collection efforts should be accompanied by a commitment to continuous training and improvement for both data “collectors” and data analysts to ensure data quality and utility.
- Behavioral health trends identified by the data should be used to swiftly mobilize change in areas where there are increased suicides or crisis responses.

Existing Data Sets Subcommittee

This Subcommittee reviewed existing statewide data sets (**See Appendix A**) and found few data sets that were collected with statewide consistency that could be utilized for crisis system performance measurement. Ones with potential that were identified include ED claims data, other Medicaid/MCO claims data (with recommended modifications below), Board data on call center utilization and disposition (which will be enhanced with 988 implementation), and data relating child protective services involvement to MH and SUD needs.

Recommendations for data collection approaches include:

- Focus on "least burdensome" approach to try to add on to where data is being collected already and adding identified relevant information to these rather than creating new data collection forms, processes, or systems
    - Is there a way for Boards to collaborate with community partners such as Hospital Systems/ EDs and Law Enforcement of all types to "add an additional question" or collect information already being recorded in a consistent way?
- Make the purpose of data collection for improvement of crisis system response for the whole community clear, making the case for the payoff and benefit for community partners such as ED/Law Enforcement to participate in consistent data collection and reporting
- **Consider using the Crisis NOW Calculator as an approximate but easy way of calculating baseline need** based on community demographics (200/month/100,000 population for adults, and 20-30/month for children) and then use ED/Law Enforcement data to look for change or impact post implementation of services in the BH crisis continuum (both for measuring effectiveness and/or identifying areas of higher quality)
- Claims data may be the only/ best set of current data related to ED utilization that is consistently available, whether from EDs or payers. Claims data for non-hospital crisis services is available through Medicaid for SUD withdrawal management.
- **For MH crisis services, other than MRSS, OMHAS and Medicaid need to develop new program categories for certification and billing, and then modify current data platforms to collect utilization and cost information based on those categories.**
- The Committee recommends progress toward an "HIE on Steroids" that connects all the various sets of data. An All-claims payer database (APCD) tied to crisis service categories as well as hospital ED and inpatient BH data would be a possible goal.
- Consider utilization of the "Innovate Ohio" platform to incorporate any sources of relevant BH crisis data such as from ODJFS, Dept of Health, Dept of Education, Dept of Rehab & Corrections, etc.

Recommendations for Performance Metrics

Full Committee Recommendations for Community Crisis System Metrics:

- **The Full Committee recommends adoption of the recommended metrics from the Roadmap of the Ideal Crisis System.**
- **Metrics addressing diversity and equity must be collected – and used for reduction of any identified disparities - whenever state and local crisis system data are being developed and reported.**

- **Crisis program categories matching the recommended proposed Crisis Services Lexicon should be developed by OMHAS and ODM and increasingly utilized for collecting cost and utilization data from all payers.**
- **Prioritized metrics include:**
    - **Increased access to crisis using 988 rather than 911,**
    - **Reduction of unnecessary BH related arrests,**
    - **Reduction of unnecessary BH ED visits,**
    - **Increased connection of children and family to BH crisis and continuing services in lieu of Children's Services or Juvenile Justice involvement, and**
    - **Increased continuity of care, stabilization, and connection to "thrive" services for people experiencing frequent and recurrent crises.**
- **Full list includes:**
    - **Community Awareness:** Percentage of people who are aware of how to get help in a BH crisis through a BH Crisis Call line (e.g., 988).
    - **Access:** Ease and timeliness of access to crisis continuum (non-ER) for:
        - adults
        - children/youth/families
        - providers
        - law enforcement, EMS and other first responders
    - **Call Center Resolution:** Percentage of calls that are resolved in the call center or successfully deployed to non-ER crisis services.
    - **Overall ER Diversion:** Percentage of crisis contacts that are addressed (including medical screening) without utilization of an ER. (Includes reduction of unnecessary ER based medical screening)
    - **Avoidance of Unnecessary Arrests/Bookings:** Number of individuals that were detained for BH reasons because of no effective alternative.
    - **Reduction of ER/Hospital Burden:** Number of individuals with BH conditions who do not need medical intervention; who are boarded or have excessive waits; or who present to medical ERs because of no alternative.
    - **Maximization of Alternative Interventions:** Percentage of deployment of mobile crisis for adults and youth (not to ERs); percentage of utilization of BH urgent care for crisis; percentage of utilization of residential crisis services vs inpatient.
    - **Reduction of Inpatient Refusals:** Number of individuals who are refused or significantly delayed admission when needed for any reason, medical, behavioral, and capacity related
    - **Continuity:** Percentage of individuals who access intensive crisis follow up within 72 hours, and for up to 30, 60, 90 days or more following an initial crisis contact (Includes both special intensive crisis programs as well as frequent outpatient follow up visits)
    - **Engagement of frequent utilizers of crisis services:** Number of individuals who are frequent utilizers of MH and/or SUD crisis services, including ERs; who are engaged in continuing care; and have reduction of utilization with improved outcomes.
    - **Reduction of suicide and violence**: Incidence of suicide or violent behavior due to untreated mental illness (Note: this is understanding that reduction of suicide and violence requires efforts much broader than just crisis response and follow up.)
    - **Overall Customer Satisfaction with BH Crisis System** (Respondents include both primary and secondary customers: people served, families, first responders, etc.)

- **Equity:** For all measures above, determine whether there is equitable access and response for racial, ethnic, and cultural minorities, significant subpopulations (children, I/DD, veterans), and rural vs. urban populations.
- **Financial Performance:** Analysis and monitoring of total resource investment of the crisis system, compared to current performance, with regular review of "value" of the investments that are being made. (This is NOT an assumption that the BH crisis system will "save money" for any specific funder; rather that the system will demonstrate added value for the whole community)

Program Specific Access Metrics Subcommittee Recommendations

Crisis Center with Observation and Access to Mobile Crisis.

Access Metrics for Mobile Crisis Response Measure: adults vs. children Measure: equity across diverse populations and geographies	• Time from call initiation, through triage, to initial dispatch decision • Time from dispatch decision to mobile crisis team departure, and then time to arrival on scene. • Percentage of mobile crisis requests that do not occur and/or are triaged to first responders because of lack of availability to come on scene in a safe and timely manner.
Access Metrics for Crisis Center with Observation Measure: adults vs. children Measure: equity across diverse populations and geographies Some of these metrics can also apply to BH Urgent Care Centers, as well as other crisis services.	• Number/percentage that left without being seen • Warm handoff turnaround time (law enforcement/EMS) (10-15 minutes or less) • Total # Clients admitted to Crisis Center • Percentage of clients referred that were denied or diverted. • Number/percentage of those accepted to crisis center that were diverted from (would otherwise have gone to) hospital emergency departments. Measure EMS referrals, law enforcement referrals, and self/family referrals. • Percentage who received medical triage/screening without going to an emergency department • Percentage admitted through law enforcement that would otherwise have been arrested.
Operational and Intra-operational Performance Metrics for Crisis Center with Observation Measure: adults vs. children Measure: MH vs SUD vs COD presentations Measure: equity across diverse populations and geographies	• Average length of stay at the Crisis Center • Total number served, and average occupancy for observation • Time from entry to seeing a peer, seeing a clinician, seeing a prescriber. • Percentage of involuntary commitment referrals converted to voluntary • Percentage of clients who receive restraint or seclusion interventions. • Percentage of clients whose evaluation includes family/friends and community service providers

	• Client rights (complaints and grievances) • Budget-to-actual service utilization
Outcome Performance Metrics for Crisis Center with Observation Measure: adults vs. children Measure: MH vs SUD vs COD presentations Measure: equity across diverse populations and geographies Note: These outcome metrics can apply as well to mobile crisis and BH urgent care services. Some of these metrics can also apply to residential crisis services.	• Customer satisfaction (person served, family, first responders, community providers) • Discharge dispositions: percentage diverted from hospitalization, percentage referred to residential crisis services, percentage referred to community crisis intervention • Percentage that left AMA • Percentage with inappropriate discharge (e.g., to street) • Percentage of individuals discharged to community reporting improvement in ability to manage future crises • Percentage completing an outpatient follow-up visit within 3, 7, 30 days after discharge to community (HEDIS Measure) • Percentage engaged in continuing services to promote thriving 30, 60, 90 days post discharge to community. • Timeliness of hospital transfer, when needed. Timeliness of transfer to residential crisis services, when needed. • Readmit (to Crisis Center, any crisis service) within 24 hrs.

APPENDIX A: EXAMPLES OF STATEWIDE DATA SETS THAT MAY MEASURE CRISIS SERVICES IMPACT

Criminal Justice/ Police Departments

- Numbers of Response Calls
    - Unknown whether data indicating whether the call was related to mental health or SUD symptoms is recorded in a discrete form
- Numbers of Arrests
    - Unknown whether data indicating whether the arrest was related to or impacted by mental health symptoms or SUD symptoms is recorded in a discrete form
- Number of Incarcerations

Emergency Departments/ Hospitals

- For hospital systems connected to an HIE, ADT (admission, d/c, transfer) data is available
    - Whether the Admission is related to a MH or SUD symptom is not always reliable
    - Not all hospital systems are participating in local HIEs

Medicaid and Managed Care Plans

- Claims data indicates ED visits and hospital admissions
    - This is usually reliable related to a MH or SUD diagnosis being a primary or secondary reason for the visit/ admission, but the data may be lagged by six months.

Schools

- Chronic Absenteeism (2+ days per month)

Children's Services

- Cases for whom the reason for involvement is related to SUD or MH issues

DD Boards

- MUI data related to arrests or unplanned ED visits or hospitalizations for persons involved with the Board of DD
    - Data may be lagged (relies on provider report)

Homeless Shelters

- None identified

National Datasets

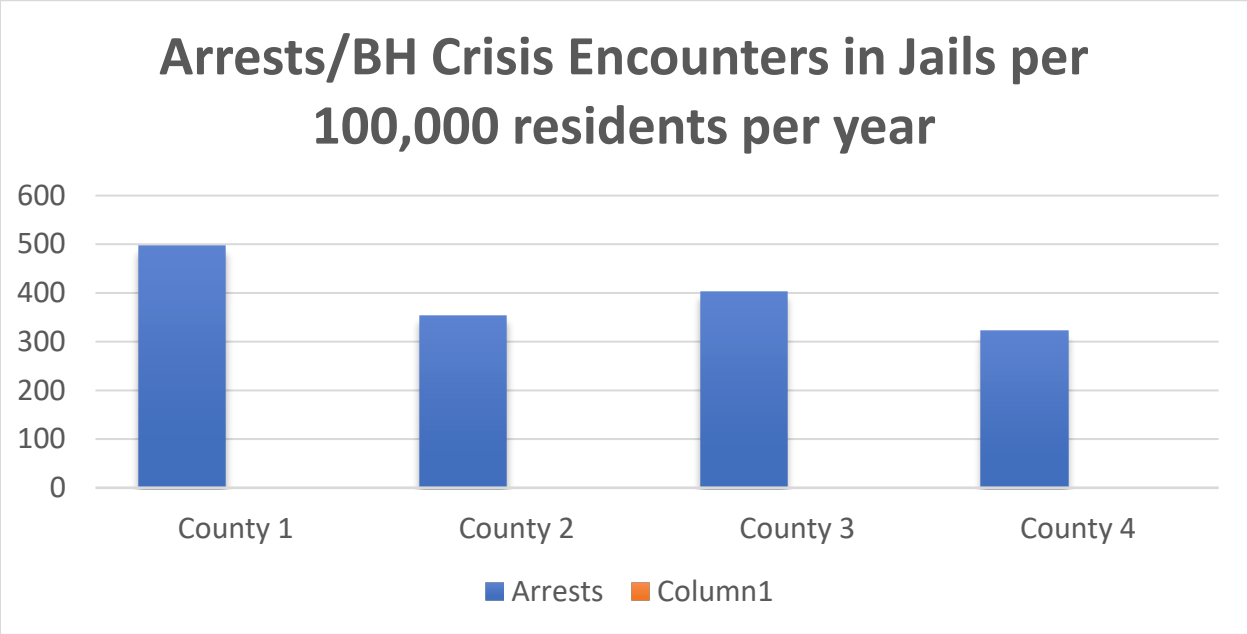
- SAMHSA—annual or semi-annual database updates (data relies on provider report)
    - Patients receiving 24 hour hospital inpatient MH treatment on a "specific date"
    - Patients receiving residential mental health treatment on a "specific date"
    - Patients receiving less than 24 hour mental health treatment during a "specific month"

Crisis Hotlines (ADAMHs Boards Usually Hold Data)

- Number and disposition of calls

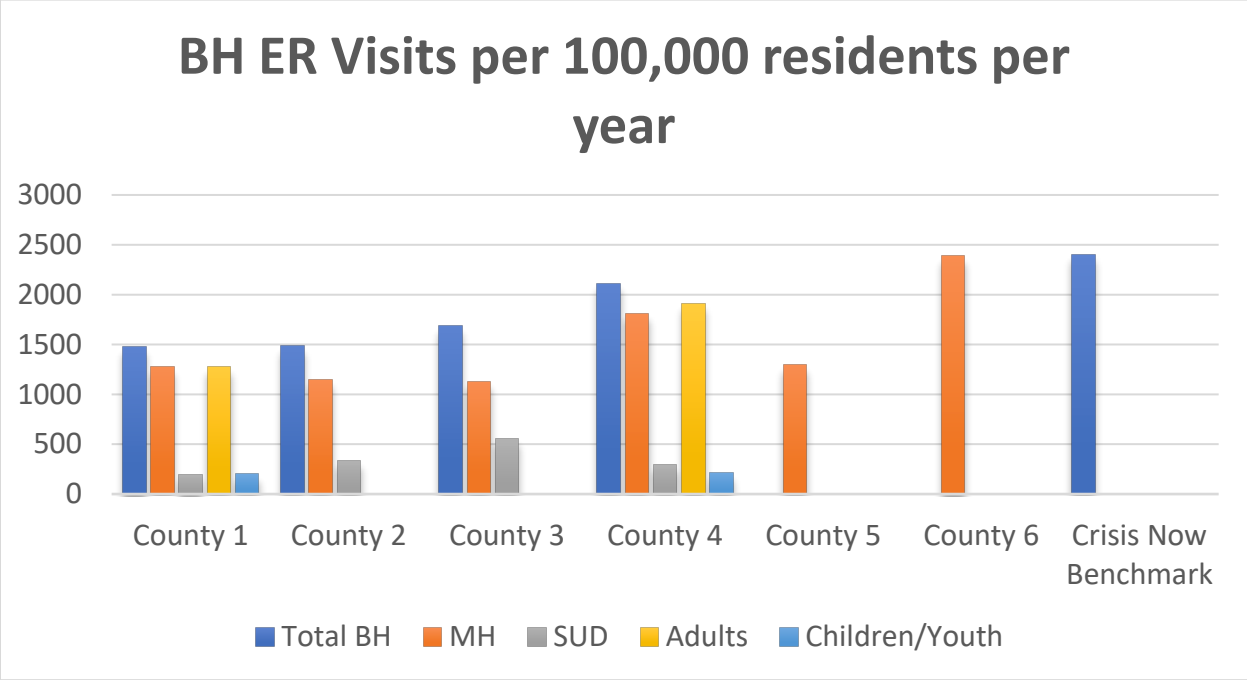
APPENDIX B: MODELING DATA – ARRESTS AND EMERGENCY ROOM

Arrest Data



- **Potential Benchmark: BH arrests pretty consistently in 300-400 per 100K range**
- County of 98K population = County Prosecutor had 486 SUD/OUD arrests (496 per 100K)
- County of 201K population – 399 BH arrests from Sheriff, 306 BH arrests from largest city (353 per 100K)
- County of 76K population – 306 of 1271 jail bookings due to drug-related offenses (403 per 100K)
- County of 372K population – 1198 total BH arrests from 4 city police departments and county sheriff (322 per 100K)
- **County of 380K population – BH Crisis Specialists in County Jail served 8,674 clients (2300 per 100K) – this is more active identification of BH issues and is probably closer to the true number of individuals with BH issues who are arrested**
- **Juvenile Detention Data was less robust – ranged from 23% to 39% of overall arrests being BH and around 80-90% of those referred for assessment having a diagnosis**

Emergency Room Data



- 24 boards were able to report some ER Data
- County of population 178K – Total for all ERs – 2270 visits for MH and 351 for SUD, for Children/Youth – 356 total (14% of total)
- County of Population 230K – 2640 visits for MH and 773 for SUD
- County of Population 75K – 1 ER – 846 visits for MH and 418 for SUD
- County of Population 116K – Total for 2 ERs – 1576 YTD (9 mo) visits for MH and 258 SUD-Overdose, 184 Children and Youth MH
- County of Population 204K – 2640 visits for MH
- County of Population 66K – 1574 visits for MH
- **Vast majority of people in crisis are being seen in ERs**

Typical County in Ohio

Population – 100,000
Crisis Now – 2,400 Crisis Episodes annually
Arrests – 400 BH related annually
ER visits – 1700 BH related – 255 children/youth
Mobile Crisis for adults – 250 responses
Mobile Crisis for youth – 175 responses
Urgent Care – 653 annually

APPENDIX C: Consultant Suggested Performance Measures for a Crisis System

- **Community Awareness:** Percentage of people who are aware of how to get help in a BH crisis through a BH Crisis Call line (e.g., 988).
- **Access:** Ease and timeliness of access to crisis continuum (non-ER) for:
  - adults
  - children/youth/families
  - providers
  - law enforcement, EMS and other first responders
- **Call Center Resolution:** Percentage of calls that are resolved in the call center or successfully deployed to non-ER crisis services.
- **Overall ER Diversion:** Percentage of crisis contacts that are addressed (including medical screening) without utilization of an ER. (Includes reduction of unnecessary ER based medical screening)
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- **Reduction of ER/Hospital Burden:** Number of individuals with BH conditions who do not need medical intervention; who are boarded or have excessive waits; or who present to medical ERs because of no alternative.
- **Maximization of Alternative Interventions:** Percentage of deployment of mobile crisis for adults and youth (not to ERs); percentage of utilization of BH urgent care for crisis; percentage of utilization of residential crisis services vs inpatient.
- **Reduction of Inpatient Refusals:** Number of individuals who are refused admission when needed for any reason, medical, behavioral, and capacity related
- **Continuity:** Percentage of individuals who access intensive crisis follow up within 72 hours, and for up to 30, 60, 90 days or more following an initial crisis contact (Includes both special intensive crisis programs as well as frequent outpatient follow up visits)
- **Engagement of frequent utilizers of crisis services:** Number of individuals who are frequent utilizers of MH and/or SUD crisis services, including ERs; who are engaged in continuing care; and have reduction of utilization with improved outcomes.
- **Reduction of suicide and violence**: Incidence of suicide or violent behavior due to untreated mental illness
- **Overall Customer Satisfaction with BH Crisis System** (Respondents include both primary and secondary customers)
- **Equity:** For all measures above, determine whether there is equitable access and response for racial, ethnic, and cultural minorities, significant subpopulations (children, I/DD, veterans), and rural vs. urban populations.
- **Financial Performance:** Analysis and monitoring of total resource investment of the crisis system, compared to current performance, with regular review of "value" of the investments that are being made. (This is NOT an assumption that the BH crisis system will "save money" for any specific funder; rather that the system will demonstrate added value for the whole community)

APPENDIX D: Suggested Performance Measures for a "Crisis Center"

The first set of measures for the crisis center are derived from the published work of Margaret Balfour, MD. Dr. Balfour recommends that metrics for a crisis center are connected to core values. These are the ones they use:

- Timely
- Safe
- Accessible
- Least Restrictive
- Effective
- Consumer and Family Centered
- Partnership and Collaboration

Examples of Core Measures

- **Patient satisfaction:** This measures the experience of people receiving service and reflects the value of being consumer centered. Family and referent satisfaction can also be measured.
- **Law enforcement drop off time – how soon are they back on the street:** This measures accessibility of the center and the satisfaction of law enforcement as important customers. This measure makes it more likely that law enforcement will use the crisis center rather than bringing the person to jail.
- **Door to Clinical Staff/Doctor/Disposition time:** This measures timeliness and accessibility. Overall performance is better the quicker the person is connected to a welcoming person, an assessment is performed, a decision is made, and a disposition effected.
- **Restraint and seclusion use:** Safety and engagement are connected to a minimal use of restraint, and maximization of engagement with peers in a "no force first" culture.
- **Community disposition rate:** The ability of the program to help people avoid hospitalization is a key measure of effectiveness.
- **Readmissions w/in 72 hours:** This measure of both safety and effectiveness balances against releasing people too quickly or underestimating level of risk and need.

Additional Core Measures for Consideration

These measures relate to other functions of a Crisis System, as well as different elements of the flow pattern:

- **Call center abandon call rate and disposition rate**: This measure looks at the accessibility and effectiveness of the call center function. Are calls answered quickly enough, and how successful is the call center in responding to caller requests so that higher levels of care are not needed?
- **Timeliness of response for Mobile Crisis:** This measures the degree to which mobile crisis workers can be quickly dispatched to the crisis by the crisis center's call center either in person or by telehealth.
- **Mobile Crisis Team disposition rate:** This measures the effectiveness of mobile crisis (as an arm of the crisis center) in preventing unnecessary ER visits or hospitalizations.
- **Emergency Department Wait Times:** This measures timeliness and accessibility of the Crisis system for individuals who initially present at the Emergency Department and need to be referred to the crisis

APPENDIX E: Suggested Performance Measures from Selected ADAMH Boards

Board 1

Hotline/Warmline/I&R	Face to Face	Other
AOD Hotline - # of contacts	AoD Crisis - # of contacts & # of hours	Waiting List - Average Waiting Length
MH Hotline - # of contacts	MH Crisis Walk-In - # of Contacts & # of hours	Reportable Incidents - # of Major Unusual Incidents
Suicidal - # of contacts	MH Mobile Crisis - # of Contacts & # of hours	# of Consumer and Family Grievances
MH I&R - # of contacts	Prescreen - # of Contacts & # of hours	
AoD I&R - # of contacts	Jail Diagnostic Assessments - # of Contacts & # of hours	
MH Warmline - # of contacts	IPE/Pharm Mgmt - # of Contacts & # of hours	
AoD Warmline - # of contacts	CPST-Medical - # of contacts & # of hours	
	Opioid Intervention - # of Contacts & # of hours	
	Crisis Debriefing - # of Contacts & # of hours	

Board 2

Emergency Services Outcomes	Crisis Stabilization Unit Outcomes	Hotline Outcomes	Mobile Crisis Outcomes
# of Clients evaluated; # evaluated because of an application for Emergency Admission	# of clients admitted; average length of stay	# of calls	Mobile crisis interactions
# of Referrals made for follow-up care; # of clients referred to private psychiatric units	Primary diagnosis of clients admittes	Count of referrals made to MH services	CIT interfaces
# referred to state hospital	# of clients who ISP is formulated within 48 hours	Count of calls that require significant emergency intervention	Referrals
	# of clients transferred to an increased level of care	Number of volunteers trained	Other Engagement
	Referrals at discharge	Number of hours of volunteer service	Decrease in repeat visits to ED and CSU
	# of clients referred from an increased level of care		Increase engagement in follow up care

Board 3

Admission diversion from hospital ED	% of individuals reporting improvement in ability to manage future crises	Accidental overdose deaths
Average length of stay	% of involuntary commitment referrals converted to voluntary	Crisis calls and dispatches related to MH and SUD
Budget-to-actual service utilization	% not referred to ED for medical care	Provider financial health
Client rights (complaints and grievances)	% of referrals accepted	Provider service claims (billing) - claims denials
Client Satisfaction	% of referrals from EMS/law enforcement (hospital and jail diversion	Provider staff vacancy rates
Cost	Population-level indicators of community health and well-being	Readmission rates
Discharge Dispositions	Prevalence of MH and SUD	Response times
First Responder Drop-Off Time	Unmet need for services	Service volumes
% completing an outpatient follow-up visit after discharge	Suicides	**Apply Equity Lend to all metrics**

COMMUNITY CRISIS COORDINATION COMMITTEE

COMMUNITY CRISIS COORDINATION COMMITTEE
BOARD RESPONSIBILITIES SUBCOMMITTEE
Recommendations – Final Draft
March 2022

Chair: John Aller, Stark County ADAMH Board
Erika Clark-Jones, Franklin County ADAMH Board

Members: mcpike@clevelandohio.gov, cwalter@oacbha.org, cdiaz@oacbha.org, moneill@oca-ohio.org, mkrause@ohio-pro.com, mmatoney@crossroads-lake.org, lauren.decamp@medicaid.ohio.gov, ptitterington@adamhmedina.org, eclarkjones@adamhfranklin.org, collver@theohiocouncil.org, kminkov@aol.com, robin_harris@gjmboard.org

Consultant Support: Ken Minkoff, Steven Hedgepeth

The subcommittee has had two meetings, February and March

Committee Objectives and Questions:

The Board Responsibilities Subcommittee was assigned the responsibility of delineating 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 (not just Board-funded clients).

Questions to be answered by this Subcommittee include:

1. **What SHOULD the role of the Board be to engage all relevant partners in community wide MH and AOD crisis planning for the Board region?**
2. **What SHOULD be the responsibility of other partners (hospitals, MCOs, etc.) to participate in the Board's convening?**
3. **Does the current or regulatory language describing the Board's responsibilities clearly enough support the expected roles of the Board and its partners in the recommended planning process?**
4. **If not, what would be the recommendation for changing the language to be more supportive of the recommended planning process?**

Background data from Board Survey and other informants (including the Subcommittee members):

Ohio's vision for its BH crisis system, as articulated in the OMHAS Crisis White Paper, clearly indicates that the system should address the needs of "all Ohioans." Further, OMHAS clearly intends that the ADAMHS Boards 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 non-identified 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.
The following recommendations are based on consensus discussion in response to the questions above, synthesized into a set of actionable steps.

Board Responsibility (for Community Crisis Planning) Subcommittee Recommendations:

Role of the Board: ***There is a necessary role for ADAMHS Boards to 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 Board regions.***

- This role should not be restricted only to Board funded services or Board contracted providers; it is about everyone.
- The Boards role should be to convene multiple partners and to facilitate collective and collaborative planning. The Subcommittee had extensive discussion about the need for the Board to have recognized authority to be the convener, but for the process itself to be collaborative in nature rather than something that is experienced by the participants as merely a mandate. Crisis planning should be a "living and breathing" process, not simply a compliance function.
- The Subcommittee indicated that leadership and direction from the state is needed to describe both the role of the Boards in this process, as well as the expected participation of key stakeholders.
- The Subcommittee recommends as well that the Board's role in community crisis planning and coordination with its stakeholder partners should include an expectation of specific deliverables that are developed collectively. Potential deliverables on an annual basis may include providing a publicly available report including:
  - Baseline analysis of needs and capacities for the whole community
  - Gathering information and data about current services
  - Delineating the intersections between Board funded services and other services in the community
  - Resolutions to identified problems
  - Developing a plan for implementing a proposed crisis continuum for the Board region
  - Developing a resource plan for how Board resources, other local resources, OMHAS funds, Medicaid and other insurers, and other funding sources will be used to implement the plan.

Role of Board Partners: ***The Subcommittee recommends a wide range of partners be considered for invitation and participation in the Board's crisis planning process or processes. Based on Board discretion, within the larger crisis planning process there may be different subgroups focusing on crisis response for adults or for children/families, and there may be partners that are more appropriate or interested in one or the other subgroup. The Subcommittee identified a list of recommended partners and stakeholders. Within that list, there was reasonable consensus on which categories of representation were essential or required, compared to which were discretionary based on the priorities and preferences of that community.***

- Stakeholders that have a necessary relationship with the crisis care continuum in each Board region should be required to participate in local crisis planning meetings.
- The expectation is that partners share de-identified data for the purposes of community planning
- **Required** stakeholders should include, at a minimum, designated representatives of each of the following constituencies:
    - For all populations:
        - People with Lived Experience, peers representing the Recovery Community
        - NAMI or other representation of families with lived experience
        - Hospital systems serving the community (emergency departments and/or inpatient units.)
        - Law Enforcement
        - EMS
        - 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

- **Optional** Stakeholders and partners that might also be considered for inclusion are
        - County/City Government (Commissioners, County Executive, Public Health Department, etc.)
        - Philanthropic Community
        - Criminal Justice System (Jail, Judges, Probation)
        - Universities and colleges
        - Primary Health representatives, such as an FQHC
        - Faith Community
        - Business community members
        - Others determined to be necessary by the Committee.
- At minimum, required partner constituencies must be informed by state level communication that their participation in effective and meaningful collaboration for crisis system planning in their local communities is an expectation, in order that all Ohioans can receive the seamless continuum of BH crisis responses that they need and deserve

Necessary Communication and Direction: There needs to be clear formal instruction and direction from state leadership about the importance of community crisis planning in each Board region, the role of the Boards and other partners, and the expected results.

- The Subcommittee's consensus was that while the current language in Chapter 340 (ADAMHS Board enabling legislation) does indicate that the Boards have a role in "planning", it does not adequately specify in detail the role of ADAMH Boards, the responsibility of stakeholder partners, and the expected deliverables in the necessary crisis planning process.
- Many members of the Subcommittee suggested the recommendation to define in statute the Board's role, as well as the roles and responsibilities of required participating constituencies, in ongoing community crisis planning and implementation.
- These Subcommittee members compared this approach to the value of having other statutorily mandated community planning committees, of which there are several examples. A statutorily designated local crisis planning committee could provide clear direction as to the responsibility of Boards, community stakeholders that must be at the table, and intended outcomes.
- Other Subcommittee members expressed concern about the possible deleterious effects of creating another statutory mandate and suggested instead that a similar result might be achieved by consistent and clear messaging from state leadership in multiple departments (OMHAS, ODM, OPS, ODI, JFS, etc.) to define more clearly the expectation of community crisis planning under current statutory authority (as an interpretive guideline, for example) and to direct representative constituencies at the local level to participate.
- The Subcommittee did not fully resolve which would be the better approach, but the Subcommittee did have consensus that more clear state level direction is needed.

Community Crisis Coordination Committee
CARE COORDINATION SUBCOMMITTEE
Recommendations – Final Draft
April 2022

Chairs: Tia Marcel-Moretti, CareSource
Tamera Hunter

Members: Lorri Charnas, Elijah Jones, Kimberly Farrier, Cresta Rodesky, Deanna Brant, Joan Englund, Marjorie Kukor, Timia DelPrete-Brown, Jennifer Cagiano, Vince Brancaccio, Dawn Carter, Julie Wilcox

Consultant Support: Ken Minkoff, Steven Hedgepeth

The subcommittee has had three meetings, February 15, March 15, and April 19

Committee Objectives and Questions:

The Care Coordination Subcommittee was assigned the responsibility of delineating a basic framework by which ADAMHS Boards, payers, providers, and other partners can routinely provide care coordination for individuals and families experiencing a MH and/or SUD 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.

Questions to be answered by this Subcommittee include:

1. **Should client specific care coordination for people in crisis be a routine component of a community crisis system?**
2. **What is (and should be) Board responsibility to work with other partners to provide crisis care coordination in a Board region?**
3. **And what is the responsibility of other partners to provide care coordination, and what is the role of those partners in relationship to the Board?**

Background data from Board Survey and other informants (including the Subcommittee members):

In the Board survey responses, **ADAMHS Boards** consistently described mechanisms by which they work with their 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 small number of 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.

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 providers and by MCOs.

Provider organizations that offer crisis services in their Board regions will routinely attempt to provide care coordination services to clients of their services. This may frequently involve outreach efforts that are not reimbursed or funded. **MRSS** services, for those relatively small number of clients and families that receive them, have care coordination capability by the providers built in and funded.

Individuals/families receiving **ACT** or **IHBT** receive care coordination from their service teams. **OhioRISE,** coordinated through **Aetna,** is now launching a comprehensive care coordination system for high need Medicaid children/families through funding **Care Management Entities (CMEs)** statewide. These CMEs provide both acute and ongoing care coordination at various levels of intensity (based on CANS) for families enrolled in OhioRISE. CMEs are neither crisis providers nor ongoing service providers, but instead coordinate across all services. The Subcommittee indicated that this model might be a useful guide for developing care coordination services for other populations.

CareSource described to the Subcommittee that as an MCO they have two levels of care coordination, with multiple entry points, and level of need determined by Health Risk Assessment. The higher level (weekly contact) is triggered by individuals displaying high levels of need, that represent approximately 2% of their total BH service population. These individuals receive an assigned care coordinator that will help to convene involved providers and work collaboratively to develop individualized service plans. Several provider members of the Subcommittee reported positive experiences with this type of care coordination, but only on rare occasions. The second level of care coordination (more episodic) can be triggered for individuals who may have recurrent crises or hospitalizations through what CareSource terms "Transitions of Care" (TOC). **Other MCOs** each have their own unique, but analogous, approaches to care management.

Accountable Care Organizations in some communities (e.g. Franklin County, Summit County) have care coordination systems that they directly operate or fund through contract (Akron Children's Care Managers).

Collaborative systems may have their own care coordination mechanisms that need to be aligned with BH crisis response and associated care coordination. As an example, MRSS and OhioRISE are aligned with child protection and juvenile justice. Other examples that should be recognized include: **Aging Services (**Area Agencies on Aging, I-Teams), **I/DD Services (**DD Boards and DD care coordination)**, Criminal Justice Services (**probation, parole, specialty courts), **Homeless Services** (homeless outreach and supported housing).

Subcommittee members representing **hospital providers** indicated that they have incentives to try to coordinate care to prevent readmissions, but that it is often difficult to identify who is responsible for care coordination for any individual admission, particularly with rapid turnover and difficulties holding consistent information from shift to shift.

Conversely, Boards, providers, and MCOs all reported significant challenges engaging hospitals as consistent partners in providing care coordination to effectively connect people to continuing services and supports following admission. Many individuals are discharged without any care coordination and consequently fall through the cracks. **Advocacy organizations** for people with lived experience and their families, such as NAMI, are often involved in trying to piece together care coordination responsibility after the fact. This is a significant issue across the state.

The following recommendations are based on input from the Subcommittee members and consensus discussion in response to the questions above, synthesized into a set of actionable steps.

The target population of these recommendations are persons who are experiencing an acute BH crisis episode, such as BH hospitalization, crisis center with observation, mobile crisis, or residential crisis services. Care coordination activities that are the focus of these recommendations are specifically focused on the crisis episode, and the transition to ongoing stabilization and continuing supports. *Some individuals and families in BH crisis will need connection to or transition to ongoing care coordination at various levels of intensity. Specific sub-populations (e.g.; Aging, OhioRISE, etc) may receive extended care management services to coordinate across different systems. These ongoing and extended care coordination services are referenced in these recommendations, but are not the specific focus.*

Care Coordination Subcommittee Recommendations:

1. **Client specific care coordination for people in Behavioral Health crisis should be a routine component of the community crisis system in every Board region.** The Subcommittee noted that the system has a "moral responsibility" to help individuals and families in crisis to navigate the service continuum successfully in order to get the help they need to stabilize and thrive. The Subcommittee also noted that at present administrative, fiscal, and clinical responsibility for care coordination is fragmented (as described above) 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.
2. **The Subcommittee recommends that 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.** The current Medicaid-funded model embedded in OhioRISE can be a template for developing similar models for adults and (non OhioRISE) children experiencing BH crises as well as similar multi-payer models. The overall vision is that each funder is responsible for providing funding to the care coordination system to serve its own funded clients, but that it will be more effective and efficient to develop one coordinated system with shared funding rather than each partner developing and funding a separate and disconnected system for a specific subset of people served.
3. **Characteristics of such a care coordination system should include the following:**
    - **The locus of accountability and the partnerships/relationships involved should be established for adults and children (including specialized populations such as the Aging, I/DD, etc) as a baseline structure and process in each community.** Trying to develop a system for care coordination once the crisis has occurred is difficult because no one knows who to talk to and information easily gets lost. Having established mechanisms in place ahead of time is particularly important for hospitals because of the fast pace and 24-hour staffing. Having a clear mechanism for care coordination in the hospital or crisis center (e.g., a care coordination team that becomes familiar with the care coordination system that is in place in each of the Board regions it commonly serves) will make the process functional on an ongoing basis because the procedures and relationships are already in place at the time each person is admitted.

- **For each Board region, the locus of accountability should involve an organized partnership between Boards, MCOs/insurers, community crisis providers, and hospitals. The more funders that are involved, the more people will be "covered" by the care management system.** Along the lines of the CME model, the care coordination function can be delegated, and may cover more than one Board region, but it needs to be systematic and predictable**.**
- **Care coordination systems for people in crisis should transcend – but include – individual providers (hospital or community) and function like an Incident Command System (ICS) in disaster planning.** In an ICS there is an established entity that pulls everyone together and everyone knows their expected roles.
- **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.** Ohio has begun to develop some examples of this kind of technology (such as Open Beds) and information sharing protocols (such as in the Central Ohio Hospital Association and OhioRISE), but it is much more developed in other states, such as Arizona, Georgia, and Michigan.
- **Care coordination should be trauma-informed and culturally appropriate, and balance proactive and assertive outreach with client rights for self-determination.** Individuals in BH crisis may need to have caring outreach by care navigators (often ideally by peer supporters) to engage successfully, but it is important that they also have the ability (if competent) to choose whether to participate. Further, care coordination should be designed to reflect both individual/family culture and language as well as community cultural preferences.
- **Care coordination should be designed to facilitate multisystem involvement in services, based on individual and family needs.** Many individuals in BH crisis will need services funded by their insurer AND services funded by the Board. In addition, many individuals and families will have overlapping needs in other systems and may require services funded by other entities. Examples include children's services (schools, family services), medical supports (e.g., home nursing), older adult services, I/DD services, housing supports, criminal justice services (probation, etc.), and veteran's services.
- **Care coordination for people in BH crisis is often time limited.** While some individuals need ongoing case management and care coordination, **many individuals in BH crisis require care coordination only during the crisis episode, for a period of 30-90 days and no longer**. The system should be designed with that in mind.
- **Care coordination for people in crisis should focus on post crisis follow up and continuing engagement with the wraparound support team identified by the client as most appropriate.** This will include a balance of professional clinical services and natural, peer, and family supports.
- **Care coordination is facilitated by having both an oversight entity (CME, ICS) that organizes coordination among providers and funders, as well as capacity for direct client facing care navigation that helps the individual or family across multiple**

care transitions. The oversight entity may directly fund care navigators or coordinate with care navigation services provided through other means.

- **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, OMHAS, Boards, and MCOs/hospitals/providers as appropriate.** That is, ODM should support MCOs and hospital/community providers to participate in the BH crisis care coordination system, as should OMHAS correspondingly support Boards and hospital/community providers as well.
- **Care coordination systems should be designed with the expectation of continuous quality improvement, with the goal that no one "falls through the cracks."** Each incidence of an individual or family in BH crisis getting "lost" to the care coordination system is an opportunity not only to attempt to re-connect with that individual or family, but to treat that event as an opportunity for improvement of the care coordination processes overall. Care coordination entities need to work with ADAMHS Boards to ensure that such QI processes are developed in collaboration with each Board region.

SEE DRAFT PROPOSAL FOR CONSIDERATION ON NEXT PAGE

PROPOSED APPROACH FOR DEVELOPING A CRISIS CARE COORDINATION SYSTEM IN OHIO

This proposal has been developed by the consultants, based on the above recommendations, for consideration by the Subcommittee.

This approach might be an achievable first step to pilot and evaluate as a potential model.

OMHAS, ODM, OACBHA, OAHP, OHA, and Ohio Council can convene to design a regional care coordination pilot that would be jointly funded by the state, Boards, and MCOs. Others may choose to contribute as well. The proposed pilot would be designed with input from people with lived experience and associated advocacy organizations, as well as other partners (first responders, Aging Services, Job and Family Services, etc.) The "regional pilot" can apply to a single large county, or to a geographically connected set of counties that are served by a cohort of general hospital psychiatric units and freestanding private psychiatric hospitals in that region. (For example, Franklin County has several psychiatric inpatient units and facilities that serve both Franklin County and surrounding smaller counties.) This approach is based on the recognition that over 50% of people hospitalized in community psychiatric units come from the county in which the unit is located or immediately adjacent counties, so the focus of this pilot will be on those individuals coming from the designated region. (Note however that nothing in this design is intended to restrict access to hospitalization based on payer or geography, any more than currently exists.) The state hospital serving that pilot region ("Region" as used here is different from the current state hospital region) can choose to participate or maintain within its Board region its current separate care coordination system, at its own discretion. The regional pilot would pool resources to create a jointly funded **Acute Care Management Entity (ACME),** that would be the highest point (pun intended) of organizing care coordination for people in that region in need of psychiatric inpatient services (initially) and other BH crisis services (over time). The ACME would work with all Boards, crisis providers, and hospitals serving that region to design a mechanism by which individuals needing hospitalization would be identified and tracked, and then would immediately coordinate connectivity to care coordination (including care navigation and peer support when indicated) to negotiate and facilitate continuity of care transitions through the continuum for 30-90 days. The pilot could focus at first on adults only or include all ages. ACME would link with OhioRISE, MRSS, ACOs, or other existing care management functions (e.g., older adult services, I/DD services) when those are in place but would otherwise assume direct responsibility for all clients in the region. Existing technology and protocols for information sharing would be utilized when available. In addition, each funder would work with its providers to develop templates for proactively sharing information through Business Associate Agreements or shared releases of information (for example) for the purpose of the ACME Pilot. Newly promulgated HIPAA rules (April 2022) facilitate proactive information sharing for these purposes without requiring consent. Protocols would be developed with each Board in the region so that individuals from that Board region would have automatic connection to the Board's service network. Similarly, protocols would be developed with each MCO so that the identified MCO lead would be automatically engaged with ACME and the relevant Board for all clients in crisis funded by that MCO. Over time, other insurers (including commercial payers) and funders (such as the VA) could opt to buy in to the system for their "covered lives." Once launched the pilot could be reviewed and evaluated after 12 months and modified accordingly. After two years, if successful, ACME models could gradually be implemented statewide.

COMMUNITY CRISIS COORDINATION COMMITTEE
SYSTEM SERVICE ARRAY SUBCOMMITTEE
Recommendations – Draft
April 2022

Co-Chairs: Dr. Valerie Alloy, OMHAS
Molly O'Neill, OCAAR

Members: Ericka Bruns, Alicia Bruce, Liz Henrich, Emily Clegg, Tammie Colon, Robert Hatcher, Megan Burke, Margaret Osborn, Michelle Vander Stouw, Ruth Simera, Michael Krause, Cheri Walter, Melissa Knopp

Consultant Support: Ken Minkoff, Steven Hedgepeth

The subcommittee has had four meetings, February 8th, February 22nd, March 8th, and March 29th

Committee Objectives and Questions:

The Service Array Subcommittee was assigned the responsibility of making the following recommendations:

- What should be included in the continuum of crisis services to all Ohioans?
- Identify which essential elements of the crisis continuum should be accessible to clients in any location, community, or region of the state.
- Suggest a service model(s) addressing which crisis services could be accessible regionally vs. locally or shared.
- Specifically address the crisis service supports needed by under-resourced communities or Board areas.

Sub-Committee Guiding Questions:

1) **Given the variability and resource capacity in counties, is there a minimum array of primary BH crisis services that should ideally be present in each county? (If so, what should that include?)**
2) **Are there secondary or tertiary services (in addition to the state Hospital) that should be available at the regional or subregional level, with distribution based on population and/or geography?**
3) **What might assist Boards with less access to resources to be able to develop that minimum array?**

System Service Array Subcommittee Recommendations:

Recommendations
There should be standards for a BH crisis system service array that is available to all Ohioans in all communities.
Standards for the system service array for Ohio should be based on developing a local continuum of crisis services to the greatest possible extent.
Standards should be developed with principles that are both aspirational and realistic

A minimum service array should be available to every Ohioan
Each Board region should have basic capacity to collect performance data on its crisis continuum that is aligned with the statewide recommendations for minimal metrics
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.

Process: To guide its work, the Subcommittee reviewed background data from the OhioMHAS White Paper, 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 behavioral health emergency services. Additional details from the background data can be found in Appendix A. The Committee also developed a set of guiding principles and tenants to align members expectations to ground its work.

Crisis System Elements listed in the White Paper:

- A centralized behavioral health call center.
- Statewide mobile crisis response services.
- Expanded mobile response and stabilization services for children.
- Increased capacity and access to intensive evaluation and observational care.
- A more extensive network of crisis stabilization services throughout the state.
- Increased use of peer supporters across the crisis continuum.
- Activated and engaged partners in local health care delivery systems.
- An improved systems approach to identify open inpatient beds.
- An increase in community services and pathways to treatment.
- A continuation of support through investments.
- An improved diversity and sustainability of fund providers.

The Subcommittee noted that these provide guidance for the discussion, but do not fully answer the questions posed. By gathering input from the Subcommittee members, the Subcommittee was able to develop more specific recommendations.

Recommendation: There definitely should be standards for a BH crisis system service array that is available to all Ohioans in all communities.

Recommendation: These standards should be developed with the following principles and tenets:

- **The standards should be 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.
- **Aspirational system design is based on: Right Person, Right Place, Right Intensity, Right Time**. That is, every person in every community gets the right response in the right place with the right intensity in the right timeframe.

- **Standards for the system service array are founded in values that reflect the experience of people in crisis and their families.** Everyone knows where to call and can count on timely response to the call and respectful, caring interventions from well-trained responders, whoever they may be (including law enforcement), whatever the situation, and wherever the response may take place.
- **Standards for the system service array are inclusive of people of all ages (children, youth, adults, older adults) and people with MH and/or SUD crises, as well as other complex human service challenges.** Local community services must be designed with the expectation that individuals in crisis may need connection to transportation, housing supports, protective services, criminal justice diversion opportunities, and other human services.
- **Access to services in every community can be enhanced through using telehealth for certain services, and should include attention to timeliness of access, distance of access, 24-hour availability, and adequate capacity to meet the volume of need in the community.** The Subcommittee suggested that **all Ohioans should have access to an immediate response within 15 minutes and a face-to-face intervention (which can occur through telehealth when appropriate) within one hour.** Immediate response includes access to a helpful call/chat/text response, but also includes access to immediate emergency intervention when there is immediate medical risk (e.g., overdose), or immediate risk of physical harm to self or others. There is a strong preference for having BH Crisis Services close to home.
- **Quality standards for the system service array should be applied consistently statewide, but with realistic timeframes for achievement (e.g., five years).** Quality standards for each community should address access to crisis services, the quality and comprehensiveness of the BH crisis services available locally and regionally, and the availability of organized mechanisms to ensure care coordination and communication across boundaries during the crisis, as well as linkage to continuing care to promote the ability to thrive once the crisis has stabilized. *(Note: the content of these standards is being addressed in other subcommittees and committees.)*
- **Realistic system service array standards must be based on person-centered values and aspirational goals, but also permit flexibility of implementation that allows for creative local solutions.** This is particularly true for Boards with no levies or in areas with limited resources.
- **Including peer support to the greatest extent in all types of BH Crisis Services in every community should be implemented over time.**

Recommendation: The Subcommittee recommends that standards for the system service array for Ohio should be based on developing a local continuum of crisis services to the greatest possible extent. The Subcommittee acknowledged that not every type of service can be available in every county and acknowledged as well the importance of specialized or tertiary services that might be developed in an urban hub to serve a wider region. However, input from people with lived experience and from first responders emphasized that people in crisis need the maximum possible access to services that are close to home, literally and figuratively (virtually). Even multi-county Board regions should be trying to develop a continuum that is accessible within EACH county in the region

Recommendation: The Subcommittee identified the following as a minimum array of crisis services.

- **The first part of this list identifies both aspirational and realistic capacities that can be developed in EACH county.**
- **The second part identifies services that can be developed in one hub county to serve a multi-county region.**
- **NOTE: Region here is not defined as "state hospital region".** State hospital regions serve an important function. However, functional BH crisis services can serve multi-county regions that are defined by geographic convenience to a population center hub, not by historical connection to a state hospital region.

Recommended minimal BH crisis system service array for each county:
Connect:

1. Connecting Options
    a. 988 access and marketing, with handoff to a local crisis call center that can dispatch or link to appropriate services.
    b. 911 – with properly trained first responders, such as BH crisis trained EMTs and CIT trained law enforcement
2. Availability of multi-disciplinary teamwork and virtual support for first responders in the field
    a. BH clinical support for EMS and law enforcement

Respond:

3. Mobile Crisis Team/Rapid engagement specialists
    a. Clinical resource that can respond face-to-face to a crisis for adults or children
    b. Should meet minimal mobile crisis standards as defined in the mobile crisis subcommittee
    c. MRSS recommended but other mobile crisis response for children is acceptable.
    d. Provides a bridge and warm handoff to community providers
    e. Telehealth support by staff with higher levels of licensure facilitates implementation
    f. Aspirational goal of 24/7 mobile response in each community, but this will need to be developed over 5 years or more.
    g. Mobile crisis capacity building can be enhanced by building on existing mobile medical capacities, such as by training EMTs to be BH mobile crisis responders with licensed clinician support.
4. Co-responders deployed via mobile crisis as needed to support first responders and vice versa
    a. Not riding with officer – Protocols for clinician support for calls once LE is engaged
    b. Protocols for first responder support (EMS, LE) for mobile crisis calls when needed
5. Behavioral Health Urgent Care
    a. Each community should have provision for after hours BH walk in services not in an ER.
    b. Meet minimal standards defined by BH UC Subcommittee.
    c. Suggest minimum of 12 hours/day availability.
    d. Medication access for bridge prescriptions on site or in a nearby medical facility
    e. BH Urgent Care capacity building can be enhanced by building BH capability into or next to existing non-ER medical settings, such as medical urgent care or FQHCs, as well as by co-locating in existing support settings like schools or school health clinics.
6. Goal is a one-hour response time: services go to the person, or the person can get to the service.

Stabilize:

7. Crisis Center with Observation

a. Any Alternative to hospital ED for individuals who are brought by law enforcement or who may need observation is preferable, but may not be available in each community, (See below for discussion of regional access to these services)
b. Rural crisis drop in centers are being piloted in Virginia, and provide an example of a service that expands on BH Urgent Care with opportunity for a period of stabilization.
c. Since every county (with few exceptions) has an ED, then there should be a combination of specialized psych ED services, supported by telehealth, with provision for observation, combined with access to mobile crisis and urgent care to minimize use of the ED. Specialized psych ED services can be a designated space and on site supports that are welcoming, trauma informed, and competent in providing initial intervention, with telehealth support.
d. Telehealth expertise can be provided by BH crisis experts who may be in a 24/7 crisis center in another county in the region. Consultation can be projected from a larger hub to support capacity building in smaller community hospitals.

8. Residential Crisis Services
    a. Residential crisis services for adults and children, for MH and SUD, are important elements of the continuum, but smaller communities may not have the capacity to support the level of need for such a program.
    b. Each smaller community should at least have provision for "as needed" residential crisis services by having access to a crisis apartment or equivalent, and provision for staff support and telehealth access to licensed professionals, so that individuals who need 24-72 hour crisis respite can do so without leaving the county.
9. Intensive Community Crisis Intervention:
    a. Continuing follow up for adults and children after the initial crisis contact for 30-90 days to ensure connection to appropriate resources to continue to stabilize and thrive.
    b. In larger communities, this may be a defined program, and in smaller communities it may be a capacity that is leveraged as needed.
    c. Includes continuing tracking, system connection, and care coordination to ensure eventual linkage to the right services: BH services, health services, human services, and peer/natural supports.
    d. Includes access to medication adjustments as needed
    e. Intensive community crisis intervention capacity can be enhanced by building on existing medical intervention services like Home Nursing Agencies.

Care Coordination:

10. Systemwide collaboration between Boards, payers, and providers to ensure a care coordination system for adults and children in BH crisis.
    a. Builds on existing strengths, such as OhioRISE and existing Board and MCO care coordination efforts
    b. Ensures that everyone in crisis has a care coordination plan in place before the crisis occurs, and that all crisis providers and payers are participating statewide.
    c. Utilizes the recommendations from the Care Coordination Subcommittee
11. Case Management/Peer navigators:
    a. Provision for assigned case management/peer navigators for individuals in crisis who cannot negotiate the transitions for themselves, particularly those with recurrent crises.
    b. These should be part of the care coordination system, as recommended above, and jointly funded by Boards and other payers.

12. Resource Manual for every community that is thorough, robust, regularly updated, and easily accessible for all crisis providers. –
    a. Includes information about providers, peers, hospital supports, other community supports and human services.
    b. Already in development in Ohio through the 988 implementation process.

Peer Support:

13. Access to Peer Support:
    a. Each community should work over time to maximize the availability of trained peer supporters and appropriate paid employment opportunities in BH crisis services.
    b. In the short run, each Board should coordinate and ensure availability to all people who may need peer linkage for people in crisis who need it, access to community recovery supports (e.g.; RCO, PROs), and linkage to statewide peer support organizations like OCAAR and OhioPRO.
    c. Address peer certification process for mental health certification and payment methods
    d. Increase the availability of peers in responding to crisis and throughout the broader service continuum
    e. Address the Medicaid reimbursement rates paid for services provided by peers

Transportation:

14. **Access to Transportation**
    a. "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 medical crises.
    b. Acknowledge the role of Public Safety partners as reliable first responders
        - Ensure responders have training in Behavioral Health crisis response (e.g.; CIT, EMS-BH)
    c. Any transportation options should take into account HIPPA privacy requirements and best practice data sharing practices.
    d. The culture shift toward an integrated model of emergency response acknowledging the role of law enforcement, transportation, payment for services peer or others

Other Needs:

15. Prescription Assistance: Local communities should obtain access to 340-B funds and other prescription discount programs to facilitate access to medications for individuals in crisis who cannot afford their prescriptions.
16. Family supports: Each Board should have provision for connecting families with loved ones in crisis to available family support programs, whether offered locally or through statewide virtual connection with NAMI.
17. Supports for Persons Recently Released from prison with BH Needs: Each community should work with local/regional jails to support transition to identified BH services at release.
18. Local crisis workforce development: Each community should initiate a program with at least one local educational institution (high school, community college, etc.) to provide pathways to jobs with training and internships. Local support and training for BH crisis workers should be provided as well. This is described in the Workforce Subcommittee recommendations.

Recommend BH crisis system service array that may be available in large counties and serve smaller neighboring counties "regionally".

1. **Crisis Centers with Observation:** Crisis Centers with Observation that meet the standards described in the Crisis Center Subcommittee recommendations should be available within one hour drive time from population centers in each county. These services should also serve as 24/7 high level BH crisis consultation tertiary centers (like Level 1 Trauma Centers) to support local crisis continua in smaller counties or in other less resourced settings.
2. **Specialized BH Crisis Services**: Specialized BH Urgent Care Services and Community Crisis intervention services for specific populations such as children and youth with complex needs (e.g., Nationwide Children's) and individuals with co-occurring I/DD and BH needs (e.g., I Am Boundless) should be developed statewide. These services are ideally located within a one-hour drive time of population centers in each county. More importantly, they can serve as centers of excellence to provide virtual teleconsultation support to local community crisis services that have less expertise or experience with those populations.
3. **Residential Crisis Services for MH and SUD:** Residential Crisis Centers for adult MH, youth MH, and SUD (withdrawal management) that meet the standards described in the Crisis Center Subcommittee recommendations should be available within one hour drive time from population centers in each county. The need for statewide distribution of youth residential crisis capacity should be a high planning priority, as those services are almost non-existent.
4. **Hospitalization:** Distribution and capacity of adult and child psychiatric inpatient beds should be planned so that 90% of Ohioans needing acute BH hospitalization can have access to hospitalization within one hour drive of their home. The need for expanded capacity and distribution – particularly for children's inpatient beds – should be a planning priority.
5. **State Hospitalization:** The role of the state hospital in the BH crisis continuum for non-forensic patients needs to be clarified. Many states have removed state hospitals from having responsibility for acute admissions and invested in building that capacity in community settings. This allows the state hospitals to focus their expertise on people with intermediate and long-term psychiatric hospitalization and rehabilitation needs and incentivizes community hospital settings (general hospitals and private hospitals) to develop capacity for those with greatest acute need.

Recommendation: Each Board region must have basic capacity to collect performance data on its crisis continuum that is aligned with the statewide recommendations for minimal metrics. Reference: recommendations of the Performance Metrics and Data Committee.

Recommendation: Planning for sustainable financing of the BH Crisis Continuum must 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. Reference: recommendations of the Financing Committee.

Appendix A:

Background data from Board Survey and other informants (including the Subcommittee members):

In the Board survey responses, and information provided in focus groups with Boards with different levels of resources, it was clear that there is currently little of 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 is unable to sustain a typical residential crisis services program in its community, and instead has rented an apartment which is available for overnight crisis stays, with on call staffing used on those occasions when the apartment is needed. These creative approaches inform what might be possible in smaller communities.

FINANCING COMMITTEE

Financing Committee

ONE-TIME FUNDING SUBCOMMITTEE

Recommendations – Final Draft

April 2022

Chair: Jeff DeLay, Unison

Members: Eric Morse, Liz Henrich, Megan Burke, Michael Doud

Consultant Support: Ken Minkoff, Hilary Hamlin

The subcommittee has had two meetings, February and March

Committee Objectives and Questions:

The One-Time Funding Subcommittee was formed as a complement to the Sustainability Subcommittee and the Financing Policy and Regulation Subcommittee in order to provide recommendations for how to best utilize access to one-time startup funding for community crisis services, whether provided by OMHAS, Boards, or other one-time funders. within a community crisis system to describe how there could be a funding approach across multiple funding partners that would provide for stable and sustainable operations of the continuum to serve all Ohioans in need, regardless of type of insurance coverage.

Questions to be answered by this Subcommittee include:

1. **What is the best role for local funding (levy or non-levy) in initial investment in developing the local crisis system?**
2. **What is the best corresponding role for one-time funds from OMHAS, distributed through the Boards or regions?**
3. **What types of services can be better supported through contributions from other partners, including but not limited to third party payers?**
4. **What is the business case to support recommendations from responses to these questions?**

Background data from Board Survey and other informants (including the Subcommittee members):

Reports from the Board surveys indicate that there although there has been availability of significant new funding from OMHAS during this biennium for the purpose of developing "crisis stabilization centers", much of these funds have not yet been encumbered. In focus group meetings, many Boards have expressed concerns about how to utilize one-time funding when there is uncertain availability of sustainable funding for ongoing operations after initial investment. Nonetheless, some Boards have made considerable progress in planning and implementing Crisis Centers with Observation and other services in their communities. Subcommittee members reported that in their direct experiences in the Board regions planning Crisis Centers, much of the one-time investment came from local funds, including Board funding (levy and non-levy) as well as funds from other donor partners. The modal approach was for the Board to work with community partners, as well as with OMHAS funds as available, to fund both initial one-time capital investment as well as to provide for five-years of operational funding as a start-up cushion, The hope of these Boards is that five years will be sufficient time for sustainable funding for these programs to be developed through third party payment and other sources. The Subcommittee discussion acknowledged that this approach was both practical and

reasonable in the current environment, but then focused on consideration of whether this is the best overall approach to recommend for one-time start up funding for crisis services.
The following recommendations are based on consensus discussion in response to the questions above, synthesized into a set of actionable steps. The Subcommittee focused specifically on one-time funding for services like Crisis Center with Observation and Residential Crisis Services that require significant capital investment as well as ongoing operational support.

One Time Funding Subcommittee Recommendations:

1. **The Subcommittee supports the need for start up funding to include both capital and start up operations, with provision for five-years of operational support to facilitate eventual sustainability.** However, the Subcommittee recommends that OMHAS and the Boards work together to develop a more systematic plan for dissemination of necessary Crisis Centers and Residential Crisis Services, to better achieve statewide coverage.
2. **The Subcommittee recommends that the "one-time funding" of developing, building, start-up operations of Crisis Centers be primarily supported by OMHAS.** The Subcommittee suggested that current ARPA funding is one potential source of this start up investment. The Subcommittee's recommendation is based on the recognition that Crisis Centers in one county may need function as "hub" services (like Level 1 Trauma Centers) to provide both consultative support and direct access for crisis systems in smaller surrounding counties that may not be able to support their own Crisis Centers. OMHAS start-up funding can facilitate Boards working collaboratively to share this resource collectively rather than having one Board fund and "own' the service unilaterally. The Subcommittee further recommended that each involved Board contributes a portion of the operational funding, potentially based on projected volume of utilization.
3. **The Subcommittee recommends that regardless of the pooled funding mechanism across OMHAS and multiple Boards, that the provider of the Crisis Center or Residential Crisis Services should have – as much as possible – a single program funding contract for state/local start-up and operational funds for the purpose of administrative simplicity, with any need for transfers of funds between Boards handled behind the scenes.** One suggested approach is for the contract to be handled through a "lead Board" using Board collaboration models already in place in Ohio. The "lead Board" would likely be the Board where the Crisis Center is located.
4. **The Subcommittee recommends that other sources of one-time funding should be considered in each Board region, including county funds, foundations, and health systems.** Sustainable funding is recommended to be based on much more substantial third-party payment models. These models are being considered by the Sustainability Subcommittee.
5. **The Subcommittee indicates that there is a business case that can be used with multiple audiences to support both one-time funding and sustainable financing of Crisis Centers.** Community-based BH Crisis Services are both more individualized and provide better value than ED visits and inpatient hospitalizations. Crisis Centers and mobile crisis reduce ED visits and hospitalizations at less than 50% of the cost per person served. Community-based residential crisis services similarly provide stabilization at less than 50% of the cost per bed day of inpatient hospitalization. Lower cost of service provides for increased client engagement in the community while in crisis, and therefore provides better outcomes and better value.
6. **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.**
7. **The Subcommittee noted that additional funders can contribute to services provided and promote sustainability. These additional funders may support the portion of services that are**

relevant to their populations or sites. Examples might include schools, universities, hospitals, the Veterans Administration, and Accountable Care Organizations. The more contributing partners, the less burden on each.

8. **The Subcommittee recommends that the primary role of OMHAS 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.** The Subcommittee noted that some payers (Medicare) may be later to the party and those services may need to be covered in the interim. ***The Subcommittee did not address what would be the right balance or respective roles between local funds and state funds for this purpose.***
9. **The Subcommittee acknowledged that 10 counties do not have levies, and that therefore local funding may be more challenging. The Subcommittee suggested however that those communities may have the option of seeking alternative strategies for funding local contribution to BH crisis services, such as levies just for crisis services, or other county/city contributions.** The Subcommittee suggested that strategic incentives for developing local contribution should be considered, such as matching some state dollars based on local contribution.
10. **The Subcommittee noted that local burden is alleviated because every community does not need to have the full array of services within its borders but may need to contribute to services for its residents that occur in neighboring counties. Funding a full continuum of transportation services using the same multi-payer sustainable funding model is necessary to support this.** Providing state funds for "regional" planning, or pooling Board funds across a shared geography may assist in designing a service array that serves a broader geography; note that "functional regions" for this purpose may have different boundaries from state hospital region for functional access to crisis services in nearby "hubs". Note as well that these issues are being addressed by other Committees.
11. **The Subcommittee clearly recommends that contribution for BH crisis services, whether cash or in kind, is appropriately provided routinely by health systems/hospitals serving those communities.** Those services impact emergency department and inpatient unit operations, and, like ambulance services, should have a framework for routine contribution from hospital system partners.
12. **The Subcommittee did not believe however that law enforcement/first responders were routinely in position to contribute sustainable funding to services beyond those directly provided by law enforcement/first responders themselves. Nor did the Subcommittee believe that SUSTAINABLE funding (vs. startup or capital funding) should be the purview of community foundations and private donors.**
13. **The Subcommittee recommends a more precise delineation of responsibility for otherwise unfunded BH crisis response for out of county services.** Currently, there is variability in how different Board regions approach this issue, and a more consistent and replicable approach is recommended. Even though this is a small volume of cases, it is a relatively significant administrative burden to sort this out, both for Boards and providers (not to mention the people served who may get caught in the middle. ***The Subcommittee did not describe the elements of this more precise definition, but this can be worked on with emphasis that individuals will be served regardless of where they present, and the provider is reimbursed for delivering crisis care.***
14. **The Subcommittee considered different approaches to different audiences for making a "business case". One recommendation involved engaging the Ohio Chamber of Commerce and the Ohio Business Roundtable to develop messaging for employers purchasing health**

plans. Wide dissemination of the ODI Parity Employer Toolkit may support employers in making informed health insurance purchasing decisions that support access to behavioral health care. Another approach involves looking at the advantages for both hospitals and payers of diversion of expensive unnecessary emergency department visits and reducing costly ED boarding. Another approach may be working collaboratively with insurers to illustrate how effective BH crisis services may help them meet target metrics and reduce penalties for unnecessary ED or inpatient readmissions through supporting both diversion and intensive community crisis services.

15. **The Subcommittee further recommended that there are opportunities for MCOs to work collaboratively to utilize their community reinvestment portfolios to invest in the development of BH crisis continua in communities served. Similarly, many hospital systems now also have community investment funds available to promote community health as well as to help them attain payment incentives and avoid payment penalties.** Note that many of these initiatives incorporate flexible funds that can provide return on investment for funding services that address social determinants of health, including housing and transportation.

16. **The subcommittee recommends that the 50% board match for capital funds be eliminated.**

FINANCING COMMITTEE
SUSTAINABILITY SUBCOMMITTEE
Recommendations – Final Draft
April 2022

Chair: Cheri Walter, OACBHA

Members: Molly O'Neill, Lisa Ward, Teresa Lampl, Tom Stuber, Megan Burke; sjackson@crossroads-lake.org; Sandy Hall, Patrick McLean; Kim Fraser; Mark Dunlap, Christina Shaynak-Diaz, Precia Stuby, Doug Day.

Consultant Support: Ken Minkoff, Hilary Hamlin

The subcommittee has had two meetings, February 7 and March 7.

Committee Objectives and Questions:

The Sustainability Subcommittee was formed as a complement to the One-Time Funding Subcommittee and the Financing Policy and Regulation Subcommittee in order to directly address recommendations for going beyond the startup of community crisis services within a community crisis system to describe how there could be a funding approach across multiple funding partners that would provide for stable and sustainable operations of the continuum to serve all Ohioans in need, regardless of type of insurance coverage.
Questions to be answered by this Subcommittee include:

1. **What is the best role for local funding (levy or non-levy) in sustaining the local crisis system?**
2. **In designing an ideal crisis system within any Board region, what funders should routinely pay?**
3. **For each type of service defined under Respond and Stabilize, what is the recommended successful financing across local, OHMHAS, third party, and other funding sources approach?**
4. **What would facilitate engagement of Medicaid MCOs and private insurers through state level and local level action?**
5. **What is the best role for funds from OhioMHAS distributed through the Boards and Region?**
6. **What types of services can be better supported with contributions from other partners, including hut not limited to third party payers?**
7. **What is the business case to support recommendations from responses to these questions?**

Background data from Board Survey and other informants (including the Subcommittee members):

Ohio's vision for its BH crisis system, as articulated in the OMHAS Crisis White Paper, clearly indicates that the system should address the needs of "all Ohioans." This implies that access to the BH crisis system, as for the emergency medical system (EMS) would be supported by all health care payers. That is currently not the case. Reports from the Board surveys indicate that there is no consistent funding mechanism for crisis services across the state. In some Boards, a certain service may be partly supported by Medicaid and third-party payment; in another Board, the same service is totally supported by Board and OMHAS funds. The overall contribution of Medicaid to funding the crisis continuum in Ohio is approximately 30%, which is lower than that reported in other states in the recent Brookings Institution report, in which Medicaid contribution ranged from 40% to over 80% (in Arizona). Medicaid reimbursement policy decisions implemented in 2018 limited coverage for crisis services and promises to add additional crisis services did not develop. Currently, crisis services are supported in largest share by local funds, followed by OMHAS funds, and then by Medicaid, with other third-party contribution

almost negligible. Only a few Boards have other consistent funding partners. Note that using "unmatched" state and local dollars to support services to Medicaid clients that could be eligible to draw down federal match is inherently inefficient. Ohio Department of Medicaid has begun some efforts to create a more comprehensive service package through its OhioRISE initiative, and with the development of funding for MRSS for children. These are promising steps in using Medicaid to fund a full array of necessary services for populations in need.

In addition to the Ohio specific information above, there has been increasing dissemination of information on possible sustainable funding approaches for the recommended continuum of crisis services, including reports that have been released just in the past few months. The SAMHSA report on Best Practices for BH Crisis Services clearly indicates that these services should be regarded through a parity lens and recommends that funding is supported through contribution from multiple payers. The Roadmap to the Ideal Crisis System report specifies the need for an "All-Payer" approach to the Ideal Crisis System. Recent reports on Medicaid funding, billing, and coding for mobile crisis services, describe mechanisms by which states can have the ability to develop Medicaid plans and waivers that provide for the ability to fund services adequately to cover the need for 24/7 capacity, and to maximize federal match in doing so. Further, the SAMHSA Certified Community Behavioral Health Center (CCBHC) model incorporates 24/7 crisis services, including mobile crisis and 988, as a core element of a comprehensive, coordinated, person centered delivery model. Under CCBHC, Medicaid reimbursement is supported by a cost based prospective payment model designed to meet the unique needs within a state. SAMHSA is currently making 2 and 4 year CCHBC Expansion and Continuation grants available to build capacity. All these various reports inform the recommendations of this Subcommittee.

The following recommendations are based on consensus discussion in response to the questions above, synthesized into a set of actionable steps.

Sustainable Financing Subcommittee Recommendations:

1. **Overarching recommendation: The Subcommittee strongly supported the view that sustainable funding starts with viewing BH crisis services through a parity lens. Just as multiple health payers support a continuum of emergency medical services (including adequate payment for facility fees in emergency departments), there should be a similar expectation that sustainable payment for the BH crisis continuum begins with maximizing payment contributions from all possible third-party payers.**
2. **In line with the above, there should be a common set of service definitions and associated billing "codes" or instructions, so that Medicaid and other insurance plans can pay for common services. Further, the Subcommittee recommended that service payment eligibility for BH crisis services be consistent across payers, so that services are not limited because certain plans only reimburse the highest level of licensure. It is necessary to define best practice interdisciplinary service teams, including peers, and provide payment for the service provided by the team, not to try to replicate payment models used for individual therapy or medication visits.** Payment should include the full recommended continuum, mobile and on site services, and a complete array of telehealth options to maximize the comprehensiveness and efficiency of service delivery.
3. **Payment methodology, starting with Medicaid, should use the most recent recommendations from CMS and experiences of other states to develop payment approaches that support the true cost ("firehouse capacity") of BH crisis services, including the true cost of recruiting and retaining skilled staff.** This represents a shift from the historical methodology of relying on

narrowly defined “allowable costs” which causes providers to operate at a loss in delivering BH crisis services.

4. **The Subcommittee recommends consideration of statewide CCBHC implementation using prospective payment opportunities within Medicaid as a comprehensive, coordinated person-centered approach.** Ohio currently has 15 SAMHSA CCBHC Expansion Grantees operating that could be used as a launching point**.**
5. **The Subcommittee recommends that Medicaid be the leader in demonstrating the most innovative approaches to funding BH Crisis services in a sustainable manner, both for the purpose of leveraging federal match, but also to provide direction to other payers.** Medicaid MCOs also have commercial lines of business, so that what starts with the MCO can be a way of introducing new sustainable payment methodologies to commercial payers as well.
6. **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.**
7. **The Subcommittee noted that additional funders can contribute to services provided and promote sustainability. These additional funders may support the portion of services that are relevant to their populations or sites. Examples might include schools, universities, hospitals, the Veterans Administration, and Accountable Care Organizations.** The more contributing partners, the less burden on each.
8. **The Subcommittee recommends that the primary role of OMHAS 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.** The Subcommittee noted that some payers (Medicare) may be later to the party and those services may need to be covered in the interim. ***The Subcommittee did not address what would be the right balance or respective roles between local funds and state funds for this purpose.***
9. **The Subcommittee acknowledged that 10 counties do not have levies, and that therefore local funding may be more challenging. The Subcommittee suggested however that those communities may have the option of seeking alternative strategies for funding local contribution to BH crisis services, such as levies just for crisis services, or other county/city contributions.** The Subcommittee suggested that strategic incentives for developing local contribution should be considered, such as matching some state dollars based on local contribution.
10. **The Subcommittee noted that local burden is alleviated because every community does not need to have the full array of services within its borders but may need to contribute to services for its residents that occur in neighboring counties. Funding a full continuum of transportation services using the same multi-payer sustainable funding model is necessary to support this.** Providing state funds for “regional” planning, or pooling Board funds across a shared geography may assist in designing a service array that serves a broader geography; note that “functional regions” for this purpose may have different boundaries from state hospital region for functional access to crisis services in nearby “hubs”. Note as well that these issues are being addressed by other Committees.
11. **The Subcommittee clearly recommends that contribution for BH crisis services, whether cash or in kind, is appropriately provided routinely by health systems/hospitals serving those communities.** Those services impact emergency department and inpatient unit operations, and, like ambulance services, should have a framework for routine contribution from hospital system partners.

12. **The Subcommittee did not believe however that law enforcement/first responders were routinely in position to contribute sustainable funding to services beyond those directly provided by law enforcement/first responders themselves. Nor did the Subcommittee believe that SUSTAINABLE funding (vs. startup or capital funding) should be the purview of community foundations and private donors.**
13. **The Subcommittee recommends a more precise delineation of responsibility for otherwise unfunded BH crisis response for out of county services.** Currently, there is variability in how different Board regions approach this issue, and a more consistent and replicable approach is recommended. Even though this is a small volume of cases, it is a relatively significant administrative burden to sort this out, both for Boards and providers (not to mention the people served who may get caught in the middle. ***The Subcommittee did not describe the elements of this more precise definition, but this can be worked on with emphasis that individuals will be served regardless of where they present, and the provider is reimbursed for delivering crisis care.***
14. **The Subcommittee considered different approaches to different audiences for making a "business case". One recommendation involved engaging the Ohio Chamber of Commerce and the Ohio Business Roundtable to develop messaging for employers purchasing health plans.** Wide dissemination of the ODI Parity Employer Toolkit may support employers in making informed health insurance purchasing decisions that support access to behavioral health care. Another approach involves looking at the advantages for both hospitals and payers of diversion of expensive unnecessary emergency department visits and reducing costly ED boarding. Another approach may be working collaboratively with insurers to illustrate how effective BH crisis services may help them meet target metrics and reduce penalties for unnecessary ED or inpatient readmissions through supporting both diversion and intensive community crisis services.
15. **The Subcommittee further recommended that there are opportunities for MCOs to work collaboratively to utilize their community reinvestment portfolios to invest in the development of BH crisis continua in communities served. Similarly, many hospital systems now also have community investment funds available to promote community health as well as to help them attain payment incentives and avoid payment penalties.** Note that many of these initiatives incorporate flexible funds that can provide return on investment for funding services that address social determinants of health, including housing and transportation.

FINANCING COMMITTEE

FINANCIAL POLICY BARRIERS SUBCOMMITTEE

Recommendations – Final Draft

April 2022

Co-Chairs: Alicia D. Smith, Peg's Foundation; Brian Stroh, M.D., Netcare Access

Members: David Ciccone, Michael Doud, Joan Englund, Michael Krause, Teresa Lampl, Lynne Lyon, Angi Lee, Molly O'Neill, and Cheri Walter

The subcommittee met on February 23rd, March 16th, and April 20th .

The Financial Policy Barriers Subcommittee was formed to support the Financing the Continuum Committee of the Ohio Crisis Task Force and provide recommendations for improvements in Medicaid, Medicare, other public, and commercial payment policies.

Questions to be answered by this Subcommittee include:

1. What regulatory changes would facilitate improved funding collaboration to improve crisis system performance?
2. Review current billing and financing policies for the various Respond and Stabilize services.
    a. What types of services can be supported in whole or in part by third party payment?
    b. What are the pros and cons of financing mechanisms, such as fee for service vs. cost-based day rate?
    c. How can payment methodologies better support 24-hour capacity and rural challenges?
    d. Should payment methodologies be consistent across multiple types of payers
3. What is the business case to support recommendations from responses to these questions?

In answering the questions, the Subcommittee considered and kept adherence to the following Vision and Assumptions of the Financing the Continuum Committee:

Committee Vision: To identify the ideal funding mechanism(s) to develop and sustain a crisis system for people experiencing MH and/or SUD crises that is client centered, equitable, trauma informed and available 24/7 across the lifespan by anyone needing to access it in Ohio and includes a "core set of services."

Committee Assumptions:

1. **Start-up Funding:** To reach this vision, there will need to be "start-up" investments in both services and capital. Reference: recommendations of the One-Time Funding subcommittee.
2. **Innovative Financing Strategies:** Financing strategies and policies, as well as payment methodologies and rates, and universal coding (payment) mechanisms, need to be designed

to be applied in an innovative manner across multiple funders, and modified, developed, or made obsolete to help us achieve sustainable funding for this vision. (

3. **Participation of Multiple Funders:** Sustainable funding cannot be achieved through a single funding source. Multiple sources of funding include OMHAS, Medicaid, Medicare (including Medicare Advantage) Medicaid MCOS, commercial third-party payers, Boards, and other federal, state, local and private funders.
4. **Parity:** The principle of parity is essential to the funding of an ideal crisis system. Parity includes the access to a "core set of services" and a universal "standard of care" for 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 how we approach funding for medical crisis response, including having a consistent standard of care across Ohio.
5. **Technology Facilitated:** Facilitating and encouraging appropriate use of technology (including, but not limited to, telehealth) for the delivery, of services should be a consideration when developing recommendations.
6. **Data-Driven:** Financing policy should be 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.

RECOMMENDATIONS

Recommendations are organized as **Near-Term** (achievable within the next year) or **Longer-Term** (i.e., can be planned and considered simultaneously with near-term recommendations but not likely achievable until 1-3 years out).

A. Recommendations for Near Term Achievement

1. Develop OhioMHAS certification regulations for services that comprise the crisis continuum. The regulations would assist in clarifying provider, practitioner (including peers), and service requirements as well as understanding implications for documentation, information technology and exchange, and quality and performance monitoring. The draft regulations could serve as the foundation for an OhioMHAS Crisis Services Policy Roadmap. The Policy Roadmap should originate with OhioMHAS out of recognition of the breadth of services funded by the agency versus the subset of crisis services that may ultimately be Medicaid covered.
2. Develop a comprehensive cross-agency data set (i.e., Medicaid claims and encounter data, OhioMHAS data, ODH Ohio Opportunity Index data, etc.) to permit identification and analysis of priority Medicaid populations and their attributes (health conditions and demographics), service utilization, and total cost of care. The data will inform establishment of a business case and priority plan for crisis services as well as provide a benchmark from which to measure changes in service utilization, cost, and experience of care resulting from implementation of crisis system improvements.

3. Explore mechanisms for sustainable funding of services across the crisis continuum, initially focusing on crisis call center, mobile crisis, and crisis receiving/stabilization services. Specifically, the state should:
    a. Explore Medicaid and other payer options for coverage of call center services, including clinical/support services and administrative activities associated with call center operations. This includes identification of states that utilize similar call center services for reasons other than crisis.
    b. Explore the feasibility of mobile crisis coverage (i.e., mobile crisis team for adults and children, mobile co-responder teams) through Title XIX, Section 1947 of the Social Security Act, which authorizes a state option to provide qualifying community-based mobile crisis intervention services for a period of up to five years (April 1, 2022 through March 31, 2027).
    c. Develop a straw model to understand financing and payment implications for existing, under development, and planned crisis receiving/stabilization centers, including BH urgent care. The straw model would define, as appropriate for each center and associated service area, priority populations to be served (i.e., high, moderate, low risk); the total cost of care for priority populations; licensure and credentialing requirements for organizations, clinicians and service practitioners; services and supports to be provided; roles and responsibilities of core staff (particularly clinicians/practitioners); and planned performance outcomes and indicators.
4. Develop a straw model for sustaining certified community behavioral health centers (CCBHCs) using prospective payment systems (PPS). The model would be informed by experiences in other states, particularly where CCBHC services are Medicaid benefits.
5. Identify and explore financing and payment methodologies for additional integrated care models and other evidence-based or emerging practices in integrated care delivery. The review of models should consider implications, opportunities, barriers, and incentives for use and exchange of health information, including, but not limited to, use of health information exchanges (HIEs).
6. Mental health peer support services are not broadly covered under Ohio Medicaid. The recommendation is to amend Medicaid rules to establish payment rates and issue coding and billing instructions for payment of mental health peer support services.
7. Provide instructions for financing that permit the certification and delivery of crisis services to individuals with co-occurring MH/SUD conditions.

B. Recommendations for Longer-Term Achievement

1. Explore mechanisms for sustainable funding of additional crisis services (i.e., targeted mobile crisis response, residential crisis services, community-based crisis intervention programs).
2. Design and implement alternative payment methodologies to permit a range of rate setting approaches for effective coverage of all elements of the core BH crisis continuum. These include per diem rates, case rates, episode-based payments, and other methods to ensure payments for different delivery modalities (e.g., firehouse model) and settings (home/natural settings, office, facility/institutional, etc.).

3. Pursue federal authority to develop and implement payment regulations for coverage of services in mental health organizations with greater than 16 beds.
4. Pursue regulatory and payment changes to ensure and maximize third-party reimbursement for the full continuum of crisis services across Medicare and commercial insurance plans.
5. Develop regulations, policies, methodologies and rate structures to support 24-hour "firehouse capacity" in all parts of Ohio, as well as to promote equity and inclusion through addressing challenges in rural geographies and other underserved populations.
6. Develop guidance on mechanisms to facilitate information sharing between crisis service providers as well as information sharing with important partners such as families, while maintaining compliance with HIPAA, 42 CFR Part 2, and state law.
7. Develop mechanisms for providing guidance on minimizing administrative burden for obtaining payment, by reducing or eliminating unnecessary documentation.
8. Explore removing the requirement for in OAC 5122 for the Board to prescreen admissions to the state hospitals. Funds currently use to support this function could potentially be used to for other crisis functions such as mobile response out in the community.

CONNECT COMMITTEE

Connect Committee

QUALITY OF CARE SUBCOMMITTEE

Recommendations

April 2022

Chair: Tony Coder – Executive Director, Ohio Suicide Prevention Foundation

Members: Cheri Walters – OACBHA, Thom Craig – Peg's Foundation, Danielle Sotcan – Coleman Health – Director of Crisis Support Services, Megan Burke – MHAC – State Program and Policy Director, Shayna Jackson – Crossroads Health, Stacey Frohnapfel-Hasson - OhioMHAS

Consultant Support: Steven Hedgepeth

Subcommittee Approach

- In the midst of the logistical changes as 988 rolls out, we need to make sure we identify quality benchmarks that keep the focus on serving those who are impacted.
- Benchmarks should be applicable to all call centers, not just 988.
- Identify consistent data elements across all call centers.

Potential recommendations

1. **Call Center Taskforce**

The sub-committee recommends the convening of a Crisis Call Center taskforce for on-going support as the state's call center infrastructure continues to evolve. Potential stakeholders should include:

- Call Center Programs – both 988 and other crisis call centers
- OhioMHAS
- ADAMH Boards
- Law Enforcement
- 911/PSAP Centers
- Youth and Adult Mobile Response, including Mobile Response and Stabilizaton Services (MRSS) for youth

2. **Training**

The sub-committee recommends a core set of trainings that are accessible to all call center staff. There is currently a CARELINE Training Series that is available for all call center staff.

https://csw.osu.edu/continuing-education/2022-careline-training-series/

- The CARELINE training series was developed by OhioMHAS with OSU.
- Trainings have been developed to support all crisis lines. It is accessible to all "carelines" (includes 988 and other call center providers)
- All trainings are available on-demand and will be made into webinars to support new carelines onboarding of staff

Additions to the current CARELINE trainings could include:

- Core OnBoarding Modules (e.g., Call Center 101, etc.)
- Personality Disorders
  - Need additional direction to support call center staff to "efficiently" move along calls that require a warm contact
- Nuero-diverse (TBI, Autism, etc.) children and adults
- Eating Disorders
- LGBTQ+
- Older adults' unique needs
- Best practices in working with 911 centers
- Best practices in working with youth Mobile Response and Stabilization Services (MRSS)

Discussion Items

Is there a pathway for call center staff certification after completion of each of these modules. SUGGESTION: On OSU's Continuing Education webpage, they have 2 certificate programs (Building Addiction Knowledge for Frontline Workers and Serving Veterans and Their Families). Given OSU has an existing format for certificate programs, I wonder if OSU would be willing to package core crisis trainings (with input from perhaps this subcommittee or other Connect subject matter experts) and offer a certificate – much like they do with the two certificates they already established.

3. Certification Standards

The sub-committee is recommending that certification standards be developed. The sub-committee is not spelling out exactly what the statewide standard should be but recommends that quality standards be grounded in national models. These standards should encompass mobile team responders as well. These standards should be inclusive of:

- Answer Rate
- Staff Experience
  - Qualified call specialists - NSPL has training requirements – make them available to all crisis centers
  - Having a licensed clinician available on every shift, able to step in or consult for caller needs
- Core Training Requirements
- Technical Capability
  - Real-time Messaging Capability (ie; Text)
  - Common data platform that allows for sharing across regions
  - Interoperability across 911, 211, etc.

National Standards that could be utilized as a base:

- **American Association of Suicidology** – most developed standards.
- **National Suicide Prevention Lifeline** – current 988 standard
- **SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practices Toolkit**
- **Council on Accreditation** (COA) - oanet.org/2019/07/joining-forces-3-opportunities-for-better-law-enforcement-human-services-collaboration/
- **Commission on Accreditation of Rehabilitation Facilities** (CARF) They have a section for crisis call centers with 13 objectives. They also share the best practice

agencies. http://www.carf.org/search.aspx?searchtext=crisis%20call%20center&category=websitesearch
- **Utilization Review Accreditation Commission** (URAC) – Some standards that relate to "Contact Centers."
- **Joint Commission** – No standards yet relate to call center operations.

4. Quality Metrics

The sub-committee recommends a core set of quality data points be developed. These metrics should apply equally across all call centers with some additions for centers with mobile teams. Metrics should include:

- Base Call Center Utilization data points
- Follow-Up
- Disposition
- Appropriate Triage
- Appropriate Response based on acuity
- Law Enforcement intervention based on calls
- Use of Alternatives
- Core Customer Service Metrics
  - Satisfaction Survey
  - Secret Shopper Calls

Additional Considerations

Ideal Characteristics of all call centers

- Caller centered
- Open 24/7
- Answers a call within five rings
- Takes the time to resolve the crisis or warm hand off to next caregiver
  - Refine how this works for each call center and the services being used, across communities/counties
- Can receive texts
- Can send someone if needed
- Can help family or concerned friend too
- Can resolve or refer food, housing, escape from violence
- Can check back to follow-up to see things are still stable

Components of a quality call center

- Good technology- data base of referrals, can tell when counselors are free or case managers
- Located in a safe building
- Provided with training that is universally accepted across the state
- Can work from home or remote location
- Qualified call specialists - NSPL has training requirements – make them available to all crisis centers
- Has strong internet and back-up systems
- Incentives such as pay differential for overnight shifts

- Can help track types of calls statewide such as suicidal ideation
- Safe, Secure Location
- State wide technology
- Interoperability with 211, 911, and other emergency hotlines
- Translators, interpretation services

Types of Certifications for centers

- 988 lifeline
- Develop a call center for MH and addiction response certification

Metrics that could support greater quality

List the problems

- No one answers
- They don't help with the problem
- We have no way of knowing which calls are mental health
- We have no idea of volume of need for incoming services
- 911 handles all the mental health or addiction calls

Connect Committee

LINKAGES SUBCOMMITTEE

Recommendations

April 2022

Chair Cheri Walter, CEO, Ohio Association of County behavioral Health Authorities

Members: Candace Pallante, Duane Piccirilli; Scott Rasmus; Tony Coder-The Ohio Suicide Prevention Foundation; Luke Russell; Kenneth Coontz Jr.; Carrie Wirick; Meg Griffing; Christina Shaynak-Diaz; Sue Villilo; Joyce Calland

Consultant Support: Steven Hedgepeth, Ken Minkoff

The subcommittee met on March 31, 2022 – followed by meeting notes and gathering of comments via email for the following three weeks.

Questions to be answered by the subcommittee include:

1. **How will Ohio's crisis call lines – 988, other crisis lines (211, hotlines and warmlines) and 911 be coordinated to support Ohioans in need.**
    - Recommend that the local ADAMH Boards 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, possibly quarterly.
    - Recommend the creation of Memoranda of Understanding among the crisis stakeholders listed above to ensure that all organizations are on the same page and have formal agreements for working cooperatively.
    - Recommend that the state and communities value all the crisis lines as a crisis safety network working collaboratively as a team to address crisis calls/texts/chats across the state. All crisis lines will be serving the same clients. This mean all lines are equally important to address suicide; mental health; those who present with addiction issues; who may be in crisis; need information and referral; and others who may be in crisis due to a different medical emergency. If competition between call center providers occurs, this will undermine the ability of the crisis system to save lives, get people into recovery, and link callers to resources.
    - Recommend that a free flow of information occur, 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. Technology should be considered that supports this accessibility of information across the crisis care network. Within this goal, the state and communities must consider applicable laws, codes of ethics, ethical principles and ethical theories in addressing what may be best for callers and clients.

2. **How will technology be employed to ensure seamless support for Ohioans who call/chat/text?**

    - Systems must be in place, at least temporarily, to support callers who have ported their phone numbers from other Ohio counties and from other states. 211 centers have the technology to go to the closest tower, determine if 988 is able to use the same system. The 988 call centers should work with any community call center, if needed, to ensure that warm handoffs take place. Most hotlines can call forward without dropping the call. Ohio needs to push for geolocation of 988 calls and texts to be in place as soon as possible.
    - Ohio's 988 call centers and other crisis call lines should share technology to enable rapid transfers, shared resources at every level and shared information to the extent possible. The NSPL/988 system will allow for other systems to be connected, "in about three years," according to Vibrant, the NSPL coordinating organization.
    - It has already been decided that the online resource guide that will be developed for the NSPLs/988 will also be available to all crisis lines in the state. We must determine what other technology resources, from 988 or already in local communities, that can be made available to all crisis lines in Ohio, i.e. iCarol software. The funding needs to be considered for these resources and how to appropriately support the cost.
    - Build in multiple independent redundancy and accessibility checks on such things as calls, texts and chat answer rates. Are the call center providers doing this to ensure their own services? A second level of call redundancy would be an organization that is hired to randomly call and evaluate the answer rate and the quality of the line services. We need to remember the callers may be at risk of death, so ensuring that the crisis line system is operating at the highest level possible is vital.

3. **How will we ensure that 988 lines will link with initial crisis services?**

    - The call center providers (988 and other crisis lines) and the county ADAMH board must work collaboratively with all their local crisis services stakeholder organizations.
    - As soon as possible the online Resource Directory must be live and available to all call lines to support the sharing of quality referrals. The directory must be updated constantly to ensure that all 988 and other call lines have a reliable and current statewide list of all local crisis contacts. This must 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 who calls 988 prior to geolocation going into effect.
    - Having updated resource guides and relationships between the 988 line and other crisis resources is key. This may also require periodic meetings between crisis lines and their initial crisis resources. The NSPL/988s and other local line resources should work together to develop a protocol on how callers should be handled. For example, NSPL/988s should answer calls and address any crisis needs immediately, but then refer to a more local line, if there is one in the caller's area, for ongoing follow-up. Crisis call center providers need to have a protocol in place for this to work smoothly to benefit the caller in crisis.

- Resources guides and service relationships need to be constantly reviewed and considered to make sure everything is current and at a high level of detail. The crisis safety net focus needs to be the theme for all lines working together to address any caller that may be at risk.

4. How will the 988 National Suicide Prevention Lifeline network be sustained beyond initial state funding for year one of 988 implementation?

This is an addendum to the overall Sustainability Committees recommendations so some of this is overlap, but it was felt that it is important to have the same basic principles of funding.

- Overarching recommendation: The Subcommittee strongly supported the view that sustainable funding starts with viewing behavioral health crisis services through a parity lens. Just as multiple health payers support a continuum of emergency medical services (including adequate payment for facility fees in emergency departments), there should be a similar expectation that sustainable payment for the BH crisis continuum that begins with maximizing payment contributions from all possible third-party payers.
- The Subcommittee noted that additional funders can contribute to services provided and promote sustainability. These additional funders may support the portion of services that are relevant to their populations or sites.
- The Subcommittee acknowledged that 10 counties do not have levies, and that therefore local funding may be more challenging.
- Recommendations for funding of 988 crisis call centers:
    - Just as Ohio funds 911, we recommend a statewide, ongoing fund to operate 988 call centers. As is done with 911, we recommend a monthly fee on cell phones/VOIP phones/landline phones/any other telephonic device.
    - If a call center has a national call center certification, OhioMHAS should utilize deemed status, so that call centers can save dollars on having to prepare for and pay for multiple certifications.
    - Identify diverse funding sources that will allow for sustainable, collaborative funding of 988 operations (local, state, Medicaid, hospitals, private funds).
    - When engaging elected officials on funding, consider providing call data to help officials understand the number of Ohioans served. Though we can't quantify how much it costs to save one life, we can share data that will help narrate this ask.
    - Consider a fee that also funds some of the responses to crisis needs.

Excerpted from the 988 Implementation Plan (SAMHSA/Vibrant, Jan. 21, 2022):

Adequate and Diversified Funding for Lifeline Centers

A key planning value for Ohio's 988 planning process has been to identify and secure diversified and sustainable funding for Lifeline centers that will answer 988 calls, chats, and texts. These efforts have focused on meeting the National Suicide Prevention Lifeline and SAMHSA's two recommended milestones related to funding for the 988 transition:

1) By the end of Phase 1 (6/30/22), (a) identify dedicated funding in place to help support Ohio Lifeline centers in handling 988 crisis contacts and follow-up calls in meeting the increased volume/costs in the early months of 988; and (b) develop a plan to leverage funding and partnerships to support the full projected costs of handling 988/Lifeline contacts and providing follow-up.

2) By the end of Phase 2 (6/30/23), secure and sustain a diversified set of funding sources to support Ohio's Lifeline centers in effectively handling 988 crisis contacts and follow-up calls, including expected year-over-year volume increases.

988 funding strategies being explored. Although Ohio does not yet have a diversified and sustainable funding stream in place to support 988 services beyond July 1, 2023, significant work has been completed during the planning process. Brief updates on each of the planned or potential funding streams are noted below.

- *Raising 988 related fees from telecommunication users*. The opportunity to increase telecommunication fees as a mechanism for funding 988 in Ohio has been acknowledged, and further discussions to fully consider the option are anticipated in efforts to deliberate all potential mechanisms for permanent, sustainable financing.
- *Medicaid reimbursements*. Ohio's Department of Medicaid has been an active partner in the 988 planning process over the last six months. However, high demand by Ohioans for existing Medicaid funding makes it unlikely that Medicaid administrative funding will become a significant feature of Ohio's 988 funding system.
- *Mental health block grant funds*. Mental health block grant funding, including COVID Relief MHBG, will be used for a portion of startup costs in the first 18 months, prior to identifying sustainable funding streams.
- *Direct engagement with State legislative budget committees for 988-specific funding.* As noted above, Committees of Ohio's General Assembly have engaged on this issue in partnership with the Administration and other stakeholders. Because these discussions are ongoing, additional information will be shared with Vibrant as decisions are made.
- *SFY 2024-25 Ohio Biennial Operating Budget.* As noted, Ohio will consider the possibility of including funding for 988 growth and operating needs in the next state biennial operating budget, which is anticipated to be enacted in June 2023.
- *Partnerships with stakeholder groups who may have the ability to contribute to 988 resources (e.g. United Way/211, private insurers, hospitals, philanthropic organizations)*. Ohio has taken a partnership approach to planning for 988 implementation and will continue to engage these stakeholder groups as partners in the crisis care system. It is unlikely that they will contribute significant funding for answering 988 calls, chats, and texts as their efforts to date have focused on support and shared advocacy for providing crisis services. However, these partnerships are important and will be pursued as hospitals and private insurers, etc. benefit from broad access to effective crisis diversion services. Local funders can be incentivized to invest and support capacity building.

- *Other sources Ohio has identified.* Ohio has leveraged funding from the American Rescue Plan Act (ARPA) to support immediate technology needs and to provide some state-level support for 988 operations and capacity-building during the first year of operation.

Connect Committee/988 Implementation Planning Committee

MARKETING SUBCOMMITTEE

Recommendations

April 2022

Chair: Stacey Frohnapfel-Hasson, OhioMHAS

Members: Lorie Altwater, Megan Burke, Tara Consolino, Katie Dillon-Luli, Daniel Eakins, Tiandra Finch, Liz Henrich, Soley Hernandez, Sandra Keyes, Kathryn Poe, Janet Shaw, Keiko Talley, Sarah Thompson
OTHERS FROM CONNECT???

OhioMHAS: Angelika McClelland, Lindsay Deering
Consultant Support: Kirsten Thompson, PIRE

The subcommittee met on March 31, 2022 – followed by meeting notes and gathering of comments via email.

Committee Objectives and Questions:

Marketing efforts for 988 call centers and others are critically important because call centers serve as one of the main entry points 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 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.

A Marketing Subcommittee of Ohio's 988 Planning Committee was formed in May 2021 and was charged with creating an initial plan for marketing 988 in the state. The Marketing subcommittee met biweekly until September 2021 and then monthly through October 2021. The committee has discussed key messaging for 988, priority audiences for 988, and ideal communication channels based on the populations to be reached. The priority audiences identified to date have included crisis system partners, the general public, people with lived experiences and their family members, African Americans, BIPOC, non-English speakers or English as a second language groups, LGTBQ+, veterans, youth, young adults, rural/Appalachian, and adult men. Work in this area is ongoing.

SAMHSA, Vibrant and the National Alliance for Suicide Prevention have begun to release 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.

The primary question to be answered:

What are the key messages we want to use in Ohio for behavioral health crisis calls and supports?

Potential recommendations:

1. **The subcommittee recommends that OhioMHAS and behavioral health crisis system partner representatives collaborate (i.e., Marketing subcommittee) to complete the following:**
    - Identify and engage a vendor agency for 988 public relations as a point of contact to work with Vibrant Communications Team, along with a state-level 988 administrator.
    - Engage target audience focus groups within state or embarked on other strategies for securing feedback and input on message effectiveness for target audiences
    - Finalize customization of national level messaging materials
    - Secure state level funding for public messaging asset creation, asset update, and dissemination for each dissemination channel
    - Finalize messaging for how 988 aligns/embeds with state resources (e.g. state crisis lines not affiliated with 988)
    - Develop a plan for tracking metrics and public messaging campaign impacts.

2. **The subcommittee recommends that the following areas of message development are completed before April 1, 2023, for a campaign launch in July 2023.**
    - Key goals of a statewide 988 messaging campaign
    - Priority audiences for 988 messaging and/or currently unserved populations to prioritize for messaging efforts
    - Key message themes to focus audiences within the state
    - Key public messaging channels for 988 messaging dissemination.